A self-review and quality improvement guide for programs serving young students with autism spectrum disorders

New Jersey Department of Education

Autism Program Quality Indicators

A self-review and quality improvement guide
for programs serving young students
with autism spectrum disorders

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Introduction

New Jersey is well known for its long history of outstanding programs serving students on the autism spectrum. This reputation is a direct result of landmark laws and regulations in the 1970s that established aggressive practices to identify children with learning disabilities and to provide programs that respond to their needs. Since then, the New Jersey Department of Education has maintained a strong commitment to educating all students with autism.

This commitment recognizes that education is the primary intervention for young children with autistic spectrum disorders. When these disorders are present early in a young child's development, they interfere with basic human accomplishment. Developmental impact is evident early in a young child's communication skills and social skills.

Effective interventions for students with autistic spectrum disorders emphasize the need for their educational experience to include not only knowledge and skill acquisition, but also an emphasis on socialization, language and communication, the reduction of problem behaviors, and adaptive skills.

High-quality programs for students with autism share common characteristics, or indicators, which in practice set standards that, can serve as best practices. This document, the New Jersey Autism Program Quality Indicators (APQI), was developed to identify research-based indicators found in successful programs.

This document is the direct result of a panel of nearly three dozen autism experts in New Jersey from the fields of education, medicine and psychology. The panel reviewed research findings and best practice models with a major emphasis on the conclusions and recommendations of the National Research Council and on documents from other states, especially the Autism Program Quality Indicators produced by the New York State Education Department.

Educators and parents can use this document as a guide that describes effective models of educating students with autism spectrum disorder (ASD), including: Autistic Disorder; Asperger's Disorder; Pervasive Developmental Disorder; Not Otherwise Specified (PDDNOS); Rett Disorder and Childhood Disintegrative Disorder. The APQI can serve as a tool for parents and professionals engaged in program evaluation. Although the guidelines described have not been linked specifically to successful outcomes, they do represent best practices from clinical experience and research findings. It is important to note that these guidelines will be most helpful in responding to needs of young children with autism, between the ages of three and eight.

In addition, school districts can use the APQI in their self-review of programs and their quality improvement efforts. The guidelines provide districts with information and guidance to plan, improve and administer programs for students with autism.

The APQI is organized in two main sections***:*** ***Program Considerations*** and ***Student Considerations***. **Program Considerations** describes factors such as personnel, curriculum, methods and community collaboration that should be taken into account in developing, implementing and evaluating a classroom program for students with autism. **Student Considerations** presents practices to consider in the development of Individualized Education Programs (IEPs) for students with autism.

Program Considerations

Program Considerations

Program Considerations presents quality indicators to consider when developing implementing or evaluating a classroom program for a student with autism. The guide below describes seven specific components to consider in order to develop effective programs for students with autism. Each component contains indicators of quality. The components include the following: program characteristics, personnel, curriculum, methods, family involvement and support, community collaboration and program evaluation.

Program Characteristics

Autism spectrum disorders present unique challenges to educators. Specifically, individuals with autism typically have marked deficits in attention, imitation, communication, socialization and motivation-all skills that are the foundation for early education. In order to adequately address these needs, educators must develop and implement an early and intensive educational experience to provide opportunities for all students to enjoy to learning process and learn new skills. Students with autism, who participate in intensive educational experiences with a focus on engagement, make substantial gains in academic, communication, and social domains.

Engagement is defined by the National Research Council (2001) as "sustained attention to an activity or person" (pg 160).

Intensity can be defined in a number of ways such as length of time in instruction (hours per week, days per year); student-to-teacher ratio; and the rate of learning opportunities. The location in which these intensive educational experiences take place should be individually determined and incorporate the student's best interest in both the immediate and the long term. The content of the educational experiences is derived from the student's needs and abilities, a curriculum and teaching methods. The program is responsible for ensuring student progress and regularly documenting the effects of its methods on student progress.

The guide below describes five basic characteristics considered to promote engagement and intensity essential for effective, successful programs for students with autism.

1. The length of the school day and the academic year of programs for students with autism, including preschoolers shall be at least as long as that established for nondisabled students. Educational services for preschool students with autism should include a minimum of 25 hours a week and an extended school year program of 210 days per year. Educational services may be provided across environments (classroom or home). When less than the minimum of recommended services is provided, the IEP should include a justification based on the student's needs.

2. In order to provide the necessary support to accomplish IEP goals, the majority of students with autism are instructed on a low student-to-teacher ratio such as two or three students to one teacher or in some instances one student to one teacher. Some students may also benefit from developmentally appropriate small group instruction to meet their IEP goals.

3. Location and the content of the activity are determined on an individual basis, depending on the identified needs of the child. Instruction may occur in school, home and community settings.

4. Systematically planned, developmentally appropriate educational activities are aimed toward identified objectives created for each student.

5. The program includes a system for documenting how effective its methods are and its students' progress.

Personnel

Staff qualifications, experience, and expectations play a pivotal role in the education of students with autism and the success of the program. Similarly, the administration responsible for supporting teachers can set the stage for success. Given the many challenges of effectively educating students with autism and the crucial role played by personnel, the training and professional development of teachers, paraprofessionals, and administrators is of paramount importance. At a minimum, these personnel should be knowledgeable and skilled in the education of students with autism. Additionally, they perform more effectively under the regular supervision or consultation from an expert in Autism Spectrum Disorders and the program's methodology. Teaching personnel should also have access to all appropriate documents and be fully informed about their job responsibilities. Consistent with these goals, teaching staff should be available in sufficient ratios to meet the educational needs of the students. Finally, ongoing and administrative support for professional development opportunities and formal dialogue designed to improve the program are critical components of a high-quality program.

The outline below addresses characteristics of effective, successful personnel in programs for autistic students:

1. Staff are knowledgeable and skilled in these areas of expertise specific to autism spectrum disorders, including:

    a. Diagnostic criteria and associated characteristics of autism spectrum disorders;
    b. Familiarity with assessment methods;
    c. Developing IEPs to meet the unique needs of each student;
    d. Curriculum, environmental adaptations and accommodations, and instructional methods;
    e. Strategies to improve communication and social interaction skills;
    f. Classroom and individual behavior management techniques; and
    g. Crisis intervention techniques.

2. Personnel with expertise in autism, e.g., Program Specialist in Autism, supervise the program to ensure that all of the knowledge and skill areas listed above are achieved.

3. Certified teachers and related service providers who have education responsibility for a student have access to that student's IEP and are informed of their responsibilities for implementation.

4. Paraprofessionals receive specific and direct instruction and supervision regarding their IEP responsibilities to the student.

5. Staff is available in a ratio sufficient to provide the support necessary to accomplish IEP goals in general education classes or self contained classes. (e.g., 1:1 or 2:1 instruction may be appropriate as determined by the IEP team.)

6. All professional development activities are provided by persons highly knowledgeable and experienced in the education of young children with autism. Professional development involves:

    a. Intensive pre-service and in-service training for entry level staff;
    b. Frequent in-service training specific to the program;
    c. Attendance at workshops and conferences designed to further develop knowledge and skills; and
    d. Ongoing consultation and technical assistance for all staff (e.g., teachers, paraprofessionals, administrators, and CST members).

7. To maximize personnel satisfaction, the program:

    a. Solicits input through mechanisms such as satisfaction surveys and program effectiveness surveys.
    b. Makes program modifications, as appropriate.

Curriculum

All programs for students with autism embrace values and goals. These values and goals provide direction for many programmatic elements. The program's philosophies regarding child development, effective education, and successful outcome have a direct impact on classroom and administrative practices. Thus, the program should explicitly state its philosophy and how it influences its educational practices. The program's curriculum should reflect these same goals, philosophy and practice. The curriculum should also include written goals that increase the student's independence and ability to respond to the environment in increasingly sophisticated ways. To do so, the curriculum must be adapted to the student's individual characteristics such as age, abilities and learning styles. Students should participate in instruction that focuses on a variety of domains such as communication, socialization, and others outlined below. The curriculum should also include written goals and objectives for students to maintain their skills over time and in a range of more naturalistic settings. Last but not least, the classroom program should use a curriculum aligned to the ***New Jersey Preschool Teaching and Learning Expectations: Standards of Quality*** *or the* ***New Jersey Core Curriculum Content Standards*** depending on the age and grade level of the student.

The guide below describes a model curriculum based on a review of best practices from the field. Administrators, program developers and evaluators should consider the elements described below.

1. The curriculum has a philosophy and written goals from which instructional objectives, methods and educational activities are derived.

2. The curriculum philosophy and goals maximize independence in a variety of settings (home, school and community).

3. The curriculum is adapted to the different ages, abilities, and learning styles of students.

4. The curriculum emphasizes the development of:

    a. Communication and language: The curriculum has a functional communication system for both verbal and nonverbal students with autism. Since, functional spontaneous communication is the primary focus of early education programming is based on the assumption that all children can learn to speak. For all students, effective teaching techniques for both vocal and, if necessary, alternative modes communication are applied vigorously across settings.

    b. Social skills: Social skills instruction is planned and facilitated throughout the day in various settings, using specific activities and interventions to meet age- appropriate and individualized social goals. The curriculum emphasizes the development of social interaction skills with adults and peers needed for a range of occasions and environments.

    c. Play, imagination, and creativity: The teaching of play skills focuses on the appropriate use of toys and other materials, representational/symbolic play, reciprocity, imaginative and cooperative play with peers, including typically developing peers.

    d. Engagement: Increased engagement and flexibility in developmentally appropriate tasks including the ability to attend to the environment, to imitate and to respond to a motivational system.

    e. Academics: Skills to meet the curriculum aligned to the New Jersey Preschool Teaching and Learning Expectations: Standards of Quality and New Jersey Core Curriculum Content Standards.

    f. Replacement of challenging behaviors: See section on challenging behavior.

    g. Self-management: The purpose of self-management is to increase one's ability to be as independent and organized as possible within a classroom or other setting.

h. Fine and gross motor skills: Skills used for age-appropriate functional activities.

5. The curriculum has clear and systematic strategies to maintain learned skills over time and to generalize those skills to more natural environments.

Effective Instructional Methods

As mentioned earlier, a program's philosophy on child development, effective education, and successful outcomes influence classroom and administrative practices. Thus, the program should explicitly state how its philosophy influences its educational practices and more specifically, its methodology. The program's methodology should reflect these same goals, philosophy, and practices. While there may be some differences among programs, all programs should employ only those methodologies that have documented effectiveness.

Ideally, programs should employ a methodology that has been empirically validated in well-controlled research studies conducted with other students with autism. In other words, a program's methodology should rely on those techniques that have been systematically tested and proven beneficial. The methodology should be written in sufficient and specific detail to inform parents, train staff, and to evaluate the staff's role in the student's progress. Similar to the curriculum, the methodology should promote a student's independence and his/her ability to respond to the environment in increasingly sophisticated ways. The methodology should also provide a written set of strategies to facilitate the maintenance of skills over time and in a range of more naturalistic settings. Last, while it is more fitting for the section on the Student Characteristics, it is worthy of mention here that the specific techniques used within a methodology must be significantly individualized and adapted to a student's characteristics such as age, abilities, and learning style. (See Appendix A and Appendix B.)

The following elements describe effective instructional methods.

1. Instructional methods have documented effectiveness and, ideally, reflect empirically validated practices.

2. The methodology promotes maximum engagement in appropriate activities and targeted skill areas.

3. Instructional methods:

   a. Emphasize the use of naturally occurring reinforcers (rewards);
   b. Promote high rates of successful performance;
   c. Encourage communication and social interaction; and
   d. Encourage the spontaneous use of learned skills in different settings.

4. While the acquisition of new skills occurs first, the generalization and maintenance of these skills are equally important when educating students with autism. Programs should have a clear plan to systematically promote the maintenance and generalization of learned skills to a variety of natural

environments. Doing so will require that a student be able to cope with the distractions and disruptions of daily living. It is noteworthy that methods used to teach new skills may differ from those that support generalization and maintenance.

5. Instructional methods are adapted to the range of ages, abilities, and learning styles of the students with autism.

Family Involvement and Support

While the majority of educational effort is rightfully focused on the student, high-quality programs also incorporate the family's values, goals, and concerns. The collaboration between educational personnel and family members is essential to the success of all young students, especially those with autism spectrum disorders. The essence of these indicators is equality and support. The program is responsible for making substantial effort to recognize, value, and assist parents as partners in the development and implementation of their children's IEP. This section outlines the many ways that high-quality programs actively support families and also the ways in which programs rely on parents to improve the program.

1. The program supports parents and family members as active participants in all aspects of their child's ongoing evaluation and education to the extent of their interests, resources and abilities.

2. The program provides parents with timely information about educational philosophies, curriculums, effective methods (empirical support from the professional peer-reviewed literature or documented progress), and service options.

3. The program demonstrates an awareness of and respect for the culture, language, values, and parenting styles of the families they serve.

4. The program makes available parent education services that:

    a. Provide parents with information about child development;
    b. Foster coordination of efforts between school and home;
    c. Support the family in behavior management; and
    d. Enable parents to acquire skills to support and implement their child's IEP to teach their child new skills and reduce challenging behaviors. Parent education opportunities should include not only didactic sessions, but also ongoing consultation in which individualized problem-solving and home-based observations and/or training occur. These activities are opportunities for parent-professional collaboration to enhance progress at home and school. National Research Council (2001, pg. 215)

5. The program provides parents with opportunities to meet regularly with other parents and professionals in support groups.

6. On a regular basis, the program provides communication to the parents regarding their child's progress and encourages parents to do the same.

7. The program works in cooperation with families to identify and access family support services provided by other community agencies. These services may include but are not limited to recreation, respite, home healthcare, transportation, and when beyond the competence of the program, home-based behavioral consultation, etc. based on the student's needs; and a designee of the local educational agency such as the case manager conveys the information listed above in a meaningful way that gives parents time to prepare to fulfill their roles and responsibilities.

Community Collaboration

Effective programs take into account the school community and enlist community support to maximize use of all resources available to address student needs. High-quality programs link with their communities to assist families to access supports and services in the following ways:

1. The program works in cooperation with the early intervention system around the transition from early intervention to preschool/special education.

2. The program assists families to access mental health and parent support organizations. (See Appendix C.)

3. The program, if it is out-of-district includes a mechanism for ongoing and systematic collaboration between a district and an out-of-district placement.

Program Evaluation

Currently, there is a national trend in accountability for education. This section provides guidelines for determining whether programs are meeting expectations in this area. All students deserve to participate in effective educational programs to maximize their performance. This notion carries great significance for students with autism because their learning needs are greater and more complex than their non-autistic peers. Students with autism often exhibit inconsistent development across and within skills. Given these characteristic inconsistencies in performance and the pervasive nature of these disorders, education personnel can encounter significant difficulties when teaching students with autism. These challenges mean that some students may exhibit a lack or limited improvement even with effective program development and implementation, even when effective programs are in place.

These complicating factors also present challenges for program evaluation. The following guidelines describe a mechanism to evaluate the educational impact of the program.

1. The program incorporates an evaluation system annually to assess program-wide effectiveness in the areas of:

    a. Student progress toward mastery of IEP goals;

b. Student performance on State and district-wide tests;
c. Student generalization of skills; and
d. Student progress toward long-term outcomes.

2. At least once per year, the program will implement a systematic evaluation by a professional with experience in the methodology used in the program.

3. The program evaluation will include measures of parent satisfaction with services.

4. The program aggregates student outcomes, parent satisfaction, and staff input.

5. The program utilizes these evaluation data for system-wide improvement.

Student Considerations

Student Considerations

Student Considerations presents practices to consider in the decision-making process for the individual student specific to assessment, the development of Individualized Education Programs (IEPs), planning for challenging behaviors through positive behavior approaches, and addressing transitions through individual planning. Considerations of engagement opportunities, the level of intensity and the location of the educational program or placement are all individual decisions based on the needs of the student. Planned opportunities for engagement which are based on individual students needs within the curriculum are the challenge for the IEP team. Intensity can be defined in a number of ways such as length of time in instruction (hours per week, days per year); student-to-teacher ratio; and the rate of learning opportunities. The location or placement in which these intensive educational experiences take place should be individually determined and incorporate the student's best interest in both the immediate and the long term.

Individual Student Assessment

Assessment of a student with autism must provide a broad-based, multidisciplinary evaluation that includes measures of current intellectual, academic, communicative, social, and adaptive functioning. The evaluator should present assessment results in a developmental framework detailing the student's abilities, strengths and needs. Student's behavior should be observed across a variety of settings such as home, school, and community. Behavior will vary depending on the degree of novelty, structure, and complexity in each of these settings. The evaluator should refrain from reporting one global score and using that score to form an impression. Using only one score or behavior as an indicator of overall functioning may grossly misrepresent a student's more typical abilities. Given the deficits in social skills and adaptive behavior commonly associated with autism spectrum disorders, it is particularly important to thoroughly assess the student's social skills with peers and adults as well as his/her ability to exhibit skills in real world settings.

The following should be considered when developing and conducting an appropriate assessment of students with autism.

1. Assessments are conducted by a multidisciplinary team made up of qualified personnel who are knowledgeable regarding the characteristics of autism. (See Appendix D.)

2. The medical and developmental history are reviewed and incorporated.

3. A variety of measures and sources of information are utilized to assess domains including but not limited to communication, social skills, and adaptive behavior:

    a. Appropriate standardized, developmental, and observational methods;
    b. Autism-specific measures;
    c. Parent and family input; and
    d. Review of recent progress and functional level.

4. An evaluation that includes the descriptions of the student's skills, strengths, and needs.

5. The report is written in a meaningful and clear manner.

6. The report reflects an integration of information from a multidisciplinary assessment and includes recommendations that guide the Individualized Education Plan (IEP).

7. A copy of the evaluation reports, documentation and information that will be used for determination of eligibility must be given to the parent not less than 10 calendar days prior to the meeting.

8. Reports may be shared with other professionals who work collaboratively with the family if the parents provide their consent.

Developing an Individualized Education Program (IEP)

Appropriate educational objectives for children with autistic spectrum disorders should be observable, measurable behaviors and skills. These objectives should be accomplished within one year and expected to improve a child's participation in education, the community, and family life.

1. Outcomes should include the development of:

    a. A functional communication system, expressive verbal language, receptive language, and nonverbal communications skills;

    b. Social skills to enhance participation in family, school, and community activities (e.g., imitation, social initiations and response to adults and peers, parallel and interactive play with peers and siblings);

    c. Play, imagination, and creativity: The teaching of play skills focuses on the appropriate use of toys and other materials, representational/symbolic play, reciprocity, imaginative and cooperative play with peers, including typically developing peers;

    d. Increased engagement and flexibility in developmentally appropriate tasks and play, including the ability to attend objects, people and events in the environment and respond to an appropriate motivational system;

    e. Academics: Skills to meet the curriculum aligned to the New Jersey Preschool Teaching and Learning Expectations: Standards of Quality or the New Jersey Core Curriculum Content Standards depending on the age and grade level of student.

f. Replacement of inappropriate behavior with more conventional and appropriate behaviors;

g. Independent organizational skills and other behaviors that underlie success in regular education classrooms (e.g., completing a task independently, following instructions in a group, asking for help); and

h. Fine and gross motor skills used for age-appropriate functional activities including daily living, creative arts, physical education and recreation.

Challenging Behaviors

Students with autism sometimes exhibit behaviors that we call, "challenging." Is this word used because it conveys that the student is struggling or is challenged in some way by a situation? Or, is it used to convey the challenge that these behaviors present to teachers and parents as we educate these students? There is truth in both of these interpretations. First, students with autism may often be challenged by a situation for many reasons. Most importantly, challenging behaviors should be viewed as communication. Given that educators and parents are well aware of the communication and social difficulties associated with autism, it is easy to see how a student's frustration could produce inappropriate behavior. Thus, intervention strategies that address problem behaviors should incorporate assessment information about the contexts in which the behaviors occur and the function of the behavior for the student. These strategies should emphasize positive behavioral supports, proactive approaches, and the range of techniques that have empirical support (e.g., functional behavioral assessment (FBA), functional communication training, reinforcement of alternative behaviors, etc.) (National Research Council, 2001, pg. 221) educators and parents often find these behaviors challenging as they attempt to teach a student how to act appropriately. Programs will find it helpful to distinguish between those behaviors that are dangerous to a student and others, those that interfere with learning, those that are socially stigmatizing, and those that are of no consequence to the student's overall well-being. Doing so enables the IEP team to prioritize behavioral goals and focus on those that will substantially improve a student's quality of life. (Challenging behavior includes but is not limited to aggression, self-injury, property destruction, and failure to respond to instruction.)

These following elements should be considered in effectively addressing challenging student behaviors.

1. The program has a school or classroom-wide behavioral system that:

   a. Defines expectations for appropriate behavior in all instructional settings;
   b. Uses proactive approaches (positive behavioral supports) to prevent challenging behavior;
   c. Provides training for staff in recommended behavioral strategies;
   d. Incorporates data collection and analysis on a continuous basis during baseline (pre-treatment), treatment, and follow-up periods. (Data measures reflect how often (frequency), how long (duration), and/or how severe the behavior is over time.);

2. A Functional Behavior Assessment (FBA) is used to direct intervention planning for persistent challenging behaviors:

    a. Multiple methods (e.g., interview, rating scales, direct observations, descriptive analysis, and with expertise, functional analysis) are used in conducting the FBA;
    b. The FBA identifies both immediate (e.g., request to perform a task) and non-school factors (e.g., poor sleeping habits) that predict the occurrence or non-occurrence of challenging behaviors; and
    c. The FBA identifies one or more functions for the challenging behaviors.

3. Interventions include:

    a. The team's assessment of the contributing factors which may include but are not limited to medical factors, circumstances out of school, curriculum, staff training, motivational systems and student/teacher ratios;
    b. Environmental accommodations and adaptations to prevent or minimize occurrences of the problem behavior;
    c. Instruction in alternative, appropriate skills which address the identified function(s) of the behavior (e.g., communication, social, self-regulatory skills, etc.);
    d. Positive supports and strategies; and
    e. A focus on long-terms outcomes (e.g., maintaining friendships, participating in extracurricular activities).

4. The program has a policy and protocols for crisis intervention and provides staff with sufficient training to implement protocols. With the exception of a standard emergency protocol, such documents are likely to vary from student to student. When a student's behavior constitutes imminent danger to self and others, the staff implements crisis intervention procedures as determined by program protocol.

5. When challenging behavior continues despite the use of the procedures above, the following should be considered:

    a. An IEP team meeting should be convened to discuss the challenging behavior and the least restrictive and effective procedures to be used;
    b. The team should re-assess contributing factors which may include but are not limited to medical, changes in circumstances out of school, curriculum, staff training, motivational systems and student/teacher ratios;
    c. Planned interventions to reduce dangerous (e.g., aggressive, self-injurious) behavior when a behavior continues despite positive interventions; and
    d. Consultation with a professional who has expertise in autism, functional assessment and positive behavior supports to potentially improve the behavior plan.

Program Options

Given that the IEP is specific to the student, the location in which the IEP is implemented must be individually determined. A full continuum of programs options must be considered.

1. The individualized education program (IEP) team first considers an age-appropriate general education placement with supports and services. Inclusion refers to including children with autism in general education programs. Opportunities for interaction with typically developing peers are systematically incorporated into the daily activities of the program.

    a. To assist students with IEPs in the general education program:
        i. The program provides peers with information and support to encourage spontaneous and meaningful interactions;
        ii. The program provides training and ongoing support to the general education staff; and
        iii. The program coordinates instruction for inclusive placements in order to facilitate the student's success in those activities with peers that the IEP team specifies.

2. According to New Jersey Administrative Code (N.J.A.C) 6A:14-4.3 a full continuum of program options including the following:

    a. Regular class with supplementary aids and services including, but not limited to, the following:

        i. Curricular or instructional modifications or specialized instructional strategies;
        ii. Supplementary instruction;
        iii. Assistive technology devices and services as defined in N.J.A.C. 6A:14-1.3.
        iv. Teacher aides; and
        v. Related services.

    b. Resource programs;

    c. A special class program in the student's local school district;

    d. A special education program in another local school district;

    e. A special education program in a vocational and technical school;

    f. A special education program in the following settings:

        i. A county special services school district;

        ii. An educational services commission; and

iii. A jointure commission;

g. A New Jersey approved private school for the disabled or an out-of-state school for the disabled in the continental United States approved by the department of education in the state where the school is located;

h. A program operated by a department of New Jersey State government;

i. Community rehabilitation programs;

j. Programs in hospitals, convalescent centers or other medical institutions;

k. Individual instruction at home or in other appropriate facilities, with prior written notification to the Department of Education through its county office;

l. An accredited nonpublic school which is not specifically approved for the education of students with disabilities according to N.J.A.C. 6A:14-6.5;

m. Instruction in other appropriate settings according to N.J.A.C. 6A:14-1.1(d); and

n. An early intervention program (which is under contract with the Department of Health and Senior Services) in which the child has been enrolled for the balance of the school year in which the child turns age three.

3. According to N.J.A.C. 6A:14-4.3(c) a preschool child the general education placement can be the district's early childhood program if available or an early childhood program operated by an agency other than a board of education according to the following:

   a. The early childhood program is licensed or approved by a governmental agency;
   b. The program is nonsectarian;
   c. The district can assure the student's IEP can be implemented in the early childhood program with any supplementary aids and services that are specified in the student's IEP; and
   d. The special education and related services specified in the student's IEP are provided by appropriately certified and or licensed personnel or by trained paraprofessionals.

4. For students who are not included in the general education classroom, the district and the receiving programs consider opportunities for interaction with nondisabled peers within the students' home district.

Transition

It is highly recommended that all programs develop a written transition plan when arranging a move from one educational setting to another. Programs should actively support collaboration between the student (whenever appropriate), his/her parents, school personnel, and related agencies.

The following factors should be considered in transition planning.

1. Every aspect of planning includes the student (whenever appropriate), parents and other family members, current and receiving professionals, and other relevant individuals.

2. Transition planning begins as soon as a change in placement is anticipated to occur. Transitions include but are not limited to: one classroom to another, one program to another and one service delivery system to another.

3. A transition plan includes:
   a. A statement of current skills and needs;
   b. Identification of necessary supports;
   c. A schedule of training for receiving staff; and
   d. A detailed description of the process.

4. The transition plan provides for sufficient time to implement all components (e.g., identified supports and training).

5. Transition planning:
   a. Begins while the student is in the current placement;
   b. Provides the student and family with the opportunity to visit the new setting (e.g., meet teachers, view classrooms);
   c. Integrates considerations of future placements (i.e., skills needed in the next classroom or school setting) with the student's current program;
   d. Includes teacher preparation and other supports to facilitate success in the new setting (e.g., training for peers and a shadow).

6. Follow-up will occur by identified personnel to ensure appropriateness of the change.

7. A Transition Summary form (see samples Appendix E) developed with the family is available prior to the transition.

Individual Progress Review and Monitoring

All students deserve to participate in effective education to maximize their performance. Specifically, students with autism often exhibit inconsistent development across and within skills. Given these characteristic inconsistencies in performance and the pervasive nature of these disorders, education personnel can encounter significant difficulties when teaching students with autism. It makes sense then to consider the possibility that these challenges will result in limited or a lack of improvement. Thus, any program designed to educate a group of students with autism needs to include a mechanism to evaluate the educational impact on each student. Individual progress should be reviewed and monitored using a collaborative, continuous and systematic process. Lack of objectively documented progress over a 3-month period is one indicator that a change in programming is necessary.

The following indicators should be considered in developing a mechanism for review and monitoring of individual student progress.

1. The program uses a systematic process for assessing individual student progress and modifies the instructional program when:
   a. Target objectives have been met;
   b. There is an unexpected change in the student's behavior or health status;
   c. Significant changes occur in the home, school or community setting;
   d. Target objectives have not been achieved within a 3-month period; and
   e. Progress is not observed within a 3-month period.

2. The program uses a systematic process for assessing individual student progress and increases the intensity of the program when:
   a. Target objectives have not been achieved within a 3-month period; and
   b. Progress is not observed within a 3-month period.

3. The program considers the following changes in the program and systematically analyzes their effects on a student's performance.
   a. Providing additional consultation and training;
   b. Increasing the use of reinforcement and motivational systems;
   c. Modifying curricula;
   d. Increasing intensity by lowering student-teacher ratios; and
   e. Increasing programming time.

4. The program provides the parent with a quarterly report that includes a statement of progress on specific IEP goals and objectives.

5. When there is a need to consider modifications to the IEP, the teacher or designee routinely reports such need to the child study team/case manager.

6. On an annual basis, student progress is summarized and reviewed by a collaborative educational team.

Appendices

Appendix A
Summary Documents

The two most commonly implemented instructional methods for young students are Applied Behavior Analysis (ABA) and DIR/Floortime (also known as the Greenspan Method). In the spirit of consistency between the New Jersey Early Intervention System and the New Jersey Department of Education, Office of Special Education Programs the information provided in Appendix A is excerpted from the New Jersey Early Intervention System, Service Guidelines: Children with Autism Spectrum Disorders. Department of Health and Senior Services.(2003) reprinted with permission.

Both methods are summarized below for utilization with families with families. Additional or combinations of effective instructional methods may be considered by the IEP team. Different teaching tools are often compatible with one another. For example: An ABA program typically would employ a range of teaching tools designed for different skills. For example, discrete trial teaching is useful for helping a child master some bodies of information such as names of objects, while a verbal behavior approach supports more spontaneous speech, and still other methods may be important in teaching social skills.

Applied Behavior Analysis

What Is Applied Behavior Analysis (ABA)

ABA is the systematic application of the science called Behavior Analysis. ABA therapists use a variety of instructional techniques to improve a person's behavior and then demonstrate that the procedures used were responsible for the improvement of the behavior. The science of ABA and behavior modification has been evolving since 1938 and has been well documented in the professional literature to be an effective teaching method for children with autism. Since it was determined that ABA was useful in teaching children with autism (e.g. Ferster, 1961, Lovaas, 1977) the behavioral approach has advanced in sophistication. Although the curriculum published by Lovaas in 1981 (The Me Book: Teaching Developmentally Disabled Children) became the basis for many programs; most ABA programs today have adopted a more contemporary approach to intervention. Contemporary programs incorporate the advances in the science by using incidental teaching, pivotal response training, verbal behavior techniques and shared control of the teaching interaction (child and adult-initiated interactions) in addition to traditional discrete trial teaching.

What are the goals of ABA?

The overall goal of ABA is to increase appropriate behaviors (skills) and to decrease inappropriate behaviors. This allows the child to engage in meaningful social interactions, acquire needed skills and function as independently as possible. Typically, teaching begins with the learning readiness skills of sitting, attending and following directions. Once the child has learned to attend, more complex and sophisticated skills are taught in a planned and controlled process.

What about Discrete Trial?

Discrete trial teaching is a structured and consistent method for teaching. Each skill to be learned is first broken down into smaller, more manageable steps. This is called task analysis. Using discrete trial teaching, the smaller steps of the task are taught individually starting with a clear

direction (called Sd) given by the therapist. The child then responds correctly or is prompted to carry out the direction. Reinforcement is then given. Trials are repeated several times in a row using the same sequence of instruction. The child's performance is documented. The individual steps of a task are then chained together until the entire task can be done independently. Discrete trial allows for the therapist to create a highly predictable learning environment for the child. Discrete trial teaching and ABA are not synonymous; rather it is one technique within ABA.

Who is trained to provide ABA?

People who teach using ABA receive their training from a variety of sources. Seminars, workshops and clinical practice opportunities are available from schools and agencies in NJ that specialize in ABA and children with autism. New Jersey currently has no standard certification or licensure for ABA interventionists. Nationally, the (BCBA) Behavior Analyst Certification Board Inc. certifies advanced degreed, highly trained persons as Board Certified Behavior Analysts or as Board Certified Associate Behavior Analysts (BCABA).

While this credential identifies the therapist as highly trained in Behavior Analysis, it does not guarantee training in teaching very young children or in autism spectrum disorder.

Family Roles

ABA techniques can be applied throughout the day both in formal one-to-one teaching sessions and as part of daily routines. Families are taught to use ABA techniques throughout the day and to recognize opportunities for teaching within their daily routines. Families also learn how to recognize the factors that lead to or reward a particular behavior of their child and how to increase or decrease behavior.

Concerns about ABA

Because many skills are initially taught in isolated discrete trials, oftentimes there are concerns that children will be unable to demonstrate their skills outside of the structured teaching interaction. Quality ABA programs will have procedures and plans for promoting skill generalization and maintenance. Most of the research on ABA programs has been conducted with children who are pre-school age and older. (National Research Council, 2001). The National Research Council (2001) cautioned that there are "questions of how best to modify well-established approaches to fit the needs of very young children" (p.151).

References:

Ferster, C.B. (1961). Positive Reinforcement and Behavioral Deficits in Autistic Children. Child Development, 32, 437-58

Lovaas, O. I. (1977) The Autistic Child: Language Development through Behavior Modification. New York: Irvington.

Lovaas, O.I. (1981). The Me Book: Teaching Developmentally Disabled Children. Austin TX: Pro-Ed

National Research Council (2001). Educating Children with Autism.
Committee on Educational Interventions for Children with Autism. Catherine Lord and James P. McGee, Eds. Division of Behavioral and Social Sciences and Education. Washington, DC: National Academy Press.

Further Resources

ABA is a complex and sophisticated method for working with children with autism. We suggest these readings for a more thorough explanation of the terms and concepts presented in this brief description.

Harris, S.L. & Weiss, M.J. (1998) Right from the start:
Behavioral Interventions for Young children with Autism. Bethesda, MD, Woodbine House

Maurice, C., Green G. & Foxx, R.M. (2001). Making a difference:
Behavioral Intervention for Autism. Austin, TX, Pro-Ed (includes a chapter on Incidental Teaching)

Sundberg, M.L. & Partington, J.W. (1998) Teaching Language to
Children with Autism or other Developmental Disabilities. Behavior Analysts, Inc.

How to teach pivotal behaviors to children with autism: A training
manual. www.education.ucsb.edu/autism/behaviormanuals.html

Developmental Individual Difference-Relationship Model

WHAT IS DIRsm?

DIRsm, the Developmental Individual Difference Relationship-based Model, is a comprehensive, family-centered approach to assessment and intervention for children with difficulties in relating and communicating. Developed and refined over the last two decades by Stanley Greenspan, M.D. and Serena Wieder, Ph.D., DIRsm is built on the foundation of well-known developmental and learning theories, some dating back to the early 1900s. The cognitive developmental concepts of Piaget, early attachment theory of Bowlby, Mahler's object relations theory, and the learning theories of Vygotsky and Feuerstein, as well as the sensorimotor origins of mental and emotional development are integrated in the DIRsm Model.

Based on the concept that feelings enable us to generate ideas and thought and are the foundation for creative, logical and abstract thought, a basic premise of DIRsm is that thinking and learning begin with our own personal emotional experience, starting first with the child's ability to form relationships and engage in interactions with his caregiver(s). The "R" in DIRsm is the child's capacity to initiate and sustain these relationships.

The child's functional emotional developmental levels form the "D" in DIRsm which consist of:

1) being able to stay calm and to take interest in the world;
2) forming connections with others in an engaging way;
3) communicating with expressions, gestures and eventually, with words;

4) connecting movement, affect (emotion) and problem solving;
5) functional and imaginative use of language and use of pretend play; and
6) emotional problem solving—from the gut, not the head (ex. Why sad?);

The "I" in DIRsm stands for individual, biologically based differences in the child's ability to process and modulate (take in and make sense of) the information coming into his body through his senses and to plan, sequence and carry out body movements. This includes auditory, visual, tactile (touch), taste, smell, and movement, as well as his perceptions of pain, where his body is in space and underlying muscle tone and strength.

Each child's unique developmental level, sensory profile, motor abilities and regulatory state determine the level and type(s) of intervention. Individual differences, not diagnosis, guide the program.

WHAT ABOUT FLOOR TIME?

Floor Time, also known as the Greenspan approach, is the heart of DIRsm. A floor time, relationship-based program includes three levels:

1) Spontaneous, follow-the-child's-lead floor time;
2) Semi-structured problem-solving sessions; and
3) Motor, sensory, sensory integration, visual-spatial and perceptual motor activities.

During Floor Time interactions, an adult partner uses the child's natural interests and motivations to encourage his ability to use thinking and problem solving, communication, and motor and sensory exploration in meaningful interactions. Starting with mutual, shared engagement, the child is "enticed" into increasingly more complex interactions in a process known as "opening and closing circles of communication." Floor time strategies can be implemented in a variety of settings - in the home, classroom and community settings. Inclusion with typically developing peers is recommended once a child can imitate gestures, sounds or words. Continual re-evaluation of the intervention program is critical as the child progresses and changes.

WHAT ARE THE GOALS OF FLOOR TIME?

The goals of Floor Time are to help the child:

1. Become more alert and aware of change;
2. Take more initiative and be less passive in his environment;
3. Become more flexible;
4. Tolerate frustration and change;
5. Sequence longer and more complex actions, plan and execute them;
6. Mediate the process of finding solutions;
7. Communicate gesturally and verbally; and
8. Take pleasure in learning and interacting with others.

Under the goals of floor time, the team works to create a warm, engaging child who recognizes himself as unique, with natural interests and abilities, and who can be motivated to fully participate in the world using these capacities. We want to see a spontaneous, independent and interactive child who can respond to others and the environment with a range of responses.

HOW IS THE FAMILY INVOLVED IN FLOOR TIME/DIRsm?

The relationship and interactions between the child and his caregivers is the foundation of the DIRsm Model. The role of the therapist in this model is to coach caregivers and family to develop skills that optimize the child's developmental progress. This is accomplished during warm, secure, pleasurable, child-led floor time interactions as well as during activities in the daily routine. DIRsm/floor time philosophy and practices are compatible with early intervention best practice in their developmental, individualized, relationship-based, family focus, in the natural environment. DIRsm emphasizes the earliest possible start to intervention and stresses the importance of the earliest stages of development, typically accomplished in infancy.

WHAT ARE THE CONCERNS?

Lack of availability of DIRsm trained interventionists makes it difficult for families and school systems to access this approach in New Jersey. Official DIRsm training and certification is currently available only through workshops and seminars under the National ICDL (Interdisciplinary Council on Developmental & Learning Disorders) located in Bethesda, MD. Ongoing parent training is needed as the child progresses through the developmental stages. Another concern is the intense commitment required by caregivers implementing this program on a 24-hour basis

Success in this intervention is measured as the child masters the functional emotional developmental milestones, not by development of specific skills. Due to a strong philosophical base, the literature regarding DIRsm weighs heavily on presentation of hypothesis and theory and less on data-based research. Research is occurring, however, the clinical data collected conforms to less rigorous scientific research criteria than more data-driven approaches.

GLOSSARY OF TERMS

Sensory processing- the ability to analyze, organize and connect (or integrate) messages coming into the brain from the different senses. It is through this process that the many parts of the nervous system work together so a person can interact with and learn from their environment effectively.
Sensory modulation- the brain's ability to regulate its own activity.
Auditory processing- the ability to receive, identify, discriminate, understand and respond to sound.
Visual processing- the ability to perceive, interpret and respond to what the eye sees.
Tactile system- sense of touch, including pressure, vibration, temperature and pain.
Sensory profile- information collected regarding how a child responds to sensory input in a variety of situations.
Regulatory state- the nervous systems ability to attain, maintain and change levels of arousal or alertness. These levels change according to demands of specific situations and activities.
Circles of communication- a core concept of floor time; the continuous flow of engagement between the child and adult. Example - child opens circle by looking at parent, parent responds by looking back, child responds to parent by smiling or vocalizing, thereby closing the circle.

REFERENCES

Interdisciplinary Council on Developmental and Learning Disorders. Clinical Practice Guidelines Workgroup. (2000). Interdisciplinary Council on Developmental and Learning Disorders Clinical Practice Guidelines: Redefining the standards of care for infants, children and families with special needs. Bethesda, MD: Interdisciplinary Council on Developmental and Learning Disorders.

Greenspan, S.I. & Wieder, S. (1999). A functional developmental approach to autism spectrum disorders. Journal of the Association for Persons with Severe Handicaps (JASH), 24, 147-161.

Greenspan, S.I. & Wieder, S. (1997). An integrated developmental approach to interventions for young children with severe difficulties in relating and communicating. ZERO TO THREE, 17, 5-18.

Autism Society of America (2001). Current Interventions in Autism-A Brief Analysis. Available from www.autism-society.org

Further Resources

DIRsm is a complex and comprehensive methodology. The following readings provide a more in-depth explanation of the philosophy, concepts and terms presented in this brief overview.

Greenspan, S.I. & Wieder, S. (1998). The Child with Special Needs: Encouraging intellectual and emotional growth. Reading, MA: Addison Wesley.

Greenspan, S.I. (1992). Infancy and Early Childhood: The Practice of Clinical Assessment and Intervention with Emotional and Developmental Challenges. Madison, CT: International Universities Press.

Journal of Developmental and Learning Disorders. Madison, CT: International Universities Press

Source: New Jersey Early Intervention System, Service Guidelines: Children with Autism Spectrum Disorders. Department of Health and Senior Services. (2003) reprinted with permission.

Appendix B
Unsupported Services and Treatments

Medication is an excluded "medical service," and is not the responsibility of a school district. It also is not recommended that therapies without any research evidence of success be implemented in a school approved program.

Auditory Integration and related therapies
Cranial Sacral Therapy
Diets (e.g. gluten-free, casein free);
Dietary supplements/Vitamins;
Holding Therapy;
Vision Management Therapy;
Facilitated Communication
Medications
Procedures that are medical in nature and are performed by health care personnel (i.e. Chelation or Secretin)

Appendix C
Web Resources

The following web resources provide information about research, education, advocacy for individuals with autism and other links. This is not an endorsement.

National Resource

Autism Society of America http://www.autism-society.org

New Jersey Specific Resources

New Jersey Governor's Council on Autism through the Child Institute at UMDNJ
http://www2.umdnj.edu/chinjweb/govcofolder.htm

National Information Center for Children and Youth with Disabilities-NJ State Resources
http://www.nichcy.org/stateshe/nj.htm

New Jersey Respite Programs http://www.respitelocator.org/n3states.htm

The Division of Developmental Disabilities http://www.state.nj.us/humanservices/ddd/

Resources Directory http://www.state.nj.us/humanservices/dds/index.html

Parent Organizations

Asperger Syndrome Education Network (ASPEN) http://www.aspennj.org

The New Jersey Center for Outreach and Services for the Autism Community (COSAC)
http://www.njcosac.org

Parents of Autistic Children (POAC) of Ocean County http://www.poac.net

Statewide Parent Advocacy Network (SPAN) http://www.spannj.org

Research

The Association for Science in Autism Treatment (ASAT) http://asatonline.org

The National Alliance for Autism Research, NAAR http://naar.org

New Jersey Tri-State Chapter of Cure Autism Now (CAN) http://www.cureautismnow.org

The Interdisciplinary Council on Developmental and Learning Disorders http://www.icdl.com

The Organization for Autism Research http://www.researchautism.org

Appendix D
Eligibility Category

The chart below identifies by eligibility category, assessments and/or evaluations that are required in addition to those assessments individually determined by the multi-disciplinary team.

Eligibility Category	Required Evaluation by Specialist	Required Standardized Test(s)
Autistic	• An assessment by a certified speech-language specialist • Assessment by a physician trained in neurodevelopmental assessment	_____ _____
Preschool Disabled	_____	_____

Appendix E
Transition Summary Forms

Name of Child:

Date of Birth :

Parent/Guardian:
Address:

Relevant Information

1. Significant Birth History

2. Diagnosis or Presenting Issues

3. Medical and/or Neurological Information

4. Any Special and/or Health Issues (include medications)

5. Other

6. Briefly describe your child's present program, progress and needs. Include the strategies that have been most successful.

TRANSITION SUMMARY

Date

DIRECTIONS: To be completed by parent/guardian with support from Early Intervention staff who are assisting the family with the Transition process. This summary should be completed prior to the Transition Planning Conference held when your child is 30-32 months old. Information summarized is intended to help begin the conversation at the Transition Planning Conference.

Name of Child

Date of Birth

Parent/Guardian

Telephone Number

Street Address

City

State

Zip Code

School District

CTS Case Manager

Telephone Number

Early Intervention Program

Contact Person

Telephone Number

Service Coordinator

Telephone Number

GENERAL INFORMATION - Please summarize below:

1. Significant birth history::

TRANSITION SUMMARY, Continued

GENERAL INFORMATION, Continued - Please summarize below:

2. Diagnosis or presenting issues:

3. Medical or neurological information:

4. Special or health-related information:

5. Other/medications:

6. Briefly describe child's program and progress with a focus on strategies that have been most successful (e.g., length of time in Early Intervention, successful strategies, current services, adaptations, etc.):

7. Family's thoughts approaching transition:

Source: New Jersey Early Intervention System, Service Guidelines: Children with Autism Spectrum Disorders. Department of Health and Senior Services. (2003) reprinted with permission.

REFERENCES

American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision. Washington,D.C.

Autism Special Interest Group of the Association for Behavior Analysis (2004). Guidelines of Consumers of Applied Behavior Analysis Services to Individuals with Autism.

Crimmins, D., Durand V.M., Theurer-Kaufman, K., & Everett, (2001). Autism Program Quality Indicators. New York State Education Department.

Green, G. (1996). Evaluation claims about treatments for autism: In C. Maurice, G. Green, & S. C. Luce (Eds.), *Behavioral intervention for young children with autism: A manual for parents and professionals* (pp. 15-28). Austin, TX: Pro-ed.

Green, G. (in press). Behavior analytic instruction for learners with autism: Advances in stimulus control technology. Focus on Autism and Other Developmental Disabilities.

Greenspan, S. (2003). Research support for a comprehensive developmental approach to autistic spectrum disorders and other developmental and learning disorders: The developmental, individual difference, relationship-based (DIR_{TM}) Model The Interdisciplinary Council on Developmental Learning Disorders.
http://www.icdl.com/Research%20support%20for%20the%20Developmental.pdf

National Research Council (2001*). Educating Children with Autism. Committee on Educational Interventions for Children with Autism*. Catherine Lord and James P. McGee, eds. Division of Behavioral and Social Sciences and Education. Washington, DC: National Academy Press.

New Jersey Early Intervention System *(2003) Service Guidelines: Children with Autism Spectrum Disorders.* Department of Health and Senior Services.

Prizant, B. & Rubin, E. (1999). Contemporary Issues in Interventions for Autism Spectrum Disorders: A Commentary. Journal of the Association for Persons with Severe Handicaps.24(3),199-208.

Tsakiris,E.. (2002) Evaluating effective interventions for children with autism and related disorders: widening the view and changing the perspective. In *Clinical Practices Guidelines: Redefining the standards of Care for Infants, Children, and Families with Special Needs.* (pp. 725-818). Interdisciplinary Council on Developmental Learning Disorders