

## Learning Disability Documentation Guidelines for Individuals at Edgewood College

It is the policy and practice of Edgewood College to comply with the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, other federal mandates, and state and local requirements regarding individuals with disabilities. Under these laws, no qualified individual with a disability shall be denied access to, or participation in, the services, programs and activities of Edgewood College because of that individual's disability. Individuals with learning disabilities that meet the legal definition of "disability" are protected under these laws and may request reasonable accommodations for their disabilities. Academic accommodations for individuals with learning disabilities are intended to provide equal access to instruction and assessment. Each academic accommodation is determined on an individual basis and made available to the extent that it meets the individual's needs and that it does not compromise the academic integrity of the College program.

Edgewood College endorses the National Joint Council on Learning Disabilities (NJCLD) definition of a learning disability. It states that a **learning disability** is a general term that refers to a heterogeneous group of disorders manifested by significant difficulties in the acquisition and use of listening, speaking, reading, writing, reasoning, or mathematical abilities. These disorders are intrinsic to the individual, presumed to be due to a central nervous system dysfunction, and may occur across the life span. Problems in self-regulatory behaviors, social perception, and social interaction may exist with learning disabilities but do not by themselves constitute a learning disability. Although learning disabilities may occur concomitantly with other handicapping conditions (for example, sensory impairment, mental retardation, or serious emotional disturbance) or with extrinsic influences (such as cultural differences, insufficient or inappropriate instruction), they are not the result of those conditions or influences. (NJCLD, 1988, p.1)

Individuals requesting an accommodation are responsible for providing documentation that a) supports the learning disability diagnosis, and b) provides justification for the requested accommodations. The diagnosis of a learning disability shall be based on **multiple forms of evidence** (i.e., standardized test results, informal assessment results, observational data, historical data) that support a learning disability diagnosis. Evidence should be precise, objective, valid and acceptable within the field. Evidence should also point towards a common hypothesis, utilize multiple methods/settings/raters/times, and reflect accurate and objective interpretation. Reports should follow statistically sound and widely accepted practices for interpreting evidence. Conflicting data should be acknowledged and objectively weighed. Alternative explanations for lower than expected performance (e.g., motivation, lack of prior learning opportunities, low aptitude, or other disabilities) should be considered (and ruled out) when making the diagnosis of a learning disability.

To establish a need for accommodation, **documentation should reflect the current impact of the learning disability** on the individual's academic life. It should clearly describe the functional impairment(s) resulting from the disability (e.g., an inability to take comprehensive notes in a lecture due to memory or fine motor deficits; an inability to read rapidly and fluently due to phonological processing deficits, etc.), and the basis for concluding that the impairment *significantly* interferes with an aspect of academic achievement requiring the ability in question.

A qualified professional trained in the diagnosis of learning disabilities in adults (e.g., school or clinical psychologist, neuropsychologist, learning disability specialist with appropriate credentials) should prepare documentation. Additional assessment from a speech pathologist is warranted when receptive and/or expressive language disorders are suspected. Psychometric tools normed for adults and/or a college population provide the most useful information about college individuals and their skills and abilities relative to their educational peers. It is generally not recommended to include projective tests, personality assessments, or other material not pertaining to the establishment of a learning disability. Such data would *only* be helpful when individuals' difficulties may be partly or wholly due to emotional disabilities.

Questions regarding learning disability documentation and assessment procedures can be directed towards the Disability Service Coordinator.

This Policy has been adapted from the McBurney Disability Resource Center at the University of Wisconsin-Madison.

## **Learning Disability Documentation Guidelines for Individuals at Edgewood College**

### **I. Learning Disability Diagnostic Models**

Edgewood College endorses the National Joint Council on Learning Disabilities (NJCLD, 1998, pg.1) definition of a learning disability and recognizes an aptitude-achievement discrepancy as the most widely held model for diagnosing a learning disability. It also recognizes alternative diagnostic models including discrepancies within specific achievement areas, an intra-cognitive pattern of discrepancy, and information processing discrepancies. Identifying a discrepancy alone, however, is not sufficient to warrant the diagnosis of a learning disability. **Documentation must provide evidence that establishes a clear link between specific deficit areas and the functional limitations experienced by the individual.**

### **II. Quality of Evidence**

Evidence in a psychological report should include the following features: precision, objectivity, validity and acceptance in the field. That is, quantitative and precise measures of a client's performance are considered more credible than qualitative, imprecise descriptions. Likewise, measures that are objectively verifiable (e.g., have known inter-rater reliabilities) are preferred to those that are subjective (e.g., clinical interpretation of behavior in an office setting without corroboration from other raters/settings). Validity means that the measures have some objective, external evidence for the interpretation that is drawn from them. For example, instruments that have a research base showing their link to the constructs they purport to measure are preferred to those that do not have such a research base. Likewise inappropriate interpretations (e.g., interpreting single subtest scores as evidence of psychological processing) are not acceptable. Finally, assessments that are widely accepted in a given field will be more valued than those that are experimental or unique to the clinician. Although Edgewood College will consider all forms of evidence, it is important for clients, and those assessing clients, to understand how evidence will be weighed or valued in determining a individual's eligibility for services or accommodations.

### **III. Integration of Evidence**

Edgewood College values the following methods for integrating evidence from assessment: a) consistency/congruence, b) multiple methods/setting/raters/times, and c) accurate, and objective interpretation.

First, consistency or congruence refers to the evidence pointing towards a common hypothesis. For example, subtests that purport to measure the same construct should show similar performances or scores. Second, evidence from multiple methods of assessment (e.g., objective tests, qualitative analyses, interviews, historical data, work samples), multiple settings (e.g., school, work, community), multiple raters (e.g., clinician, teachers, client) and times (e.g., educational history, present functioning) is preferred to evidence that presents only one method, setting, rater, or time. Accuracy and objectivity of interpretation is essential when integrating evidence. Frequently, clinicians report scores but draw inaccurate interpretations from them. Common errors in interpretation are assigning meaning to non-significant, unreliable score differences (e.g., differences of a few points between WAIS-III subtests or composites), reporting standard scores as percentile scores to exaggerate differences between scores, and other practices that are incompatible with accurate psychometric interpretation. Reports that do not follow statistically sound and widely accepted practices for interpreting evidence are generally not deemed credible.

Finally, many reports fail to provide objective analyses of available evidence. Because it is rare for evidence to be entirely consistent with a diagnosis, we prefer reports that note the ambiguity inherent in conflicting evidence. Reports that selectively present evidence favoring a particular diagnosis, while overlooking or ignoring contrary evidence, are generally less acceptable than reports that objectively weigh and acknowledge conflicting evidence. Ideally, a report presents a coherent body of evidence and justification for accepting or rejecting a disability diagnosis and recommended accommodations.

#### IV. Report Guidelines

Acceptable clinical assessment utilizing multiple forms of evidence must answer the following questions:

1. What is the client's disability?
2. How severe is the disability? (Include evidence that the client's performance is unusual relative to the general population.)
3. Is there evidence of the client's average/above average aptitude? (Rule out low aptitude as a contributing factor.)
4. What evidence is there of one or more of the following:
  - A. An aptitude/achievement discrepancy in one or more areas listed in the NJCLD definition of LD (listening speaking, reading, writing, reasoning or mathematical abilities)?
  - B. An intra-cognitive discrepancy demonstrated by a pattern of significant strengths and weaknesses in cognitive skills?
  - C. A processing deficit in one or more areas of psychological processing?
  - D. An intra-achievement discrepancy evidenced by widely discrepant performance across one or more achievement areas.
5. How are the identified deficit areas (i.e., the skill areas, cognitive profile, processing deficits or achievement areas) related to the area of functional limitation?
6. What alternative explanations for the deficits have been considered (e.g., limited English proficiency, poor instruction, limited attendance) and how have they been ruled out?
7. If accommodation recommendations have been made, how will they lessen or assist the individual in compensating for the specific functional limitations identified in the assessment?
8. What treatment or intervention has been implemented (e.g., tutorial support, informal test accommodations, repeating of classes, etc.) and what has been the outcome? Specify the type of intervention, treatment, or accommodation; its implementation (duration, intensity, frequency); the client's effort and consistency in adhering to the implementation plan; and the outcome(s) for the client and others.

In addition to the above, the following data shall be included:

- **Composite standard scores.** For technical reasons, these scores are preferred to other types of metrics.
- **Scale and subtest scores.** These scores are helpful in evaluating the presence and severity of discrepancies.
- **Statistical comparisons among scores.** These data help establish the degree to which the reported discrepancies are likely to occur in the general population.
- **Performance or achievement in non-disabled domains.** These data can be helpful in establishing individual strengths.

Questions regarding learning disability documentation and assessment procedures can be directed towards the Disability Services Coordinator or committee members.

Committee members: Elizabeth A. Watson, M.Ed., LPC, CRC, Disabilities Services Coordinator  
Kathie Moran, M.A., Academic Advisor  
Carol Cohen, Ph.D., Associate Academic Dean  
Meera Rastogi, Ph.D., Psychology Department