Fremantle Peel Student Services
Students With An Intellectual Disability
Brief Strategic Plan

Introductory Comments:
This plan seeks to place the support for students with an intellectual disability within the context of the Department's *Students at Educational Risk* policy. Thus:

- Any students with an intellectual disability that are not achieving the academic and social standards expected of them are considered to be at educational risk.
- Assessment to determine if a student can be considered to have an intellectual disability is only one strategy amongst a number employed to support schools to help such students achieve at their expected level.

Our Vision:
Schools provide for all students with an intellectual disability within the framework and spirit of the Department's *Students at Educational Risk* documents.

Our Outcomes:

1. Schools are supported to ensure that their students identified as having an intellectual disability achieve the academic and social standards expected of them at key stages of schooling. (Adapted from the "Overall Objective", *WA Plan for Government Schools 2004 – 2007* p 9)
2. At each stage of schooling, students with an intellectual disability will participate in engaging learning programs that are tailored to their individual needs, aspirations and interests. (Adapted from the "Strategies for achieving Key Objective 1" *Ibid.* p 14)

Our Key Strategies:

1. Schools are supported to correctly identify that subset of their students at educational risk who have an intellectual disability.
2. Schools and parents are provided with accurate information that will enable an informed, collaborative decision to be made about use of available resources to help students identified as having an intellectual disability participate in appropriate learning programs.

Our Key Targets:

1. 100 % of students who meet the eligibility requirements to be considered as having an intellectual disability are identified by the end of their second primary school year.
2. No ineligible student is classified as having an intellectual disability.
3. 100 % of students identified as having an intellectual disability are appropriately resourced and placed taking into account parental and school wishes, the educational needs of the student and Departmental guidelines.
4. 100 % of students submitted for consideration for Supported Education will be deemed eligible by the Supported Education Committee on the basis of the initial information supplied.

Other Disorders of Infancy, Childhood, or Adolescence. This grouping is for disorders that are not covered in the sections listed above. **Separation Anxiety Disorder** is characterized by developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the child is attached. **Selective Mutism** is characterized by a consistent failure to speak in specific social situations despite speaking in other situations. **Reactive Attachment Disorder of Infancy or Early Childhood** is characterized by markedly disturbed and developmentally inappropriate social relatedness that occurs in most contexts and is associated with grossly pathogenic care. **Stereotypic Movement Disorder** is characterized by repetitive, seemingly driven, and nonfunctional motor behavior that markedly interferes with normal activities and at times may result in bodily injury. **Disorder of Infancy, Childhood, or Adolescence Not Otherwise Specified** is a residual category for coding disorders with onset in infancy, childhood, or adolescence that do not meet criteria for any specific disorder in the Classification.

Children or adolescents may present with problems requiring clinical attention that are not defined as mental disorders (e.g., Relational Problems, Problems Related to Abuse or Neglect, Bereavement, Borderline Intellectual Functioning, Academic Problem, Child or Adolescent Antisocial Behavior, Identity Problem). These are listed at the end of the manual in the section "Other Conditions That May Be a Focus of Clinical Attention" (see p. 675).

DSM-III-R included two anxiety disorders specific to children and adolescents, Overanxious Disorder of Childhood and Avoidant Disorder of Childhood, that have been subsumed under Generalized Anxiety Disorder and Social Phobia, respectively, because of similarities in essential features.

Mental Retardation

Diagnostic Features

The essential feature of Mental Retardation is significantly subaverage general intellectual functioning (Criterion A) that is accompanied by significant limitations in adaptive functioning in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety (Criterion B). The onset must occur before age 18 years (Criterion C). Mental Retardation has many different etiologies and may be seen as a final common pathway of various pathological processes that affect the functioning of the central nervous system.

General intellectual functioning is defined by the intelligence quotient (IQ or IQ-equivalent) obtained by assessment with one or more of the standardized, individually administered intelligence tests (e.g., Wechsler Intelligence Scales for Children—Revised, Stanford-Binet, Kaufman Assessment Battery for Children). Significantly subaverage intellectual functioning is defined as an IQ of about 70 or below (approximately 2 standard deviations below the mean). It should be noted that there is a measurement error of approximately 5 points in assessing IQ, although this may vary from instrument to instrument (e.g., a Wechsler IQ of 70 is considered to represent a range of 65–75). Thus, it is possible to diagnose Mental Retardation in individuals with

IQs between 70 and 75 who exhibit significant deficits in adaptive behavior. Conversely, Mental Retardation would not be diagnosed in an individual with an IQ lower than 70 if there are no significant deficits or impairments in adaptive functioning. The choice of testing instruments and interpretation of results should take into account factors that may limit test performance (e.g., the individual's sociocultural background, native language, and associated communicative, motor, and sensory handicaps). When there is significant scatter in the subtest scores, the profile of strengths and weaknesses, rather than the mathematically derived full-scale IQ, will more accurately reflect the person's learning abilities. When there is a marked discrepancy across verbal and performance scores, averaging to obtain a full-scale IQ score can be misleading.

Impairments in adaptive functioning, rather than a low IQ, are usually the presenting symptoms in individuals with Mental Retardation. *Adaptive functioning* refers to how effectively individuals cope with common life demands and how well they meet the standards of personal independence expected of someone in their particular age group, sociocultural background, and community setting. Adaptive functioning may be influenced by various factors, including education, motivation, personality characteristics, social and vocational opportunities, and the mental disorders and general medical conditions that may coexist with Mental Retardation. Problems in adaptation are more likely to improve with remedial efforts than is the cognitive IQ, which tends to remain a more stable attribute.

It is useful to gather evidence for deficits in adaptive functioning from one or more reliable independent sources (e.g., teacher evaluation and educational, developmental, and medical history). Several scales have also been designed to measure adaptive functioning or behavior (e.g., the Vineland Adaptive Behavior Scales and the American Association on Mental Retardation Adaptive Behavior Scale). These scales generally provide a clinical cutoff score that is a composite of performance in a number of adaptive skill domains. It should be noted that scores for certain individual domains are not included in some of these instruments and that individual domain scores may vary considerably in reliability. As in the assessment of intellectual functioning, consideration should be given to the suitability of the instrument to the person's sociocultural background, education, associated handicaps, motivation, and cooperation. For instance, the presence of significant handicaps invalidates many adaptive scale norms. In addition, behaviors that would normally be considered maladaptive (e.g., dependency, passivity) may be evidence of good adaptation in the context of a particular individual's life (e.g., in some institutional settings).

Degrees of Severity of Mental Retardation

Four degrees of severity can be specified, reflecting the level of intellectual impairment: Mild, Moderate, Severe, and Profound.

317	**Mild Mental Retardation:**	IQ level 50–55 to approximately 70
318.0	**Moderate Retardation:**	IQ level 35–40 to 50–55
318.1	**Severe Mental Retardation:**	IQ level 20–25 to 35–40
318.2	**Profound Mental Retardation:**	IQ level below 20 or 25

319 Mental Retardation, Severity Unspecified, can be used when there is a strong presumption of Mental Retardation but the person's intelligence is untestable by standard tests (e.g., with individuals too impaired or uncooperative, or with infants).

Department of
Education
and Training

STUDENT SERVICES MANAGERS AND SCHOOL PSYCHOLOGISTS

Identification of Intellectual Impairment in Western Australian Schools

The effectiveness and/or equity of our services for students requiring teaching and learning adjustments are under review. *The Review of Educational Services for Students with Disabilities in Government Schools* has provided an opportunity to examine the purpose and type of assessment needed to support teachers, schools and districts to achieve optimal learning outcomes for all students.

We are in a transition stage. The education system is moving from existing assessment practices toward a needs based assessment model. During this period of change and while the needs based model is being developed, districts and student services should apply the guidelines contained in this document. These guidelines are provided to assist district staff to clarify their understanding of the term intellectual impairment and to ensure that they operate within legislative and administrative requirements when considering educational programming.

Many students with an intellectual impairment benefit from being educated in a mainstream classroom. Decisions regarding the most appropriate educational enrolment must be based on the educational needs of the student and must demonstrate evidence of fully informed parental consent, and collaboration between parents, educators and key agencies. Not all students with an intellectual impairment will require specialised resource allocation to access the curriculum.

An intellectual impairment refers to a condition where the student's global comprehension and information processing abilities are such that his or her educational performance is substantially lower than their peers. An intellectual impairment has three key elements that must exist concurrently:

1. **The student must experience functional limitations in carrying out educational activities.**

   Supportive evidence including adaptive behaviour and academic functioning should accompany a comprehensive assessment of intellectual functioning. The assessment is the responsibility of a school psychologist in collaboration with other appropriately trained professionals. It must consider cultural and linguistic diversity as well as differences in communication, emotional and behavioural factors. Further, the existence of limitations in adaptive skills must occur within the context of community environments typical of the individual's age and peers.

2. The student is unable to access the curriculum to the same extent as other students and requires ongoing teaching and learning adjustments.

The following questions may need to be asked when considering a student for an IQ assessment:

(a) What teaching and learning adjustments are needed to assist the student to achieve agreed learning outcomes?
(b) How would such adjustments affect the learning and teaching environment and
(c) If such adjustment could be made for the student to succeed in a mainstream environment, would you still recommend a referral for a standardised assessment of intellectual functioning?

3. An intellectual impairment must be present.

A student with an intellectual impairment will demonstrate a performance level of at least two standard deviations below the mean on a standardised intelligence test, presenting concurrently with adaptive behaviours and levels of academic functioning that prevent him or her from achieving the developmentally appropriate learning outcomes of their peers.

Within the context of the Diagnostics Standards Manual - IV (DSM-IV) definition, and as described in the WISC-III, WPPSI, Stanford Binet and Leiter manuals, the Department of Education and Training clarifies the following criteria as the basis for considering a student to have an intellectual impairment:

(a) Full Scale intelligence quotient (IQ) of 69 (assuming a scale mean of 100) +/- the Standard Error of the Measurement (SEM) which will vary according to the age of the student and the standardised assessment used. A summary of the SEM is attached and details the acceptable upper limit of IQ.
(b) When a student's performance on a standardised assessment of intellectual functioning is at the upper end of the SEM range, the supportive information on adaptive behaviour (eg. Vineland Adaptive Behaviour Scales) should be included.

It is important to note that when a significant difference is obtained between the verbal/language and performance/non-verbal scores on a standardized intelligence test, the full scale or composite score should not be used to determine if a student has an intellectual impairment.

When the highest scale score is below 69 +/- SEM then the student can be considered to have an intellectual impairment.

Standard Error of Measurement (SEM) for Full Scale IQ (or equivalent) in each age group.

Major IQ Assessments

WISC-III

Age Group	SEM	Age Group	SEM
6	3.35	12	3.00
7	3.67	13	3.35
8	3.00	14	3.35
9	3.35	15	2.60
10	3.00	16	3.00
11	3.35		

WPPSI-R

Age Group	SEM	Age Group	SEM
5	3.04	6½	3.43
5½	3.28	7	3.91
6	3.27		

Stanford Binet 4th Edition

Age Group	SEM	Age Group	SEM
5	2.77	12	2.26
6	3.20	13	1.60
7	2.77	14	2.26
8	2.77	15	2.26
9	2.77	16	2.26
10	2.26	17	1.60
11	2.26		

Leiter International Performance Scale-Revised

Age Group	SEM
2-5	4.24
6-10	4.50
11-20	3.97