Workshop Objectives

From this workshop it is hoped that participants will increase their...
1. understanding of the clinical, Federal (IDEA), and Stated definitions/criteria for ID.
2. ability to conduct ID eligibility evaluations.
3. understanding of special issues associated with ID eligibility evaluations.

NOTE: The presenter, Stephen E. Brock, has no known financial conflicts of interest related to this presentation.

Preface

We as a Nation have long neglected the mentally ill and the mentally retarded. This neglect must end, if our Nation is to live up to its own standards of compassion and dignity and achieve the maximum use of its manpower.

-John F. Kennedy, address to Congress on February 5, 1963

Preface: General Rules for the Assessment of Students with Disabilities

1. Focus on student needs.
   - Student needs dictate interventions, not simply what's convenient for adults.
2. There is no such thing as bad data.
   - There are bad data interpretations.
3. Use tests, don't let them use you.
   - School psychologists make psycho-educational recommendations, tests don't.
4. Everything is data.
   - There are many ways to understand a student and develop recommendations.
5. Never draw a conclusion from a single data source.
   - Look for multiple sources of agreement before coming to any conclusion.

Preface: Rules of School Psychology

6. Look for information that will guide interventions.
   - Meaningful data provides guidance that leads to student success.
7. There is no such thing as an “un-testable” child.
   - There are students for whom standardized tests are psychometrically invalid.
8. You will need to ask difficult questions and deliver bad news.
   - This will make you uncomfortable, but you need to GET OVER IT!!!!
9. You need to earn the right to share an expert opinion.
   - Just because you are a “school psychologist” doesn’t mean you will be listened to.
10. Always strive to give away psychology.
    - Psycho-educational strategies are not a covert and should be understood by all.

Preface: Rules of School Psychology

11. Be attentive to what students do well.
    - Assertively identify student strengths and use this information to guide interventions.
12. Always tell students what to do.
    - Avoid simply telling students what not to do.
13. Never think you have all the answers.
    - Always ask good questions and be a life-long learner.
14. Be a critical consumer of psycho-educational tools & interventions.
    - Use empirically supported tools/interventions, but remain open to new approaches.
Preface: Historical Definitions

- **DSM I (p. 18): Chronic Brain Syndrome**
  - These categories are provided for the group of mental disturbance formerly diagnosed as secondary mental deficiency. Clinically, a general developmental defect of mentation is superimposed on the chronic brain syndrome, and when prominent may require the addition of the qualifying phrase, Mental deficiency. The degree of defective intelligence will be specified as mild, moderate, or severe, and the current IQ rating will be added to the diagnosis (see Mental deficiency).

Sources: American Psychiatric Association (1952)

Preface: Historical Definitions

- **DSM I (pp. 23-24): Mental Deficiency**
  - Here will be classified those cases presenting primarily a defect of intelligence existing since birth, without demonstrated organic brain disease or known prenatal cause. This group will include only those cases formerly known as familial or “idiopathic” mental deficiencies. The degree of intelligence defect will be specified as mild, moderate, or severe, and the current I.Q. rating, with the name of the test used, will be added to the diagnosis.


Preface: Historical Definitions

- **DSM I (pp. 23-24): Mental Deficiency (continued)**
  - In general, mildly divertive functional (vocational) impairment, as would be expected with I.Q.’s of about 70-85; moderate, is used for functional impairment requiring special training and guidance, such as would be expected with I.Q.’s of about 50-70; severe refers to the functional impairment requiring custodial or complete protective care, as would be expected with I.Q.’s below 50. The degree of defect estimated from other factors than merely psychological test scores, namely, consideration of cultural, physical and emotional determinants, as well as school, vocational and social effectiveness. The diagnosis may be modified by the appropriate qualifying phrase, when, in addition to the intellectual defects, there are significant psychotic, neurotic, or behavioral reactions.

Sources: American Psychiatric Association (1952)

Preface: Historical Definitions

- **DSM II (p. 14): Mental Retardation**
  - ... refers to subnormal general intellectual functioning that originates during the developmental period and is associated with impairment of either learning and social adjustment or maturation, or both.

- **DSM III (p. 30): Mental Retardation**
  - The essential features are: (1) significantly subaverage general intellectual functioning, (2) resulting in, or associated with, deficits or impairments in adaptive behavior, (3) with onset before the age of 18 years

- **DSM IV (p. 39): Mental Retardation**
  - The onset is before age 18 years.

- **DSM IV-R (p. 43): Mental Retardation**
  - The essential features are: (1) significantly subaverage general intellectual functioning, (2) resulting in, or associated with, deficits or impairments in adaptive behavior, (3) with onset before the age of 18 years

Sources: American Psychiatric Association (1968, 1994)

Preface: Historical Definitions

- **DSM III-R (p. 28): Mental Retardation**
  - The essential features are: (1) significantly subaverage general intellectual functioning, accompanied by (2) significant deficits or impairments in adaptive behavior, with (3) onset before age of 18

Preface: Current Terminology

- On Tuesday, October 5, 2010, President Obama signed into law S. 2781 (“Rosa’s Law”)
- Changed references in Federal statutes (including IDEA) that referred to “mental retardation” to refer, instead, to “intellectual disability.”
- The story behind Rosa’s Law (video)

Preface: Historical Age of Onset Criteria

- 1908
  - A state of mental defect from birth, or form an early age, due to incomplete cerebral development (Tredgold, p. 2).
- 1941
  - A state of social incompetence, obtained at maturity, or likely to obtain at maturity, resulting from developmental arrest of constitutional origin (Doll, p. 215).
- 1959
  - Which originated during the developmental period (i.e., birth through approximately 16 years; Heber, p. 3).

Source: Schalock et al. (2010, p. 9)

Preface: Historical IQ Cutoff Criteria

- 1959
  - Less than one standard deviation below the population mean of the age group involved on measures of general intellectual functioning (Heber, p. 3).
- 1973
  - Two or more standard deviations below the population mean (Grossman, p. 11).

Source: Schalock et al. (2010, p. 10)

Preface: Historical IQ Cutoff Criteria

- 1983
  - IQ of 70 or below on standardized measures of intelligence; upper limit is intended as a guideline and could be extended to 75 or more (Grossman, p. 11).
- 1992
  - IQ standard or of approximately 70 to 75 or below, based on assessment that includes one or more individually administered general intelligence tests (Luckasson et al., p. 5).
- 2002
  - Approximately two standard deviations below the mean, considering the standard error of measurement for the specific assessment instruments used and the instruments’ strengths and limitations (Luckasson et al., p 76).

Source: Schalock et al. (2010, p. 10)

Preface: Historical Adaptive Behavior Cutoff Criteria

- 2002
  - Performance that is at least two standard deviations below the mean of either (a) one of the following three types of adaptive behavior: conceptual, social, or practical or (b) and overall score on a standardized measure of conceptual, social, and practical skills (Luckasson et al., p 76).
Preface: AAIDD Assessment Framework

- Functions (and questions) of the assessment
  1. Diagnosis
     - Is the student a person with ID?
  2. Classification
     - Does the student require special education
  3. Planning/development of support system
     - What are the IEP goals and objectives?

Source: Schalock et al. (2010, pp. 21-25)

Preface: AAIDD Assessment Framework

- Function (and methods) of the Assessment
  1. Diagnosis
     - IQ tests
     - Adaptive behavior scales
     - Age of onset documentation
     - History
     - Social & educational record review
  2. Classification
     - Levels of adaptive behavior
     - IQ range or levels
     - Environmental measures
     - Etiology-risk factors
     - Mental health measures

Source: Schalock et al. (2010, pp. 21-25)

Preface: AAIDD Assessment Framework

- Function (and methods) of the Assessment
  2. Classification
     - Levels of adaptive behavior
     - IQ range or levels
     - Environmental measures
     - Etiology-risk factors
     - Mental health measures

Source: Schalock et al. (2010, pp. 21-25)

Preface: AAIDD Assessment Framework

- Function (and methods) of the Assessment
  3. Planning/development of support system
     - Speech/language, motor, sensory assessment
     - Achievement tests
     - Functional behavioral assessment
     - Functional analysis assessment

Source: Schalock et al. (2010, pp. 21-25)

Workshop Outline

1. Intellectual Disability (ID) Defined
2. Identifying ID for Special Education Eligibility Purposes
3. Special Issues
4. The ID Psycho-educational Report Template
APA Definition

• DSM-5 Definition: Intellectual Disability (Intellectual Developmental Disorder)
  ▪ “... a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains.”

Source: APA (2013, p. 33)

APA Definition

• Changes from DSM-IV-TR
  ▪ Name change
    ▪ No longer referred to as Mental Retardation
    ▪ Intellectual Disability (Intellectual Developmental Disorder)
    ▪ “Intellectual Development Disorder” in ICD-11
  ▪ Severity determined by adaptive functioning
    ▪ No longer determined by IQ scores
    ▪ Severity level specifiers “mild,” “moderate,” “severe,” “profound” (see pp. 34-36)

Source: APA (2013, pp. 33-36)

APA Definition

• Rationale for DSM-5 Changes
  ▪ Intellectual Disabilities is now the more common (preferred) term
  ▪ PL 111-256, Rosa’s Law
    ▪ ID is quite literally PC
  ▪ Need for comprehensive assessment
    ▪ Emphasizes clinical assessment AND standardized cognitive testing

Source: APA (2013)

APA Definition

• Consequences of DSM-5 Changes
  ▪ Less reliance on the IQ score
    ▪ Ensures IQ tests are not over emphasized
  ▪ Greater emphasis on adaptive functioning
    ▪ Severity levels (mild, moderate, severe, profound) based on conceptual, social, and practical behaviors

Source: APA (2013)

WHO Definition

• ICD 10 (pp. 369-370): Mental Retardation
  ▪ A condition of arrested or incomplete development of the mind, which is especially characterized by impairment of skills that contribute to the overall level of intelligence, i.e., cognitive, language, motor, and social abilities. Retardation can occur with or without any mental or physical condition. Degrees of mental retardation are conventionally estimated by standardized intelligence tests. These can be supplemented by scales assessing social adaptation in a given environment. These measures provide an approximate indication of the degree of mental retardation. The diagnosis will also depend on the overall assessment of intellectual functioning by a skilled diagnostician. Intellectual abilities and social adaptation may change over time, and, however poor, may improve as a result of training and rehabilitation. Diagnosis should be based on the current levels of functioning.

AAIDD Definition: Intellectual Disability

- **Intellectual Disability** (p. 1)
  - Intellectual disability is characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. This disability originates before age 18.

Source: Schalock et al. (2010)

IDEA Definition: Intellectual Disability

- According to the Code of Federal Regulations “intellectual disability” (formerly referred to as mental retardation) is a term, used to describe a student with a disability who needs special education and related services.
- More specifically...

Source: CFR, Title 34, Chapter III, Part 300, §300.8 (Child with a disability), (a)(1)

**IDEA Definition: Intellectual Disability**

- Intellectual disability means **significantly subaverage general intellectual functioning**, existing concurrently with **deficits in adaptive behavior** and **manifested during the developmental period**, that **adversely affects a child’s educational performance**.

[Emphasis added]

Source: CFR, Title 34, Chapter III, Part 300, §300.8 (Child with a disability), (c)(6)

**Discussion**

- Looking back at the historical definitions and criteria (associated with what we now refer to as intellectual disability)...
  - What are the significant changes that have occurred?
  - Do these changes create any opportunities?
  - Do they create any challenges?
  - The power of words


**Workshop Outline**

1. Intellectual Disability (ID) Defined
2. Identifying ID for Special Education Eligibility Purposes
3. Special Issues
4. The ID Psycho-educational Report Template

**Identifying ID: Three Clinical Criteria**

1. Age of onset
   - “...manifested during the developmental period...”
2. Intellectual functioning
   - “...significantly below average general intellectual functioning...”
3. Adaptive behavior
   - “...deficits in adaptive behavior...”

Sources: Schalock et al. (2010, pp. 27-28); CFR, Title 34, §300.8 (Child with a disability), (a)(1)
Identifying ID: Clinical Criterion 1. Age of Onset

- Manifest during the developmental period.
  - Age at which the disability began.
  - Purpose is to distinguish ID from other forms of disability that may occur later in life.
    - ID typically originates close to birth.
    - Sometimes, ID may originate later.
    - Thus, ID does not necessarily have to have been diagnosed, but must have begun during the developmental period.

Source: Schalock et al. (2010, pp. 27-28)

Identifying ID: Clinical Criterion 2. Intellectual Functioning

- "...an IQ score that is approximately two standard deviations below the mean, considering the standard error of measurement for the specific assessment instruments used and the instruments' strengths and limitations."
  
  \[\text{Emphasis added}\]

- Discussion:
  - What is the IQ score that indicates the presence of ID?
  - Why is the word "approximately" used in the AAIDD definition?

Source: Schalock et al. (2010, p. 27)

Identifying ID: Clinical Criterion 2. Intellectual Functioning

- There is no "hard and fast cutoff point/score" for ID.
  - "A fixed point cutoff score for ID is not psychometrically justifiable."
  - Due to the fact that an individual's true score is a hypothetical construct.

- Question???
  - What is the "true score" on a measure of intelligence?

Source: Schalock et al. (2010, pp. 36-41)

Identifying ID: Clinical Criterion 2. Intellectual Functioning

- Issues to consider when evaluating an obtained score include:
  - "Although the statistical reliability of most scales, especially intellectual, is well established before the test is published, it is still important ... that professionals carefully consider the possible statistical error in any score, the variability of scores across different tests, and the importance of the testee's physical limitations, motivation, and cultural background."

Source: Schalock et al. (2010, p. 62)

Identifying ID: Clinical Criterion 2. Intellectual Functioning

- Issues to consider when evaluating an obtained score include:
  1. Measurement Error
  2. Test Fairness/Differences
  3. The Flynn Effect
  4. Practice Effect

Source: Schalock et al. (2010, pp. 36-41, p. 62)
Identifying ID: Clinical Criterion 2.
Intellectual Functioning

1. Measurement Error
• No IQ test is 100% reliable.
• The formula for a CI is
  \[ SE_{m} = SD\sqrt{1-r} \]

The "r" in this formula refers to the correlation coefficient.

1. Measurement Error
• No IQ test is 100% reliable.
• SE_{m} is obtained by multiplying the standard deviation (SD) of the test by the square root of 1 minus the reliability coefficient of the test.

For example, the WISC-IV (2003) has a SD of 15 and an internal consistency reliability coefficient of .97, then...

\[ SE_{m} = 15\sqrt{1-.97} = 15\sqrt{0.03} = 15(0.17) = 2.6 \] (round up to 3)

SE_{m} is used to develop confidence intervals (CI).

Distribution of Obtained Scores

Confidence Intervals (SE_{m}=3)

• 68% of error scores = \[ z \pm SE_{m} \]
  \[ 1.645(3) = 3 \]
  \[ 1.65(3) = 4.95 \] (or 5)

• 99% of error scores = \[ z \pm SE_{m} \]
  \[ 1.96(3) = 5.88 \] (or 6)

2. Test Fairness
• Requirements for a verbal response from individuals who have severely limited verbal abilities.
• Testing individuals of diverse ethnicity or culture.
3. The Flynn Effect
• IQ scores have been increasing from one generation to the next by about 0.33 point per year.
• Consequently, Flynn has suggested that obtained IQ scores be adjusted 0.33 points for each year the test was administered after standardization.

Sources: Lukens & Hurrell (1996); Schalock et al. (2010, pp. 36, 38)
Identifying ID: Clinical Criterion 2.

Intellectual Functioning

3. The Flynn Effect
- Initial student IQ 55-85
  - Retested on same WISC version = ↑1 IQ pt.
  - Retested on a newer WISC version = ↓5.6 IQ pts.
- Initial student IQ borderline
  - More than 1/3 of reclassified at ID upon retesting with a newer version of the WISC

Source: Kanaya et al. (2003, p. 787)

4. Practice Effect
- If a given test is re-administered within a short time interval there is an artificial increase in IQ scores.
  - Thus, established clinical practice is to avoid giving the same IQ test within the same year.

Source: Schulock et al. (2010, p. 41)

Identifying ID: Clinical Criterion 3.

Adaptive Behavior
- Adaptive behavior is the collection of conceptual, social and practical skills that have been learned and are performed by people in their every day lives.
  - Conceptual
    - language; reading and writing; money, number, and time concepts
  - Social
    - interpersonal, social responsibility, problem solving, rule following, naiveté.
  - Practical
    - personal care, occupational skill, travel/transportation, health care safety

Source: Schulock et al. (2010, pp. 43-44)

Identifying ID: Clinical Criterion 3.

Adaptive Behavior
- For the diagnosis of intellectual disability, significant limitations in adaptive behavior should be established... operationally defined as performance that is approximately two standard deviations below the mean.
  - Either one of the three types of adaptive behavior
  - Or an overall score
- Question???
  - Why is the word “approximately” used in the AAIDD definition?

Source: Schulock et al. (2010, p. 43)
Deficits in adaptive functioning ... refer to the extent to which an individual fails to meet community standards of personal independence and social responsibility, in comparison to others for similar age and sociocultural background.

- **Conceptual (academic) domain**
  - Memory, language, reading, writing, math reasoning, acquisition of practical knowledge, problem solving, and judgment in novel situations

- **Social domain**
  - Awareness of others' thoughts, feelings, and experience; empathy; interpersonal communication skills; friendship abilities; and social judgment

- **Practical domain**
  - Learning and self-management across life settings, including personal care, job responsibilities, money management, recreation, self-management of behavior, and school and work task organization

Source: APA (2013, pp. 37-38)

Identifying ID: Clinical Criterion 3.

Adaptive Behavior

- **DSM-5 Severity “Specifiers:” Conceptual, Mild**
  - For preschool children, there may be no obvious differences. For school-age children and adults, there are difficulties in learning academic skills involving reading, writing arithmetic, time or money, with support needed in one or more areas to meet age-related expectations. In adults, abstract thinking, executive function (i.e., planning, strategizing, priority setting, and cognitive flexibility), and short-term memory, as well as functional use of academic skills (e.g., reading, money management), are impaired. There is a somewhat concrete approach to problems and solutions compared with age-mates.

Source: APA (2013, pp. 34-36)

Identifying ID: Clinical Criterion 3.

Adaptive Behavior

- **DSM-5 Severity “Specifiers:” Conceptual, Moderate**
  - All through development, the individual’s conceptual skills lag markedly behind those of peers. For preschoolers, language and pre-academic skills develop slowly. For school-age children, progress in reading, writing, mathematics, and understanding of time and money occurs slowly across the school years and is markedly limited compared with that of peers. For adults, academic skill development is typically at an elementary level, and support is required for all use of academic skills in work and personal life. Ongoing assistance on a daily basis is needed to complete conceptual tasks of day-to-day life, and others may take over these responsibilities fully for the individual.

Source: APA (2013, pp. 34-36)

Identifying ID: Clinical Criterion 3.

Adaptive Behavior

- **DSM-5 Severity “Specifiers:” Conceptual, Severe**
  - Attainment of conceptual skills is limited. The individual generally has little understanding of written language or of concepts involving numbers, quantity, time, and money. Caretakers provide extensive supports for problem solving throughout life.

Source: APA (2013, pp. 34-36)

Identifying ID: Clinical Criterion 3.

Adaptive Behavior

- **DSM-5 Severity “Specifiers:” Conceptual, Profound**
  - Conceptual skills generally involve the physical world rather than symbolic processes. The individual may use objects in goal-directed fashion for self-care, work, and recreation. Certain visuospatial skills, such as matching and sorting based on physical characteristics, may be acquired. However, co-occurring motor and sensory impairments may prevent functional use of objects.

Source: APA (2013, pp. 34-36)

Identifying ID: Clinical Criterion 3.

Adaptive Behavior

- **DSM-5 Severity “Specifiers:” Social, Mild**
  - Compared with typically developing age-mates, the individual is immature in social interactions. For example, there may be difficulty in accurately perceiving peers' social cues. Communication, conversation, and language are more concrete or immature than expected for age. There may be difficulties regulating emotion and behavior in age-appropriate fashion; these difficulties are noticed by peers in social situations. There is limited understanding of risk in social situations; social judgment is immature for age, and the person is at risk of being manipulated by others (gullibility).

Source: APA (2013, pp. 34-36)
Identifying ID: Clinical Criterion 3. Adaptive Behavior

- DSM-5 Severity “Specifier:” Social, Moderate
  - The individual shows marked differences from peers in social and communicative behavior across development. Spoken language is typically a primary tool for social communication but is much less complex than that of peers. Capacity for relationships is evident in ties to family and friends, and the individual may have successful friendships across life and sometimes romantic relations in adulthood. However, individuals may not perceive or interpret social cues accurately. Social judgment and decision-making abilities are limited, and caretakers must assist the person with life decisions. Friendships with typically developing peers are often affected by communication or social limitations. Significant social and communicative support is needed in work settings for success.

Specifiers: Social, Moderate, Practical, Moderate

Source: APA(2013, pp. 34-36)

Identifying ID: Clinical Criterion 3. Adaptive Behavior

- DSM-5 Severity “Specifier:” Social, Severe
  - Social language is quite limited in terms of vocabulary and grammar. Speech may be single words or phrases and may be supplemented through augmentative means. Speech and communication are focused on the here and now within everyday events. Language is used for social communication more than for explanation. Individuals understand simple speech and gestural communication. Relationships with family members and familiar others are a source of pleasure and help.

Specifiers: Social, Severe, Practical, Severe

Source: APA(2013, pp. 34-36)

Identifying ID: Clinical Criterion 3. Adaptive Behavior

- DSM-5 Severity “Specifier:” Practical, Mild
  - The individual may function age-appropriately in personal care. Individuals need some support with complex daily living tasks in comparison to peers. In adulthood, supports typically involve grocery shopping, transportation, home and child-care organization, nutritious food preparation, and banking and money management. Recreational skills resemble those of age-mates, although judgment related to well-being and organization around recreation required support. In adulthood, competitive employment is often seen in jobs that do not emphasize conceptual skills. Individuals generally need support to make health care decisions and legal decisions, and to learn to perform a skilled vocation competently. Support is typically needed to raise a family.

Specifiers: Practical, Mild, Social, Moderate

Source: APA(2013, pp. 34-36)

Identifying ID: Clinical Criterion 3. Adaptive Behavior

- DSM-5 Severity “Specifier:” Practical, Severe
  - The individual requires support for all activities of daily living, including meals, dressing, bathing, and elimination. The individual requires supervision at all times. The individual cannot make responsible decisions regarding well-being of self or others. In adulthood, participation in tasks at home, recreation, and work requires ongoing support and assistance. Skill acquisition in all domains involves long-term teaching and ongoing support. Maladaptive behavior, including self-injury is present in a significant minority.

Specifiers: Practical, Severe, Social, Severe

Source: APA(2013, pp. 34-36)
Identifying ID: Clinical Criterion 3.
Adaptive Behavior

- DSM-5 Severity "Specifier": Practical, Profound
  - The individual is dependent on others for all aspects of daily physical care, health, and safety, although he or she may be able to participate in some of these activities as well. Individuals without severe physical impairments may assist with some daily work tasks at home, like carrying dishes to the table. Simple actions with objects may be the basis of participation in some vocational activities with high levels of ongoing support. Recreational activities may involve, for example, enjoyment in listening to music, watching movies, going out for walks, or participating in water activities, all with the support of others. Co-occurring physical and sensory impairments are frequent barriers to participation (beyond watching) in home, recreational, and vocational activities. Maladaptive behavior is present in a significant minority.

Source: APA (2013, pp. 34-36)

Identifying ID: Clinical Criterion 3.
Adaptive Behavior

- How is Adaptive Behavior Assessed?
  - Requires both
    - Clinical assessment
    - Adaptive behavior scales
  - Must use "Individualized, culturally appropriate psychometrically sound measures"
  - When identifying ID, deficits must be noted in
    - One of the three types of adaptive behavior
    - Or an overall score
    - Must be directly related to ID

Source: APA (2013, pp. 34-36)

Identifying ID: Clinical Criterion 3.
Adaptive Behavior

- How are Adaptive Behavior Scales Developed?
  - Hypothetically, any psychological test variable measured enough times (given a large enough sample of individuals) will be normally distributed.
  - In other words, the obtained scores will be normally distributed.
    - What does it mean to say that adaptive behavior measure scores are "normally distributed?"
    - Answer is on the next slide

Source: APA (2013, pp. 34-36); Sattler & Hoge (2006)

Identifying ID: Clinical Criterion 3.
Adaptive Behavior

- How are Adaptive Behavior Scales Developed?
  - Mean, Median, and Mode are the same.
  - 50% of scores are above the mean
  - 50% of scores are below the mean
  - ± 1 SD = 68% (most) of the obtained scores
  - ± 2 SD = 95% (almost all) of the obtained scores
  - ± 3 SD = 99.7% (virtually all) of the obtained scores

Source: APA (2013, pp. 34-36); Sattler & Hoge (2006)
Identifying ID: Clinical Criterion 3. Adaptive Behavior

How are adaptive behavior scales developed?

- With a large enough sample size the scores of a psychological test should be normally distributed. We can use the test to tell us how far above or below the mean and individual student is (in terms of standard deviations) on the variable (e.g., adaptive behavior) measured by the assessment tool.

Source: Sparrow et al. (2008)

Identifying ID: Clinical Criterion 3. Adaptive Behavior

How are Adaptive Behavior Scales Developed?

Source: Sparrow (2008, p. 89)

Identifying ID: Clinical Criterion 3. Adaptive Behavior

- To whom does the Vineland II compare evaluation subjects?
  - A nationally representative sample of individuals from birth to 90 years.
  - From a pool of over 25,000
  - Survey Interview Form & Parent/Caregiver Rating Form: n = 3,605 (20 age groups, birth – 90 years)
  - Expanded Interview Form: n = 2,151 (20 age groups)
  - From a pool of over 19,000
  - Teacher Rating Form: n = 2,570 (15 age groups, 3-18 years)
  - Evenly split between males and female
  - Designed to match 2001 U.S. Census regarding race/ethnicity, SES, Geographic region, community size, special education placement
  - Clinical samples: ADHD, ASD, ED/BD, Hearing impaired, LD ID (mild, moderate, or severe/profound) and visual impaired

Source: Sparrow et al. (2008)

Identifying ID: Clinical Criterion 3. Adaptive Behavior

- Use standardized measures
  - Common rating scales for use with parents and teachers
    - Adaptive Behavior Scale-School (2nd ed.)
    - Adaptive Behavior Evaluations Scale-Rev. 2nd ed.
    - Scales of Independent Behavior-Rev.
    - Adaptive Behavior Assessment System (2nd ed.)
    - Vineland Adaptive Behavior Scales (2nd ed.)
  - Focus on typical performance
  - Use knowledgeable respondents

Sources: Harrison & Raineri (2008); Schalock et al. (2010, p. 47)

Identifying ID: Clinical Criterion 3. Adaptive Behavior

- Strengths of Rating Scales
  - Focus on behaviors in natural settings
  - Obtain information from multiple respondents
  - Provide a developmental reference for adaptive skills
  - Can be used to develop goals and objectives

Source: Harrison & Raineri (2008)
Limitations of Rating Scales
- Dependent on the rater’s perceptions
- May reflect rater’s expectations/standards
- May be influenced by student’s characteristics
- Reflect a sample of behaviors

Best Practices
- Select rating scales carefully
- Should have current norms and be developed on a representative sample of the general population.
- Make sure scales used are technically adequate
- Reliable, valid, generalizable, developed with the identification of ID in mind
- Appropriate for the specific student
- Represented in the normative sample
- Account for physical conditions
- The evaluation of individuals with vision, hearing, and motor impairments is complex

Best Practices (continued)
- Consider other factors that influence scores
- Opportunities
- Relevant context/environments
- Sociocultural considerations

Handout 1: AAIDD guidelines for selecting adaptive behavior scales

Adaptive Behavior Profile & Genetic Syndromes
- Prader-Willi was found to have the highest adaptive profile, with marked decreases in motor abilities.
- The adaptive profiles of Fragile-X and Williams had very similar levels and trends, except for lower communication skills in Williams.
- Down syndrome showed a flat profile, with limited differences between the areas.
- Angelman syndrome showed the lowest profile, with strong deficits in socialization and motor skills.

"...adversely affects a child’s educational performance."
Identifying ID: Concluding Comments

• "A ... common misuse of classification concerns misleading assumptions regarding precision of scores. Examples include an IQ of 75 versus a score of 69 leading to qualitatively different eligibility decisions or determining eligibility or diagnosis on the basis of a single score or assessment.”

Source: Schalock et al. (2010, pp. 81-82)

Clinical Judgment Strategies

1. Clarify/state the 3 reasons (diagnosis, classification, program planning) for the school psychologist’s evaluation.
2. Conduct a thorough review of the student’s history.
   • Social, medical, & educational
3. Make use of broad-based assessments.
4. Synthesize the obtained data
   • Keep in mind “Rules” #3 & #4

Source: Schalock et al. (2010, p. 90)

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2. Identifying ID for Special Education Eligibility Purposes
3. Special Issues
4. The ID Psycho-educational Report Template

Special Issues: Etiology

• "Etiology represents a multifactorial construct composed of four categories of risk factors (biomedical, social, behavioral, and educational) that interact across time and affect the individual’s functioning.”

Source: Schalock et al. (2010, pp. 57-72)

Reasons for identifying include:
• May be associated with other health-related problems.
• May be treatable.
• Associated with specific behavioral phenotypes.
• Families can be referred to others with the same etiology for information and support.
• Facilitates long term planning.

Source: Schalock et al. (2010, pp. 57-72)

Risk factors for ID:
• Biomedical
• Social
• Behavioral
• Educational

• See Handout 2.
• See also Handout 3 for behaviors associated with selected genetic disorders.

Source: Schalock et al. (2010, pp. 57-72)
Special Issues: Mental Health

- **Prevalence**
  - Among children/adolescents comorbidity of ID with a mental disorder is between 30 to 50%.
  - While children ages 6/7 yrs. with ID and borderline IQ “account for 15% of the total child population, they account for up to 40% of the total child psychiatric morbidity within their age group.”
  - Controlling for socio-economic disadvantage significantly reduced, but did not eliminate this increased prevalence.

Sources: Einfeld et al. (2011); Emerson et al. (2010, p. 584); Fletcher et al. (2007)

Special Issues: Mental Health

- **Assessment**
  - *Diagnostic Manual – Intellectual Disability (DM-ID)*

Special Issues: ADHD

A.(1) **Inattentive Type**
  - When assessing developmentally inappropriate inattention, compare the student to age and intellectual peers.
  - (b) Student may gaze into space, need 1:1 aide, or require constant verbal prompts to stay on task.

Source: Fletcher et al. (2007, pp. 127-131)

A.(2) **Hyperactive/Impulsive Type**
  - When assessing developmentally inappropriate hyperactivity, compare the student to age and developmental peers (rather than with younger typical children of comparable developmental level).

Source: Fletcher et al. (2007, pp. 127-131)
Special Issues: ADHD

B. If an early developmental Hx is not available, the age requirement may be dropped.

D. There must be clear evidence of clinically significant impairment in social or academic functioning that is related to inattention, hyperactivity, or impulsivity and not just the ID.

Source: Fletcher et al. (2007, pp. 127-131)

Special Issues: ADHD

• Conners Parent Rating Scales-R Cut-off Scores
  - CPRS-R may distinguish between student with ID who are ADHD from those who are not.
  - CTRS does not do so
  - Not applicable to students with severe and profound ID.

<table>
<thead>
<tr>
<th>Age</th>
<th>Cut-off</th>
<th>Sensitivity</th>
<th>Specificity</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-9 yrs.</td>
<td>50</td>
<td>.95</td>
<td>.84</td>
</tr>
<tr>
<td>10-17 yrs.</td>
<td>43</td>
<td>.88</td>
<td>.67</td>
</tr>
</tbody>
</table>

Source: Deb, Dhaliwal, & Roy (2010)

Special Issues: PTSD

A.(1): Stressor
  - Within the special needs population, by age 18, 42.5% of girls & 28% of boys have been sexually assaulted.
  - The range of potential “extreme traumatic stressors” is greater for students with ID.
    - For example may include residential placement, or developmental crises.

Source: Fletcher et al. (2007, pp. 365-378); Surfas (2012)

Special Issues: PTSD

A.(2): Response
  - Response to stressor more likely to be expressed as disorganized or agitated behavior (as DSM-IV-TR suggests is common among children).

Source: Fletcher et al. (2007, pp. 365-378)

Special Issues: PTSD

B. Re-experiencing Symptoms
  (1) Among students with severe to profound ID symptoms may include behavioral acting out.
    - Self-injury may be a symptom
  (2) Distressing dreams may not have recognizable content.
  (3) Trauma specific enactments.
    - Caution: Can be symptoms of psychosis in adults

Source: Fletcher et al. (2007, pp. 365-378)

Special Issues: PTSD

C. Avoidance/Numbing Symptoms
  (1) Assessment difficult given difficulty communicating about internal states.
  (2) Avoidance may be reported by caregivers as “noncompliance.”
    - These students may have difficulty verbalizing their desire to avoid.
  (3) Need to ensure failure to recall important aspects of the traumatic event are not due to ID.

Source: Fletcher et al. (2007, pp. 365-378)
Special Issues: PTSD

C. Avoidance/Numbing Symptoms
(4) Diminished interest/participation may be reported by caregivers as “noncompliance.”
- These students may have difficulty verbalizing their feelings.
(5) Feelings of “detachment or estrangement” may be viewed by caregivers as self-isolation.

Source: Fletcher et al. (2007, pp. 365-378)

Special Issues: PTSD

C. Avoidance/Numbing Symptoms
(7) Need to account for the fact that many students with ID do not have normative expectations for their future.
- They may not have the ability to project themselves into their future.
- They may not have the expectations of age peers due to their ID (and not to trauma exposure).
- Limited utility with severe/profound ID.

Source: Fletcher et al. (2007, pp. 365-378)

Special Issues: PTSD

D. Increased Arousal Symptoms
- No adaptation.

E. Documenting symptom duration can be challenging as functional impairments can also be associated with the ID (and not just trauma)
F. Documenting “significant distress” and or “impairment” can be challenging as these may appear solely related to the ID.

Source: Fletcher et al. (2007, pp. 365-378)

Special Issues: Mental Health

• Treatment Options
  ▪ Psychological Interventions
    - The opportunity to explore problems and find practical solutions.
    - May involve the use of charts, pictures, photos, drawings and diaries to help describe feelings and worries
  ▪ Behavioral Interventions
    - To improve the skills and environment of the person
  ▪ Skills Training
    - Social skills, anger management, relaxation and/or assertiveness training
  ▪ Medication
    - With close medical supervision to monitor possible side-effects.

Source: Taylor et al. (2008)

Special Issues: Mental Health

• Treatment Options
  ▪ Cognitive-Behavioral Therapy
    - Exclusion of people in the mild-borderline ranges of intellectual functioning from CBT is probably not warranted.
    - Emerging evidence suggests the majority of people with mild ID have the ability to engage in/benefit from CBT.
    - Clients with mild ID have the skills necessary for CBT’s cognitive component.
    - e.g., emotional labeling/recognition and, to a lesser extent, understanding of the mediating role of cognitions.
    - These skills appear to decline as verbal ability (receptive vocabulary) decreases.

Source: Taylor et al. (2008)
Special Issues: Mental Health

- Recommendations


Special Issues: Pain

- Assessment strategies
  - Checklist Pain Behavior (25 item)
    - Pain Behaviour Checklist (10 item)
    - Non-communicating Children’s Pain Checklist
      - [http://pediatric-pain.ca/files/02/79/NCCPCPV_200901.pdf](http://pediatric-pain.ca/files/02/79/NCCPCPV_200901.pdf)
      - Paediatric Pain Profile

Workshop Outline

1. Intellectual Disability (ID) Defined
2. Identifying ID for Special Education Eligibility Purposes
3. Special Issues
4. The ID Psycho-educational Report Template

Report Template

- See Handout 4.
- Review and discuss the template.
- Make specific edits.
  - Do you have better/alternative parent/user friendly language?
  - Offer general suggestions.
    - Are there any missing elements?
- Offer any general observations about the process/product of the psychoeducational evaluation of the student with an intellectual disability.

References

References


References


References


References


Handout 1: AAIDD’s (Schalock et al., p. 54) Guidelines for Selecting an Adaptive Behavior Assessment Instrument

- Select an instrument that is a comprehensive measure of conceptual, social, and practical adaptive behavior skills and is applicable to the population in questions. In that regard, one should (a) read the User’s Manual; (b) review all components of the instrument; (c) consult with colleagues who may have familiarity with the instrument; and (d) search the literature for research on its usage, particularly as related to validation of its use for the particular setting, population, and purpose in question.

- For the purpose of making or ruling out a diagnosis of ID< the instrument must be normed on the general population, including individuals with and without disabilities. The selected instrument’s norms should be current.

- Determine, based on the publisher’s specifications and state and professional regulations, who is properly trained to administer the instrument (e.g., instruments that require direction interaction with the client require greater expertise than rating scales completed by others, such as teachers or parents).

- Determine that the assessment instrument has acceptable reliability and established validity for its intended purpose. In this regard, one should read review of the instrument in manuals such as the Mental Measurements Yearbook or Test Critiques.

- Determine whether scoring software has been “error-trapped” to prevent the entering of impossible answers or to control for circumstances such as missing data that may yield errors.
# Handout 2: Risk Factors for Intellectual Disability

<table>
<thead>
<tr>
<th>Timing</th>
<th>Biomedical</th>
<th>Social</th>
<th>Behavioral</th>
<th>Educational</th>
</tr>
</thead>
</table>
| Prenatal | 1. Chromosomal disorders  
2. Single-gene disorders  
3. Syndromes  
4. Metabolic disorders  
5. Cerebral dysgenesis  
6. Maternal illness  
7. Parental age | 1. Poverty  
2. Maternal malnutrition  
3. Domestic violence  
4. Lack of access to prenatal care | 1. Prenatal drug use  
2. Parental alcohol use  
3. Parental smoking  
4. Parental immaturity | 1. Parental cognitive disability without supports  
2. Lack of preparation for parenthood |
| Perinatal | 1. Prematurity  
2. Birth injury  
3. Neonatal disorders | 1. Lack of access to prenatal care | 1. Parental rejection of caretaking  
2. Parental abandonment of child | 1. Lack of medical referral for intervention services at discharge |
| Postnatal | 1. Traumatic brain injury  
2. Malnutrition  
3. Meingoencephalitis  
4. Seizure disorders  
5. Degenerative disorders | 1. Impaired child-caregiver interaction  
2. Lack of adequate stimulation  
3. Family poverty  
4. Chronic illness in family  
5. Institutionalization | 1. Child abuse and neglect  
2. Domestic violence  
3. Inadequate safety measures  
4. Social deprivation  
5. Difficult child behaviors | 1. Impaired parenting  
2. Delayed diagnosis  
3. Inadequate early intervention services  
4. Inadequate special education services  
5. Inadequate family support |

# Handout 3: Behaviors Associated with Selected Genetic Disorders

<table>
<thead>
<tr>
<th>Syndrome</th>
<th>Behavioral manifestations that are often present</th>
</tr>
</thead>
</table>
| Down           | Better performance on visuospatial tasks than on verbal/auditory task  
Adaptive behavior strength relative to intelligence  
Pleasant sociable personality  
Depression common in adulthood                                                                                                                                 |
| Williams       | Strength in language, auditory memory, and facial recognition  
Limitations in visuospatial functioning, perceptual-motor planning, and fine motor skills  
Strength in theory of mind (interpersonal intelligence)  
Friendliness with impaired social intelligence  
Anxiety disorders common at all ages                                                                                                                                 |
| Fragile X      | Verbal skills better than visuospatial skills  
Relative strengths in daily living and self-care skills  
Frequent association with inattention, hyperactivity, and autistic-like behaviors                                                                                                                                 |
| Prader-Willi   | Impaired satiety, food-seeking behavior, and obesity  
Strength in visual processing and solving jigsaw puzzles  
Obsessive-compulsive disorders and impulse control disorders common at all ages  
Occasional psychosis in adults                                                                                                                                 |
| Velocardiofacial | Verbal skills better than nonverbal skills  
Inattention and hyperactivity common in children  
Schizophrenia and mood disorders more common in older adolescents and adults                                                                                                                                 |
| Rubinstein-Taybi | Inattention and impulsivity common in children  
Friendliness and interest in music  
Occasional association with mood disorders, tics, and obsessive-compulsive disorders                                                                                                                                 |
| Smith-Magenis  | Delayed speech acquisition  
Relative weakness in sequential processing  
Sleep disorders common  
Frequent stereotyped and self-injurious behaviors  
Impulse control disorders common in children                                                                                                                                 |
| Angelman       | Bouts of inappropriate laughter are characteristic in younger persons  
Generally happy disposition at all ages  
Hyperactivity and sleep disorders in younger persons                                                                                                                                 |

**HANDOUT 4: PSYCHOEDUCATIONAL REPORT TEMPLATE**

**PSYCHOEDUCATIONAL EVALUATION**

[DATE OF REPORT]

<table>
<thead>
<tr>
<th>NAME:</th>
<th>SCHOOL:</th>
</tr>
</thead>
<tbody>
<tr>
<td>BIRTH DATE:</td>
<td>GRADE:</td>
</tr>
<tr>
<td>ASSESSMENT DATES:</td>
<td>TRACK:</td>
</tr>
<tr>
<td>AGE:</td>
<td>TEACHER:</td>
</tr>
<tr>
<td>PRIMARY LANGUAGE:</td>
<td>EXAMINER:</td>
</tr>
</tbody>
</table>

**REASON FOR REFERRAL**

Name was referred for testing by the Student Success Team (SST). It was hoped that this evaluation would aid in the determination of his/her special education eligibility. At the time of referral specific concerns included: *(From SST data list reasons for referral)*. From this referring concern, the following suspected area(s) of disability was/were identified and is/are evaluated by this assessment: intellectual disability *(List and be sure to assess all other areas related to the suspected disability)*.

It is important to note that before initiating this evaluation the effects of environmental, cultural, and economic disadvantage on this students’ learning were considered. From the available data it was concluded *(Report conclusions regarding the effect of these variables on learning and, if necessary, justify the decision to proceed with a special education evaluation)*.

**PSYCHOEDUCATIONAL PROCEDURES** 1, 2, 3, 4

1 Because Name's primary language is *(Primary language)*, the assessment team requested that his/her language facility (in both English and *(Primary language)*) be assessed. Using the *(Language Fluency Measure)* English was found to be Name's dominant language *(Measure)* score in English was #; *(Measure)* score in *(Primary language)* was #). These data, combined with the Examiner's basic awareness of this student's cultural and ethnic background *(State how awareness was obtained.*), lead to the conclusion that it was appropriate for this Examiner to conduct this evaluation and to do so in English.

2 Before beginning this assessment the Examiner ensured that the interpreter had received adequate training to act as an interpreter *(state qualifications)*. Experiences within the testing sessions lead the Examiner to conclude that use of this interpreter facilitated attainment of valid test scores.

3 All psycho-educational procedures were selected and administered so as not to be racially, culturally, or sexually discriminatory, and have been validated for the specific purposes for which they were used.

4 This assessment was completed in accordance with a judgment by Federal District Court Judge Robert Peckham *(in response to C-71-2270 RFP, Larry P. vs. Riles)*, which bars the administration of certain tests to this student.
The following procedures were used to obtain a valid estimate of Name's psycho-educational functioning:

[List traditional assessment procedures]

[If there are concerns regarding the validity of tests due to relevant student characteristic (e.g., English language facility, severe physical disabilities, limited vision and/or hearing, limited opportunities), then use the following qualifying validity statement and then specify alternative assessment procedures.] In analyzing these results it needs to be kept in mind that the norm-referenced tests listed above were standardized on (Describe the relevant/important characteristics of the standardization sample that differentiated it from the student, e.g., monolingual English-speaking children). Thus, for the purposes of special education eligibility, the obtained scores are psychometrically invalid. Children with Name's characteristics (i.e., List relevant/important student characteristics that were not included in test standardization samples) were not included in the test's standardization sample. Consequently, the obtained test scores reported below do not necessarily indicate the presence of learning challenges. While the obtained scores may not accurately measure construct the tests purport to measure (for Name), they nevertheless do give information regarding Name's present levels of functioning relative to the standardization sample (and as such can facilitate understanding of Name’s performance in the general education environment). These scores can, for example, be used for baseline and follow-up measures. Regardless of test validity, it is important to acknowledge that test scores alone should never be used to justify placing any student into special education. Alternative assessment procedures used during this assessment included the following:

[List alternative assessment procedures]

BACKGROUND INFORMATION

Data obtained from Name’s cumulative folder indicates (Discuss school functioning. Report the student's current academic achievement levels, grade-level changes/retentions, discipline records, work habits, prior special program placements, prior referrals, number of schools attended, attendance record, and learning strengths and weaknesses.)

Program Modifications

Educational interventions already attempted to meet Name's educational needs within a less restrictive environment have included: (e.g., specialist consultations, support services, minimum day, independent study, home teaching, suspension, alternate instructional methods, parent conferences/communication). At this time, these modifications have/have not allowed Name to be successful in the general education program.

Social/Emotional interventions attempted have included: [As indicated list interventions (e.g., counseling) and their duration. Describe the outcome of these interventions].

Specific behavior interventions attempted have included: (As indicated list behavioral interventions and their duration. Describe the outcome of these interventions).

Developmental and Health History

Pregnancy and birth history. During the parent interview Name's mother/father/step-mother/step-father (Parent's Name) indicated that Name's prenatal biomedical risk factors for intellectual disability included (List documented chromosomal disorders, single-gene disorders,
syndromes, metabolic disorders, cerebral dysgenesis, maternal illness, parental age). Other prenatal risk factors reported were (As indicated specify student exposure to poverty; maternal malnutrition; domestic violence; lack of prenatal care; parental drug use, alcohol use, smoking, immaturity).

Name was born at term/premature at (Number of weeks gestation) weeks gestation. Labor lasted (Length of labor) hours. Birth weight was (Birth weight). Problems reported to have occurred during the delivery included (Problems during delivery. In particular note anoxia during birth.). Birth weight was (Birth Weight). One and five minute Apgar scores were (1 Min. Score) and (5 Min. Score) respectively.

**Major developmental milestones.** Developmental milestones are reported to have been (Report milestones to help document that onset of the intellectual disability occurred within the developmental period).

**Health history.** According to (Data source), postnatal biomedical risk factors for intellectual disability include (As indicated describe traumatic brain injury, malnutrition, meingoencephalitis, seizure disorders, degenerative disorders). Other postnatal risk factors include (As indicated specify lack of adequate stimulation, familial poverty, chronic illness in family, institutionalization, child abuse/neglect, domestic violence, inadequate safety measures, social deprivation, difficult child behaviors. NOTE: if age of onset cannot be documented during the prenatal or perinatal stages of development, and intellectual disability is suspected, one should find one or more of these postnatal risk factors to be present).

Prior to his/her diagnosis with (as indicated specify chronic or acute health problems), Name’s health history was (Describe history). Recent school screenings (Date) suggest (Vision) vision and (hearing) hearing.

**Family history.** During the parent interview it was reported that there was no history of family members with biomedically based learning or behavior difficulties. –OR– During the parent interview it was reported that there was a history of other cases of intellectual, behavioral, and/or learning disabilities within the family. Specifically, (specify the family history of intellectual disability and when ever possible report the specific biomedical risk factor, and any other learning or behavioral disability).

**Previous Assessment Findings**

Name was previously assessed on (Date or dates of previous testing) by (Examiner). Prior intelligence test suggested (List prior IQ tests, and provide overall scores, with associated confidence intervals). Prior assessment of adaptive behavior has suggested (List prior adaptive behavior scores. Include overall composite scores, as well as specific scores measuring conceptual, social, and practical behaviors). NOTE: This would be another part of the report wherein onset of the intellectual disability maybe documented as having occurred within the developmental period.

**BEHAVIORAL ASSESSMENT**

Adaptive Behavior Ratings

**Measurement validity.** Validity of the (Adaptive behavior measure used) is considered to be good/adequate/poor. (In addition to ensuring that relevant student characteristics are represented in the measure’s standardization sample, as indicated discuss how knowledgeable individual raters were about the behaviors being quantified. For example, what behaviors rated may have not been
directly observed by the respondent, or influenced a specific rater's perceptions of the student. Also, specify the extent to which the student may have had limited opportunities to engage in the behaviors being measured.)

- **Conceptual/Language Abilities.**
- **Social functioning.**
- **Practical/Daily Living Skills.**

**Social/Emotional Ratings**

**Behavioral Observations**

- **Classroom.** (Include observations of level of conceptual/language development, and social skills.)
- **Playground.** (Include observations of social skills.)
- **Home.** (Include observations of practical/daily living skills.)

**Test Taking Behavior.** (Emphasize behaviors that lead to conclusions about the idiosyncratic validity of test results for the student on the days tested. Include any observations relevant to conclusions about the student’s level of adaptive behavior.)

**INDIVIDUAL PSYCHOEDUCATIONAL TESTING**

**Validity Statement**

(Note: Depending upon the previously discussed need for alternative assessment, this validity statement may need to be modified.) The standardized tests administered were appropriate for Name and the purposes for which they are used. Name is representative of the norm group, and the tests were administered following standardized procedures. This fact, along with Name’s (describe test taking behaviors that supported testing) test taking behavior, suggests that the following test scores represent a reasonable estimate of Name’s current levels of functioning. However, as is the case with all standardized measures, obtained test scores include a degree of measurement error. Consequently, it is best to consider a score as falling within a range, which is referred to as a “confidence interval.” A confidence interval of (specify either 68% or 90% confidence interval) was used for this assessment. Throughout this report, all confidence intervals are noted in parentheses.

**Intellectual Ability**

**Academic Functioning**

**Language Functioning**

**SUMMARY AND EDUCATIONAL IMPLICATIONS**
Name is a (CA), (Grade) grade (Gender), who has been assessed to help determine his/her eligibility for special education assistance. At the time of referral specific concerns included (List reasons for referral).

Educationally relevant health and developmental findings include (Specify all biomedical risk factors and as indicated report age of onset of intellectual disability.)

Environmental, cultural, and/or economic disadvantage have (Discuss how these variables effect educational performance, test validity, and may or may not be related to a possible intellectual disability.)

Name’s second language acquisition has affected his/her learning (If appropriate discuss how language acquisition has influenced performance and may or may not be related to a possible intellectual disability.)

Intelligence test results suggest that Name’s present level of intellectual functioning is in the (provide the test’s appropriate qualitative descriptor) range. Taking into account measurement error, this result is (use the appropriate term, e.g., “not,” “approximately,” “just over,” “over,” or “well over”) two standard deviations below the mean. Prior testing data (if available discuss how prior estimates of global intelligence are, or are not, consistent with the current obtained scores.) Behavioral data consistent with this observation include (discuss behavioral observations and/or caregiver reports that are consistent with the obtained intelligence test score). These findings are consistent/inconsistent with the presence of an intellectual disability.

Evaluation of Name’s adaptive behavior suggests that Name’s global skill level is (use the appropriate qualifier, e.g., “not,” “approximately,” “just over,” “over,” or “well over”) two standard deviations below the mean. –OR– Evaluation of Name’s adaptive behavior is (use the appropriate qualifier, e.g., “approximately,” “just over,” “over,” or “well over”) two standard deviations below the mean in the following areas: (specify which of the areas is deficient: conceptual, social, practical). His/Her adaptive behavior is not two standard deviations below the mean in the following areas: (specify which of the areas is not two standard deviations below the mean: conceptual, social, practical). Behavioral data consistent with this observation include (discuss naturalistic observations across settings and/or caregiver reports that are consistent with the obtained intelligence test score). These findings are consistent/inconsistent with the presence of an intellectual disability.

Qualitatively, these data suggest that Name’s intellectual disability is mild/moderate/severe/profound. This level of intellectual disability is typically associated with the need for (report the level of support typically associated with the estimated level of intellectual disability, i.e., mild = “intermittent supports provided on an as-needed basis. Name would not appear to require continuous or daily support.” Moderate = “limited supports provided over a period of time. Name would appear to require at least intermittent support.” Severe = “extensive supports on a daily basis across many different settings.” Profound = “pervasive supports provided continuously in all settings.”)

For instructional planning purposes it is important to note that Name’s learning strengths would appear to include (List assets to be used in recommendations). Learning weakness include (discuss challenges to be addressed in recommendations).
**Name**’s academic functioning would appear to be affecting his/her social functioning in the following ways: (Describe this relationship and as indicated make appropriate social/emotional recommendations).

From the current battery of tests the following recommendations are made:

1. From this assessment it would appear that **Name** meets eligibility criteria as an individual with exceptional needs, and that these needs cannot be corrected without special education assistance. Specifically, **Name** has significantly below average general intellectual functioning existing concurrently with deficits in adaptive behavior. These deficits were manifested during the developmental period and adversely affect a his/her educational performance.

1. **Name** does not appear to meet eligibility criteria as an individual with an intellectual disability [according to the California Code of Regulations - Title 5, Division 1, Chapter 3, Handicapped Children, Article 3.1, Section 3030 (h)]. This conclusion is based upon the following assessment finding(s):

   (a) **Name** was not found to have significantly below average general intellectual functioning.

   (b) **Name** was not found to have significantly below average adaptive behavior in one or more of the areas that define this construct.

   (c) The effect of the documented disability would not appear to limit **Name**’s ability to benefit from general education program instruction.

   (d) **Name**’s learning difficulties appear to be primarily due to environmental disadvantage.

   (e) **Name**’s learning difficulties appear to be primarily due to cultural disadvantage.

   (f) **Name**’s learning difficulties appear to be primarily due to economic disadvantage.

   (g) **Name**’s learning difficulties appear to be primarily due to a lack of English proficiency.

   (h) The available date suggests that a lack of instruction in (reading and/or math) plays a primary role in **Name**’s learning difficulties.

2. Additional areas of suspected disability not addressed in by the current assessment include the following: From this observation the following additional assessments are recommended: (List additional assessments that are judged required to address all areas of suspected disability, e.g., physical therapy, occupational therapy, recreational therapy, psychotherapy, etc. NOTE: the IEP meeting should not be held until these areas are assessed).

3. From **Name**’s learning strengths, the following specific interventions are recommended to address **Name**’s anticipated learning needs:
4. Additional recommendations for the development of Name’s individualized educational program include:
   a) 
   b) 
   c) 

5. 

6. 

The final decision as to whether or not Name meets special education eligibility will be made by the individualized education program (IEP) team, including assessment personnel, and will take into account all relevant material available on Name. No single score or product of scores, test, or procedure should be used as the sole criterion for the decision of the IEP team as to his/her eligibility for special education, the development of goals and objectives, or the least restrictive special education placement.

______________________________
Stephen E. Brock, Ph.D., NCSP
Licensed Educational Psychologist
5 CCR 3030 - Eligibility Criteria

A pupil shall qualify as an individual with exceptional needs, pursuant to Section 56026 of the Education Code, if the results of the assessment as required by Section 56320 demonstrate that the degree of the pupil's impairment as described in Section 3030 (a through j) requires special education in one or more of the program options authorized by Section 56361 of the Education Code. The decision as to whether or not the assessment results demonstrate that the degree of the pupil's impairment requires special education shall be made by the individualized education program team, including assessment personnel in accordance with Section 56341(d) of the Education Code. The individualized education program team shall take into account all the relevant material that is available on the pupil. No single score or product of scores shall be used as the sole criterion for the decision of the individualized education program team as to the pupil's eligibility for special education. The specific processes and procedures for implementation of these criteria shall be developed by each special education local plan area and be included in the local plan pursuant to Section 56220(a) of the Education Code.

a. A pupil has significantly below average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period, which adversely affect a pupil's educational performance.