Chapter 1

General Introduction
1.1 Introduction

A new educational law regarding personal budgeting for children with special needs became operative in 2003. As part of this law, children with profound intellectual and multiple disabilities (PIMD) were given greater options with regard to special education. Prior to the introduction of the law, called ‘the backpack’, most children with PIMD attended Centres for Special Education (CSEs), which are not formal educational institutes. Given the new situation, extensive knowledge and expertise became necessary in schools as they would now be expected to be able to educate children with PIMD.

In this thesis the education of children with PIMD in schools is central, as are the problems associated with the introduction of this new educational law. This introductory chapter will briefly discuss the historical background to the education of children with special needs in general and PIMD in particular. Attention will then be paid to the changes that have occurred in education policy during the last decade. The consequences of the new policy will be described concisely, as will the measures taken by authorities to guide the implementation of the new act with respect to children with PIMD. The chapter will finish with a statement of the aims and directions as well as an outline of the thesis.

1.2 Historical background of special education

The Netherlands have a long history of special education for children with all kinds of special needs. As early as 1790, the first special school was founded, catering for children who were deaf (Rietveld-van Wingerden, 2003). In the nineteenth century, more schools for children with a wide range of sensory disabilities were founded, and the first special school for children with intellectual disabilities was opened around 1850. These special schools did not have a formal status at that time, as the authorities took the view that special schools were primarily a form of therapy (Rietveld-van Wingerden, 2003). The schools were either financed by local authorities or were private initiatives.

When primary education became compulsory for all children in 1900, a discussion about how to care for children with intellectual disabilities ensued. As all children, including those with disabilities, were required to attend school, more special schools were needed. In 1920, special schools were legally recognized and more and more schools for children with intellectual disabilities were founded. A differentiated system of special schools was created over the years and by the 1970s fifteen different types of special school could be found for children with all kinds of disabilities (Den Boer, 1990).

1.3 Special education for children with PIMD

Within the special education system, children with PIMD have long held a special position. Although many forms of special education appeared during the
twentieth century, for a long time children with PIMD were not recognized as a group that could benefit from education, most probably due to the profoundness of their disabilities. Children with PIMD are described as having profound intellectual disabilities, with an estimated IQ of below 20–25 (Ware, 1994; Vlaskamp & Nakken, 2004), comparable with developmental levels of up to 24 months. In addition, they have profound to severe physical disabilities (Ferguson, Willis & Meyer, 1996; Vlaskamp, 1999; Logan et al., 2001). This group is also described as having profound and multiple learning disabilities (PMLD). Usually these children are entirely dependent on carers for all aspects of daily living (Van der Putten, Vlaskamp, Reyners & Nakken, 2005) as they cannot sit, stand or move without support. In addition to intellectual and physical disabilities, sensory impairments, such as visual and hearing disabilities are common (Evenhuis, Theunissen, Denkers, Verschuure & Kemme, 2001). Furthermore, many medical problems can be found within this population. Almost all children have physical difficulties with food ingestion and many need gastrointestinal feeding tubes (Zijlstra & Vlaskamp, 2005). Epilepsy is also very common in these children, and many suffer from gastro-oesophageal reflux (Böhmer et al., 1999), which can lead to chronic respiratory disorders and recurrent pneumonia. Sleep disorders are also common (Didden, Korzilius, Van Aperlo, Van Overloop & De Vries, 2002).

Formally, children with PIMD had the right to attend school, as education was compulsory for all children within a certain age range. In practice this hardly ever occurred as special schools maintained a lower limit for their students, claiming that a developmental age of at least 24–30 months was the minimum for receiving education. Children with PIMD, who have an estimated developmental age below 24 months, were usually exempted from education, with a request for exemption being a possibility on physical or mental grounds (Special Education Law; Ministerie van OCW, 1969).

For a long time there were no day facilities for children with PIMD and most were raised in residential facilities (Vlaskamp & Nakken, 2004), these being the only facilities to which parents could apply. It was only in the 1970s that services specifically designed for children with PIMD were developed. These changes occurred in the context of a wider international tendency in the 1970s towards providing developmental and educational services for children with PIMD. The way these services were delivered differed between countries. Some countries, for example, the UK (1970), the USA (1975), Norway (1975), Germany (1978) and Australia (1980) chose to place these children within an educational setting, whereas others, including the Netherlands, Finland and Belgium, chose to provide services within the health system.

In the Netherlands, these services, which are called centres for special education (CSEs), or special educational centres (SECs) provide medical and educational support and specialized aid for children with various disabilities aged 3–20 years. They also provide children with planned and purposeful support in their development. They make use of programmes and methods such as the Portage programme (Bluma, Shearer, Froman & Hilliard, 1976; Marle-Dekker, Van Oudheusden, Van der Meulen & Sipma, 1999) and the Educational
Programme (Vlaskamp, 1993, 1999; Vlaskamp, Poppes & Zijlstra, 2005). Interdisciplinary cooperation with paramedics is common and most children attending a CSE receive at least one form of therapy. Furthermore, a physician is usually attached to a CSE to provide medical care and information. Direct support persons (DSPs), also referred to as carers, are trained to provide medical routines. The combination of providing medical care and developmental stimulation is reflected in the staff education. One-third of the DSPs have had medical care training, whereas two-thirds have received sociocultural training (Inspectie voor de Gezondheidszorg, 2000). Most CSEs are open during school holidays and many also provide after-school care. Some CSEs can also be attended on Saturdays for so-called ‘Saturday care’. Besides the support that is offered to the children, CSEs also play an important role in giving advice or assistance to parents when necessary, for example, in applying for aids. In addition, most parents are informed about their child on a daily basis (Fonteine, Zijlstra & Vlaskamp, 2006) and parents also have a strong input into the formulation of the Individual Educational Plan (IEP) which all children ought to have (De Geeter, Poppes & Vlaskamp, 2001; Poppes, Vlaskamp, De Geeter & Nakken, 2002).

In 2000, 91 CSEs could be found in the Netherlands with a total of over 3,550 places (Inspectie voor de Gezondheidszorg, 2000). Most CSEs are designed for children with a wide range of disabilities, while nine CSEs specifically designed to provide for children with PIMD can be found throughout the Netherlands.

1.4 Changes in education policy

During the 1970s and 1980s, the segregated school system for children with special needs became the subject of discussion, although the discussion at that time was not concerned with children with PIMD. Following examples in other countries such as Sweden and the United Kingdom, integration and inclusion became more desirable, as it was assumed that learning in an environment which included non-disabled children would positively affect the development of children with disabilities. Despite this discussion, over the years the percentage of students in segregated special settings remained very high compared to other European countries (Meyer & De Jager, 2001).

In 1990, a new government policy document entitled ‘Going to School Together Again’ was released, with the intention of making a fresh start at integrating pupils with special needs (Pijl & Van den Bos, 2001). The new policy was especially directed towards children with mild intellectual disabilities or learning difficulties. Children with more severe intellectual disabilities, sensory, motor, or multiple disabilities were not included.

Due to a shift in paradigm with regard to the position of people with disabilities within society, the provision of services for children with PIMD had to change as well. The Salamanca statement (UNESCO, 1994), for example, states that special attention should be paid to the needs of children and adolescents
with severe and multiple disabilities as they have the same rights as others in the community to achieve maximum independence as adults, and should be educated to the best of their potential towards that end (Salamanca statement, article 20). Although CSEs provide good quality care and developmental stimulation, their segregated nature can be criticized, with children attending CSEs being placed outside society. It was thought that if education was a right for all children then it should not be withheld from a specific group. A further disadvantage of CSEs that was identified was the lack of transition possibilities for older children. Once a child leaves a CSE, there are few options open, other than to apply for daycare facilities for adults.

A new policy of personal budgeting (‘the backpack’) was developed during the late 1990s and focused particularly on special education for students with more severe disabilities. Students with special needs were no longer automatically enrolled in special schools, but could take the funding for such schools with them to a regular school of their parents’ choice. The ‘backpack’ policy also provided governmental support for children with PIMD to join special education. Schools were no longer permitted to reject pupils on the grounds of the severity of their disability. The new policy also prescribed a reorganization of all special schools into Expertise Centres divided into four clusters: those for children with visual disabilities (cluster 1), those for students with communication and hearing disabilities (cluster 2), those for children who have intellectual and motor disabilities (cluster 3), and those for students with behavioural problems (cluster 4) (Pijl & Hamstra, 2005).

Children with PIMD will most likely be placed in cluster 3 schools. There are two types of cluster 3 schools that are expected to receive students with PIMD. The first type are schools for children with intellectual disabilities (‘ZML’ schools). However, these schools (116 in total) need to apply for broadened admission criteria before being required to accept children with additional disabilities. The second type of cluster 3 schools that would be likely to receive students with PIMD are those for children with motor disabilities, possibly combined with intellectual disabilities (‘mytyl’ and ‘tyltyl’ schools).

In 2003, the law that introduced the ‘backpack’ policy was endorsed in the Netherlands. From that moment on the parents of a child with PIMD could more easily apply for a place for their child at school. There is no saying to what extent this will happen and to what effect. Figures from Ireland, for example, show that sixteen years after education became available for children with PIMD, half of the school-aged children still did not have access to a teacher (Ware, Julian & McGee, 2005).

The Dutch situation is complicated by the fact that ZML schools that did not apply for broadened admission criteria are not obliged to accept children with PIMD into their classes. Also, the new law does not change the right to request exemption for children with severe disabilities. The new education law has also had little impact on the provision and role of CSEs, which have neither been closed following the introduction of the new law, nor changed into formal educational institutes. They remain the responsibility of the Ministry of Health. Even after the introduction of the law, children can still easily attend a CSE. If
parents want their child to make use of educational facilities, the children have to be transferred to cluster 3 schools.

### 1.5 Consequences of the new policy

The transfer of a group of children with complex problems from CSEs to cluster 3 schools has many consequences for the cluster 3 schools. Firstly, schools have to meet the requirement of physically integrating these children. New facilities such as wheelchair access, changing rooms and hoists may therefore be necessary. However, having the right facilities is not sufficient. The heterogeneity, complexity and vulnerability of this group of children provide many challenges to the schools and to teachers who are usually unfamiliar with this group. Nonetheless, they are expected to provide adequate educational programmes in which they meet the educational, developmental and medical needs of these children. Problems will occur if teachers lack the knowledge and skills that are essential in meeting all those needs.

With regard to educational and developmental needs, teachers will require, for example, specific knowledge of functional abilities and skills (Haney & Cavallaro, 1996), levels of communication (Downing, 2001, 2004; Cascella & McNamara, 2005) and the preferences of the children (Logan & Gast, 2001). Teachers also need information about how to stimulate the development of the children, which is complicated as these children usually make little progress in their development. The teachers need to extend their ideas on progress from a linear model of learning to other forms, for example, a child needing less support.

With regard to medical needs, teachers require knowledge about how to cope with a wide range of medical problems, as well as feeding and sleep problems. They need to learn about the medication these children take and the side effects (Dugger Wadsworth & Knight, 1999; Wolff Heller, 2004). In addition, teachers need the ability to recognize an epileptic fit, and they need the skills necessary to administer tube feeding and to provide other medical care (Wolff Heller, 2004).

All knowledge has to be applied in practice, as teaching activities (for which the term ‘curriculum’ is common in education) must correspond to the needs, preferences and abilities of these children. There are clear consequences for the kind of teaching activities that should be offered, and the time and manner in which teaching activities should be offered. Teachers cannot rely on the usual teaching and planning strategies that they may be using to teach children with higher cognitive and motor levels.

Flexibility in planning is required with regard to the time that the activities should be offered. The teacher must be aware of the fact that a substantial part of the school day is needed to provide medical care and nursing (for example, eating, drinking, changing). In addition, children with PIMD are usually not able to maintain an active state of alertness long enough to undertake typical instructional activities (Blaha, Shafer, Smith & Moss, 1996). Many children with PIMD appear dull or drowsy, or may fall asleep during the day (Sandler & Voogt,
2001; Zijlstra & Vlaskamp, 2005) due to sleep disorders (Didden et al., 2002), medication or exhaustion. Epileptic insults may also have a great impact on determining when to offer activities. Teachers have to be constantly aware of the state of awareness of a child, and must respond to this state when determining the kind of activities they offer at a particular point in time.

Another important consideration is how to organize the activities. Group activities are usually difficult to perform. Many children are not able to perceive other children in a group activity and this means that it can be a frightening experience. Others do not understand the concept of ‘waiting for your turn’ which also makes attending a group activity challenging (Vlaskamp, 2005). For such children, group activities need to be replaced by individual activities.

To sum up, teachers must meet many requirements with regard to knowledge and skills in order to successfully teach children with PIMD. Problems are likely to occur if these requirements are not met. Gaining the required knowledge and skills is complicated by the fact that teachers cannot rely on specific instruments that could help them to gain knowledge of the child. Nor can the teachers rely on a specific curriculum that could help them to develop their teaching activities.

1.6 Actions of the authorities

As described above, providing support to these children requires teachers to acquire broader knowledge and new skills. Given the problems that may occur if children with PIMD attend school, it is expected that the implementation of the new law will not follow as a matter of course. In order to facilitate its introduction, the government has supported several developments aimed at the successful implementation of this law. Before the policy was officially legislated, the government funded several collaborative projects between schools and CSEs in relation to the education of children with PIMD. Teachers and DSP worked together with a group of children with PIMD. Both the expertise of the DSP and the teaching skills of teachers could be deployed. The task of these projects, which started in the spring of 2001, was to do pioneering work that would contribute to the enhancement of knowledge and experience in four related domains defined by the government. These domains were:

- To develop an instrument to categorize the characteristics of children with PIMD
- To develop a suitable curriculum for children with PIMD based on the child characteristics
- To map the expertise that is necessary for educating children with PIMD
- To map the preconditions necessary to optimally educate children with PIMD

Knowledge and experience in all domains was expected to contribute to the development of ‘good quality education’ for children with PIMD and was to be spread among other schools that would also be responsible for teaching children
with PIMD. To be able to profit optimally from all the knowledge and experience that would be collected, representatives from the collaborative projects assembled in joint focus groups to build on their knowledge. Teachers, DSP, educational psychologists from participating schools and CSEs, as well as members of several organizations in the domain of special education were participants in these focus groups. Four focus groups were initiated, each directed to one of the four domains.

The authorities decided that next to the knowledge and experience that would be gained in the collaboration projects, it was important to scientifically follow and underpin the developments with regard to the new educational law. Therefore, the University of Groningen (RuG) Department of Special Education was asked by the authorities to contribute to the introduction of the new education policy in the form of a research project covering the topics of ‘child characteristics’ and ‘developing a suitable curriculum’. Before explaining the purpose of this research project, both the domain of child characteristics and the domain of curriculum development need some further explanation.

1.7 Considerations with regard to categorizing child characteristics

Accurate insights into the abilities of people with PIMD are of importance (Vlaskamp, Van der Meulen & Zijlstra, 2002) to assure that the nature and content of a proposed programme are suitable. If no reliable assessment is available, deficiencies in essential personal and environmental adaptations may result (Vlaskamp et al., 2002). As no valid and useful instruments capable of describing child characteristics were available that were relevant to the Dutch situation, it was decided to develop a new instrument. However, choices had to be made with regard to the nature and content of this instrument as these factors could have an impact on the information collected and the time it takes to administer the instrument. The variance that can be seen between children also needs consideration. Furthermore, information on child characteristics, although very necessary, may not be the only information that is necessary for teaching a child with PIMD. It may be necessary to use a broader range of instruments and it is therefore essential that there is a critical evaluation of the instrument that is developed.

1.8 Considerations with regard to developing a curriculum

The government decided that a curriculum for children with PIMD was needed. Reviewing similar initiatives in other countries with more experience in teaching children with PIMD showed that there is a lack of clarity with regard to the direction of the curriculum. No generally accepted model can be found in the relevant literature. In fact, several approaches towards curriculum development for children with PIMD can be found over the past 30 years (Logan, Alberto, Kona & Waylor-Bowen, 1993; Horner, 1994; Ware & Healey, 1994; Orelove &
Sobsey, 1996; Rainforth & York-Barr, 1997; Orelove, Sobsey & Silberman, 2004). Although working systematically towards a plan is highlighted in most curricula (e.g. Orelove & Sobsey, 1996; Orelove et al., 2004; Aird, 2001), the content and scope usually show great differences. This seems to depend on the theoretical and methodological framework that is chosen as a starting point. Several paradigms underpin the approaches (Browder, et al., 2004) and the leading education policy within a certain country also influences the framework and content of the curriculum for children with PIMD.

The developmental approach popular in the 1970s was pupil centred and relied on the scope and sequence of normal development. The curriculum content was developed through administering an informal checklist or developmental scales (Eichinger & Downing, 2002; Browder, et al., 2004). The limits of this approach are that it is not age-appropriate, and the reliance on normal developmental sequences is not in line with the developmental patterns of children with PIMD. The functional approach (Brown et al., 1979), which attempted to overcome some of the disadvantages of the developmental approach, taught concepts with age-appropriate materials and within natural environments. However, it remained based on developmental sequencing (Horner, 1994), and there are still no established criteria of what is functional for the students (Rainforth & York-Barr, 1997). The functional approach was replaced by the ecological approach (Horner, 1994), which was also pupil centred and age appropriate. Here the content of the curriculum is highly individualized. It no longer relies on developmental sequencing, but allows for an understanding of the individual child’s unique learning needs (Howie, 1999). The involvement of parents and therapists in deciding the content of what should be taught is emphasized within this approach. Although this approach seems to fit with the needs of children with PIMD, criticism can be directed at the fact that no real inclusion can be established using this approach (Dymond & Orelove, 2001).

The most recent approach to curriculum development is a subject-based approach. This is an age-appropriate approach in which common subjects are taught to all children of a certain age. Within the inclusion movement, this approach is given high priority. However, disadvantages of such curricula can also be found. It is difficult to achieve a synthesis between a subject-led curriculum and the developmental and learning needs of children with PIMD (Aird, 2001). For instance, the subject-based National Curriculum developed in the UK turned out to be far too demanding for children with PIMD. As a result, it was virtually impossible for students with PIMD to show any meaningful progress (Ware, 1994). In order to meet the needs of children with PIMD, alternative, elaborated and additional curricula are used. Examples of such curricula are: the sensory curriculum (Longhorn, 1988), the elaborated 5–14 curriculum (Calvert & Gargan, 2001), and the early curriculum for ‘self’ development (Mallet & Naylor, 2001). Other authors suggest changing the function of the National Curriculum by using the subjects within the National Curriculum as a ‘context of experience’ (Grove & Peacey, 1999).

Regardless of the point of view, little evidence can be found for the effectiveness of the curricula (Nietupski & Hamre-Nietupski, Curtin & Shrikanth,
What can be learned from developments abroad is that curriculum development for children with PIMD is not simple. There are some important considerations that should be taken into account with regard to the functionality, atypical developmental sequences, the involvement of parents, and understanding of the unique learning needs of every child. However, developments abroad do not have much persuasive power with regard to curriculum development in the Netherlands. It was therefore decided that a new curriculum had to be developed that was suitable for the Dutch situation.

It was recommended that both the practices in the educational situation and current practices in CSEs be reviewed. Cluster 3 schools are legally required to write IEPs for their students and to make use of a systematic system of instruments and procedures to follow the students’ progress (Law on Expertise Centres, 2003). At the start of the research project no general or national curriculum was in use, although it was thought that some major topics ought to be included within special education (for example, sensory and physical experiences, social and creative skills). Exceptions could be made for children with multiple disabilities and no requirements are made with regard to the content of these topics (Law on Expertise Centres, 2003).

However, the practice in special education is subject to change. The authorities were planning to prescribe a more subject-based approach, and this was expected to operate as a guide for all special schools from 2006. As a consequence, the Dutch Council for Curriculum Development (SLO) was asked to develop a subject-based curriculum (so-called ‘leerlijnen’) for use in special education. This curriculum contains eleven subjects and six cross-curricular fields of learning such as ‘play’ and ‘social & emotional development’. It is noteworthy that the curriculum developed by the SLO did not focus on children with PIMD.

CSEs do not use a curriculum either, but instead use programmes and methods to determine their IEPs. The Educational Programme (Vlaskamp, 1993, 1999; Vlaskamp et al., 2005) is used frequently and found to be effective (Vlaskamp, 1993; Poppes & Vlaskamp, 2001). The theoretical underpinning of the Educational Programme concurs with the ecological approach. The programme is a systematic, functional, goal-oriented approach, in which optimally stimulating children in their developmental process is central. A fixed procedure is used to draw up a strictly individual education programme (De Geeter et al., 2001). Long-term goals are defined through the mutual agreement of parents, direct support people and therapists.

Given the different approaches in schools and CSEs choices had to be made on the kind of curriculum that should be developed and the scope of the curriculum. Given the difficulties that may occur in developing and using curricula for children with PIMD, it is important to reflect upon the direction of the curriculum for children with PIMD.
1.9 The aim of the research

As mentioned above, the RuG was invited to participate in the developments concerned with the education of children with PIMD in cluster 3 schools. The major problems mentioned with regard to the implementation of the new education law were the lack of specific instruments that teachers can rely on to gain knowledge of the characteristics of children with PIMD, the lack of a specific curriculum that would help teachers to determine teaching activities, and the uncertainty about whether children with PIMD will actually go to schools or remain in CSEs. Hence, a research project was initiated at the beginning of 2002. The central aim of this project was to contribute to the development and evaluation of a suitable educational approach for children with PIMD.

The focus of the project is threefold:
• the development of a reliable and useful instrument to categorize the characteristics of children with PIMD
• the development and implementation of a specific curriculum for children with PIMD
• the evaluation of the characteristics of children with PIMD in schools and CSEs.

1.10 Directions of research

The research consisted of two main phases. The first phase was funded by the Ministry of Health, Welfare and Sports and the Ministry of Education, Culture and Science. Starting at the beginning of 2002, the attention of this phase was focused upon the development of an instrument (called the checklist of child characteristics) and upon the development of a curriculum that could be used to design an IEP. Many cluster 3 schools and CSEs took part in the initial developments. Both subjects – which are closely related, as assessing the child should be the first step in developing an IEP – were studied in conjunction with the representatives of the cooperation projects who joined the focus groups on ‘curriculum development’ and ‘child characteristics’. Attending meetings of the two focus groups dealing with ‘curriculum development’ and ‘child characteristics’ was part of the project. Although there was consultation, the RuG had an independent position, and the activities of the two ‘focus groups’ and the RuG did not correspond exactly. Strikingly, the development of the curriculum for children with PIMD was characterized by a duality. The focus group dealing with curriculum development decided to use the SLO curriculum as the guiding principle for the proposed curriculum. Their aim was to expand the SLO curriculum to include children at the 0–24 month level, and this was expected to accommodate children with PIMD. Not all subjects seemed suitable, and the members of the focus group only chose one subject (language and communication), as well as four cross-curricular learning fields. Developmental
sequences on all five 'domains' were chosen as the starting point. The authorities agreed with the approach of the focus group on curriculum development.

At the same time, however, the RuG was asked by the authorities to develop a curricular framework based on the Educational Programme (Vlaskamp, 1993, 1999; Vlaskamp, Poppes & Zijlstra, 2005) given the fine-tuning of this programme to the needs of children with PIMD. The authorities expected to achieve a satisfactory synthesis of the various elements – derived from both the Educational Programme and the SLO curriculum – which would make up the entire curriculum for children with PIMD, although the assumptions of both methods (ecological versus subject based) did not seem to match.

The second phase of our research (funded only by the Ministry of Education, Culture and Science) focused on the implementation of the curriculum and the evaluation of the education policy thus far. This phase started in September 2005 and was directly linked to the distribution of a CD-ROM that contained the entire instrument and the whole curriculum that had been developed by the RuG and the focus group concerned with curriculum development. All cluster 3 schools received this CD-ROM. The use and implementation of it was subject to evaluation, as it is acknowledged that failure in implementation is the most common reason for outcome failures (Mills & Ragan, 2000).

Along with the implementation of the curriculum, the characteristics of children with PIMD who were already in schools and the characteristics of children who remained in CSEs were investigated. This was an important question as children with PIMD can still request exemption from education and go to a CSE throughout the years of compulsory education. Evaluation of the effect of the new law is required, as only then it becomes clear if there remain differences in population in both schools and CSEs and what extra facilities, knowledge and skills are needed in order to guarantee education for all. Three years after the new law had been implemented seemed an appropriate moment to evaluate what the new law had yielded with regard to the placement of children with PIMD in schools.

### 1.11 Outline of the thesis

The present thesis reports firstly on the development and use of an instrument describing child characteristics. Second it reports on the implementation of a curriculum that was developed specifically for children with PIMD. Finally, the thesis reports on the implementation of the new educational policy.

The thesis is divided into six chapters. Following this first introductory chapter, the development of an instrument called ‘the checklist of child characteristics’ for use in the education of children with profound and multiple intellectual disabilities will be described in Chapters 2 and 3. The psychometric properties and content of the checklist will be described in Chapter 2. The
validation process as well as the use of the instrument will be reflected upon in Chapter 3.

Research with regard to the implementation of an educational programme (curriculum) for children with PIMD was conducted in a small number of schools. The results will be presented in Chapter 4.

Chapter 5 will examine the implementation of the new education law with respect to the shift from CSEs to schools. It gives an overview of children who are already in education and children who remain in CSEs despite the introduction of the new law.

In Chapter 6 the results of the study will be presented, and the general conclusions that can be drawn from this study are made and subjected to further discussion. Finally, the limitations of the study and its implications for further research will be discussed.
References


