



Student and Community Services
Psychological Services

Developmental Disability (MR)

Psychological Assessment Checklist

A full assessment should include:

- Developmental History: cover prenatal, birth history, early development, and health history
- OSR Review: document learning, communication and social problems that interfere with classroom performance
- Observation: direct behavioural observation of the child, including unstructured social settings, such as the school yard, daycare or home
- Cognitive Assessment: evaluate cognitive ability and any other learning disorder (if the child is able to complete formal assessment measures)
- Adaptive functioning evaluation: administer a survey to parents/teachers to examine the pattern of adaptive skills

Other sources of information:

Medical Assessment: by a paediatrician, neurologist, psychiatrist, etc. to determine the need for other medical studies (e.g., genetic studies, neurological assessment, endocrine studies etc.) There may also be co-morbid neurological and psychiatric conditions.

Diagnosis of Developmental Disability (MR): The Specifics

In diagnosing Developmental Disability (Mental Retardation), behavioural observations, psychometric measures, clinical judgement and qualitative information must be considered in coming to the diagnosis.

Mental Retardation (from a definition supported by the American Association on Mental Retardation – AAMR) refers to substantial limitations in present functioning. It is characterized by significantly sub-average intellectual functioning, existing concurrently with related limitations in **two or more** of the following applicable adaptive skill areas:

Communication, self-care,
home living, social skills,
community use, self-direction,
health and safety, functional academics,
leisure, work

Mental retardation is manifested before age 18.

There are four assumptions essential to consider when applying the definition, according to the AAMR. First, a valid assessment considers cultural and linguistic diversity, as well as differences in communications and behavioral factors. Secondly, the existence of limitations in adaptive skills occurs within the context of community environments typical of the individual's age peers and is indexed to the person's individualized needs for supports. Thirdly, specific adaptive limitations often co-exist with strengths in other adaptive skills or other personal capabilities. Finally, the AAMR believes that with appropriate supports over a sustained period, the life functioning of the person with mental retardation will generally improve.

There are four ranges of mental retardation with the following IQ correlates:

	I Q Range	I Q deviation	Extent of Concurrent Adaptive Limitations
Mild	55-70	- 2 SD	2 or more domains
Moderate	35-54	- 3 SD	2 or more domains
Severe	20-34	- 4 SD	All domains
Profound	<20	- 5 SD	All domains

- Developmental History:

Be sure to obtain information (as available and appropriate) about pregnancy and the child's early development, developmental course of the symptoms, and the current

symptoms. Enquire about motor development, emotional attachments, communication and language development and self-care skills. Screen for prenatal stress, prenatal complications, degree of environmental stress, and deprivation. Probe for present and past stresses in the family that could impact on the child.

Also obtain a medical history from the parent (or medical practitioner), including allergies, gait abnormalities, infectious history and courses of treatment. Also, vision and hearing should be checked.

- Review of the OSR:

To document academic, communication, fine and gross motor, and social skills development. While gross motor development may be fair, in mild and moderate developmental disability, delays in academic, communication, self-help and social skills are evident. In severe developmental disability, motor development is poor, speech is minimal and self-help skills are poorly developed.

- Observation:

Observe the child directly, with a particular focus on unstructured social settings, such as the schoolyard, daycare or home. Systematic observation of communication, cognitive, motor, social, play, self-help and attentional skills are invaluable in documenting the child's developmental level in each of those areas of functioning.

- Cognitive Assessment

Intellectual screening is important to establish the child's cognitive functioning level. As stated above, there are four ranges of mental retardation with the following IQ correlates:

	I Q Range	I Q deviation
Mild	55-70	- 2 SD
Moderate	35-54	- 3 SD
Severe	20-34	- 4 SD
Profound	<20	- 5 SD

Some children may be difficult to engage in a formalized testing situation (due to limitations in attention, co-operation or language skills). For these children it will be difficult to establish a cognitive level using traditional intelligence tests. For these

children, the information obtained through the developmental history, observation, OSR review and the adaptive behaviour evaluation is essential in order to describe the child's functioning level and needs.

- Adaptive Behaviour Evaluation:

Use a standardized adaptive behaviour rating scale, based on reports of the parent/guardian and, where possible, the teacher or daycare provider. A characteristic profile shows delays in Daily Living, Socialization and Communication skills of 2 standard deviations or more.

	I Q Range	Extent of Concurrent Adaptive Limitations
Mild	55-70	2 or more domains
Moderate	35-54	2 or more domains
Severe	20-34	All domains
Profound	<20	All domains

Suggested Adaptive Rating Scales:

AAMR Adaptive Behaviour Scale –School (Second Edition) (ABS-S2)
Scales of Independent Behavior – Revised (SIB-R)
Vineland Adaptive Behaviour Scale (VABS)

Suggested Cognitive Measures:

- DAS
- Leiter –R
- Stanford-Binet – Fourth Edition
- UNIT
- WISC-III

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