

MS1

EVALUATION OF ELIGIBILITY FOR DEVELOPMENTAL DISABILITIES

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Bureau of Clinical Services
Division of Developmental Disabilities (DDD)

Public Law 106-402(Oct 30, 2000)

A. In General--Developmental Disability is a severe, chronic disability of an individual that

1. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
2. Is manifested before the individual attains age 22
3. Is likely to continue indefinitely;
4. Results in substantial functional limitations in 3 or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency
5. Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of life-long or extended duration and are individually planned and coordinated.

Public Law 106-402 (cont.)

B. Infants and Young Children—An individual **from birth to age 9**, inclusive, who has a substantial developmental delay or specific congenital or acquired condition, may be considered to have a developmental disability **without meeting 3 or more of the criteria** described in clauses of subparagraph (A) if the individual, without services and supports, has a high probability of meeting those criteria later in life.

Role of DHS in eligibility

- The DHS has the responsibility to oversee the accuracy, quality, and appropriateness of services provided by its contracted entities, including those provided by its ISC agencies. As part of this process, the Department reserves the right to review and approve or reject any PAS assessments and determinations made by its contracted entities (PAS manual 020.00)

Role of ISC Agencies in eligibility

- **To ensure compliance with applicable federal and state laws,** arrange for and conduct assessments, make necessary determinations regarding eligibility for services, educate individuals and families, and make referrals and provide linkage to appropriate and needed services.
- The PAS process will **prevent inappropriate admissions** to long-term care facilities and **inappropriate enrollments** in waiver programs. (PAS manual 020.00)

Role of ISC Agencies in eligibility

- ISC agencies must guard against the temptation to make a determination of DD as a way of providing social services to an individual. Such activity violated the purpose of pre-admission screening. A determination of DD when no such disability exists may bring into the DD system an individual whose needs will not properly be met, creating additional burdens and difficulties for the person and for the system (PAS manual 500.20 G.)

Determination of Developmental Disability (DDPAS-5)

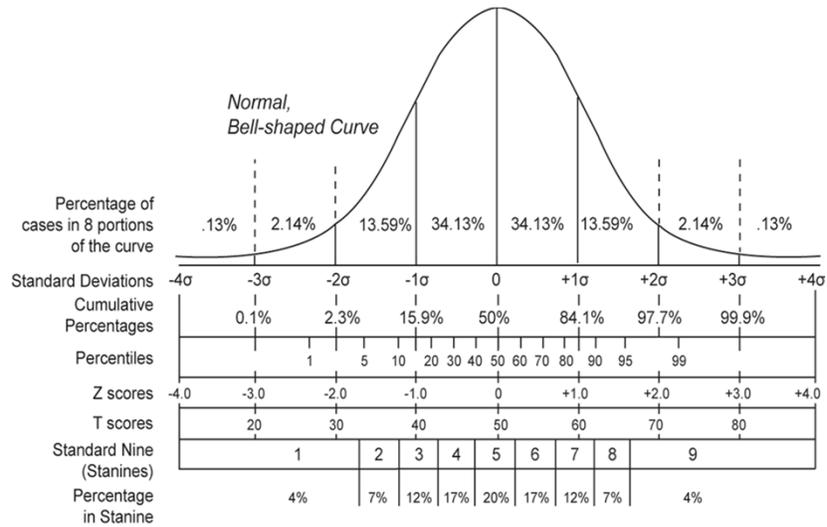
1. Part I: Whether the individual has intellectual disability (ID) or a related condition
2. Part II: Whether the individual requires active treatment

Part I: Determination of ID

DSM-5 Diagnostic Criteria for ID

1. Deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing
"In DSM-5, Intellectual Disability is considered to be approximately two standard deviations or more below the population, which equals an IQ score of about 70 or below." (DSM-5 Intellectual Disability Fact Sheet)

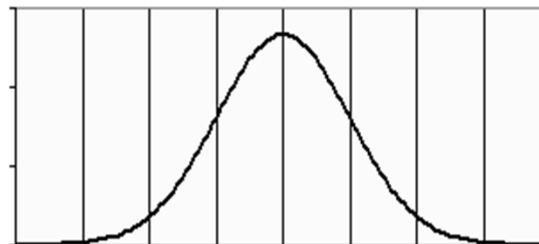
What is normal/abnormal?



The Meaning of IQ scores

IQ Comparison Site
www.iqcomparisonsite.com
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IQ Normal Curve



Standard Deviations	-4	-3	-2	-1	0	1	2	3	4
Wechsler IQ	40	55	70	85	100	115	130	145	160
Stanford-Binet IQ	36	52	68	84	100	116	132	148	164
Cumulative %	0.003	0.135	2.275	15.866	50.000	84.134	97.725	99.865	99.997

The Meaning of IQ scores

- Different tests yield different IQ scores.
- An IQ score is a snapshot of cognitive functioning of individual at the moment.
- Individual's mood, physical/mental condition, level of cooperation can affect IQ scores.
- The person administering the test (e.g., level of training, degree of rapport with the individual) can affect IQ scores.

Part I Determination of ID

DSM-5 Diagnostic Criteria for ID

2. Deficits in adaptive functioning that result in failure to meet developmental and sociocultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community.

Part I Determination of ID

DSM-5 Diagnostic Criteria for ID

Domains of adaptive functioning

- Conceptual domain: language, reading, writing, math, reasoning, knowledge, and memory
- Social domain: empathy, social judgment, interpersonal communication skills, the ability to make and retain friendships, and similar capacities.
- Practical domain: self-management in areas such as personal care, job responsibilities, money management, recreation, and organizing school and work tasks

Part I Determination of ID

DSM-5 Diagnostic Criteria for ID

- To meet diagnostic criteria for ID, the deficits in adaptive functioning must be directly related to the intellectual impairments (DSM-V p38).
- The levels of severity are defined on the basis of adaptive functioning, because it is adaptive functioning that determines the level of supports required. Moreover, IQ measures are less valid in the lower end of the IQ range.

Part I Determination of ID

DSM-5 Diagnostic Criteria for ID

3. Onset of intellectual and adaptive deficits during the developmental period

Onset during the developmental period refers to recognition that intellectual and adaptive deficits are present during childhood or adolescence.

Part I Determination of ID

Psychological evaluation: recent update

- **Suspected mild range prior to age 18:** A psychological evaluation must be completed within five years prior to the date recorded on the DDPAS-2, Part II.
- **Documented moderate range prior to age 18:**
A psychological evaluation completed within five years prior to the date recorded on the DDPAS-2, Part II; or two psychological evaluations completed within the individual's lifespan before the age of 18.
- **Documented severe or profound range prior to age 18:**
A psychological assessment on record i.e. it is not necessary to obtain a new assessment.

Part I Determination of ID

Psychological evaluation for Adults:

- Wechsler Adult Intelligence Scale (WAIS) IV
- ✓ WAIS versions should not be used for individuals with IQ 40 or lower (WAIS-IV IQ range: 40-160).
- ✓ WASI versions are NOT valid for DD population.
- Stanford-Binet 5th Edition (IQ score range: 40-160)
- ✓ Extended norm available for IQ scores below 40 or over 160 in the Interpretative Manual
- Leiter International Performance Scales-3: non-verbal test
- Slossen Intelligence Test-R3: verbal test
- Woodcock-Johnson IV Tests of Cognitive Abilities

Part I Determination of ID

Psychological evaluation for Children: :

- Stanford-Binet 5th Edition
- Wechsler Intelligence Scale for Children (WISC)-IV
- Leiter International Performance Scales-3
- Slossen Intelligence Test-R3
- Woodcock-Johnson IV Tests of Cognitive Abilities

Part I Determination of ID

Psychological evaluation should be reliable and valid:

- Psychological evaluations must be completed by a licensed clinical psychologist, or a Nationally Certified School Psychologist (NCSP);
- The most recent versions of tests should be used (Flynn effect).
- An abbreviated version of WAIS (WASI) or a brief test (Kaufman) are not appropriate for eligibility determination.

Part I Determination of ID

Psychological evaluation should be reliable and valid:

- If the test results were obtained during the early childhood of the individual, the test results may not represent the current level of intellectual functioning of the individual as an adult.
- Results of an evaluation for intelligence while the individual was experiencing a psychiatric illness may not represent the true ability of the individual.
- A psychologist should report the mental status, test-taking behavior, and the level of cooperation of the individual during the testing.

Part I Determination of ID

Adaptive functioning:

1. Early and ongoing interventions may improve adaptive functioning throughout childhood and adulthood. In some cases, these result in significant improvement of intellectual functioning.
2. It is common practice when assessing infants and young children to delay diagnosis of ID until after an appropriate course of intervention is provided.
3. If the improvement of adaptive functioning is contingent on the presence of supports and ongoing interventions, the diagnosis of ID is still appropriate.

Part I Determination of ID

Adaptive functioning:

Psychological evaluation (adults and children)

Suggested instruments are:

- Vineland Adaptive Behavior Scale-II: should be administered by a professional.
- AAIDD Adaptive Behavior Assessment System-2
- AAIDD Supports Intensity Scale

The ICAP is not an adequate assessment of adaptive functioning as a part of psychological assessment.

Part I Determination of ID

ICAP (Inventory for Client and Agency Planning)

- “The ICAP must be administered by a Qualified Intellectual Disability Professional (QIDP), six months prior to the date on the DDPAS 2, Part II (PAS manual).”
- “The ICAP must be completed by a person who has known the individual for at least 3 months and who sees him/her on a day-to-day basis (ICAP manual)”.

Scores from standardized measures and interview sources must be interpreted using clinical judgment (DSM-V p37).

Part I Determination of ID

Age of onset:

1. The age of onset is to differentiate ID from dementia.
2. It is not sufficient to show that the subaverage intellectual functioning exist now (unless the person is not yet 18).
3. School records (IQ testing, achievement evaluations, behaviors at school are more important than educational/intervention programs).
4. Old individuals who do not have proper documentation for the evidence of ID prior to age 18 should be referred to Bureau of Clinical Services.

Part I Determination of ID

Age of onset: Special Education Services

1. The history of special education services is NOT necessarily an evidence of ID.
2. The classification of EMR (Educable Mental Retardation) is NOT necessarily an evidence of ID:

“EMR was once used to describe a person with a mild to moderate to high mental retardation who could learn to the 5th grade level” (Psychology Dictionary).

Part I Determination of ID

History of ID:

1. 1921 AAMR: Three levels of MR (IQ 50-75, 25-50, 0-25)
2. 1952 DSM-1: Mental deficiency (IQ 70-85); moderate (IQ 50-69); severe (IQ 0-49).
3. 1973 AAMR revised the definition of MR to “significantly sub-average general intellectual functioning determined by a score of at least 2 standard deviation below the mean on an intelligence test.”

Part I Determination of ID

Dual diagnosis vs Psychiatric illness

- Dual diagnosis: Individuals with ID are likely to experience psychiatric symptoms. A psychiatric diagnosis does NOT necessarily rule out intellectual disability.
- Some psychiatric illnesses may cause cognitive impairment (some of them cause permanent impairments, and some cause transient impairments), but not all psychiatric illness cause cognitive impairment.
- Cognitive functioning should be evaluated when the individual 's mental status is stable.
- The description of test-taking behavior is important.

PART I: Determination of Related Conditions

1. Cerebral palsy or epilepsy; or
2. Any other condition, other than mental illness, found to be **closely related to intellectual disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with intellectual disability** (e.g., Autism and other disorders within the autism spectrum, traumatic brain injury, and Prader-Willi syndrome if all criteria are met).
 - Most diagnosable syndromes, such as Fetal Alcohol Syndrome, are not related conditions.
 - Disorders of nerves and muscles (e.g., muscular dystrophy) are not related conditions.

PART I: Determination of Related Conditions

- The diagnosis of Intellectual Disability intrinsically implicates severe deficits in adaptive functioning. However, the diagnosis of a related condition DOES NOT.
- Therefore, DD eligibility based on a related condition requires severe deficits in adaptive functioning at least 3 out of 6 life skill areas (similar to the level of individuals with ID).

PART I: Seizure disorder

- The diagnosis of epilepsy should be confirmed by a neurologist's evaluation.
- Staff member/care taker/teacher's observations of seizure activities are not sufficient to support the diagnosis.
- Age of onset prior to age 22: Hx of seizures during the childhood may not be sufficient to support the diagnosis (**Public Law 106-402. ...is likely to continue indefinitely**)

PART I: Cerebral Palsy

The physical examination and the medical history must address the diagnosis and the degree of deficits.

PART I: Fetal Alcohol Syndrome

1. Fetal Alcohol Spectrum Disorder: FAS, Partial FAS, Prenatal Alcohol Exposure, Alcohol-related Birth Defects, Alcohol-Related Neurodevelopmental Disorder
2. Diagnostic criteria for FAS: Facial abnormalities, growth deficits, abnormalities of CNS and neurobehaviors
3. Reports of alcohol consumption during pregnancy do not necessarily support the diagnosis of FAS.
4. Even when an individual has FAS, the outcomes of FAS vary significantly depends on the early environment, care, and support available.

PART I: Genetic Disorders

Genetic disorders (abnormal findings on genetic testing) are NOT related conditions, unless there is an evidence of ID, autism, or seizure disorder due to the genetic disorder.

- A diagnosis of ID should not be assumed because of a particular genetic or medical condition (DSM-V p40)
- ASD: Even when an ASD is associated with a known genetic mutation, it does not appear to be fully penetrant. Risk for the remainder of cases appears to be polygenic, with perhaps hundreds of genetic loci making relatively small contributions (DSM-V p57)

PART I: Related Conditions

Other assessments, depending on need, may include communication, audiological, physical therapy, occupational therapy, and behavior therapy assessments.

e.g.) an autistic individual with language deficits may need a communication assessment which must include the following components:

- Background information that includes past and present test results and findings.
- Description of the individual's functional communication abilities (level of intelligibility and clarity of communication; ability to express needs and wants; ability to initiate, maintain, and respond in communication exchanges skill to communicate across a variety of settings such as work, home, and community; level of support needed to be successful in a variety of settings; language comprehension adequate for daily living activities)
- Receptive/expressive communication (skills relative to communication, based on person's adaptive level and discrepancy between comprehension and production of communication).
- Mode of communication (techniques used to express him/herself and effectiveness of the communication device).
- Appropriateness of communication (description of social and communication skills; relevant, coherent and fluent communication).
- Independence of communication (level of spontaneous communication, types of prompts needed to elicit communication; conditions that facilitate spontaneous communication)
- Treatment recommendations (types of therapy/training; purpose and focus of the therapy/training; devices and equipment to promote communication; referrals needed).

PART I: Autism Spectrum Disorder

DSM-5 Diagnostic Criteria for ASD

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history

1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back and forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interests in peers

PART I: Autism Spectrum Disorder

DSM-5 Diagnostic Criteria for ASD

B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., hand flipping, finger flicking, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
2. Insistence on sameness, inflexible adherence to routine, or ritualized patterns of verbal or nonverbal behavior (e.g. extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).

PART I: Autism Spectrum Disorder

DSM-5 Diagnostic Criteria for ASD

B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history

3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests) (e.g., a toddler strongly attached to a pan; a child preoccupied with vacuum cleaners; an adult spending hours writing out timetables).
4. Hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement.)

PART I: Autism Spectrum Disorder

DSM-5 Diagnostic Criteria for ASD

C. **Symptoms must be present in the early developmental period** (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).

D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.

E. These disturbances are not better explained by ID or global developmental delay. ID and ASD frequently co-occur; to make comorbid diagnoses of ASD and ID, social communication should be below that expected for general developmental level.

PART I:Autism Spectrum Disorder

Development and Course of ASD

- Deficits in social-emotional reciprocity (i.e., the ability to engage with others and share thoughts and feelings) are clearly evident in young children with the disorder, **who may show little or no initiation of social interaction, no sharing of emotions, along with reduced or absent imitation of others' behavior.**
- An early feature of ASD is impaired joint attention as manifested by a lack of pointing, showing, or bringing objects to share interest with others, or **failure to follow someone's pointing or eye gaze.**

PART I: Autism Spectrum Disorder

Diagnostic Features of ASD

- Impression of "odd, wooden, or exaggerated body language"; Someone may have relatively good eye contact when speaking, but noticeable in poor integration of eye contact, gesture, body posture, prosody, and facial expression for social communication.
- Absent, reduced or atypical social interest, manifested by **rejection of others, passivity, or inappropriate approaches** that seem aggressive or disruptive.

PART I: Autism Spectrum Disorder

Diagnostic Features of ASD

- Preoccupation about a circumscribed topic or interest with great intensity often to the exclusion of other activities are all-encompassing and **interfere with the acquisition of basic skills.**
- Asperger's Disorder (DSM-IV-TR): The lack of social reciprocity is more typically manifest by an eccentric and one-sided social approach to others (e.g., pursuing a conversation topic regardless of others' reactions) rather than social and emotional indifference

PART I: Autism Spectrum Disorder

Development and Course of ASD

- Symptoms are typically recognized during the second year of life.
- First symptom frequently involve delayed language development, often accompanied by lack of social interest or unusual social interactions (e.g., pulling individuals by the hand without any attempt to look at them), odd play patterns (e.g., carrying toys around but never playing with them), and unusual communication patterns (e.g., knowing the alphabet but not responding to own name).

PART I: Autism Spectrum Disorder

Development and Course of ASD

- During the second year, odd and repetitive behaviors and absence of typical play become more apparent.
- Many typically developing children have strong preferences and enjoy repetition. The clinical distinction is based on the type, frequency, and intensity of the behavior (e.g., **a child who daily lines up objects for hours and is very distressed if any item is moved-- abnormal**)
- A small proportion of individuals deteriorate behaviorally during adolescence, whereas most others improve.

PART I: Autism Spectrum Disorder

Social communication disorder:

- Deficits in using communication for social purposes, such as greeting and sharing information, in a manner that is appropriate for the social context.
- Impairment of the ability to change communication to match context or the needs of the listener.
- Difficulties following rules for conversation and storytelling, such as taking turns in conversation, rephrasing when misunderstood, knowing how to use verbal and nonverbal signals to regulate interaction.
- Difficulties understanding what is explicitly stated and nonliteral or ambiguous meanings of language
- **NO restricted/repetitive patterns of behavior, interests, or activities**

PART I: Autism Spectrum Disorder

Attention Deficit/Hyperactivity Disorder:

- Mild delays in language, motor, or social development often co-occur (previously it was called "minimal brain dysfunction").
- Low frustration tolerance, irritability, or mood lability is associated.
- Peer relationships are often disrupted by peer rejection, neglect or teasing of the individual with ADHD.
- Individuals with ADHD obtain less schooling, poorer vocational achievement, and higher probability of unemployment.
- **ADHD: social dysfunction and peer rejection vs. ASD: social disengagement, isolation, and indifference to facial and tonal communication cues.**
- **ADHD: difficulty during a transition because of impulsivity or poor self-control vs ASD: tantrums because of inability to tolerate a change from their expected course of events**

PART I: Autism Spectrum Disorder

Schizophrenia:

- Age of onset: typically between late teens and the mid 30-s. Earlier onset and males tend to have worse prognosis.
- Impaired cognition is common, and alterations in cognition are present during development and precede the emergence of psychosis (prodromal stage), taking the form of stable cognitive impairments during adulthood (Dementia Praecox).
- A prodromal state has been described in which social impairment and atypical interests and beliefs occur, which could be confused with the social deficits seen in ASD.

PART I: Autism Spectrum Disorder

Schizophrenia:

- Negative symptoms: Diminished emotional expression in the face, eye contact, intonation of speech, and movements of the hand, head, and face that normally give an emotional emphasis to speech; Avolition: a decrease in motivated self-initiated purposeful activities; Alogia: diminished speech output; Anhedonia: decreased ability to experience pleasure from positive stimuli or a degradation in the recollection of pleasure previously experienced; Asociality: lack of interest in social interaction.

PART I: Autism Spectrum Disorder

Schizophrenia:

- Disorganized motor behavior: childlike to unpredictable agitation, negativism, repeated stereotyped movements, mutism, ecolalia
- Disorganized speech: switch from one topic to another, answers to questions may be obliquely related or completely unrelated, incoherent
- Inappropriate affect, dysphoric mood, anxiety, anger
- Schizophrenia with childhood onset usually develops after a period of normal or near normal development.
- Hallucinations and delusions are NOT the features of ASD.

PART I: Autism Spectrum Disorder

Schizoid Personality Disorder:

- Pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings. They appear to lack a desire for intimacy, seem indifferent to opportunities to develop close relationships, and do not seem to derive much satisfaction from being part of a family or other social group. They often appear to be socially isolated or “loners” and almost always choose solitary activities or hobbies that do not include interaction with others.
- They may be oblivious to the normal subtleties of social interaction and often do not respond appropriately to social cues so they seem socially inept or superficial or self-absorbed.

PART I: Autism Spectrum Disorder

Schizoid Personality Disorder:

- There may be great difficulty differentiating individuals with schizoid PD from those with milder forms of ASD, which may be differentiated by more severely impaired social interaction and stereotyped behaviors and interests.

PART I: Autism Spectrum Disorder

Schizotypal Personality Disorder:

- Pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities of behavior. These individuals may be superstitious or preoccupied with paranormal phenomena that are outside the norms of their subculture.
- They experience interpersonal relatedness as problematic and are uncomfortable relating to other people. Although they may express unhappiness about their lack of relationships, their behavior suggests a decreased desire for intimate contacts. As a result, they usually have no or few friends or confidants other than a first-degree relative. They are anxious in social situations, particularly those involving unfamiliar people.

PART I Autism Spectrum Disorder

Schizotypal Personality Disorder:

- There may be great difficulty differentiating children with schizotypal PD from the heterogeneous group of solitary, odd children whose behaviors is characterized by marked social isolation, eccentricity, or peculiarities of language and whose diagnoses would probably included milder forms of ASD or language communication disorders. Milder forms of ASD are differentiated by the even greater lack of social awareness and emotional reciprocity and stereotyped behaviors and interestes.

PART I: Autism Spectrum Disorder

Avoidant Personality Disorder:

- Pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation that begins by early adulthood.
- They avoid work activities that involve significant interpersonal contact because of fears of criticism, disapproval, or rejection. They avoid making new friends unless they are certain they will be liked and accepted without criticism. They will not join in group activities unless there are repeated and generous offers of support and nurturance. Interpersonal intimacy is often difficult for them.
- They react strongly to subtle cues that are suggestive of mockery or derision. Doubts concerning social competence and personal appealing become especially manifest in settings involving interactions with strangers. These individuals believe themselves to be socially inept, personally unappealing, or inferior to others. They are usually reluctant to take personal risks or to engage in any new activities.

PART I: Autism Spectrum Disorder

- Exhibiting autistic behaviors do not necessarily warrant the diagnosis of autism.
- ASD diagnosis should be supported by an evaluation by a psychiatrist or a clinical psychologist (school teachers are not trained for psychiatric disorders).
- Detailed information for early childhood is essential—autistic behaviors as an adult are not sufficient to support the diagnosis.
- The initial evaluation which the individual obtain the ASD diagnosis is essential—many clinicians just adopt the diagnosis based on family's report (should be listed as a hx of autism).

PART I: Autism Spectrum Disorder

- The diagnostic evaluation should be based on multiple sources of information (e.g., clinician's observations, family's report, clinical scales) for multiple settings (e.g., home, school, work).
- Diagnosing ASD should NOT be based on the result of a single rating scale (e.g. Gilliam Autism Rating Scale-3) "GARS-3 results should NEVER be the sole criterion for diagnosing autism. This scale is designed to be a component of a complete assessment effort, including test data, a case history, and other pertinent diagnostic information. GARS-3 results can be a valuable part of the assessment of individuals with autism, but should never be the only part. (Gilliam Autism Rating Scale-3 Manual)"

PART I: Autism Spectrum Disorder

GARS-3 for different subgroups (Gilliam Autism Rating Scale-3 Manual)

Group	sensitivity	specificity
ASD vs typically functioning	.96	.95
ASD vs. ADHD	.96	.88
ASD vs. ED/BD	.96	.62
ASD vs. SLI	.96	.78

PART I: Autism Spectrum Disorder

Age of onset:

1. Who did the initial diagnostic evaluation for ASD and when?
2. Do not rely on one clinician's diagnosis of autism—look at the general consensus of clinicians' diagnoses.
3. School IEPs, especially detailed description of behaviors at school regarding peer relationship, difficulties during transitions, observation of repetitive behaviors, are extremely important.

PART I: Related Conditions Adaptive functioning

- It results in substantial functional limitations in three or more of the following areas of major life activity: self-care, language, learning, mobility, self-direction, and/or capacity for independent living.
- For all related conditions other than CP and epilepsy, the ISC agency must take care to determine that **the person's limitations are similar to those caused by ID.**
- The individual's substantial functional limitations must have existed before the age of 22. It is not sufficient to show that the substantial functional limitations exist now (unless the person is not yet 22).

PART I: Related Conditions Adaptive functioning

- **The substantial functional limitations must be related to the person's related condition and not due to other conditions,** such as other health problems, emotional disorders, substance abuse, or personality problems.
- Individuals with a related condition diagnosis (e.g., epilepsy) and a non-related condition diagnosis (e.g., a severe mental illness) must be evaluated in terms of the degree to which the **related condition diagnosis, considered on its own, leads to substantial functional limitations in one or more areas, apart from the influence of the non-related condition diagnosis.** For example, for persons with a severe mental illness, PAS agencies should try to evaluate **the individual's functioning at his/her highest.**

PART I: Age of onset

Three levels of reliability for identifying the age of onset:

1. Primary Professional Sources
Including diagnostic assessments performed by licensed practitioners that document the diagnosis of intellectual disability or a related condition (clinical psychologist or psychiatrist).
2. Secondary Professional Sources
Assessments performed by other licensed professionals (such as physical therapists, licensed social workers, registered nurses) may refer to specific diagnoses of developmental disabilities that are derived from primary professional sources (above).
3. Anecdotal and Hearsay Sources
Verbal reports from parents, relatives, and other caregivers; and casual, unsupported references in school, hospital, and social welfare records. Taken alone, these sources are insufficient for a determination of developmental disability.

PART I: Required Assessments for Eligibility Review Medical Review

- Consisting of: medical history, medication review, and physical examination.
- must be completed by a licensed physician, an Advanced Practice Nurse, a Physician Assistant, or a Registered Nurse (RN). If completed by an RN, the assessment must be co-signed by a licensed physician.
- must be current within one year prior to the date recorded on the DDPAS 2, Part II.
- For an individual with significant change in medical status within the year or an individual being admitted to a nursing facility, the assessment must be current within 90 days prior to the date recorded on the DDPAS 2, Part II.

PART II: Determination of need for Active Treatment

1. Active treatment is a continuous program for each individual, which includes aggressive, consistent implementation of a program for specialized and generic training, treatment, health services and related services.
2. Active treatment is directed toward; a) the acquisition of behaviors necessary for the individual to function with as much self-determination and independence as possible; b) the prevention or deceleration of regression or loss of current optimal functional status.
3. Active treatment does not include services to maintain generally independent individuals who are able to function with little supervision or in the absence of a continuous active treatment program.

PART II: Determination of need for Active Treatment

1. The individual requires continuous programming to acquire new skills or maintain current ones.
2. The individual requires aggressive and consistent programming in order to acquire new skills or maintain current ones.
3. "Aggressive" connotes the idea that staff will seek appropriate opportunities to provide the necessary programming and will not simply wait for the individual to ask for the needed service.
4. "Consistent" suggests that a program must be administered in the same way by all staff, in all settings, at all times of the day.
5. "Aggressive and consistent programming" does not include services that are used to address individuals whose needs are for nursing services, physical supports, continuous psychiatric or forensic services, monitoring to prevent substance abuse, or other interventions that may also be provided on an aggressive and consistent basis, unless those needs are also accompanied by the need for or in support of specialized training for developmental needs.

PART II: Determination of need for Active Treatment

6. The individual requires a program that includes specialized and generic training, treatment, health services, and related services in order to acquire new skills or maintain current ones.
 - **Specialized training** includes training in skill areas that non-disabled individuals have generally mastered by the onset of adolescence, such as Activities of Daily Living (bathing, grooming, use of the bathroom, dressing); orientation to one's home and community environment; the practice of basic etiquette and social customs; and basic problem-solving and decision-making. **The essential feature of specialized training is that it addresses an individual's developmental (especially cognitive) needs.**
 - **Generic training** includes skill areas that many adults without disabilities might also utilize, such as work skills training, home maintenance, meal preparation, etc. **Generic training is needed at times both by persons with developmental disabilities and persons without developmental disabilities.**

PART II: Determination of need for Active Treatment

7. The following services are supportive of the specific active treatment training and goals described above. **The necessity for these services alone is not sufficient to support a need for active treatment.** These services are aimed at the acquisition or maintenance of real skills for independent functioning:
- **Treatment** includes occupational therapy, dental prophylaxis, etc. Treatment is needed at times both by persons with developmental disabilities and persons without developmental disabilities.
 - **Health services** includes physical exams and hearing exams. Health services are needed at times both by persons with developmental disabilities and persons without developmental disabilities.
 - **Related services** include social services, case coordination and guardianship. Related services are needed at times both by persons with developmental disabilities and persons without developmental disabilities.

PART II: Determination of need for Active Treatment

- **The substantial functional limitations must be related to the person's related condition and not due to other conditions,** such as other health problems, emotional disorders, substance abuse, or personality problems.
- Individuals with a related condition diagnosis (e.g., epilepsy) and a non-related condition diagnosis (e.g., a severe mental illness) must be evaluated in terms of the degree to which the related condition diagnosis, **considered on its own,** leads to substantial functional limitations in one or more areas, **apart from the influence of the non-related condition diagnosis.** For example, for persons with a severe mental illness, PAS agencies should try to evaluate **the individual's functioning at his/her highest.**

**PART II: Determination of need for Active Treatment:
Self-Care: Eligible**

- The individual is unable to perform daily activities such as feeding, bathing, toileting, dressing, and hygiene and grooming; or the individual can perform them when supervised **but is unable to perform them without continuous reminders.** The individual lacks understanding regarding the need for these activities and their proper location, timing, and/or performance.

Ex) Joseph experienced severe TBI at age 21. His self-care skills are rudimentary in nature and are inadequate to meet his needs. He tends to eat with his fingers, does not use soap and shampoo when bathing, unless supervised; and has daily bowel or bladder accidents that are not physically based, according to his physician.

**PART II: Determination of need for Active Treatment:
Self-Care: Not eligible**

- The individual understands that one's day is structured to include attention to the routine tasks of self-maintenance. The individual understands where, when, and how to accomplish the tasks. The individual is generally able to perform the tasks for himself/herself, although he/she may not always choose to do so. The individual may be able to refine or further develop skills in these areas, but the current level of accomplishment is satisfactory for sustaining the individual's health, safety, and general well-being, and the level of accomplishment is generally acceptable within social settings to which the individual has access or seeks access.
- Ex) Carol experienced TBI at age 20. She has trouble communicating and organizing her thoughts, but she is able to perform all the above self-care activities appropriately without reminders from another person. Sometimes she chooses to ignore her grooming and hygiene, especially when she is particularly depressed over her condition, but she knows how to do these things and does so when she is feeling fine.

**PART II: Determination of need for Active Treatment:
Language: Eligible**

- The person may or may not use an alternative mode of communication. Expressively, the person would not be able to make known his/her needs to other, non-disabled individuals who do not know the person. Receptively, the person would not be able to understand basic communication from a stranger—for example, a police officer directing foot traffic around an accident, a store clerk giving directions for finding a sale item, or a bus driver indicating what time the next bus will leave.
- Ex) Joni, a person with moderate ID, cannot describe what is wrong when she feels sick. She is not able to describe events of the workshop day to family members when she returns home. She asks questions that show she does not understand plans that are being carefully explained to her.

**PART II: Determination of need for Active Treatment:
Language: Not Eligible**

- Expressively, the individual would be able to make known his/her needs to other, non-disabled individuals who do not know the person. Receptively, the person would be able to understand basic communications from a stranger.
- Ex) People like to talk to Jessie, a person with moderate ID, because she comes up with unfamiliar but effective ways of expressing her feelings, thoughts, and wishes. She is very capable of using simpler words to say what she means when she forgets bigger words. If she does not understand something, she won't stop asking questions until she is satisfied.

**PART II: Determination of need for Active Treatment:
Learning: Eligible**

- The person takes substantially more time to learn a new skill or behavior, adjust to new environments, and develop new perceptions than persons without disabilities. **The difficulty is experienced in all settings (work, home, social life, organizations, etc)**
- Ex) Richard, a 20-year old with autism, has an IQ of 80. His ability to learn and grasp new information at school is very limited. At home, he gets very frustrated and gives up or becomes agitated when being taught simple chores. At the day program, he cries quickly and loudly when presented with new tasks; he prefers to do the same things over and over.

**PART II: Determination of need for Active Treatment:
Learning: Not Eligible**

- The person occasionally has difficulty learning a new skill or behavior, adjusting to a new environment, or developing new perceptions, **but this difficulty does not appear often or does not occur in all settings.**
- Ex) Charles, a 20-year old with a diagnosis of PDD NOS and an IQ of 83, has mastered basic math skills and reading and writing at school. At home, he performs basic chores and is amenable to learn new tasks, especially those that he can perform alone. At the local recreation program, he is capable and willing to learn new tasks. He learns them more quickly than many of his peers, although he has difficulty working in groups and in talking or socializing with others.

**PART II: Determination of need for Active Treatment:
Mobility: Eligible**

- Even though equipped with and trained to use mobility assistance devices or other adaptive equipment, the individual is able to do the following activities only slowly and with difficulty, or not at all: move from one point to another (on the same level); move in and out of automobile, buses etc; physically obtain and use routine supplies and equipment (shampoo, cooking supplies, writing equipment, communication equipment, etc)
- Ex) Josie has severe CP. She uses an electric wheelchair and requires frequent assistance to reach switches for automatic doors and to get around corners in the building where she works. It is difficult for her to reach and grasp many items. She requires specialized vans and buses to transport her and her chair.

**PART II: Determination of need for Active Treatment:
Mobility: Not Eligible**

- With or without mobility assistive devices or other adaptive equipment, the individual may do the following activities somewhat slowly, but is able to perform them routinely and regularly throughout the day without serious disruption of schedule and without substantial loss of energy or risk of injury: move from one point to another (on the same level); move in and out of automobile, buses etc; physically obtain and use routine supplies and equipment (shampoo, cooking supplies, writing equipment, communication equipment, etc)
- Ex) Carol has mild CP. She uses braces to assist her in walking and a variety of devices to reach and use everyday objects. She is always on time for work and for social engagements. She uses public transportation to go between work, home, and leisure activities. She has an adapted kitchen that allows her to cook for herself.

PART II: Determination of need for Active Treatment: Self-Direction: Eligible

- Even with extra time and appropriate assistive technology (especially for communication), the individual does not demonstrate **the capacity to make independent, age-appropriate reasoned decisions** in important areas of the individual's life (e.g. vocational, social, financial, legal, spiritual, familial, etc). Reasoned decisions are those which usually include the following elements: gathering of information; development of several options; assessment of the benefits and risks of each option; selection of a preferred option or creation of a prioritized list of options; revision of one's choices if the preferred option does not work out.
- **Individuals who have shown the capacity to make reasoned decisions in some areas, but who choose not to make reasoned decisions in those or in other areas are usually NOT considered eligible in self-direction, because they possess the capacity for self direction (but choose not to use it).**
- Ex) Anthony, a middle-aged man with mild ID, lives with his sister, who makes most of his decisions for him. Anthony appears content with this arrangement, although occasionally he gets angry about not getting his own way. When people at church invite him to a social function, he always says, "Ask Sue Ellen." He is not used to spending money. His sister picks out the clothes that he will wear each day. things have been this way all of his life. At first, it was his mother who made the decisions; now it is his sister.

PART II: Determination of need for Active Treatment: Self-Direction: Not Eligible

- With or without extra time and appropriate assistive technology (especially for communication), the individual demonstrates the capacity to make independent, age-appropriate reasoned decisions in important areas of the individual's life (e.g. vocational, social, financial, legal, spiritual, familial, etc). Reasoned decisions are those which usually include the following elements: gathering of information; development of several options; assessment of the benefits and risks of each option; selection of a preferred option or creation of a prioritized list of options; revision of one's choices if the preferred option does not work out.
- **Individuals who have shown the capacity to make reasoned decisions in some areas, but who choose not to make reasoned decisions in those or in other areas are usually NOT considered eligible in self-direction, because they possess the capacity for self direction (but choose not to use it).**

PART II: Determination of need for Active Treatment: Self-Direction: Not Eligible

- Ex) Andrew, a middle aged man with mild ID, lives in an apartment on his own. His sister checks with him each day by telephone and visits him once a week to see how he is doing. They go over his money situation and his food supply and review his plans for the coming week. Andrew likes to make plans each week about going to movies or a sporting event. Sometimes he does things with his sister's family and sometimes he chooses not to. He is saving money for a DVD player and has about two months to go before he can buy one. He has two opportunities for a vacation next summer—one with Special Olympics in Seattle and one with his day program to Nashville. He is studying brochures and talking to friends who have been there, trying to decide which trip he wants to take.

PART II: Determination of need for Active Treatment: Capacity for Independent Living: Eligible

- With or without the use of adaptive technology, **the individual requires the supportive presence of other persons throughout the day** in order to arise in the morning, prepare for the day, prepare meals, participate in work or day programs, learn to perform tasks independently, benefit from leisure time, associate with friends and family, and engage in other meaningful activity.
- The individual may need one or more of the following forms of support (or other supports not listed) regularly throughout the day: physical supports in accomplishing tasks; supervision and guidance in accomplishing tasks; coordination of activities and scheduling; emotional support; planning and assistance with decision-making; implementation of behavioral plans; provision of equipment and supplies; personal safety; familiarity with and orientation to one's usual environment

PART II: Determination of need for Active Treatment: Capacity for Independent Living: Eligible

- Ex) Michael is a 37-year old man with CP who uses a wheelchair exclusively. He requires physical supports to dress, complete his bathing and hygiene, and to prepare meals. He requires specialized transportation to go to work and to leisure activities. During fire drills at work and at home, Michael becomes confused and anxious and is not able to follow necessary steps to protect himself. Michael enjoys going to the mall, but becomes distracted when there are a lot of people and needs someone to help guide him and make decisions during such times.

PART II: Determination of need for Active Treatment: Capacity for Independent Living: Not Eligible

- With or without the use of adaptive technology, the individual functions satisfactory without the need for the supportive presence of other persons throughout the day in order to arise in the morning, prepare for the day, prepare meals, participate in work or day programs, learn to perform tasks independently, benefit from leisure time, associate with friends and family, and engage in other meaningful activity.
- **The person may benefit from, but does not require,** the forms of support listed in order to manage activity effectively throughout the day and week.
- Ex) Monroe is a 32-year old man with CP who uses a wheelchair for longer trips, but ambulates with the use of braces during other times. He is able to get up, shower and dress himself, and get to work on time. He generally uses public transportation to get to work and to leisure activities, but sometimes he stays home on bad snow days and sometimes he chooses to go with groups for leisure activities (instead of going on his own). His weekend routine is to go to the mall on Saturday and to church on Sunday. Sometimes he goes alone and sometimes with friends or staff from his workplace. During drills, Monroe follows prescribed procedures for tornados and fires.

**PART II: Determination of need for Active Treatment:
Indicators of the Need for AT**

- a. The individual's ability to engage in routines of daily living without substantial ongoing supervision or direction:
- Can the individual perform basic activities of daily living without substantial ongoing supervision or direction?
 - Can the individual perform more complex self-care tasks (e.g. meal planning and preparation, simple transactions for goods and services, laundry and house cleaning) without substantial ongoing supervision and direction?
 - Can the individual go to and from work, shopping, religious and social gathering places, and friends' and family members' homes without substantial ongoing supervision and direction?

**PART II: Determination of need for Active Treatment:
Indicators of the Need for AT**

- b. The individual's vulnerability that is, the individual's ability to avoid injury, harm, or exploitation without substantial ongoing supervision or direction.
- Has the individual recently been involved in a harmful relationship?
 - How would the individual treat a stranger who approached him/her for money for food?
 - Can the individual turn away unwanted sexual overtures?

**PART II: Determination of need for Active Treatment:
Indicators of the Need for AT**

- c. **The individual's ability to cope with changes or unexpected events** without substantial ongoing supervision or direction:
- Is there now (or can the individual and his/her support team easily establish) a reliable on-call safety network or set of procedures, allowing the individual to live independently and move about the community without the immediate presence of staff?
 - Is the individual able to tolerate disruption in schedules and routines?
 - Would the individual be able to communicate his/her needs if he/she were in an unfamiliar part of town, without the assistance of someone who knows him/her?

**PART II: Determination of need for Active Treatment:
Indicators of the Need for AT**

- d. The individual's ability to initiate, maintain, or generalize activities without intervention by staff and the individual's dependence on structured activities.
- Is the individual able to occupy himself/herself for two to four hours in the evening or on weekend?
 - Does the individual practice reasonable standards for getting out supplies/equipment for projects and putting them away?
 - Does the individual have interests that he or she pursues when unstructured time is available?

**PART II: Determination of need for Active Treatment:
Indicators of the Need for AT**

- e. The individual's ability to conduct himself/herself appropriately when away from responsible adults:
- When away from responsible adults, does the individual limit unusual behavior to settings where it can be tolerated?
 - Does the individual adhere to socially accepted behavioral norms in public places?
 - Is the individual generally considered to be emotionally stable by most persons who know him/her?

**PART II: Determination of need for Active Treatment:
Indicators of the Need for AT**

- f. The individual's ability to recognize and react appropriately to emergencies, dangerous situations, and unusual events (power outage, fire, robbery, out of money, illness, injury).
- Does the individual avoid unusual or dangerous situations/experiences?
 - Does the individual have a sound instinct for dangerous or unusual circumstances?
 - When fearful or worried, does the individual ask for assistance if needed?
 - Can the individual demonstrate basic safety and shelter seeking procedures in the event of fire, tornado, and car accident?

**PART II: Determination of need for Active Treatment:
Indicators of the Need for AT**

- g. **The individual's need for 24-hour availability of responsible adults,** even if the adults are not on-site:
- Has the individual experienced spending eight to ten hours away from responsible adults, without problems, successfully and often?
 - Is the individual comfortable when responsible adults are not one minute away?
 - Is it considered unnecessary frequently to monitor the individual's well-being when he/she is in his/her home or work place setting?

**PART II: Determination of need for Active Treatment:
Indicators of the Absence of a Need for AT**

- a. The individual is independent without aggressive and consistent training: Does the individual require repeated and consistent prompts, directions, or prompts in order to get through most activities of the day?
- b. The individual is usually able to apply skills learned in training situations to other settings and environments: if the individual has learned skills at home, at school, or in a day program, has he/she shown the ability to use those skills somewhere else?

**PART II: Determination of need for Active Treatment:
Indicators of the Absence of a Need for AT**

- c. The individual is generally able to take care of most of their personal care needs, make known to others their basic needs and wants, and understand simple commands: can the individual do these things or direct others to perform them or assist in performing them?
- d. The individual is capable of working at a competitive wage level without support, and to some extent, are able to engage appropriately in social interactions: has the individual already demonstrated skills for which he/she could be hired without supports, and is the individual usually able to interact appropriately with others in a workplace environment?

**PART II: Determination of need for Active Treatment:
Indicators of the Absence of a Need for AT**

- e. The individual is able usually, to conduct themselves appropriately when allowed to have time away from the facility: (for person not now in a facility) does the person behave appropriately when he/she is not at home or in a structured residential or day program setting, especially when not receiving staff assistance?
- f. The individual does not require the range of professional services or interventions in order to make progress: has the individual demonstrated the capacity to grow, learn, and make gains in functioning, without the benefit of active treatment?

