PRESIDENT'S COMMISSION ON SPECIAL EDUCATION

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ASSESSMENT AND IDENTIFICATION

TASK FORCE HEARING

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Courtroom of Borough Hall

Brooklyn, New York

Tuesday, April 16, 2002

8:10 a.m.

APPEARANCES:

CHAIRMAN JACK FLETCHER
COMMISSIONER ADELA ACOSTA
COMMISSIONER TERRY BRANDSTAD
COMMISSIONER ALAN COULTER
COMMISSIONER FLOYD FLAKE
COMMISSIONER NANCY GRASNICK
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COMMISSIONER BOB PASTERNACK
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COMMISSIONER CHERIE TAKEMOTO
COMMISSIONER KATIE WRIGHT

P R O C E E D I N G S

DR. FLETCHER: We will begin with a welcome from Brooklyn Borough President Marty Markowitz.

MR. MARKOWITZ: Thank you very much. I am sorry about the heat. Who would expect on April 16th the weather we have been having the last few days. We are at the mercy of the building across the street, when they put it on, that's when we get air conditioning. We will, hopefully, try to make it as comfortable possible.

May I welcome you to Brooklyn, USA, the heart of America. Good morning, Chairman Fletcher and the members of the President's Commission on Excellence in Special Education.

There is perhaps nothing more important than ensuring that children with disabilities are afforded every opportunity to receive a high quality level education. Educating all students including those with disabilities is the key goal of New York City Public School System. In recent years the system has undertaken important reforms

in the delivery system for its disabled students. These reforms embrace the Individuals with Disabilities Education Act which emphasizes that students with disabilities shall be held to similar standards as their nondisabled peers in the least restrictive environment to suit each students needs.

I applaud the Central Mission Study comprised by the President's Commission on Special Education programs with the goal of recommending policies to improve special education services throughout America. I am confident today's panel of expert witnesses will provide useful testimony and guidance to enhance current conversation on ideas for reauthorization. I also believe their insights will ultimately serve as a basis for the Commission's final recommendation to President Bush on ways to strengthen, even improve, special education in the nation's public schools.

Thank you again for coming to Brooklyn and for your tireless efforts in the important area of public education policies. Thank you.

DR. FLETCHER: Thank you, Mr. Markowitz. We very much appreciate the opportunity to be with the citizens of New York in this wonderful facility, air conditioning or no air conditioning.

I am Jack Fletcher, I am the Chair of the Assessment and Identification Task Force of the President's Commission on Excellence in Special Education, and I welcome you all to our meeting. The focus of hearing today is the identification of children with high incidence disabilities.

Before we get started, I want to briefly describe to you the mission and activities of the Commission. President Bush established this Commission last October to collect information and to study issues related to federal, state and local special education programs. The Commission's ultimate goal is to recommend policies to improve the educational performance of students with disabilities so that no child will be left behind. The no child left behind message has become a familiar and important one. It is the guiding

principle of the newly reauthorized Elementary and Secondary Education Act that now comes into play with the work of this Commission.

Why? Because children with disabilities are at the greatest risk of being left behind. The Commission's work is not designed to replace the upcoming Congressional reauthorization of the Individuals with Disabilities Education Act, but rather, the report we produce and issue this summer will not only provide vital input into the reauthorization process, but also to the national debate on how to best educate all children.

The Commission and this Task Force has held hearings in Houston, in Denver, Des Moines, Los Angeles and Coral Gables, Florida. We have looked at issues such as parental involvement, teaching quality, accountability, research and funding and cost effectiveness. Our topic today is a very important one. Effective identification of children with high incidence disabilities is one of the most complex issues in special education. While some children are overidentified or

misidentified for special education services due to racial, cultural or linguistic factors, other students who need services are not identified.

In order for our public schools to truly serve all students and ensure that no child will be left behind, we have to develop better methods of screening and identifying high children with incidence of disabilities. African-American students, in particular, are more likely to be overidentified with high incidence of disabilities, for example, while African-American students represent 16 percent of public school enrollments, they constitute 21 percent of the total enrollments in special education. Some school systems have recently taken important steps to improve identification of students.

Here in New York City, the Board of Education and the U.S. Department of Education reached agreement in 1997 allowing the City's school system to significantly reduce the number of inappropriate and disproportionate referrals of African-Americans, Hispanics and English-deficient

students student. The schools did this through the increased use of remedial and pre-referral intervention programs. The U.S. Department of Education Office of Civil Rights is awaiting further data from the Board to confirm the success of these programs.

Educators and parents need to be aware and understand the range of factors that influence identification. These factors include teachers training, teachers referral practices, funding, parents educational levels, household income, race, class size, the categories of services as defined by IDAE, crime rates in schools and urban, suburban and rural environments. This an outcome-oriented Commission that is eager to hear from you. We need your suggestions. Tell us about what works.

We will have a public comment period this afternoon to ensure that you have a chance to provide us with input. If you want to provide more input, we are open to cards and letters and e-mails. Thank you for your interest in our work. We will now begin today's hearing.

The first witness is Dr. Harold Levy, the Chancellor of the New York City schools, who will testify about the experience of the system in 1998 OCR Agreement for subsequent reduction in over-referrals of minority students in special education. On May 17, 2000, the Board of Education of the City of New York unanimously voted to appoint Harold O. Levy as Chancellor. Mr. Levy, a corporate attorney and a proud alumnus of the New York City Public School System has served as an Interim Chancellor since January 2000.

Mr. Levy has a long and distinguished career. Prior to his appointment as Chancellor, he served as Director of Local Compliance for Citi Group, and he was also an appellate attorney at the U.S. Department of Justice Civil Rights Division and was affiliated with the New York law office of Skadden Arps, et al. Mr. Levy has devoted much time and energy to education, particularly the New York City Public School System. In 1995, he was asked by the Chancellor of the New York City schools to serve as Chairman of the Commission on

School Maintenance and Facilities Reform. In March 1997, he was elected by the New York State Legislature to serve as a member of the Board of Regents. The Commission looks forward to Mr. Levy's testimony.

Mr. Levy.

MR. LEVY: Thank you, Chairman Fletcher.

Good morning, ladies and gentlemen. I had the privilege of being with you, as some may recall, in Houston, and enjoyed that very much. I think I got to understand while I was there a sense of what your business is and the seriousness of your purpose. I, accordingly, have tailored my remarks to make very specific recommendations so that they may be considered as you write your report.

I want to thank you for the opportunity to discuss the important issue of special education with you. As head of the largest school system in the country, I hope that our experience will be useful to the Commission and to the school

districts facing many of the same issues. New York City, as you know, has budget of between 11 and 12 billion dollars. We have 1,100,000 children in the system.

The next-largest systems, Chicago and Los Angeles, have 600,000 and 400,000, so the New York City system is by leaps and bounds the largest. What you will see is that the problems that arise in any of these federal programs tend to arise more pointedly here and tend to be more visible. The Individuals with Disabilities Act, the IDEA, has helped to provide a high quality education for literally thousands of disabled children in New York City and should be praised for many of its accomplishments.

Let's me also say that I have a personal interest in this for the reason that I had a sister who was in the New York City School System before the IDEA; indeed, before many of the special ed improvements that have taken place. She died before I was born of polio. And the less than tender mercies of the New York City School System

were something that my family lived with as a scar for many years, so this is an area that I feel a personal -- a strong personal view on. I think the IDEA has raised the level, the quality of education for children who otherwise would not have had a chance, and has done truly important work. However, I am equally passionate about where it has not served the educational interests of disabled students well and where it needs to be reexamined.

The IDEA secured services for students with disabilities where previously no such guarantee existed. Having ensured the provision of services, it refocused on the location of those services in the least restrictive environment. IDEA has been overwhelmingly successful; however, there are some negative consequences that I think should be addressed in the upcoming reauthorization. I want to make clear that I support the statute, that I think it is a strong statute, and that what we are talking about today are areas of improvement.

Let me begin. First, the criteria for

determining the existence of a disability are inadequate within the current IDEA framework, and in my judgment, contribute to misidentification and overrepresentation. The reauthorization must address more rigorous eligibility criteria.

IDEA has led to an ever increasing percentage of students being classified as disabled. The structure of IDEA provided powerful incentives to schools to classify students as disabled as a means of securing increased funding. In their quest to access additional revenues, school districts created overly broad criteria for eligibility for special ed services. This resulted in the segregation of many low performing students in special education classes. Additionally, some enterprising parents have taken advantage of minor procedural flaws within the system in order to secure special education services in private schools.

There are a number of areas of disability that are clear-cut, often medically diagnosed and the subject of clinical subjectivity.

For example, there is the far less clinical judgment involved in determination of deafness, blindness, orthopedic impairment, autism than in such areas as learning disability and emotional disturbance, LD and ED. It is no surprise that the vast majority of students classified as disabled are those are with relatively mild disabilities or, indeed, the subject of subjective clinical judgments and would, I believe, be better served by intervention and prevention programs in general education.

To address misidentification, we have adopted the application of rigorous eligibility criteria for classification as learning disabled and emotionally disturbed. Two classifications there were often broadly defined and resulted in overrepresentation. Currently learning disabled represents approximately 49.4 percent, and ED, emotionally disturbed, represents 12.6 percent of the entire special ed population.

While IDEA regulations state that the term "emotionally disturbed" does not apply to

children who are socially maladjusted, there appears to be a predisposition in the law to classifying students who exhibit any social maladjustment. While 85 or 86 percent of our entire school population is minority, 89 percent of students classified as emotionally disturbed are minority. For example, we have students who have exhibited behaviors that included destroying school property, fighting, violence tendencies or substance abuse who are increasingly being labeled emotionally disturbed. In many cases, the Committee on Special Education's determination that the student is not emotionally disturbed is overturned in the due process hearing.

In New York City, our programs that serve severely emotionally disturbed students, known as SIE VII and SIE VIII -- the SIE stands for Specialized Instructional Environments -- provide highly intensive management and supervision, crisis intervention and guidance services. The number of students attending these programs has increased by 24 percent in the last three years alone and now

stands at almost 8,000 students.

I welcome Reverend Flake. We need the home team represented.

There is a thin line between social maladjustment and emotional disturbance. With the increase of students with acting-out behaviors being overidentified as emotionally disturbed, I have made creating a safe and orderly school a top priority. My own initiatives, combined with the requirements of the state's Safe Schools Against Violence in Education Act, so-called SAVE Act, adopted in June 2000, which I supported, provide a framework that ensures that each school will have an optimal place for teaching and learning.

Let me pause to say that the state's SAVE Act allows teachers to remove children from their classroom, although not suspend them. After repeated removals, suspension is required. The combination of having the SAVE Act and the initiatives I have taken, which I will describe, is an attempt to promote a safe and orderly environment, but there is an inherent tension here

with the special ed requirements themselves.

I have redesigned and expanded our second opportunity schools, the so-called SOS schools. We now have three Second Opportunity Schools that serve middle school and high school students whose violent and antisocial behavior resulted in being suspended from their regular school programs. SOS programs have been developed in collaboration with community-based organizations such as one of the settlement houses such as The Door, Wild Cat Academy, all very well respected organizations within the New York City community-based organization community. They have unique expertise and experience in serving socially maladjusted students. Currently, 242 students are in our SOS schools. We have the capacity to serve 300 students. We have also expanded our alternative to suspension programs. These initiatives are vital to address the growing need in general education.

The 1997 IDEA amendments in the area of discipline were clearly intended to provide schools

with greater ability to discipline students who posed a danger to themselves and others. IDEA still provides greater protections for classified students than general education, thereby contributing to the overidentification.

Let me observe, for example, a child who, say, intentionally scratches a car, could be viewed as either -- that action could be viewed as either adolescent mischief or evidence of psychological malady. The categorization which comes at the time of the due process hearing or of the CSE, take very different considerations into account. CSE tends to rely on an overall judgment, trying to take best interest of the child into account. The due process hearings have a tendency to categorize as special ed on the basis of almost any testimony from someone with the appropriate credentials. It is very hard -- let me say it a different way, it is very hard for someone sitting as a hearing officer to reject that testimony, and very easy to accept it. Even when the determination hinges more on the quality and the

nature of the witness, than it does perhaps on the quality and the nature of the child's problem.

Second recommendation. IDEA should be amended to allow funding of intervention and prevention strategies to support students in general education who are experiencing academic, social or behavioral difficulties that place them at risk of referral to special education.

Rather than any particular systemic bias, I am convinced that overrepresentation is primarily the result of a lack of intervention services in the general education environment, particularly in our poorer schools. During my tenure as Chancellor, on of my highest priorities has been to improve instructional and support programs on a unified, whole school basis. Whole school approaches create a single, seamless service delivery system for all students, disabled and nondisabled alike. They predicated upon the belief that students are more alike than they are different and that integrating resources results in improved student outcomes for all. This strategy

puts an end to what I believe is an unhealthy and unproductive competition for resources between general education and special education, where spending can be three times higher per pupil than in general education.

Our recently adopted "Continuum of Special Education Services" reflects the input of teachers, parents and the advocacy community, and fully embraces these principles. The new Continuum encourages creativity and flexibility in the development of instructional programs for students with disabilities including those with severe disabilities. It emphasizes intervention and prevention and instructional strategies and student supports rather than the labeling of students. It breaks the definitions that are far too limiting and prominently features the concept of least restrictive environment.

We are witnessing gains as a result of these reforms. Overall, initial referrals to special education decreased by 27 percent in the 1996-1997 and 2000-2001 school years. Between

those two years, we had a 27 percent drop. In addition, decertifications from special education during the same time have increased by 43 percent. Based at least in part upon the initiation of more objective eligibility criteria, post-evaluation acceptance rates into special education have decreased by 4 percent over the same time period. Similarly, placements in less restrictive special education settings have increased by 7 percent systemwide.

As a consequence of the way IDEA has been structured, we spent $2 billion in support of approximately 145,000 students who are labeled special education, and only $1 billion, literally half the amount, for twice as many children, 296,000, general education high school students. That's a factor of 4, twice the kids, half the money. This imbalance was not created by choice, but fostered by our compliance with IDEA. In addition to being disproportionate, it strikes me as fundamentally flawed to ignore the special needs of our general education high school students who

need to be classified as disabled in order to receive the benefit of the additional financial support. At its very core, such a process presupposes that the way to assist and provide vital educational services to our student population is after the fact rather than before it in the form of intervention and prevention and support services.

As part of Memorandum of Agreement with the U.S. Department of Education Office of Civil Rights to address mutual concerns regarding overidentification, substantial efforts were made to increase intervention/prevention programs in general education. The results of those efforts contributed to our systemwide reduction in referrals to special ed. There is also powerful research suggesting that a lack of instructional and behavioral interventions is a contributing factors to special education referrals. We are constrained by the limitations imposed by IDEA. The legislation must be amended to allow the discretionary use of funding for whole school

approaches. I firmly believe that this will result in a reduction of the overidentification.

Now, I want to say very clearly, I strongly support full funding of IDEA. This is an extremely important issue for school districts and this school district in particular. We provide services to students with severe disabilities that have extraordinary needs, that often require very costly services in order for these students fully to participate in school. I will give you a few examples that make the point. Currently, we have six students with disabilities whose recommended services exceed $100,000 per year. This compares with spending an average of approximately $9,000 on general education students, $28,000 on students classified students educated in the community school districts, and $43,000 on classified students in our most specialized programs in District 75, the special ed district. Most recently, for example, just one example, we modified the windows and lighting of a large portion of a school building and equipped a vehicle

with state-of-the-art ultraviolet eliminating materials so that a single student with extreme light sensitivity could attend an educational program in a less restrictive environment. If we are serious about innovative programming, then IDEA has to provide additional funds. Presently, local school districts absorb these extraordinary costs without any additional reimbursement, and that is unfair to all.

Third recommendation. IDEA must shift from an emphasis on regulatory compliance to greater accountability for program improvement and student outcomes.

While IDEA funding is already limited, I am deeply concerned that the current emphasis on regulatory compliance rather than accountability for student outcomes, diverts preci precious financial and human resources away from meeting the actual educational needs of disabled children. IDEA procedural requirements are often redundant. The IEP team membership provisions that require the participation of teachers that are, quote, "likely"

to teach the student are counterproductive in large urban systems. Too often teachers and other staff are diverted from their primary task of instruction. This is especially an acute problem in large cities like New York where school districts are challenged by a severe shortage of special education teachers and other qualified staff.

Even the most basic change in the student's IEP, for instance, requires teachers and other professionals to be pulled away from their core duties and spend significant time on largely administrative items. As a result, an inordinate amount of special education funding is spent on administrative compliance. This has resulted in a reduction in the already limited amount of funding available for improving instruction and supplementary services to students. We must simply existing IDEA procedural requirements and make the special education process less unwieldy and complicated. This will provide a greater benefit to the local school districts and the students they

are committed to serving.

Fourth. IDEA language must be clarified and strengthened to avoid abuse, particularly abuse through litigation. I speak now as somebody who is both a lawyer and someone very much committed to education reform.

While the intended purpose of IDEA was to support students with disabilities and assist them in securing high quality educational services, and it has done so marvelously, the statute has also given birth to a cottage industry of attorneys specializing in this part of the law and has led to a rapid escalation of law suits against school districts, especially in the area of the Carter case tuition reimbursement requests.

Now, I know that you have heard this before and I know that this is familiar turf, but I think it is important for us to go through at least our experience so you that you see how it plays against some of the smaller districts that I know you have heard from.

In New York State, as well as

nationwide, litigation of issues through due process proceedings has increasingly focused on the procedural aspects of IEP development and minor technical errors. Procedure is subject to significant levels of scrutiny, that is gentle way to phrase it. I have seen some of the hard-fought litigation cases take place in these hearing rooms, and it is a series of pleadings and analytical descriptions that it becomes hermeneutic, they are doing careful readings of scripture and text. That's not what it is about, in my judgment, to help children.

In Carter tuition reimbursement cases, failure to comply with even minor or nonmandated procedural details has been leading to decision for full tuition reimbursement. This is not Miranda, this is not, you know, we throw the case out if you make a procedural error. Yet, that has become entirely too frequently what the hearing officers do. Clearly, these outcomes were not contemplated by IDEA.

I will give an example. Parents have

unilaterally abused placed students with substance abuse problems in highly segregated, residential settings as far as away Oregon and Maine and have then requested the New York City school system to fund the cost of the programs and attendant transportation under the Carter decision. In such cases, the students classification is at question. The system's position may be that the student is demonstrating social or behavioral maladjustment but not classifiable under the IDEA, and not in need of so restrictive an environment so far from home. Yet, a minor technical error in such matters has resulted in full funding for such a questionable placement. Funding of such restrictive settings is the rule, despite least restrictive environment provisions of the IDEA. This hallmark of the legislation is generally disregarded in light of the fait accompli nature of the parents' unilateral choice. This result if often because of a minor, technical error not resulting in substantial deprivation of a free appropriate public education. I am not opposed to

a free appropriate public education. I am opposed to abuse of the system.

In another case, tuition reimbursement was awarded do to the fact that the student's teacher participated by telephone so she would not have to leave school and stop teaching. Due to the fact that the teacher did not have the evaluation of the student available at the moment when the call was put through, even though she was testifying about classroom performance only, full tuition reimbursement was awarded rather than remanding the case back to the CSE to convene a new meeting.

Last year alone, we had 1,240 requests for Carter tuition reimbursement. Perhaps most troubling is that 50 percent of the cases, fully 50 percent of the cases, were pursued by parents whose children have never attended nor plan to enroll in public school, but see the opportunity for their child's private education to be paid for at public expense. Carter reimbursement for one year in this system was over $13 million. This does not include

substantial personnel and administrative costs. The Carter issue has created a serious and increasing financial burden on the school system, diverting resources from the classroom, and unless dealt with, will grow.

I am willing to be held accountable if we are unable to meet the needs of any student with a disability. This decision, however, must center on the substance of the child's needs and our capacity to address them, and not on compliance with procedural technicalities.

Chairman Fletcher, on behalf of the New York City Public Schools, I want to thank you again for inviting me to testify and for considering the record and the needs of our system. I am convinced that amending the IDEA to be a more flexible, better funded and less regulatory statute will assist us in our mission of creating a single, seamless service delivery system for all students.

I would also like to introduce several members of my staff who are here whose work and persistence, and shall I say nagging me to get it

right, has been a great help. Fran Goldstein, Linda Wernikoff, in particular, have really led the fight for special ed reform inside the system, and in my judgment, there are no more true advocates on behalf of the children.

I would be happy to take any questions, but I forewarn you, I am going to lean heavily on them to answer.

DR. FLETCHER: Thank you, Chancellor Levy, for your testimony. We are going to open for questions by the Commission, and in order to ensure that each Commissioner has a chance to ask questions we are going to start with Commissioner Acosta and give each person about five minutes to ask questions. We won't let you ask questions for more than five minutes and if you don't have questions, we will go to the next person.

Ms. Acosta.

COMMISSIONER ACOSTA: Good morning. Thank you for your testimony, and I am a native New Yorker, so I am happy to be back home. Little did I know that when I went to school there I would be

sitting in Borough Hall with such an illustrious group of fellow New Yorkers. So I thank you for your testimony.

I just have a couple of questions, Chancellor, about the SAVE Act. Could you clarify for me, it sounds to me that all schools should have an overall schoolwide discipline plan, but is this something extraordinary?

MR. LEVY: All schools do have a safety plan, a discipline plan. The State Legislature this past year, at the urging of the teachers union, the UFT, and with my support, passed a law that permits each individual teacher to remove any child who is disruptive in the classroom from the classroom for essentially up to three days. And there is various procedural safeguards built in, but what it boils down to is that any teacher can remove a child from his or her classroom for up to three days. It is not to say that they can suspend the child, it is not to say that they can expel the child, but they can remove the child from the classroom.

So if a child is disruptive, it gives that teacher a legal authority to say "You are out of here." I think of it as the kid gets a time out.

COMMISSIONER ACOSTA: Because it is legal, is there a time restraint for special education kids? Is there a certain amount of days that a special education child can be removed from the classroom.

MR. LEVY: Is there a different standard?

I am told that there is not.

COMMISSIONER ACOSTA: There is not. So if I am a special ed kid in the school and I am disruptive, I can be taken out of my learning environment?

MR. LEVY: Fran, why don't you answer?

MS. GOLDSTEIN: It is not that we send them out of the building. We provide them with an alternative setting within that building with instructional supports and guidance supports.

MR. LEVY: One of the things I did

early on, indeed, before this statute was enacted, was I saw having a safe and orderly environment as being a high priority in the school system and I concluded that on the basis of the public agenda polls, on the basis of a poll that we did of all parents, 10 percent of our parents, it is very clear that a safe and orderly environment is high on their priority.

So what I did was I created an in-school suspension center. I proposed it to Mayor Giuliani to fund in every school. In fact, we funded it so that there is at least one in every district, and in some districts there is one in multiple schools. And the idea is that it be a small environment, that there be teaching that goes on and there could be all kinds of support mechanisms for children sent in.

Indeed, in some ways, the way I was thinking about is children often call out for attention by acting out, and this would get them a teacher who is supportive, more attention because it would be a much smaller classroom setting, and

the idea was that we would get the work assignments from the regular class sent in, so that two-to-one, four-to-one, five-to-one setting could work to benefit the kid and then send them back. That's the model. We haven't able fund it near the level that it should be.

When the SAVE legislation was enacted, these two came to fit together, so that a teacher who would say "I am removing you from my class," would wind up sending the child to that kind of environment. Now, that's a best case.

What has also happened, I regret to report, is that a teacher would take somebody out and that that child would simply go to another teacher's class. And that's something I have tried to halt, because that doesn't serve the other teacher, it doesn't serve the child, it doesn't serve the first teacher. It gets rid of the kid, but that's not what I want. My theory on this has been quite simply denying a child an education should never be used as a form of discipline.

And it is easy to say, I mean, in this

system we don't expel kids. As you well know, there are plenty of systems in the country that do expel kids. The only time we say enough is when a child reaches a certain age and acts at, then we say, "Okay, that's it," but that's the only point, when they reach 18 or whatever the age is.

COMMISSIONER ACOSTA: Are there any special trainings that teachers receive, like staff development, so that there is -- you mentioned earlier that there are socially maladjusted students who are not emotionally disturbed or don't qualify under IDEA. And I am backing that up with my question about are there still cases -- or where are the cases in New York City school systems where racially and linguistic minority students are overidentified and who does the overidentification -- who does the identification, rather?

MR. LEVY: Do you want to describe the evaluation process?

DR. FLETCHER: Please introduce yourself.

MS. GOLDSTEIN: I am Francine

Goldstein, I am the Chief Executive for School Programs and Support Services for the New York City School System.

We have a very complex evaluation system. When a child is referred, the referral goes to the school principal, either by a parent or by a teacher. Then there is a committee of clinicians who are composed of a psychologist, a social worker and an education evaluator. There is a social intake with the parent, the child's history is taken, and then there is a battery of tests if they deem that this child needs to go through the battery of tests.

For a child who is not English speaking, in many cases, they receive the battery of tests in their native language. Then there is a determination made on the eligibility. What we have done in the last several years and with the agreement with OCR was to strengthen the criteria, because what we have found was, as the Chancellor described, that it was very easy for students to be classified as learning disabled and emotionally

disturbed. And we spent a long time with groups of real professionals and universities going over what the criteria should be for a learning disabled child and an emotionally disturbed child.

In the past, we found that the clinicians wouldn't ask "Is the child in need of special referral?" But the answer was "Where do we put the child?" It was a place, it wasn't a service. And that's what we have spent the last several years doing, making sure that they received training with Mel Levine from Chapel Hill, Don Daschler, Marilyn Friends from the University of Kansas. We use our universities and hospitals in New York. We use NYU Child Study Center to train teachers on how to work with children who may have some sort of behavior problem but not necessarily need to be in need of special education.

COMMISSIONER ACOSTA: Thank you so much.

DR. FLETCHER: Ms. Goldstein, the Commission would like to leave the record open and ask for a copy of your criteria for identifying

children with learning disabilities.

MS. GOLDSTEIN: We will be happy to provide you with that.

DR. FLETCHER: In fact, any high incidence disabilities. We would be very interested to see that.

COMMISSIONER ACOSTA: We will be happy to provide you with any information.

DR. FLETCHER: Thank you.

Commissioner Coulter?

COMMISSIONER COULTER: Chancellor Levy, first of all, I want to thank you very much for your testimony. It is heartening, I think, to see the chief executive officer of the largest school system so concerned about children with disabilities and the need of effective education.

Let me just ask you two questions in two separate areas. You spoke, I think, eloquently to the concept of a whole school in a single system meeting the needs of all children in a seamless system. I think one of the key factors in ensuring that you have a seamless system is regular

classroom teachers, general education teachers, implementing interventions for children who have instructional needs. Especially, I think, in your description, these are children that in more traditional systems would go through a referral process, be evaluated and be identified as needing special education.

In that conception, the key variable, at least as we have heard testimony, is the regular classroom teacher knowing what to do, having sufficient support in order to do it, and some accountability, I think, at the administrative level, that that teacher will follow through affirmatively and assiduously and make certain that it gets done. As, Chancellor, what are your administrative provisions within the school system to make certain that folks do the right thing?

MR. LEVY: You ask a very important question. One that I think goes to the heart of the matter.

A seamless web whole school approach only works if the participants are held to a high

standard and there is a methodology to make sure that that is happening. I am going to talk about three things and then I will let Fran embellish.

One, the quality of special ed, the amount of placement and the professional development for the teachers, the general ed teachers, is part of the evaluation of every one of superintendents and is a core part. When we go through the analysis that we do for each district, and I have conversations one-to-one with the superintendent, what I look at is a set of data that includes school-by-school, grade-by-grade, how the special ed kids are doing. It identifies the number of certifications, the number of decertifications, and instructionally by performance how the children are doing. So we can spot with some degree of precision, you know, "In the third grade in P.S. 189 it looks like the ELL kids are doing better, it looks like the general ed kids are being worked on, but your special ed kids are falling off a cliff in math. What are you doing about it?"

And the conversation can be as robust as that. So the core preventive, if you will, is taking the data and analyzing it very carefully. My experience in coming to this position is that school systems are great generators of data and lousy users of it. And what I've tried to do is use this wealth of information that we have. Indeed, just this week it all went up a on website. So you can actually, and I invite you to do it, sit there and do the manipulations yourself, the question you asked earlier, how many and where, you can identify it school-by-school where the concentrations are. So it gives me a great tool. So one answer is, we evaluate the superintendents and we keep it in part of their performance profile.

Two is we put it on a website so that the parents and the advocacy community can use it and respond and pressure us to get it right.

And three is we have extensive training. Not nearly enough. We have 80,000 teachers in this system, of whom 13,000 are not

certified to teach. I won't even go into the question on how many are certified to teach in the subject matter that they are teaching.

So the broad answer is, we have managerial ways, reporting ways to check it, and we have programs to provide professional development at the systemwide level, at the districtwide level and at the schoolwide level. And we have teams in place in each school that are supposed to be doing this. I use the word "supposed to be" because I have walked into too many SBSTs where there is nothing going on, school based teams. But that's the work, that's the job.

DR. FLETCHER: Thank you very much.

MS. GOLDSTEIN: I just want to add two other things. That we have pupil personnel teams that are not for special ed youngsters, and that is to really answer the general ed question. We have teams in every school and we have done a lot of training with them to ensure that if there is a child in need of services, that child receives the service or a group talks about what kind of

services are available for the child and family.

And the other thing is that we provide, really, the dollars to the schools in general ed so that they can have the preventive services, because without the dollars, you cannot do this.

COMMISSIONER COULTER: Thank you.

MR. LEVY: Thank you, Commissioner.

DR. FLETCHER: I'm sorry, we forgot to announce that we have an interpreter for the deaf in the front. Would you please identify yourself for the people who need these services.

(Interpreter complies.)

DR. FLETCHER: Thank you very much.

Commissioner Rivas.

COMMISSIONER RIVAS: I want to thank Chancellor Levy for his testimony. I have one quick question.

Back to your secondary opportunity school, the percentage of minorities, I guess, that are referred to that, are they pretty much in proportion with your general school population?

MR. LEVY: No. I think that there are

more minorities in there.

COMMISSIONER RIVAS: Do they get, I guess, reevaluated and are able to get reintegrated into the regular school system or is that a permanent designation?

MR. LEVY: It is not a permanent designation. There is a discrete period of time, a minimum of a year, some have actually gone six months, and there is a maximum period as well. A year is the most.

New York City has a mixed history on this, and let me just say, there used to be something called the 600 schools, which some of us who went through the New York City Public School System remember. 600 schools were schools for children who had acted violently, had acted out. To those of us who weren't in them, we thought of them as reform schools. And they were disbanded, they were pretty miserable places. And the 600 designation was so many of our schools have numbers and this would 625, 628, and so on.

That needed to be shut down and was

done years ago. I was very conscious of that when we set this up because I did not want this to be a holding pen, you know, a prison, a baby prison. I wanted this to be an educational institution that had people in it who were skilled in dealing with children who present these kind of problems. And I think we have accomplished that because we have hooked up with community based organizations, who in means instances, know how to do this better than the traditional school approach.

COMMISSIONER RIVAS: Thank you very much.

DR. FLETCHER: Commissioner Flake.

REVEREND FLAKE: Thank you very much.

I welcome you, Mr. Chancellor, and I thank you for the time you have spent out of this setting trying to help us with some of these issues.

In our discussion the other day, item number 4, we talked about the classification language must be clarified and strengthened to afford use of legislation, particularly as it

relates to the common problem, and you indicate that your are spending astronomical sums in many instances trying to solve individual cases, many of those cases the needs not being able to be met within the district, but those are actually dollars going out somewhere else.

You are not specific here in terms of recommendations. Do you have more specificity for how you would suggest this problem gets resolved?

AUDIENCE: Excuse me, we have no idea what you just said. Not one word.

MR. FLAKE: Really, I'm sorry.

DR. FLETCHER: You asked for clarification. I think you need to lean more towards the mike.

MR. FLAKE: Okay. Essentially what I asked for was clarification of point number 4. I'm sorry, as a preacher, I should know better.

MR. LEVY: I never thought I would live to see the day where anyone would ask Reverend Floyd Flake to raise his voice.

MR. FLAKE: Please forgive me.

MR. LEVY: I have made some specific recommendations in here, but I guess the telling point here is technical violations and technical procedural improprieties should not give rise, and certainly not in the first instance, to orders of provision of services. I think this is, I mean, I can take my hat off as Chancellor and start lawyering a bill, but I would simply say this quintessentially a process issue and it is a question of providing standards to the hearing officers to exercise discretion and giving them more precise criteria. I think that might be a way to do it.

But I would happy to try to provide further guidance and talk with counsel on this. I actually invited somebody who was a member of the American Arbitration Association Board and one of the real deans of the arbitration hearing world to take a look at these Carter cases for me on a pro bono basis. And he came back with a very interesting observation. He said you are losing these cases because there is inadequate attention

to procedural detail on the part of board lawyers.

And I said is it incompetence, do we just need more bodies here? And he said no, these are being very sharply litigated on the other side, and what you need to do is litigate it as sharply as that. That's one answer, simply what we could do as a way to prevent this from happening is lawyer it up and down the CSE path to make sure that the fact pattern fits what has to be done. And that may be, if we don't change this, my judgment, that is what is going to happen all across the country, you are just going to have school boards retaining outside counsel and telling them every CSE determination, every one that has the potential for being expensive, we are going to lawyer in a heavy way. That, in my judgment, would be a terrible waste of our special ed money.

Another way to run that, in my view, is to establish different criteria and have a rule of in effect no material injury, so as to lift the procedural barrier and put it on a different level. But I would be happy to go back and try and come up

with some language level changes.

DR. FLETCHER: Thank you very much.

The Chair yields to the Assistant Secretary who has a question.

MR. LEVY: If I might make to Reverend Flake just one other thought on that.

In the criminal setting, when cases go up on appeal and courts of appeal are reluctant to overturn, although there has been a violation, there is the harmless error notion, there is no reversal because although there was error, it was harmless error, would not have impacted the result.

MR. FLAKE: But that can't be remedied by legislation then?

MR. LEVY: Oh, yes.

MR. FLAKE: It can?

MR. LEVY: That absolutely could be put here as a standard.

The offsetting consideration is we want to make sure that the child who has a genuine need, gets it addressed. And then you also want to make sure that where it's, you know, this case of the

telephone, we didn't want to take the teacher out of the classroom, we wanted the teacher to participate at the hearing. We thought we were doing something which was called for by hearings and arbitration and flexibility, and we said, "Fine, we will get the teacher on the phone."

The teacher didn't have the file in front of her, and on that bases, the child gets remanded to a different form of remediation. I just think that is not what the statute had in mind.

DR. FLETCHER: Dr. Pasternack.

DR. PASTERNACK: There are a number of questions, but in the interest of time, I will try to ask just a couple. I was intrigued with many of the things that you testified about. I would like to take you back to the issue of socially maladjusted versus emotionally disturbed young people.

It is has been reported to us that you are spending a large amount of money on assessing kids for eligibility for possible placement in

special education. I wonder if you could comment whether if we eliminated IQ testing, whether that would allow your school psychologists to help you in making more accurate determinations and differentiations between emotionally disturbed and socially maladjusted youngsters and whether, in fact, that might be a remedy for the problems that you articulated so eloquently earlier.

DR. FLETCHER: Please identify yourself for the record.

MS. WERNIKOFF: My name is Linda Wernikoff, I am the Deputy Superintendent of Special Ed Initiatives in New York City public schools.

Yes, I think if you would eliminate mandatory IQ testing it would certainly be a way of having our school psychologists spend their time doing intervention and prevention. One of the major things that we have done in New York City is increase the flexible way that school psychologists spend their time, so that in addition to serving on Committees of Special Ed, they have been an

integral part of our intervention and prevention, conducting functional behavior assessments, doing behavior intervention plans, not only for students who are referred to Committees on Special Ed, but youngsters who are in general ed who are having difficulties, so we would say yes.

DR. PASTERNACK: Thank you.

Chancellor, I wonder if you could talk to one of the issues that we are primarily interested in today, as you know, is the disproportionate identification of African-American youngsters in the category of mental retardation that was so well documented in the recently released NRC report. I wonder if you could talk to us about why you think that may be occurring in the New York City schools.

MR. LEVY: I tried to address that in the testimony. I think if we had greater opportunity to have a more seamless prevention model, we would reduce that. That's a partial answer, that's not a total answer.

I come back to the issue of distinction

between emotionally disturbed and socially maladjusted. It is too easy to label and to categorize. The same child who in another context would be said he scratched the paint because he was under stress, this is an emotional concern and he is having terrible problems with his family, in another context with other kinds of assistance, with other kinds of advocates, winds up being labeled as ill, as sick, as having a psychological impairment.

Lawyers are in the business of categorizing, you know, is it a tort or is it a contract? Is it a criminal matter or is it an administrative matter? We do that all the time. That's part of the lawyer's training. And, you know, the lit-crit people understand this notion with greater subtlety then even the lawyers do, in my judgment, because what they are doing they are going about their training and imposing it on the world. They are going to graph it and chart it and everybody's got their place and every action has their category.

I think what is going on here, at least in part, is a function of taking the same behavior and categorizing it differently, in part in virtue of who the advocates for the child are and in part in virtue of what the socioeconomics of the child are. And we do a disservice. I think on the whole, the categorization of emotionally injured is a stigma, and we sort of expect adolescent mischief but it is different if the child is ill.

Well, the way I think of it simplistically is, is the kid ill or is the kid bad? That decision should not turn on the child's skin color or the wealth of family, but rather ought to turn on some other criteria more objectively imposed. So I would answer your question, at least in part, by saying, the system comes down on different kids in different ways. And that's what we need to resist.

DR. PASTERNACK: I know I don't have much time left, so another question I would like for you to quickly address, if you could, is in the difference between your highest achieving schools

and your lowest achieving schools, as it effects students with disabilities, what is the biggest difference?

MR. LEVY: A very big question.

I would say, if I had to answer it as bluntly as that, I would say let me give you two answers.

One, quality of teachers. The amount of professional development, the selectivity, the assignment makes a big difference. And the level of interest and concern and attention paid by school leadership, meaning the principal and people on the school leadership team, the people who are the administration of the school. If they take their eye off the ball, things go in the wrong direction.

DR. PASTERNACK: So instructional leadership, quality of personnel are two issues that account for the differences between the highest achieving and the lowest achieving schools?

MR. LEVY: Yes.

DR. PASTERNACK: Thank you.

I would like to just quickly introduce our newest colleague at the U.S. Department of Education of the Assistant Secretary for the Office of Civil Rights, who is here in the audience with us today, the Honorable Jerry Reynolds. And I appreciate him being here and wanted the Commission to recognize him.

MR. LEVY: As a former member of the Civil Rights Division of the Department of Justice, welcome.

Commissioner Takemoto.

COMMISSIONER TAKEMOTO: Welcome. I am the Executive Director of Virginia's Parent Training Information Center, and I am always fascinated when I hear administrators and others complaining about the high cost of litigation from parents, because from the parents I speak to, they feel like they are outgunned, procedurally, legally, by school systems and their attorneys. And it seems to me, in my observations, that families who have the access to attorneys get the services, while families in the lower socioeconomic

brackets, which in our country is represented largely by minorities, are not getting the services that they need.

So my question is -- I agree, procedures should not be the determining factor for children receiving an appropriate education, and sometimes it is the devil that you know is better than the devil will that you don't know, but I would like to know from you, would you rather that we looked at something like meaningful educational benefit as a criteria for whether or not a child would have a higher level of services, because I have yet to meet a parent who walks in and says, "My kid is doing well in school, therefore, I am going to go sue the system to get more."

So would you be willing to trade some of the procedural losses and gains for a system that said a child will make meaningful, educational progress, and forget about whether or not they got they are evaluation in 60 days?

MR. LEVY: I would only be willing to do that if you could assure me sufficient funds to

do it for all the kids. The issue -- one person's technical, procedural impediment is another person's safeguard of their rights. I accept that. But also recognize that Carter cases are coming along and, candidly, middle class parents and upper class parents are using that to pay for a level of services that we can't provide to anybody in the system. Everyone is entitled to a first class education, and I say to you, that a significant number of people are not getting it. And it is not necessarily the ones who can afford lawyers.

I take your point entirely, that there are people who need lawyers and need procedural safeguards. And I am not suggesting in the slightest that we ought to eviscerate IDEA. I am saying that there are problems that need to be tinkered with here. If, as a matter of litigation, if as a matter of, you know, here's the procedural standard and with an order that ends with the line "so ordered," I could assure quality of education for each of my 1,100,000 children, I assure you, I would sign that order today.

The problem is administratively putting it into place, and therein lies the issue. How do I say this? I used to be on the Board of Regents. On the Board of Regents, we could pass standards and high level aspirations and regulations. I am cursed to actually implement the damn things I voted for.

COMMISSIONER TAKEMOTO: And as this task force considers some of the early intervention initiatives that are going to keep kids out, my concern is are schools going to be able to produce to not only keep the kids who should not be in special education out, but make sure that the kids that are in special education get benefit?

I believe that's a civil right and it seems to me that folks are already signing letters of assurance that all their students are getting appropriate education anyway. So I am wondering if a higher standard of meaningful educational benefit would be more difficult to deal with than worrying about whether or not procedures have been passed and whether or not that would be more meaningful.

MR. LEVY: The exercise for me is not to distinguish as between general ed and special ed as to who gets good education. I hold them accountable to provide the education at a certain level and a certain standard, and that applies to both general ed and special ed.

DR. FLETCHER: Commissioner Grasnick.

COMMISSIONER GRASNICK: Thank you, Chancellor Levy, for your excellent testimony today.

If you or members of your staff would identify some key areas of research that would assist in more precision in the identification of students with special needs?

MR. LEVY: We will be pleased to provide that.

COMMISSIONER GRASNICK: Thank you.

The second question I have is, I think as I have heard your testimony and others, that the IEP process is often very much an input system and not results oriented. And I applaud the diminished number of students you have identified as special

needs, but I am interested on the other end, as you track the students and their performance and the development of the IEP, do you have a benchmarking system that once students are identified will allow you to track their continuous progress to the point of exiting the identification?

MR. LEVY: Do you mean is there a systemwide program that monitors them as they go?

COMMISSIONER GRASNICK: Based on a results oriented system?

MR. LEVY: There is no separate one for special ed. We have a systemwide sort of monitoring and tracking, as you would in any system, but, no, there is not a special one for special education.

COMMISSIONER GRASNICK: So I guess the question I am really asking is, when you develop the IEP, are there benchmarks or progress that are anticipated and reflected as part of that process.

MR. LEVY: Sure, absolutely. And there are periodic meetings and every child is evaluated in a regularized way.

Do you want to add to that?

MS. GOLDSTEIN: Yes, there are goals and objectives on the IEP, and teachers meet with parents and meet among themselves and review the IEP and the goals and all of that. And there are re-evals and triennials as in any other system.

But we also do standardized testing with our youngsters, and if the child is not within the standardized testing, then they have adjustments made to their testing or modifications.

COMMISSIONER GRASNICK: And if the students, either individually or collectively, are not performing well, are there specific interventions?

MS. GOLDSTEIN: Candidly, our special ed youngsters don't perform as well on tests as our general ed youngsters. And that's why we just revamped the whole continuum and all of our special ed programs, because one of the concerns that we had was that once they were placed in special ed, they were not performing as well as they should be as well.

COMMISSIONER GRASNICK: My final question, if I haven't exceeded my time, it is my impression that many students are identified because of, in a sense, default from what we haven't done in regular education.

Could you just speak for a moment to very early intervention services, when we look at accountability for regular education and what that would mean in terms of identification.

MR. LEVY: There is no question, the earlier the identification, the better. And what we need to do is train our people so that the evaluation can take place at an early enough level and done in a professional way so that we have early intervention or the opportunity to really do something to bring the kid back into general ed.

The increase in the number of decerts, in my judgment, is an indication that they system is working. And that's something that hadn't occurred for many years, the recognition that children could move back in.

The other observation I would make,

something that a number of you took interest in Houston. We test our special ed kids. They are part of our testing regime, and have always been. And the state has what is called the RCTs, which apply to some kids, but pretty much, everyone gets tested. And that's part of the New York City tradition.

How do you address this? Early intervention, quality intervention, make sure the general ed teachers recognize the warning signs when they occur and don't wait for something severe. I track this stuff on a monthly basis, and it worth making a point. I get a report which shows me by district, how many kid go from general ed to least restrictive, to SIE VII. How many referrals, how many decerts, where there are upticks. And I talk to the superintendents about this on a monthly basis.

One of Fran's functions is to track and monitor who is doing what? So if I see, for instance, a large number of children going from general ed immediately into SIE VII with no stops

in between, that's a red flag to me. That tells me someone is taking their eye off the ball, because that should not happen. It is rare, rare, rare, that a child would suddenly manifest, without any warning, these kind of problems.

The other thing that I monitor with some care is how we are doing on our cases. I ask our general counsel from time to time to show me the hearing officer decisions, so that I get a quality control notion of how we are doing. You know, the decisions are sort of a sampling, a skewed sampling but an important sampling of which are the squeaky wheels, what are the things we are doing wrong. And when there are criticisms, we try and respond to that.

The criticisms that I worry about, what I was trying to say before is, I think sometimes the decisions are over the top.

COMMISSIONER GRASNICK: Thank you.

DR. FLETCHER: Thank you.

Commissioner Wright, the last shall be first.

COMMISSIONER WRIGHT: Good morning.

As the last one, because you can see that I am a "W" and if the Chair is going in alphabetical order, then I am always last, and that can be good or bad. It is bad that I have to make sure that I listen to everything to make sure that I am not asking questions that have already been asked.

And so I guess, I am batting clean up, is that right, Mr. Chair?

DR. FLETCHER: That's correct.

COMMISSIONER WRIGHT: To my knowledge, I think that just about everything has been asked and answered, but I am curious to know, maybe you have answered this, what are your services for and how do you identify your severely developmentally disabled? I mean, like your TMH kids, trainable mentally retarded and --

MR. LEVY: I'm sorry, we are having trouble hearing you.

COMMISSIONER WRIGHT: Severely mentally retarded, your severely developmentally disabled. I would like to know what do you do about that?

MS. GOLDSTEIN: We have a separate district for the severely disabled youngsters, but a lot of those youngsters are referred, not only by our evaluators, but obviously through medical kinds of reports. Our autistic youngsters, many of the mentally retarded youngsters, are referred by physicians and come in with severe medical diagnoses, in addition to some of the psychological and other kinds of things that we do.

COMMISSIONER WRIGHT: Are these children, I know that there is not too much to include them, but what does New York City -- where do you serve these children? Do you pay tuition for them to be served by other agencies?

MS. GOLDSTEIN: No. They are served in a New York City public school. We call it our District 75, which is our severely disabled, but we service -- we have severely impaired both physically and mentally challenged youngsters in our schools, we have autistic youngsters in our schools, and they are served in public schools. Some of them may be in their own buildings, but

they are within our public school system.

COMMISSIONER WRIGHT: So you do not have to buy service for them from other agencies?

MS. GOLDSTEIN: No, not at all.

We may use some hospitals just as a support for us, but we don't necessarily use them as the full support.

COMMISSIONER WRIGHT: My last question is: Do you refer children, and I am sure you do, when you work with other agencies, such as mental health agencies and like that, do you refer children to mental health?

MR. LEVY: Yes.

Let me say on District 75, I have visited a number of these schools, and I must say that I did not go there with great relish, because for me personally, it is a very difficult, emotional thing to go to those schools. I can't tell you how impressed I am by the quality of instruction and the quality of care in the special ed district.

There are schools all throughout the

city and the gentleness and the concern and the quality of the care given is really quite extraordinary. Those are people who do amazing things for children with terrible deformities and handicaps and do them very well.

COMMISSIONER WRIGHT: Excuse me, I couldn't hear what you were saying because of that siren, could you repeat what you said?

MR. LEVY: I say I visited a fair number of the District 75 schools, and I want to tell you and assure you, that the quality of the services that I have seen is very high, and that the care and care-giving of the people who work in that district is quite extraordinary.

It is not just clean buildings, it is not just adequate supplies. It is a degree of concern and compassion for the children that is very impressive and makes you proud of what public government can be about.

COMMISSIONER WRIGHT: I certainly appreciate your input today and your testimony. Thank you so much. It is good to see you again,

Chancellor.

MR. LEVY: Good to see you again.

DR. FLETCHER: If we could clarify, it sounds like you are describing a school environment that is predominantly self-contained for children with severe disabilities.

MR. LEVY: Yes.

DR. FLETCHER: What do you do about LRE, least restrictive environment, for these children?

MS. GOLDSTEIN: We have moved a lot of general ed children into the buildings for space issues. And where we can, many of these youngsters are on respirators and need very specific kind of buildings. And that's why originally those programs were in their own building. As we are moving more, and we have a five-year plan with the state to move more of those youngsters into LR settings. We have been moving general ed or other kinds of special ed programs into those buildings. Or where there are accessible buildings, we are moving them into the community school districts or

high school settings.

We have a lot of inclusion programs for those youngsters. We have over 8,000 of our District 75 youngsters in inclusion programs.

DR. FLETCHER: Thank you very much for your testimony.

Did you want to add something to that?

MR. LEVY: I neglected to mention that the vice president of our school board is here, if I might introduce, Dr. Rena Pellizzari.

DR. FLETCHER: Welcome.

MR. LEVY: Thank you very much.

DR. FLETCHER: We will move on to the next panel. We have a panel of three distinguished presenters. This panel is on categorization and will address issues involving referrals, categories in special education programs. I am going to go ahead and introduce all three speakers who will talk in turn.

The first speaker will be Dr. Frank Gresham from the University of California-Riverside, he does research and professional

activity in areas that involve social skills assessments and training children in applied behavior analysis.

The second speaker will be Dr. James Ysseldyke, who is a Professor of Educational Psychology at the University of Minnesota. Dr. Ysseldyke has many years of experience in education, has worked as a secondary teacher, special education teacher, school psychologist and university professor and researcher. His research and writing have focused on issues in assessing and making instructional decisions about students with disabilities.

The third speaker will be Dr. Gwendolyn Cartledge, who is a Professor of Special Education at the School of Physical Activity and Educational Services at the Ohio State University. Dr. Cartledge has been a faculty member at Ohio State since 1986. Prior to that, she was on the faculty of Cleveland State University from 1975 to 1986 and has been a teacher and a supervisor in several different school systems.

We will begin with Dr. Gresham, if you are ready.

DR. GRESHAM: Thank you, Chairman Fletcher. I would like to say I appreciate the opportunity to testify before the Commission today on issues related the validity of IDEA categories, the effect of categories on the incidence and types of referrals and the impact of categories on the existence of early intervention services.

Let me state at the outset, and I think it is important point to make, that what I have to say is restricted entirely to so-called high incidence disabilities, which include specific learning disabilities, mild mental retardation and emotional disturbance. Controversy over issues of early identification and validity of categories is virtually nonexistent for low incidence disabilities such as deaf, blind, orthopedically handicapped or students with chronic illnesses who might otherwise be served as other health impaired.

Many of these low incidence disabilities are identified before school entry,

sometimes at birth, but the validity of the assessment procedures used to identify these students are well-established and not controversial and there is often a direct link between assessment procedures and intervention strategies. Unfortunately, the same cannot be said about high incidence disabilities. I might also add that I have two young children with low incidence disabilities, one that was diagnosed at age three with childhood cancer. He is now five years post-chemo and doing fine. And one is two years old, was borne profoundly deaf and has just recently had cochlear implant surgery.

The process by which public schools identify students with high incidence disabilities often appears to be confusing, logically inconsistent and unfair. Research indicates that students with high incidence disabilities are often misidentified by public schools. Misidentification can occur in three ways.

One, students can be misidentified within one of the 13 special education categories.

This form of misidentification is the most common, where students who would other otherwise meet established criteria for mental retardation are misclassified as learning disabled. Over the past 25 years, there has been a 283 percent increase in the prevalence of learning disabilities and a corresponding 60 percent decrease in the prevalence of mental retardation. These prevalence rates, at least in part, might be explained by the form of misclassification.

The second type or form of misidentification occurs when students who do not meet eligibility criteria for any category are assigned a disability label, thereby creating what is known as a false positive identification. Again, the enormous increase in the prevalence of learning disabilities over the past 25 years might be explained in part by this form of misidentification. To be sure, there are children with slower rates of learning who are not disabled, and many misidentified non-disabled students may result from poor instruction or extenuating family

circumstances rather than a disabling condition. Misidentification of nondisabled students may inhibit future achievement and access to appropriate education within a general education environment.

The third type of misidentification occurs by error or omission when students who would otherwise meet eligibility criteria for disability are misidentified as not having a disability resulting in a false negative identification. These students are never referred for assessment, are never exposed to a quality pre-referral intervention and, thus, will never receive special education and related services to which they are entitled or would be entitled.

It is tempting to interpret the above findings as a reflection or the failure on the part of school personnel to comply with state special education codes governing eligibility determination; however, classification has three purposes, advocacy, services and scientific study. So-called error rates in school identification of

students with high incidence disabilities can be estimated by validation of cases of schools for purposes of service delivery against criteria specified in state education codes that are relevant for scientific study.

Joe, would put up the first overhead for me, please.

What this table represents, these data show the convergence -- these data, I might add, were based on a sample of 150 carefully selected kids as part of a research grant from the Office of Special Education Programs on identification of high incidence disabilities. What this table reflects is children who we identified in the project as having a specific special learning disability based on California's state education code, which fundamentally uses an IQ achievement discrepancy of approximately 22 points between ability, IQ and achievement.

And what the school identified what the contrast is, the relationship between who we identified meeting state eligibility criteria and

also who schools identified as learning disabled, assuming they used the same criteria, what you will see here are there were a total of 61 cases that were identified by schools at least as learning disabled. And the agreement between the project identified and school identified cases of learning disabilities is somewhat underwhelming. In fact, we would have done slightly better by simply flipping a coin. So we had about a 47 and a half percent convergence.

I might also add that of the 61 school identified learning disability cases, 30 percent of those cases had IQs of less than 75, and obviously exhibited no discrepancy between ability and achievement.

Jim, if you would throw the next one up there, please.

What this particular overhead shows is that if you look at the overhead, you see a comparison of four groups. And, remember, false positives are students who are not meeting eligibility criteria who were classified by schools

as LD, and false negatives are students who would meet eligibility criteria but who were not identified by schools as LD. I am going cut to the chase here in terms of this slide and I want to point out that these data suggest that an absolute level of low achievement, and not low achievement relative to aptitude is the defining characteristic of who schools call learning disabled.

So you might also put the other one up, Jim.

What we've got here in this particular overhead, given the same data, these are again the 113 cases on whom schools had reached decisions regarding eligibility and how they stacked up relative to our project diagnostic criteria, and so what you see running through here is a lot of comorbidity between kids who are identified as LD but also identified as ADHD, also identified as emotionally disturbed and so on.

What I want to point out, Jim, if you will slide up the bottom of that slide, you will see that of the 19 cases in this case of whom

schools call learning disabled, these kids would probably, given current diagnostic criteria at least in California, would probably be suspected of having mild mental retardation, although the State of California is about average in terms of prevalence rate of learning disabilities, but they are among the lowest in the prevalence rate of mental retardation. Something on the order of one half of one percent of the school population.

Do you have another one up there? Okay, you can leave that up there.

I have argued in the past and have written a comprehensive paper for the Learning Disability Summit that was held last in Washington D.C. last August, which, by the way, was Dr. Pasternack's first day on the job as Assistant Secretary of Special Education, that the field should adopt a responsive to intervention approach, to not only learning disabilities but also other high incidence disabilities as well. To summarize this position, I would maintain the following:

One, that a child's inadequate

responsiveness to an empirically validated intervention can and should be taken as evidence for -- and should be used to establish eligibility for special education and related services.

Two, the strength, intensity and duration of intervention should increase only after the child has failed to show an adequate response to intervention.

Three, assessment procedures used to measure responsiveness to intervention must have treatment validity.

And, four, the assessment of treatment integrity are what some people might call treatment fidelity, should be a central feature of the entire process of adopting a responsiveness to intervention model for children with high incidence disabilities.

What you see this depicted here in this particular slide is a modification or adaptation of the special education eligibility model used in Heartland Education Agency in Iowa. And what this model is is a multiple gating procedure, as you can

see four levels, where the intensity of the intervention increases only after a child -- it has been demonstrated that a child is unresponsive to intervention. This particular overhead was written for my paper for the Learning Disability Summit, and it specifically relates to learning disabilities, more specifically to reading disabilities. However, it is can be modified and adapted for other disability groups as well, particularly, emotional disturbance, for example.

I have made some recommendations to the Commission in the document that I submitted to them, and I will simply go through these very quickly. The current approach to defining learning disabilities based on IQ achievement discrepancy should be summarily abandoned because it is fundamentally flawed, invalid and prevents early identification intervention efforts.

School study teams should give more weight to teacher judgments in the special education eligibility process. Particularly at the referral and placement steps. Assessment

procedures that contribute information to informed instructional decisions should become primary instruments of special education eligibility determination. Current assessment practices utilizing static assessment procedures that contribute nothing to a structural decision-making should also be abandoned.

Measures used to determine eligibility and monitor academic progress should have established treatment validity, a point I made earlier, in that they should monitor academic growth, can distinguish between ineffective instruction and unacceptable individual learning and are suitable for making instructional decisions and are sensitive to detecting intervention facts.

A child's inadequate responsiveness to intervention can be taken for evidence of high incidence disabilities, I have already mentioned, and a responsiveness to intervention models should be conceptualized as a multigated procedure with the strength of interventions. And I define strength by either the frequency, intensity and/or

duration of interventions as matched to the level of unresponsiveness to interventions.

DR. FLETCHER: Thank you very much, Dr. Gresham.

Dr. Ysseldyke.

DR. YSSELDYKE: Dr. Wright, you alluded to the challenge you face. Going through school with a name like Ysseldyke, I've always gone last and I've had to go fast, so that is what I am going to do today, is move very quickly through this. My friends refer to me as a passionate professor, and I am passionate about improving educational results for all students, especially students at the margin, so, Reverend Flake, today I get to preach about my favorite chapter and verse, so if I seem a little overly passionate, I am.

I don't get an opportunity to do this very often. And I believe you folks don't either. So I think you have a unique, historical opportunity, and that is, you have an opportunity to make some significant changes in what is going on out there in practice. I think you have the

opportunity to legitimize the bootlegging of good assessment practices. As I travel around the country, my diagnostic personnel tell me that they engage in far too much time assessing children, making predictions about their lives, and far too little time making a difference in their lives, and they tell me that is because the federal government makes them do that. I believe they are lying, but you have to help them understand that they can actually do some of these things.

You have an opportunity to free diagnostic personnel of the guilt that they feel when they do good things. And I would simply call your attention to the fact that I believe, I think there is substantial research to support my contention that there is absolutely no shortage of knowledge about what to do instructionally with kids with disabilities. As you say, we can't ever get there because we are spending out time engaging in what Seymour Sarrison from Yale University called an incredible search for pathology.

I have made some recommendations, I

will only highlight a couple of these and then I will take an approach based on logic rather than research. I want to stress three major recommendations that serve as the theme of what I have to say. I was asked to talk about whether the diagnostic categories -- whether the special ed categories are valid.

I think we just ought to stop the debate about whether categories are valid, real, relevant to instruction and beneficial to children. We know the answer to that question, and the answer is that, for the most part, with some exceptions that I will mention, they are not. You have an opportunity as a Commission to call a halt to categorical special ed eligibility determination practices that require a search for pathology; that is, static, test based documentation within students deficits, deviance and disabilities. And you have an opportunity, as a Commission, to require a shift in focus in special education to one of competence enhancement, where we work very hard together to use evidence based instructional

practices to move all students from where they are to where we want them to be.

That's going to require allowing diagnostic personnel to spend considerable time documenting evidence of having applied effective instructional strategies before engaging in kind of a psychometric robot activity of looking for deviance. And it is going to require a push for the use of diagnostic paradigms in which assessments and classifications lead to treatments with known or predictable outcomes.

I would like respectfully to suggest that the question that we consider is not whether the IDEA categories are valid, but whether we still want them to be the organizing constructs that drive our response to the needs of students with disabilities. We have been doing that for at least 80 years, since Orin, in his textbook, laid out all of those terribly named categories. The names have changed over time, but we have still been engaging in an activity of trying to find the kids. And I would submit to you that we can continue to do

that, we can do it with considerable, incredible sophistication. We can fractionate subtype, define and redefine, but in my opinion, this will not be in the best interest of children.

The answer to the question of whether the categories are valid is a no, but. In Minnesota we say, "Yeah, but," this is a no, but. You have to differentiate some of the kids out of there. Frank did a good job of that, mentioning kids who are blind, deaf, kids with other health impairments, kids with traumatic brain injuries, severe mental retardation. But the other categories have only had meaning in social context and we change the categories in order to fit the needs of the day.

We knew this in 1975 when Cromwell, Blashfield and Strauss in their classic chapter on classification in Howe's book on Classification of Children pointed out that diagnostic constructs are specialized types of scientific constructs that have four pieces. A, historical, etiological information, and, B, assessable student

characteristics. Their usefulness, that is the assessable student characteristics, historical information, only has meaning when we know what treatments to apply in order to get predictable outcomes. So the only legitimate diagnostic paradigms are those that include C and D information, that is, where what we do diagnostically leads to treatments with known outcomes.

I would submit to you, that for the most part in special education, we are missing that. Cromwell, Blashfield and Strauss also pointed out to us that in order for categories to make sense they need to have four characteristics. They need to be reliable, reproducible, their needs to be universality. All members of the category have to have at least one thing in common, all beagles have at least one thing in common. There also has to be at least one specific, that is, one characteristic that differentiates members of the category from nonmembers of the category.

Frank, I am going to be ready for the

overheads here in just a second, we will go fast.

These are all data. I want to show you, we took 50 students identified by schools as learning disabled and then we took 26 operationalizations of the definition of learning disabilities, and we categorized each of those school identified LD kids according to each of the different definitions. Every time you see a color rectangle, that is an LD kid called LD by the schools who meets the criteria for being called LD according to the definition.

Frank, next slide, please. Then we took 50 low achieving kids, these are kids who were consistently performing below the 25th percentile on achievement tests, applied the same definitions. Every time you see a color rectangle, this is a situation in which a low achieving youngster meets the criteria for being LD.

Next slide, Frank. For all individual measures, we computed just plain old frequency distributions. Looking at the extent to which the scores earned by students were learning disabled

disabilities differed from the scores earned by students with low achievement. We got an average of 90 percent overlap between the two groups on all psychometric measures.

I brought these slides along, they are old but I want to make it very clear what I've said in the past and I am saying today. I have argued that there is no psychometrically reliable and valid way to differentiate members from nonmembers of the category learning disabilities. This does not mean, and I have not said that there is no such thing as LD. But, please, free us from the straight jacket of IDEA diagnostics and allow us to focus, instead, on responding to the needs of kids.

And, by the way, I want to tell you that there is very competing explanations for the findings which I have shared. I will be real quick in a couple of summary comments. I spent last weekend with two-year old grandson so I watched too many "Bob the Builder" videotapes, and I heard over and over again that old phrase "Can we do it?" "Yes, we can."

If federal law includes mandated categories of disabilities, we will fractionate kids with incredible sophistication. We will come up with types and subtypes and subtypes of subtypes. And I would submit to you, that I would hope that you would free us of having to engage in that kind of activity. Please do not give professionals the opportunity to engage in expensive, elaborate, diagnostic sorting practices that have no demonstrated instructional validity.

I would push you to the kind of problem solving modeling that Frank Gresham has mentioned. There are so many instances in which practitioners -- I am more familiar with school psychologists -- have demonstrated really good ways to find the right kids to serve and to improve instructional outcomes for all kids without having to engage in all of the elaborate sorting practices. They are also among the practitioners who feel the most guilty about what they do. So you have a wonderful opportunity to free them of that.

90 percent of the kids who are referred

by teachers are tested. 73 percent of the kids who are tested are declared eligible for special ed. Now, either that's a little high or we could just the whole paradigm, put them all in special ed and then try to figure out where we made our mistakes.

I thank you for the opportunity to make these comments and I look forward to a chance to respond to your questions. Thank you.

DR. FLETCHER: Thank you very much.

Dr. Cartledge is next.

DR. CARTLEDGE: Good morning. I want to thank you for inviting me to present my comments. I just want to say that Frank and Jim come from a slightly different background than I do as a school psychologist, and I would love to say that over the years, I have followed their work, but actually it is probably the reverse, that I am older than they are.

But at any rate, I am coming from a perspective as a teacher, as opposed to a school psychologist, and focusing on assessment. I also have identified much more testimony than I can

read, so it will just go into the record I hope. I am going to skip around and I apologize for having to skip around here.

Also as preliminary statement here, I have been asked to really focus on the overidentification of minority children. It has already been pointed out that there is an overrepresentation of minority children, particularly African-American children as well as Native American children or American Indians. This data, even though we can say things like African-American children make up 16 percent of the school population and something like 20 percent of all new children identified in special education, something like 34 percent of all the children identified with mental retardation, 26 percent of all the children identified in programs for seriously emotionally disturbed. That data needs to be desegregated in terms of regions and areas.

For example, we know that some states, and one piece of data that I received was that in the State of Virginia, nearly half of their

children in programs for mild mental retardation are African-American. So it varies from state to stay, even though we say things like Asian-Americans are under represented, if we would look at the State of Hawaii, that is not exactly the case, that native Hawaiians are overrepresented in special education. So many of us are left to ponder exactly why this is the case. And I don't have any hard and fast answers, but I do have a couple of areas that I would like to focus on.

I also want to point out that gender is a major issue. Although impoverished and culturally and linguistically diverse children as a group have long been educationally marginalized, the subgroup must vulnerable for this distinction is culturally and linguistically diverse males. Males, in general, tend to be disproportionately identified for special education. Particularly, in the categories of behavior disorders and mild mental retardation, and placed in programs for serious emotional disturbances at a rate that is three and a half times that for females.

When male status and cultural linguistic diversity are combined, special education status and other undesired outcomes are even more predictive. Black males, compared to while males, regardless of socioeconomic level are much more likely to be suspended at a younger age, receive lengthier suspensions, be tracked in low ability classes, be retained in their grade levels, placed in special education classes, programmed into punishment facilities such as juvenile court, rather than treatment, and given more pathological labels than be warranted.

Socially conscious authorities increasingly assert that U.S. schools are failing their students and disproportionately fail students of color. A pronounced example of a school's failure and its disciplinary measures --

DR. FLETCHER: Use the mike, please.

DR. CARTLEDGE: Is that better?

DR. FLETCHER: Much better.

DR. CARTLEDGE: The over emphasis on punishment and coercive practices can be

ineffective, leading to negative modeling as well as causing students to devalue school, the schooling process and school personnel.

Suspensions and punitive practices start very early in the child's schooling. In my recent work in the schools, I have noted kindergarten children, first grade and second grade students suspended and suspended regularly. Often it is the same child experiencing repeated suspensions and it is not uncommon for the youngster to have little or no understanding of the reason for these actions.

For example, at least two youngsters that I have been working with recently were suspended because they found a knife on their way to school, had the knife in their pockets and weren't doing anything wrong with the knife, except that when it was determined that these youngsters had the knifes, they were suspended for something like six weeks of school. Each of these youngsters received something like two hours a week of tutoring during this time of suspension. And what

makes these -- and then when the youngster comes back to school, he is further and further behind.

This starts a trajectory of more and more discipline problems, and very soon the youngster is referred for special education. Now what makes this very problematic for me and egregious in my mind, is that, one, the youngsters fall further and further behind academically. But even more important, the youngsters receive no instruction about what they did wrong or how to correct their behaviors in the future. So my background, in terms of teaching social skills, I really strongly recommend that we focus on, one, prevention, and, two, teaching children more adaptive ways to behave.

Last week the State of Ohio released its disciplinary data. And this data for the first time was reported according to race and gender. Consistent with national data, African-American students were disciplined more often than whites and other groups, with a few exceptions where they were exceeded by Hispanics and native American

youngsters.

Particularly noteworthy was the observation that in one district, Shaker Heights, to be specific, all the minorities, including Asian-Americans, had higher rates than whites, and the rate for blacks was 12 times that for whites. Now, in the other districts, the rates for black children tended to be something like two or three times that for whites. The interesting thing is it was noted that as the white membership of the school district increased, the chances of a black student being subjected to disciplinary actions, correspondingly increased.

This observation parallels the research findings on special education referrals for minority students discussed later on in this paper. Essentially what that says is that we not only have disproportionate referrals with minority youngsters, particularly African-American and American Indian youngsters, but what the literature tells us is that for all minority youngsters, as the school system becomes increasingly white, the

likelihood of that youngster being referred for special education goes up accordingly. Now, I am at a loss as to how to explain that data except to say that the disciplinary data closely parallels the data for referrals to special education. And the other thing that we know, there are two factors that determine whether or not a youngster is referred for special education. One happens to be a reading problem, the other happens to be a behavior problem.

Low expectations is the other factor that I feel contributes to special education referrals, disproportionate referrals for minority children. Another way in which schools contribute to the disproportionality of CLD students is through low expectations. Consider the case of the psychological I received recently for a youngster who I refer to as D. He was assessed for an SED program or a program for emotionally disturbed.

His cognitive scores put him at or about 34 percent of his peer group. His academic assessment in reading and math put him at 13

percent and 19 percent of his peer group respectively. Interestingly, the examiner concluded that his attained achievement scores appear commensurate with his overall level of cognitive ability and frequent disruptive behavior. As he neared the end of first grade, he was already severely behind his age mates in the basic skills of reading and moderately behind in math. A profile of disruptive or aggressive behaviors, coupled with first grade academic failure is highly predictive of behavior disorders and overall school failures. Assessments that suggest that D is making expected progress, would undoubtedly lead educators to continue with current teaching strategies and to maintain relatively low expectations for school success. Low expectations is one of the factors that severely plague CLD children, especially African-American males.

This is one reason why I concur with some of the other testimony that we really need to eliminate IQ testing for this purpose. I am going to skip over here and talk about instructional

issues.

Too often these children are poor, entering the schooling process with approximately one-half the language and academic readiness of their more affluent peers. Impoverished CLD children are unlikely to receive early learning experiences needed for success in school. Their unreadiness sets the occasion for a trajectory of increasingly greater failure. After a period of sufficient failure, the schools initiate a process of labeling and special education placement.

The special education label suggests some disorder within the child and the need for more resources. Too often, however, especially for CLD children, special education is a place to put students when they do not perform. instead of being sources for habilitation, special education for black and many minority students is often marked by low-level instruction, restrictive placements and limited opportunities to return to the mainstream. The curriculum in many of these classes, especially in programs for children with

behavior disorders, is one of control so that the classes essentially become holding stations until students eventually drop out or are pushed out of school.

Children with behavior disorders have the poorest outcomes of all the children in our schools. The importance of a challenging curriculum and effective teaching and robust learning cannot be overemphasized for these students. One of my more encouraging recent experiences has been observations of urban African-American males identified with behavior problems fully intergrated into general education classes where scripted, high-paced, dynamic lessons were being conducted by teachers trained in direct instruction. These lessons, characterized by high rates of oral and written student responses are so tightly structured that students are constantly engaged in academic responding with limited opportunities to act otherwise. These conditions reduce the opportunities for students to disrupt and undermine the learning of fellow classmates.

In the general classrooms where we observed, the typical uniformed observer could not easily pick out the labeled student. And I will move through this quickly to point out that in this school, because of overcrowding, this is a school that a lot of parents wanted their children into, because of overcrowding, the administration was deciding to remove the children with behavior disorders and put them back into special classes. But because these youngsters were doing so well in their general ed classes with the special curriculum, the teachers refused to let them be returned to their special classes so that they took in additional children as opposed to returning them to special ed. And this finding, this occurrence is very consistent with some national data, some national findings that suggest that good instruction and good direct instruction can be highly effective in preventing the overreferral of minority children.

Teacher issues - I am going to just point out that teacher skill is an extremely

important factor relative to overrepresentation. Preservice teachers appear to be no more prepared for student diversity than their predecessors. Children in diverse classrooms are more likely to be taught by inexperienced teachers until after a survival period when the teachers are given a more rewarding classroom.

The quality and quantity of instruction provided students from diverse backgrounds often are inferior to instruction offered to more affluent peers. These students need to be taught more, not less. Their instruction needs to be explicit and it needs to be active, giving students many opportunities to respond.

My recommendations: Disproportionality is a complicated issue compounded by many factors, not the least of which are poverty and racial bias. And by the way, I just want to point out that one of the most recent reports that come out, suggested that one of the main reasons for overrepresentation for minority children happened to be poverty. Well, poverty is one factor, but many authorities

in this area fail to address the fact that when we move into more affluent districts, these children are even more likely to be identified, so you can't just say that poverty is the only factor. There also happens to be an issue of culture in the way that we perceive these children.

Overrepresentation is a critical concern if we wait for children to fail and then place them in programs that are least likely to foster their academic and cognitive growth. The point of focus needs to be on prevention. How do we provide the preschool and general education instruction that leads to school success and greatly reduces the number of CLD children, particularly African-American, who need specialized services and placement.

The first recommendation is early intervention and education. For children at the greatest risk, early intervention needs to parallel, if not exceed, those services that are currently available to families of infants with low incidence disorders such as sensory disabilities

and Downs Syndrome. CLD children born into families with specific markers associated with school failure, for example, extreme poverty, premature parenting, parent criminality, family disorganization and so forth, need to be targeted for early intervention. These interventions should include family support and education, health services, sustained high quality care and cognitive stimulation.

Preschool children from this population need access to high quality preschool programs. Recent scientific reports showing lasting effects of quality early childhood child care into adulthood is instructive. These authors, Campbell and her colleagues at the University of North Carolina and Chapel Hill, found high-quality early childhood child care to have a lasting effect on cognitive and academic development even into high school. And it was interesting that her findings showed that children who were in these programs, not only achieved better, but were less likely to be referred for special indication, were less

likely to access the criminal justice system, were more likely to finish high school, and more likely to go into college.

Emphasis needs to be placed not only on remediation for those at risks for school failure, but also on stimulating the cognitive abilities for youngsters who show promise of giftedness. And this is the other side of the coin. These youngsters are least likely to be identified for advanced programs and gifted programs, partly because we are waiting for them to succeed and we are waiting for them to succeed when they often are in less than adequate school programs.

The second recommendation is general education personnel preparation. I really think that this is largely a general ed, not a special ed problem, and that it needs to be addressed from that perspective. Children are labeled and placed in special education programs only after an expanded period of failure in general education classrooms. For many children, improvements in school performance can be brought about through

increased teacher support and effective instruction behavior management practices. Preservice and in-service training for general ed teachers needs to be designed to equip personnel at least with the following competencies. One happens to be cultural competence. I will skip over that and move on to the next one which is effective instruction.

I am moving quickly, because right now I have a model school's project going in the Columbia City schools that I am really quite excited about and what we are doing is to help teachers develop good instructional skills. Skills along the lines of what I was talking about earlier where children are having success. And we are having success too. One of the things that we are doing, though, in addition to providing after-school professional development seminars which are voluntary and you don't always get teachers to participate, I have my highly trained graduate students, Ph.D. level graduate students, working in the classrooms with the teachers, serving as what I call coaches.

And what we have done is we have helped teachers to identify, design, implement instructional strategies to work with all of the children in the classroom. And we have been collecting data, I didn't bring my slides, but essentially what the data shows is that when these teaching practices are in effect, not only are children responding more correctly academically but the level of disruptive behavior goes down dramatically. And we have seen a reduction in disruptive behavior for all of the youngsters in the classes where we are working. So that leads to the second --

DR. FLETCHER: Dr. Cartledge, we need you to wrap up, please.

DR. CARTLEDGE: Stop now?

DR. FLETCHER: No, you can wrap up. I just wanted to alert you.

DR. CARTLEDGE: I just wanted to say that teachers need to acquire skills in behavior management and we need to create schools that address all of these issues, and I just -- I am not

going to talk about that.

I just want to mention families of culturally and linguistically diverse learners. Families have been an important driving force behind much of the special education legislation and programming. And we all recognize and respect the role that they play. However, most of these families have been white middle class families. We need to aggressively pursue the involvement of CLD families and schools need to be trained to make outreach to families.

Thank you.

DR. FLETCHER: We appreciate your testimony, Dr. Cartledge.

The Commission members do not have written copies of your testimony, so we will keep the record open and ask you that provide that for us.

DR. CARTLEDGE: I sent two copies to Troy.

DR. FLETCHER: We will chastise him later, but I want to officially leave the record

open so that we can receive it.

We have some time for questions, but I will ask the Commission members to limit themselves to their most important questions starting with Dr. Wright.

COMMISSIONER WRIGHT: I get to bat lead off this time, right, Mr. Chair?

DR. FLETCHER: That's correct.

COMMISSIONER WRIGHT: Dr. Cartledge, if you could just elaborate just a little bit more on family support. Your presentation, it appears to me to be very strong in family support, and I am very interested in family support. Could you talk a little bit more about the family support.

DR. CARTLEDGE: First of all, there are some people that do a much better job of this than I do, and one of the most recent issues of "Exceptional Children," there was an article by Park, Turnbull and Turnbull, where they talk about poverty in general and they talk about the kinds of services that we need to provide families of poor children. Most of us are sort of oblivious to the

kinds of stressors that present themselves to impoverished families and how that interferes with children's learning.

And the supports that they need deal with both physical as well as emotional as well as cognitive and intellectual needs. Many of these impoverished families don't know the kinds of things that they need to do to stimulate the children's emotional as well as intellectual well-being, so I think there is a real need to address that issue if we are serious about prevention.

COMMISSIONER WRIGHT: Thank you.

DR. FLETCHER: Thank you very much. I will refer Commission members to the research of Dr. Susan Weander, which provides systematic parent education programs for high poverty families, exactly what you mentioned and what Dr. Cartledge just described.

Dr. Grasnick.

COMMISSIONER GRASNICK: I would direct this to any of the panel members. Thank you for your presentation.

What do you see as the role of a well-functioning language system as it relates to the identification of children with special needs, particularly learning disabled, and does it beg for much more intervention in terms of developing the language system early on for children, particularly those with circumstances of poverty or who are from families who are speakers of other languages?

DR. YSSELDYKE: I will just make one comment, and that is, I guess, to refer the Commission where I would look, and that's to the Hart and Grissley book on "Meaningful Differences," which points to the significant discrepancy in language background of children in poverty and children who are not in poverty and highlights for us in very clear, empirically documented ways the tremendous need for early intervention in language.

DR. FLETCHER: Does anybody want to add?

DR. CARTLEDGE: I would point out that the children come to school, impoverished children come to school with one-half the language of the

middle class.

But I also want to point out that a lot of our problems with culturally and linguistically different children is the way we assess them. We fail to assess them in their native language, we fail to understand cultural differences.

DR. FLETCHER: Commissioner Takemoto?

COMMISSIONER TAKEMOTO: This is an issue that is near and dear to my heart in many way, but I will try to limit my important questions to probably my most important question about this issue.

Someone that I heard recently said that far too many minority and language diverse children, particularly males, are consigned to a system of hopelessness and failure when they get eligible and enter special education services. That touches me deeply because a part of me knows that with all this research-based intervention and recommended practices and from what we know about special education, special education works and it has worked for millions of kids who had no hope and

were in that failure of hopelessness cycle before. Yet, I know far too many of those students, particularly minority students, who are still in that hopelessness failure system.

We have heard a lot about early intervention here. Tell me more about special education and how we could look at things like meaningful educational benefit within that, and whether we know enough so that all students, including minority students, will make gains and will not be left behind?

DR. FLETCHER: I think Dr. Gresham could address that because it is essentially in his testimony on page 13, talking about the research evidence on response to intervention.

COMMISSIONER TAKEMOTO: For students who end up in the special ed.

DR. GRESHAM: I'm sorry, I didn't understand.

COMMISSIONER TAKEMOTO: We have heard a lot of evidence about response to intervention as a means of keeping kids out of special education.

But in the area of, for those students who I am also very concerned about, including my own child and children of parents that call me, once you cross over that line called special education, what do we have in terms of evidence-based instructional practices that they will make meaningful education benefit?

Are we at a point where we can hold schools accountable for that meaningful educational benefit?

DR. GRESHAM: I think Dr. Cartledge probably addressed part of that, as I heard her in her testimony.

COMMISSIONER TAKEMOTO: The focus of the testimony was on early intervention, but I do know that many families of students who are minority families, as you know, Dr. Gresham, are calling because they want their kids in special education because they know special education can work, and far too many minority families are now calling me saying because of this overrepresentation issue, we don't have access to

special education?

What on the special education side do we have to offer families that is so wonderful that children will make meaningful progress, or is special education still a place of hopelessness and failure that people are saying it is?

DR. GRESHAM: I think at least with high incidence disabilities, in my reading of research on that question, somebody wrote an article one time, it escapes me who wrote it, maybe Jim knows, "What is Special About Special Education?" The answer to that question is nothing. Meaning that special education is sometimes just a place where you receive instruction under entitlement but in terms of instructional strategies, good teaching is good teaching, effective instruction is effective instruction.

So I think there is a lot of research on effective teaching literature, to show that you can get a measurable education benefit out of good instruction.

Dr. Cartledge, I think mentioned direct instruction being a good example.

DR. YSSELDYKE: Can I mention one thing?

It is really critical that we recognize if you want to improve instructional outcomes for kids, you have to know where you are going. We have done a good job recently of specifying standards, goals and objectives. You have to know how to get there. There is a well-confirmed ed knowledge base on how to teach kids and it is not restricted to kids with disabilities.

Most importantly, you have to know whether you are getting there, and we have a long history in this country of excluding students with disabilities from our assessment and accountability systems. That's changed recently. In our work at the National Center in Educational Outcomes, we have seen significant increases in participation in kids with disabilities in state and district assessment systems, and that's meant good things for kids with disabilities.

We see standards in their IEPs. We see kids making progress towards standards, and we see some school systems for the first time in history, assuming that they have responsibility for improving outcomes for those kids because they count. So I would also encourage the Commission to just reinforce, strengthen that part of our law right now which says that you must account for the performance and progress of all students, for indeed, we count who we count.

COMMISSIONER TAKEMOTO: Thank you very much.

DR. FLETCHER: The Chair will ask three quick questions, very fast, starting with Dr. Gresham since he is standing up there.

Dr. Gresham, we have heard testimony that essentially the data is not adequate to implement response to the instruction models and that, therefore, they should not be implemented at this point in time until we do more research. Is that the opinion that you were expressing on page 13 of your testimony?

DR. GRESHAM: I think there are places where that particular model has been very successful. I point out, in the overhead I pointed out to you Heartland AEA-11 model had been using that particular approach to eligibility determination for about the past eight or nine years with a dramatic amount of success in terms of eligibility entitlement decisions. Not only monitoring academic progress, but also entitling children to special education.

So I think we've got a working model at least in one state. Now that state may not be representative. That argument certainly can be made, but there are other districts I think that are also using a similar approach, a problem-solving model like that.

DR. FLETCHER: Thank you.

Just real quickly, Dr. Ysseldyke. Dr. Cartledge and Dr. Gresham both recommend elimination of IQ tests. You didn't say anything about whether you thought IQ tests were valid or not for the identification of children. I was

wondering what your recommendation was.

DR. YSSELDYKE: I would third the recommendation, or I guess it is fourth this morning, that we eliminate the required use. I point out the required use because school psychologists think that they have to do this stuff in every case, so WISC, RAST and Bender kids over and over again and write reports.

And anything that you can do to help alleviate that thinking, that that's what we have to do, would be appreciated. And knowing a youngster's IQ tells us nothing about how to teach the youngster. You learn how to teach students by teaching students and gathering data on the extent for which what you do moves them toward the goals and outcomes that you hold for them. Not by knowing whether they are a 38, a 78 or a 138.

DR. FLETCHER: Thank you.

Dr. Cartledge, you testified about the value of direct instruction instructional approaches. Just a point of clarification, direct instruction means lots of different things to

different people. And I was wondering if you meant programs specifically called direction instruction programs or if you are really talking about the importance of explicit instruction?

DR. CARTLEDGE: Both.

DR. FLETCHER: So you would essentially advocate or see value in the use of what is traditionally called direct instruction programs for children with disabilities, who are also, for example, poverty or minority status.

DR. CARTLEDGE: Right, yes.

I closely observe these programs and I have seen real good outcomes, although teachers -- many teachers don't like them because they are so structured and scripted, but what I am concerned about is that a lot of teachers don't get good training in providing explicit instruction unless they do go through a program of this sort.

What we are doing right now, we are not using, DI. We are using variations of that. But what we are trying to do is to get teachers to present instruction where it is very explicit and

requires students to respond continuously. But what we are having to do is to have coaches go in there and work with the teachers to make sure that they are able to do it.

I know I am sort of long-winded --

DR. FLETCHER: We really do need to move on. You have answered my question very nicely. Thank you.

Reverend Flake.

REVEREND FLAKE: Thank you very much, Mr. Chairman.

This is for anyone. The question of discrepancies, even when there is culpability as it relates to socioeconomics as related to economics, not just poverty, would that suggest there are some preclusions about the socilogical imperatives that teachers may perceive based on the background of the child before they are even assessed, and then the assessment confirms for them what they were thinking in the first place, as opposed to a purer analysis that says that maybe some of these kids are just behavioral problems that are at certain

growth levels that can be adjusted within a traditional classroom structure?

DR. YSSELDYKE: I will just give you a quick response because it is something that I didn't say in the testimony.

We spent a lot of time studying the process of referral. And the answer to your question is incredibly complex. What we know for sure is that teachers refer kids who bother them. Different kinds of teachers are bothered by different kinds of kids. So when a youngster walks into a teacher's classroom uttering a long string of four letter words, the teacher in one case refers him immediately for assessment for behavior disorders. The other teacher says, "Thank you, thank you for sending me Alan. The last three didn't talk. This one at least talks, we will change the words that he used."

So the response to your question has to be taken in social context, and I think that's reflected really nicely in Dr. Cartledge's data on different school districts in Cleveland and the

kinds of kids you get. I would submit to you that one the difference -- the racial difference occurs in a place like Shaker Heights is that those kids differ from the other kids that folks are used to teaching in their classes, and they probably demonstrate some behaviors that bother folks.

DR. GRESHAM: I just want to reinforce what Jim said, and also if you look at the bottom of page 4 of my prepared testimony, it talks about referral. Basically, referral decisions are not based on standardized test results, so that is the second stage where the real determination takes place, referral definitely takes place using local norms based on teachers local norms, and that can be relative. It is relative to kids in that classroom, kids in that district.

Also, as Dr. Ysseldyke pointed out, teachers tend to refer kids that bother them, kids that demonstrate what we call externalizing behaviors.

REVEREND FLAKE: Just one question in general to think about, would I be correct in

assuming that in many instances there is already a predetermined lower expectation that these kids will ultimately be able to perform or come out of the special ed class?

DR. GRESHAM: I think that may be true in some cases. I don't know how prevalent that is, that belief.

REVEREND FLAKE: So that has not been analyzed?

DR. FLETCHER: It was discussed in the RC report.

REVEREND FLAKE: All right, thank you.

DR. FLETCHER: Commissioner Rivas.

COMMISSIONER RIVAS: I would like to thank you each of your for your excellent testimony. You have given us much information and many recommendations.

I guess my question for you is, due to the time frame that we have to compile a report that we have to present to the Commission as a whole, and this being one of many tasks forces, I would like for you to give me what your top

recommendation for the improvement of the assessment and identification part of IDEA.

DR. GRESHAM: The committee?

COMMISSIONER RIVAS: Each one of you, because we got many recommendations.

DR. GRESHAM: What I would recommend for my part is number one on my recommendation list, which is the current approach to defining learning disabilities based on IQ achievement discrepancy should be abandoned. That's number one for me.

Number two would be we should adopt a responsiveness intervention model instead.

DR. YSSELDYKE: You can in short time have immediate impact. Look at Lucas and Louisiana and Mississippi, where it was mandated that folks provide evidence that they had actually taught kids and had data on the extent to which those students were profiting from alternative instructional procedures before they were allowed to put kids into an assessment.

Your two approaches that may work is to

recommend that we provide special ed services to the bottom 20 or 22 or 23 percent of the school age population based on documented performance and progress and achievement. My good colleagues, Maynard Reynolds and Margaret Wong, who is now deceased, demonstrated you will get the same kids as you get with all the categorical stuff.

But I think it is requiring that people provide evidence that they have actually employed, evidence based practices, and that the kid is not profiting from that kind of instruction. So the multiple gating procedures that Gresham talks about, that Hill Walker talks about, that lots of the folks talk about, dual discrepancy kinds of approaches. I would strongly recommend that you go that way and, yes, please, get rid of the discrepancy.

DR. FLETCHER: Thank you.

Commissioner Coulter -- oh, I'm sorry.

DR. CARTLEDGE: I don't have a simple remedy here. I would essentially say that one of the things that we need to do is to provide

specialized intervention within general ed classrooms.

When youngsters are identified as having a problem, instead of sending that youngster on to special education or providing intervention, I would suggest that we provide specialized intervention within those settings. And then if the youngster is not responsive, then perhaps placed in special education. But I don't think most general ed teachers know how, on their own, to implement the recommendations that are provided by the special ed teams. Many of them make a good effort, but they don't have that expertise and we are not providing the training for them.

DR. FLETCHER: Thank you.

Dr. Gresham, do you want to add to that? You don't have to.

DR. GRESHAM: No.

DR. FLETCHER: Okay, Dr. Coulter.

COMMISSIONER COULTER: Once again, like the other Commissioners, I want to thank you very much for your remarks.

We have heard testimony in previous hearings with regard to the lack of scientific basis for the use of the IQ discrepancy model, and I have been troubled by at least several national organizations that have appeared to be taking the position that, despite the fact that there is no science to support this model and despite we obviously have, at best, mediocre results for children with disabilities, including drop out rates that are 50 percent or greater in some instances, that they continue to push for the status quo. And I can accept a fear of change, so to speak, but I guess Dr. Ysseldyke, if I heard your testimony correctly, you said that there are number of places in the United States today that are operating under alternative systems for identification and that those people, it sounded like you said it was like trying to operate this as almost -- I think the word you used was a bootleg place process.

Could you speak to the capacity of the country today. If we took away that rule, could

people rise to the challenge and do something that is scientifically valid rather than simply repeating what they have been doing in the past, that I think all three of you have testified does not make sense?

DR. YSSELDYKE: Okay, I did it again. I would refer you to the work in Heartland AEA, people like Jeff Crimes, Dan Rashley, Dave Tilley and Randy Allison have good evidence on the effectiveness of noncategorical approaches and they have a text on that I can give you the reference to. Joe Kovalevsky, Dave Prosy and their colleagues in Chicago schools have been operating with a problem-solving model based on the Iowa approach. Minneapolis Public Schools, my colleagues Doug Marst and Andrea Kantor, people like that have had a waiver on having to classify kids for a period of time.

And I guess rather than just to refer to more places, I would refer you to several publications of the National Association of School Psychologists where they document those best

practices, and to the new Volume IV of "Best Practices in School Psych," that lay that out. And my read on the school psych profession is that they have been calling for this for a very, very long time and haven't been able to get a receptive ear.

So those are at least some of the locations, Alan, just off the top of my head.

DR. FLETCHER: Thank you.

Commissioner Acosta.

COMMISSIONER ACOSTA: Once again, the last shall be first and the first shall be last, Dr. Wright.

I thank you for your excellent testimony, and as many of my fellow Commissioners have already asked the questions, so let me ask quickly, when I was in school in New York City, reading was used as a category for identification of special education.

Should reading be used as a category? Is it still being used? What with can we do about it? And that is for Frank or Jim. And, Jim, with all due respect to Bob the Builder, "juntos

podemos" first.

DR. GRESHAM: I would just refer you back to, this was Chairman Fletcher's idea, we had a follow-up meeting, I think, wasn't it back in November for the LD Summit, and what we did in that case would be, as know the current law, IDEA, defines seven categories at least in learning disabilities, seven subcategories of specific learning disabilities. I think we did a poor man's factor analysis -- or poor woman's factor analysis -- they reduced that to about three or four, if memory serves.

Is that not correct?

DR. FLETCHER: We tried, but we weren't able to get consensus on that.

DR. GRESHAM: Right. The point is the overwhelming majority of children who are placed in learning disability programs are for reading. And we know much more about reading than we do any other academic area in terms of remediation. A lot of that being due to the research that has been funded over the years from NRCHD. We know less

about remediation now in some of the other categories, so I don't know whether a separate category of reading is justified because a kid could probably read okay but also have some specific math issues.

Unless you have another one.

DR. YSSELDYKE: I just wouldn't categorize them. I would take his reading problems and provide him with effective instruction and there is knowledge base on how to do that. If you have to figure out who to serve and it is a resource question, decide how many dollars you've got and serve the bottom X percent of the population based on their performance in reading, I think we will address a lot of that through what is left of the REA and of the Reading First initiatives.

COMMISSIONER ACOSTA: Thank you.

Just one last statement to Gwen. I come from a community where, unfortunately, I agree with you, that we have to raise expectations of teachers, but how about families who have low

expectations as well as teachers, both minority and non-minority teachers, and that is where the rubber meets the road for me, a lot of my minority teachers have low expectations of minority children. And how do we do that within the context, because one of the other issues that we are facing as a Commission, is making recommendations for teacher preparation?

DR. CARTLEDGE: That's a very good question, and I would agree with you totally, and I have dealt with it all in terms of my applied work.

And, forgive me, Reverend Flake, but I don't think that preaching is going to do the job here.

REVEREND FLAKE: I agree with you.

DR. CARTLEDGE: I think that the best thing that we can do is to go into the schools and show that the children can do it. And we do have schools where children are doing it. And I think that the proof of the pudding in this case is in the eating. When teachers begin to see that children achieve, then they will begin to believe.

When parents begin to see that their children achieve, they will begin to believe.

COMMISSIONER ACOSTA: Thank you.

DR. PASTERNACK: The testimony that you have provided this morning is supportive of the President's charge to this Commission, that it is tame for us to focus on how we achieve excellence in special education. And I thank you all very much for coming before the Commission.

I have many questions, but in the interest of time, I will start with the same question for all three of you, and that is, why, in your opinion or based on the data that you are aware of, is the drop out rate for students with disabilities twice the drop out rate for their nondisabled peers?

DR. CARTLEDGE: Well, I think it is just for all of the reasons that we have mentioned. That is, first of all, we are dealing with, to a large extent, especially in the high incidence area with the exception of LD, we are dealing to a large extent with impoverished children. We are dealing

with youngsters who may not have much hope anyway. We are dealing with youngsters that schools see not only as different, but difficult. Many times these youngsters are pushed out of school.

And the data that came out in Ohio, one of our school systems south of Columbus has decided to stop suspending youngsters for truancy and things of that sort, and this at the high school level, and the reason is what they found is that the youngsters were dropping out of school. It was counter-productive. So with the measures that we use in school very often to address the youngster's problems are very often ineffective and they drop out.

DR. GRESHAM: I would just add to that, besides the cultural and family issues that might help explain that, I think a very behavioral explanation of that, when you are confronted with a situation where you know you are going to fail, and you can predict that you are always going to fail in that situation, there is no really hope. Somebody mentioned the word "hopelessness" before.

It is an easy choice to drop out of school.

And I think there is a very good reason why kids do, simply because they know they can't be successful, because they never received adequate instruction, apart from some family background issues that might contribute to that.

DR. YSSELDYKE: I would agree. I think it is an issue of instructional match. As we look at what goes on in schools, the area we find and observe in classrooms, the one thing we find most often with kids is that instruction is inappropriately matched to the level of skill development of the learner, and then the expectations are out of whack.

I guarantee you that if you tell me that I can't get out of a situation until I get a score of 80 in gold, I am going to drop out immediately. If instead, you employ a concept of personal best, and say, "Jim, what is the best you have ever done?" And I say "Maybe 110," and you set realistic goals and then provide me with feedback that tells me that I am moving towards

those and that I am a successful person, then I am going to do what Frank suggests.

I think kids drop out because they feel they have no chance of being successful. You tell me I got to shoot a decent score in golf, I am out of here. I don't want to hang around. And there are really good programs, I have to tout some of ours at the University of Minnesota, a program called Check and Connect. My colleagues Sandy Christiansen and Caramel Lair, where they have also developed some procedures to make sure that kids actually attend school. The kids who drop out are the kids who learn over time that it is a better deal not to be there than to be there. So if we get folks checking on them and connecting with them and making sure that they are there experiencing success, we can make some changes in that.

DR. PASTERNACK: Did we hear testimony today that you all believe that we have instructional strategies to be able to achieve excellent results for students with disabilities?

That is just a quick "yes" or "no."

DR. YSSELDYKE: Absolutely. There is a well-confirmed knowledge based on effective instruction.

DR. PASTERNACK: Then why don't we have more effective results for students with disabilities in this country?

DR. YSSELDYKE: Because of a lot of contextual considerations. We put teachers -- one, teachers sometimes know about things like retroactive and proactive inhibition and they don't know what to do on a daily basis with kids, so we haven't got as much good training as we ought to have on implementation of empirically demonstrated strategies and tactics so that teachers know precisely what to do on a daily basis with kids.

Secondly, we create, in many instances, overwhelming circumstances in which we expect folks to be successful with kids, including kids with disabilities.

DR. PASTERNACK: I know we are out of time, but I have to ask one more quick question, and that is the issue of pathologizing kids and the

critical need to identify kids earlier.

Is there a noncategorical way to identify kids earlier so that we can being to intervene in the lives of those kids earlier without having to continue the flawed model that you have all talked about eloquently this morning with labeling kids?

DR. YSSELDYKE: I am just going to refer you to the work of Charlie Greenwood, Julie Carter, Scott McCollum, Mary McEvoy and the folks at Oregon, Ruth Kaminsky, Roland Good, on monitoring the progress toward instructional, all kinds of very young children, they can predict very early which kids are going to experience difficulty, and they've got well-designed interventions for those kids.

DR. PASTERNACK: And since the Chair has left the room for the moment, can we ask, Dr. Ysseldyke, that you provide the Commission with those sites so that we will be able to go ahead and access that literature.

DR. YSSELDYKE: All right, and it is

the OSEP funded Early Outcomes Institute, which is a combination of those three universities, so we will get you that.

DR. PASTERNACK: Thank you very much.

COMMISSIONER WRIGHT: Who is presiding?

DR. PASTERNACK: It is Commissioner Pasternack.

COMMISSIONER WRIGHT: I have one other thing that I wish to say. I wish to say that in preparation for this, I went back to my Ysseldyke tapes, so I got prepared for this.

And I want to say this to you, that your testimony today is consistent with your work in your textbooks that we use and so I didn't have to ask you a lot questions because I am familiar with your work and we use your work in our college textbooks. Thank you.

COMMISSIONER JONES: One short administrative announcement, and this is also for the benefit of the public as well. We have a luncheon speaker that we have added, which wasn't

on the schedule. So over lunchtime, we will be continuing with that, although obviously, you are free to leave at any time, the observers.

For the Commission members, we are bringing in lunch, and everyone, I believe except Commissioner Grasnick has been made aware of this, everyone needs to get their order together now and give the money to me or to Linda, so we can actually feed you here at lunch.

The Commission is going to take a ten-minute recess.

AUDIENCE: Who is the luncheon speaker?

DR. PASTERNACK: The speaker at lunch is Dr. Dorothy Kerner Lipsky, who is the Director of the Center for School Restructuring and Inclusion at the City University of New York in the great City of New York.

COMMISSIONER JONES: The Commission stands in recess.

(Recess.)

DR. FLETCHER: We are going to get

started now if people would take their seats.

Our next witness is Dr. Howard Abikoff. Dr. Abikoff is a Professor of Child and Adolescent Psychiatry at New York University School of Medicine. He is also a Director of the Institute for Attention Deficit Hyperactivity and Related Disorders at the New York University Child Study Center.

As you might imagine, Dr. Abikoff is going to talk about issues that pertain to the identification of children with Attention Deficit Disorder.

Dr. Abikoff.

DR. ABIKOFF: Thank you, Commissioner. I want to thank the Commission for inviting me to meet with you all today and to provide some testimony, and I look forward to an interesting question and answer period.

As you can see from the title of my slide, I am going to be presenting an overview today of ADHD, including a description of diagnostic procedures and treatment approaches, and

I would also like to present some policy recommendations regarding ways to facilitate the identification, management and education of these youngsters in school settings. Before I begin, however, I would just like to provide the Commission with a copy of an International Consensus Statement on ADHD that was prepared in January of this year, and it was signed by an international consortium of scientists around the world. And this statement can serve as a reference regarding the status of the scientific findings concerning ADHD, the validity of the disorder, and the impact it has on those individuals diagnosed with the disorder. So I have this here, I will be happy to give it to you at any time.

DR. FLETCHER: Thank you, Dr. Abikoff, we will enter that into the record.

DR. ABIKOFF: With that said, why don't we take a quick historical trip and see how this disorder has been conceptualized historically. And I have up here a historical time line.

I think it is important to recognize

that ADHD is what is considered to be a neuro behavioral syndrome, and it has undergone definitional changes over the years, especially as our knowledge of this condition has increased. The key issue, however, is that the core symptoms of this disorder always have been defined on the basis of behavioral characteristics. As you see, as we move to the left of the slide, the early conceptualizations, MBD, if you will, both minimal brain damage, and then slightly later, minimal brain dysfunction, they were very vague and over inclusive. And they refer basically to a cluster of symptoms, including learning disabilities, hyperkinesis, impulsivity and short attention span.

In 1937, Dr. Bradley in Connecticut reported some positive effects of amphetamines when he was treating youngsters with behavior disorders, and he found that it reduced their disruptive behaviors and facilitated academic performance. However, beginning in 1960 and then going on into the late '60s, there was a special dissatisfaction with the term MBD. And, in fact, it led to coining

of the term "hyperactive child syndrome," which in 1968 was changed to the "hyperkinetic reaction of childhood," which stressed motoric symptoms. However, modern classifications, and those include the diagnostic and statistical DSM-III, 3R, and the more recent 4, have described the signs and symptoms of the disorder without implying any specific etiology, as did MDD, even though it was nonspecific. And that's important and we will get to that more in a moment.

So the current emphasis of ADHD emphasizes really three main behavioral areas - inattention, impulsivity and hyperactivity. And I will be talking about that in more length shortly. How prevalent is this disorder? There has been concern that maybe it is only a U.S. phenomena, and, in fact, that is not the case at all. What we see from studies from around the world, is that the prevalence is fairly consistent across diverse geographic racial and socioeconomic populations. And basically the differences in prevalence rates that we see here are, more than anything, largely a

function of the diagnostic criteria that are used.

For example, the ICD-9, the international classification of diseases, and now it has been updated to ICD-10. Those criteria for attention deficit disorder are much more restrictive than the DSM criteria. The result is that you get lower prevalence rates in countries where the ICD criteria are used. As an aside, it is interesting to note that if you have clinicians, for example, in Britain, who use the ICD criteria, if you have them diagnose youngsters using DSM criteria, you end up with the same rates that are found here in the states.

The earlier DSN criteria has a narrow focus and they were largely based on hyperactivity and the current criteria, especially DSM-IV, include again, as I said, hyperactive, impulsive and inattentive subtypes. And those have resulted in higher rates of diagnosis.

Now, what do we know about the etiology of this disorder? Well, we are fairly certain that it is caused by a complex interplay of factors.

For example, there are biological factors that can predispose an individual for ADHD, including post-traumatic or infectious encephalopathy, lead poisoning and fetal alcohol syndrome. There are environmental factors such as abuse, sexual or physical, or neglect, female adversity and situational stress. And there is also evidence, increasing evidence now from neuro science and from neuro imaging research of abnormalities in brain function and anatomy, including abnormalities in frontal networks, in frontal striatal dysfunction and dysregulation in neurotransmitter systems in the broken, especially the dopamine systems.

What have the neuro imaging studies, in fact, shown us, and here is a summary slide. The recent studies have basically pointed out that there are different brain structures in ADHD youngsters, which are smaller than individuals without ADHD. And, in fact, those differences are about 10 percent. And these include such areas as the basal ganglia and the two areas in there known as the cordate and the globus pallidus, that are

very rich in dopamine receptors, again, the neurotransmitter system that is assumed to be critical for functioning related to ADHD.

There are also smaller areas in the cerebellum in ADHD youngsters, particularly an area known as the cerebella vermis. Frontal lobes, which are very much involved in executive function, have also been shown to be smaller in ADHD youngsters than in controls. And again the frontal lobes are also very rich in these dopamine receptors.

And, again, these differences of approximately a 10 percent decrease in size compared to individuals without ADHD are strong evidence for a biological basis for the disorder and the fact that the biological group differences exist. However, it is important to note that the findings from these neuro imaging studies are based on group mean differences and that there can be overlap in the findings in children with ADHD and without ADHD. In essence, if you rely on neuro imaging alone, you will end up with a lot of false

positives and a lot of false negatives. So I think what is important to know right now, although this is a terribly important research tool, and it is providing us with many, many leads, neuro imaging is not a valid diagnostic tool for individual patients.

What about genetic findings? There has been strong evidence that has been collected over the past few decades that elucidate a genetic component to ADHD, and these include twin studies, family studies, especially of siblings and relatives, as well as adoption studies. And what do we know about the heritability of ADHD. Well, what I have tried to depict here on this slide is the heritability for different disorders, and I have listed panic disorder, for example, ADHD and schizophrenia and height. And what we know is that the high heritability of ADHD has been borne out in numerous studies and that genetic factors are implicated in measures of attentiveness and activity as well as in the diagnosis of ADHD.

And as you can see on the slide, the

studies confirm a genetic basis for ADHD with a heritability of about .75. What this means is about 75 percent of the variants in the phenotype for ADHD can be attributed to genetic rather than to environmental factors. If a disorder was completely attributable to genes, the heritability would be 1.0. And it if were caused by the environment, the heritability would be zero. And, again, what I have shown for reference is the heritability of panic disorder, schizophrenia and height.

So what do we know in terms of the summary of our findings for a genetic basis of the disorder? Well, it comes from, number one, twin studies, where we know that there is a 92 percent concordance in monozygotic twins for the disorder. And, in fact, even in full siblings, there is a 50 percent concordance rate. Family studies show that first degree relatives of ADHD children have a higher risk for the disorder than do relatives of controls. We also have information of adoption studies that's very informative. And they indicate

that the adoptive relatives of children with ADHD are less likely to have the disorder than are biological relatives of these children.

And then finally, new work that is going on in molecular genetics also points to the relationship that genes have in this disorder. And we know that ADHD, for example, has been associated with mutations in the human thyroid receptor-beta gene. Although this was something that really hit the press several years ago, we now know that this condition is very rare and can only account for a few cases of ADHD; however, there is more work to suggest that two specific genes, the dopamine transporter gene and what is known as the D4 receptor gene may be playing a role in the heritability of the disorder.

With that as a very quick summary of some of the scientific evidence to validate the presence of this disorder, I want to turn now to how this disorder impairs functioning in individuals who have ADHD.

As you can see on the slide, it impacts

all aspects of patients' lives and results in impairments of peer, family and adult relationships, in school functioning, in functioning at work, in leisure activities and in self-esteem. These are children and individuals who have many, many failure experiences. And as a result, many of them feel quite badly about themselves, eventually become dysphoric and even depressed as a result of the consequences of the disorder.

These are youngsters who have very deficient social skills, they have few friends. Many of them are neglected by other children, or if they are aggressive, in fact, they are more often than not rejected. Their academic functioning is severely compromised even if they don't have learning disabilities. I am sure we will be talking about that more today. And we see this compromised functioning in terms of lower grades, they are held back much more than typical children, and fewer of them go on to college.

We also know that as they get older,

because this is really now a disorder which we know to be chronic, many of them in terms of their job performance leave jobs more often and change jobs or they get fired. And in addition, they also suffer from more marital conflicts than do adults without ADHD.

Now, what are the core symptom areas of this disorder? It is characterized by symptoms in two core areas as I have listed, inattention and impulsivity hyperactivity. And I am going to review each of these in turn shortly, but we need to keep in mind that these aspects of functioning are developmental in course and they change their presentation with age. And it is very important in addressing symptoms that a clinician must consider normal age-related development of the ability to pay attention, to inhibit, and to control restlessness and control impulsive behavior.

There are subtypes of the disorder, and I have listed the three of them here, and we will go into them in a little bit more detail, but I think what is important to keep in mind that with

the new DSM-IV, we now have three different subtypes of the disorder, the most common of which is the one on the bottom which is the combined type in which children meet criteria that I will describe in a minute for both the inattentive type and the hyperactive impulsive type. The next most common is, in fact, the inattentive type of the disorder. And the least common is the hyperactive impulsive type. And we are more often likely to see that in younger children and not as children move on into elementary school grades.

So what does the inattentive type look like? What I have done is I have listed directly from the DSM the symptoms that, in fact, are evaluated in order to determine whether or not, at least in part, a youngster may, in fact, have a predominantly inattentive type of the disorder. And, again, what is important to note is that a youngster must consistently show at least six of the symptoms that are listed there. And the other thing to keep in mind, and we will see it in a slide that is coming up, although all of this needs

to be met, it is not sufficient by itself. There are other criteria that need to be met in order for the diagnosis to be made. Again, I will get to that in just a moment.

What are the symptoms of impulsivity and hyperactivity? Here, too, what I have done is I have listed the symptoms that make up these two constellations, and that is six or more of the following of any of them have to be manifested often, and as we will see, in more than one setting. And as you can see, the impulsive behaviors would include blurting out answers before a question is finished, a child who had difficulty awaiting turn in any situations. It could be while waiting on line, playing games with other children and the like. These are youngsters who, because of their impulsivity, tend to interrupt others or intrude on others. It is just very, very difficult for these children to wait.

In terms of their hyperactivity, it demonstrates in both minor motor movement and in more gross motor movement, so the children may

fidget a lot in their seat, and you will see that in terms of a lot of movements and squirminess in the seat, a lot of playing with materials at their desk with their hands. These are children who in situations in which it is expected that they stay seated, they find it extremely difficult to do so. And that would be not only in the classroom, but it might be at a movie theater, it might be at a church or synagogue, it might be at a restaurant, et cetera.

And what they also show is inappropriate running and climbing, a restlessness. And this is excessive, over and above what you might expect in a situation in which this should be moderated. They have difficulty in engaging in leisure activities quietly. A good description of these kids is that they always appear to be on the go. And the other is, although it is not the best term, what we sometimes here is, "My goodness, these children have motor mouth." They are constantly talking. And as you might imagine, in a classroom setting, that can be very, very difficult

for both the other children and the teacher as well. With that as a background in terms of what these symptoms look like, we need to recognize that there is considerable variation in symptoms.

Number one, the symptoms must appear in more than one setting. It is not just enough that the symptoms I have just described occur at home or at school. They must occur in at least two settings. Although when that happens, it may occur more in one than in the other. The other thing we need to keep in mind about this disorder is that there is extreme variability, even day to day, and sometimes within the day. Some of that is setting specific, but, in fact, the variability in symptoms is one of the hallmark characteristics of the disorder.

And the other thing is that we need to know, in fact, there are times when these children in certain kinds of novel, stimulating settings especially, may appear to be able to maintain sustained attention for long periods of time. We hear from parents often, who will say "My child

will play in front of that computer game for three hours and not leave. How can he do that?"

Well, in fact, we have what is called interest-based performance, and what sometimes happens is that we see that there is both variability in functioning and this kind of ability to sustain attention in some settings for at last some period of time, it leads to the false impression among some that these children are either lazy, uncooperative or willful, especially when typical boring tasks are asked of them. And that is not the case at all. Everything else that I have described before are behaviors that these youngsters are absolutely unable to control.

Now, what are the other criteria that need to be considered in order for the diagnosis to be met, in addition to the symptoms that I indicated? And these are not transient symptoms and, therefore, they must persist for at least six months. The other thing is that they are more frequent and severe than is typical of the individual's level of development.

The other thing is that this is something that had to have started before the children began school, prior to age seven. In fact, we often see this historically in children as young as three, and parents will report for some children that they were the most active infant they had ever seen, that they were crawling very early, coming out of the crib early, and, in fact, needed less sleep than other children.

The other thing that is critical is that these symptoms must impair the youngsters functioning in two or more settings. And impairment is a critical criterion here. We are not just talking about children who engage in some of these behaviors more often than other children, they are not just at the end of the normal distribution. They are that, but in addition, these symptoms must interfere with their functioning. And that differentiates them from youngsters who may be especially active or may at times be inattentive, but nevertheless, they are able to function well in situations when sustained

attention or ability to sit is required of them. That's not case with these children.

And I have listed the other two criteria there. It must cause significant impairment in social, academic or occupational functioning if they are older. And the symptoms cannot be better accounted for by another mental disorder. I will talk about that again in a moment.

Again, it is important to keep in mind, hyperactivity is not required for the diagnosis of ADHD. And, briefly, there are, in fact, two other ADHD diagnoses listed in the DSM, and I have put them up here. Some individuals can be classified as ADHD in partial remission, and that is, it was diagnosed in the past but the criteria are no longer met, even though clinically significant symptoms remain. And then, finally, you have ADHD not otherwise specified or NOS. And that is where we have individuals with prominent symptoms of inattention or hyperactivity impulsivity, but they do not meet full criteria for ADHD. And those are

individuals classified as NOS.

Now, how does this disorder present over time? What is the course of the disorder? And what I have tried to show here on this time line is that we know it is chronic, and, in fact, based on a whole host of follow-up studies that have now been done, anywhere from 50 to 70 percent of individuals diagnosed with ADHD in childhood can be expected to have significant problems associated with this disorder, certainly into early adulthood and probably beyond as well. Nevertheless, there are some, in fact, for whom the disorder does dissipate over time, but even for those for whom it continues, the nature of the symptoms change over time, and what we see is that hyperactivity, in fact, to some extent decreases. At least the overt motor restlessness. You still get reports from these individuals of a kind of an internal restlessness or agitation, but they don't show as much overt motor activity. And to some extent, there is some reduction in impulsivity as well.

What tends to maintain over time is

inattention and all of the symptoms associated with it, especially those related to executive function deficits, including organizational, time management and planning deficits. So that's what we tend to see over time. But, obviously, we are most concerned here at this meeting about the children with ADHD who are especially in elementary school. And that's where we know most about the disorder and where most of our work, our studies and our evaluations have taken place.

What do these kids look like? I have tried to list up here for you how a youngster might present in a school setting and how he appears relative to his other peers. I am hoping that most of you can read that list here, so that I don't have to take you through each of them in turn. What I think is critical is when you have a youngster who presents with this kind of picture, what we know is that this will adversely effect their academic performance, it causes increasing difficulty in peer relationships. And that is a very strong risk factor for the development of

later psycho pathology. Children who have poor peer relationships and get on poorly with other youngsters their age, if that continues, are at significant risk for the development of other psycho pathology as they get older, including conduct problems, higher risk for substance abuse and the like.

I think the key, as we will talk about later today, is that without intervention, especially because as I indicated, for most of these individuals, this does not disappear with age without intervention, this kind of a picture and the failures that are associated with this may lead to poor self-esteem and depression and can compromise their functioning in many, many ways as they move through adolescence and adulthood.

In fact, with that said, what about adolescence? What do these children look like? Number one, as I indicated, mother restlessness decreases and there is instead a kind of inner restlessness which is sometimes reported. We know that because of their impulsivity which continues

to some extent, adolescents are going to be much more involved in rule-breaking if they are ADHD then if they are not. They get into a lot of conflict with authority figures. They get involved in a lot of risky behaviors, so what we see are a lot of car accidents. These kids end up having more speeding tickets, and if you review Motor Vehicle Bureau records, you will see a significant difference in both accidents and speeding tickets for youngsters with ADHD then for those without.

Their poor peer relationships continue through adolescents and they also show a lot of emotional lability. And as I have indicated as well here, their vocational outcome is quite problematic. And these youngsters are also -- youngsters with ADHD, which I think is very important to keep in mind of its public health consequences, not only are they at high risk for drug and alcohol abuse, but also for delinquency and antisocial behavior. Not only do they not meet their potential, but they result in great cost to society in terms of having to treat them, and in

some cases, having to incarcerate them.

Now, what's important to keep in mind about this disorder, it is terribly important, that it frequently does not occur by itself. Rather, in fact, it tends to co-occur, or the term we use is to be comorbid with other diagnoses. And what we know is that in general about two-thirds of children with a diagnosis of ADHD, are also likely to have another comorbid condition. In fact, many of them will have three.

The other issue, of course, is that these other conditions will not be recognized without appropriate evaluation and are frequently missed. About half of the children can be expected to meet criteria for two other disorders which make up what is called the disruptive behavior disorders of childhood. And those are known as both oppositional defiant disorder or ODD and conduct disorder. And both of those are more common in boys than in girls.

A number of children with ADHD also have mood disturbance. Many of them clinically

significant. Those rates vary widely, and it depends on the criteria that we use to make the diagnosis, so based on different studies, we may see rates as low as nine percent or rates as high as 38 percent for depressive disorders. And in these cases, the rates are similar for boys and girls.

Many of these children are also especially anxious, with full-blown anxiety disorders, whether it is a generalized anxiety disorder, separation anxiety disorder or the like. And in general, about 25 percent of them or so tend to meet criteria for these disorders. And, again, based on criteria for making a diagnosis, it ranges anywhere from 8 to 30 percent and the rates in boys and girls tend to be similar.

With regards to the prevalence of learning disorders, be it reading, spelling or arithmetic, here it very much is going to depend on the classification procedures that are used to make that definition we heard an awful lot about today by out other distinguished speakers. So, in fact,

if a very liberal criteria is used, we may get anywhere from 40 to 60 percent of youngsters with ADHD also meeting criteria for a learning disorder. If more conservative criteria is used, the rate drops to between 20 to 30 percent. Regardless, we tend to find that this is more common in boys than in girls. So we know that it's occurring with other disorders, but the issue of making a differential diagnosis when a youngster presents with suspected ADHD becomes critical in helping us to understand what is going on in a particular youngster. And I have listed here some issues that need to be kept in mind. I've indicated that we know that there are common comorbid disorders that do occur with ADHD, but it also can be complicated by a large number of conditions that can mimic ADHD.

What we know, for example, is that there are environmental factors that may be contributing to ADHD symptoms. For example, physical, emotional or sexual abuse and severe family discord can produce symptoms of inattention,

impulsivity and hyperactivity that will mimic the disorder, but, in fact, are not indication if one does an appropriate clinical evaluation of an actual Attention Deficit Hyperactivity Disorder.

I've listed across on the right side a number of disorders, some of which co-exist, some of which can mimic and present with symptoms that look like ADHD. And it is critical in our clinic evaluations that we attempt to determine whether or not any of these conditions exist in order to rule out other explanations for the problems a child presents with.

Now with that said, how do we make the diagnosis? I have listed here different techniques. And the reason I have done so is because what's critical to keep in mind is currently there is no single marker that can be used to make the diagnosis. There is no biological test, there is no laboratory test for which one could say if the child is positive on this, we know this youngster has ADHD. So instead, what clinicians do is to use a combination of techniques

and measures to assess ADHD symptoms, impairment, and also to assist in the differential diagnosis. As I have indicated there, these include interview and history. There are standardized assessment measures, including rating scales and neuro psychological tests, as well as ruling out, through neurological and physical testing, alternative explanations for the symptoms the child might present with.

Now, in terms of practice guidelines, what I would like to bring to the Commission's attention is, in fact, recently in 2000, the American Academy of Pediatrics published some very useful clinical practice guidelines both for diagnosis and for the evaluation of a child with ADHD. And those appears in Pediatrics itself in 2000 Volume 105. And I have also listed for those who are interested, the website where one could actually download in those practice guidelines in their entirety. That is a quite useful document.

Now, what is done in the interview? Well, I have listed up here the kinds of

information that it is important to obtain in order to get a better understanding of the youngster's functioning. And it is critical to work with the parents and the child. In fact, what we know about clinical interviewing with children is that for youngsters under the age of 9, the reliability and, therefore, the validity of the information that they offer is quite suspect and oftentimes of little, if any, clinical utility. It is even more difficult for children with ADHD because they tend to be youngsters who find it difficult to report accurately about their own behavior. The term that is sometimes used is an "illusory correlation," and what we mean by that is that these children will often tend to describe themselves as doing just fine, when, in fact, parents and teachers and the like say just the opposite. You might have a youngster who is crawling around on your desk, and if you ask him if he has any trouble sitting in his seat, he will say "No, not at all," while you are trying to pull him down off the desk. These children tend not to self-reflect and are not

introspective, so it hard for them to provide you with detailed historical and current information that is accurate about their functioning. So instead, we rely, especially if the children are young, we rely especially on information that is obtained from parents, as well as from teachers. And much of that information must be historical. We need to get a developmental history. We must get an unfolding the parents of the youngster's functioning from early-on to the present day. And as we collect that information, we are also trying to find out whether or not there might be alternative explanations for why child is having the difficulties that he or she is presenting with. Certainly, we are also trying to get medical information to rule out the possibility of other explanations, including lead poisoning, for example.

It is also very useful to get family psychiatric history. That can provide useful hints as well. As I indicated, the disorder is highly heritable, and we will find in many of these

families, one member, be it another sibling or a dad, may also have ADHD as well as other disorders that tend to occur more frequently in family members of someone who has ADHD than in family members of children without ADHD. So a comprehensive clinical evaluation is critical.

And there are a number of different interview schedules that available. And I have listed some up them up there. Two very common ones are the diagnostic interview schedule for children, DISC, and another one called the DICA. These are available in written and electronic forms, they cover all the childhood diagnoses. Now what is good and bad about it is it requires little input from the interviewer and can be administered by trained nonprofessionals. However, the problem there is that you will sometimes end up with false positives because the bottom line is that to make an accurate diagnosis, although you collect information about the symptoms, you must be able to probe, to do follow-up questions, to understand the information that you are obtaining from the

informant to make certain that they both understand the nature of the question and that the response they are giving is truly characteristic of the problems specific to ADHD, and not due to another complication.

DR. FLETCHER: Dr. Abikoff, you have four more minutes.

DR. ABIKOFF: Okay, in that case, some quick points.

Rating scales, they are easy to use. They provide important information about how deviant the youngster is compared to other kids, but they cannot be used to make a diagnosis. I can't repeat that enough. Scores on a rating scale, whether it is the Conners rating scale or the Accembac, will not be used to make the diagnosis. And I have listed those there.

Neuropsychological tests similarly, although they may point out strengths and weaknesses which can help in terms of treatment planning, will also not be diagnostic. Another thing, if the child is put on medication and

improves, that means he must be ADHD. Not so. That does not validate a diagnosis of ADHD, because we know from studies done with normal volunteers, they will show similar benefits to at least acute dosing with stimulants that mirror what we see in ADHD kids.

How do we manage it? There are a variety of techniques for trying how to plan how to intervene with a youngster based on the needs profile that they present with. Perhaps in the question and answer, we can talk about stimulant medication. There are a whole host of medications that are now out there. Especially some newer ones that work throughout the whole school day and don't require a second dose during the day. It is the first line established treatment for ADHD. This has been the most studied treatment of anything in all of child psychiatry. We know what it does, and I have listed it there, and hopefully you can read all of that. But it is not a cure for the disorder. About 80 to 90 percent of children will show at least moderate benefit if they are tried on

one or two stimulants. Where problems remain in terms of pro social skills deficits, some children have side effects, parent management techniques continue, problems with organizational and time management skills which are terribly important for these children, do not improve with medication, and they need to be addressed in other ways.

There are psychosocial approaches that are available in treating these youngsters. What is key to keep in mind, for many of these approaches as much time is spent working with the adults who live and help manage these children, meaning the parents and the teachers, as the work gets done with the children. And, hopefully, we will be able to go into that in some detail. I have listed up here the kinds of work that can be done with families. There is some work that can be done with children. If you do social skills training, it must be done in groups. One-to-one in your office is going to get you nowhere with these children. And to the extent that you can work with them and have the teachers and parents aware of

what it is you are focusing on so that they can reinforce it and prompt it at home and at school, you will end up looking much better.

I have indicated here the kinds of interventions that can be done in the classroom, including the use of classroom rules, typical contingency management techniques, the use of daily report cards, very useful. You target certain behaviors and set goals for the children in the classroom. The teacher monitors it, at the end of the day they indicate on the card the degree to which those goals were met. That report card is brought home to mom. Mom looks at it, and based on how well the child did, the child is given various rewards and reinforcements at home. It places minimal demands on the teacher and is quite effective.

Other suggestions for the teacher are listed here. Kids lose their books all the time. Have an extra set of books at home. Kids can't find their homework assignment or they don't know what it is that needs to be done. Let the kids

make certain that when they leave the classroom, that homework assignment sheet is filled out and signed by the teacher. Put the kid in the front of the room so that the teacher can give frequent prompts and also reword the kid with praise. Do not give lengthy, serial instructions, they won't keep it in mind. Make sure that you are consistent in the way in which certain instructions are given each day to the children.

Quickly, policy recommendations. We have heard this from some of our other speakers today. It is critical that there be more work done to teach educators, both regular and special educators about this disorder. How do we do it? It needs to start early on in training back in college. We need to make changes in the college curriculum, and in addition, there needs to be on-going in-service training programs.

There must be from day one, when they are in college, a familiarity with behavioral strategies and their use and usefulness in classroom settings. They need to know what ADHD

look like and what it isn't. Many of the teachers are just not familiar enough with how this disorder presents in the classroom, and we must debunk misconceptions about the disorder.

Another important thing, we must make better use of our school psychologists. They are doing too much testing as opposed to not enough intervention work with teachers and not enough assessment of this disorder as it appears in school settings. Last thing, we have heard about early identification and intervention, we can talk about that more. It goes without saying, it is critical.

The communication between school personnel and treating clinicians who are not in the schools, it is an absolutely essential component of our work with the schools as we work with children with ADHD whether the treatment is medication, behavioral treatment or both, and I can talk to you about results from a study I have been involved in that point to the terrible importance of that second point here.

Organizational and time management

skills. The schools need to develop specific curriculum to teach the kids, all of them, how to do better with these skills. It is assumed that children learn it on their own, they don't. Some kids do pick it up on their own. This is especially problematic for children with ADHD. There needs to be specific curricula taught to teachers and then implemented in the classrooms.

And then my last point is that the parents need to be very much involved in the total IEP process. I think I went over four minutes, but I think I got it in.

DR. FLETCHER: Thank you very much for your testimony and all the wonderful information that you have provided to the Commission. I am going to start the questioning and then I will move to my left to each of the Commissioners. I think you have probably have time for one or two questions per Commissioner.

One of the big issues that our panel is supposed to address are identification practices for all children. The one concern that has been

expressed is the significant increase in the number of children identified under the "other health impairment" category, which many attribute to the specific eligibility set forth for children with ADHD in the last reauthorization.

Can you make any comments about why there might be such a tremendous increase in the number of children identified as ADHD and placed in special education?

DR. ABIKOFF: That's, obviously, a critical issue. And I think a lot of it has to do with the misidentification of children because of the inappropriate use of criteria for making that diagnosis, and that can occur in several ways.

The rating scales that I alluded to briefly before, the Conners rating scale is probably the most widely used of all. A lot of professionals, not only educators, but especially educators, take it to be, for lack of a better term, a quick and dirty way of making a diagnosis of ADHD. You can't do that. You can have children who are going to be elevated on those scales and it

not because they have a clinical diagnosis of ADHD. They could be active, they could be inattentive, but the point is, how impairing is it, at what age did it occur, and what are the other possible explanations for those behaviors occurring.

Without an appropriate clinical evaluation, one is unable to decide whether or not information based just from those criteria are sufficient. So I think part of it has to do with the way in which the diagnosis itself is made. We also know there are halo effects that color the assessments that are made of youngsters who present, for example, with conduct problems. You have a negative halo effect and what it does is it tends to color the way in which those adults will also report on the children's other aspects of functioning, even though those other aspects of functioning may not be impaired.

We have done some studies to show that if you show teachers videotapes of children who are showing oppositional behavior in the classroom, but those children are not hyperactive and inattentive

and we have controlled the rates, and we asked the teachers to rate those children in terms of their hyperactivity and inattention, they are rated as high, very high. Even though, in fact, it is not a function of what the child is doing, it is, in fact, a function of a negative halo effect that is impacting the teachers' perceptions and judgments about that individual.

So I think as a quick, I don't know if it is a complete answer, but as a quick answer, I think that in an attempt to get more children special education services, more children than should be are being inappropriately identified as ADHD, when I am fairly certain that for many of them that diagnosis is not appropriate.

DR. FLETCHER: That's very helpful. So what you are really saying is that if a school system wanted to do something about the identification of children with ADHD, they should institute more rigorous evaluations. And I presume, for example, that these evaluations are very much within the purview of appropriately

trained school psychologists?

DR. ABIKOFF: I think so, Commissioner. That's a very important issue. I think that if they haven't gotten that training, there is no reason why in master's and Ph.D. level school psychology programs that could not be a focus of their training. And there is no reason why if they were, in fact, fully equipped through their training to do so, that they could help, if not, in fact, make that diagnostic decision in school.

My concern is that many of my school psychology colleagues have, in fact, not received appropriate training in those diagnostic procedures and the schools don't rely on them. So I think that is an issue that is worthy of attention.

DR. FLETCHER: But, in fact, many schools refer out for what I call independent medical evaluations specifically for ADHD, and I think it is fair to say those evaluations are not much better either.

DR. ABIKOFF: There is no doubt that

many of my colleagues in medical settings, be they pediatricians, pediatric neurologists, child psychiatrists, and my boss will kick me for that, may, in fact, not do as good a job as they should, especially because there are issues of comorbid diagnoses as well that must be paid attention to, and folks who are in pediatric practice without extensive mental health training and background, may, in fact, frequently miss other comorbid disorders that are impacting on a youngster's life and, therefore, the treatment plan and recommendations that are made may not be the best one for the youngster.

DR. FLETCHER: Thank you. One other quick question.

I am wondering if you would comment on what it is that makes a child with Attention Deficit Disorder disabled. As you know, eligibility for special education is a two-prong determination, you have to have a disorder, but there also has to be a demonstration of educational need. And what I am going really getting at is

whether it is Attention Deficit Disorder per se that makes most children disabled, or is it really the comorbidities that contribute to the disability itself.

DR. ABIKOFF: It can be both, and I will try to be quick about that.

You can have a youngster with ADHD alone, without a comorbid learning disorder, whose educational functioning is terribly compromised. And what you can see, for example, is in fact, you can have a youngster of 140, I have worked with many of them who were brought to me because of difficulties in terms of academic functioning. These are children who because of, number one, misbehavior in the classroom, interrupt the classroom functioning. But more so than that, these are children who because of executive function deficits may not be able to get their work in, even though they did it. They may want to do their work when they get home, but they can't find it because they can't find their homework assignment book. These are children who will rush

through their work so that if you have them go back and force them to check, they are likely to correct errors that they made that instead were careless, so instead what we find is on achievement testing, especially in a group setting, these kids will do much worse than they would in a one-to-one. They will rush through their work, they will make careless errors, they will skip entire pages and not even be aware that they have done so.

So for a variety of reasons you can end up with compromised academic functioning, even for children who do not have concomitant learning disorder. In children for whom both are present, as you might imagine, then you have serious skills deficits in addition to everything I have just mentioned and the academic functioning is even further compromised.

DR. FLETCHER: Would it be correct to say, though, that a lot of the recommendations that you would make for a child who only had Attention Deficit Disorder would be what we would call curriculum modifications and that they could be

done either through special education or through the 504 process?

DR. ABIKOFF: Yes, absolutely so. That is absolutely critical.

And to the extent that through 504 you might be able, for example, even at the end of the day to have an aide who comes in and checks the child's bookbag and makes certain that everything in that bookbag that the child is taking home is supposed to be in there and should go home that day, including a homework sheet, the books that are needed and the like. That's just a small example of that.

You can have other situations in which right in the classroom the aide is there to help prompt the child to engage in behaviors and master on their own, although that will take some doing.

DR. FLETCHER: Thank you.

Reverend Flake.

REVEREND FLAKE: Just a quick comment and question. I am thankful that my children are adults now because this impulsivity and

hyperactivity seemed to be a major part of their lives, so I am glad I got this report after they have moved on to college.

The only question i have, and I think all of want to know your opinion on the continuation of IQ test as a primary assessment tool versus all of the other things you have listed, and where would you put the IQ in this process?

DR. ABIKOFF: I would agree with what my colleagues spoke about in the previous presentation. I am not quite sure it helps us very much, and in fact, one of the things that we know about children with ADHD is because of their impulsivity and their inattention, they will frequently on IQ tests, score much lower than their actual intellectual functioning would suggest. For example, if a child is on stimulant medication and doing well, and you give him the same test or a variant of the test, their score can go up anywhere from 7 to 10 points and sometimes more.

The medication didn't make them

smarter. All that happened was their ability to focus appropriately and to consider and reflect on their responses results in a better estimation of their functioning, and in fact, the disorder, part and parcel, results in some lower scores than you would get. So I have my concerns about how useful that is for some placement issues and the like.

DR. FLETCHER: Commissioner Rivas?

COMMISSIONER RIVAS: I just want to thank you for your testimony. I don't really have any questions right now. I know we are limited on time. I will pass it to Commissioner Coulter.

COMMISSIONER COULTER: I think we all want to express our thanks to you for your testimony and the fact that you tried to cover a lot of ground in a relatively small period of time.

I am concerned that some of the interventions that you have described, for instance, you gave a very good example about the need to systematically teach children how to manage time, how to organize materials, et cetera. I get the impression that when you are recommending that,

you are really recommending that for any child who would evidence a problem in that area, right?

DR. ABIKOFF: That's correct.

COMMISSIONER COULTER: I don't think that is specific to any particular diagnosis.

DR. ABIKOFF: That's correct.

COMMISSIONER COULTER: So if, in fact, you have a problem oriented approach to looking at problems of children as they exhibit themselves in classrooms, if that's present, where is the value in the specific diagnosis of ADHD?

DR. ABIKOFF: Although I gave that as one indication of a way in which one could intervene in a classroom, and you are correct, I think there we, along a dimension from kids who are very good in terms of their executive function organizational skills, to kids who are very poor, and there may be some children who are poor who are not ADHD, the difference, though, I think, number one, is even the severity of it is going to be greater in ADHD children than those who are not.

You cannot imagine the kinds of

problems that arise in the lives of these kids because of these difficulties. But that is just one aspect of their dysfunction, if you will. It is everything else that results in that diagnosis. They are impaired in almost every aspect of their functioning that is important for a child. And I have emphasized not only the problems they have at home with siblings and with parents, their peer relations are so severely compromised that many of these children have no friends or they end up gravitating to kids who will accept them who are like them, and more often than not that means they are hanging out with kids who are similarly troubled with severe conduct problems and the like because other kids just don't want to be with them.

So what we are describing is a condition that is incredibly pervasive, persistent, chronic and impairing. And that's the key issue. There are children would may forget things at school, and we can provide them with some guides. That is one aspect of the dysfunction of these children, and they do it much more than other kids,

but it needs to be viewed in the broader context of an impairment that effects almost all aspects of the lives of these children.

COMMISSIONER COULTER: Once again, I think in the description we were given earlier, the testimony of a multi-tiered model of providing interventions for kids in varying contexts and in varying degrees of intensity, it would appear as though what you were talking about would fit within that model once again, that in those instances where the problems were pervasive, they would in fact be more resistent to intervention, requiring then more intensive intervention, if you would, in order to address the problem in a variety of environments.

DR. ABIKOFF: That's correct.

And the other thing that we need to keep in mind is that for children for whom the disorder is severe and is truly compromising function in many settings, we need to recognize something else, and the data speak to this better than anything else, and that is that although I

think the types of psychosocial interventions that I have tried to briefly take us through today are an important part of that treatment package, the bottom line is stimulant medication is a critical component in the lives of these children. And without it, the degree of improvement that we are going to find for these children who do not receive it is invariably going to be considerably less than when a youngster is appropriately managed with medication. And it is the issue of appropriate that I would be happy to talk to you all about, because the school place a critical role in that.

And if I could, I would like to mention one finding -- am I coming through?

DR. FLETCHER: Loud and clear.

DR. ABIKOFF: Okay. There is an issue that is very important here. I was involved in the largest clinical trial ever done in the world for children with ADHD, it is called the MTA study. It was funded by the National Institute of Mental Health and the Office of Special Education. It took place in seven university sites in the United

States and Canada. Almost 580 children with ADHD participated in this study.

The children received one of four different kinds of treatment and they randomized to it. A quarter of the children were treated with medication by the clinicians in the studies at the sites. A quarter of them received very intensive behavioral treatment for 14 months. A quarter of the children received a combination in the study of behavioral treatment and medication. And a quarter of the children were referred right back to the community where they could get anything that the parents were interested in obtaining for their children.

At the end of the study, not surprisingly, we found out that two-thirds of the families who were referred back to the community ended up getting medication for their children. But we had a quarter of the children in the MTA who were also on medication. And it gave us an opportunity to do some comparisons about how well the children did in the community if they were

treated by community practitioners, versus being treated in the MTA where we used a very specific set of guidelines and algorithms. And the kids who treated in the MTA did much better.

Why is that? Medicine is medicine. Not so. There were a number of differences that we found, and we are still working very, very hard to tease out all of this. It is terribly complicated statistically. But there are some issues to keep in mind.

Not only were the children on very low doses in the community, considerably lower than the doses we used, but just as importantly, they were seen every month by their practitioner and they were monitored and the medication was managed appropriately, and we got monthly feedback from the school. We got it at the beginning, ever more so, to help manage the dosage and regimen for the child, and each month we spoke to the teacher. The teacher told us how well or how poorly that child was doing, and we made accommodations and modifications in a child's medication regimen as a

function of feedback from the parent and the school.

How often did that happen in the community? Twice a year, sometimes once a year. Which meant that we had many, many physicians who were medicating the child and continuing to medicate the child without getting feedback from the school. I can't impress upon the Commission enough how essential it is to get the school personnel involved in working with clinicians who are outside of the school in terms of treatment planning and treatment monitoring of a child who is being treated for ADHD.

COMMISSIONER COULTER: Thank you.

DR. FLETCHER: Commissioner Acosta.

COMMISSIONER ACOSTA: Thank you for your excellent testimony. It is much more than we have time for, unfortunately, but let's see if I can get through this.

Puerto Rico, as we know, is a Commonwealth of the United States, and what concerns me is that impact of the children coming

from Puerto Rico to the mainland schools as well as those schools from Nicaragua, Salvador, et cetera. And when you talked about world-wide prevalence, Puerto Rico came out in very large numbers, particularly here in New York City and in Ohio and in other neighboring states, we do have a large group of children who are linguistically different, racially different. And we have already talked about the danger of inappropriate categorization and the influences of low expectations for these children. And I am really curious about this attitude, what is this, how do we measure for partial remission?

I am not clear how we do that. I work in a community where convincing African-American and Latino parents that their child needs to take medication as an inclusive regime, if you will, of other interventions is very, very difficult. The resistance to medication by the minority community, and Reverend Flake, you can help me out here, is very high. So we have several issues, low expectations being herald by statistics that say,

yes, Latino children are disproportionately high in terms of having ADHD, and my basic question is, how do we measure for partial remission and what is it?

DR. ABIKOFF: A number of very important issues that you've raised.

In terms of partial remission, again, what that refers to is an individual who originally met full diagnostic criteria for the disorder, had ADHD, if you will, at some time in the past, and now currently, if you were to do a full diagnostic evaluation, what you would see is that they no longer meet full criteria for the diagnosis but they still continue to show many of the symptoms of the disorder, some threshold for the diagnosis and that those symptoms are still interfering and impairing in the youngster's life.

In terms of the issue of high rates among, at least in that study in Puerto Rico, and I am trying to remember who the author was of that and I can't get it. I don't know if it was Hector Berg or someone else at Psychiatric Institute. There are no differences in prevalence rates across

racial groups, ethnic groups or SES. In any one sample, you may get a slightly higher rate than another and part of it may be based on the diagnostic criteria that are used. When you use the same identical criteria, you are going to find very, very similar rates across different settings.

However, if you have a youngster who comes into a school setting and is linguistically impaired because they are struggling with English and they are now in a classroom where it is difficult for them to follow everything that is going on, that youngster is going to show some disturbance in the classroom, rightly so, be it inattention, be it looking around the room because they are not following what is going on, they are bored, they are starting to act up, they are upset that they are not following it. And to some extent what might happen is the teacher might say, "Look how him. Look how inattentive he is and overactive he is. I wonder if he has ADHD."

Well, we know he is inattentive and he is overactive. Does he have ADHD? Perhaps. You

would not base it on that. So, again, the clinician needs to take into account cultural issues and language issues, especially for youngsters for whom English is not the primary language, to understand to what extent that might be implicated, if you will, in the difficulties the child is having in that classroom. Does that explain it all? Not at all.

There are youngsters who are linguistically impaired and are ADHD as well. And I think a good clinical diagnosis is necessary to do it and a rating scale will not.

COMMISSIONER ACOSTA: One last question, and I have had parents ask me this: My child has ADHD today. If I give him Ritalin, if I give him all these interventions, can he be cured?

DR. ABIKOFF: There's a Nobel Prize to that question. We know that youngsters who are now treated with medication for reasonably long periods of time in a systematic way, my colleagues and I in Montreal and in New York did a study in which, in fact, we treated children for two full years with

medication. And what we found, in fact, was that all the gains they got initially were maintained completely through those two full years and there was no decrease or attenuation in those effects, which was a concern.

The clinical literature suggests that people who took stimulants early on, and perhaps took them for up to five years or so intermittently, their outcome later on in life does not appear to be very different than the outcome of individuals who did not take medication.

I think what that says is several things. Number one, the medication is not a cure for the disorder. The disorder tends to persist in most people through adulthood. For some it desists. We don't know for whom it desists and for whom it persists, if you will. We don't have that answer yet. One possibility that we might need to consider is we take a diabetes model, and we think of this as a chronic disorder which benefits from certain kinds of treatments, including medication. And it may be that for some individuals, if we can

find a way to do so, it may mean that they need to be kept on a maintenance medication regime in addition to everything else that we are talking about in order to glean the benefits of our treatment.

We know that psychosocial treatments by themselves tend to work not as well as medicine, and work only as long as they are delivered. When you stop those treatments when they are intensive, the symptoms tend to reemerge, just as they do when you stop medication, they tend to reemerge. So if this is a brain disorder, if we can't change the way in which neurons fire and chemicals are let out in the brain, if you will, well, then, maybe we can help to regulate it. And right now the treatments that we have regulate it, but they don't cure the underlying disorder.

COMMISSIONER ACOSTA: Thank you.

DR. FLETCHER: Thank you. In a sense, I guess you are talking about the need to create environments for the children in which they can function in order to facilitate their persistence?

DR. ABIKOFF: Yes, that is very important. But as I am sure you know, Commissioner, no easy chore.

DR. FLETCHER: Right.

Dr. Wright?

COMMISSIONER WRIGHT: Again, I don't have to say much and ask much because so many of the other people have said a lot and have asked a lot, so I don't know if I am batting clean up or not.

I want to say that I am familiar with your work, and I very much appreciate your presentation. It has been wonderful. You have covered it from etiology all the way through characteristics of these children all the way to remediation. I would like to just point out, though, something. I am an old special educator. Years ago, kids who had these kinds of characteristics, we just called them MH. We just called everybody mentally retarded. Finally, in 1963 when Sam Kirk came along, he said, "These children that have these characteristics are

learning disabled."

And now we have separated it out and said they have some of the learning disabled characteristics and they have some of the other characteristics. I would like to point out, too, that some adults have some of these characteristics. I have some. I feel here, I just want to sit up and blurt out, and that's part of the characteristic.

These children can be very successful, as you have pointed out, but, of course, they do need some remediation. Also I think it was Commissioner Acosta who asked the question about the issue on using drugs with these children, medical things with these children. That is certainly a very big issue. I don't have to say much because it is all here. You brought it out and I am just thrilled with your presentation, and I am not going to take up any more time.

DR. ABIKOFF: Thank you very much.

COMMISSIONER GRASNICK: Thank you for precision of your presentation.

My question would surround what I consider to be the indiscriminate use of medication. There is almost a vogue now and the fact that all of the children are labeled as special education, almost all of them. And I think that you have not, in your presentation, homogenized these students. You have discerned the difference between those who need specific IEPs, et cetera and medications. So what are we doing in terms of professional development so that teachers don't communicate to parents, "Put this child on medication. This child needs an IEP," et cetera, when, in fact, the child may simply need some strong structuring both at home and at school. What is happening in that arena?

DR. ABIKOFF: Yes, that's a very important question.

I don't think it is the role of teachers to tell parents that their children need medication. Teachers are not physicians and they are not clinicians. They are educators. Now, that said, there is a role for teachers vis-a-vis

parents that is very important.

The teachers have these children for the major part of the day. They have experience with hundreds, if not thousands, of youngsters over time, especially if they are experienced, and they are quite good at recognizing a youngster who is not doing well relative to his or her peers. And that youngster may not be doing well for a number of reasons. One possibility, based on what it is that is presenting in the classroom might be ADHD. The role of the teacher, as I see it vis-a-vis the parent, whether it is through parent-teacher conferences, letters home or whatever, is to inform the parent when there is a problem in the classroom that the parent is not aware of but that is troubling the teacher, and to bring that to the recognition of the parent so that the parent is then in a position to seek out, when necessary, other types of assessments, including whatever is going to be done in the school. Because if the teacher is concerned about something going on in the school setting, he or she is probably going to

speaking to SBS team members and the like to say, "Jimmy is not doing well with this," but I think the parent needs to know about this as well.

And when the parent knows about it, they are in a better position and better informed to consider who they might want to seek out and what kind of evaluation should be done. So to the extent that a teacher has an unruly, unmanageable child in the classroom, and thinks, well, the best thing is to medicate that kid. Well, they have no business making that decision, they are not in a position to make it. They are in a position to bring to the attention of the parent what it is that is going on in the classroom that is not well, so that the parent can then pursue it.

COMMISSIONER GRASNICK: I just want to follow-up on this, though.

Do you find that our teacher preparation institutions in higher ed are addressing this so that students are, number one, being managed properly in terms of appropriate interventions?

DR. ABIKOFF: I think they are not. We spend a lot of time with teachers and educators, and I think that the training they get in their college classes does not prepare them to help identify and work with these children. I think they are underprepared, especially teachers in general education.

To the extent that many of these children are going to be maintained in general education classes but are going to be given 504 plans and maybe resource room, well, the teachers need to understand what this condition is and how to work with these youngsters, but they can't do it alone. They need the support of other school personnel. This is not just the teacher problem; it is a schoolwide system problem, and I think the training needs to occur early on in undergraduate and graduate school. There needs to be in-service training workshops all the time.

One of the things that the Child Study Center does right across the river at NYU, we have a contract with the New York City Board of

Education, we have been working for the past three years with I don't know how many now, hundreds, if not thousands of educators, teachers, guidance counselors, psychologists alike, teaching them not only about ADHD, but giving them training in functional behavioral assessments and functional behavioral analysis. And they come in to learn how to do this in classroom settings.

Is it enough? No, but it is a start. And this kind of work, I think, is absolutely essential if we are going to have our teachers feel comfortable and equipped to work with these children in public schools.

DR. FLETCHER: Dr. Abikoff, are there any written descriptions of that program?

DR. ABIKOFF: I think the NYU Child Study Center has manuals on it.

DR. FLETCHER: I would just like a description that we could share with our other Commission members.

DR. ABIKOFF: I will ask my colleagues when I get back for something, and,

Jack, should I contact you and find out how to get it to you?

DR. FLETCHER: It would go to the Commission staff, Mr. Jones here. But we are going to leave the record open and ask for some information about what your professional development program consists of.

DR. ABIKOFF: Sure, okay.

DR. FLETCHER: Thank you.

COMMISSIONER WRIGHT: One other thing I wanted to mention, and I had it written here, about stereotyping.

Would you address that as a cause of overrepresentation of minorities in LD and ADHD, and all of that, racial stereotyping and racial profiling. Could you address that?

DR. ABIKOFF: Well, I think that's a very important issue. I think although there hasn't been that much work, there has been some, and I believe it is Edmond Sanuga Barke, his last name is spelled B.A.R.K.E., and Edmond works in England. And Edmond has looked at the impact of a

child's ethnicity on teacher judgments and ratings. And I can't retrieve the specific reference, it came out within the past two to three years. In fact, he has done more than one study on it.

And I think he has demonstrated quite clearly that that does have an impact. And as I have mentioned before, the whole issue of misbehavior, especially oppositional behavior to an adult, is something that is viewed as very aversive, rightly so, I guess, by parents and teachers. When we show teachers videotapes of kids behaving that way, the children tended to be rated as inattentive and hyperactive, even though in fact when one truly measured that on the videotapes, that behavior was not there. It is a negative halo effect and it is important for us to educate our teachers to that phenomena.

It is not unique to teachers, it is a universal human phenomena, but to the extent that that impacts on their judgments, they need to be aware of it, and that is part of what I think the teacher training program needs to cover along with

many other things.

DR. FLETCHER: Again, Dr. Abikoff, you have introduced some material that the Commission finds of interest, and we are going to ask you to provide that reference for the Commission because it is very relevant to our work.

DR. ABIKOFF: The reference about the halo effect is in the CV that I sent you.

DR. FLETCHER: Oh, it was your study?

DR. ABIKOFF: Yes, that one.

But the other two by Edmond Sanuga Barke are not mine, but I can contact Edmond and get it.

DR. FLETCHER: Well, or just give us the references. That's all we actually need.

DR. ABIKOFF: Sure, I will be happy to do it.

COMMISSIONER TAKEMOTO: Thank you for your interesting testimony.

Part of the heartbreak of ADHD is, what I hear from families, is a standard treatment for ADHD as being containment, punishment, suspension

and expulsion, and I have a lot of questions. I just want to, if it's a yes answer, I want a little bit more, but if it's a no answer, is there any evidence in research that this is an effective intervention or treatment for ADHD?

DR. ABIKOFF: Probably the worst thing you could do when working with a child with ADHD, I would say the four things you just said.

COMMISSIONER TAKEMOTO: So there's no research that says that what you ought to do with a student with ADHD is you contain them, you punish them, you suspend them and you expel them.

DR. ABIKOFF: Nothing whatsoever. Nothing to show it's effective.

COMMISSIONER TAKEMOTO: My second question is lack of treatment or inappropriate treatment of the disability, I have a hypothesis that this leads to some of the comorbidity, some of the psychiatric disorders that you outlined here, that the majority of students with ADHD have. Could many of these students end up without these other significant disabilities or comorbidities

with appropriate treatment?

DR. ABIKOFF: That's an interesting question. I think you're right, in part. I'll tell you what I mean. What we frequently find is ADHD is a precursor to the more serious conduct disorders, but why do children develop conduct disorders? Part of it is that the simple picture of ADHD, especially the impulsive behavior, makes it more likely they're going to engage in those behaviors, but the whole picture of ADHD, children who are not doing well in school, who are shunned by their peers, who tend to engage in risky behavior, makes it more likely they're going to stay with children who also misbehave in a conduct disorder.

Now, that said, if in fact you treat these children early on appropriately, that might include for many of them medication, there's an important question to ask. The MTA study mentioned before is in the process of asking that right now, because we're following those children up. They started with us at age 7 to 9, now we're looking at

them here almost age 20. One of the things we want to see is what happens to the course of the development of comorbid disorders in children with ADHD who are treated early on as a function of which treatments, and as we treat them for their ADHD, what happens to co-occurring comorbid disorders that are already there. So I think the possibility exists that for some disorders, treating the ADHD may change the course or even the development of comorbid disorders, but not all.

COMMISSIONER TAKEMOTO: And then my last question is a followup to the first question by Dr. Fletcher about the ability for school practitioners to diagnose ADHD, but at the same time you're talking about the efficacy of the drugs, the drug aspect of the treatment, so one is an eligibility issue and the other is treatment.

DR. ABIKOFF: That's correct.

COMMISSIONER TAKEMOTO: For eligibility issues, I want to clarify that many practitioners, non-M.D.'s can make the diagnosis.

DR. ABIKOFF: Yes, they can. For

example, I'm a licensed psychologist, a PhD, I'm not an M.D. I've worked with families and children with ADHD for most of my career, and I feel confident in making that diagnosis.

However, I will even also have them seen by my M.D. colleagues when there are other types of possible neurodevelopmental problems that I think might be there that I feel less equipped to make a diagnosis about, but basically, if someone is well trained in clinical diagnostic procedures, they should be able to make that diagnosis, even if they're not able to make some others, but well trained means being able to rule out other explanations for this as well.

COMMISSIONER TAKEMOTO: But in terms of, that's for diagnosis. In terms of treatment, would the school still have a role in insuring access to a person with the ability to prescribe appropriate medication?

DR. ABIKOFF: Well, there are, I think a variety of models that are out there. I know in the New York City school system certain districts

have one or more child psychiatrists who work with the District, and I believe they are involved not only in evaluating these children and in making recommendations for medication. Whether or not they prescribe I'm not sure, I don't want to misspeak, but I don't think so, but I think that there are two ways in which we could do this.

One is that if -- well, this gets very difficult. Let me back up. The school should work with clinicians in a community who are medicating the children who are attending that school. The school can't necessarily refer a parent for medication. What they could do is to say, "I think your child might benefit from additional evaluations in addition to what's going on at school. If you'd like a list of potential people or agencies to contact and you don't know who to contact, we might be able to do so," so I think there's some role for the schools vis-a-vis treatment, but we need to be careful about this for the reasons I've stated before. The school should not say, "Get your child on medicine."

COMMISSIONER TAKEMOTO: But what about those families that don't have access to the ability to pay for the prescriptions as well as the ability to find a person that's capable of disposing or prescribing the medications that you say are critical for treatment of ADHD?

DR. ABIKOFF: In terms of if they don't know who to seek out, that's where I think a list of appropriate professionals and practitioners could be provided, assuming that was something that the school system felt comfortable doing because it means they feel comfortable with the merit of the people they're suggesting. So it might be rather than a person, it might be an agency.

The American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics or Behavioral Treatment, the American Society for Behavioral Therapy. In terms of cost, that deals with a whole other issue in our country that is I think a much bigger issue than perhaps what we can address today.

COMMISSIONER TAKEMOTO: Thank you.

DR. FLETCHER: Dr. Pasternack had a question.

DR. PASTERNACK: Thank you Mr. Chairman. In the interests of time, I'll make it brief.

Earlier today we heard exquisite testimony about the need to perhaps disband our categorical taxonomy and move to a noncategorical system. In your testimony it seems you're advocating that we would need to continue having a category of ADHD. I'm curious if you would help us reconcile the two sets of testimony that we heard.

DR. ABIKOFF: I'm not sure I heard the first part of the testimony you said, but I could understand that there are rationales and folks out there who promote that position. I think for ADHD, in fact, a categorical approach is still very useful.

I listed the diagnostical criteria up there for a reason. If we make it dimensional criteria only, my concern is what's going to happen is we are going to end up inappropriately labelling

children as ADHD who are not, because these are children who may be extremely inattentive or overactive or impulsive for a variety of reasons having nothing to do with ADHD, or they may in fact have no other co-occurring condition, but the fact that they're very impulsive and very inattentive is still allowing them to function well enough that it's not impairing and interfering with their functioning.

I think we all know, if we think back to childhood, kids who were antsy or kids who seemed to daydream a lot, and maybe even kids who called out a lot, who were bossy. The description that I put up there of the symptoms, everyone shows some of that some of the time and some people show it even a lot of the time, but it doesn't interfere with their functioning. If we keep this as a dimensional criterion rather than categorical, and the category allows us to do other things.

We're assessing frequency, chronicity, duration, impairments and also ruling out other explanations and I think it's critical to do that,

so from my vantage point, I still feel quite comfortable with the categorizations of this particular disorder.

DR. PASTERNACK: One of the internships I had with a pediatrician, I trained with at that time said what we ought to do is not give medication to the kids, but we ought to give tranquilizers to the parents.

Another question, I guess, is what do we know about the differences in outcomes for kids with ADHD that are placed in special education versus kids with ADHD that are not placed in special education? Apropos of the excellent questions the chair asked earlier, there are convincing data, I believe, that suggests that the vast majority of students with ADHD are not in fact in special education.

DR. ABIKOFF: I don't know if there have been consistent studies that have looked at that. As you might imagine, they have become very complicated because the outcome to some extent may be biased. If there was a real reason for putting

kids in special education so their functioning was more compromised than kids that were not, you might expect differential outcomes, not because they're in special education, but because of the characteristics that resulted in them being put in special education, assuming that wasn't random. However, I think the MTA study I mentioned before, hopefully in a few years is going to be able to look at that as well, because we have information about children not only in terms of their treatment history, but exactly what it is that they received in school and in fact we're working with the Office of Special Education in Washington right now to do more exquisite evaluations of the exact services that children are getting in classrooms.

What they've gotten and what they're currently getting, and our goal is to look at that to see how well it predicts subsequent outcomes. So I think right now the answer to your question is probably not readily available, but it might be in a couple of years.

DR. PASTERNACK: Mr. Chairman, I know

it's time for a break, but the Commission has been made aware of I believe it's New Jersey and Connecticut, which are states that have now passed legislation prohibiting educators from getting involved in the diagnosis of ADHD. Would you comment on whether you believe that other states should emulate that and whether in fact there should be federal pools regarding that?

DR. ABIKOFF: By "educators" in those two states, do they mean teachers or guidance counselors?

DR. PASTERNACK: Yes.

DR. ABIKOFF: I would agree. I think those folks in those professions are excellent in what they do, but they're not trained clinicians and they have no basis for making that diagnosis.

DR. PASTERNACK: The state of Mexico just passed legislation, the Governor signed, allowing psychologists to prescribe medication. Do you believe that's something that should be emulated?

DR. ABIKOFF: This is an issue that my

field has been grappling with for a number of years and there have been suggestions that for psychologists who want to go back to school in essence and take seven years of courses in psychopharmacology and courses related to that, that there may be some situations where those individuals might be appropriate in terms of what they do, not unlike psychiatric nurse specialists or clinical nurse specialists who are not M.D.'s, but take detailed courses in psychopharmacology and anything related to it.

So I see no reason why that might not be done, but I think the accreditation and the requirements that would need to be met need to be quite strict.

DR. PASTERNACK: And in the interests of time, one last question. I know you've gone over this before, but could you just briefly summarize for us the need for the students with ADHD to receive special education as differentiated from students with ADHD that would not need special education?

DR. ABIKOFF: I think it depends on the -- I'll use the word "need" -- on the needs of the child. In the same way that clinically we try to tailor treatment to the needs of a particular child in terms of what it is that he's presenting with, where is he having difficulty in his life.

In a school setting, it seems to me that the same situation occurs, an ADHD kid is not an ADHD kid is not a ADHD kid. They have all the same diagnosis, they're all unique individuals.

Based on the cluster, the profile of needs, deficits and strengths that they present with, you would hope that in a meeting in which you have educators sitting down and planning on what the needs are of that particular child, some kind of informed decision can be made about whether or not this youngster may be able to be maintained in a mainstream classroom with a 504 plan perhaps with an aide, perhaps with special dispensation in terms of test taking and the like, or is it the case that given the picture of this child and the problems he or she has, that a smaller, more contained

classroom with skilled personnel would be better.

I am reluctant to say this should be a blanket decision that should be made. I think it behooves the school in the same way it behooves the professionals who work with these children to make that decision.

DR. PASTERNACK: Mr. Chairman, is it true that the NIH in the process they undertook regarding ADHD did not come up with a diagnostic strategy for ADHD or a diagnostic paradigm?

DR. FLETCHER: The short answer is that's not true, but Dr. Abikoff might want to comment on that.

DR. PASTERNACK: I thought NIH tried to have a conference where they tried to arrive at a consensus model paradigm for ADHD and were not able to achieve consensus.

DR. ABIKOFF: I actually participated and presented at that consensus conference. I think at the end the statement that came out was wonderful in terms of showing what the field knows about the disorder and one of the main concerns at

the beginning had to do with whether or not it was a valid disorder and we hope and we think that we put that question to rest finally and forever.

In terms of the best way to make a diagnosis, I think the AAP guidelines I referred to in my talks as well as the American Academy of Child and Adolescent Psychiatry tend to overlap and are quite similar in terms of what I described on our slide, that it becomes the ascertainment through history and interview of current and past functioning, as well as eliminating and ruling out other possible explanations for that presentation, and until we come up with a marker, and I think we're ten to 25 years away from that, until that happens, this is the best we can do.

DR. PASTERNACK: Thank you very much.

DR. FLETCHER: Thank you for your testimony, Dr. Abikoff, and Dr. Pasternack will be applying for CE credits later.

(Laughter.)

DR. FLETCHER: The Commission will take a short break. We will be having lunch here

on the stand and listen to our guest speakers, but we will try to get on track as close to our track as possible.

Thank you very much.

(Brief recess.)

DR. FLETCHER: Ladies and gentlemen on the Commission our next witness is Dr. Dorothy Koerner Lipsky, the director of the Center for Educational Restructuring and Inclusion at the Graduate Center of the University of City of New York. She is could author or principal author of 50 articles and five textbooks on the subject of inclusion has worked around this country and around the world as a former teacher, administrator, School Board member and I think of importance to some of the people on the Commission as well as the audience, and is the parent of the young man with spinal bifida, who is now thirty years old, so it is my great privilege to introduce to the Commission Dr. Dorothy Koerner Lipsky.

DR. LIPSKY: Thank you very much. I appreciate the honor to address you, it puts a new

twist on a lunch speaker.

I was trying to think about in the short time we'll have today what I might say that are things you haven't heard before. In fact, I know what you've had an opportunity to do is hear from some wonderful speakers about the efforts that IDEA must now address. What I'd like to do is just tell you a little bit for a moment my own history of how I come to this, because I think it's important for you to know the hats that I've worn and how I come at the issues that I'll speak about.

My son Danny was born 30 years ago. I have two other wonderful children as well. Dan was the last child. He was at a public school in Brooklyn, P.S. 91. I finally had a chance to do some work there, so it was exciting to see what happened in the school. I guess having a child that's born with such a severe disability really changes your life. There's no other way to say it throws everything up in the air, you've got to reformulate your own thinking on so many issues.

Luckily, Danny did survive. This is

the group of kids, remember, that had spine bifida, that were put in institutions. We were told that there's really no reason to bring kids like Dan home because it would hurt the family, divorce was going to be absolute, the other children would not be able to do well, and there would be no quality of life for Daniel.

We did bring him home, and of course he continued to grow and change, as so many of the children that we counted out during those times. I went back to school and have a doctorate in research, so much of the things that we talk about here will be research oriented, but comes from what I have seen not only for Danny, but so many children like Danny.

I've worked with parent organizations to hear from them what it is that we need to be able to take the next steps in education for our children. The fact is, I also went through administration, I have been both a principal, A Superintendent of schools and also sat on a school board here in New York. So I come at this from a

number of different vantage points.

The National Center was established six years ago because the Annie Casey Foundation wanted to find out what was happening in special education and how they could help make a difference. We looked at every state in the country five years ago to try to determine what was happening in the area of inclusion. They identified what they thought were their quality programs and we talked with administration, parents, students, both general and special education; State Ed directors and attempted to determine what were the quality indicators of inclusion, what was it that we should try to get into the first legislation that IDEA was looking at.

We were very, very impressed. The research had two very large documents about outcomes and what we were finding. The surprising fact to us was that nobody started their programs exactly the same. It was definitely school by school approaches that were so important.

What we found was that teachers needed

professional development to be able to do the work, but once they had that professional development, lo and behold, it was not just good for special education children, but the outcomes were significant for both groups of students. You know, the most important factor, perhaps the one we felt really touched us, was that parents of special education children said that for the first time their children were invited to birthday parties, that when they had been in self-contained classes, they were isolated from communities.

What do we want for our children? We want the children to be able to be part of a full society. And therefore inclusion was what most of the parent groups were telling us they wanted.

What do we mean by inclusion? It's not even in the law. What we mean by inclusion, and of course we have definitions in all our books, but there is, by the way, if you go out and do training, you can't find two people who define inclusion the same.

Let me read to you what we want

inclusion to be. Providing to all students, including those with significant disabilities, equitable opportunities to receive effective educational services with the needed supplementary aide and support services in appropriate classrooms in their neighborhood schools in order to prepare students for productive lives as full members of society.

Once the research was done in terms of determining that the outcome for both general and special education students were effective, and there's much research, Peck has done much research, in terms of what we've seen for research in terms of academic outcomes, social outcomes, behavioral outcomes, this is well documented, I'm not going to bore you with the numbers, they are definitely in our books and many other books.

What we have found, however, and one of the, you heard from the Chancellor here in New York City schools, my partner who would have loved to have been here, Dr. Gartner, is now going to be part of his staff, I greatly miss him, but I'm

telling you that one of the things that New York City schools did is allow Allen and I to really help develop their new continuum that I believe was mentioned here this morning. When we looked at the new continuum, at what was the old system versus the new systems, there's no doubt the biases that were built into the old system for children. We don't have to tell you how many minority children continue in self-contained classes instead of classes that are in general education and inclusionary with the supplemental aides and supports.

Visionary leadership is key for effective inclusion. Principals for the most part do not yet have the skills to do the job that we need to see done. New York City schools is in the process of developing a principals' training manual. There are easy steps to take to determine how we can take our self-contained classes that presently are highly minority and now integrate them into the general education mainstream, and what we find in developing our unitary system,

non-categorical approach, saying what do the children need to be successful in the general education class. How do we adapt the curriculum, how do we modify the curriculum?

We know that when we've done that now, the data is clear and here in the New York City schools they are looking at that specifically, because they have been able to code it. You will see great gains in the standardized testing for the general education children, because now in those collaborative classrooms, they're getting what they need. There's no teacher that I've ever done, I've trained across the country, there's no teacher that tells us that our IEP is really helpful to them. Isn't that sad? We put so much time and energy. We were the parent group that fought to have this, but I've not found a teacher who said this has been helpful to us.

And I must tell that you of all the groups we tried to train, unfortunately, sometimes our professional groups who are our psychologists and our social workers who are geared into the old

system of separate are having a very hard time crossing over into understanding instructional requirements of adaptations and modification.

What do we do in the general education classroom that can make you successful? We have lots of data to show that the general education teachers find training helpful, but then can work with all children with all disabilities across the country.

To the surprising results, it isn't just one group of students that really we can look at and say it's only our LD students that can go into the general education classrooms and we should be able to do that, because we have found that there are some school districts that have found it easier to integrate students with the most severe disabilities and some who have started with the most mild disabilities. There is not one disability that we can say is the only group of students that should be included. We can look at what is needed for that student to be successful in the class.

I would just like to stress before we, I know you're on a tight schedule, I know I promised to address my issues in fifteen minutes, but I know I'd like to leave time for asking questions. What I see operating now with IDEA and the strength of IDEA, because while it doesn't mention inclusion, is very much supportive of inclusion and I don't have to tell you, you know the law more than I do, what's in there that supports inclusion, but what I would like to find out is the research based practices that IDEA can reinforce, and it's related to school reform.

We are not talking about changing special education. We are talking about changing school systems. School reform and IDEA have to be linked together. In fact, as we looked at the major school reform movements in the United States and other studies that we did, in the majority of those studies we're not addressing students with special needs. There is special ed and general ed continuing to this day. We need to link those and IDEA can do that.

Let me address a couple of points and turn it to you in case you have any questions. The first issue I think you have to address is the high expectations and "Leave No Child Behind." The second issue would be the whole school approach; as I said, it's one of the things that we've done in our book, but mainly others now are talking about that as an issue. It's not a secret how to do it, but it must be the whole school that we move towards.

The third issue is that the need for the special populations must be addressed as a service. It's not the place, it's the service. Collaboration between the particular group of general or special education teachers, we have found here in New York City and across the country, that when those special ed and general ed teachers and specialists that in the past had served only one group of students now are collaborating, there's great outcomes for both groups of students, that includes speech, physical therapy, occupational therapy, surety terms of academics.

For special ed teachers, the things they told us most often when they now are in an inclusionary class was to say, "Oh, my goodness, I didn't think the children could do that." They had a whole shifting of thinking in terms of what the outcomes for the special education could be and the general education teacher most often talked about, "Hey, this isn't really all that different. Most of the children in my class needed that, too." The idea to have the two people work together in collaboration is really critical.

The use of instructional supports needs to be reinforced. You talk about supplemental aides and services and now you have to continue to push that concept. Accommodations and modifications in assessment are not yet being done well, and cooperative learning was one of the things, by the way, that teachers told us across the country, when you say what were the most important things that helped you in an inclusion classroom, it was cooperative learning and technology. It isn't just putting two groups of

kids working together, but it's how you do that effectively.

Many teachers talked to us about needing more supports with behavioral. You heard of the approach before of functional assessment. In fact, in the State of New Jersey, what they're looking at is many different types of approaches and allowing the school to choose the approach depending on what the types of children that were there, the types of understanding that teachers had about behavior modification approaches, it's not one approach. Functional assessment is one and it's a good one, but there are many others.

For the most part, there isn't a teacher that I believe in the school system, I believe there are some, but I'm fortunate not to have met them, that doesn't want to do a good job. We go into teaching because we believe it's a profession where we were make a difference. The fact of the matter is professional development is a key factor that needs to be done. But school by school again, we're looking at now saying yes, we

thought it could be system wide, now we're breaking it down to school by school approach.

I believe that IDEA already had most of these concepts within it. I'm suggesting that you strengthen them and you give more reinforcement to inclusionary practices that would make a difference for both general education students and special education students and I believe it's what the parents want. Thank you.

DR. FLETCHER: Thank you. I believe we have time for a few questions. I believe Ms. Takemoto has a question.

COMMISSIONER TAKEMOTO: First of all, I want to thank you for all the research that you've produced, because I'm a consumer of that information and have used it not only in my own life, but also for other families that I refer your work to and thank you for funding those studies.

Where I have a -- where there's a disconnect for me with the inclusion issue, however, is that a number of families are saying that they want more restrictive environments, they

want a specialized setting to meet emotional, behavioral, learning disabilities. We heard this morning about Public School 75 where students get really nice services when they go to that public school environment.

Help me think through, you said we might have to strengthen part of IDEA. How would we strengthen IDEA to find more students to have access, because we found not enough students have access to that environment to safeguard, at least their parents are telling me, I don't know, the parents are telling me they need a more restrictive environment.

DR. LIPSKY: Here in the City we've done a lot of work with District 75 to put the curriculum together. We find that depending on the age of the child, parents have a hard time changing their attitude about inclusion and believe that the self-contained classroom their child was in, if their child has been there a long time, is the best possible placement.

In fact, we decided in the new

continuum to leave that group alone, because they do believe very strongly that what they have has been best for their children.

COMMISSIONER TAKEMOTO: So we still need the full continuum?

DR. LIPSKY: I think at this point in time we need to have those parents who have children in a segregated placement who are older, the children who are now aging out of our system, those parents are going to have a very hard time accepting that their students could be in a high school inclusion program.

COMMISSIONER TAKEMOTO: Could you speak to specifically strengthening IDEA so more children have access to an inclusive environment?

DR. LIPSKY: Particularly those children, we find the parents who have children in inclusive preschool programs--

COMMISSIONER TAKEMOTO: I have to interrupt you a little bit, because my colleagues are going to be angry they didn't have questions answered, but strengthening IDEA, what would happen

to IDEA, what language would you recommend that would improve access to inclusion to many students who are not currently included?

DR. LIPSKY: I believe you have the language. You say in there that the general education curriculum--

COMMISSIONER TAKEMOTO: But it's not being implemented. So do you have any suggestion for language. It's not being implemented across the board. We found that.

DR. LIPSKY: Let me give this some more serious response than a quick response and if you will, I'd like to write some thoughts to you on this issue, how I would consider strengthening specific wording that would allow for more inclusionary practice.

COMMISSIONER TAKEMOTO: Thank you very much.

DR. FLETCHER: That means that you owe us a document for the record. So the record will be open.

Just to follow up real quickly, last

week in Miami, we heard many examples of parents opting out of public school inclusionary environments for what were essentially self-contained placements, and I would say if anything, the age range tended to be on the younger side. I don't understand the disconnect between the sorts of recommendations that you're making and the practices that you've implemented and yet the choices that many parents seem to want to make.

DR. LIPSKY: Well, I think the question is what do they mean by inclusionary practice? We have gone now, not just here in New York City, but across the country, I have to tell you that there is not one specific way of looking at inclusionary practice, so it will often depend on what it is that's happened within the public school setting, and many things that are called inclusionary practice are not.

If a child's IEP says they're supposed to get supplementary supports and are not getting them, then really we're just giving lip service to the word "inclusion," as we have mainstreaming

previously. The fact is, inclusion is not being implemented many places that we could feel comfortable calling it inclusion. There are some standards, however, there are assessments that can be done. When you call it inclusionary, I want to be able to call it inclusionary.

DR. FLETCHER: I don't think that's the issue. In the examples that we heard, parents were opting out of public education altogether in favor of settings that were clearly not inclusionary, were clearly segregated and self-contained. So, I mean, the issue of how effective the program was is one thing, but parents were not opting for a less restrictive environment, they were choosing a more restrictive environment.

DR. LIPSKY: Well, I must say that again I would have to come back with effectiveness of the program. If a parent is opting out to a program that isn't functioning to a high level, one could almost understand their frustration. Here in the City, I can tell you when parents have had an opportunity to go from a more segregated into a

quality inclusion program, I can show you there's much research to show you parents who have opted into a quality inclusion, because I don't think parents have really seen what quality inclusion looks like, and in fact when we think about our children first, Danny when he was first born, they felt would have a quality separate program. They thought I as a parent couldn't accept my handicapped child if I wanted them in an inclusionary type setting.

The fact of the matter is we have to think of the children for the future, as well as employment and into a full society and that's not going to happen as much in segregated facilities. So I think inclusion has to be looked at as to is this quality and then let me hear that the parents are still opting out.

DR. FLETCHER: Well, I mean, I understand that, but I have to say I think that reason is a little circular. It's ex post facto reasoning, but I have to stop because I know that Commissioner Acosta has a question and then we're

going to go on.

COMMISSIONER ACOSTA: I defer to you, Dr. Fletcher.

DR. FLETCHER: I'm done.

COMMISSIONER ACOSTA: I asked you, you talked about District 75. Where is that located?

DR. LIPSKY: It isn't just one location, it's a concept, and unfortunately, it is now a concept that is very strong. Twenty years ago it was the most severely disabled children here in the New York City school system and when we first came into the New York City school system and did some work, they were segregated by disability.

And then when we moved across categorical skill, those were the most severe were put into what is called a district, but it is not one placement. Those classes are also within the regular public schools, although there are some special schools. Those are the children who have also been included into general education classes, even with the most severe disabilities. They have many children with emotional and physical

disabilities in regular classrooms and can show their success.

District 75 itself has also integrated children into regular classes.

COMMISSIONER ACOSTA: Do you have a large number of Latino and minority children in District 75?

DR. LIPSKY: Oh, yes.

COMMISSIONER ACOSTA: What is the accountability measure, what accountability measures are in place to insure that those children in that District, for the sake of this conversation, are served?

DR. LIPSKY: Well, since I don't work in the New York City public schools, you understand, I'm at the Graduate Center of City University, we just support the new continuum efforts. I don't think I'm the best person to answer your District 75 question.

DR. FLETCHER: Thank you very much.

DR. WRIGHT: I'd like to ask a question.

DR. FLETCHER: Yes, Dr. Wright.

COMMISSIONER TAKEMOTO: In the meantime, I wonder if we can ask New York City Schools to answer some of those questions, as well as some statistics on when they say there are actually students physically located in these schools, who those students are.

DR. FLETCHER: Of course we can. I'm sure staff picked up on that. Dr. Wright, please, quickly.

DR. WRIGHT: I learned from your presentation and enjoyed it, as much as I enjoyed the hamburger that I was gobbling down, and I apologize for eating while you were talking, but I tried to give my attention.

What I wanted to ask you, I'm sure that you covered it, but you're at the university level, you're a teacher trainer?

DR. LIPSKY: Yes, that, too, yes. We do research, we do dissemination, we do professional development.

DR. WRIGHT: Could you just speak for a

moment or so about your teacher training, your staff development in inclusion? Are your teachers being trained in the inclusion model? Could you speak for a minute about that, please?

DR. LIPSKY: Well, I would be glad to try to, but actually I'd be glad to give you a copy of what we do. That might help, because this is also a school by school approach, what we see as staff development for teachers and principals, so if it would be all right I would be glad to let you have a copy of this, since I brought it to use. Is that okay?

DR. FLETCHER: Sure. Thank you very much.

We need to move on to our next witness. Doctor Julie Berry Cullen is an assistant Professor of Economics at the University of Michigan and she's a faculty research fellow at the National Bureau of Economic Research. She's a Robert Wood Johnson Health Policy Scholar from 1999 to 2001 and Dr. Cullen is going to testify on how funding formulas effective implication has had. Welcome,

Dr. Cullen.

DR. CULLEN: Thank you very much. I noticed so far funding hasn't come up very often and I think we wish it wouldn't matter how special education was financed; that children would be treated the in same way regardless of how much state and federal funding there is. But as a practical matter, the method of funding does affect both how students are classified and the types of services that they receive.

So there's a real tension in designing a system between--tension in financing special education between targeting financing towards districts that happen to have high rates of student disability, so this is a concept that resources should flow to where there's more needed, versus the potential of that to lead to overclassification of students.

So that's a tension that's increased over time in special education just because of the way that special education has changed.

Back in 1975 when federal funding for

special education was introduced, it was really introduced to resolve the problem of the special ed students being excluded from the public school system. Since then the face of special education has changed, so the rates of disability has grown dramatically and most of the growth has been in the category of milder disabilities. So currently about 80 percent of the students who are disabled are either learning disabled, speech impaired or emotionally disturbed.

So what's happened is that the degree of local discretion inside special education programs has increased over time. So one of the things critics worry about is that the dramatic growth that we've seen in the number of children classified as disabled can partly be attributed to the way we finance special education. The fact that by classifying more students, school districts are able to leverage more state and federal funds could in part explain the high rates of disability.

So what I want to do today is I'm going to start with a simple review of the basic types of

funding mechanisms that we have for special education, how each of those could differently affect classifying students as disabled and then turn to what the evidence is that we currently have on how financial incentives relate to classification of students and finally conclude with a couple of recommendations from what I think we've learned so far.

First, turning to the methods of finance, it's helpful to start with the big picture, which is this is a really extensive program. Some recent estimates estimate that one in every five dollars in operating budgets goes towards special education and it's a very heterogeneous program, so the spending is disproportionate to the number of students in special education, because the excess costs are fairly high.

On average, this is an estimate from the late '80s but it's held up, on average it costs about 2.3 times as much to educate a student in special education as opposed to regular education,

but beneath those numbers is a great deal of homogeneity.

Recent estimates from data from the University of Massachusetts suggests that ranges from as low as 1.2 for students with the mildest cases of disabilities up to 30 times for severely disabled students with multiple disabilities.

That's one of the things I want you to have in the background of your mind. That this really is a very heterogeneous population that we're talking about under the umbrella of special education.

In order to support localities in financing these excess costs, both the state and federal governments provide substantial aid to school districts. The federal share has never been that important, so it's been traditionally less than about 10 percent of total funding for special education. State roles have been greater, typically slightly above 50 percent. Again. There's a lot of heterogeneity across states and a lot of heterogeneity in the types of policies that

different states use.

So I'm going to start by classifying the types of policies that the federal government has used and state governments have used into three broad categories. I'm going to draw parallels to health insurance. I think we see the exact same methods of cost reimbursement in health and they're more used to thinking with the types of sort of undesirable behavior, that those types of incentive systems can create.

The first system is a cost reimbursement system, which simply means that districts are reimbursed based on some extent of excess cost. And that has a very strong advantage, which is that it does insure districts against the possibility that they might have a high incidence of student disability, so it provides a lot of insurance to school districts, and it also targets resources towards need.

The potential cost or the potential negative is it really doesn't provide school districts with any incentive for cost containment,

so the parallel to this in health insurance is a fee for service plan. So it's essentially paying providers of medical services based on the amount of care they provide.

So if you think about it, they're asking the person who is being paid for supplying the service how much of that service you need and that's the exact same problem that you can run into in special education that by providing additional services, by classifying more students, school districts are able to generate more revenue through this program and so it's a common problem, very parallel to fee for service and not unique to special education.

I think this first case highlights a trade-off we'll see in all finance methods, which is there is this trade-off of insurance, which is making sure that resources get to the districts that have higher needs than other districts and these incentives, which is trying to remove incentives to overclassify students or to make sure that districts are providing the right level of

services.

So this form of reimbursement, which is the partial cost reimbursement, is most appropriate to severely disabled students, and the reason is there we don't have a lot of debate about whether the student should be classified as disabled or not, and so we can look at this, and we might have more debate about whether the level of service is appropriate or not. There we can look at the level or the number of students and that is a true indicator of the underlying incidence of disability and so it make sense to target resources based on that signal of district need.

If instead we're looking at milder disability categories, then the costs or the expenditure of the School District partly reflect underlying, incidence of underlying disability, but also partly reflect practices of classification that are district specific, and so what could happen is two districts that really had the same underlying incidence of disability could have very different special education expenditures and so if

we're targeting resources based on expenditures, we can end up having a very arbitrary pattern of resource distribution to districts, based on what their decisions are, the classification decisions are of a district. That's one potential cost of that type of system.

The second type of system is a system that doesn't reimburse based on actual expenditures, but reimburses based on program size. This is like the federal system before the 1997 amendments, where school districts or states received a fixed amount per student classified as disabled. That falls under this category based on the number of students who fall under this program, and this is also the most common method that states use to reimburse districts for special education. Normally this happens to a people weighted formula where the foundation aid or whatever method of aid that the state uses includes a count of pupils, but is not a strict count of pupils, it's a weighted count of pupils, so the special education student would count as more than one student and would

boost aid through the basic aid program.

This is, again, turning to the parallel in health insurance, this is very similar to the case mix form of reimbursement, where providers of medicine are reimbursed based on the characteristics or diagnosis of patients they serve, so they're receiving some average payment based on expected costs, but not based on actual services that they provide. So this, unlike reimbursing based on actual share of expenditures, this does provide some incentives for cost containment, and so the providers now benefit from anything that's not expended over the average expenditure level, but it can lead to the problem what's been termed in the medical literature as diagnosis creep and this is what happened following the introduction of diagnostic resource groups back in the 1980's under Medicare, where there are very specific categories of diagnoses and each of those was associated with a specific reimbursement, following that introduction, patient creep, so diagnoses moved into those categories that are

reimbursed, so the way that that kind of creeping can happen in special education with this kind of finance system is first of all on the border between regular and special education, which is since special education is reimbursed at a higher rate, you have students on the margin between regular and special education more likely to be classified with special needs, and also within special education, there's different categories of disability or different instructional settings carry different weights then districts also have incentives to shift students to those programs that are better reimbursed.

The third type, which is something that both the Federal Government and several states have moved to try to remove these kinds of incentives to classify students as disabled, is what's known as a prospective reimbursement system. And so the way the federal system works currently is aid is distributed based on 85 percent on total enrollment and 55 percent on poverty rates and it's not based on the actual count of students who are disabled.

And so the reason behind this is that there's some underlying propensity for individuals to have special needs, and that should be proportional to the population of students and weighted up by other factors that determine disadvantage like the poverty rate.

In several states you're using systems like this, too, which is based on prospective expenditures not related to actual expenditures, not related to professional education, not related to actual program size. What this is parallel to in the health care literature is to the per capita payments that are received by HMOs. HMO will receive a fixed flat fee regardless of what types of services they provide to that enrollee, so this has obvious very, very strong incentives to cost control, is one of the big positives. Also allows for a great deal of flexibility in the types of services or for how the provider in health care settings decides to allocate resources across patients.

The negatives is it completely shifts

the risk to the provider. In this example, within the context of health, it's now the provider of the health care services who bears all the risk if they happen to have, say, a sicker than expected population. And that's the same concern that we worry about in special education, is that regardless of the characteristics of the students that a district actually serves it's still receiving the same amount of aid, say, from a higher level of government so it's not at all insured against happening to have a higher than expected incidence of disability.

So that's probably the biggest negative associated with this. What I would say is it's not appropriate for severe disabilities where districts can really impose a large negative shock on district budgets and may be appropriate for the milder disabilities because it does remove the incentives to classify students on the margin. There's now no advantage to manipulating the size of a special education program at all. What some people would worry about, there's no system that's

classification neutral. So this sounds like it takes away all the issues about classification. What it also does is it removes the incentives to classify students as disabled and that's where we started back in 1975, was with a system to make sure that all students were being appropriately served, so that's the trade-off to keep in mind is that no system is classification neutral.

The per capita system does remove the incentives to overclassify, but provides no incentives to students to be classified as disabled. So that could lead to a positive outcome where students are now treated in a more flexible manner, not having to be labeled or a negative label and these students are not receiving adequate services.

I focused on the financial costs. This is all across the backdrop of what goes into determining whether a student is disabled or not, so clearly ideology, fiscal and nonfiscal costs so what we want to do is say, theoretically these kind of reimbursement streams could effect whether

students are classified and how they're served, but in practice are these financial incentives really important or is it something that's dominated by the other factors that determine whether students are classified or not.

We don't have a great deal of evidence. The evidence that I'm familiar with is there are two earlier case studies that looked at changes in state reimbursement; one that went in the direction of being more generous and one that went in the direction of becoming less generous. The first was an example from Oregon where the system moved to a new reimbursement system where school districts were reimbursed at two times the rate of regular education students up to a cap of 11 percent. And this was not a quantitative study, but was a qualitative study where the researcher conducted interviews and tried to figure out how special education directors were responding to this policy and what they found is the special education directors were being pressured by the principals and superintendents to bring the count of

disability up to that 11 percent cap and they said that the ways that they had done this was by pushing classification to earlier grades, so starting to classify students in kindergarten and before where they hadn't before.

In Vermont, the change went in the opposite direction where they moved from a generous special education system to the per capita reimbursement form. Again, not a quantitative study, but what the researchers found three years following that reform, disability rates had fallen by 17 percent. So these two studies looking at movements in completely opposite direction show there's definitely room for the rates to respond to fiscal incentives.

I've done some more quantitative work looking at a specific state, so this has been looking at Texas. And actually trying to measure what is the change in the percent of students classified as disabled for every change in the margin of revenue that comes from the state for classifying a student as disabled. The way the

system works there, it is one of these weighted pupil systems, so having been a higher pupil count increases both foundation aid and Texas has a matching grant program. Both of those forms of aid increase with the pupil count, so districts have an incentive to generate revenue by classifying more students as disabled.

There was an extreme policy change in 1994 that was not driven by special education, it was driven by equalization interests. But because of the way the special education is weighted, it did change the relative incentives for very high wealth districts and lower wealth districts to classify students as disabled so what I was able to do is ask what happened, so some districts had sharp increases in the ability to classify students as disabled other districts had sharp decreases or their incentives remained flat. So I was able to track how do the changes, how do they parallel these movements in financial incentives, and they actually tracked them really closely. You see a close correlation between changes in disability

rates and changes in these relative financial incentives and what the results implied is that if you were to increase the reimbursement from the state by about 10 percent, you'd see a 2 percent increase in the disability rate and that increase is coming where you would expect it to come, it's in the categories where the definitions are more subjective, so it's in speech impairment, learning disability.

Obviously, we're not seeing any effect at all in the physical impairment categories.

And looking at the broad picture, what does that mean about the role of financial incentives. The change in financial incentives over the six-year period I was looking at could explain 40 percent of the increase in disability rates over that same six-year period so it's not a nontrivial factor. The way that special education is reimbursed is a very significant determinant of the number of students and the size of these programs and composition of these programs.

So I think you could still ask well, so

what, is it a good thing or bad thing if more students are classified as disabled and the direct question is to say well what happens to the students who are classified on the margin. Do they seem to benefit from these services? Even if that's a positive effect, we don't know what the spillover effects could be to other students. It could be positive or it could be negative.

In this same study I did have some evidence on the direct effects where I could say it looked like the students who are classified are benefitting from being classified as special education. There are two things that point to this not necessarily being in the best interests of the children who are being shifted on margin.

One is it tends to be, even given a disproportionate rate at which minority students are classified into special education, on the margin they're shifted at disproportionate rates into special education in response to these financial incentives and more so, the less minority the teacher population is, which is something that

you heard about earlier, so the less minority the teacher population, the more likely minority students were to be shifted in at disproportional rates in response to these financial incentives.

The second thing is that it was the school districts that were really financially constrained that saw sharp cutbacks their aid to the state that were most likely to respond to this financial incentive. You might think this looks like a good thing, it's more aid to special education, generous programs, pulled down some of the barriers so districts are now moving students into special education that didn't have access before, but it's actually those districts that are fiscally constrained in other areas, so it looks like it's being done for fiscal constraints not for students shifted on the margin.

I tried to get more direct evidence on what the welfare effects are in classifying students in response to fiscal incentives and this is using a national panel data set so now we can ask is Texas unusual or do these results generalize

to other states. In looking at this national panel data find a very similar magnitude of response of disability rates to these sort of financial incentives and what I'm also finding, these are just preliminary results and is it that the increased resources are not showing up in quality of special education programs, they appear to be shifted to other programs, so that's another concern is that these resources may not be going where they're intended to go.

And so regardless of how we interpret the fact that fiscal incentives do play an important role, it's important to realize there are two different programs really within special education, so the classification response only shows up for the milder disabilities, so the evident disabilities, the physical disabilities, the classification is evidence it's not being responsive to physical incentives.

So from other research I think it's worth highlighting that even though the rates of disability do not respond to financial incentives,

that there can be big costs to this program being underfunded. I found using Texas data that each additional dollar that was spent on special education in the short run reduced spending on other programs by a dollar and this was for the outlays, surprise, big outlays for severely disabled students in Texas. It looked like there was one for one crowdout of spending in special education budget. Voters weren't voting to raise these costs, it was coming out of a fixed education budget.

And so researchers who looked at New York have a similar finding, so it's one thing to point out is that underfunding can have negative effects on district budgets.

I want to conclude with a couple of recommendations. Starting from an economist perspective, what the justification is of having special education programs. I really am thinking of it as a form of insurance. Where at one level it's insuring parents against the risk of happening to have a child who is very expensive to educate

and that's justification for providing this in a public forum, public schools and the justification for having federal and state funding flow to the schools to support data providing this is to insure schools against the risk of having a higher than expected or more costly than expected population to educate.

So from that perspective, the behavior that we're talking about is what's termed in other insurance contexts as moral hazard. It sounds like a value laden word, but all it means the size of the program or the use of the program is a function of the generosity of the program. So the better reimbursed a special education program is, the bigger special education programs will be and that's a standard finding with insurance programs.

What that means is that if there is a high degree of moral hazard, then you certainly don't want to fully unsure, so you would not want to fully fund this. You would like to have the districts internalize the benefits when making decisions about how many students to classify.

That's my first recommendation, that we start by recognizing there really are two programs within special education. There's one part of the program which addresses severely disabled students that are not subject to these same sorts of moral hazard.

There's the second program where the same classification where moral hazard is really important. What that implies from a funding perspective, one system of reimbursement is probably not appropriate for both of these programs.

So the more tenuous recommendations that I had were how to finance into these two halves and the first is thinking about the severely disabled program. There I think it is reasonable policy to fully fund this either at federal or state level in order to insure localities against the risk of having high costs for extremely disabled students and the reason is that moral hazard is not a big issue on the classification side, these students will be identified in the same

way regardless of where they live, so it reflects differences in incidences of disability regardless of location and on the service side, where we heard stories earlier today about high expenditures in New York, we have a built in mechanism for the severely disabled student through the private system. So there's some degree of competition and others argued that's one reason why vouchers would work in the market of severely disabled students. We have a well developed private market.

So I think even on the level of service provision, there's not as much moral hazard with the more severely disabled.

So both of those things would point towards getting the benefit of insuring districts and a fully funded program. For the mildly disabled, fully funding is not an appropriate option because moral hazard is so important in terms of classification. So there, if we knew a great deal about costs, knew a great deal about appropriate interventions, then we might be able to implement a system like a pupil weighting system

that basis the ability of a district receives on the diagnosis of a student, but I think we probably aren't there label wise. Probably there research wise.

Once we set these weights and apply them, if it affects behavior and instruction, then we're really manipulating instruction policy. So with the absence of a great deal of information about the appropriate treatments, the level of costs, what I think makes the most sense is using a prospective reimbursement system where we recognize somewhat similar to Title I, where we recognize there are some districts that are likely to have higher incidents of disability, we'd like to target more resources to those districts so they could flexibly decide how to allocate them across their special needs and other students.

The danger which I highlighted before with prospective payment systems is we worry it may return us to a system where students are not receiving adequate services, and so what I would recommend, which is a theme that I heard come up

earlier today, is combining this with some kind of accountability system. So many states, and Texas is one state that has in the past excluded special needs students from testing, and I think that's a real danger. Both change the system of finance and not make it fully inclusive on the accountability side.

So that would be a dual recommendation if you move towards prospective payment to combine it with some system of accountability.

Thanks a lot and I look forward to your questions.

DR. FLETCHER: Thank you very much. I have to say that was the most cogent and lucid presentation on special education financing I've ever heard and I'm afraid I heard lots of them, unfortunately.

We're going to start with a question from Dr. Pasternack, since he's the designated Federal office for the expenditure of IDEA funds.

DR. PASTERNACK: Thank you, Mr. Chairman. Thank you for the presentation as

well. I think there are a lot of people in the country who would agree that it doesn't cost the same to educate all kids with disabilities, yet we have a federal finance system that provides the same amount of money for all kids with disabilities, so I think your comments are particularly timely.

One question I'm sure that other Commissioners would have is how you would define students with severe disabilities?

DR. CULLEN: If there was some agreement that students with severely high disabilities would be classified the same across the schools, that's where we can say this isn't subjective, it's something that's objective and combined with perhaps knowing how to treat this. Actually, I've seen several studies that show if you take the level of functioning of students across different districts, that there are dramatic variations as to whether that same student would be classified in special education in one district versus another in this mild category, so that would

be one criteria it would have to be something stable across districts where whether a student is served in special education or not or is classified as disabled would not be a function of where they live, that it would be more objective.

DR. PASTERNACK: How would you suggest that we structure the system so that we would not encourage people to label kids as having a severe disability because of financial incentives, that would be provided for students in order to serve those students with severe disabilities?

DR. CULLEN: This is where what I would define severe disabilities as those categories that are not subjective so it would not be subject to financial incentives.

DR. PASTERNACK: Are you aware of any data that would indicate that there is a direct correlation, positive correlation between the amount of money spent and the outcomes achieved by students with disabilities who are recipients of those high cost services?

DR. CULLEN: No, we actually know very

little I would say about either the high incidence or the low incidence, mainly because of difficulties in controlling for selections. We don't know what the outcomes for these students would be in the absence of these services.

DR. PASTERNACK: In the private schools that you were referring to, do we have any data? I know you're a fiscal person as opposed to a programmatic person, but in the fiscal reviews that you've done, have you encountered any programmatic data which shows that people receiving fiscal incentives in those programs would have the same outcomes as those not receiving?

DR. CULLEN: This is based on secondhand readings, but from what I understand about reading from these programs, it's a perception that it's pretty well known what services need to be provided and there's where the competition is more on the cost level and less on the types of services that are provided to severely disabled students.

DR. PASTERNACK: Your recommendation

to us to take back in terms of the structuring of the finances for the IDEA would be those categories you referred to; the mild disabilities, I think that's the language you're using and severe disabilities, is that correct?

DR. CULLEN: That's correct.

DR. PASTERNACK: Thank you very much. Thank you, Mr. Chair.

DR. FLETCHER: Commissioner Rivas?

COMMISSIONER RIVAS: Thank you for your presentation. What would be the separation between the mild disabilities and the severe disabilities, I guess, that they would be using as a guideline to separate the financing of these? Are you talking about like low incidence and high incidence cases or--

DR. CULLEN: I think this is the same question so, I must not have answered it quite before, which is you're saying if I think there should be two programs where should be the line be drawn between students which should be in each program. And I'm not qualified to say, but my

judgment would be that those disabilities that are evident, that no one would debate whether a disability exists or doesn't exist and that may evolve with assessment, with knowledge, with medical practice, but those cases where there would be no debate about whether a student was disabled or not would be the cases that I would count as being objective, and not subject to the same level of moral hazard, but does coincide with low incidence.

DR. FLETCHER: Thank you. Dr. Coulter?

DR. COULTER: No questions.

Commissioner Acosta. Commissioner Wright?

DR. WRIGHT: I don't have much of a question but I'm a former director of special education from Illinois and we just had so much always needing more money, whether for funding, at least partial funding and all that, so your presentation has certainly given me another perspective.

I remember and Dr. Pasternack could probably relate to this, I remember back last year

when President Bush called in an about a hundred black leaders from across the country to meet with him, Secretary Page and some others and the first thing I said to Secretary Page, Dr. Pasternack, was, "I came here to tell you and the President that we must have more money for special ed across the board, we must have full funding, and." Dr. Page, if you ever met him, is very calm, cool and collected. He said, "You know, Dr. Wright, we can't give you full funding, but we promise you we will give you more money than you've ever had for special education," and that stuck with me.

You've given me a perspective that it doesn't have to be across the board. You're saying that to separate it out into certain programs and I want to thank you for giving me another perspective to think about, and that's my comment.

DR. FLETCHER: Thank you. Nancy.

COMMISSIONER GRASMICK: Just a quick question, I just want to understand in summary the money follows the student. If you take as a premise the two categories, the money follows the

students whether that's public or non-public, et cetera, is that correct?

DR. CULLEN: Do you mean through the way financing these things work?

COMMISSIONER GRASMICK: I'm suggesting that these two categories that you've articulated that students who are low incidence, high cost, go into non-public facility for money follows the student.

DR. CULLEN: Yes.

COMMISSIONER GRASMICK: Okay, thank you.

COMMISSIONER TAKEMOTO: Thank you for your comments and I was very intrigued by a piece of what you said about the dollar for dollar. You put one dollar into special education and you save a dollar. What studies, what is your basis for information on this?

DR. CULLEN: One is a study I've done myself and another is a study by Hampton Blakeford and Kim Wykoff in New York. This really is a separate analysis from what I was describing about

the milder disabilities, because in Texas those categories are actually overfunded so that there's excess revenue, based on my calculations from classifying students as mildly disabled. The severely disabled cases are greatly underfunded, so what I was looking at was looking at district budgets, changes over time if a district had to serve a deaf blind student or a student with multiple disabilities and trying to see how that affected spending on regular education, so it could mean in the long run there's less of a budgetary impact, but one or two years after the extra money that was expended for the severely disabled student came dollar for dollar out of spending on regular education students, so per people spending on regular education was reduced directly in proportion to the spending on special education.

COMMISSIONER TAKEMOTO: So when you have a budget of $100 and you spend $51 on a student with severe disability, regular education for people, well, in general, it goes down, the regular education side is $49?

DR. CULLEN: That's right. So the way I interpret it is that the education budget in the short run is largely fixed, so the other alternative is that the local government could raise more tax revenue, so they could budget for this year and residents could vote to pay higher taxes. That doesn't happen.

COMMISSIONER TAKEMOTO: And then the other part when you talk about students, it's less costly to educate students in the regular classroom, you were referring to, I just want to clarify, you are not referring to students with severe disability who have one-on-one services and appropriate education for that severe disability, yet are spending their full day, a majority of their day in the regular education class, is that correct?

DR. CULLEN: You mean when I said--excess revenue?

COMMISSIONER TAKEMOTO: No, now I'm talking about in general you said that students in the regular classroom are less costly to educate

than students who are not in a regular classroom. I just want to clarify, you are not speaking about students with severe disabilities who are being included in regular education, spending the majority of their day in regular education classes, yet have an intensive level of service needs.

DR. CULLEN: No. And a good source for this is a chapter by Chambers in a recent book that came out that analyzes Massachusetts data and very carefully outlines the excess cost by disability by setting. So when I say that the expenses could be as low as many in excess of 24 percent over the amount needed to educate a regular education student, that would be for a mildly learning disabled student served in a regular education setting and we have a very different figure for students with severe disabilities served in a regular education setting.

COMMISSIONER TAKEMOTO: In the insurance environment, when insurance companies are reimbursing per capita, they might reimburse someone, let's just say someone who is deaf blind

differently than they would reimburse someone who has cerebral palsy, different from someone, but you're saying two tiered.

Can you tell me why you've gone to two-tier, and I also need to know in doing so, are you, let me just ask some categories. Are you talking about blindness?

DR. CULLEN: As one--

COMMISSIONER TAKEMOTO: As one of the low incidence?

DR. CULLEN: Yes.

COMMISSIONER TAKEMOTO: Blindness, autism, severe mental deterioration?

DR. CULLEN: Yes.

COMMISSIONER TAKEMOTO: I wondered where your cutoff is there.

DR. CULLEN: I was hoping people in the field could draw where this line is, but I think conceptually we can split up these two types of programs, but I'm not the person to say where that line is. I see that partly conceptually what we would like to do and what ends up happening in

practice are different things. If we came up with an ideal plan had a careful composite analysis and decided what the appropriate categories are, how you reimburse with each one once that's implemented in the political realm, it ends up over time diverging from what ideally we'd like to see.

So the more parameters you put in a program the more dangerous it is. I've seen this in places where the placement specific weights for mainstreaming education have become politicized. There are lobby groups that lobby for these weights and it differs from what a cost analysis person would say these placements should be.

I've seen this in district size adjustment. First there is a small adjustment, then large districts, then midsized districts lobbied for their own adjustment.. Again, it's related to this moral hazard having too many political players in a program.

COMMISSIONER TAKEMOTO: Thank you for clarifying, that helps us as we're considering all this.

DR. FLETCHER: Just a quick question. You cited a paper by Moore that said that 13 percent of the costs of special education were in evaluation costs. I note that the date on that paper is 1988. Are you aware of any more recent analyses of evaluation costs, because the impression that many of us have is that these costs have increased substantially, particularly for the milder disabilities over the last ten years.

DR. CULLEN: I'm not aware of any. I'll take a look at that Chambers article again. That's the first place I can look of to check.

DR. FLETCHER: Since he's a Commissioner, we can ask him.

Then I have a comment and that is simply that while I understand the distinction that you're making between severe and mild disabilities, if a child with a so-called mild disability doesn't receive adequate instruction, they will essentially develop severe disabilities and the cost of actually intervening with those kids, probably exceeds what has been provided, which is

essentially where they had the difficulty to begin with, but I appreciate the analysis very much.

DR. CULLEN: That's where I think the accountability would come in, is replacing it with careful monitoring.

DR. FLETCHER: Also the issue of the number of kids that would never need this form of instruction if we had the appropriate sorts of early intervention programs in place.

I think Mr. Jones had a question.

MR. JONES: Yes, as part of your research work and I don't know if it was exclusively quantitative or through interviews and so on, to gain a deeper understanding--

DR. CULLEN: Quantitative.

MR. JONES: Qualitative. The issue of the actual process that goes on, of referral or overidentification or change in weight, I can recall during the last Congressional debate on this folks who appeared before the House and Senate subcommittees said, "Of course, I as a teacher or no teacher would ever consciously do something like

that," and of course you would say, "Of course not, it's not a conscious decision, it's a reaction to incentives and institutional pressures or supervisory pressures."

I wanted to ask if there were any areas identified as you investigated that were some of the ways that plays out. So, for example, one of the things I can remember hearing five years ago was that, in fact something Chancellor Levy said this morning, is for referrals out of the system there becomes no incentive to actively scour the needs, or review the needs of the kids that are existing special ed students to determine if they're no longer in need of services, so they stay on the roll and that inflates the roll.

Were there discussions of things like that and if so what were those things?

DR. CULLEN: I actually haven't been able to look at that with the data I have. But I know some individuals using Texas data at the individual level are able to look at entry and exit. I had aggregate percent of students to

special ed, but I think that's really likely that there's less exit as well as probably more entry. What I've done can't distinguish that.

MR. JONES: Okay, thank you.

DR. FLETCHER: And we all know, just to punctuate that, when students are excluded in the accountability system, even Texas data is somewhat limited because you're restricted to only those kids who participate in the State accountability.

DR. CULLEN: I've actually looked at that just recently and am finding all kinds of bizarre behavior in regard to who is classified as special needs depending on how far from the next target pass rate the school district is, so in that context you're finding gating as well. Similar principle to the financial, but it's just evident that these categories are mutable and there's a lot of discretion as to where the line is drawn between able and disabled.

DR. FLETCHER: We'll finish with a followup question from Dr. Pasternack.

DR. Pasternack: Thank you, Mr. Chair.

You asked the question I wanted to ask, but you asked it much better.

A couple of questions I wanted to follow up on. What do you think should be the percentage of funds spent based on the research you've done and the percentage of funds we should spend on accountability?

DR. CULLEN: That's a really tough question for me to answer. I'm not on the grand level enough to know what the assessment costs are, but my general suggestion would be is to shift further away from assessment of specific individuals and more assessment of all individuals. So moving to more of a universal system with universal accountability, individual specific and have goals for each individual, maybe less on, certainly less on deciding which categories of disability apply, except in a context where we have an intervention that we know works.

DR. PASTERNACK: What do we know about the relationship between funding and outcome?

DR. CULLEN: In special education or

in regular education?

DR. PASTERNACK: Well, of course, since we are the President's Commission on Excellence in Special Education, our interest is in special ed, but if the Chairman would allow, I'd be interested in a quick answer to both if we know something about both.

DR. CULLEN: I was just joking, because we know very little even at the level of regular education of what actually translates into better outcomes. I think that's part of the reason that as a nation and across the states we've shifted from a system that's evaluated input where you place emphasis on standards, class size, teacher certification, shifting now to a focus on outputs, such as student performance, dropout rates is that we really don't know that much about the process, we don't know what's effective, so we're trying to let the bureaucracies of schools on their own decide how best to allocate their resources and evaluate them based on what comes out, but we don't know very much about--the regular ed process.

The only study now, this is not coming from the education literature, but coming from the economics literature, is a study from Texas done by Rick Hanyushe (ph) and John Kanes, Steve Rifkind, that just asks, again it's not resource based. It asks does it look like students benefit from being classified as special needs, and they find small positive effects for some students, but that's really the only systematic evidence that I've seen on the effects of special education.

DR. PASTERNACK: Are you aware of the percentage of revenues which might be Medicaid based that schools are receiving for educating students with disabilities?

DR. CULLEN: What share is not local? So on average, it's 60 percent, but it varies. On average 60 percent would be federal plus state or maybe about 65 percent and 45 percent is financed locally, but that varies a great deal across the state, so ranging, whether the locality is responsible for a larger share, but that's on average.

DR. PASTERNACK: Of the 83 percent that is not federal, these non-IDEA anyway, not federal, you're saying that 65 percent of that is state and the remainder of that is local?

DR. CULLEN: You're talking about non-special education?

DR. PASTERNACK: I'm talking about special education.

DR. CULLEN: Of total expenditures of special education, about 45 percent on average is local.

DR. PASTERNACK: And we don't--well, I guess the answer is we don't really know the relationship between funding and outcomes, and that would be as we move to our research agenda later this week, that would be an area that would be important for us to--let me ask you this question. Would you think that would be important for us to know?

DR. CULLEN: That's one thing I want to plug, we need data to answer these questions. I tried before to get spending data. When I was

living in Massachusetts they made it very difficult. I had to write it down by hand, I could have gotten it. This is ten years ago. I notice states are making more data available on the web, but that's where we need to start to make the financial data available so we can analyze this.

DR. PASTERNACK: Finally, Mr. Chair, would you be in favor of giving the states the ability to use, as was proposed in the SEA reauthorization debate 50 or more of the IDEA money for things other than providing special education and related things to students with disabilities?

DR. CULLEN: This is essentially what already happens with state funding, about half of the states, actually 35 of the states do not tie the receipt of special education funds to having to expend those in special education, so it's a smaller issue, but it's currently a smaller amount of funding, but I would be in favor of a movement that addresses students at need and at risk more generally and places less of an emphasis in identifying who is and who is not disabled.

DR. PASTERNACK: Has anyone done the analysis of ranking states by the amount of money they spend per student and the outcomes on things like this? Is that simple a level of analysis that you're able to start with?

DR. COLE: That's been done. The huge problem is that there's so much selection, so mainly people haven't looked at the state level, but you certainly look at a school district that has high spending compared with a school district with low spending, then you have to ask what are the backgrounds of the students in these two places like how more or less involved are their parents, so it's incredibly hard to separate resources from other inputs.

DR. PASTERNACK: Thank you very much for your testimony. Thank you, Mr. Chairman.

DR. FLETCHER: Thank you, Dr. Cullen. I want to point out for the record the Hanshack study, that found special education reading sites maintain a gain of .04 standard deviations a year, which means that if you replace the special

education second percentile, four years later he'd be reading at third percentile and many of us do not regard that as particularly satisfactory. The gain in math was a little bit larger, it was .12 standard deviations, but those of us in special education really do not regard that as a terribly actively significant conclusion as well.

DR. CULLEN: Thank you.

DR. FLETCHER: We're going to move on. Our next witness is Dr. Joseph Webby, who is an assistant professor in the Department of Special Education Vanderbilt University. He is also a Kennedy Center investigator and fellow. Dr. Webby specializes in children and youth with behavior disorders, observational assessment, functional assessment of aggressive behavior and risk factors in the development of problem behavior.

Thank you, Dr. Webby.

DR. WEBBY: Thank you, Mr. Chairman. Given the previous testimony today, I think the issue of teacher preparation is an important one, given that for most teachers, the first nudge

towards special education comes from the general education teacher.

Thank you for the opportunity and honor to speak in front of his commission today. My testimony will outline recommendations for improving the training that general and special education teachers receive to serve children with severe behavior disorders (SBD) in school settings. My recommendations are as follows:

1. Increased behavior management training should be provided to general education teachers, special education teachers, school administrators, and related service personnel. This training should focus on evidence-based practices that addressed behavior needs at the whole school and individual child levels.

2. An emphasis needs to be placed on the importance of quality academic instruction as a critical component to any behavior management program. Teacher training programs in the area of severe behavior disorders should require at least one primary course in the area of academic

instruction, specifically in the area of reading.

3. For students with severe behavior disorders, functional behavior assessment plans (FBA) and subsequent behavior intervention plans (BIP) should be the cornerstone of the individualized education plans. Current federal guidelines emphasize the use of FBA as a last step before removal from an educational placement. Both the general and special education teachers should receive training that emphasizes the importance of behavioral assessments to the initial development of defective programming for these students.

4. Given the poor post-school outcomes reported for students with severe behavior disorders, teacher preparation should include transition planning as an important piece of the training process.

5. Continued research on effective strategies is needed to determine the efficacy of different models of behavioral and academic intervention for students with severe behavior disorders. As the number of evidence-based strategies increases this

information needs to be incorporated in both preservice and in-service training programs for general and special education teachers.

My testimony will focus on each of these issues. I will address the current state of practice and will propose specific actions that should be taken to meet the needs of children and youth who are at risk or engage in severe behavior disorders in school settings. Finally, the term severe behavior disorders SBD will be used it to describe this population of students. Although this term is traditionally used to describe students identified as emotionally disturbed under IDEA, it certainly includes other children with high incidence disabilities (LD, MMR) who engage in unacceptable rates of problem behavior.

The issue of training teachers to work with students with severe behavior disorders within schools is incredibly complex. To date, there is not an agreed-upon knowledge base with the specific sets of requisite skills to work with children and youth with behavior disorders. In addition, it

appears that many personnel preparation programs lack any empirical foundation. Schools and state agencies continue to use unequal standards in identifying children and youth for special education services. Children and youth with SBD are typically served by multiple agencies with multiple theoretical bases, practices and objectives (e.g., mental health, juvenile justice, family services). Perhaps one of the greatest challenges in the field is working within school systems that continue to use, advocate, and promote punishment and exclusion strategies in response to behavioral challenges, while the evidence is clear that these strategies not only failed to reduce challenges, but may in fact increase problems.

An examination of recent policies and trends directed at students with challenging behavior provides a blueprint for educational practices. To date, the field has not sufficiently prepared children and youth with SBD to meet benchmarks established through federal and state policies. For example, all U.S. schools are to

provide a safe and drug-free learning environment for all students, according to the Goals 2000 Education Act. However, it is reported that one in 10 Americans schools had at least one serious violent crime in the 1996-97 school year, 57 percent of principals reported that one or more incidents of violence resulted in police involvement, and one-third of parents in the nation do not feel that their children are safe at school or in their neighborhood. Specific mandates in the recent reauthorization of the Individuals with Disabilities Education Act also speak directly to concerns common among students with SBD. IDEA mandates that contingent upon disciplinary action that results in a removal of a students with a disability from school beyond 10 days, the district must develop or revisit the functional behavioral assessment (FBA) and the related positive behavioral support plans (PSB) in an attempt to successfully keep students in a less restrictive environment.

The concepts of FDA and PBS are a

reflection of emerging evidence-based practices that have been identified over the last several years. However, students with SBD continue to be removed from school settings due to problem behavior more so than any other disability group. IDEA further mandates increased access and participation in the general education curriculum. However, students with SBD continue to be served primarily in pull-out programs, more so than any other disability group. In sum, while improvements in our approach to meeting the needs of students with SBD has improved, there is still a great need for improving services for these students.

Teachers and administrators alike have expressed concern regarding the problem behavior that is often exhibited in schools by students with disabilities as well as those students who are at-risk for developing severe behavior disorders. Unfortunately, schools have responded to problem behavior in a manner that can best be described as reactive. Students who exhibit problem behavior are often removed from classrooms and schools,

usually after a crisis has occurred. Unfortunately, numerous surveys have shown that teachers, particularly those in general education classrooms, and school administrators lack the training to address severe problem behavior.

In response to educators' and the Public's concern over aggressive and violent behavior in schools among children and youth with disabilities, the 1997 and reauthorization of the Individuals with Disabilities Act IDE provides specific rules that are designed to promote increased prosocial responding and avoids simply removing students with disabilities from school. For example, positive behavioral interventions, strategies and supports, and functional behavioral assessments FBA or components of a proactive approach referred to as positive behavior supports. Positive behavior supports, PBS, is a set of strategies and systems designed to increase the capacity of schools to A, reduce school disruption and, B, educate students with problem behaviors. The emerging literature on building PBS plans for

students with disabilities clearly points to the need to build larger overall school systems of supports to A, ensure that PBS plans are implemented with a high degree of integrity and, B, to prevent problem behaviors from developing into chronic patterns that will ultimately require specialized services. In addition, this literature suggests that FBA and PBS technology should be routinely used with non-identified children to prevent behavioral problems from developing into chronic patterns that may then lead to special education services.

Over the past several years, a model of school-wide PBS has emerged that is designed to improve the capacity of schools to manage problem behavior of all children. A three-tiered approach has been proposed. At the first level, a primary school-wide intervention is implemented with a focus on developing a common set of behavior expectations and a method for teaching those behaviors in all settings within a school.. At the second level (secondary), specialized interventions

are designed and implemented for small groups of students who are nonresponsive to the school-wide intervention. At the third level (tertiary), individualized programs of supports are developed for those students who continue to demonstrate high rates of inappropriate behavior. These plans are often based on FBAs and may include students currently receiving special education services.

This model of PBS is an extension of evidence-based practices developed in the area of behavior analysis and has been the subject of a number of research and clinical evaluations (many of which have been funded by the Office of Special Education Programs). This systems or community model addresses some of the limitations in current teacher preparation programs by providing basic behavior management training to all school personnel. Research on this model has demonstrated its effectiveness in reducing general disruptive behavior in schools as measured by office referrals and disciplinary contacts with students. Although continued research is needed, it appears that this

approach has broad acceptance with educators and administrators in both general and special education.

Recommendations in the area of behavior management:

1. Increased behavior management training should be provided to general education teachers, special education teachers, school administrators and related service personnel. This training should focus on evidence-based practices that address behavior needs at the whole school and individual child levels. To this end, I suggest that some specific areas need to be studied to improve the capacity of schools to meet the needs of students with SBD.

A. Identification of the characteristics of children who are nonresponsive to primary level behavior support programs. If a common set of characteristics can be determined, implementation of more intensive levels of support can begin much earlier.

B. Implementation of longitudinal

evaluations of PBS models in order to determine if durable changes in student outcomes can be achieved.

C. Development of assessment instruments that measure the impact of secondary and tertiary levels of intervention that will be adopted by administrators, teachers, and other school personnel. Currently, the evaluation of most school-level interventions incorporates readily available measures such as office referrals and discipline contacts. These measures may not be sensitive to changes in significant behavior such as positive peer interactions and increased academic engagement.

D. Development of training materials for preservice teacher preparation programs. Currently, training in the area of behavior management appears to occur at the in-service level. To better prepare general education teachers, special education teachers, and school administrators to meet the needs of students with SBD, relevant training and experiences should be

delivered as early in the preparation process as possible.

Increased academic instruction:

It has been reported that teachers of students with SBD use effective teaching practices infrequently, thus exacerbating the academic deficits of these students. Research indicates that teachers' instruction is both more limited and characterized by easier tests for children exhibiting problem behaviors than for those who are not. While there are many reasons for the lack of instruction given to students with SBD, a major factor is the lack of specific training of pre- and in-service teachers in the area of instructional methods, particularly in the area of reading. This trend is unfortunate, given that there is significant body of evidence that has documented a common current relationship between academic underachievement and emotional and behavioral problems in school-age youth. As a group, students with severe behavior disorders exhibit academic deficiencies in most subject areas. Although the

exact nature and directionality of the relationship remains equivocal, it is evident that academic and behavioral difficulties exist as highly correlated characteristics.

It has been the contention of several experts in the field of severe behavior disorders that addressing the achievement needs of these students through exquisite and direct instruction may have the effect of improving student problem behavior and, consequently, the quality of teacher interactions with these students. In fact, there is a small but growing body of literature demonstrating that improvements in academic achievement corresponds with improved social behavior in schools. Since many students with severe behavior disorders show significant deficiencies in their reading ability, I believe that teachers of students with or at risk for SBD need to receive intensive training in the evidence-based approaches for teaching reading skills and comprehension of material.

Recommendation in the area of academic

instruction:

1. An emphasis needs to be placed on the importance of quality academic instruction as a critical component to any behavior management program. Teacher training programs in the area of severe behavior disorders should require at least one primary course in the area of academic instruction, specifically in the area of reading. In conjunction with this recommendation, I propose that additional research is needed in the following areas:

A. Studies are needed on the efficacy of different models of reading instruction for students with SBD. A recent review of this literature reported that there have been very few intervention studies that have investigated the impact of reading programs with this population of students. Although the preliminary evidence is somewhat positive, more research is needed to determine whether particular types of reading programs are more effective for these students.

B. Studies are needed on the factors

that influence the efficacy of reading interventions with students with SBD. As mentioned above, relatively few reading studies have been conducted with this group of students. Given the heterogeneity of this group it is possible that students with SBD and similar reading difficulties will respond differently to the same reading program. We need to understand those factors that might predict success or failure in this crucial area and train teachers to use that information when determining instructional programs.

C. In addition studies are needed on the factors that influence the delivery of quality reading instruction by teachers. As mentioned, descriptive research has shown that there is an absence of instruction in many classrooms that serve students with SBD. A better understanding of factors inhibiting instruction by teachers would lead to the development of stronger preparation programs for teachers interested in working with this population of students.

Functional behavior assessments:

Aggressive and disruptive behaviors often characterize children and youth with SBD and set them apart from children with other primary handicapping conditions. A comprehensive understanding of the factors that maintain the externalizing and internalizing behaviors characteristic of this population has eluded researchers and practitioners alike. Failure to fully comprehend the stimuli that vocation and maintain these behaviors has led to treatments with limited promise for positive, long-lasting outcomes. Several factors have contributed to our lack of knowledge about effectively assessing and treating specific problem behaviors. The use of comparative behavior rating scales and checklists is pervasive in the identification of children with psychopathology. The use of this type of information is extremely important in identifying who is deviated from normative samples of children. It has been aptly noted, however, that these assessment devices often provide little information regarding the specific causes of the problem

behavior (i.e., why a child hit another child on this particular date at this particular time). Thus, the emphasis in behavioral assessment often has been discovering who acts differently under similar environmental conditions (e.g. home or classroom) instead of determining why they act differently.

Over the last 15 years, there has been an expanse in literature identifying methods for isolating the causes of severe behavior problems. As described by several researchers, these approaches can be categorized broadly either as functional assessments or functional analyses. Functional assessment relies on the identification of apparent associations between specific problem behaviors and environmental variables to develop testable causal hypotheses about classroom or social conditions leading to or maintaining problem behavior. Functional assessments is extended to a functional analysis when environmental variables are directly manipulated to determine their effect and relation to specific problem behaviors. For

the purpose of this testimony, the term functional assessment will be used hereafter to denote descriptive assessments or experimental analyses conducted specifically to determine the operative function of problem behavior (e.g., escape motivated, attention motivated).

Despite the renewed emphasis on assessments conducted to determine the functional purpose of specific problem behaviors, the applicability of typical functional assessment methodology is just beginning to be explored for students with SBD. The majority of functional assessment research has been conducted with a population characterized as having severe developmental disabilities and relatively high rates of aberrant behavior. However, the application of functional assessment strategies for children and youth with SBD is increasing. Although many positive results have been reported, continued application and replication of functional assessment methodologies within SBD populations is needed before we can recommend a single best

practice. At best, the literature regarding functional assessments with SBD populations is emerging and along with it so will best practice. However, several apparent inconsistencies in the recent literature provide guidelines regarding how best to implement functional assessments within an applied treatment context for this population of students. These guidelines point toward a behavioral-ecological approach to assessing environmental determinants of problem behavior. Emphasizing the social ecology of a classroom (e.g., students, peer and teacher behavior, physical arrangement of the classroom, classroom daily schedule) has resulted in positive improvements in social behavior. Thus, this functional approach is more effective because it minimizes inference, is contractually bound, and is linked directly to ongoing behavioral and environmental events that can be an apparently tested and validated. Such factors have important conceptual and practical implications for persons working with students with SBD. If a functional

perspective is held, then assessment proceeds by identifying, describing and analyzing environmental correlates related to instances of problem behavior. Once the correlates are reliably identified (i.e., once the function of the problem behavior is known), we then know exactly where to target and how to develop our intervention or remediation efforts. Simply put, a functional perspective provides a pragmatic platform from which teaching professionals can begin to understand and effectively change their students' problem behavior. Because a functional assessment approach may result in many of the aberrant behaviors characterizing children and youth being understood as purposeful, intervention approaches are educational rather than simply reductive can be designed and implemented.

For teachers to better understand students with SBD, provisions should be made in teacher education programs for explicit instruction on the nature of problem behavior and the opportunity to practice effective functional

assessments in the context of ongoing classroom routines. Furthermore, ample instructional and practical time should be allocated to learn how to translate assessment results into classroom-based interventions. Given the increasing student (and behavioral) diversity within special and regular education classrooms, this training, either incorporated within traditional behavior management courses or through specialized instruction, should be an integral aspect of preparing special education teachers. Ignoring this aspect of preservice preparation ensures that teachers will continue to apply behavioral technology without understanding why the behavior occurs.

At the policy level, school districts need to incorporate assessment procedures within their stated disciplinary plans for reducing problem behavior. Assessment procedures should be a required component of all behavior reduction packages and/or disciplinary procedures. All my support for these procedures is provided, it is unlikely that teachers and other personnel within

school systems will incorporate these types of assessment strategies into their behavior management plans.

Recommendations in the area of functional assessment:

1. For students with severe behavior disorders, functional behavior assessments plans (FBA) and subsequent behavior intervention plans (BIP) should be the cornerstone of the individualized education plans. Current federal guidelines emphasize the use of FBA as a last step before removal from an educational placement. Both general and special education teachers should receive training that emphasizes the importance of behavioral assessments to the initial development of effective programming for these students. In addition, research is needed in the following areas:

A. As noted, much of the information on the effectiveness of functional assessment technologies is based on persons with severe developmental disabilities. Although the number of

functional assessment studies conducted with high incidence populations is growing, much more work is needed. I propose that systematic research continue in this area so that a set of empirically valid functional assessment procedures can be developed for students with SBD.

B. Procedures for incorporating functional behavior assessments within ongoing individualized education plans are needed. It has been suggested that for many students, development of behavior plans are being completed without considering the goals and objectives for a particular student. Guidelines are needed for making functional assessments relevant to the educational needs for each child with SBD.

Transition planning:

Longitudinal data from a number of sources indicates that students with SBD may have the poorest outcomes of any disability group. These outcomes include having the lowest grade point average of all disability categories, failing one or more courses in their most recent school

year, failing the competency exam for their grade level, and failing to complete school. Further, students with severe behavior disorders are at great risk for dropping out of school. In addition, for the vast majority of adolescents with SBD, the transition from school to work is marked with disappointing employment outcomes. It has been reported that four years after high school, almost 20 percent of all young adults with SBD have never held a job. Unemployment rates during the first five years after leaving high school range from 42 percent to 70 percent. Even among participants of model demonstration transition programs for adolescents with SBD, unemployment rates still climb as high as 31 percent to 46 percent. These unemployment rates far exceed those of high school graduates without disabilities and those experienced by any other disability group, including young adults with mental retardation, visual disabilities or physical disabilities.

Little is known about secondary practitioners' training and qualifications for

preparing adolescents with SBD for the transition to adulthood, particularly in the areas of employment and vocational education. It has been reported that teachers of students with SBD believe it's very important to know about career education, vocational education and vocational rehabilitation agencies and to be competent teaching job search/maintenance skills, administering vocational assessments and selecting/evaluating community-based instruction sites; these teachers reported only moderate knowledge of these issues. Moreover, these teachers reported generally low levels of involvement in many areas related to vocational training (e.g., supervising students on the job, planning community-based vocational programs, working with employers and employees, identifying job sites).

There appears to be considerable variation in the amount of preparation in transition planning that teachers of students with SBD receive. Data from teacher surveys suggest that the majority of training takes place in the

form of in-service training. These surveys also suggest that a large percentage of teachers for students with SBD are somewhat more highly unprepared to transition students with SBD to post-secondary placements. Moreover, given that paraprofessionals are likely to be delivering much of the transition programming, we have very little information regarding the skills that these individuals possess.

These outcomes present a significant challenge to secondary personnel who serve adolescents with SBD. Given these students' underutilization of adult services, secondary transition programs are likely to comprise the last educational and vocational services that the majority of students with SBD receive. Therefore, it is critical that effective services be designed and delivered within secondary programs, as these services may play a critical role in improving student outcomes. Secondary transition services represented critical piece of effort aimed at improving vocational outcomes. Several

federally-funded model demonstration programs have been implemented during the past decade with the purpose of improving the vocational outcomes for adolescents with SBD (e.g., Career Ladders; Job Designs; Project RENEW). These programs clearly demonstrate that adolescents with the SBD are capable of obtaining and maintaining meaningful employment. As mentioned above, there is little evidence that the strategies developed in these programs have been incorporated into personnel preparation programs.

Recommendation in the area of transition planning:

1. Given the poor outcomes reported for students with SBD, teacher preparation programs should include transition planning as an integral piece of the training process. In addition, research on transition planning is needed to help guide the preparation process.

A. Development of transition models is needed for students with SBD. As with research on functional assessment, much of what we know

regarding the transition from school to community comes from students with development disabilities. Whether the evidence-based practices from that population apply to high-incidence students with SBD is unknown. I recommended that research in this area become a priority under part D of IDEA. Identification of best practices in transition may result in better preparation of teachers in the transition process.

B. Research on inter-agency collaboration is needed in the area of transition planning for students with SBD. It is logical to assume that success transition would require the coordination of a number of agencies (e.g., Vocational Rehabilitation) that currently focus their resources on students with mental retardation and other developmental disabilities. Understanding barriers to those services for students with SBD could lead to improve post-school outcomes for this group.

Research on defective strategies:

As outlined in my above comments, we

have made significant progress in the area of SBD since the passage of 94-142. However, the field of SBD is still fraught with practices in the above areas that have little evidence to support their use. As we prepare the next generation of teachers, we must provide them with a set of empirically valid tools to meet the unique needs of this population. Continued research on effective strategies for addressing problem behavior is needed to determine the efficacy of different models of behavioral intervention. As the number of evidence-based strategies increases, this information can be incorporated in both pre-service and in-service training programs for general and special education teachers. I have made some recommendations in specific areas; however, this by no means is an exhaustive list. I would like to end this testimony by reiterating the important connection between research and the preparation of personnel to work with students identified as SBD. The reauthorization of IDEA should reflect this connection and provide the mechanisms necessary for

our field to continue in this process.

Thank you for your time.

DR. FLETCHER: Thank you, Dr. Webby. I'd like to start the questioning with Dr. Wright.

DR. WRIGHT: I have not prepared my question, I would like to pass.

DR. FLETCHER: Commissioner Grasmick.

COMMISSIONER GRASMICK: Thank you very much for your presentation. I think inherent in your presentation is the notion of a standards drift for teachers, particularly in the academic areas working with these students, that they don't hold the students to high standards and you spent a considerable amount of time talking about reading. I just wondered why you don't also identify mathematics, since it's a gateway skill for success in higher education, and many of these young people are very capable.

DR. WEBBY: The primary reason I'm focussing on the reading, if you look at developmental literature or risk factors or comorbidity around the issue of these kind of

problems, by and large most research would suggest that reading, maybe because they're not investigating mathematics, I'm not sure, reading seems to come up as the most important academic issue addressed in this population of students and that's what we're addressing, that particular issue.

Someone mentioned earlier, I think given, with identified children behavior disorders the limited amount of intervention research that's being done doesn't even last as long as that, and I could not stand up here and tell you that there's been a single study, an intervention study, with kids identified and receiving special education for severe behavior disorders that look at math, and math construction, particularly curriculum math.

COMMISSIONER GRASMICK: But you certainly wouldn't be in opposition to look at that?

DR. WEBBY: No. The bottom line I think is reading, the importance of reading in terms of school performance and postal outcomes is

well documented. For me the issue, though, is academic instruction. As I mentioned earlier, I don't think this is purposeful, I think it's a training issue possibly, my experience has been that historically if you talk with teachers who work with students in special education or general education setting and ask them about children who have severe behavior disorders, the first thing they will say on average we've got to get the behavior under control first before we can teach them and I think the movement continues to go that those two things are not two separate issues, they're not mutually exclusive.

So to comment a little further, if you think about the issue of behavioral assessments, I think you need to broaden the context to understand what's happening to these kids in the schools. Are they getting quality instruction at the same level as other students, and that's not to say that, that's not to say anything specific. It happens with kids who show problem behavior in the regular general education classroom. You see different

treatment around instruction than you do for kids in the general population.

COMMISSIONER GRASMICK: The second part of my question has to do with the emphasis which I agree with, on preservice professional development, but I think there's a need given the weak state of research at this point on continued professional development and linked to that I guess I would ask the question of as you ferret out the best practices that can then certainly be communicated to a wider audience of teachers, what about the use of technology to identify important classroom tools that would help in this ongoing professional development.

DR. WEBBY: So the question is would I support--yes. I didn't mean to suggest that in service training is not effective. In fact, if you look at the work being done, the positive behavior support model being implemented around the country, their model is an in service model. They train people a couple of days at the end of the year, they have booster sessions during the course of the

year, you're seeing in the school wide level that these programs seem to be having some impact.

COMMISSIONER GRASMICK: And you would agree that with the developing state of the art of technology that we ought to be using it more for dissemination of excellent practices.

DR. WEBBY: Yes. And I'm having a really hard time hearing you all. Was that a "yes" or "no" question?

COMMISSIONER GRASMICK: You answered it, thank you very much.

DR. FLETCHER: Dr. Wright.

DR. WRIGHT: Mr. Chairman I was looking for something in the presentation, but I didn't see it so I'll ask the question. It's probably here, and I didn't find it, you probably talked about it and I didn't hear it. But my question has to do with diversity training and cultural training, cross cultural training of teachers of behavior disorders, because as you know, certain cultures have certain behaviors and other people might look upon those behaviors as bad behaviors and they

really are not, they're just part of the culture and the environment.

I was looking for that in your presentation that's why I wasn't ready for the question.

DR. WEBBY: It's not there, but I'll highly support within the context of talking about behavioral expectations what behaviors to support, what behaviors to look to remediate that issue of cultural expectation within different socioeconomic levels, different regions of the country is implicit in that training and it needs to be provided as we try to support schools in dealing with severe behavior disorders.

It's not there explicitly, but for the record I'll support that.

DR. WRIGHT: In teaching methods, showing teachers how to teach the behavior disorder, I use the Walker Shea textbook, James Walker/Thomas Shea textbook and there is a really good chapter on there on diversity. Talking about diversity, the different cultures and all, saying

okay, we might, some cultures it's okay to talk a lot and to talk out loud, to look some people right in the eye and in other cultures it's different, so I really wanted to address that, but the Walker Shea textbook really addresses that, and I use that when I taught the methods of teaching behavior disordered children.

DR. WEBBY: Thank you.

DR. FLETCHER: Commissioner Takemoto.

COMMISSIONER TAKEMOTO: I love those two words put together, "functional" and "behavior." I think about, mostly a couple of situations. One that you highlighted quite well, which is if you're not performing academically, it is actually functional if you get to go somewhere else, get kicked out time out and those sorts of things.

When you're talking about assessment, you're not only talking about the child, you're talking about environment, also saying this is not dysfunctional, it's not going to help them in the long run, but at the time it's serving a function

of getting away from an environment of failure.

DR. WEBBY: Exactly. I think we're starting to do that better. I think historically in the field of behavior problems and identification, the first, at least it's always been what's wrong with that student, not what's happening in this environment to support or not support that student.

COMMISSIONER TAKEMOTO: The other student that worries me is the student who has a diagnosis of a severe emotional disability is a well behaved student with an emotional disability, goes to those schools where that good behavior is dysfunctional because they in essence will disappear in that classroom.

So again, there are some environmental issues, it's not just the diagnosis of a child, there are some environmental issues that contribute to things that aren't really functional in the world out there, but become functional in dysfunctional classrooms.

DR. WEBBY: I think you're exactly

right. You're beyond the child, but looking within the school systems, classrooms, hallways, lunch rooms but looking at how the support is being provided.

The issue you raised, which again I didn't address in the comments and I'll be glad to take somebody else's time to address them, but the issue of internalizing behavior problems, kids that are depressed, socially withdrawn, we know a lot less about those students and that is certainly an area of need not only with training but research.

COMMISSIONER TAKEMOTO: Because they're not bothering anybody, so they're in there quietly failing.

DR. WEBBY: Exactly.

COMMISSIONER TAKEMOTO: That brings me to my final question in terms of practice. We heard from, I'll call them advocacy organizations, who say give us the opportunity to do what we need to do to teach our own kids. If they're being disruptive, if they're keeping us from educating our students, let us get them the heck out of

there, let us remove them from the classroom. It doesn't sound like that's what you're saying here.

DR. WEBBY: What I would be saying is that before I would go towards removing a child for disruptive behavior, I would conduct these sort of assessments of the behavior, the environment. I think the nice part within this proposed model, I think it's similar to any sort of nonresponsiveness or responsive identification, responsive treatment, if you provide a school wide support plan across the board, and kids aren't responding to it and you know it's being faithfully implemented. That should be an indication that he's not a responder at that level go to the next level; provide small group or individual attention. If that works, great; if not, go to a more individual level.

So with some students it might be necessary to remove them into classroom with small teacher ratios and intense individualized academic behavior and instruction, but that is sort of a first choice is inappropriate unless these other types of functional assessments have been

conducted. So I don't want to say--

COMMISSIONER TAKEMOTO: I don't think anyone is saying never. The reason this is all coming up is that teachers have told us that the regulations last time around went way too far, all we're doing is we're having to document, document, document how we've tried to do the right thing and at the same time this child is disrupting, disrupting, disrupting. And they've complained to Dr. Pasternack over here and say they want those regulations out of there. Can you tell me how that plays with your research and what you would recommend? You're familiar with the regulations and what you have to do, the manifestation and all the other--

DR. WEBBY: Exactly. We've been working on primarily looking at these students and looking at if you do provide, trying to add to the literature and look at academic instruction particularly in the area of reading and see what impact it has on children's behavior.

COMMISSIONER TAKEMOTO: Which is part

of the regulations.

DR. WEBBY: Right.

COMMISSIONER TAKEMOTO: Is there anything in the regulations that you would change that would help these teachers who want to get these kids the heck out of there or feel like we're usurping their teaching authority or what?

DR. WEBBY: The emphasis as I read the regulations is the functional assessment process seems to be we're going to remove the child from the setting. It seems to me that should be sort of the first step. If kids aren't responding to primary levels of intervention or they're showing significant behavior problems that make them stand out, we should look at the functional assessment process sort of here's what we need to do, not to determine whether or not a child should be removed from an educational setting, but determining what the program should look like.

COMMISSIONER TAKEMOTO: So in terms of results for students with disability, in terms of those students with behavioral disorders, you're

saying from a results basis the regulations, with the exception of possibly moving the functional behavioral assessment forward are high?

DR. WEBBY: If you could tell me specifically which part of the regulations you have questions about, then I would feel more comfortable in answering them. I'm trying to be cautious about it. My interpretation--

COMMISSIONER TAKEMOTO: I was told to be specific about what I think and ask you if you agree. Do you agree or disagree if I made that into a statement, that the regulations as currently stated with the possible exception of moving the functional behavioral assessment step forward has foundation, it's recommended practice? And I've been limited to agree or disagree.

DR. FLETCHER: Just "yes" or "no", please.

DR. WEBBY: No. I don't think there's a strong research base.

DR. FLETCHER: But it does sound like it's consistent of what you would think likely in

viable practice, just "yes" or "no".

DR. WEBBY: Maybe.

DR. FLETCHER: Thank you. Real quickly, one of the characteristics of your research that we've been saying from our other witnesses is frequent calls for research. My question is, is it a problem that we actually need more research or we don't implement the research that we have?

DR. WEBBY: I think we need more research, primarily because in two areas that I focused in on, academic interventions there's limited research on academic interventions with kids who have real severe behavior disorders. For me to stand up here and say the literature on reading instruction that's been shown to be effective for kids who are low achievers or have learning disabilities, does that also apply to kids with severe behavior problems, that's tentative at best. There's not enough out there.

In addition, while we do have an emerging growing number of studies that have looked

at functional behavior assessments for children with high disabilities, the majority of that research was done with students with developmental disabilities, autism, and I'm talking about the removal of assessment students. We need more research before I can say here's the best functional basis of practice.

The functional perspective is logical, I think it makes good sense, but we need to look at the broader picture for these students and the primary reason is that most of the functional behavioral assessment literature with children with severe behavioral disabilities has been conducted when children engage in high frequency behaviors.

For most children with severe behavior disorders, significant occurrences of physical aggression or violent behavior is a rare occurrence. That's a much more difficult behavior to assess. So for me to say the high frequency technology applies to low frequency behavior, it seems to be, but we still need more work.

DR. FLETCHER: I guess I'm a little

confused, because I have some idea about how much money is spent on research under the IDEA, and I'm also aware one of the major emphasis of OSA is on essentially the three tier model and problem based learning, things of that sort.

Are you saying we don't have enough research on the three tier level? Is that what you're really saying, because I'm aware of several large scale implementations of the three tiered model, for example, that's been really built on OSAC research.

DR. WEBBY: The research on that model, the reports we're seeing now have been reports at the primary level. At the secondary level if you look at research on secondary interventions like social skills training, meta analyses would suggest those studies have moderate impact. If you look at secondary and tertiary level interventions that are outside this model, yes, we've been effective.

What I've not seen and why I think that, and whether or not this is coming out, again,

I've just seen the reports that come out on the primary level, is looking at kids who don't respond to the primary level within that system of support, determining who needs secondary level interventions and how those are chosen. I've not seen that literature within the context of that model yet. I'm anticipating it's coming, but I've not seen that literature yet.

DR. FLETCHER: That's something that should be part of our research agenda to reduce what I believe are the enormous expenditure of research funds on the primary level, but spend more at the secondary and tertiary level?

DR. WEBBY: My recommendation is research dollars should continue to look at the impact of the primary level in terms of general disruptive behavior, but the research still needs to be continued about the model and that's my point.

DR. FLETCHER: I'm confused, because as I understand it, at least the three tier model is being widely implemented in I think I heard 640

schools, for example. I'm not trying to put you on the spot, but I'm genuinely confused over the state of research in this area, and certainly have the impression that some fairly significant claims about all three tiers being made on the basis of research you're saying that we haven't even done enough on the primary level at this point?

DR. WEBBY: What was that last?

DR. FLETCHER: We haven't done enough on the primary level at this point?

DR. WEBBY: Seems to me there's a pretty good database on the primary level.

DR. FLETCHER: Probably should begin to focus on research dollars on secondary and tertiary?

DR. WEBBY: That I would agree.

DR. FLETCHER: Dr. Pasternack, do you have a question?

DR. PASTERNACK: I will yield my time, Mr. Chairman.

DR. FLETCHER: Dr. Coulter?

DR. COULTER: I want to thank you for

the presentation, also want to thank you that you have your coat on at this time. While the rest of us are heat challenged, you seem to be doing very well, especially given the heated questions.

I'm going to add a little bit to the heat, so if you want to take your coat off, that's fine with me.

You've mentioned a number of times about the importance of a functional behavioral assessment. I think you made a good and effective argument for that. One of the things I was concerned about in listening to your testimony is that given the current status of implementation of those practices, we certainly as Commissioners have heard a number of complaints about the fact that teachers are not doing it, and I didn't necessarily see any comment in your testimony on the frequency or veracity of implementation of these requirements, so I guess let me ask you a couple of specific questions:

First of all, are there currently accepted measures of implementation integrity of

functional behavioral assessment? In other words, can we determine who's doing it right and who's not doing it right?

DR. WEBBY: At the research level, I think there is an accepted set of steps that we would expect a person to go through, including observation, interview with teachers, looking at different settings and situations where the problem behavior is likely to occur. So I think at that level, do I think that those same steps are being implemented at the school level? No. I suspect that often what we're seeing in schools we may be seeing more paper compliance and less sort of functional application of the assessment procedures.

DR. COULTER: So I take it from your remarks, it's possible to construct an assessment not just a functional behavioral assessment of the student, but an assessment of the integrity or the adherence to scientific procedures of that assessment. We can tell who's doing it right and who's not doing it right?

DR. WEBBY: Yes.

DR. COULTER: Okay, that's very helpful.

Now, within that context I think one of the things, I don't want to in any way diminish the importance of what you're doing by focussing on serious behavior disorders, because I think a lot of comments you made are applicable to children in general that would experience any kind of behavior problem in school in terms of levels of intervention. However, I think you know that a percentage of children at school are actually identified as having emotional disturbance as specified in the regulations. That varies from state to state. For instance, in Mississippi it's 2 percent who are considered mentally disturbed.

So with that in mind, I saw some mention of academic instruction, some behavior assessments, what are the accepted research validated treatments for what would generally be considered mental health issues for kids with severe behavior disorders or severe emotional

disturbance?

DR. WEBBY: Mental health in terms of traditional sort of counseling services?

DR. COULTER: Is there any data to support the effectiveness of school counseling in terms of dealing with behavior of children in school?

DR. WEBBY: I'm not familiar enough with that literature to say one way or the other how effective it is.

DR. COULTER: What about school psychological services as it relates to students with severe behavioral disorders?

DR. WEBBY: Again, I'll talk about my peripheral experiences working with schools. I think a comment was made by an earlier presenter in terms of whether or not school psychologists were trained from this perspective and from what I gather from his testimony they weren't. They should be if they're not, so I would agree while I did not attend a school psych program, it seems they give limited information on this from a

functional perspective.

DR. FLETCHER: We need to move on Dr. Coulter.

DR. COULTER: Thank you, ran out of time.

COMMISSIONER ACOSTA: We have been told there's a national teacher shortage, and that's certainly of general education teachers and we know the shortage of special education teachers. Would you just give me your opinion, what are some of the incentives for teachers, regular ed teachers to each special ed students in a general inclusive classroom? What incentives would you recommend?

DR. WEBBY: I think the biggest incentive would be support around issues of behavior management and additional behavior management training. Again, I don't believe that as any exist that general education teachers at the preservice level achieve strong behavior management training, specifically when we talk about severe behavioral disorders. So what incentive, I don't know what incentive that would be, but what I heard

general education teachers tell me they need to have more information, more support about working with these types of children.

So if that was in place, I think you might see at least more willingness to work with these kids in general education settings.

COMMISSIONER ACOSTA: Thank you.

DR. FLETCHER: Thank you very much.

DR. WRIGHT: If I may, will you stay during the break, I have one question to ask you because I only asked you one and that took one minute.

DR. FLETCHER: I'm sorry, Dr. Wright, I asked you twice if you have questions so I'll ask you to reserve your question for the break. We have to move on to our next speaker.

Thank you very much for your testimony, Dr. Webby.

Our next witness is representative Lenny Winkler, who is a State Representative, I believe, from Connecticut. Representative Winkler has played an instrumental role in addressing many

of the key issues facing Connecticut and as a State Representative from the 41st district in 2001 she was a primary sponsor of Public Act 0114, which has been hailed as landmark legislation by medical authorities throughout the United States. This legislation is the first in the nation to address what many health authorities feel to be the overuse of psychotropic drugs by children and merited national and international attention.

Welcome, Representative Winkler.

REPRESENTATIVE WINKLER: Good afternoon, distinguished members of the President's Commission on Excellence in Special Education. I'm very pleased to be with you today, and thank you very much for inviting me.

I'd like to take a few moments to explain how Connecticut's psychotropic drug legislation came about. As I often mentioned, in my home state, I wear two hats; one as a legislator and one as an emergency room nurse. While performing my hospital duties, I recognized a distinct problem with children arriving for

treatment. As patients are evaluated, we determine what medications they're taking. What stood out to me was a tremendous increase in the number of children who have been prescribed psychotropic drugs.

Before children started their psychotropic drug therapy, the following baseline tests are done. Metabolic and liver profiles, a complete blood count, urinalysis and electrocardiogram. During these procedures, I noticed children as young as seven who were being placed on these medications. It is important to note that psychotropic drugs can affect all body systems. Unfortunately, there are no long term studies regarding the impact of these medications on children.

As a nurse and as a legislator, I realized this was a problem in Connecticut, and after researching the subject, it was more apparent to me that this is a nationwide problem and we need to reassess the effects of psychotropic drugs on children.

I am especially concerned with how this is impacting our nation's future and troubled by the possible connection between psychotropic drugs and incidents of school violence. In many cases of school violence, the offenders had been prescribed and were taking psychotropic drugs. As you all know, anyone using medication builds up a tolerance over time and requires a stronger drug at some point. After introducing this legislation, I received many calls from parents who had been told by school personnel that their child was disruptive in class, had ADD or ADHD. Some were even told that their child would not be allowed to attend school if they did not place their child on medication.

I have the utmost respect for teachers in my state, but they simply are not qualified to offer a medical diagnosis any more than I am qualified to tell them how to teach a class. I proposed the bill in January. It was unanimously passed by the House of Representatives and Senate in April, and signed by the Governor the following

month. And I will briefly describe for you what this legislation does.

Beginning October 1 of this past year, each local Board of Education is required to develop and implement a policy that prohibits school personnel from recommending to parents or guardians the use of psychotropic drugs for children under their care. It does allow a designated school official to recommend to a parent or guardian that a medical evaluation be performed on their child. Also with the permission of a parent, school personnel may exchange relevant information with a child's physician.

Another clause in the legislation prohibits the State Department of Children and Family from removing a child from their home because the family refused to place the child on a psychotropic drug unless neglect or abuse was determined under state statutes.

I would like to mention that this has been dubbed the Ritalin bill by certain media outlets. Although Ritalin is a psychotropic drug,

there are many other psychotropic drugs and the legislation is relevant to each medication. I have written to Connecticut's Congressional delegation and asked them to ban direct advertising in magazines regarding the use of psychotropic drugs. Only physicians should receive this information and base their treatment regimen after careful consideration and a thorough evaluation.

I consider the legislation enacted last year a good start and am very pleased that Connecticut is the forefront of this issue. This year, a followup bill has been proposed to help clarify last year's legislation. It would specify what psychotropic drugs are and give examples as to who the appropriate contact personnel at schools would be regarding medical and behavioral evaluations.

I believe it's time that we consider alternatives to psychotropic drugs. I believe State and Federal governments should look at establishing pilot programs of neurotherapy, which would enable children to actually change and

improve their social skills, grades and hopefully remove them from psychotropic drug therapy.

Through the process of neurotherapy, the regulatory process of the brain can be substantially improved. However, as I understand it, we can customize each child's treatment through the use of brain mapping techniques. Modern database analysis allows the comparisons to normal patterns to identify specific deficits to correct. Properly applied modern neurotherapy provides a traditional learning model which empowers each child to develop personal self-control and regulation of their mental abilities and actions.

Neurotherapy offers the opportunity to reduce the need for services in the ongoing years as the child progresses through school. It's good for the child's education, their sense of achievement and the future.

It is not just a question of educational opportunity. It is also about the chance for effective learning to empower a child for a lifetime of success. It is about optimizing

all of our teaching efforts in special education, so that the child becomes a good learner, a good student.

At the same time, we will be able to reduce expenses for education and health care. This is a genuine win-win situation. We can do the right thing to enhance the lives of children in need and get a handle on our special education costs.

I'd like to say, Connecticut is a very small state and our special education budget is $500 million a year and is going up. I think we have to look at something to address this issue.

As more states recognize the need to protect children from unnecessary medications and address the behavioral and learning needs in other ways, we will insure a healthy future for our children and our country.

I'd like to share with you three recommendations that I would have that I would love to see you look at. One of them would be to require federal legislation that would prohibit

school personnel from recommending the use of psychotropic drugs. I'm personally not against the use of them, but this is not the decision of a teacher, it's the decision of a medical professional.

I have received phone calls, e-mails from all over the United States. People have shared with me some horrific stories on these issues. I would also like to see drug advertisement banned in magazines. The only people that should receive these advertisements are people who have prescriptive authority and can order the medication. What good is it to advertise this medication to a parents out there who have no knowledge of the side effects and the contraindications?

The last recommendation I would like to offer is I wish you would consider offering grants at the federal level to states to implement pilot programs in the neurotherapy area.

With me today I have Dr. Jonathan Marsalis, who is a neuropsychologist who I have

been working with in Connecticut to establish a pilot program. He has the expertise and can answer any of your technical questions on that issue. Thank you very much.

DR. FLETCHER: Thank you very much, Representative Winkler. We'll start with Commissioner Acosta.

COMMISSIONER ACOSTA: Thank you for your testimony. I just have a question, what is, $500 million?

REPRESENTATIVE WINKLER: $500 million.

COMMISSIONER ACOSTA: Is there a breakdown, where is that money spent specifically?

REPRESENTATIVE WINKLER: It is the amount of money that is classified that is being used for special education. I am sure we could get a breakdown of this.

COMMISSIONER ACOSTA: Could you, please? That would be very helpful. Thank you. And that's all that I have, thank you.

DR. PASTERNACK: Thank you, Mr. Chairman. Representative Winkler, could we

just get a brief description for the record of what neurotherapy is?

REPRESENTATIVE WINKLER: Yes, and I'll let Dr. Marsalis speak with you.

DR. PASTERNACK: Because of the sensitive nature of the Commission and our inability to endorse any particular model, I'm just going to profess my ignorance and just ask if you could please provide a very brief description for the record as to what we're talking about.

DR. Marsalis: Certainly, sir. You have to understand, this is nothing more than a formal behavioral intervention. It's using a form of computer game in order to help the child learn to self regulate their own brain wave activity. One of the problems that we when we hear a lot of what's been discussed here today about behavioral interventions and the like, always there's the underlying assumption that the child has willful control of their behavior, that it may choose not to engage in these disruptive oppositional behaviors, they would be able to stop doing it.

The fact is, Dr. Abikoff today referenced the fact these are neurological disabilities. There's something wrong with how the brain works. The child can't stop this disability of oppositional behavior any more than he can sit still in his chair. It's not a matter of teaching your child control through a behavioral technique. You have to help the child learn how to have control over that brain wave activity. What we do through a computer analysis is enable the child to actually gain that behavioral control in the brain, not just in terms of external behaviors and that's in a very short form what this involves.

DR. PASTERNACK: Thank you. Basically, would it be fair to characterize it as some derivative of biofeedback?

DR. MARSALIS: Neurofeedback is part of it, yes, but only a part of what you have to do in the program. You have to do the other kinds of work as well.

DR. PASTERNACK: Thank you.

Representative Winkler, there NAEP

data, I believe, which indicated that Connecticut scores in the top of the United States in the states out of the 39 states that volunteered to take the national assessment of educational progress. I wonder if you would be able to share with us your view of what is working so well to produce such good results for the students in general education who take the NAEPs. As we have not disaggregated those data, I can't tell you how kids with disabilities on your state are doing on NAEPs, but I'm curious about your perception about why is Connecticut doing so well?

REPRESENTATIVE WINKLER: It is very difficult to hear your question. Was this regarding how well they're doing with the state mastery tests?

DR. PASTERNACK: National Assessment of Educational Progress, the name, which is the only national test that we have at this point, really. States volunteer, as you know, to take that test, 39 states participated last go around. Connecticut scores 1 or 2 and I am curious as to

your perception or your sharing with the Commission what is working so well in the public schools within the State of Connecticut to produce those kinds of results.

REPRESENTATIVE WINKLER: Connecticut, I believe, has a wonderful special education department, and when I met with them on this issue, I shared with them that this is to be another tool for them to use. It is not to replace what they're doing. I think they're doing an excellent job. But we're still seeing our dollars increase tremendously and at this point we need to do something.

DR. PASTERNACK: I guess I will thank you very much for your comments and that's it for now, Mr. Chairman.

DR. FLETCHER: To follow up on Dr. Pasternack's question, we heard earlier testimony that identification rates lead to increased expenditures for special education. Do you think there's anything unique in identification rates in Connecticut that results in the increase

expenditure for special education? For example, Greenwich, I believe, has one of the highest identification rates for children with learning disabilities in the country.

DR. PASTERNACK: 20 percent, Mr. Chairman.

DR. FLETCHER: It is also one of the most affluent areas of our country.

REPRESENTATIVE WINKLER: If you looked at the breakdown of all the 169 towns in the state, it would be very--it's a real eye opener. The special education is very high in many of the towns that you would expect that it would not be. The, obviously, the special education is higher in your bigger cities such as Bridgeport, New Haven, Hartford, Waterbury, and I think that's because, I think that it's because a lot of the school systems, there was a move to look at school choice, to allow, to improve the school system. The overall grades in these testing scores in these grades are not that good. If you look at the overall scores, you'll find that Connecticut is

down quite a ways on the overall list of mastery tests.

DR. FLETCHER: I'm not sure which scores you're referring to.

REPRESENTATIVE WINKLER: I'm talking about the mastery scores at this point.

DR. FLETCHER: As a state? The state or some of these districts?

REPRESENTATIVE WINKLER: The scores are high in some of your more affluent areas and in your poorer areas, the scores are quite low, so that overall it brings the state scores down.

DR. FLETCHER: But in national assessment Connecticut is traditionally at the very top.

REPRESENTATIVE WINKLER: I'm not sure.

DR. FLETCHER: I'll testify for the record it's number 2 on the NAEP, Connecticut was cited on the NAEP report for making the most significant improvements in reading achievements of any state in our country.

The other question I have is for your

expert on neurotherapy and I would like to know if there are randomized clinical trials that demonstrate efficacy for neurotherapy relative to other interventions for children specifically with ADHD?

DR. MARSALIS: Yes. The most classic one is eight or nine years.

DR. FLETCHER: Randomized trials, please.

DR. MARSALIS: Yes, specifically a test of neurotherapy against Ritalin shows twenty sessions had the same effect in terms of controlling behavior that Ritalin did.

DR. FLETCHER: I'm amazed at that study. I don't believe it was a randomized trial.

DR. MARSALIS: I believe it was a randomized trial, related to those conditions.

DR. FLETCHER: Maybe we're thinking of different articles.

Would you agree that many reviews of neurotherapy for children with many of the conditions for which it's been recommended, which

range from children with attention deficit disorder to autism to learning disabilities and so on, that many reviews of the efficacy of this practice have not concluded that it's terribly efficacious or concluded that the research necessary to establish it as a viable modality has yet to be completed?

DR. MARSALIS: I would not entirely agree with that statement, no, sir.

DR. FLETCHER: Would you agree that other people, other experts in the area like Russell Barclay, for example--

DR. MARSALIS: Russell Barclay has had that position for a long time.

DR. FLETCHER: He would take that position.

DR. MARSALIS: Absolutely.

DR. FLETCHER: There's no consensus on that opinion?

DR. MARSALIS: No, sir, nor on functional analysis either.

DR. FLETCHER: Functional behavioral analysis for who? How about the use of

Methylphenidate?

DR. MARSALIS: There's agreement it works on about 70 percent of the children.

DR. FLETCHER: 70 percent on the first dose but--

REPRESENTATIVE WINKLER: If you use multi drugs, it raises 80 to 90 percent.

DR. FLETCHER: Does neurotherapy work with 80 to 90 percent--

DR. MARSALIS: Yes. Again, there's not as many randomized trials as I would like to see, I believe there are some.

DR. FLETCHER: And do other experts in the area like Russell Barclay, for example, agree with your assessment, the statement you just made?

DR. MARSALIS: Certainly Russell Barclay would not.

DR. FLETCHER: In fact, there are others who would not agree with that statement as well.

DR. MARSALIS: Certainly some, but there are many that would.

DR. FLETCHER: I'm curious, Representative Winkler with this level of discord, why you would recommend to the panel that we initiate state pilot grants for neurotherapy.

REPRESENTATIVE WINKLER: Because I go back to what I see in the emergency room, where the young children coming in more and more on psychotropic drugs, and I don't mean just Ritalin. I see them come in on Ritalin, Zoloft, Prozac, Clonopin, Wellbutrin, any combination, multiple drugs. And I question what we're doing to the future for these children, for the State and for the nation.

I'm looking at school violence that has occurred across the United States by children who have been on psychotropic drugs. I mention you build up a tolerance to anything when you're on medication for any length of time, and I believe eventually we are going to look at doing some neurotherapy programs, because what we have is not working all that well.

I realize what you said, and I'm sure

Connecticut is doing a good job, but why are we spending $500 million in a small state on special education costs?

DR. FLETCHER: Well, I frankly would suggest that you read the testimony of our previous expert on the economics of special education, you might get a clue of how identification practices drive the cost of special education, particularly for children with mild disabilities, and I'd also like to indicate for the record that tolerance is not the same thing as addiction, for example, or withdrawal, and tolerance is not really a word that's typically used in conjunction with medications like methylphenidate for example.

REPRESENTATIVE WINKLER: I couldn't hear you.

DR. FLETCHER: I said I do not believe that tolerance is the same thing as indicated dependence on a drug or that a drug like methylphenidate, for example, specifically associated with the significant development of tolerance that changes in doses, for example, were

more related to growth in the child as opposed to tolerance per se.

REPRESENTATIVE WINKLER: I would agree with that.

DR. FLETCHER: Thank you.

Dr. Grasmick.

DR. GRASMICK: Thank you, Representative Winkler. I'd like to ask you how teachers responded to your legislation, psychotropic drugs.

REPRESENTATIVE WINKLER: There was a very mixed feeling. Some teachers felt this was not needed because it was not happening. Others were very responsive and supported the legislation. I received calls from my own district, from the special education director, who commented that he was very pleased to see the legislation going forward. He said that he had told all of his 80 something special ed teachers never to make the recommendation that a child be placed on medication; that it was not under their purview. It was well received.

However, he said that he mentioned to me that in many instances he saw other teachers in the school district, including guidance counselors, make the recommendation and tell the parents that their child needed to be placed on medication.

DR. FLETCHER: Commissioner Wright?

DR. WRIGHT: Thank you, Mr. Chairman. Since we're horribly over time, I will not take the time, I will just go with his five questions and whatever else you can say that you have here and I will not take the time to question you. Thank you.

DR. FLETCHER: We have fifteen minutes for this particular witness, if you have some questions. Are there any other questions for Commissioner Winkler?

Thank you very much. We're next going to open our public comment period, but we'll take a fifteen-minute break before we start that. We're in recess.

(Brief recess.)

DR. FLETCHER: We're going to start precisely at 4 so we're going to start to ask

everybody to start moving back. We're hoping our public commenters have been given a number, because we are going to go in the order in which you signed up. We're about to start precisely at 4. Let the chair note that the record is open for offers of additional information from Dr. Webby that Commissioner Takemoto requested. What was that information, please?

COMMISSIONER TAKEMOTO: It was related to the IBM regulations, recommended practices, and I asked him if he would--he wanted the opportunity to respond more in detail to what recommended practices were vis-a-vis the regulations.

DR. FLETCHER: Thank you.

Dr. Pasternack?

DR. PASTERNACK: I just for the record, Mr. Chairman, wanted to thank you for the stellar way in which you conducted this hearing today and I'm just continually amazed at how much you know and your actions and I wanted to state that publicly. I also wanted to thank the people

who were kind enough to wait in the warm room here. Shows their passion for these issues and we look forward to hearing their insightful comments.

DR. FLETCHER: Thank you very much, Dr. Pasternack, for the kind comments. I am especially grateful to our troops who have endured the increasing heat waiting to hear from the public.

We're going to start and as I said before, we're going to go right down the order in which you signed up. We're going to ask our potential speakers that are lined up on the side. We already have our first four speakers. I want to ask that you talk with the microphone and please remember that you have three minutes to speak.

We have a timer right in front of us, I believe that's a green dress that's she's wearing. She has a timer that will go "beep-beep-beep." She will also hold up warning signs so you may want to look at her periodically and we will be as strict as we can about the three minute limit.

I will apologize in advance for

butchering people's names, but I come from a long tradition of chair types who cannot pronounce people's names. The first speaker I'm told by Dr. Pasternack is Tom DePaola. Welcome.

MR. DiPAOLA: Good afternoon. I want to thank the Commission for this opportunity to both comment on, suggest some strategies for the improvement of special education in this country this afternoon.

My name is Tom DiPaola, I'm the State Director of Special Education from the State of Rhode Island. I'm also the parent of three children, two biological children and a foster son and I'm also a lifelong Yankees fan. So in addition to being here this afternoon, I'm hoping to get to the Bronx this evening to watch the Yankees play the Baltimore Orioles.

DR. FLETCHER: Be careful on the subway.

MR. DiPAOLA: I'm here this afternoon representing my colleagues, we represent a loosely knit consortium of twelve small states roughly

defined as having populations of under 1.3 million people. I've provided copies of a more detailed summary. I'm basically just going to highlight a couple of the points that we think were important in the consideration for improving special education as we move forward with a reauthorization of the IDEA.

Basically what we'd like to do is convey the message that for the small state we actually operate as fairly large school districts, so the two points we wanted to emphasize have to do with funding and professional development. The area of funding certainly we were in favor of the proposals to have the full 40 percent of excess cost funding reinstated or to be instated. But short of that is we were hoping for some language that would allow us to have sufficient funds at the state level to be able to administer the programs and to provide technical assistance to the District.

Frankly, where we are in Rhode Island with that is, because our percentage of holdback

money is so small at this point, it's likely to have been cut for the past few years, so statewide initiatives really aren't having the effect of programs that could serve children in the state, we're really not able to do successfully.

Relative to professional development, our hope is to have a little bit more linkage between professional development dollars to our state improvement activities. When we identify programs of services that need improvement in the state, we need to have a little more authority. Frankly, what happens at this point is the institutions of higher ed are able to apply for professional development funds. They may or may not match up with our needs at the state level and frankly we would like to have a little more control over how those dollars are spent.

I appreciate the opportunity. Thank you very much. Thank you.

DR. FLETCHER: Next speaker is Ron Benner followed by Rosa Hagin.

MR. BENNER: Hi, I'm Ron Benner, school

psychologist from Seymour, Connecticut.

We must change our current deficit model to one of proactive intervention. We must not wait until the student is failing to bring in a model that may or may not work. We need to base all our programs on data, research-based, field tested interventions with positive outcomes.

Now, particulars. Full funding of IDEA. I recommend that we fully fund IDEA. For now, let's fully fund only those areas of IDEA where there is no controversy. This will start the flow of funding dollars now.

Early intervention: We need to move intervention timeline down till reading skills are mastered by the end of the third grade. We need to go below phenomic awareness to do a speech and language evaluation. Without language, reading does not happen. We need to use curriculum-based measures to adequately sample student's progress based on this evidence, interventions could be implemented.

We need the uncategorized label in all

states to the eight year old level. Identification of eligibility consistency: We need to develop criteria that will identify and service similar students, no matter where they live. An LD student in one town should be the same as an LD student in another town.

Paperwork: I would suggest that the government give us the individual education programs forms they want filled out, make it uniform across all states. Make the states have their own forms for the information that they want correct.

Discipline: If a behavior impacts the education of a student, then there should be a program to correct the problem. First, we need to respond early to these behavioral needs so that they have a better chance of positive outcomes. Next, we need to offer continuum of services. These should have multiple steps to allow movement to and from the most restricted programs.

We need to provide funding formula that does not penalize school districts by making them

wait until the end of the school year to receive reimbursement. We need to hire administrators that show skill at working with and changing the behavior of these students. We need to train our administrators to better handle these students. We need programs that change the negative behaviors to positive ones and not just look for programs to lock away students.

Every student deserves education. We must have mental health providers, school psychologists, counselors and social workers in every school.

Disproportionality: We need early intervention with programs that are researched-based and field tested. We need to start with birth to three, upping the services, and our schools need to follow that service.

Lastly, I would like the Commission to put out a draft report so the public can comment on it before the final is published.

Thank you very much.

DR. FLETCHER: Thank you. Rosa Hagin

followed by Lynne Thies.

DR. HAGIN: In view of the time limits, I will read.

My name is Rosa Hagin. I am a licensed psychologist and a diplomate of the American Board of Professional Psychology. I have worked in public schools for ten years as school psychologist and director of special services in inner city schools in New Jersey, and for twelve years in projects in prevention and remediation of learning disabilities sponsored by the Learning Disorders Unit of New York University School of Medicine in schools in lower Manhattan.

This is a personal statement on assessment issues, but it also reflects the beliefs and policies of the 50,000 parents and professionals of the Learning Disabilities Association of America.

DR. FLETCHER: Could you speak into the mike, please?

DR. HAGIN: Of the Learning Disabilities Association of America, of which I

have been an active member since the very beginning of its work.

In the interests of time, this is a brief summary statement, a more detailed written statement has been prepared for the consideration of the committee.

I am concerned that the Commission, disappointed that the promises of the 1975 legislation have not been fully realized, will turn to new and untried approaches and ignore the lessons learned in the 27 years since the laws have been enacted. I would therefore draw attention to what has been learned about learning disabilities and show you hoe this knowledge can shape future decisions.

One, learning disability is a heterogeneous, lifelong condition that may manifest itself in many aspects of language, literacy and mathematics learning. The nature of these manifestations depends on the unique individual patterns determined by the age of the individual and his or her strengths and needs.

Two, assessment must, therefore, be broad based. No single diagnostic procedure can be expected to identify all individuals who need help. Comprehensive, multidisciplinary, clinical methods have the value of telling us not only that a student is failing, but also the causes of the failure. It follows that no single instructional procedure can be expected to serve all individuals equally well. Comprehensive multidisciplinary diagnosis can target structural methods, content and have the greatest opportunity for success. A one size fits all method will not suffice.

Learning disability is a hopeful condition when appropriate educational and clinical services are provided. Thank you.

DR. FLETCHER: Thank you, Dr. Hagin. Lynn Thies, followed by Patricia Weathers.

DR. THIES: Hi. Thank you for the opportunity to speak. I'm here representing the New York Association of School Psychologists, of which I'm the immediate past president. I'm also a member of the Government and Professional Relations

Committee of the National Association of School Psychologists, but my comments are my own, but I'm here representing all of them, although these are my unique comments.

My background is that I started off as a special ed teacher working with learning disabled children in the 1970's. Then I was trained as a school psychologist. I've been working as a school psychologist for the past 22 years on Long Island, a suburban community. I'm also a part-time trainer of school psychologists at St. John's University, so I'm involved at both the practitioner and trainer level.

I prepared my comments prior to today's hearing, so I'm talking about some things that were addressed already, so I'll read what I wrote so you can look at it as I prepared it beforehand.

Recently I heard Dr. Robert Pasternack speak at the National Association of School Psychologists annual convention in Chicago. He described the future of special education as one where all children would be taught with research

validated approaches and that failure to show adequate progress after using such approaches would be one the criterias for referral to special education.

This implies that school personnel will be familiar with the best practice literature on strategies for teaching reading, writing and mathematics. Unfortunately, my experience is and those of my colleagues have indicated that instruction is often based on the trends in the local education community, rather than on research-based methods. Although we currently know definitively which skills are necessary for success in early reading, many of us have limited control over decisions that are made by school districts regarding curriculum choices. As one possible remedy for this dilemma, I would like to discuss a role function, two views that school psychologists hold in our school; that of facilitator of database decision making.

In our role as evaluators of students with behavioral and learning difficulties students

we have been trained to use data from a variety of situations and to rely on the most valid and accessible instruments. This approach should be taken when making decisions about instruction and curriculum as well. School psychologists can provide a valuable service for students in their schools by using these research-based decision making skills to guide early screening and early intervention programs and to evaluate the effectiveness of such approaches in order to make adaptations as necessary.

This focus will help us to reach students whose weaknesses can be remediated prior to referral for special education services and to insure that the instructional practices are accomplishing what they are supposed to accomplish.

And then I wrote a little bit about programs in other states and I'm not going to talk about and then basically, I wanted to say that we would like as school psychologists to work with the Commission in making this paradigm shift from a disability focus to a focus on teaching all

children with quality instructional approaches. Thank you.

DR. FLETCHER: Thank you. Next is Patricia Weathers, followed by Lisa Hyman than by Sarah Sander.

MS. WEATHERS: My name is Patricia Weathers. I am a mother from New York. I have a considerable concern regarding the outcome of these hearings. My son is profiled for ADHD, which led to a classification of learning disabled. In 1997, my son's first grade teacher filled out an ADHD checklist and sent it to his pediatrician. This checklist, along with a fifteen minute evaluation by the pediatrician, led to my son being diagnosed with ADHD and put on Ritalin. After a while my son started to exhibit serious side effects from the drugs. He was not socializing, became withdrawn and began chewing on different objects. His behavior became more bizarre. Instead of recognizing the side effect of these drugs, the school claimed he had a social anxiety disorder and immediately produced the name of a psychiatrist.

Within another fifteen minute evaluation he was diagnosed with social anxiety disorder and prescribed yet another drug.

The drug cocktail caused even more side effects, making his behavior even more out of character. I could no longer recognize my on son. Fearing what these drugs had done to him, I stopped them. Once the school found out I was no longer giving my son these drugs, amazingly enough, they went as far as throwing him out of school and calling Child Protective Services on me, charging me with medical neglect, a charge that was ladder ruled unfounded. Surprisingly, I found that many parents have undergone similar coercion and pressure to label and drug their children, which is why I began publicly speaking out about this issue.

To date, my story has been featured in The New York Times, Time Magazine, Good Morning America and CBS Evening News, among many others.

Parents are coming forward from across the country with similar stories and states across the U.S. have begun implementing laws to curb the

pressure and coercion that parents received from school personnel to label and drug their children. The fact that states need to implement laws to counter the federal law known as IDEA should be a clear message to Congress. Today my son is being home schooled and is doing well both academically and emotionally. He is drug free. He never should have been categorized as special education, all he needed was standard academics and an intensive phonics based reading program.

I wish to address several key points that I strongly urge this Commission to consider when making their final assessment. Parents are never given an accurate portrayal of the controversy ranging around ADHD. Parents are never told that no legitimate tests exists to scientifically prove that their child suffers from it. Parents are never told that their school gets additional funding for every child labeled with this disorder and medicated. Parents are never told that their child will be ineligible to serve in the Armed Forces.

Unfortunately, all these points eventually work their way into the realm of special education. I am asking this Task Force to prevent other American families from having to endure my dilemma. They can do this by taking out school district incentives to mix so-called behavioral disorders with true physical, provable organic medical handicaps.

Please don't let other parents go through what my family went through. Thank you for hearing my story.

DR. FLETCHER: Thank you, Miss Weathers. Next we have Elisa Hyman, followed by Sarah Sander and by Cassandra, whose last name I can't read.

MS. HYMAN: Hi, good afternoon, I'm Elisa Hyman, and I'm the Deputy Director of Advocates for Children, which is a parent training information center in New York City. Advocates for Children has thirty years of experience assisting parents of public school children to attain quality appropriate education services. We've been a PTI

program for more than fifteen years. We focus on supporting parents of children with disabilities who face the greatest barriers for receiving services, including those of poverty, race, limited English fluency or involvement in the juvenile justice system.

I have prepared some comments today that I frankly abandoned in light of the testimony and I'm thinking of submitting more extensive written comments at a later date. I realize the Commission is under time pressure. I'll do my best to get them to you quickly. Instead, I'd like to respond to what appear to be some key questions to the Commission today and I'm going to make those responses very brief and broad.

Particularly Dr. Pasternack focused on why aren't kids achieving and why is there overrepresentation and stigmatization for many kids in the school system. My overall response is very simple. I think we need to insure that the law as designed is actually in force and adequately funded. In New York City, for example, there's

tremendous need for cultural competency in the school system. There's also a need to support teachers and administrators to manage behavior, not only to use exclusion as a method to address children with behavior problems. Certainly, I think we need to insure that quality educational and other kinds of evaluations are provided that actually can give recommendations for instructional methodologies.

Finally, perhaps most importantly, we need to guarantee the promise of IDEA by enforcing laws to ensure that districts used research-based, empirically valid state of the art practices in teaching and behavior management and focus on positive outcomes.

Finally, I'd like to just, I know we didn't talk about cessation of services for kids who are suspended today, but I'd really like to stress that the Commission take a very hard look at this issue, particularly in New York City there were 50,000 suspensions last year. Half of the long-term suspensions, which means suspensions over

five days, were of kids with disabilities. Almost 70 percent of those suspensions were of African American students. 98 percent of kids who are getting alternative education services, which means they basically get no instruction for almost a year, are minority students, and I really don't think that, leaving aside the issue of disability discrimination from the juvenile justice prevention perspective and looking at the disproportionate impact on minorities, student cessation should even be considered.

There's nothing worse than having at risk students out of school for months unsupervised.

I'd like to conclude that I'm sure the Commission has a very hard job in front of them, and I'm sure they'll do the right thing. Thank you.

DR. FLETCHER: Thank you. Next is Sarah Sander, followed by Cassandra and then by Ellen McHugh.

MS. SANDER: Hello, my name is Sarah

Sander. I am the mother of four children, including the second one, Moishey, who has Downs syndrome. I am also the founder and editor of a magazine entitled "Downs Syndrome Amongst Us," the first of its kind within the Orthodox Jewish Community.

Life with Moishey is truly wonderful and he makes our family complete. We would never wish to forego the experience of raising such a wonderful child who lends so much joy to our immediate and extended family. However, for years we have been plagued with one area of distress; Moishey's education. As an Orthodox Jewish boy attending public school, Moishey was becoming a stranger amongst his own people. His ignorance of his rich heritage, culture and religion created a gap between him and his family and community, a gap that widened with each passing year.

Thank God my husband and I were inspired enough to do something about it, and this past September, 2001, we opened our very own Yeshiva program, at tremendous personal cost and

sacrifice. A beautiful and large mainstream Yeshiva in Brooklyn opened its arms and heart to us and we are now a part of their Yeshiva. We hired a professional staff of teachers and assistants, recreation therapists, et cetera, who live, eat and breathe with just the students on their minds. Our children are mainstreamed for appropriate activities daily. They eat lunch in a mainstream cafeteria and have already established some very close friendships with the quote normal students.

What shall I tell you? Our boys are shining. They have finally come home. They now receive Hebrew as well as secular instruction. However, we are now paying thousands of dollars in tuition to fund our son's Yeshiva education. Already we are cutting out some very much needed family projects that are deeply affecting our other children.

We implore the distinguished Commissioners to please take into account that our son and his friends were in the public school, where they cost the system hundreds of thousands of

dollars over the years. We opted to leave the public school system because we couldn't bear it that Moishey was not receiving a religious education, which was so vital for him as an integral family and community member.

We now ask that those thousands of dollars be transferred towards his Yeshiva education, thereby not generating new expenses for our Government, just reallocating old ones to more desired programs.

On September 11th our boys watched in horror from the roof of their Yeshiva building as the Twin Towers crumbled to the ground and like Yeshiva students all across the United States, they went into their classrooms and prayed. They prayed for their country, their President and for all the victims and heroes of that fateful day. This was the first week ever that our boys were able to pray at school.

My plea to the President's Commission is as follows: Please take into consideration the option of allowing us concerned parents to choose

the schools that we deem as best suited for our special needs children and please, by all means, help us fund our children's education.

I understand that parental choice is becoming an ever more recognized alternative path in American education, specifically in special education.

DR. FLETCHER: Ms. Sander, please finish. Thank you.

MS. SANDER: Thank you very much.

DR. FLETCHER: Next we have Cassandra, I'm sorry, I can't read your last name, so I'll ask you to say your name for the record, please. Followed by Ellen McHugh, and then Eytan Kobre, I believe.

MS. ARCHEE: My name is Cassandra Archee, and I am the Parent Information Center project director.

DR. FLETCHER: Could you speak into the microphone, please?

MS. ARCHEE: Yes. That's better? I'm Cassandra Archee, project director for the Advocacy

Center, Rochester New York.

I would like to immediately acknowledge that all of the New York State PTI's are here in the room with the CPRC, so we join our colleague, the Commissioner, on this very important topic here.

I'm going to spend a minute and a half on two halves. The first half will be that of the PTIC director. When we look at the issues around the reauthorization of Part D, we are very concerned and involved about it being fully funded, because the PT's are funded like every other IDEA. We know it expires September, 2002.

The next piece I will talk about is my parent role. I plan to bring into the room the voice of an African American male, my son, to this process of special education. I think's real important that as we talk about overidentification that we understand sometimes the cycles that exist for African American males and I want to leave you with his experience in the special education process.

When he was very young in elementary school, we had some testing done, they showed that he needed some support in his performance and his ability. And understanding that he needed those supports, we were very concerned about how to get those special education services became an option. We knew that as an African American male he went to school already needing to show up believing that he could achieve and convincing staff that he could do that, and when special education services were considered for him, we said yes. He said no. He vitally opposed being a part of the special education services because of the label and the stigma that was attached to it. We said yes.

He continued in the special education process and his behavior became an issue. He was saying no. We were saying yes. And as we said yes, retention became the next step as he continued in the process of special education. He said no and finally we said no. We said no to special education.

Today, he is a second year student at

the University of Central Florida in Orlando.
Thank you.

DR. FLETCHER: Thank you, Miss Archee.

Next we have Ellen McHugh, followed by Eytan Kobree.

MS. McHUGH: Good afternoon, welcome to the hottest day on record in New York City so far.

DR. FLETCHER: Speak in the mike.

MS. McHUGH: My name is Ellen McHugh. I am the parent of an individual who has a disability. He is deaf. I was not planning on making a comment until the Chancellor spoke this morning and I would like to make some clarification.

This is still a system that blames parents. The Chancellor blamed the parent forced to exercise his or her due process rights. If you look at numbers that currently exist in New York City of 125,000 odd students receiving special education services and the number of people who are forced to go to impartial hearings, 1,240, you're looking at 1 percent of a population that is forced

into a due process confrontational right.

Obviously, there are some positives. In addition to this, the system evaluators often characterize the parents and particularly the mother as in denial and unable to accept the child's limitation. The worst phrase that people can hear in a school building is "here comes the mother" or said in Brooklyn as "here comes the mudder."

Administrative staff grows separated from students and the teaching staff and one of the issues becomes how is a teacher supported. I don't know any teacher that gets up in the morning and says I would like to do damage to any child, nor do I know any parent who gets up in the morning and says, I want you to be dumb or poorly educated which was shocking when the Chancellor seemed to accept responsibility for a system that is consistently failing and offering that consistently failing baseline to those individuals who are presently disabled.

Even though I might be temporarily

disabled, I had a knee operation, I am in more sympathy than I have ever been with those individuals who have to navigate systems.

In conclusion, I would like to say that I fully support 40 percent funding, that I do urge you to draft a report that can be commented on by the public, and I do ask you to have, which may not be one of the better parts of life, an information session for parents only. I know we rant and rave, and I know we can be difficult to deal with and sometimes illogical and loud, but we also need to have a voice that is not present here today because of the formality of the meeting, and I would ask that you could use the website that you created as an interactive tool so that we can make comments through that methodology.

I will be writing something now that I'm indignant. I have to tell you that I do suffer from long standing self righteous indignation, but I still have a child who succeeded in a system that did not allow for participation, but did allow for me to passively pass through,

should I have chosen to do that. Thanks.

DR. FLETCHER: Thank you, Ms. McHugh.

Next is Eytan Kobree, followed by Brenda Townsend and then Leslie Jackson.

MR. KOBRE: Good afternoon. Thank you for the opportunity to share my views with you today, and for bringing the warm weather with me from Miami.

I'm Eytan Kobree, I'm associate general counsel for education at Agudath Israel of America, a National Orthodox Jewish organization, which among other functions, advocates for the interests of students and families in Jewish religious schools across the country, including more than 100,000 students right here in New York State.

Today's hearing is devoted to issues of assessments and identification and I'd like to make some brief remarks in that regard.

IDEA's current funding formula, based as it is on a ratio of public to nonpublic school students within a population of students identified as disabled, creates the financial disincentive for

districts to identify the disabilities of nonpublic school students. This problem is not theoretical but actually practical. To illustrate, we at Agudath Israel are now conducting a detailed survey on special education and the implementation of IDEA in the hundreds of Jewish elementary and secondary schools nationwide. The responses have just begun to come in and when they've all been tabulated, we look forward to sharing them with the Commission and Assistant Secretary Pasternack.

Judging from early returns in this survey, however, one would never know that Child Find and consultation regarding services are unequivocal legal mandates upon LEAs. Almost three quarters of respondents so far have never even heard of Child Find and over half of them were never even consulted by the District regarding how best to provide the services that students are entitled to by law.

These responses confirm oral reports we've received from around the country of district's delaying or even refusing to evaluate

students referred to them, of district evaluators consistently finding no disabilities present, contrary to other professional opinion, and of districts refusing to provide services arbitrarily and based on capricious legal grounds.

We have the following recommendations.

One, base IDEA funding on the ratio of total non-public school students to public school students, since the incidence of disability is likely the same for both groups.

Two, strengthen the accountability of LEA's to the Federal Government, including requiring them to demonstrate compliance with their obligations to non-public school students as a condition for receiving federal funding.

Three, provide early intervention services to nonpublic school students, which will catch and address problems before they become learning disabilities, thereby saving the government more money they already save due to these students enrolling in nonpublic schools.

In closing, I note that earlier today

there was a discussion of the vexing lapses of the special ed programs vis-a-vis minorities. Those problems can and should be addressed.

There is, though, another minority that needs to be addressed, and I refer to the 6 million plus nonpublic school students in the U.S. today. They deserve access to the full range of services in the school as much as any other child, and we trust President Bush will insure that they, too, are not left behind.

Thank you for listening.

DR. FLETCHER: Thank you, Mr. Kobre. Next is Miss Townsend, followed by Leslie Jackson and Donald Lash.

MS. TOWNSEND: Good afternoon. I thank you for the opportunity to address the Commission. My name is Brenda Townsend. I'm an associate professor at the University of South Florida in Tampa and I also address several projects which are recruiting and preparing African American males for urban special education teaching careers and a year ago I started a center at the University of South

Florida, which is called CAESL Center, Center for Action and Effective School Leadership.

I want to extend the conversation that was begun this morning when Dr. Pasternack asked the very timely question of over-representation of African Americans in particular, and he asked about the possible causes, and when you said that, I immediately thought, I reflected all the way back to my childhood and a conversation with my grandmother and I can remember breaking what I thought was just an old plate of hers and it happened to be a cherished piece of China and when she asked me about it, I said I didn't know how it got broken. Well, her admonishment to me was that I cannot go through life throwing rocks and hiding my hand.

So as I think about the overrepresentation as a teacher educator, I want to today reveal my hand in the role of overrepresentation.

I think we at the universities have much to do with overrepresentation.

I want to give a recommendation that has pretty much been alluded to, but I really want to underscore it this afternoon, that of teacher quality. Now, any documents that we read lately, the No Child Left Behind document and others, the NRC report that was just released about overrepresentation, all talk about the poor teacher quality that minority children and impoverished children in particular are subjected to. However, the NRC report does not give that prominence. Instead it gives factors such as tobacco usage and lead poisoning and so forth. So I really want to underscore the cultural competence piece.

I mean, we know the Reverend this morning asked the question about teacher expectations and we can remember, those of us that are fairly young, I can remember the '70s, those studies on self fulfilling prophecy and the Pigmalion effect, where they gave out locker numbers to teachers and teachers were told those were IQ scores and those teachers then in effect, their interactions with those students pretty much

played out those low expectations.

So I want to say that the differences in urban and suburban classrooms in teacher quality are, teachers in inner city and urban classrooms tend to not be prepared, both in the technology of teaching or in culturally responsive pedagogy. In suburban classrooms, I submit they, too, are ill prepared to respond to their learner.

So I say we as teacher educators, if we need to take the onus, then we need to insure that no teacher is left behind.

Thank you very much.

DR. FLETCHER: Thank you. Next is Leslie Jackson, followed by Donald Lash.

MS. JACKSON: Good afternoon. I'm Leslie Jackson, I'm with the American Occupational Therapy Association. I also co-chair the Education Task Force of a national Washington, D.C. based coalition, the Consortium for Citizens with Disabilities and I just want to say to the Commission, thank you all for hanging in with this heat and the, all the things that have been going

on, so we appreciate your focus and attention as well.

I actually want to make several points in response to discussions that I heard this morning. I'm not speaking on behalf of my association or CCD with this. I'm speaking from personal experience, as a person of color, as an educator of color and as a parent of children of color who are in public schools.

They do not have disabilities, but we have to deal with the same issues that all parents have to deal with in public schools. And one has to do with the assumption that I think we need to be very careful about making when we talk about cultural competence. We need to be very clear about what we mean by cultural competence. Cultural competence does not mean necessarily having someone who is of the same racial and ethnic and diversity and linguistic background, because we all know that that is no guarantee that persons who look like me are necessarily going to be as effective in teaching my children. So we need to

be clear what we mean by cultural competence.

We need to be clear that individuals are socialized into particular disciplines. I'm an occupational therapist by training, I was trained to think like an occupational therapist, but I bring a whole lot of other things to that. So when we talk about teachers and low expectations or no expectations, whatever language we put to that, be mindful of the fact that they were trained to think, teacher trainers just talked about in the teacher preparation program, they bring to that their own personal values and beliefs about how children learn, what parents are like, how parents should be involved in schools, and so we're talking and thinking about that, we need to be aware of those kinds of issues.

I also have to say that when we're talking about the use of effective practices, it's not enough to think about disseminating information down. We also need to be thinking about why professionals may or may not adopt those practices and there's lots of reasons for doing that or not

doing that. So it's not enough to say we're doing research or not doing research.

You also need to make sure we help folks adopt those practices and then give them the supports to use those practices and then my advocates hat on I have a question, and that is how the Commission beyond these meetings what is the deliberative process going to be for the Commission, how are you going to come to agreement about your recommendation and decide what you're going to recommend and not recommend and how involved is the public going to be in that process.

And with that, I thank you again for your attention and this opportunity.

DR. FLETCHER: Thank you very much. Next is Donald Lash followed by Barry Barbarach and Dee Alpert.

MR. LASH: Good afternoon. My name is Donald Lash. I'm the executive director of Sinergia, a nonprofit agency which, among other things, operates the Metropolitan Parent Center with state and federal support and the Long Island

Parent Center with state support. In 2000, we completed a report based on an overrepresentation, based on an analysis of three years of data, corrected plans from seven districts that developed directed plans and a series of community-based forums for parents teachers and community-based organizations.

I don't have a prepared statement, but a copy of the report was submitted to the Commission.

I just want to highlight a couple of conclusions briefly from our experience of the report. Because of the size of New York City and the diversity of the population, it really isn't one pattern and one trend. There are multiple patterns and multiple trends because every district has a different population, has different dynamics, and I think it's appropriate that the burden of defending corrective strategies for overrepresentation be at a district level, be at a small enough level that it's meaningful to the population and the district.

I also wanted to say that measures of disproportionality have to be varied enough to encompass different aspects of the issue. If we only speak about referral we're ignoring placement and disproportionality is very relevant to placement outcomes. Also integration, it's important that corrective strategies addressed to overrepresentation be integrated with other education reforms, other activities within the district.

Some New York City school districts have a plan to address the implementation of the new curriculum, the revision of the special ed system. They have another plan to address disproportionality and the two haven't been coordinated and some personnel may not be aware of both plans existing. There really is a close connection.

Finally, I just as a suggestion for an area for legislation, I see this as analogous to the area of limited English proficient students and the obligation of the district to develop a plan.

There are guidelines, it's going to be individualized, to meet the needs of the district and three brief suggestions to get to the end. A corrective plan should demonstrate knowledge of patterns and trends within the districts, there should be a hypothesis about why patterns exist within a district and there should be a rationale for strategies that's identified and enacted on the strategy and hypothesis.

Thank you.

DR. FLETCHER: Thank you, Mr. Lash.

Next is Barry Barbarasch, followed by Dee Alpert and Rick Ostrander.

MR. BARBARASCH: Good afternoon. My name is Barry Barbarasch. First, I'd like to thank the Chairman for pronouncing my last name correctly.

DR. FLETCHER: Give credit where credit is due.

MR. BARBARASCH: I'm a school psychologist from Harrison Township in New Jersey, also a member of the Government and Professional

Relations Committee of the National Association of School Psychologist and past president of the New Jersey Association of School Psychologists.

Today we've heard several references to the role school psychologist played in the area of identification and assessment, but I would like to talk a little bit about the role school psychologists play in the delivery of mental health services in the schools.

Today there is an increased concern for maintaining a safe and secure school environment. School psychologists are uniquely positioned to provide an array of mental health services to address these concerns. The school psychologists are trained to not only respond when a crisis occurs, but also to recognize those characteristics of students in the school environment which may be a forerunner of a crisis.

School psychologists provide other types of mental health services as well. Individual counseling, including management, conflict resolution and social skills training,

assist students in maintaining appropriate school behavior as well as developing positive relationships with peers and school staff. Of equal importance are programs which prevent mental health difficulties and school psychologists have training and expertise in these services as well.

The provision that these services offer other benefits to school districts; frequently children, particularly those with behavioral and emotional difficulties, are placed in out of district school settings at considerable expense, partly due to the greater availability of mental health services in these settings. Given similar availability of these services through district school psychologists, many of these students could be educated in school-based programs, thereby saving school districts the considerable resources associated with these out of district programs.

In addition, with all students having access to an array of mental health services, including those programs which focus on prevention, school districts may find they can greatly reduce

their reliance on self-contained special education programs, which is a frequent placement for children with behavioral and emotional difficulties and make greater use of lesser restricted programs such as the use of supplementary interservices.

School psychologists also are in a position to be involved with the training of teachers in the area of classroom and behavior management. They're knowledgeable in the use of positive behavioral supports and can train teachers to use these supports in the classroom for children who exhibit behavioral difficulties.

School psychologists play a role in providing student mental health services. They provide an array of mental health services for children's schools, school personnel and families, which can be critical in maximizing achievement and maintaining a safe school environment. Thank you very much.

DR. FLETCHER: Next Dee Alpert, followed by Rick Ostrander and Robert Silver.

MS. ALPERT: My name is Dee Alpert.

What I'd like to do very briefly is just share some information and sources of information that I think the Commission doesn't have at this time and I think that you need.

First of all, I have a request of Dr. Pasternack. Previous to about three or four weeks ago, the Board of Education's website had school report cards for every school in the City listing the standardized test scores and things of that nature. Including for District 75, which is a self-contained district for children who are moderately to severely disabled. The District 75 reports were removed when the state came up with new data for this year.

Similarly, last year they removed the district profile for District 75. Consequently, parents of children who are disabled and who wish to look at the data for schools and districts in District 75 before they have their children placed in it or before they continue having their children placed in it no longer can get any objective information whatsoever.

Both OSEP and State Ed have been informed about this, as has Chancellor Levy. Nevertheless, nobody will do anything about it and I would like to point out that if you can't enforce or if nobody is able to enforce the IDEA's data requirements, data application requirements, then I'm not sure that there's a whole lot of hope for it voicing anything else as the law stands now or as it may be amended, so I'd like to bring that to your attention and point out that parents do need that information.

Secondly, I've given a few people copies of the district 75 profile which was on the Board's website, I printed it out, thank goodness, before they removed it and I can put it in PDF form and e-mail it to everyone else. One of the reasons they may want this data not to be available anymore is because District 75 has the Board program so that children who are autistic, and this states that in April 2000, which is the period they were measuring, 8 percent of the speech and language services reflected on the IEPs of the children in

District 75 were actually delivered, which means that 92 percent were not delivered.

I'd like to point out that I cannot imagine a program for children for autism, for example, that only provides 8 percent of the recommended speech and language services, and I also should point out that I have reasons to believe that they are medicated as per the IEPs not as per the actual services delivered. I think that's an area of legitimate inquiry, whether it be fraud or whether children come in and don't go out.

Thirdly, the New York City Board of Education has a special thing you should know about. Office of Special Prosecutor New York City Board of Education, telephone number is 212-510-1400. I'm recommending that each of you or jointly call that office, ask to sit with the staff and discuss with them what I believe they will tell you about the routine falsification of all kinds of special education documentation on the individual, group, school and program level. If you look at the data, somebody looks at the data, I really

think you ought to understand the quality of what you're looking at, particularly--

DR. FLETCHER: Thank you, Ms. Albert.

MS. ALPERT: I will submit the rest of this in writing, but they do have a number of reports I think are particularly germane to the issue of data quality. Thank you so much.

DR. FLETCHER: Rick Ostrander, followed by Robert Silverberg and Diane Karvelas.

MR. OSTRANDER: My name is Rick Ostrander. I'm an assistant professor at Georgetown Medical Center where I also serve as chief of child psychology. I've been a school psychologist teacher, as a matter of fact as a school psychologist I worked at Little Rock, not too far away from some of your stomping grounds, Dr. Pasternack.

I'm also a parent of a child with a disability. I just wanted to bring out a couple of comments. I wasn't planning on speaking. But I made a couple of notes, I think may bear your consideration.

One is that I think that what we know is probably a lot less than what we don't know, and what I mean by that is if you look at the interventions that were articulated throughout this conference, we see a lot about interventions related to identification interventions. Those are pretty well established to be effective.

However, less is known about reading comprehension, math, reading disabilities. The studies available in those areas are really looking at treatment versus nontreatment. Anyone who has been a researcher knows you're very motivated to do right by your data, make sure you do right by your data. You want good treatment fidelity, treatment sensitivity to the measures, you want to make sure it works. So when you look at these research findings, what you find is essentially that treatment typically works better than no treatment, but you have to be motivated to make it work and that's what's lacking in our current educational system.

There isn't the incentive, the same

incentives that researchers have in order to make treatments work. And so one thing I would encourage you to consider is there needs to be a mechanism to make sure the incentives are there to make treatments work effectively.

That can be done by two mechanisms. One is the way it's currently done, which is to use parents as a way of asserting a check and balance system within the educational system. That is, through due process hearings. And if you just leave, if the means of identifying and demonstrating special education placements purely up to the schools, they may not do that. And we see that in today's data, where you see the generalizability of research findings to the community is very poor.

The other way to do it, of course, is to create incentives to make sure that the outcomes, they must be concrete and that children who achieve these outcomes or schools that achieve these outcomes are rewarded in a concrete fashion or demonstrating. Without that kind of incentive

approach, no matter what is tried will be diluted within the school environment because they, A, don't have the resources and, B, don't have the incentive to change and many of us are psychologists here, we remember that old joke about how many psychologists it takes to change a lightbulb. Just one, but the lightbulb really has to want to change.

Okay. So let's hope that the schools really want to change.

DR. FLETCHER: Thank you. Next is Robert Silverberg, followed by Diane Karvelas and James Wendorf. I'm sorry, is Robert Silverberg here? Calling Robert Silverberg.

Diane Karvelas, then James Wendorf and then Tamika Williams Ortiz, if she's still here. Thank you.

MS. KARVELAS: My name is Diane Karvelas, I'm a school psychologist with 22 years of experience. I'm a member of the New Jersey National Association of School Psychologists. I just want to briefly comment on my work experience,

as I feel it relates to the reauthorization of IDEA.

I currently work in an upper middle class school district in central New Jersey. A majority of the parents in this district are well educated professionals. The curriculum in this district is quite challenging. There are high district and parent expectations for academic achievement. Teachers feel pressured to cover a very comprehensive curriculum in a limited amount of time. When students have difficulty, there is little time for differentiation of instruction. It's very limited.

There are some opportunities for remediation for basic skills reading and math programs. These programs have criteria, entrance criteria based on test scores and ironically, what I find is that at times a student may not meet the criteria for basic skills program, but then they'll be referred for special education classification. This is due to the fact that this is seen as the only way for students to get services or

accommodations. In fact, I feel that part of the reason why there has been such an increase in ADD diagnoses is this is a way to obtain special education services for children who do not otherwise qualify.

In fact, in my district many parents seek special education classification on the basis of ADHD diagnosis and they have gotten this on their own. A reauthorization of IDEA needs to address the dichotomy between regular and special education. There needs to be more of a collaborative approach in dealing with students with learning and/or behavioral difficulties. Reauthorization of IDEA needs to support reinforcement in centralization. As a school psychologist, I have been trained in the areas of education, child development, behavior therapy, cognitive assessment and consultation. I am able to provide teacher and parent training, social skills training and counseling services in the schools. I collaborate with school staff to develop strategies and programs for individual

students as well as school wide programs.

Finally, I would like to comment on the earlier recommendation to eliminate IQ testing. I agree that the sole purpose of a psychological evaluation should not be to obtain an IQ score. I also agree that the discrepancy model for identification learning disabilities is not valid. However, I do feel that it is possible to obtain available information from many cognitive assessment measures that directly relate to instruction. Although writing psychological reports can be time consuming, so can writing increasingly lengthy IEPs. These seem to be designed to meet the needs of state and federal monitors rather than the needs of students, families and educational staff.

Thank you.

DR. FLETCHER: Thank you very much. James Wendorf? Is Tamika Williams Ortiz here? Okay, thank you, you'll be next.

MR. WENDORF: Good afternoon, my name is James Wendorf. I'm the executive director for

of the National Center for Learning Disabilities and I thank the Commission for the opportunity to speak and be heard. Thank you very much.

NCLD is a nonprofit organization founded in 1977 that promotes the widespread implementation of research-based practices while also seeking to insure that students with learning disabilities have access to those services. Our 25 year commitment to children with LD is based on the guiding principle that federal policies should reflect what research tells us, and from research we know that learning disabilities are neurological in origin, they affect some 5 percent of the population based upon recent and long term studies, they do not go away. They require early and accurate identification and effective intervention if students with LD are to succeed in school and in life and we also know that up to 90 percent of students with LD have primary problems in the area of reading and hence, our own very special focus of reading at the National Center for Learning Disabilities.

Our primary goal in presenting recommendations to this Commission is to improve the unacceptably low academic outcomes that students with LD currently achieve. They are abysmal. If you look at dropout rates, if you look at the low matriculation rate from high school into higher education, these are areas that have to be benchmarked, serious benchmarks that have to be improved.

In that spirit, we urge Congress to maintain access to a free and appropriate public education in the least restrictive environment and consider improvements to IDEA that are informed by research and that focus on four areas:

One, improving early identification and intervention programs. Two, improving research-based classroom instruction. Three, increasing the numbers of qualified personnel for students with disabilities, and four, strengthening part D of IDEA to improve educational outcomes for students with disabilities.

And for the purposes of oral comments,

I want to just focus on the first one, early identification. The preamble to the 1997 amendments of IDEA encourages prereferral intervention as an effective technique for assuring that students with disabilities are provided special ed services. There is also a wealth of convergent gent research to suggest that any viable conceptualization of intervention for students with LD must encourage early identification before school failure is experienced.

In kindergarten through 12th grade we support the timely identification of students who are thought to need special ed services and we recommend a functional assessment in making eligibility determinations. We support a model that engages general and special ed educators in a relationship working together with school psychologists that employs curriculum based measurement to pinpoint instructional needs and measure a students' responsiveness to education.

DR. FLETCHER: Thank you, Mr. Wendorf.

MR. WENDORF: Thank you and I'll submit

the rest of the comments for the record.

DR. FLETCHER: Our final public commenter will be Tamika Ortiz. Thank you for coming. Who is that with you?

MS. ORTIZ: This is my son Lorenzo. My son was just recently evaluated on March 12th for special education, so I'm fairly new to what the procedure is.

After the evaluation his classification was emotional disturbance. Now they want to send him to a SIE-VII District 7 school here in New York which I was told is the most restricted environment that you can send a child to.

Upon visiting the school with my husband, the school was gated, barred, the classes were eight to twelve kids in a class with three adults and I was told that was a fairly good day and the children were running all about. Right now I'm standing to have an impartial hearing because I'm refusing to send my eight year old son to a place where they were gated and there were numerous high school children inside the building also.

I'm just here today to say that there needs to be a medium. My child is not violent. He's only confrontational when someone is approaching him and that's where the behavior problem starts. He has above average IQ, his reading level is low. He gets no extra help from resource room because his reading level is low but he's not classified as learning disabled, only emotional disturbance, so the focus is on counseling, which he gets outside counseling therapy on his own. As a parent I take him to another service.

Also, he's not, like I said, a violent child and I run into parents where there needs to be a medium where there can be children who have high IQ but have emotional problems that is not sent to a most restricted environment where they can also develop their intellectual which they seem to have.

I just want to hope that your Commission would speak to whoever to decide there needs to be a medium, instead of sending them to

somewhere where they're a gated community and send them where they would have no help for their intellect. Thank you.

DR. FLETCHER: Thank you very much for your comments and thanks for bringing your child.

That concludes our public comment section. We do have a little bit of time for comment by the panel.

I'd like to start by responding to the question about what our deliberation process will be. That was outlined in our Miami hearings by Chairman Granstat and Mr. Jones. Essentially each subcommittee will be responsible for preparing a capsule report. These reports will be posted for public comment prior to the Commission's next public hearing.

The next hearing of the entire Commission is at the end of May, at which point the committee will continue the deliberation over the next few weeks at that meeting and then subsequently prepare the final report that will be submitted to the President.

Did I leave anything out about the process?

COMMISSIONER TAKEMOTO: Many of the task forces are meeting, not only in these public meetings but we're meeting via telephone and other face to face to make sure, or to work very hard to make sure that what it is that our task forces are recommending are consistent with our testimony and the people that have given us input. So your input is very important to that process.

DR. FLETCHER: Does any other Commission member have a comment they would like to make.

COMMISSIONER RIVAS: Some people have been coming up and asking about how soon we need to have information and data submitted for our reports and where to submit them to.

DR. FLETCHER: I would simply say that you submit it as soon as you can, because the committees are meeting and deliberating even as we speak, but we'll certainly be accepting information through the month of April and the submission is to

Mr. Jones, who is the director, the executive director.

There's the website www.ed.gov -- I don't think I can give you all this.

VOICE: It's actually outside.

DR. FLETCHER: Essentially, you submit it to the executive director, Mr. Jones.

DR. PASTERNACK: There are copies of the website address on the table outside where you came in and please feel free to take them and send e-mail. Thank you.

DR. WRIGHT: A question.

DR. FLETCHER: Commissioner Wright.

DR. WRIGHT: One of my main concerns in coming all the way here from Illinois is the overrepresentation of minority children in certain areas of special education, and I was glad to hear some school psychologists speak to that and particularly parents of American children.

I have a question, I did not get this parent's name who said that her minority son is in special or didn't get special or whatever, but he

is now at the University of Florida, and I wanted to know how she extricated her child from special.

Does anybody here know how we can extricate kids from special? Having been a teacher of special. You know, it used to be and still is that way. Once a child is labeled something and put somewhere, sometimes it is very hard to get them out of special. You get them there, never to be heard from again, and I want to know from this parent if she's still here whose child is now at the University of Florida how did she accomplish this. Is that parent still in the house?

MS. ARCHEE: I'm still here.

DR. FLETCHER: Identify yourself again for the record.

MS. ARCHEE: I'm Cassandra Archee.

Yes, my son did receive special education services. He went in two special education services to really look at closely the gap between his testing and his performance and I think I mentioned before the cycle that happened for him in special education which went from

behavior to actually suggest the retention piece and finally we said no.

You talk about how did he get out of special education. How did he stop receiving services from special education. I think that's more appropriate. It took extreme involvement on my part to answer the question for me what do I need to know, what do I need to do and how do I need to do whatever I need to know to make sure that he receives appropriate education.

We started very briefly with looking at and talking to him, because he went in as a fifth grader, in talking to him about issues related to learning, issues related to the disconnect, the cultural disconnect that he was having in the classroom, issues related to the stigma of him being identified as a special ed student, an African American male in a predominantly white school. We looked at all those factors and decided that those factors had a bigger impact on him than the factor of him going to school and learning and he was spending too much time dealing with those

factors and we needed to get rid of those and so we started very, very basically going to the school with discussions about what appropriate services are really impacting the bottom line for him and any of those we see were not we got rid of them, we actually discontinued.

He went from receiving special education services to a 504 plan and we realized what he really was a gifted child with special needs. I'm so glad we realized it and we hung in there for a very long time.

The one thing I would say for all parents who look like me and all parents everywhere. We need the codes to the system. We need to know how to navigate that system and we need to share that information.

I would add that I didn't get your recommendation, but I know there's been a lot of research done. I would only add that research needs to be done to include the voices of parents or children that are overidentified so you get feedback, comments, stories, best practices from

them to add to your report.

Thank you.

DR. FLETCHER: Thank you very much. Commissioner Takemoto.

COMMISSIONER TAKEMOTO: I want to thank everyone who set up this stage and ditto to what Dr. Pasternack said and also speak to the question or what I consider a challenge from one of the people bringing up testimony this afternoon about meaningful parent input and involvement in this dialogue and this discussion.

I'd like to encourage families and folks who have access to families to submit information for the record through the website as well as to ask staff particularly at the San Diego hearing, we have multi lingual translation for families there who do not speak English. I would also like to ask staff if they would get for the record the information that was given to me about Public School 75, because I think there's some implications for our Task Force and monitoring on that.

Thank you.

DR. FLETCHER: Thank you. Any other comments to my left?

We're adjourned. Thank you very much for staying with us during the day.

(Time noted: 5:14 p.m.)

C E R T I F I C A T E

We, MARGARET EUSTACE AND LINDA FISHER, shorthand reporters and notaries public within and for the State of New York, do hereby certify that we reported the proceedings of the ASSESSMENT AND IDENTIFICATION TASK FORCE HEARING, on Tuesday, April 16, 2002 and that this is an accurate transcription of what transpired at that time and place.

Margaret Eustace,
Shorthand Reporter

Linda Fisher,
Shorthand Reporter