



**British Columbia Association of School
Psychologists (BCASP)**

**Best Practice Guidelines for the Assessment,
Diagnosis and Identification of Students
With Learning Disabilities
(2007)**

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I Introduction

In July, 2006 the Ministry of Education revised its Manual of Policies, Procedures and Guidelines for the identification and assessment of students with learning disabilities (LD). In response to those revisions, The British Columbia Association of School Psychologists (BCASP) decided to develop a more specific description of the roles and the responsibilities of school psychologists in the assessment, diagnosis, and identification of students with LD. A committee of BCASP members was established to undertake this task. In writing this paper, the committee was informed by a number of sources including a surprisingly timely paper on the identification of students with LD that was published by the National Association of School Psychologists (NASP) in July, 2007, as the committee was developing this paper.

References:

BC Ministry of Education Special Education Services: A Manual of Policies, Procedures and Guidelines
http://www.bced.gov.bc.ca/specialed/ppandg/planning_3.htm

“NASP Position Statement on Identification of Students with Specific Learning Disabilities”
National Association of School Psychologists
http://www.nasponline.org/about_nasp/positionpapers/SLDPosition_2007.pdf

II BC Ministry of Education Definition

In March 2007, The Learning Disabilities Association of Canada released a national study on learning disabilities in Canada, *“Putting a Canadian Face on Learning Disabilities”*. The paper made a number of important recommendations about improving the services that are provided for students with learning disabilities. One recommendation relevant to this paper is as follows:

“Endorse a consistent definition and a comprehensive diagnostic assessment protocol for learning disabilities to be used in all publicly funded programs such as education, social service, health and other service areas.” (Executive Summary pg. 6)

In response to this recommendation for a consistent national definition, BCASP supports the Canadian Learning Disabilities Association definition of LD that was adapted for use in BC by the BC Ministry of Education in 2002.

The current BC Ministry of Education definition of LD is as follows:

"Learning Disabilities refer to a number of disorders which may affect the acquisition, organization, retention, understanding or use of verbal or nonverbal information. These disorders affect learning in individuals who otherwise demonstrate at least average abilities essential for thinking and/or reasoning. As such, learning disabilities are distinct from global intellectual deficiency.

Learning disabilities result from impairments in one or more processes related to perceiving, thinking, remembering or learning. These include, but are not limited to: language processing; phonological processing; visual spatial processing; processing speed; memory and attention; and executive functions (e.g. planning and decision-making).

Learning disabilities range in severity and may interfere with the acquisition and use of one or more of the following:

- *Oral language (e.g. listening, speaking, understanding);*
- *Reading (e.g. decoding, phonetic knowledge, word recognition, comprehension);*
- *Written language (e.g. spelling and written expression); and*
- *Mathematics (e.g. computation, problem solving).*

Learning disabilities may also involve difficulties with organizational skills, social perception, social interaction and perspective taking.

Learning disabilities are generally lifelong. The way in which they are expressed may vary over an individual's lifetime, depending on the interaction between the demands of the environment and the individual's strengths and needs. Learning disabilities are suggested by unexpected academic under-achievement or achievement which is maintained only by unusually high levels of effort and support.

Learning disabilities are due to genetic and/or neurobiological factors or injury that alters brain functioning in a manner which affects one or more processes related to learning. These disorders are not due primarily to hearing and/or vision problems, socio-economic factors, cultural or linguistic differences, lack of motivation or ineffective teaching, although these factors may further complicate the challenges faced by individuals with learning disabilities. Learning disabilities may co-exist with various conditions including attention, behaviour and emotional disorders, sensory impairments or other medical conditions." (Special Education Services: A Manual of Policies, Procedures and Guidelines, 2006, p. 46)

References:

BC Ministry of Education Special Education Services: A Manual of Policies, Procedures and Guidelines

http://www.bced.gov.bc.ca/specialed/ppandg/planning_3.htm

“Putting a Canadian Face on Learning Disabilities”

By the Learning Disabilities Association of Canada

http://www.pacfold.ca/what_is/index.shtml

III Intervention for Students Considered “At-risk”

Best practice, in the process of assessment, diagnosis, and identification of students with LD, is that any student who is considered as possibly struggling with a learning disability receives a series of individualized levels of intervention and support, prior to a comprehensive psychoeducational assessment. Several models exist to describe how those progressive interventions can be implemented. Three particularly relevant examples for BCASP members are as follows:

A) Progressive Intervention Models

1) Ministry of Education Model

“Most students included in the Learning Disabilities category will be identified by the school system through the progressive assessment and systematic documentation process described in Section C – Developing an Individual Education Plan:

- *comprehensive assessment of learning needs and use of alternative instructional strategies by classroom teacher;*
- *consultation with the parent and student, with possible screening to investigate whether there is a health basis for the learning difficulty;*
- *collaboration with school-based personnel to develop additional assessment and intervention strategies;*
- *referral to the school based team for further assistance in implementing strategies or coordination of support services; and*

- *possible referral for an extended assessment (psychoeducational assessment) to determine the presence, nature, severity and educational implications of a learning disability and provide additional information for planning.”*

(Special Education Services: A Manual of Policies, Procedures and Guidelines, 2006, p. 47)

2) Response to Intervention (RTI) Model

Response to Intervention or RTI is a heterogeneous group of procedures that is currently being examined by some school districts in North America. Some aspects of RTI look promising in the currently published research. School psychologists may want to consider recommending aspects of the RTI process to their schools as procedures for implementing appropriate progressive intervention. At this time, the procedures of RTI cannot be used as the sole means of diagnosing LD.

RTI is a process that emphasizes how well students respond to changes in instruction. The essential elements of an RTI approach are: the provision of scientific, research-based instruction and interventions in general education; monitoring and measurement of student progress in response to the instruction and interventions; and use of these measures of student progress to shape instruction and make educational decisions. The core features of an RTI process are as follows:

- High quality, research-based instruction and behavioural support in general education;
- Universal (school-wide or district-wide) screening of academics and behaviour in order to determine which students need closer monitoring or additional interventions;
- Multiple tiers of increasingly intense scientific, research-based interventions that are matched to student need;
- Use of a collaborative approach by school staff for development, implementation, and monitoring of the intervention process;
- Continuous monitoring of student progress during the interventions, using objective information to determine if students are meeting goals;
- Follow-up measures providing information that the intervention was implemented as intended and with appropriate consistency;
- Documentation of parent involvement throughout the process.

3) NASP Multi-Tiered Model

NASP advocates the use of a multi-tiered model that incorporates relevant data from multiple sources of information. A multi-tiered model addresses the learning needs of all children, including children with learning disabilities. A multi-tiered model is intended to provide for quality education before a referral for a comprehensive psychoeducational assessment is considered. While various versions have been developed, the multi-tiered model presented here is a widely used generic framework that offers many advantages.

- Tier 1: High quality instructional and behavioural supports for all students in general education.
- Tier 2: Targeted supplemental services for students whose performance and rate of progress are below what is expected for their grade and educational setting.
- Tier 3: Intensive, individualized intervention that has been designed based upon comprehensive evaluation data from multiple sources.

References:

BC Ministry of Education Special Education Services: A Manual of Policies, Procedures and Guidelines
http://www.bced.gov.bc.ca/specialed/ppandg/planning_3.htm

“Response to Intervention (RTI): A Primer for Parents”

By Mary Beth Klotz, PhD, NCSP, and Andrea Canter, PhD, NCSP

National Association of School Psychologists

<http://www.nasponline.org/resources/factsheets/rtiprimer.aspx>

“NASP Position Statement on Identification of Students with Specific Learning Disabilities”

National Association of School Psychologists

http://www.nasponline.org/about_nasp/positionpapers/SLDPosition_2007.pdf

B) Early Intervention

The following discussion has been adapted from A. Harrison’s article “Recommended Best Practices for the Early Identification and Diagnosis of Children with Specific Learning Disabilities in Ontario” published in the *Canadian Journal of School Psychology* (2005).

Children entering Kindergarten programs arrive with diverse experiences, and widely varying levels of developmental maturity. Although the majority of these children adapt to the level of programming offered during the early school years, a minority of them show evidence of learning difficulties that place them significantly behind their peers in key areas of readiness for the acquisition of appropriate literacy and numeracy skills. These learning difficulties may arise due to a myriad of factors, including physical, biological, personality, emotional, family, and socio-cultural issues, which may singly or in combination influence how learning difficulties are expressed in academic, home, or social settings. The extent of such learning difficulties can be established by comparing individuals to their same-age peers on various global and standardized measures of academic progress, or by determining highly significant variances in cognitive and academic abilities.

From the results of such comparisons, specific criteria may be applied in order to determine which children are at risk of failure, for whatever reason, and for whom additional support will be provided. Such a screening is non-categorical in nature; that is, children are determined simply to be "at-risk" without specifying a particular diagnostic category or identification label. Specific programming can then be implemented, either within the classroom in general, or to small groups of children with common learning needs, geared toward skill-building in preparation for entry to the Grade 1 program. The degree of success will usually depend to a great extent on the specific types of difficulty, the causes of the difficulty, the timeliness of the intervention, and the appropriateness of fit of the remedial programs used.

While generic intervention programs may result in improvements in some individuals, there will be a subgroup of children who will require more in-depth assessment to pinpoint each child's specific areas of difficulty related to learning and individualize intervention programs so that the probability of success is maximized. Therefore, it is strongly recommended that appropriate screening of all children be undertaken in Kindergarten, and again in Grade 1 using measures associated with the development of early literacy and numeracy skills. This could, for example, include measures of phonological, orthographic, and morphological awareness, visual-motor integration, and number sense administered by school staff or in some cases by district personnel such as school psychologists.

Screening should also evaluate possible medical or biological causes for learning difficulties, such as vision or hearing impairments, genetic disorders, etc. By this means, all children who are "at-risk" for

learning failure, regardless of cause could be provided with appropriate supports and interventions. Those children, whose learning problems are remediable or are due to factors other than a learning disability, would then receive appropriate assistance in a timely manner.

Ongoing and dynamic screening and intervention throughout the school year are also recommended to constantly evaluate how well the remediation programs are working, and to adjust the delivery or method as required. The screening process can be executed effectively by teachers, and subsequent remediation may be provided by qualified personnel within the school system, for example, speech and language pathologists, and early literacy specialists. When such dynamic screening and interventions are in place during Kindergarten and Grade 1, it will be more readily apparent which children are still failing to benefit from assistance, despite appropriate remediation efforts.

References:

“Recommended Best Practices for the Early Identification and Diagnosis of Children with Specific Learning Disabilities in Ontario”

By Allyson G. Harrison

<http://www.queensu-hcde.org/rarc/publications.html>

Harrison, Allyson G. (2005) “Recommended Best Practices for the Early Identification and Diagnosis of Children with Specific Learning Disabilities in Ontario”, *Canadian Journal of School Psychology* 20(1 & 2): 21-43.

Learning Disabilities Association of Ontario, “Learning Disabilities: A New Definition”:

<http://www.ldao.ca/resources/education/pei/defsupp/index.php>

IV Assessment, Diagnosis, and Identification

A) Psychoeducational Assessments

Students who fail to respond to significant school-based interventions (for example, learning assistance over a reasonable period of time), or who may otherwise be “at-risk” of having a learning disability may be referred for a psychoeducational assessment to be completed by a qualified psychologist. The results of assessment are described in a written report, and all of the following components must be included in the report unless a valid rationale for the omission is provided:

1. A specific clear diagnostic statement that the individual has a learning disability, if applicable;
2. Information about home language use (original language, dialect, language(s) spoken in the home);
3. Relevant medical/developmental/family history, including results of any vision/hearing evaluations;
4. Relevant information from other professional evaluations (e.g., speech-language, occupational therapy, educational consultant, etc.) including previous psychological assessments;
5. Examiner’s statement regarding the validity of the present assessment results;
6. Behavioural observations during the testing sessions, as well as available observations (both anecdotal and from rating scales) from parents, teachers, classroom visits, etc.;
7. Reporting and interpretation of formal test results, including a description of the individual’s strengths and needs, an indication of how the observed pattern of abilities and achievement demonstrates the presence of a specific disability, and adequately documented evidence as to how an observed processing problems is the presumed cause for the documented learning difficulties;
8. Clear statements evaluating an individual’s relative strengths and needs in the four areas relevant to a diagnosis of learning disabilities: thinking and reasoning abilities, academic achievement, psychological processes related to learning, and coexisting conditions (by using, for example, base rates, clinical significance, descriptive categories, or diagnostic subtypes).
9. Based on the individual’s strengths and needs, recommendations / suggestions / indications for further action and intervention in the areas of skill instruction, compensatory strategies, and self-advocacy skills, along with requirements for appropriate accommodations at home, and in school, community and/or workplace settings;
10. Signature of an appropriately qualified psychologist, such as a certified school psychologist, a registered psychologist, or a registered psychological associate. The qualified psychologist must be present (preferably in person or in real-time audio or visual connection) when oral diagnostic reports are delivered.

B) Differential Diagnosis Versus Formal Identification

For the purposes of making the definition of learning disabilities operational, a clear distinction must be made between **diagnosis** which is made by an appropriately qualified psychologist and **identification** which is usually made by an authorized administrative officer of a school district. Appropriately qualified psychologists include certified school psychologists or registered psychologists and registered psychological associates who have appropriate education, training, and experience to work in school settings. School board personnel working in the special education field must understand the difference between diagnosis and identification in order to clearly explain programming decisions for students with learning disabilities, based on the results of a comprehensive psychoeducational assessment.

According to Harrison (2005) the difference between diagnosis and identification is as follows:

“Identification...involves consideration of multiple sources of information in order to determine whether a pupil meets the Ministry of Education’s definition of an exceptional student. For instance, identification may involve reviewing reports from parents and teachers, and in some cases from psychologists and other regulated health professionals. Unlike diagnosis, which involves a professional’s formal opinion concerning the cause of an individual’s symptoms, identification is accomplished through a school board committee and is carried out solely for the purpose of planning how best to meet a pupil’s needs in the educational environment. There is no obligation to determine the actual cause of academic or other problems in the identification process.”

According to the Learning Disabilities Association of Ontario (2001)

“The formulation of a diagnosis is usually made in the course of a psychological assessment that takes the observations of an individual’s strengths and weaknesses further to identify and integrate causes, antecedents, and determinants in such a way as to provide a psychological interpretation consistent with an accepted nomenclature and associated body of knowledge and research.

In the course of providing assessment and consultation services, a diagnosis is formulated in circumstances where the assessment or consultation...determines that a person has a learning disability in that his or her skill level in an area of academic functioning is markedly below the

level expected on the basis of the person's intellectual capacity, where the discrepancy is not due to deficient educational opportunities, cultural or linguistic difference, hearing or vision impairment, physical disability, or primary emotional disturbance.

Considering all of the above points, the term "learning disability" constitutes a diagnosis when it is used to provide an explanation for a learning problem through a classification, formulation or causal statement linking it to a neuropsychological disorder, and, when this information is communicated to the individual, or to his or her personal representatives under circumstances in which he/she or they could be expected to rely upon the diagnosis (i.e., generally in a face-to-face meeting or through a written report).

In the context of the school system, diagnosis refers to the classification of a learning disorder by a qualified psychologists based on a psychoeducational assessment. On the other hand, identification refers to the designation of services for which the student is eligible, as determined by an administrative officer or district committee. So, for example, it is conceivable that a student with a perceptual motor processing disorder and poor handwriting could be diagnosed "learning disabled" in elementary school. The student could then also be identified as "learning disabled" and given instruction in the use of a computer rather than in penmanship. However, that same student could still continue to have a diagnosis of "learning disabled" in Grade 12 but might not be identified as "learning disabled" if the student is very successfully performing like many other students in his grade just by using a laptop computer for all his writing needs.

The use of the term learning disability for both differential diagnosis and formal identification is problematic. As Harrison (2005) points out in an Ontario context:

"Unfortunately, it is the case that a sizeable number of children who are identified through the IPRC process do not actually meet the diagnostic criteria for a specific learning disability. Most of these children and their parents are unaware of the distinction between identification and diagnosis. Later, upon application to college or university, many of these students are justifiably upset to discover that the documentation they provide of their disability is not sufficient to obtain accommodation at the post-secondary level. Indeed outside of the Ontario public school system, accommodation of a disabling condition almost always requires that the disorder be formally diagnosed, rather than simply identified."

1) Differential Diagnosis

In order for a diagnosis of Learning Disability to be made, consistent with the guidelines advocated by the Learning Disabilities Association of Canada, **all** of the following criteria must be met unless a valid written rationale is provided in the report:

1. A non-random, clinically significant discrepancy (for example, a base rate below 10%) between abilities essential for thinking and reasoning, and one or more of the psychological processes logically related to learning such as phonological processing; memory and attention; processing speed; language processing; memory and attention; perceptual-motor integration; visual-spatial processing; or executive functions. (see Appendix A and Appendix C)
2. Academic achievement that is unexpectedly low relative to the individual's thinking and reasoning abilities OR academic achievement that is within expected levels, but is sustainable only by extremely high levels of effort and support. (See Appendix A and Appendix B)
3. Evidence that learning difficulties are logically related to observed deficits in psychological processes. (For example, low scores in reading decoding are logically related to low scores in phonological processing.)
4. Evidence that learning difficulties cannot primarily be accounted for by:
 - Other conditions, such as global developmental delay, primary sensory deficits (e.g., visual or hearing impairments), or other physical difficulties;
 - Environmental factors, such as deprivation, abuse, inadequate or inappropriate instruction, socio-economic status, or lack of motivation;
 - Cultural or linguistic diversity, including developmental levels of ESL.
5. If a coexisting condition is present, the learning difficulties cannot primarily be accounted for by this coexisting disorder. (See Appendix D)

2) Formal Identification

The following steps have been adapted from the Ministry of Education guidelines (2006). BCASP recommends that students formally identified for funding and documented as special needs students in the learning disabilities category should be identified by the school system through a process that includes progressive intervention, a psychoeducational assessment, a differential diagnosis, and an IEP as follows:

1. Comprehensive assessment of learning needs and use of alternate instructional strategies by classroom teacher;
2. Consultation with the parent and student about possible screening to investigate whether there is a health basis for the learning difficulty;
3. Collaboration with school-based personnel to develop additional assessment and intervention strategies;
4. Referral to SBT for further assistance in implementing strategies or coordination of support services;
5. Consultation with a qualified psychologist to develop additional assessment and intervention strategies;
6. Referral to a certified school psychologist, registered psychologist, or registered psychological associate to obtain a psychoeducational assessment that contains a differential diagnosis;
7. Implement and evaluate recommendations from the psychoeducational assessment in consultation with a qualified psychologist.
8. Develop or update Individualized Educational Plan (IEP) that is consistent with any psychoeducational assessment recommendations regarding the student's diagnosed special needs.
9. Submit comprehensive documentation about the student to an authorized administrative officer to request formal identification when the psychoeducational assessment results, the diagnosis, and the educational plan justify the need for special education services.
10. Periodically monitor intervention and programming decisions in relation to student progress to determine if a reassessment or a change of identification is warranted.

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“Recommended Best Practices for the Early Identification and Diagnosis of Children with Specific Learning Disabilities in Ontario”

By Allyson G. Harrison

<http://www.queensu-hcde.org/rarc/publications.html>

Harrison, Allyson G. (2005) “Recommended Best Practices for the Early Identification and Diagnosis of Children with Specific Learning Disabilities in Ontario”, *Canadian Journal of School Psychology* 20(1 & 2): 21-43.

“LD Defined: Official Definition of Learning Disabilities”

By the Learning Disabilities Association of Canada

http://www.ldac-taac.ca/Defined/defined_new-e.asp

“Cross-Battery Assessment and Learning Disability Determination”

By Dawn P. Flanagan, PhD, and Samuel O. Ortiz, PhD

<http://www.crossbattery.com/>

BC Ministry of Education Special Education Services: A Manual of Policies, Procedures and Guidelines

http://www.bced.gov.bc.ca/specialed/ppandg/planning_3.htm

V Psychometric Issues

A) “Average” Ability

In order to be identified as having a learning disability in B.C., the Ministry of Education uses a Canadian definition which stipulates that students must be of at least “average” ability on a measure of cognitive ability, or, on a norm-referenced measure of reading comprehension, math reasoning, or written language. In addition, students must have persistent difficulties in the acquisition of academic skills and significant weakness in one or more cognitive processes. It should be noted that the DSM-IV-TR does not stipulate or define “average” ability.

The stipulation of “average” ability in the Canadian definition of LD poses a number of conceptual and methodological problems for psychologists. First, notwithstanding the correlation between cognitive ability and measures of reading comprehension, mathematical reasoning or written expression, the latter are not synonymous with cognitive ability, and their inclusion as measures of “average” intelligence in BC Ministry of Education policy guidelines is potentially misleading. For example, a student with a nonverbal learning disability might score below average on measures of reading comprehension, math reasoning, or written language, while verbal intelligence on an intelligence test may be well-within or above average. More commonly, children with language-based learning disabilities often struggle in all three academic areas, while showing above average nonverbal reasoning abilities.

Second, it has been argued that children with learning disabilities tend to do poorly on measures of intelligence as a result of cumulative deficit or what has been termed “Matthew Effect” (Stanovich, 1986). Essentially, it is argued that IQ tests are measures of prior learning, largely language-related, and are heavily influenced by cultural and socio-economic factors. Children with LD have difficulty learning and, therefore, may score lower on tests of measured intelligence than other children. Moreover, children with LD may perform at lower levels on IQ tests than other children because their processing deficits, especially in the areas of processing speed and memory, interfere with test performance.

Third, it has been suggested in research that the distinguishing feature between children with reading disabilities and low achievers is not intelligence, but a weakness in one or more specific cognitive processes such as phonological awareness or working memory. Therefore, the stipulation that only children of average intelligence can be considered as having a learning disability is potentially misleading. Children with below average ability (IQ below 70) are typically identified as having mild intellectual disabilities. However, children whose ability falls within the “gray area” between “average” ability and mild range intellectual disability will be ineligible for special education services, despite having specific processing weaknesses.

Fourth, while there appears to be an under-identification of learning disabled students in the “gray area”, there is a potential problem of over-identification amongst students who are currently described as being gifted, learning disabled. The current definition of a learning disability includes the criteria that a learning disability is suggested by an unexpected academic under-achievement. The question that must be asked is whether or not a student who is performing at the same level as his or her peers and at the same level as the

educational materials presented to them should be considered as, “performing at an unexpected level” and described as disabled. In addition, students who score at very high levels on cognitive ability tests can easily score much lower on processing tests due simply to statistical regression. Actual functional impairment with the academic demands of the classroom may be a more significant factor in determining if a student is disabled as opposed to simply comparing IQ scores that are well above average with achievement scores that are in the average range but basically meet the expectations of the student’s educational environment.

In conclusion IQ testing is controversial, particularly in the assessment of learning disabilities (e.g. Gardner, 1993; Gould, 1996; Klassen, Neufeld, and Munro, 2005; Siegel, 1989; Valencia and Suzuki, 2001). It is beyond the scope of this position paper to resolve these complex issues. However, it is important to raise these psychometric issues regarding the assessment and diagnosis of learning disabilities for future discussions and considerations. Such discussions will hopefully help to develop an appropriate definition and a comprehensive diagnostic assessment protocol for learning disabilities across Canada.

B) Beyond “Average”

Another problem associated with the use of “average” ability and discrepancy formulae involves problems with the psychometric properties of the tests used, as well as influences from statistical phenomena such as regression to the mean. The use of tests that measure ability and achievement, based upon different normative samples, greatly complicates the degree to which scores from these tests can be meaningfully compared. In addition, due to their imprecision, the use of age-equivalents and grade-equivalents as a basis for comparison between tests is indefensible and contributes to serious under- as well as over-estimation of students with learning problems. The best practice would be to compare standard scores from co-normed tests of ability and achievement (in other words, tests based upon the same normative sample), using proper statistical procedures and tables for comparing the degree of discrepancy and the frequency of such a discrepancy among the normative sample.

Some of these psychometric issues are especially problematic in the assessment of students who are outside the traditional “average ability range” as far as standardized scores are concerned. It is generally accepted that the diagnosis of learning disabilities calls for greater diagnostic and clinical judgement when the student’s full scale measured I.Q. is more than one standard deviation from the mean, in other words, is below 85 (16th percentile) and above 115 (84th percentile). BCASP contends that a good assessment,

based on information collected from a variety of test and non-test sources and augmented by clinical judgement, will focus on identifying the primary causes of the difficulties and the most appropriate forms of intervention. A key requirement is to ensure that in the diagnostician's judgement, the manifestations of academic and other difficulties that can logically be attributed to the observed psychological processing deficits and that neither can be more accurately ascribed to another condition.

VI Recommendations

To ensure that appropriate interventions occur in a timely manner, that all relevant factors and other possible conditions are considered, and that the likelihood of students being misdiagnosed or mislabelled is minimized, BCASP makes the following recommendations:

1. School psychologists should strongly encourage schools to implement a program of progressive intervention prior to a referral for a psychoeducational assessment so that the information regarding the student's response to that intervention can be incorporated into the assessment report.
2. Psychoeducational assessments must integrate multiple sources of relevant information, including test performance and responsiveness to intervention, to provide a comprehensive interpretation of the results.
3. School psychologists must take steps to ensure that psychoeducational assessments are only completed by appropriately qualified psychologists who are either certified members of BCASP or they are registered members of the College of Psychologists, with the appropriate education, training, and experience to work in school settings.
4. School psychologists must take steps to ensure that students are only formally identified in the Ministry of Education category of Learning Disabled by an administrative officer or district committee if those students have been previously given a written diagnosis of a learning disability by a qualified psychologist.
5. School psychologists should strongly encourage schools to take steps to ensure that all students who have significant educational needs, whether or not they have been diagnosed as learning disabled, receive the appropriate educational interventions or services as recommended in their psychoeducational assessments.
6. School psychologists are to provide ongoing consultations regarding the appropriateness of educational programming decisions for students who have received psychoeducational assessments.

VII References

BC Ministry of Education Special Education Services: A Manual of Policies, Procedures and Guidelines

http://www.bced.gov.bc.ca/specialed/ppandg/planning_3.htm

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By Dawn P. Flanagan, PhD, and Samuel O. Ortiz, PhD

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"NASP Position Statement on Identification of Students with Specific Learning Disabilities"

National Association of School Psychologists

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Further references for Response to Intervention (RTI) research

"Response to Intervention References and Weblinks"

By the National Association of School Psychologists

<http://www.nasponline.org/advocacy/rtireference.pdf>

Further references for calculating a non-random, clinically significant discrepancy

"Issues in Severe Discrepancy Measurement: A Technical Assistance Paper for Special Educators"

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“IQ Test: Where Does It Come From and What Does It Measure”

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Further references on the “Matthew Effect”

“The Matthew Effects” By Dr. Kerry Hempenstall

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“Matthew Effects in Reading” By Sebastian Wren, PhD

<http://www.balancedreading.com/matthew.html>

Stanovich, K. E. (1986) ‘Matthew Effects in Reading, Some Consequences of Individual Differences in the Acquisition of Literacy’, *Reading Research Quarterly* 21, 360-406.

Psycho-Educational Assessment	Differential Diagnosis	Formal Identification
<ol style="list-style-type: none"> 1. A specific clear diagnostic statement that the individual has a learning disability, if applicable; 2. Information about home language use (original language, dialect, language(s) spoken in the home); 3. Relevant medical/developmental/family history, including results of any vision/hearing evaluations; 4. Relevant information from other professional evaluations including previous psychological assessments; 5. Examiner's statement regarding the validity of the present assessment results; 6. Behavioural observations during the testing sessions, as well as available observations (both anecdotal and from rating scales) from parents, teachers, classroom visits, etc.; 7. Reporting and interpretation of formal test results, including a description of the individual's strengths and needs, an indication of how the observed pattern of abilities and achievement demonstrates the presence of a specific disability, and adequately documented evidence as to how an observed processing problems is the presumed cause for the documented learning difficulties; 8. Clear statements evaluating an individual's relative strengths and needs in the four areas relevant to a diagnosis of learning disabilities: thinking and reasoning abilities, academic achievement, psychological processes related to learning, and coexisting conditions (by using, for example, base rates, clinical significance, descriptive categories, or diagnostic subtypes) 9. Based on the individual's strengths and needs, recommendations / suggestions / indications for further action and intervention in the areas of skill instruction, compensatory strategies, and self-advocacy skills, along with requirements for appropriate accommodations at home, and in school, community and/or workplace settings; 10. Signature of an appropriately qualified psychologist, such as a certified school psychologist, a registered psychologist, or a registered psychological associate. The qualified psychologist must be present (preferably in person or in real-time audio or visual connection) when oral diagnostic reports are delivered. 	<ol style="list-style-type: none"> 1. A non-random, clinically significant discrepancy (for example, a base rate below 10%) between abilities essential for thinking and reasoning, and one or more of the psychological processes logically related to learning (phonological processing; memory and attention; processing speed; language processing; memory and attention; perceptual-motor integration; visual-spatial processing; executive functions). 2. Academic achievement that is unexpectedly low relative to the individual's thinking and reasoning abilities OR academic achievement that is within expected levels, but is sustainable only by extremely high levels of effort and support. 3. Evidence that learning difficulties are logically related to observed deficits in psychological processes. (For example, low scores in reading decoding are logically related to low scores in phonological processing.) 4. Evidence that learning difficulties cannot primarily be accounted for by: <ul style="list-style-type: none"> • Other conditions, such as global developmental delay, primary sensory deficits (e.g., visual or hearing impairments), or other physical difficulties; • Environmental factors, such as deprivation, abuse, inadequate or inappropriate instruction, socio-economic status, or lack of motivation; • Cultural or linguistic diversity, including developmental levels of ESL. 5. If a coexisting condition is present, the learning difficulties cannot primarily be accounted for by this coexisting disorder. 	<ol style="list-style-type: none"> 1. Comprehensive assessment of learning needs and use of alternate instructional strategies by classroom teacher; 2. Consultation with the parent and student about possible screening to investigate whether there is a health basis for the learning difficulty; 3. Collaboration with school-based personnel to develop additional assessment and intervention strategies; 4. Referral to SBT for further assistance in implementing strategies or coordination of support services; 5. Consultation with a qualified psychologist to develop additional assessment and intervention strategies; 6. Referral to a certified school psychologist, registered psychologist, or registered psychological associate to obtain a psychoeducational assessment that contains a differential diagnosis; 7. Implement and evaluate recommendations from the psychoeducational assessment in consultation with a qualified psychologist. 8. Develop or update Individualized Educational Plan (IEP) that is consistent with any psychoeducational assessment recommendations regarding the student's diagnosed special needs. 9. Submit comprehensive documentation about the student to an authorized administrative officer to request formal identification when the psychoeducational assessment results, the diagnosis, and the educational plan justify the need for special education services. 10. Periodically monitor intervention and programming decisions in relation to student progress to determine if a reassessment or a change of identification is warranted.

VII
Table I (Assessment – Diagnosis – Identification)

Appendix A: Tests of Thinking and Reasoning Abilities

Differential Abilities Scale Second Edition (DAS II)

- GCA
- Verbal IQ
- Spatial IQ
- Nonverbal IQ

Kaufman Assessment Battery for Children – II

- Mental Processing Composite
- Fluid Crystallized Index
- Mental Processing Index
- Nonverbal Index

Leiter-Revised

Matrix Analogies Test Expanded Form (MAT-EF)

Stanford Binet Intelligence Scales Fifth Edition

- Full Scale IQ
- Verbal IQ
- Nonverbal IQ

Universal Nonverbal Intelligence Test (UNIT)

Wechsler Adult Intelligence Scale-III (WAIS-III)

- Full Scale IQ
- Verbal IQ
- Performance IQ
- Verbal Comprehension Index
- Perceptual Reasoning Index
- General Ability Index

Wechsler Intelligence Scales for Children-IV (WISC-IV)

- Full Scale IQ
- Verbal Comprehension Index
- Perceptual Reasoning Index
- General Ability Index

Wechsler Intelligence Scales for Children-IV - Integrated

Wechsler Nonverbal Scale of Ability (WNV)

Wechsler Preschool and Primary Scale of Intelligence-III (WPPSI-III)

- Full Scale IQ
- Verbal IQ
- Performance IQ

Woodcock-Johnson-III Tests of Cognitive Ability

- Broad and/or Extended Cognitive Ability
- Thinking Ability
- Fluid Reasoning

Woodcock-Johnson-III Tests of Cognitive Ability – Diagnostic Supplement

Appendix B: Tests of Academic Achievement

General Achievement Batteries

Kaufman Test of Educational Achievement-II (KTEA-II)
Peabody Individualized Achievement Test – Revised Normative Update (PIAT-R/NU)
Wechsler Individual Achievement Test - II (WIAT - II)
Woodcock Johnson - III Tests of Achievement (WJ-III)

Oral Language

Bracken Basic Concept Scale – Third Edition
Clinical Evaluation of Language Fundamentals – Fourth Edition (CELF-4)
Comprehensive Assessment of Spoken Language (CASL)
Detroit Test of Learning Aptitude – 4 (DTLA-4)
Kaufman Test of Educational Achievement-II (KTEA-II)
NEPSY 2

- Language Domain

Oral and Written Language Scales (OWLS)
Test of Adolescent and Adult Language – Third Edition
Test of Language Competence – Expanded Edition
Test of Language Development – Primary: Third Edition
Test of Problem Solving – Third Edition (TOPS-3)
Wechsler Individual Achievement Test - II (WIAT - II)
Wechsler Preschool and Primary Scale of Intelligence-III (WPPSI-III)

- Verbal IQ

Woodcock Johnson - III Tests of Achievement (WJ-III)

- Oral Language
- Listening Comprehension

Woodcock-Johnson-III Tests of Cognitive Ability

- Diagnostic Supplement

Woodcock-Munoz Language Survey Revised
Word Test – Revised

Reading

Gray Oral Reading Test – Fourth Edition (GORT-4)

Gray Silent Reading Test

Kaufman Test of Educational Achievement-II (KTEA-II)

Multilevel Academic Survey Test (MAST)

Peabody Individualized Achievement Test – Revised Normative Update (PIAT-R/NU)

Test of Reading Comprehension – Third Edition

Wechsler Individual Achievement Test – II (WIAT-II)

Wide Range Achievement Test – Fourth Edition (WRAT-4)

Woodcock Johnson - III Tests of Achievement (WJ-III)

- Diagnostic Reading Battery

Reading Decoding

Illinois Test of Psycholinguistic Abilities – Third Edition (ITPA-3)

Kaufman Test of Educational Achievement-II (KTEA-II)

- Letter and Word Recognition
- Nonsense Word Decoding
- Rapid Automatized Naming
- Timed Letter and Word Recognition
- Phonological Awareness

Peabody Individualized Achievement Test – Revised Normative Update (PIAT-R/NU)

Process Assessment of the Learner – 2nd Edition (PAL-2)

Wechsler Individual Achievement Test – II (WIAT-II)

- Pseudoword Decoding
- Word Reading

Woodcock Johnson - III Tests of Achievement (WJ-III)

- Diagnostic Reading Battery

Reading Rate

Kaufman Test of Educational Achievement-II (KTEA-II)

- Fluency (Semantic and Phonological)
- Timed Nonsense Word Decoding

Gray Oral Reading Test – Fourth Edition (GORT-4)

Test of Silent Word Reading Fluency

Test of Word Reading Efficiency (TOWRE)

Woodcock Johnson - III Tests of Achievement (WJ-III)

- Reading Fluency

Spelling

Kaufman Test of Educational Achievement-II (KTEA-II)

Peabody Individualized Achievement Test – Revised Normative Update (PIAT-R/NU)

Wechsler Individual Achievement Test – II (WIAT-II)

Wide Range Achievement Test – Fourth Edition (WRAT-4)

Woodcock Johnson - III Tests of Achievement (WJ-III)

Test of Written Language – Fourth Edition (TOWL-4)

Test of Written Spelling – Fourth Edition (TWS-4)

Mathematics

Comprehensive Math Abilities Test

Kaufman Test of Educational Achievement-II (KTEA-II)

Key Math-Revised: Normative Update

Multilevel Academic Survey Test (MAST)

Peabody Individualized Achievement Test – Revised Normative Update (PIAT-R/NU)

Process Assessment of the Learner – 2nd Edition (PAL-2)

Stanford Tests of Mathematical Ability

Wechsler Individual Achievement Test – II (WIAT-II)

Wide Range Achievement Test – Fourth Edition (WRAT-4)

Woodcock Johnson - III Tests of Achievement (WJ-III)

Written Language

Kaufman Test of Educational Achievement-II (KTEA-II)

Oral and Written Language Scales (OWLS)

Peabody Individualized Achievement Test – Revised Normative Update (PIAT-R/NU)

Process Assessment of the Learner – 2nd Edition (PAL-2)

Test of Written Language – Fourth Edition (TOWL-4)

Wechsler Individual Achievement Test – II (WIAT-II)

Woodcock Johnson - III Tests of Achievement (WJ-III)

Appendix C: Tests of Psychological Processes Related to Learning

Executive Functions

Behavioural Assessment of Dysexecutive Syndrome for Children (BADS-C)

Behavior Rating Inventory of Executive Functioning (BRIEF)

Brown ADD Scales

Conners 3

Delis-Kaplan Executive Function System (D-KEFS)

NEPSY – II

- Attention
- Executive Functioning

Psychological Processing Checklist (PPC)

Token Test

Tower of London DX 2nd Edition

Wisconsin Card Sort Test

Woodcock-Johnson-III Tests of Cognitive Ability

- Executive Processes
- Planning Subtest

Language Processing

Bracken Basic Concept Scale – Third Edition

Clinical Evaluation of Language Fundamentals – Fourth Edition (CELF-4)

Comprehensive Assessment of Spoken Language (CASL)

Detroit Test of Learning Aptitude – 4 (DTLA-4)

Expressive Vocabulary Test – II (EVT – II)

Kaufman Assessment Battery for Children – II

- Knowledge / Gc

Peabody Picture Vocabulary Test – Fourth Edition (PPVT-IV)

Stanford-Binet V

- Knowledge

NEPSY – II

- Language

Test of Adolescent and Adult Language – Third Edition

Test of Language Competence – Expanded Edition

Test of Language Development – Primary: Third Edition (TOLD-P:3)

Test of Oral Language Development (TOLD)

Test of Problem Solving – Third Edition (TOPS-3)

Wechsler Adult Intelligence Scale-III (WAIS-III)

- Verbal IQ
- Verbal Comprehension Index

Wechsler Intelligence Scales for Children-IV (WISC-IV)

- Verbal Comprehension Index

Wechsler Preschool and Primary Scale of Intelligence-III (WPPSI-III)

- Verbal IQ

Woodcock-Johnson-III Tests of Cognitive Ability: Diagnostic Supplement

Woodcock-Munoz Language Survey Revised

Memory and Attention

Children's Memory Scale

Detroit Tests of Learning Aptitude – IV

Differential Abilities Scale Second Edition (DAS II)

- Working Memory
- Recall of Objects

Kaufman Assessment Battery for Children – II

- Learning / Glr
- Sequential / Gsm

Leiter-Revised

NEPSY-II

- Memory
- Attention/Executive Functioning

Rey-Osterreith Complex Figure

Stanford-Binet V

- Working Memory

Test of Memory and Learning-II (TOMAL-II)

Wechsler Adult Intelligence Scale-III (WAIS-III)

- Working Memory Index

Wechsler Intelligence Scales for Children-IV (WISC-IV)

- Working Memory Index

Wechsler Memory Scale-Third Edition (WMS-III)

Wide Range Assessment of Memory and Learning II (WRAML-II)

Woodcock-Johnson-III Tests of Cognitive Ability

- Short-term memory factor (Gsm)
- Long-term memory factor (Glm)

Orthographic Processing

Jordan Left-Right Reversal Test – Third Edition

Process Assessment of the Learner – 2nd Edition (PAL-2)

Test of Silent Word Reading Fluency

Phonological Processing

Comprehensive Test of Phonological Processing (CTOPP)

Differential Abilities Scale Second Edition (DAS II)

- Phonological Processing

Illinois Test of Psycholinguistic Abilities – Third Edition (ITPA-3)

NEPSY-II

- Phonological Processing

Process Assessment of the Learner – 2nd Edition (PAL-2)

Rosner Test of Auditory Analysis

Test for Auditory Processing Disorders in Children – Revised (SCAN-C Revised)

Test of Auditory Processing Skills (TAPS-3)

Test of Language Development – Primary: Third Edition (TOLD-P:3)

Test of Phonological Awareness (TOPA)

Woodcock-Johnson-III Tests of Achievement (WJ-III)

- Phoneme-Grapheme Knowledge

Woodcock-Johnson-III Tests of Cognitive Ability

- Auditory Processing Factor (Ga)
- Diagnostic Supplement

Perceptual-Motor Processing

Beery-Buktenica Developmental Test of Visual-Motor Integration V (VMI)

Beery-Buktenica Developmental Test of Motor Coordination V

Beery-Buktenica Developmental Test of Visual Perception V

Bender Visual Motor Gestalt Test – Second Edition

Differential Abilities Scale Second Edition (DAS II)

- Recall of Design

Evaluation Tool of Children's Handwriting (ETCH)

Gardner Test of Visual Perception Skills

Gardner Test of Visual-Motor Skills

NEPSY-II

- Design Copying
- Visuo Motor Precision

Test of Visual Perceptual Skills – Third Edition (TVPS-3)

Visual Motor Assessment (ViMo)

Processing Speed

Differential Abilities Scale Second Edition (DAS II)

- Processing Speed

Detroit Tests of Learning Aptitude – IV

Wechsler Adult Intelligence Scale-III (WAIS-III)

- Processing Speed Index

Wechsler Intelligence Scales for Children-IV (WISC-IV)

- Processing Speed Index

Woodcock-Johnson-III Tests of Cognitive Ability

- Processing Speed factor (Gs)
- Diagnostic Supplement

Sensorimotor

Dean-Woodcock Sensory Motor Battery

NEPSY – II

- Sensorimotor

Process Assessment of the Learner (PAL)

Visual-Spatial Processing

Comprehensive Test of Nonverbal Intelligence (CTONI)

Kaufman Assessment Battery for Children – II

- Planning / Gf

Leiter-Revised

NEPSY – II

- Visual
- Spatial
- Sensorimotor

Stanford-Binet V

- Visual Spatial Processing

Test of Nonverbal Intelligence Third Edition (TONI-III)

Wechsler Adult Intelligence Scale-III (WAIS-III)

- Performance IQ
- Perceptual Reasoning Index

Wechsler Intelligence Scales for Children-IV (WISC-IV)

- Perceptual Reasoning Index

Wechsler Preschool and Primary Scale of Intelligence-III (WPPSI-III)

- Performance IQ

Wide Range Assessment of Memory and Learning -II (WRAML – II)

Woodcock-Johnson-III Tests of Cognitive Ability

- Visual-Spatial Thinking
- Diagnostic Supplement

Appendix D: Tests of Coexisting Psychological Conditions

Personality, Behavioural, and Emotional Functioning

Achenbach Child Behavior Checklists

Beck Youth Inventories

Behavior Assessment System for Children- II (BASC-2)

Children's Apperception Test

Children's Depression Inventory (CDI)

Children's Dissociative Experiences Scale (CDES)

Conners Comprehensive Behavior Rating Scales

Conners Continuous Performance Test II Version 5 (CPT II V.5)

Conners' 3

Coping Inventory for Stressful Situations (CISS)

Jesness Inventory – Revised

Feelings, Attitudes and Behaviors Scale for Children (FAB-C)

Multidimensional Anxiety Scale for Children (MASC)

Piers-Harris Children's Self-Concept Scale - 2

Robert's Apperception Test

Rorschach Test - Comprehensive System

Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and
Lifetime Version (K-SADS-PL)

Social Skills Rating Scales (SSRS)

Trauma Symptom Checklist for Children (TSCC)

Adaptive Functioning

Adaptive Behavior Assessment System – II (ABAS-II)

Scales of Independent Behavior – Revised (SIB-R)

Vineland Adaptive Behavior Scales – II

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Terms of Reference

The following motion was passed and the 2006 Annual General Meeting of the British Columbia Association of School Psychologists (BCASP):

That the executive of BCASP undertake, or assign a subcommittee to undertake, to develop a best practices document intended to:

- a) harmonize the assessment, identification and documentation of learning disabilities across school districts in BC, and*
- b) recognize the value of the discipline of school psychology and the unique skills and contributions of school psychologists as they relate to that process.*