opportunities and challenges when using the washington group questions to determine eligibility for special education

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**introduction**

Disability represents a complex interaction between a person and his or her environment, be it physical, social, cultural or legislative. Measuring disability prevalence can be challenging, even more so in environments where there are high levels of negative attitudes and stigmas that may impact individuals’ willingness to self-identify. Disability prevalence tools that ask participants directly regarding the presence of a disability, either generally or in specific domains (such as hearing, seeing, etc.) have been shown to lead to the underreporting of disability. A number of factors may contribute to this trend, including social stigmatization around disability, the idea that only the most severe cases count as disabilities, or an individual’s unfamiliarity with their own diagnosis. On the other hand, tools that ask participants regarding their level of functional capacity in several domains, including bodily functioning and activities of daily living, are more likely to address the limitations that occur between an individual and his or her environment. These tools often identify higher rates of functional limitations and, due to their focus on universal experiences rather than specific disabilities, their results are more likely to be cross-culturally comparable.[[1]](#footnote-1)

The Washington Group on Disability Statistics (Washington Group), established in 2001, worked to address these issues by developing a census tool that can more accurately identify prevalence rates of persons with disabilities. The Washington Group, named after the location of their first meeting, brings together representatives from national statistical offices, disabled people’s organizations (DPOs) and other international organizations from around the world with the purpose of fostering international cooperation in the development of disability data collection tools suitable for use in censuses and national surveys.[[2]](#footnote-2) [[3]](#footnote-3) The Washington Group therefore chose to use the International Classification of Functioning, Disability and Health (ICF) as a model in the development of tools that could obtain information on functional difficulties across the domains most closely associated with activity and participation.[[4]](#footnote-4)

The purpose of the Washington Group tools is to provide a method for obtaining cross-nationally comparable measures of disability. At a national level, the tools are intended to help a country monitor the implementation of the United Nations Convention on the Rights of Persons with Disabilities (CRPD), and to help inform policy on equalization of opportunities for the population with disabilities.[[5]](#footnote-5) In order to assess the equalization of opportunities for persons with disabilities, the Washington Group tools must be used in conjunction with other census or survey indicators such as questions about employment or education. Disability status can then be cross-classified with, for example, a measure of education participation to gauge the equalization of opportunity.[[6]](#footnote-6)

**understanding the washington group questions**

The Washington Group surveys include the following three tools which are described in more detail below.

1. **The Washington Group Short Set on Functioning (WG-SS):** The WG-SS contains six questions and covers six functional domains: seeing, hearing, walking, cognition, self-care, and communication.[[7]](#footnote-7) The WG-SS is intended to be used for adults aged 18 and older.
2. **The Washington Group Extended Set on Functioning (WG-ES):** The WG-ES contains 37 questions, some of which are optional based on a respondent’s answers to previous questions on the tool, and covers the six functional domains included in the WG-SS, as well as questions regarding affect (anxiety/depression), upper body functioning, and pain and fatigue. The WG-ES also contains questions regarding the use of assistive devices such as glasses, hearing aids or canes/crutches/wheelchairs.[[8]](#footnote-8) Like the WG-SS, WG-ES is also intended for a population aged 18 and older.
3. **The Washington Group/UNICEF Child Functioning Module (CFM)[[9]](#footnote-9)** The CFM has two submodules: one for children from 2-4 years of age and one for children 5-17 years of age.[[10]](#footnote-10) The CFM submodule for children 2-4 years of age contains 16 questions and covers the domains of seeing, hearing, mobility, fine motor, communication, cognition (learning), playing and controlling behavior.[[11]](#footnote-11) The CFM submodule for children 5-17 years of age contains 24 questions and covers the domains of seeing, hearing, mobility, self-care, communication, cognition (learning, remembering and concentrating), accepting change, controlling behavior, relationships and affect (anxiety and depression).[[12]](#footnote-12)

Each of the Washington Group tools has several response categories for each question along the lines of “no difficulty,” “some difficulty,” “a lot of difficulty,” or “cannot do at all.” For those questions that ask regarding functional difficulties that exist along a continuum, those questions then ask whether such difficulty occurs “daily,” “weekly,” “monthly,” “a few times a year,” or “never.” The range of response categories allows for the choice of different cut-off levels depending on the purpose for which the tool is intended. Cut-off, in this case, means the point at which disability is determined. The cut-off for determining disability recommended by the Washington Group for international reporting and cross-national comparability is the response of “a lot of difficulty” or “cannot do at all” in at least one domain.[[13]](#footnote-13)

**advantages of the washington group questions**

The Washington Group Questions provide a more accurate way of determining possible disability prevalence rates using censuses and surveys. Additional advantages include:

1. **Provides international comparative data**. Prior to the WG tools, governments and international organizations used very different approaches and tools to identify disability prevalence. This inconsistency in methodology made comparison of data between countries unfeasible. For example, disability prevalence rates for children with disabilities can vary significantly, from 0.4 percent to 12.7 percent, depending on the study and assessment tool that is used to collect the data.[[14]](#footnote-14) Use of the WG questions helps ensure a consistent way of collecting data on persons with disabilities that provides a cross-national comparison.
2. **Tools identify functional limitations**. The 2011 World Report on Disability sets the global disability rate at around 15%.[[15]](#footnote-15) As mentioned previously, however, reports on disability can vary widely depending on both the tool that is used to measure disability as well as the definition of disability. Factors such as age and functional ability also exist along continua that make disability determination even more subjective. The Washington Group tools serve to identify persons with functional limitations that may put them at risk for greater exclusion. The tools define disability, therefore, as a lot of difficulty (orcomplete inability) to perform a core basic activity which would be universally debilitating across cultures.[[16]](#footnote-16)
3. **Questions are easy to understand**. While it is not possible to eliminate all sources of error on survey instruments, Washington Group tools underwent several rounds of evaluation and testing, including cognitive interviewing to ensure cross-cultural comparability. The CFM, for example, was administered to a total of 385 persons in six countries across four rounds of cognitive interviewing. Four types of revisions were made to questions according to the results of these evaluations: revising confusing or ambiguous words; moving, adding or deleting clarifying phrases; revising questions for conceptual clarity; and the addition of examples where necessary.[[17]](#footnote-17)

**challenges in implementing the washington group questions**

Two of the main challenges regarding the use of Washington Group Questions include issues with establishing the appropriate cutoff to determine disability, and the potential risks to using a proxy respondent. These two challenges are described more below.

1. **Challenges with establishing cutoff to determine disability.** A number of studies have examined the appropriate cut-off level to be used when administering the Washington Group tools. Although the recommended cut-off for determining disability proposed by the Washington Group is at the level of moderate to severe difficulty (a lot of difficulty/cannot do at all), a study conducted in India and Cameroon found that almost half of persons who were identified as having a disability in a clinical examination only reported “some difficulty” on any functional domain. In particular, subjects were less likely to self-report difficulty in vision and hearing. Using “some difficulty” as the cut-off, on the other hand, would increase the disability prevalence to half of the population.[[18]](#footnote-18) Studies in Fiji report similar findings when using the CFM to identify students with disabilities. When applying a cut-off of “a lot of difficulty,” unacceptably high numbers of students with disabilities in the domains of seeing, hearing and walking were missed.[[19]](#footnote-19) Another study in Fiji found that “some difficulty” was statistically identified as the optimal cut-off for identifying students with speech disabilities, but over 30% of students with no speech disabilities were also falsely identified.[[20]](#footnote-20)
2. **The use of proxy respondents**. Ideally, The Washington Group tools are intended to be answered directly by an individual, unless the person in question is incapable of answering for themselves. However, due to the nature of census distribution, it is frequently the case that a head of household or primary respondent will respond on behalf of all household members.[[21]](#footnote-21) While the Washington Group tools do not expressly forbid this practice, a number of risks may arise when using proxy respondents. Previous research conducted with the population of persons 18-64 years of age using the National Health Interview Survey on Disability (NHIS-D) found that proxy respondents were less likely to report functional, sensory or mental-health limitations than were people providing self-reports. As disabilities became more observable or interactional, the difference in discrepancies were smaller; however, as most disabilities are not readily observable, proxy reports are likely to underestimate the prevalence of disability.[[22]](#footnote-22) Similarly, when comparing child and parent reports of health related quality of life (HRQoL), a systematic review of the literature found that there was greater agreement between parents and children on observable functioning, but greater disagreement of ratings on non-observable factors such as emotional and social quality of life.[[23]](#footnote-23) This lends weight to an argument for also acquiring responses directly from children whenever possible.

**Use of the washington group tools in schools**

A number of international aid organizations, including the United States Agency for International Development (USAID) and the United Kingdom’s Department for International Development (DFID), encourage the use of the WG-SS to collect data on disability status of beneficiaries across programs. This is due in large part to the fact that the WG-SS is simple, inexpensive, and takes less than 2 minutes to administer.[[24]](#footnote-24) [[25]](#footnote-25) Children aged five years and older may have challenges in the functionality areas determined by the WG-SS, and the Washington Group acknowledges the fact that the WG-SS does not cover several key aspects of child development important for identifying disability in children, including learning, interacting with peers, coping with change, and focusing attention. Thus, the short set of six questions is not ideal for use with children younger than 17 years of age and should never be used for children younger than five.[[26]](#footnote-26) Any use of the short set with persons younger than 17 years of age is likely to result in underestimations of the number of children with disabilities.[[27]](#footnote-27)

While it is clear that the WG-SS has limitations when used to measure disability in children under the age of 17, there are also challenges when using the CFM to determine eligibility in school settings. These challenges will apply to both the CFM as well as the WG-SS. These main challenges include:

1. **Using teachers as proxy respondents instead of parents.** As the CFM was intended to be asked of parents and caregivers and not children, then teachers must serve as proxy respondents in environments where the parents are not available to participate in the screening process, such as schools. Very limited research has examined the validity of teachers as proxy respondents for children when filling out the CFM. One study conducted in Fiji compared teacher and parent inter-rater reliability with results on clinical evaluations on a sample of students drawn from special education schools or mainstreaming programs and a similar number of controls. The study found that parents had slightly higher accuracy than teachers when determining disabilities in the easily observable domains of seeing, walking, and speaking. Teachers, on the other hand, demonstrated better accuracy than parents in the cognitive domains of learning, remembering, and focusing attention. It is important to point out, however, that overall accuracy in the cognitive domains was poor overall. Teachers’ higher accuracy in these domains over parents does not necessarily reflect the tool’s ability to identify students with cognitive disabilities. The study also found considerable variability in the way severity was reported across functioning domains. When combined with the ambiguity around the most appropriate cut-off level for each domain, the study concluded that the CFM is not accurate enough to be used as the lone determinant of disability status in children.[[28]](#footnote-28)
2. **Large class sizes.** A field test conducted in Tanzania used questions based on the CFM in their Education Management Information System (EMIS) to ascertain how many students had difficulties in several functional domains. The questionnaires were administered to teachers, who indicated how many students had “some difficulty” or “a lot of difficulty” on a range of activities. Teachers reported having difficulties in filling out the forms due to a lack of familiarity with their students’ abilities, thanks in part to large class sizes. This problem may be exacerbated in the case of students with “invisible” disabilities: those that are not readily observable. Other potential difficulties that were identified in focus group interviews with teachers included the possibility that teachers may misattribute student disability to stubborn behavior, the fact that girls may hide their disabilities more often than boys, and that language differences between communities may be misunderstood as intellectual disability.[[29]](#footnote-29)
3. **Timing of identification.** For a teacher to identify students with perceived functional limitations, they must have spent a considerable amount of time with the students in the classroom. Because of this, the WG questions cannot be used in the beginning of a school term, and therefore a teacher must wait to administer the test until later in the year. This signifies that many students who might benefit from intervention must wait for supports and services for many months until screenings are conducted.
4. **May not capture all disabilities or identify all students who may benefit from support.** The focus of the Washington Group tools is on examining the difficulties an adult or child may have while performing a functional activity; in this sense, the tools do not identify specific disabilities but rather difficulties that arise in the interaction between the child and his or her environment.[[30]](#footnote-30) For example, a study in Fiji that examined teacher reliability in evaluating students with seeing, hearing, and walking difficulties found that a number of students who were identified as having difficulties walking were later found to have low vision or to be obese upon clinical evaluation. The same study pointed out that children with upper-limb disabilities were overlooked, as no question specifically targeted fine motor skills.[[31]](#footnote-31)
5. **Risk of bias in teacher evaluation of student functioning**. A number of papers have documented the over-representation of minority students labeled as having disabilities in the United States.[[32]](#footnote-32) [[33]](#footnote-33) In the late 19th century, especially during an increase in immigration to the United States, African Americans and other minorities were portrayed as inferior to whites in mental abilities and their disposition to illness.[[34]](#footnote-34) Today, the over-representation of minorities in special education is especially true for “soft disabilities,” that is to say, disabilities that are based on a teacher’s judgement, such as in the case of intellectual/learning disabilities and emotional/behavioral disorders.[[35]](#footnote-35) These topics are important factors to consider when applying the Washington Group tools in contexts with high levels of immigration or where teachers and students may come from different cultural or ethnic backgrounds, especially if teachers are assigning their perceptions on student functionality.
6. **Does not capture the full range of disability as many children with disabilities remain out of school.** Research has found that children with disabilities are less likely to have ever attended school, more likely to be out of school, and are less likely to complete elementary or secondary school.[[36]](#footnote-36) A field test conducted using the CFM in Pakistan confirms these findings. Among children who were identified as having moderate to severe disabilities, 23% were out of school. Of those children with moderate to severe disabilities who attended school, these students were more frequently absent and more likely to repeat school years than children without disabilities.[[37]](#footnote-37) Based on its findings from a field test in Tanzania, UNICEF cautions that the use of data collection tools in schools will not capture information on the vulnerable population of children with disabilities who do not attend school.[[38]](#footnote-38)

**Annex a: washington group questions in rwanda**

As the usage of the Washington Group Questions becomes more prevalent in low-resource settings, there is also a risk that they may be used inappropriately. This is particularly relevant for Rwanda, which is looking to strengthen its inclusive education system. Rwanda is committed to both identifying students as having a disability and providing students with an inclusive education. Research shows that the Washington Group Questions are an appropriate tool to use within censuses and household data; however, challenges arise when using the tool to identify students with a disability in the classroom setting and when using teachers as proxies. Additional complications arise when using the WG-SS within the classroom instead of the CFM. This challenge has been documented in recent research by Save the Children in Rwanda which found that using the WG-SS significantly underestimated the prevalence rates of disability within students.[[39]](#footnote-39) With these challenges in mind, IDP presents the following recommendations related to the Soma Umenye UDL pilot:

* Though recent research shows that using the Washington Group CFM alone may not be an effective classroom identification tool, donors and other implementing partners are increasingly using this tool in the classroom setting. Therefore, the UDL pilot will compare results from vision and hearing screening tests together with the results of Response to Intervention (RtI) against results from the CFM. These results can then be compared to the research conducted previously by Save the Children.
* Teachers, instead of caregivers, will be asked to complete the CFM as this is an approach that has yet to be fully documented and researched. This is also an approach that is being used in many USAID projects including within Nepal and Ethiopia.[[40]](#footnote-40) This practice was also used in Senegal by Humanity and Inclusion, an organization which is continuing to advocate for this approach to be used in other countries. Having a better understanding of how this approach compares to actual hearing and vision screenings will help inform not only Rwanda’s future approach but can also contribute to the global dialogue on best practices for identification of students with disabilities.

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