Current functional assessment of children with special needs in Belgium

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Assessment re-assessed: Current Assessment Practice in Europe: weaknesses, strengths and needs. In what way does assessment favour or inhibit inclusive education?

The objective of the European DAFFODIL project is to innovate assessment & coaching systems and methods of children with “special educational needs” in order to enable their development and facilitate inclusive education. The motivation for this project is based on the observation that, despite international developments towards inclusion (the Unesco Salamanca conference 1994; the UN 2006 Convention on the Rights of People with Disability) many children are still deprived of adequate education because of impairment, learning- and functional difficulties. We wanted to know in what way do methods and habits, by which children with developmental and learning difficulties are assessed (functional assessment as well as assessment of learning), hamper or facilitate their participation in education.

A first step herein was to get to know which systems and methods are currently in use, to assess functioning and learning of children with special needs, and how satisfying these are as to the needs of professionals and parents. To that purpose we organized an online survey, with professionals working in assessment institutions, with parents and teachers. This survey was held in the partners’ countries Sweden, Portugal, Hungary, Belgium, Romania, Norway and the British Virgin Islands.

This article reports about the situation in Belgium. We will first describe the assessment system and its organisation. Then we will report the results of the questionnaires and interviews.

Introduction
Assessment takes an important part in the life of a child who does not have a “typical development”. At many occasions a child is evaluated and important decisions are made, based on assessment results: assessment may have financial implications (e.g. increased family allowance for children with disability; personal assistance budget, access to health-insurance reimbursed speech and physiotherapy). Assessment results may determine what kind of educational opportunities a child may get or not and where the child will be educated: a special or a regular school, the level of special education needs programme; access to different types of schooling; access to university, job opportunities often depend on assessment results. And sometimes therapeutic opportunities are dependent on assessment. For example, in Belgium, the reimbursement of speech therapy depends on the results of language tests and IQ tests. With an IQ under 80 the child does not get reimbursement after two years and has to go to public rehabilitation centres, who, however, have long waiting lists. On the other hand, a child with an IQ above 70 who has serious learning and behaviour difficulties is not considered “disabled enough” to obtain increased family allowance, which would allow families to pay for educational assistance and/or cognitive/mediational intervention.

In many countries, access to regular schooling still depends on sufficiently high results on cognitive, behavioural and learning tests. Just to give one typical example: Ronald, a child with Down syndrome, now 6 years old. His mother said that since he was born, he was subjected to many developmental tests. At 2.5 years an extensive developmental testing was made at the Centre for Developmental Disturbances: language tests, intelligence tests, motor,
Organisation of assessment of functioning in Belgium

Belgium has a complicated political organisation. There are three regional communities (Flemish, French and German community) and six governments. Health matters are under a federal jurisdiction, whereas education and welfare depend on the respective regional governments. This means that the organisation of education and assessment may be different in different parts of the country. Up till now, Belgium has been one of the most separatist countries as regards education of children with special needs (EADSNE, 2003). Recently there are reforms which intend to give incentives to a more inclusive approach. Equally, for a long time, assessment of children with special needs was basically an orienting assessment towards special provisions. Only recently things are slowly starting to change.

Assessment starts early in a child’s life when development is impaired, or later when only school learning is impaired. Roughly speaking, three “domains” of professionals are dealing with assessment: health professionals, psychologists and educational professionals.

Usually, when a developmental problem is detected, parents first go to a health-related profession and institution. In Belgium, early detection is fairly well organized: all infants are monthly followed up to the age of three years by the (now regionalized) Child & Family public institution, as far as their health, development and well-being are concerned. It has a very low threshold, is free of charge and covers practically the whole population. It has centres in every community and city quarter. The team consists of paediatric nurses, a doctor, social workers and volunteers. The goal is prevention: they do only screening, but do not make a diagnosis. The Child & Family Centres are responsible for supervising good nutrition, the vaccination programme, growth curves, and watching development. Part of the programme is that all children receive a hearing screening test with the Algo-system, thus ensuring a rapid detection of congenital hearing loss, leading now to more and more timely surgical intervention with cochlear implants, which ensures a practically normal language development. As to other developmental areas, if a problem is detected, a child is referred to a paediatrician; if the problem is serious enough to a neuropaediatrician or child psychiatrist.

The child may be referred for more extensive multidisciplinary functional evaluation to a Centre for Developmental Disturbance, where various professions will subject it to a series of observations and standardized developmental tests, in order to evaluate the child's motor, language, social and cognitive development in relation to what would be expected for the child’s age. There are 4 of these CDD’s (COS in Flemish) in Flanders (for 6000000 inhabitants), linked to a university hospital. The CDD’s only assess, help in defining a diagnosis, formulate developmental perspectives and give advice to families; refer to rehabilitation clinics, therapists, special or regular schools and home guidance centres; and inform about assistive technology and social security matters. They see the child once or a few times. Any parent or
professional can make a request and it is free of charge.

**Ambulatory Rehabilitation Centres** also make diagnoses (and treatment) in the area of intelligence, language, motor and social development at almost no cost to families. Next to these public federal health ministry-subsidized centres, there are a number of private clinicians and therapists doing diagnosis and treatment, because the public centres have long waiting lists.

Children with social-emotional – behavioural developmental disturbances usually start with a consultation in a [hospital child psychiatry unit](#), and from there go to an ambulatory Centre for Mental Health Care or a residential Centre for Observation and Orientation. These are all financed by the Regional Ministry of Health & Welfare.

When a child goes to school (in principle allowed from the age of 2.5 years), the child may be referred for assessment by the [School Psychological Services](#) (CLB in Flemish). Since the year 2000 there was a reform of the school accompanying services: the preventive school health centres, the school guidance centre for special education and the guidance centres for regular education merged into one entity, a School Psychological Service, which has a multidisciplinary team consisting of (mainly) psychologists, medical doctors, nurses and social workers. Each school is linked to one of the 73 SPS in Flanders, employing 2786 staff members in 2007-08, caring for a total of more than 1100000 children, which is a staff/pupil ratio of 2.5 ‰ (Ministry of Education, 2008). Service is free of charge. The SPS goes to the school and works on request by the school: if the school signals a problem. They use classroom observation, formal testing, talk to pupils, parents and to teachers’ teams.

A new trend in Belgium and the Netherlands is the establishment of university based “laboratories” diagnosing [specific learning disabilities](#) (dyslexia, dyscalculia, dysorthography, …), paralleled by private “clinics” staffed by educational psychologists.

**Official authorities** responsible for the recognition of disability and its implications (deciding on the allocation of services, assistance and assistive technology) base their decisions on reports made by [multidisciplinary teams](#) (MDT), which are based in the above mentioned centres. There are 240 of those MDT recognized by the Flanders’ public authority. The Federal Government’s Department of Disability also decides about recognition of disability and deals with money: increased family allowance, disability pension and tax exemption. It has 150 medical doctors. They do not test themselves, but rely on test reports by the above mentioned centres; they have to see the child in person and use a battery of scales to determine the degree of disability.

### Organisation of special education in Belgium

In Belgium, special education is in a period of transition. Actually there are 8 types of special education, which are based, not on the children’s needs, but on their impairments, which is the “classic medical” model. Type 1 is for children with mild, type 2 with moderate to severe intellectual impairment; type 3 for children with behavioural disturbance; type 4 for children with motor disturbances; type 5 for chronically ill children, 6 for children with visual impairment, 7 hearing or language impairment and 8 for specific learning impairments. The total of children in special needs provisions is 4.97% of the school population (2.5-18 years). 85% of the children receiving these “types” of special education are in separate special schools. Children are allowed to be integrated in regular schools, but this is conditional on the child’s capacity to take the regular curriculum. Support is limited to 2 to 4 hours (for visually impaired children) per week. There is an experimental group of 75 children with intellectual impairment who are integrated in regular schools with an individual education programme and 5 hours support teacher per week.

Because the referrals to special schools have increased, even almost doubled in 10 years time, despite financial incentives to keep children in the mainstream, the government decided that the special needs’ system needs to be reformed and become more inclusive, also in response to international pressure to have a more inclusive school system in accordance with international developments. This plan required a completely different way of assessing special needs, based on a “needs-based assessment”, integrated assessment with school functioning and parents’ cooperation. In 2008 we tested this new way of assessment, which will be reported below.

### Evaluation of testing procedures: research in Flanders/Belgium

What kind of assessment instruments are commonly being used in Belgium? The latest research about the most commonly used diagnostic instruments dates from 2001. A national survey was done in Belgium where psychologists were asked to make a judgement as to the quality of the instruments and their application, and...
to identify the existing needs in assessment (Schittekatte e.a., 2003). A European study with the same purpose was done in 1999 in Croatia, the Netherlands, Spain, U.K. and Slovenia (Muniz e.a., 2001).

**Diagnostic instruments used**

In the 2001 survey, diagnosticians from all sectors reported a wide variety of instruments: 400 different tests were used. The across domains top-15 diagnostic instruments most commonly used by Flemish diagnosticians were intelligence test batteries (7 out of 15), behavioural & personality scales (23.9%), developmental scales and school achievement tests:

- for cognitive functioning: the Wechsler intelligence test batteries outreach by far all the other intelligence tests in all diagnostic sectors; the Raven's matrices are still used quite commonly, as are the Rey neuropsychological tests such as Complex Figure and 15 Word memory; to a lesser extent the SON (Snijders-Oomen Non-Verbal Intelligence Test), which has been created in the Netherlands, but has become internationally available as well.
- to assess behavioural problems: CBCL (Child Behaviour Checklist), MMPI (Minnesota personality inventory), children apperception test, sentence completion, family relations test
- developmental tests: mostly McCarthy scales and Bailey scales; and Reynell scales for language development; VMI (visual motor integration test) and Frostig's DTVP
- school achievement tests: these are not international, but limited to Dutch usage, such as the AVI reading scaling and the Individual Pupils' Follow up system (LVS)

In 2009, in line with the Daffodil project's aims, we wanted to know more about the relation of assessment and inclusive education. We therefore sent an online questionnaire to the 240 diagnostic centres in the Flanders’ Region, as well as to a selection of schools and parents, with the aim to find out which tests they were using, what their experience was, what difficulties they experience with regard to practicability, how useful reports were and more specifically, what their experience is with regard to participation of students with special needs to mainstream education. Although the main purpose of Daffodil is not to do scientific research (but to formulate and test training proposals), we nevertheless thought it useful to start from an analysis of needs and problems. Due to the unfortunate timing of the questionnaire (at the end of the school year and beginning of holidays), we received only few responses (18 professionals, 9 parents and 7 teachers), which is too few to allow a reliable quantitative analysis; but it nevertheless yielded interesting qualitative data.

In this research, there was not much difference with the inventory obtained 8 years ago. Wechsler scales are still on N°1 for intelligence, as are CBCL for behaviour. Other batteries coming up are the Kaufman ABC; Peabody language tests (and its Dutch variant Schlichting), TOM (Theory of Mind tests for autistic functioning).

Only 2 reported to use a dynamic instrument. Also in the 2001 research, nobody reported a dynamic functional test procedure.
In the multidisciplinary teams of the National Agency for People with Disability, autonomy scales are used which take into account degree of impairment, activity and participation and need of help. Ideas of the ICF (International Classification of Functioning of the WHO) are the basis of this approach.

**Way tests are used**

Since the 2001 survey was mostly interested in the experience with the instruments themselves, it is not surprising that respondents, who were all psychodiagnosticians, answered to use the tests strictly according to the book instructions: in a standardized procedure, scoring objectively, without interfering, and then putting the scores against a norm reference. The diagnostic process was done in a highly individual way, testing only the child with the functional problems. Only 1 test was reported to look at the child-in-context (the Family Relations Test).

In 2008 we coordinated a research project with the purpose of validating the new model for “graded learning support” (Lebeer, Struyf e.a., 2008), introduced by the Minister of Education of Flanders. The plan proposed a classification matrix whereby the special needs are first characterized by a pupil’s level of required educational assistance, and in a second time identifying and clustering “disturbances”. Pupils would receive the same level of financial support, regardless of whether they are in a special or mainstream environment. To determine validity and reliability of this new system, a sample of 8648 pupils (aged 2,5-18) from regular and special education, has been assigned to one of the matrix places. Collaborators of all School Psychological Services (SPS) were asked to assign special needs, according to the new criteria. A manual, wizard and electronic web-based form have been designed, trainings organized, a helpdesk installed, and a
In the 2001 survey, most professionals were satisfied with the diagnostic instruments they were using. They had been asked to rate the instruments according to the quality of the materials, guidelines, instructions, reference norms, language and scoring procedure. The only dissatisfaction consisted in the difficulty with norms and scoring ways. Scientific test experts are much more severe as to the quality of testing instruments. They base their judgement on criteria of reliability, presence of reference norms, criterion validity and content validity, which in the Dutch language area are called the COTAN criteria. However, a large percentage (33%) reported a need for adapted tests in function of different children with special needs, in particular children with light intellectual impairment, autistic spectrum, gifted children, emotionally disturbed children and difficult-to-test children.

In our 2008 research with school psychologists, we also asked them to report their difficulties with testing procedures. We received a high number of remarks about the difficulty to use stringent IQ criteria in determining the special needs of a child. Especially the group with an IQ between 70 and 90, though officially not considered to be mentally retarded, showed to have a high degree of social and academic learning difficulties, and largely come from a socio-economically disadvantaged background.

In our 2009 study with a small sample (N=18) of professional diagnosticians, we found that they were on the whole satisfied with the way evaluations are currently done. They think that they ensure children to get to the right kind of therapeutic intervention, that they give adequate advice to teachers and parents. However, they reported unanimously time, financial and human resources constraints as the most important problems experienced when evaluating children with special needs. They recognize that evaluating the evolution of the child across time would be better, but there is hardly a possibility to do that. Other experienced difficulties were a lack of coordination between the disciplines, the negative tone of reports when mentioning deficiencies and the ambiguity concerning labelling “disturbances”. One professional formulated a more fundamental critique on the supremacy of IQ:

"The framework of IQ forces children to leave the school, because they are said 'not to fit into the group’ or 'not to benefit from the offer'. In observation the child is often more capable. Then there are not tests measuring potential"
**Teachers**

The nationwide 2001 survey did not ask how the end-users of assessment, i.e. teachers experienced the reports. In our small sample, teachers admit that test reports help them to better understand learners’ problems, to adapt their teaching and how to activate the children. However, on the whole they are less enthusiastic about the quality of evaluation than the test providers: they complain about long waiting lists, too negative formulations, the kind of tests used and also time constraints. One teacher formulated it this way:

“We would be involved more in evaluation, but our system does not give us time to do that. Good evaluation demands sufficient time”

**Parents**

In contrast to professional diagnosticians and teachers, parents report widely varying experiences with testing: only one very satisfied (because they had the feeling they were understood, there was a recognition of the problem of the child, and because of that the blame was taken away from the parents, the evaluation was in-depth, comprehensive and useful); others were unhappy to very dissatisfied (because of pessimistic prognostic formulations, because parents did not feel understood, because the child’s learning potential was not taken into consideration, because reports were too negative). Parents have problems with the kind of tests used (not adequate, too standardized, the child did not understand instructions), the negative report style, the lack of useful recommendations, and the negative prognosis as a result of testing.

One parent summarizes a shared experience in this way:

“There should be more communication between the school psychologist, the centre for developmental disturbance and the school. In their training, teachers, speech therapists, occupational therapists... receive too little attention as to the potential of children. They attach a primary importance to impairments. As a parent, you are not considered objective”.

**Discussion**

First, it is striking how many people deal with functional diagnosis in various centres, using a variety of testing methods. In the whole of a relatively small region of Flanders about 400 different tests appear to be used. Tests have a profound impact on the lives of children. Although one can still spot a territorial defence of professional competences (the psychologists protecting their exclusivity in being competent to evaluate a child’s functioning), there are trends to cooperate more and evaluate in an interdisciplinary way. Parents request to have their voice heard more and to have more communication between the professionals.

Research (our own pilot research this year as well as the large 2001 survey) has shown that assessment is almost universally translated into “testing”. Professional field workers, and even more so their university tutors, strongly hold to a testing paradigm, which is characteristically individual child oriented, striving for objectivity (excluding as much as possible tester’s influence), norm references, criterion validity and content validity. The child’s functioning, by using the norm references, is plotted against a peer-aged population, and this leads to a listing of impairments and deficiencies. In this way the testing paradigm is based on a medical model of disability (equalizing disability to individual impairment). The model is taught at the universities and is culturally dominant. It becomes evident in the predominant use of the Wechsler intelligence tests.

Similarly, the blooming expansion of - private as well as university based – diagnostic centres for specific learning disabilities, with a main purpose of delivering certificates of SLD and formulating advice, may be explained by the trend of school teachers to accept to take differentiating, compensatory or dispensatory measures only when an external expert has certified “a diagnosis”. This is also a highly medical, biological, individualistic, impairment-based view on functioning.

Whether there is indeed an epidemic increase in developmental disabilities (more specifically ADHD, ASD, and SLD) or just an increase in the sensitivity of diagnosis, is still a matter of debate. In any case, the long waiting lists of child psychiatric services, the Centres for Developmental Disturbance and the Diagnostic Centres for SLD, are a sign of an increasing need for recognition of an impairment. It is by no means coincidental that the referrals to special education have risen 50% in the past 16 years in Flanders (Van Rompu, e.a, 2008), despite measures to keep the children in the mainstream.

The underlying philosophy of these testing practices is far from the cultural model of disability, which underpins e.g. the UN Convention of the Rights of People with Disability, the ICF-model of disability of the WHO (International Classification of Functioning, Disability and Health) and the Inclusive Education movement as is being advocated by association of people with disability. The social model of disability sees the degree of disability as a result of complex interactions between a child’s bodily or functional impairments and the barriers to learning and functioning which exist in the external world (barriers can be attitudes,
physical, norms, rules, habits, etc.) or personal circumstances. However, no trace of this thinking can be found in the testing paradigm. Professional diagnosticians, at least in the way they use testing, seem to be hardly concerned with a child's social and learning context. Only 1 instrument out of 400 was used in the 2001 survey, which explicitly takes into account a child's functioning within its environment. Or rather, there seems to be a disparity in their habitual test use and the reality in the field, which calls for other forms of testing. In practice, professionals do observe children in their context, talk to parents and teachers and compare their results with findings by others, but basically, they try to convince others of the objectivity of their diagnosis. In many cases, however, test results indeed lead to exclusion from a regular learning environment. Professional assessors also seem to be hardly concerned with how the end-user (teachers, families, clinicians) experience test results (Hodges, 2004). Very few research has been done. As to our knowledge, no systematic research has been undertaken in the Dutch language area. No wonder that fundamental conceptual conflicts arise between diagnosticians on the one hand and families on the other hand.

There are signs that in 2009 things are beginning to change. A working group has been formed, PRODIA, instigated by the Ministry of Education, to reform school psychological assessment, and design a new protocol. Another working group has been formed on the initiative of school psychologists, to study the alternative, more contextual and needs-based assessment, which purpose is to be really educationally informative and not only deliver a "classifying diagnostics".

The evaluation of assessment and testing procedures themselves depend largely on their purpose. Assessment is often used to obtain a kind of benefit (recognition, money, assistance, a placement) from a public instance. In that case, highlighting deficiencies and impairments, and measuring them in an objective way using "objective" tests, is more seen as an aid than as an impediment. Similarly, parents and teachers are satisfied when assessment is thorough and comprehensive, when it gives them cues to understand a child's functional impairments, and thus de-blames parents of pedagogical mischief. This is especially the case in the blooming diagnoses of children with social-behavioural difficulties, such as autistic spectrum disorder, ADHD, DCD, specific learning disabilities (dyslexia, dyscalculia).

On the other hand, when the purpose of evaluation is to design educational or therapeutic intervention plans or to assign a child to a special or a regular school, it becomes very important to highlight a child's potential. This is the area which is most lacking, according to all parents, and some of the teachers. Because, in order to design intervention, or plan inclusion, to recommend teachers and parents what to do, how to make a child learn, how to make a child participate in a diverse group, one needs to understand a child's learning-in-context. There are methods of assessment which specifically probe into a child's actual learning and possible (potential) learning, which are summarized under the term "dynamic assessment". But current practice hardly shows a trace of them; they are, at least in our region, in an embryonic stage.

In fact, it is not so much the testing itself per se which constitutes the centre of the debate, but the place of testing in the whole of a comprehensive assessment and the way test results are used and interpreted, which is based on the purpose and the underlying paradigm. Clearly this is an area of friction between the culturally dominant "biological disturbance" testing paradigm and the emerging cultural, contextual, or ecological paradigm.

Severe fundamental criticisms to the testing paradigm have been formulated by Stephen Gould (1996), who denounces the 19th and 20th century testing practice as a "mismeasurement", thereby creating negative cultural prejudice towards large groups of disadvantaged people, e.g. the Afro-Americans in the US.

Feuerstein et al. (1989), following herein André Rey, state that (static) testing gives no information about learning and is based on a static conception of immutable intelligence as if this were a characteristic of a person's biology. Static testing disadvantages lower-functioning children, by denying them the proper educational programmes and cognitive stimulation. Feuerstein et al. consider a child as basically modifiable, and modifiability as a result of a social-constructionist process of mediated learning experience. Assessment should be oriented at exploring the conditions of a child's modifiability. If we want to transform schools towards inclusive education, then the concept of modifiability becomes crucial to trigger a child's optimal learning processes.

An even more fundamental criticism is made by Julie Allen (1999), who questions the practice of testing per se, as a "technique of surveillance", a "disciplinary gaze", reducing children with special needs to constantly observed "objects", using techniques which are "inert, deficient and inconsistent" (Allen, o.c. p.75) and completely "missing the point" (p.84).

Indeed, current testing practice often "misses the point", i.e. how to include children, how to understand how a child is functioning and how can we learn to make them learn. This will be the subject of a second report in the Daffodil project.
References


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