

Documentation of an Assessment for a

Learning Disability

I. A Qualified Professional Must Conduct the Evaluation

Professionals conducting assessments and rendering diagnoses of specific learning disabilities and making recommendations for appropriate accommodations must be qualified to do so.

Comprehensive training and relevant experience with an adult LD population are essential.

Competence in working with culturally and linguistically diverse populations is also essential. It is of utmost importance that evaluators are sensitive and respectful of cultural and linguistic differences.

In Ontario the following professionals would generally be considered qualified to evaluate specific learning disabilities for university students provided that they have additional training and experience in evaluating adult learning disabilities: clinical or educational psychologists; school psychologists; neuropsychologists; psychological associates; medical doctors with training and experience in the assessment of learning problems in adults. Use of diagnostic terminology indicating a specific learning disability by someone whose training and experience are not in these fields is not acceptable. All reports should be on letterhead, typed, dated, signed, and otherwise legible.

Note: Appropriately documented, informed consent for a psychological assessment must be obtained in advance from the individual concerned by the individual who will be conducting the assessment. In addition to information regarding the assessment procedures themselves, such informed consent must include an explanation regarding: the potential release of information and/or the report to any third party; the potential distribution and storage of the assessment information and documentation, the individual's rights regarding withholding or withdrawal of consent; and the right of direct access to the qualified member of the College of Psychology who is responsible for the diagnosis.

II. Testing Must Be Current

It is generally acknowledged that once a person is diagnosed as having a Learning Disability the disability is normally viewed as life-long. Although the learning disability will continue, the effects of learning disabilities may be expressed differently over time, depending on the match between the demands of the environment and the individual's pattern of strengths and weaknesses. Thus it is necessary to provide recent and appropriate documentation. A diagnosis, based on a competent and complete assessment that was conducted after 18 years of age is generally considered conclusive.

However, because the provision of all reasonable accommodations and services is based upon the assessment of the current impact of the individual's disabilities on his or her academic performance, it is in a candidate's best interest to have a current assessment. It may be appropriate, depending on when the full assessment took place, to update or augment the assessment in order to provide this information. Durham College requests that an assessment must have been conducted within the past 3-5 years.

III. Documentation Necessary to Substantiate the Learning Disability Must be Comprehensive

Prior documentation may have been useful in determining appropriate services in the past. However, documentation must validate the need for services based on the student's current level of functioning in the educational setting. School plans such as an individualized education program (IEP) or documentation from an Identification, Placement, and Review Committee (IPRC) are insufficient by themselves, but can be included as part of a more comprehensive assessment battery. A comprehensive assessment battery and the resulting diagnostic report must include a clear diagnostic statement, and documentation of intellectual/cognitive ability, academic achievement, information processing skills, and social/emotional development.

A. Background Information

Because learning disabilities are commonly manifested during childhood, though not always formally diagnosed, relevant historical information regarding the student's academic history and learning processes in elementary, secondary, and postsecondary education, as well as relevant developmental, medical and psychosocial history, must be investigated and documented. An evaluation report should include the summary of a comprehensive diagnostic interview by a qualified evaluator. A combination of candidate self-reporting, interviews, and historical documentation, such as transcripts and standardized test scores, is recommended.

B. Assessment

The evaluation for the diagnosis of a learning disability must provide clear and specific evidence that a learning disability does or does not exist. The assessment, and any resulting diagnosis, must consist of and be based on a comprehensive assessment battery that does not rely on any one test or subtest. Objective evidence of a substantial limitation to learning must be provided.

Diagnosis of a specific LD requires that there be **a significant impairment** in some area of academic achievement relative to other students of the same age. Further, the LDAC/LDAO definition asserts that the noted **academic impairments must be caused by disorders in the underlying processing skills necessary for adequate development of academic ability**. Indeed, it is held that the achievement problems associated with LD are manifestations of an underlying impairment in a related aspect of information processing, and not the “cause” of the disability itself. As such, utilizing the criterion of a severe academic achievement deficit, in isolation, is not always the best indicator of an underlying LD.

Regrettably, many clinicians seem to confuse processing impairments as outlined in the LDAO/LDAC definition with the actual diagnosis of LD. Underlying processing impairments were identified in the definition as being essential for diagnosis, but **low scores on tests of information processing on their own do not constitute a LD**. Indeed, as research has shown, many non-disabled individuals produce subtest scores on commonly administered psychological tests that fall below the average range. In fact, in Binder, Iverson and Brooks (2009) and Iverson and Brooks (in press) most recent articles, they clearly demonstrate that the majority of the non-disabled normative sample participants in the WAIS-III/WMS-III had at least two subtest scores that fell below the 16th percentile, almost half had at least one subtest in the impaired range, and that intra-test discrepancies increase as intelligence increases. Further, they note that as the number of tests administered in a flexible battery increase, so too does the likelihood of obtaining more scores that fall below average. **Hence, having a few subtest scores on any flexible test battery that fall within the below**

average or impaired range is neither unusual nor unexpected, and is certainly not, in and of itself, diagnostic of any type of disability.

Since many individuals have low scores in some areas of cognitive processing, this in and of itself is not proof of a disability. Indeed, "an impairment only becomes disabling when it interferes substantially with an individual's ability to carry out a regular or routine task that relies on the use of skills or knowledge in that area" (LDAO supporting document, page 7). The LDAO definition makes it clear that the first necessary condition for diagnosis of a LD of any sort is that there is evidence of unexpectedly low academic achievement. Only then must one demonstrate that the academic achievement deficit is caused by impairment in one or more of the underlying processes necessary for learning or production of that skill. This was instituted because there can be many reasons for an individual performing poorly on tests of academic achievement, only one of which is a LD. Hence, having **evidence of "unexpectedly low" academic achievement is essential, and one must further demonstrate that the academic achievement deficits are caused by a processing impairment in a skill that is integral to that academic function.** Simply documenting low scores on tests of processing speed or working memory, in the absence of any academic impairment, is not sufficient to demonstrate the need for academic accommodations

Objective evidence of a **substantial limitation to learning** must be provided in the assessment report. Minimally, the domains to be addressed must include the following (The following measures are suggestions only and not exclusive):

1. Intellectual/Cognitive Ability

A complete intellectual assessment with all assessment results reported is essential. (i.e., WAIS-III, WJ III Cognitive,)

2. Academic/Achievement

A comprehensive academic achievement battery is essential, with all results reported appropriately. The battery must include current levels of academic functioning in relevant areas such as reading (decoding, comprehension), mathematics, and oral and written language. (i.e., WJ III Achievement, WIAT-II, Nelson-Denny Reading Test,)

3. Information Processing

Specific areas of information processing (eg. short- and long-term memory, processing speed, executive functioning, motor ability, etc.,) should be addressed (i.e., WMS-III, Bender motor Gestalt Test, TOAL-e, Rosner Test of Auditory skills, etc.,)

4. Social/Emotional

Measures to rule in or out coexisting neurological and/or psychiatric disorders (i.e., to establish a differential diagnosis). (PAI, MMPI,)

Other assessment measures, such as classroom performance and informal assessment procedures or observations, may be helpful in determining performance across a variety of domains. In addition to standardized tests it is also very useful to include informal observations of the student during test administration.

C. Documentation Must Include a Specific Diagnosis

Nonspecific diagnoses, such as individual "learning styles," "learning differences," "academic problems," "computer phobias," "slow reader," and "test difficulty or anxiety," in and of themselves do not constitute a learning disability. It is important to rule out alternative explanations for problems in learning, such as emotional, attentional, or motivational problems, that may be interfering with learning but do not constitute a learning disability. The diagnostician is encouraged to use direct

language in the diagnosis and documentation of a learning disability, avoiding the use of such terms as "suggests" or "is indicative of." : for example, "Student is diagnosed with a Learning Disability"; "Current assessment meets the diagnostic criteria for a Learning Disability" . **At the post secondary level, we adhere to the LDAO definition of a learning disability.**

If the data indicate that a learning disability is not present, the evaluator must state that conclusion in the report.

D. Actual Test Scores from Standardized Instruments Must be Provided

Standard scores and/or percentiles must be provided for all normed measures. **Reports of grade equivalents must be accompanied by standard scores and/or percentiles based on age-relevant norms.** The data must logically reflect a substantial limitation to learning for which the student is requesting the accommodation. **The particular profile of the student's strengths and weaknesses must be shown to relate to functional limitations that may necessitate accommodations.** The tests used should be reliable, valid, and standardized for use with an adolescent/adult population. The test findings must document both the nature and severity of the learning disability. Informal inventories, surveys, and direct observation by a qualified professional may be used in tandem with formal tests in order to further develop a clinical hypothesis.

E. Each Accommodation Must Include a Rationale

It is important to recognize that accommodation needs can change over time and are not always identified through the initial diagnostic process. Conversely, **a prior history of accommodation, without demonstration of a current need, does not in and of itself warrant the provision of a like accommodation.**

The diagnostic report must include specific recommendations for accommodations as well as a detailed explanation of **why each accommodation is recommended.** If no prior accommodations have been provided, the qualified professional and/or the candidate should include a detailed explanation of why no accommodations were used in the past and why accommodations are needed at this time.

Disability offices will make a decision on a case-by-case basis as to whether disability related barriers for the student may be encountered in the current educational program. (It is noted that if no learning disability is diagnosed, accommodations may still be provided for other diagnosed conditions – ie. generalized anxiety disorder).

IV. An Interpretative Summary Must be Provided

A well-written diagnostic summary based on a comprehensive evaluative process is a necessary component of the report. Assessment instruments and the data they provide do not diagnose; rather, they provide important elements that must be integrated by the evaluator with background information, observations of the client during the testing situation, and the current context. It is essential, therefore, that professional judgment be used in the interpretative summary. The clinical summary must include:

1. Indication that the evaluator ruled out alternative explanations for academic problems such as poor education, low effort, poor motivation and/or study skills, emotional problems, attentional problems, and cultural/language differences
2. Indication of how patterns in cognitive ability, achievement, and information processing are used to determine the presence of a learning disability

3. Indication of the substantial limitation to learning presented by the learning disability and the degree to which it affects the individual in the learning context for which accommodations being requested
4. Indication of why specific accommodations are needed and how the effects of the specific disability are mediated by the accommodation

NOTE: The final determination for reasonable accommodation(s) rests with disability office in collaboration with the individual with the disability and, when appropriate, faculty, all of whom have a responsibility to maintain confidentiality of any information.

(adapted from Queen's University <http://www.queensu.ca/hcds/documents/LDdocumentation.pdf>)

Documentation Requirements for ADHD

Diagnostic criteria

Diagnostic criteria as specified in the Diagnostic and Statistical Manual of Mental Disorders, (4th edition DSM-IV-TR [American Psychiatric Association], 2000) are used as the basic guidelines for determination of an Attention Deficit/Hyperactivity Disorder diagnosis. Students with an ADHD diagnosis must meet all the DSM-IV-TR criteria including the following:

A. Demonstrating that they exhibit a sufficient number of symptoms (listed in DSMIV-TR) of Inattention and/or Hyperactivity/Impulsivity that have been persistent and maladaptive. The exact symptoms should be specified and described in detail and it should be shown how the student meets criteria for a long-standing history of impairment in two or more major life areas.

B. Since ADHD is by definition a disorder that is first exhibited in childhood or early adolescence, the documentation must provide evidence to support a childhood onset of symptoms and associated impairment. Individualized Education Plans (IEPs), Identification Placement and Review Committee (IPRC) documents, early psycho-educational assessments, academic reports, teacher comments, documentation from tutors or learning specialists, and disciplinary records may all be useful sources of collateral information (but, in and of themselves, are not considered clinical documentation).

C. Providing objective evidence demonstrating that both past and current impairment from the symptoms is present in two or more major life settings. Since ADHD tends to affect people over time and across situations in multiple life domains, it is necessary to show that the impairment is not confined to only the academic setting or to only one circumscribed area of functioning.

D. A determination that the symptoms of ADHD are not a function of some other mental disorder (such as mood, anxiety, or personality disorders, substance abuse, low cognitive ability, poor effort etc.), medical disorder (e.g. Thyroid disorder), or situational stressors (such as relationship issues, family, or financial crisis, etc.).

In addition, the following information explains some important considerations regarding ADHD documentation:

A qualified diagnostician must conduct the evaluation.

Professionals conducting assessments and rendering diagnoses of ADHD must be qualified to do so. Comprehensive training in the differential diagnosis of ADHD and other psychiatric disorders and direct experience in diagnosis and treatment of adolescents and adults with ADHD is necessary. The name, title, and professional credentials of the evaluator, (including information about licensure or certification, areas of specialization, employment, and province in which the individual practices), should be clearly stated in the documentation. All reports should be on letterhead, typed in English, dated, signed, and otherwise legible.

Documentation must be current.

Because the provision of reasonable accommodations and services is based upon assessment of the current impact of the student's disability on the academic activity, it is necessary to provide "recent" and appropriate documentation. In most cases, this means that a diagnostic evaluation must have been completed within the past three years.

A detailed academic history must be provided.

Because developmental disabilities such as an ADHD are usually evident during early childhood (though not always diagnosed), historical information regarding the individual's academic and behavioral functioning in elementary and secondary education should be provided. Self-report alone, without any accompanying historical data that validate developmentally deviant ADHD symptoms and impairment, is not sufficient.

The documentation should build a case for and provide a sound rationale for the ADHD diagnosis.

An ADHD evaluation is primarily based on an in-depth history reflecting a chronic and pervasive history of ADHD symptoms and associated impairment beginning during childhood and persisting to the present day. The evaluation should provide a broad, comprehensive understanding of the student's relevant background including family, academic, behavioral, social, vocational, medical, developmental, and psychiatric history. There should be an emphasis on how the ADHD symptoms have manifested across various settings over time, how the student has coped with the problems, and what success the student has had in coping efforts.

Diagnosis must be clearly stated based on test scores and evidence of impairment

The reporting of test scores must be complete, not selective. If grade equivalents are reported, they must be accompanied by standard scores and/or percentiles based on comparison to others of the same age. Test scores or selective subtest scores alone should not be used as the sole basis for the diagnostic decision. A neuropsychological or psycho-educational assessment can be helpful in identifying the individual's pattern of strengths and weaknesses and whether there are patterns supportive of attention problems. However, a comprehensive testing battery alone, without illuminating a pattern of real world functional impairment, will not be sufficient to establish an ADHD diagnosis or a disability. Checklists and/or ADHD symptom rating scales can be a helpful supplement in the diagnostic process, but by themselves are not adequate to establish a diagnosis of ADHD.

Why is psychometric testing needed to document ADHD?

Psychometric testing is needed:

- 1) to demonstrate that an attention problem substantially affects academic performance;
- 2) to document that an individual remains substantially impaired on academic tasks despite medical treatment, if medication is being taken;
- 3) to provide objective data to balance self-report and observational data, and to assess for malingering;
- 4) to rule out the possibility that attention is being impaired by factors other than ADHD
- 5) to provide clear evidence of a logical link between the attention impairment and the accommodations requested; and

6) to provide estimates of speed on academic tasks, which will inform decisions concerning accommodation recommendations.

Psychometric testing is necessary to allow students with ADHD full access to disability services. **Many students arrive at post secondary with only a brief physician's note as documentation of ADHD. With such minimal documentation, disability service providers are able to justify only limited services. For graduate and professional admission tests, typically no accommodations would be granted.**

Diagnosis alone does not entitle a student to accommodations. Each accommodation recommended by the evaluator must include a rationale and be linked to data.

Accommodations are not granted on the basis of a diagnostic label. Instead, accommodation requests need to be tied to evidence of current functional impairment that supports their use. The evaluator must describe the type and degree of impact the ADHD has (if one exists) on a specific major life activity and on the individual. A detailed explanation must be provided as to why each accommodation is recommended and should correlate specifically to documented functional limitations. In addition to a comprehensive diagnostic evaluation, the report should also address the history of prior accommodations the student has received and the objective of those accommodations. It is important to note that a prior history of receiving accommodations in previous academic environments is not a guarantee one will be granted accommodations at post secondary. Prior documentation may have been adequate in determining appropriate services or accommodations in the past. However, a prior history of accommodations without demonstration of a current need does not in itself warrant the provision of similar accommodations. If no prior accommodations were provided, the qualified professional must include a detailed explanation of why accommodations are needed at this time.

Information for Evaluators

Evaluators are encouraged to keep the following points in mind as they prepare disability documentation:

- An ADHD diagnosis should not be made without clear evidence of impairments dating back to childhood, although symptoms may not become functionally limiting until adolescence.
- There must be evidence of the functional impact of the disability based on DSM-IV-TR criteria. Having a disorder does not mean it is disabling.
- There is a need for multi-dimensional assessment that includes data from different sources (e.g., client, significant other, parents, school records, employment performance records, neuropsychological testing).
- An ADHD diagnosis should never be made solely from a symptom count based on a checklist or rating scales.
- While neuropsychological and psycho-educational testing is not yet able to reliably diagnose ADHD, it can help determine the current levels of severity of the ADHD and quantify the impact of the disorder on cognitive or academic functioning.
- Success in an educational arena is not by itself a reason to rule out the diagnosis of ADHD.
- Many evaluators recommend extra time and/or a separate testing room for students with ADHD without providing any rationale for the request. Again, all recommended accommodations must

be accompanied by a data-driven rationale, which psychological and neuropsychological testing can be used to support.

Assessing Adolescents and Adults with ADHD

The diagnosis of ADHD is strongly dependent on a clinical interview in conjunction with a variety of formal and informal measures. Since there is no one test, or specified combination of tests, for determining ADHD, the diagnosis of an Attention Deficit/Hyperactivity Disorder requires a multifaceted approach. Any tests that are selected by the evaluator should be technically accurate, reliable, valid, and standardized on the appropriate norm group. The most recent version of the test should always be used unless the evaluator can offer a rationale for use of an older version. The following list includes a variety of measures for diagnosing ADHD and/or LD/ADHD. It is meant to be a helpful resource to evaluators but not a definitive or exhaustive listing.

The Clinical Interview - The evaluator should: 1) provide retrospective confirmation of ADHD; 2) establish relevant developmental and academic markers; 3) determine any other co-existing disorders; and 4) rule out other problems that may mimic ADHD.

Specific areas to be addressed include:

- Family history
- Results of a neuromedical history
- Presence of ADHD symptoms since childhood or early adolescence
- Presence of ADHD symptoms in the last 6 months
- Evidence that symptoms cause a significant impairment over time
- Qualitative information regarding the extent of current functional impairment (e.g., academic, occupational, social)
- Results of clinical observation for hyperactive behavior, impulsive speech, distractibility
- Presence of other psychiatric conditions (mood or anxiety disorders, substance abuse, etc.)
- Indication that symptoms are not due to other conditions (e.g., depression, drug use, neuro-medical problems, symptom exaggeration)
- Relevant medication history and response to treatment
- An accounting for periods during which the student was symptom-free
- Determination of what accommodations, if any, have minimized the impact of functional limitations in the past or in the present setting
- Determination of which remediation approaches and/or compensating strategies are and are not currently effective

Rating Scales - Self-rated or interviewer-rated scales for categorizing and quantifying the nature of the impairment may be useful in conjunction with other data.

Selected examples include:

- Achenbach System for Empirically Based Assessment (ASEBA)
- ADD-H Comprehensive Teachers Rating Scale (ACTeRS)
- ADDES-Secondary Age
- ADHD Rating Scale-IV
- ADHD Symptom Checklist - 4 (ADHD-SC4)

- Attention-Deficit Disorders Evaluation Scale: Secondary-Age Student (ADDES-S)
 - Beck Anxiety Inventory (BAI)
 - Beck Depression Inventory (BDI-II)
 - Behavior Assessment System for Children-2 (BASC-2)
 - Behavior Rating Inventory of Executive Functioning (child or adult version)
 - Conners' Parent Rating Scale (age 3-17 years)
 - Conners' Teacher Rating Scale (age 3 -17 years)
 - Conners' Rating Scales-3 (Conners 3)
 - Conners' Adult ADHD Rating Scales (CAARS)
 - Conners' Comprehensive Behavior Rating Scales (Conners CBRS)
 - Wender Utah Rating Scale (WURS) and Parent's Rating Scale (PRS)
- * Please note that scales such as the Brown Attention-Deficit Disorders Scale have been shown to be non-specific and to over-identify non-disabled students as having ADHD. As such, scores from this measure alone are not deemed to be reliable as a way to determine if a student is demonstrating symptoms consistent with ADHD.

Observational Forms - primarily for children and teenagers in the classroom setting
Selected examples include:

- ADHD School Observation Code
- ADHD Direct Observation System
- BASC-2 Student Observation System
- CBC/Test Observation Form
- Child Behavior Checklist/Direct Observation Form
- School Hybrid Observation Code for Kids

Neuropsychological and psycho-educational testing - Cognitive and achievement profiles may suggest attention or information-processing deficits. No single test or subtest should be used as the sole basis for a diagnostic decision. Selected examples include:

Tests of Intellectual Functioning

- Kaufman Adolescent and Adult Intelligence Test
- Reynolds Intellectual Assessment Scales (RIAS)
- Stanford-Binet 5 (SB5)
- Wechsler Adult Intelligence Scale - IV (WAIS-IV)
- Woodcock-Johnson - III Tests of Cognitive Ability

Attention, Memory, and Learning

- Attention Capacity Test (ACT)
- California Verbal Learning Test-Second Edition (CVLT-II)
- Conners' Continuous Performance Test (CPT)
- Detroit Test of Learning Aptitude - 4 (DTLA -4)
- Detroit Test of Learning Aptitude-Adult (DTLA-A)
- Gordon Diagnostic Systems (GDS)
- Integrated Visual and Auditory Continuous Performance Test (IVA+Plus)
- Kagan Matching Familiar Figure Test (KMFFT)
- Learning and Memory Battery-College Edition (LAMB-CE)
- Paced Auditory Serial Test (PASAT)
- Test of Everyday Attention for Children (TEA-Ch)

- Tests of Variable Attention Computer Program (TOVA)
- WAIS-III Working Memory Index
- Wechsler Memory Scales - III (WMS-III)

Executive Functioning

- Delis-Kaplan Executive Function System
- Stroop Color and Word Test
- Trail Making Test Parts A and B
- Tower of London-Second Edition
- Wisconsin Card Sorting Test (WCST)

Academic Achievement

- Scholastic Abilities Test for Adults (SATA)
- Stanford Test of Academic Skills (TASK)
- Wechsler Individual Achievement Test - II (WIAT-II)
- Woodcock-Johnson Psychoeducational Battery - III: Tests of Achievement

Supplemental achievement tests such as:

- Gray Oral Reading Test (GORT 4th Ed).
- Nelson-Denny Reading Test (using Standard scores (mean of 200) rather than grade-based percentile scores)
- Stanford Diagnostic Mathematics Test
- Test of Written Language - 3 (TOWL-3)
- Woodcock Reading Mastery Tests – Revised

Specific achievement tests are useful instruments when administered under standardized conditions and when the results are interpreted within the context of other diagnostic information. The Wide Range Achievement Test - 4 (WRAT-4) or the Nelson-Denny Reading Test are not a comprehensive measure of achievement and should not be used as the sole measure of achievement.

Medical evaluation - Medical disorders may cause symptoms resembling ADHD.

Therefore, it may be important to rule out the following:

- Neuroendocrine disorders (e.g., thyroid dysfunction)
- Neurologic disorders
- Impact of medication on attention if tried, and under what circumstances
- Sleep disorders

Psychological evaluation - Psychological disorders may cause symptoms resembling ADHD.

Therefore, it is important to rule out the following:

- Anxiety disorders (please note that test anxiety is not considered an anxiety disorder)
- Mood disorders
- Personality traits such as perfectionism or obsessive compulsive personality disorder
- Post-traumatic stress disorder
- Factitious disorder

Collateral information - Include third party sources which can be helpful to determine the presence or absence of ADHD in childhood.

- Description of current symptoms (e.g., by spouse, teachers, employer)
- Description of childhood symptoms (e.g., parent)
- Information from old school and report cards and transcripts

(adapted from Queen's University <http://www.queensu.ca/hcds/documents/ADHDdocumentation.pdf>)