
Learning Disability: Definitions and Contexts



**Professional Affairs Board of
The British Psychological Society**

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Membership of the Working Group

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Introduction

Following the introduction of new and revised mental health and local government legislation in the 1980s¹, the British Psychological Society published a guidance document, *Mental Impairment and Severe Mental Impairment: A Search for Definitions* (BPS, 1991). This document highlighted the different definitions used within the respective Acts, and offered guidelines on operational criteria. The document was generally well received within the profession and was followed, in 1995, by a similar paper relating specifically to the Mental Health (N. Ireland) Order 1986.²

The original documents focused on specific pieces of legislation which used the terms '*severe mental impairment*' and '*severe mental handicap*'. This led to some debate regarding the need for a broader document with respect to 'learning disability' and its relation to other legislation in a wider context. As a result, the Society's Professional Affairs Board invited the Special Interest Group (Learning Disabilities) of the Division of Clinical Psychology to look again at these documents, with a view to updating and, where appropriate, amending them to cover a broader field. This document is the result of that review.

The guidelines presented in this document are not intended to be sufficient for a full psychological assessment for adults with learning disabilities. The nature of any such assessment would obviously depend on individual circumstances but, within most contexts, reliance solely on overall figures derived from assessments of intellectual functioning and/or other norm-based assessments would have limited value.³ Indeed, presenting an overall figure derived from such assessments may be misleading and potentially damaging, particularly if used in any predictive sense.⁴ Psychologists should be sensitive to the issues related to labelling⁵ – particularly in terms of test scores alone – and should resist simplistic interpretations of an individual's need based on broad classifications.

There has been a welcome trend away from assessments based exclusively on psychometric test results which lead solely to simple classification and categorisation of 'learning disability', to one which seeks to assess individual need and to identify the necessary supports to meet that need.⁶

¹ The Mental Health Act 1983, the Mental Health (Scotland) Act 1984, the Abolition of Domestic Rates (Scotland) Act 1987 and the Local Government Finance Act 1988.

² British Psychological Society (1995). *Mental Handicap, Severe Mental Handicap and Severe Mental Impairment: The Mental Health (N.Ireland) Order 1986. Definitions and Operational Guidelines*.

³ It is accepted that the use of such instruments to *profile* abilities, particularly within a neurological context, does have value and, used in this way, such, well chosen, assessments afford people with learning disabilities access to the same type of service provided for people with disorders of neurological functioning but who do not have learning disabilities. However, within this context, it would be the interpretation of the *range* of scores that would be of importance, not the overall figure *per se*.

⁴ This point is relevant in all areas but particularly so for children and young adults.

⁵ Labelling can be socially devaluing. Equally, it can be argued that it is not the labelling *per se* which is of prime significance but the *social consequence* of the labelling. Construed in this way, meaningful change for individuals would include change within the wider social and political systems (see Bell, 1989; Szivos, 1992; Brown & Smith, 1992, for general discussion).

⁶ The American Association on Mental Retardation (AAMR, 1992) avoids reliance on IQ scores to assign a level of disability by suggesting a framework which relates the person's needs to the intensities of '*... the supports necessary to enhance their independence/interdependence, productivity and community integration.*' However, even under this system, there is an agreed definition of Mental Retardation which does rely on assessments of intellectual and social functioning.

To be valid, a psychological assessment needs to be based on a comprehensive analysis, including reference to biological, psychological and interactional factors, within the broader social/cultural and environmental context.

As the concept of learning disabilities may be seen as a social construction⁷ – even when the biological/neurological basis is known – the idea of any permanency of the concept must be questioned, as the phenomenon of IQ drift, and its changing criteria, clearly illustrate.

However, *given* its social construction, and whatever one's views are on its theoretical basis, it has to be acknowledged that the concept is enshrined within our social and legal systems. As such, the concept affects peoples' legal and civil rights.

Some psychologists may find that the concept of classification presents some personal difficulties, particularly as it may have lasting implications on an individual's life. Over time many injustices have been done to people labelled as *different*. However, there are situations in which an opinion on classification can assist a person to gain access to civil and legal rights and protections. For example, to prove discrimination, to argue against denial of an 'appropriate adult' during police questioning⁸, to consider a case under the Sexual Offences Acts 1956⁹/1967, at some point it may be appropriate to consider whether a person could be seen to have a (*severe*) learning disability. Without acknowledgement of the disability a person might be denied rights to justice and/or equality.

This document was proposed in response to an expressed need for guidance on how the concept of learning disabilities, as used within a health and personal social services setting, relates to its use in civil, legal and medico-legal contexts.

Much of the content of the Society's original documents has been retained. The Society wishes to reaffirm its view that the guidance offered should be used both with caution and in full knowledge of the limitations of classification within specific contexts.

⁷ See Clements (1998) for discussion.

⁸ Under the Police and Criminal Evidence Act 1984 (PACE).

⁹ For Scotland, Mental Health (Scotland) Act 1984 (s 106).

Scope of the Current Guidelines

The functions of this document are to outline the features that make up the definition of 'learning disability', as used within a health and social care context, and to introduce the complexities of the use of that term in a variety of other contexts. Recommendations regarding good practice are also included.

There are a number of areas *not* covered by these guidelines, one of which is 'mental (in)capacity'. This is a legal concept, involving a person's ability to make informed decisions (e.g. about medical treatments, financial matters, contracts, wills, etc.). Clearly, there is a relationship between intellectual ability and mental capacity. However, 'learning disability' and 'mental incapacity' are *not* synonymous, and it is possible for someone to have a 'learning disability' and yet also to be deemed as 'mentally capable'.¹⁰ Further, mental incapacity may arise for reasons other than learning disability (e.g. dementia, mental illness, acquired brain damage in adulthood, etc.). Any assessment relating to mental incapacity or consent should not rely on generalised inferences relating to the broad categorisation of people. Assessments for this purpose should always be conducted within the context of the particular issue in question and of the particular individual concerned.¹¹

Equally, even if an assessment is made with respect to classification, it is unlikely – except in certain instances¹² – that this will be sufficiently comprehensive or meaningful. Further work would be required to assess exactly how the learning disability might affect a person's performance within the relevant setting, and what additional supports he/she might need.¹³ Again, discussion on the range of assessment required within this context falls outside the scope of these guidelines.

This document deals only with *adults* with learning disabilities, and as such specifically excludes discussion on legislation and assessment relating to children. Guidance on the assessment of children is available elsewhere within the Society.¹⁴

Owing to the different legislative systems, some difficulties are encountered when producing one document that is relevant for use throughout the UK. Because of this, Part 2 of this document, *Associated Contexts*, makes some compromises and, thus, focuses on commonalities (whilst *highlighting* differences) between the respective UK legislation. Readers requiring specific detail on a particular piece of legislation should refer to the appropriate Statute.

¹⁰ Williams (1995) notes that there '*...should be an assumption that witnesses with learning disabilities are competent, both in law and in practice, and that the burden of proof for determining otherwise should be put on the party challenging competence*'.

¹¹ Command Paper Cm 3803 (1997); Command Paper Cm 4465 (1999); Cohen (1998); Gelsthorpe (1998).

¹² Perhaps within the context of the Sexual Offences Acts 1956/1967.

¹³ For example, as a witness in court (see Sanders *et al.*, 1996).

¹⁴ Contact the Division of Educational and Child Psychology and the Division of Clinical Psychology, Special Interest Group – Children and Young People.

Part I: Defining ‘Learning Disability’¹⁵

People with learning disabilities do not constitute an homogeneous group. However, in terms of diagnosis and classification there are a number of features of learning disability which have gained widespread acceptance across professional boundaries within the UK and America.¹⁶ Irrespective of the precise terminology, or the wording in the various definitions, there are three core criteria for learning disability:

- **Significant impairment of intellectual functioning;**
- **Significant impairment of adaptive/social functioning;**
- **Age of onset before adulthood.**

All three criteria must be met for a person to be considered to have a learning disability (see Appendix I for further details of the main clinical definitions).

Difficulties in assessing adaptive/social functioning have contributed, in the past, to a tendency amongst clinicians to concentrate on assessment of intellectual functioning only. The assumption has been that, provided a significant impairment of intellectual functioning has been demonstrated, similar deficits in adaptive/social functioning are likely. However, this is not always the case.

The Society recommends that, in accordance with the various definitions, classification of learning disability should only be made on the basis of assessed impairments of both intellectual and adaptive/social functioning which have been acquired before adulthood.

1.1 ASSESSMENT OF IMPAIRMENT OF INTELLECTUAL FUNCTIONING

The principal method for determining levels of intellectual functioning still remains psychometric assessment. Assessments which are based on an explicit model of normal distribution of general intelligence are the procedures of choice.

Assessment of general intellectual functioning, for clinical, medico-legal and other purposes, should be obtained through the use of an individually administered test which is recognised as being reliable, valid and properly standardised. The test employed in any given case must be appropriate for the person’s age, cultural, linguistic and social background.

¹⁵ At present, within the UK, *learning disability/disabilities* is the terminology with the greatest currency and, within the context of health and social care, has largely replaced the term *mental handicap* – although *mental handicap* is still used in the Mental Health (N Ireland) Order, 1986. *Intellectual disabilities* is favoured by some authorities – but using this terminology, there is a danger that the concept could be construed solely as one relating to intellectual impairment (i.e. excluding the aspect of adaptive/social functioning). The term *mental retardation* is in common usage in North America.

¹⁶ American Association on Mental Retardation, 1992; World Health Organisation, 1992 (ICD-10); American Psychiatric Association, 1994 (DSM-IV); Department of Health, 1998.

Using tests based on a normal distribution of general intelligence, significant impairment of intellectual functioning has, by convention, become defined as a performance more than two standard deviations below the population mean. On the Wechsler Adult Intelligence Scale – Revised (WAIS-R) (Wechsler, 1981; Lea, 1986), the most commonly used measure of general intellectual functioning for the adult population, and the more recently published WAIS-III^{UK} (Wechsler, 1999), the mean is 100 and the standard deviation is 15. More than two standard deviations below the mean thus corresponds to an Intelligence Quotient (IQ) of 69 or less.¹⁷

IQ scores for individual cases should always be quoted with explicit confidence limits. Confidence limits represent the probable extent of measurement error for scores derived from a particular test. On the Wechsler scales, the 95 per cent confidence limits vary with age group and measured IQ level (see Appendix III).

When conducting psychometric assessments of intellectual functioning, careful consideration should be given to differentiating between performance which is due to learning disability and performance which is impaired by other factors. For example, the presence of emotional/psychological distress (or other psychological/psychiatric factors), medication, alcohol or other drugs, may have consequences in terms of (perhaps, temporary) diminution in performance. Similarly, caution will need to be exercised regarding the assessment of individuals with cognitive impairments acquired during adulthood as a consequence of neurological trauma or disease. These acquired impairments may exhibit through generalised flattening of scores, or extreme variability in IQ or test Index or sub-test scores, or through specific deficits.

The findings from these assessments should always be interpreted in the light of knowledge of the individual's personal, cultural circumstances, clinical status and other assessment information, and with a sound knowledge of the uses and limitations of such assessment methods.

The Society notes that psychometric test results, in particular, are open to misrepresentation or inappropriate usage. In order to achieve the best possible understanding of the technical information given, and to avoid misuse, non-psychologist readers of this document are encouraged to make use of available help from a qualified psychologist whose credentials are recognised by the profession, i.e. a Chartered Psychologist.

1.2 IMPAIRMENT OF ADAPTIVE/SOCIAL FUNCTIONING

1.2.1 DEFINITION OF ADAPTIVE/SOCIAL FUNCTIONING

The concept of adaptive/social functioning is very broad and relates to a person's performance in coping on a day-to-day basis with the demands of his/her environment. It is, therefore, very much related to a person's age and the socio-cultural expectancies associated with his/her environment at any given time. It is concerned with what a person *does* (i.e. actual behaviour/performance).

¹⁷ The 'cut-off' for 'learning disability' of an IQ of 69 is in line with both ICD-10 and DSM-IV (see Appendix I): the former states that 'an IQ of 69 or below is indicative of mental retardation', while the latter notes that the 'disorder is characterised by significantly sub average intellectual functioning (an IQ of approximately 70 or below)'. It should be noted, however, that any overly strict cut-off criterion would not fully reflect the limitations inherent within each test. Informed clinical judgement would be required especially around transitional cut-off points.

The concept of '*adaptive functioning*' has been further refined by reference to its component parts. Both the American Association on Mental Retardation (AAMR, 1992) and DSM-IV¹⁸ adopt a criterion of impairments in 'at least two' of the following areas: *communication, self-care, home living, social/interpersonal skills, use of community resources, self direction, functional academic skills, work, leisure, health and safety*. The use of '*at least two*' impairments as a criterion may, however, produce some anomalies, with little face validity. For example, in the case where, perhaps, only *work* and *leisure* are impaired (with other skills intact), the extent of the overall impairment of adaptive skills may be questioned. Additionally, the DSM-IV gives no guidance concerning the *severity* of impairment within the respective areas.

Within the context of 'mental impairment', the BPS document (1991) focused on the concept of '*social functioning*', which included only those skills that may be considered as *personal life survival skills* – other skills, related more to interpersonal/cultural/social aspects of day-to-day living, and alluded to in other definitions, were omitted.^{19,20,21} By excluding wider aspects of social/community adaptation, it is now considered that the previous BPS definition (1991) is unduly restrictive. By broadening the criteria, it is accepted that the tightness of the previous definition has been lost. Nevertheless the following is recommended:

Impairment of Adaptive/Social Functioning – The individual requires significant assistance to provide for his/her own survival (eating and drinking needs and to keep himself/herself clean, warm and clothed), and/or with his/her social/community adaptation (e.g. social problem solving, and social reasoning).

The degree of assistance required may vary in terms of intensity (e.g. physical or verbal prompting) and frequency (e.g. daily or less often than daily), but the required assistance should always be outside the range of that expected within the individual's particular culture/community.

1.2.2 ASSESSMENT OF ADAPTIVE/SOCIAL FUNCTIONING

Despite the difficulties in defining adaptive/social functioning, there exists a variety of scales purporting to measure it. These are completed usually by direct observation and/or in conjunction with at least one informant who knows the person well (for example, a parent, carer or friend).

¹⁸ *Diagnostic and Statistical Manual of Mental Disorders – 4th Edition* (American Psychiatric Association, 1994).

¹⁹ Gunn (1996) notes that, from a legal perspective, '*social functioning ... includes such matters as: ability to care for oneself; personal hygiene; personal and social (perhaps sexual) relationships with others*'.

²⁰ Nunkoosing (1995) cites two components: '*personal independence*' (being able to sustain oneself in everyday living activities) and '*social responsibility*' (being able to conduct oneself appropriately in social situations).

²¹ AAMR (1992) refers to two facets of social functioning: '*practical intelligence*' and '*social intelligence*'.

Assessments of adaptive/social functioning may be norm-referenced, criterion-referenced and those of the skills checklist variety.^{22,23} The use of any one such assessment should be considered only after some scrutiny, and with reference to the specific item content, as some scales consist of items that may extend the definition of adaptive/social functioning beyond that given above.²⁴

An assessment of adaptive/social functioning must be made with reference to the person's age, gender, socio-cultural background, religion and community setting. To be relevant, within the context of learning disability, any impairment of adaptive/social functioning must not *solely* be a consequence of other disabilities (e.g. physical illness, mental health problems or sensory impairment).

Despite the inherent difficulties with many such instruments, the use of a formal assessment of adaptive/social functioning should be seen as good practice. At least one assessment (preferably completed with more than one informant, and on more than one occasion) should be carried out.

The Society believes that there is not, as yet, sufficient consensus within the area for one single assessment to be recommended. Judgement will need to be made based on item analysis of the assessment and on the significance of any impairment (see Section 1.4.2).

1.3 AGE OF ONSET

For a person to be considered to have a learning disability, significant impairments of intellectual and adaptive/social functioning must have been acquired during the developmental period. There is some consensus that the Age of Onset criterion is *below 18 years*.^{25,26} However, there is some concern, shared by many clinicians, that people acquiring learning disabilities later in childhood (but before the age of 18 years) as a consequence of cerebral trauma may face different challenges than a person showing learning disabilities from infancy.

This issue may not be significant if individualised assessments are undertaken with the intention of identifying a person's support needs. However, if such assessments are simply used to serve a 'gate-keeping' function, for example (see Section 2.5 below), such a person may be disadvantaged if this results in exclusion from a more appropriate service (e.g. one designed for people with acquired brain damage).

²² For information about the validity and reliability of the tests available, Hogg and Raynes (1987) remains a useful text although some assessments have had subsequent revisions.

²³ Those scales that list some psychometric properties and/or normative data include the *AAMR Adaptive Behaviour Scale – Residential and Community* (Nihira, Leland & Lambert, 1993); the *Vineland Adaptive Behaviour Scales* (Sparrow, Balla & Chichetti, 1984) and the *Hampshire Assessment for Living with Others* (Shackleton Bailey *et al.*, 1982).

²⁴ Analysis of some assessments of adaptive/social functioning reveal sub-tests of a *descriptive* nature (e.g. *Physical Disability, Posture*) rather than having an *operational* criteria – the former may have an *influence* on adaptive functioning but do not *measure* actual behaviour/performance.

²⁵ Whilst both the DSM-IV and the AAMR (1992) recommend an age criterion for *Age of Onset* of before 18 years, the ICD-10 (WHO, 1992) makes no specific criterion other than '*... during the developmental period*'. Hatton (1998) draws attention to the cultural nature of this age criterion.

²⁶ Given its cultural nature, and with reference to Sexual Offences legislation, theoretically there may be some advantage to linking this age of onset criterion to the 'age of consent' for sexual relationships. However, this would also lead to major discrepancies, particularly with respect to the variable ages of consent in different countries (even within the UK) and/or where age of consent is dependent on gender and/or type (heterosexual or other) of sexual relationship.

In order to determine the most appropriate service support, it is recommended that the effect of acquired impairment on a previously higher, non-impaired level of functioning is taken into account. Particular reference should be made to any profile of psychometric sub-test scores that would indicate, clinically, that the person's abilities would be more appropriately construed as specific brain/neurological damage.

The Society recommends that in all cases where a medical condition or trauma is present, the age this occurred should be documented, whether before birth, at birth or during childhood.

Age of onset before adulthood may be demonstrated by historical evidence from medical records (e.g. developmental milestones), educational records such as a Statement of Educational Need, or records of previous use of specialist health and social services. However, it is always possible for an individual to have 'slipped through the net'. Any historical information needs to be interpreted with care as functioning can change over time and the results of different psychometric assessments are usually not directly comparable.

1.4 SYSTEMS OF SUB-CLASSIFICATION

Within the clinical context, sub-classifications of *mild, moderate, severe and profound* 'mental retardation' are used in two main classification/diagnostic manuals.²⁷ Although these systems employ the same descriptive categories, the quoted IQ ranges do not correspond exactly.

It is notable that the AAMR (1992) no longer uses these four clinical sub-categories, favouring instead a classification system of 'mental retardation' which specifies *the level of support required within respective areas of functioning*. Such a system is seen by the Association as being '*...more functional, relevant, and orientated to service delivery and outcomes than the labelling system currently in use.*'

Traditionally, in the UK, two (occasionally three) categories of learning disability have been favoured.^{28,29} However, more recently, the Department of Health (1999) has referred to *mild, moderate, severe and profound* learning disabilities, reflecting the categorisations in the classification/diagnostic manuals.³⁰

The operational guidance issued by the Society in 1991 did not comment on sub-classification of learning disability *per se* but made a two-category subdivision into *significant* and *severe* impairments of intelligence and social functioning in the context of mental health legislation categories of 'mental impairment' and 'severe mental impairment'.

The Society recommends that decisions involving sub-classification of 'learning disability' should make reference to both intellectual and to adaptive/social functioning using the criteria below as guidance. Furthermore, it is considered good practice to make reference to the levels of supports required.

²⁷ ICD-10 (1992) and DSM-IV (1994)

²⁸ DHSS/Welsh Office (1971); National Development Group (1977); DHSS (1980); Audit Commission (1988); DoH, (1992).

²⁹ For more recent discussion see Dodd & Webb (1998).

³⁰ See also Evers & Hill (1999) and, in contrast, Dodd & Webb (1998).

1.4.1 SUB-CLASSIFICATION OF IMPAIRMENT OF INTELLECTUAL FUNCTIONING

In line with the previous BPS document (1991), *significant* impairment of intellectual functioning is considered to be represented by an IQ between two and three standard deviations below the population mean, and *severe* impairment of intellectual functioning is considered to be represented by an IQ of more than three standard deviations below the mean. On the most commonly used measures of intellectual functioning (the Wechsler scales), with a standard deviation of 15 points, these cut-off points correspond to IQs of <70 and <55 respectively:

Significant Impairment of Intellectual Functioning: **IQ 55-69**
Severe Impairment of Intellectual Functioning: **IQ <55**

Again, it is noted that owing to errors of measurement³¹ there is some flexibility around these transition points (see Appendix III).

Whether based on standard deviations (as in DSM-IV) or arbitrary cut-offs (as in ICD-10) the use of fine-grained sub-divisions below an IQ of approximately 55, in the case of adults, depends on IQ figures which are hypothetical or extrapolated. There seem to be no reliable or valid psychometric instruments, for the adult population, to enable the clinician to arrive at the IQ figures needed to make these distinctions. Thus sub-classification on the basis of IQ scores from directly administered IQ tests cannot be carried out reliably for the lowest levels of intellectual functioning.

In practice, some clinicians are known to use child development scales or children's intelligence tests to profile aspects of intellectual functioning of very disabled adults. Whilst, clinically, this may have some use in assessing performance on specific tasks, attempts to derive extrapolated IQ scores from the use of developmental scales or child intelligence tests constitutes extremely dubious practice and is not recommended. Likewise, the practice of referring to 'mental age' when reporting on the level of intellectual or social functioning of adults should be avoided.

<p>Note: In early versions of the WAIS-III^{UK} manual, the section on '<i>Diagnosing Severe Learning Disability</i>' quotes the criteria for <i>significant</i> (i.e. not <i>severe</i>) learning disability. This is an error.</p>

1.4.2 SUB-CLASSIFICATION OF IMPAIRMENT OF ADAPTIVE/SOCIAL FUNCTIONING

The operational guidance issued by the Society in 1991 distinguished between requiring 'partial help' (a *significant* impairment) and 'continued assistance' (a *severe* impairment). However, this guidance did not define the difference between these two levels of help. How the degree of adaptive/social impairment is associated with *level* of learning disability has led to some debate. Dodd and Webb (1998) suggest using certain score profiles on the HALO (Shackleton Bailey *et al.*, 1982) to distinguish between *significant* and *severe* impairment of social functioning. The Vineland Adaptive Behaviour Scales (Sparrow *et al.*, 1984) classifies 'adaptive' levels into 'mild, moderate, severe and profound deficit' on the basis of standard scores.

³¹ Approximately ± 5 IQ points on the Full Scale scores of the WAIS-R (Wechsler, 1981).

Given the presented definition of adaptive/social functioning and the item content of the many scales which profess to measure the concept, no one particular assessment can, at this stage, be recommended for determining levels of adaptive/social functioning. However, when making a judgement as to the degree of impairment of adaptive/social functioning, the following levels of support (AAMR, 1992) are considered useful as a guide:³²

Intermittent	Supports on an 'as needed basis'. Characterised by episodic nature, person not always needing the support(s), or short-term supports needed during life-span transition (e.g. job loss or an acute medical crisis). Intermittent supports may be high or low intensity when provided.
Limited	... supports characterised by consistency over time, time-limited but not of an intermittent nature, may require fewer ... [resources] than more intense levels of support ...
Extensive	Supports characterised by regular involvement (e.g. daily) in at least some environments (such as work or home) and not time-limited ...
Pervasive	Supports characterised by their consistency, high intensity; provided across environments; potential life-sustaining nature ...

When determining level of impairment of adaptive/social functioning, the following may be used as a guide:

- **Intermittent and Limited support indicate a significant impairment of adaptive/social functioning;**
- **Extensive and Pervasive support indicate a severe impairment of adaptive/social functioning.**

It should be stressed that the above is presented as a *guide*.³³ The judgement will rest on both the intensity of the assistance (e.g. verbal or physical prompting, or carrying out tasks on the individual's behalf) and on its frequency (e.g. daily or less often than daily); the required assistance should always be outside that range of that expected within the individual's particular culture/community.

³² For the complete tabulated descriptions refer to *Mental Retardation: Definition, Classification, and System of Supports – 9th Edition* (AAMR, 1992).

³³ The categories of support defined by AAMR (1992) generally reflect both the *frequency* and *intensity* of support – although not consistently so. With respect to intensity, the *Intermittent* and *Pervasive* categories contain relatively clear operational criteria; the *Limited* category contains some reference, whereas the *Extensive* category contains no reference. Particularly with these latter two categories, a judgement will have to be made based on the criteria which appear in the other categories. The criteria for frequency is more consistent, ranging from an 'as needed basis' for *Intermittent* to their 'constancy' for *Pervasive* support.

1.4.3 REQUIREMENT FOR CONCURRENCE OF THE TWO IMPAIRMENTS

Learning disability requires that significant impairments of intellectual and adaptive/social functioning coexist. This means that a person with a *significant* (or even *severe*) impairment in one of the two domains only, and with no significant impairment in the other, may not be adjudged to have a learning disability.³⁴

Similarly, for *severe* learning disability, severe impairments of *both* intellectual and adaptive/social functioning must be evident.

For some individuals, levels of intellectual functioning and adaptive/social functioning will be relatively consistent. For others this may not be the case.

When there is large discrepancy between intellectual functioning and adaptive/social functioning, great care must be taken during assessment – particularly when the extent of a person’s impairment in intellectual and/or adaptive/social functioning is near the boundary between *severe* and *significant*, or between *significant* and *non-significant*. Bearing in mind the limits in rigour of, especially, adaptive/social functioning assessments, it is in these circumstances that such judgements need to be approached with appropriate caution.

³⁴ DSM-IV (1994) notes that: ‘*Mental retardation would not be diagnosed in an individual with an IQ lower than 70 if there are no significant deficits or impairments in adaptive functioning.*’

Part 2: Associated Contexts

Learning disability, or associated terminology, appears in a wide range of contexts:

- Mental Health Legislation;
- Criminal Justice System;
- Local Government/Benefits Legislation;
- Miscellaneous.

It should be noted that within these contexts, similar terminology is often used with *different definitions* (see Appendix II). For instance, the term *severe mental impairment* under the Mental Health Act 1983 has a different definition from the same term used within local government legislation. Thus, it is important to ensure that the specific context in which any classification occurs is made explicit, and that classification in one particular context does not imply classification in any other.

In addition, many legal classifications, whilst appearing similar, should not be confused with clinical or psychological classification. It must be accepted that the context is different. However, within a legal context, clinical or psychological terminology may justifiably be used to assist the Court to make its judgement.

Within contexts other than the purely clinical it is important that the psychologist should first identify the appropriate clinical classification, and then judge how this relates to the specific definition used within the applied context.

Above, we have argued that classifications used by psychologists can be valid and justified within certain contexts. Equally we would argue that, in certain contexts, classification *per se* has no valid role – it would be important to recognise other factors that are more significant than inferences drawn from broad classifications.

As was mentioned above (page 3), owing to the complexities of relating the different legislative systems to each other, some compromises have been necessary in order to produce one document which is equally relevant throughout the UK. Thus, in this section, the document draws mainly on the commonalities between the respective UK legislation. Where significant differences occur, these are highlighted, but readers requiring more specific detail on a particular piece of legislation should refer to the appropriate Statute.

2.1 MENTAL HEALTH LEGISLATION

This part of the document relates to those categories that appear within the respective Mental Health Acts/Orders, throughout the UK, and which pertain to Admission for Assessment and for Treatment under the Acts/Orders.

With respect to the Assessment and Treatment sections that are potentially relevant to people with learning disability there is much similarity between the Mental Health Act, 1983 (England & Wales) and the Mental Health (Scotland) Act 1984.³⁵

There are, however, differences between these Acts, specifically relating to crimes *against* the person who is subject to the Act. For instance, in addition to the sections relating to Assessment and Treatment, the Mental Health (Scotland) Act 1984 includes a range of legislation relating to unlawful sexual intercourse with women with 'mental handicap'.^{36,37} Sections relating to aspects other than Admission for Assessment and Treatment are further discussed in Section 2.2 of this present document.

The categories in the Mental Health (N.Ireland) Order 1986 differ from the above Acts. These are discussed in Section 2.1.3 below.

The 'conduct' criterion (i.e. abnormally aggressive and/or seriously irresponsible conduct) which appears in the definitions of *mental impairment* and *severe mental impairment* appears in certain categories in all the Acts/Orders, and is further discussed in Section 2.1.4 below.

2.1.1 MENTAL HEALTH LEGISLATION' ENGLAND AND WALES

The Mental Health Act 1983 uses the term mental disorder which is defined as:
mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind.

Although the phrase *arrested or incomplete development of mind* is relevant to people with learning disabilities, for many purposes of the Act it is not sufficient that a person is suffering from mental disorder *per se* but from one of the four *specific* categories of mental disorder specified in the Act. The main two categories that are potentially relevant to people with learning disabilities are *mental impairment* and *severe mental impairment*.

Although related, the terms *mental impairment* and *severe mental impairment* are not synonymous with 'learning disability'. Under this Act these terms are defined as follows:

- **Mental Impairment:**
... a state of arrested or incomplete development of mind not amounting to severe mental impairment which includes significant impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned. [s 1(2)]
- **Severe Mental Impairment:**
... a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned. [s 1(2)]

³⁵ Under the definition of 'mental disorder', the Mental Health (Scotland) Act 1984 does not contain specific reference to 'psychopathic disorder' or to 'any other disorder or disability of mind' which appears in the Mental Health Act 1983.

³⁶ Reference to homosexual acts appears in the Criminal Justice (Scotland) Act 1980.

³⁷ Similar, but not directly comparable, legislation appears, in England, in the Sexual Offences Acts.

These definitions of *mental impairment* and *severe mental impairment* make reference to two of the three ‘core’ criteria for learning disability (i.e. *significant/severe impairment of intelligence* and *social functioning*) but also include a criterion of ‘*abnormally aggressive or seriously irresponsible conduct*’.

Again, it should be emphasised that these terms are legal classifications, to be used for the purposes of the Act, and as such are distinct from medical/clinical terminology.³⁸ As the criteria specified in the Act are not further defined, the importance of clinical judgement is acknowledged. The Mental Health Act 1983 Memorandum³⁹ notes that:

*The distinction between ‘severe mental impairment’ and ‘mental impairment’ is one of degree: the impairment of intelligence and social functioning is ‘severe’ in the former and only ‘significant’ in the latter. Slight impairment cannot fall within either definition. The assessment of level of impairment is a matter for clinical judgement.*⁴⁰

Whilst the above guidance states that the assessment of degree of impairment is a matter for clinical judgement, it is the view of the Society that such a judgement should be based on a full assessment as outlined in Part 1 above (in addition to the ‘conduct’ criteria’ see Section 2.1.4 below).

It should be noted that the *level* of mental impairment (i.e. significant or severe) is of some consequence under the Act, as different legal consequences may ensue from the respective classifications. The Mental Health Act 1983 Memorandum states:

This distinction between the two degrees of mental impairment is important because there are differences in the grounds on which patients can be detained, or have their detention renewed if they suffer from severe mental impairment as opposed to mental impairment. [s.10]

With regard to assessment, the Mental Health Act 1983 Code of Practice gives the following guidance:

No patient should be classified under the Act as mentally impaired or severely mentally impaired without an assessment by a consultant psychiatrist in learning disabilities and a formal psychological assessment. This assessment should be part of a complete appraisal by medical, nursing, social work and psychology professionals with experience in learning disabilities... [s.30.4]

2.1.2 MENTAL HEALTH LEGISLATION – SCOTLAND

The Mental Health (Scotland) Act 1984 also uses the term *mental disorder*, albeit defined slightly differently from the Mental Health Act 1983:

Mental illness, or mental handicap however caused or manifested.

As with the Mental Health Act 1983, for most purposes of the Act it is not sufficient that a person is suffering from mental disorder *per se* but from one of the four *specific* categories of mental disorder specified in the Act. Again, the main two categories that are relevant to people with learning disabilities are *mental impairment* and *severe mental impairment*.

³⁸ Gostin (1983) *A Practical Guide to Mental Health Law*. London: MIND.

³⁹ Department of Health and Welsh Office (1998) *The Mental Health Act 1983, Memorandum on Parts I to VI, VIII and X*. See also Department of Health and Welsh Office (1999) *Mental Health Act 1983 Code of Practice Mental Health Act*.

⁴⁰ Department of Health and Welsh Office (1999) *The Mental Health Act 1983 Code of Practice* adds that this clinical judgement should be ‘... guided by current professional practice and subject to the relevant legal requirements’.

The definitions of *mental impairment* and *severe mental impairment* are identical to the definition appearing in the Mental Health Act 1983 (see above).

2.1.3 MENTAL HEALTH LEGISLATION – NORTHERN IRELAND

The Mental Health (N. Ireland) Order 1986 defines Mental Disorder as:

Mental illness, mental handicap and any other disorder or disability of mind.

The following terms, further defined in the Act, are relevant to people with learning disabilities:

- **Mental Handicap:** *a state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning.*
- **Severe Mental Handicap:** *a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning.*
- **Severe Mental Impairment:** *a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned.*

Within this Order it should be noted that the definition of *severe mental impairment* is identical to that of *severe mental handicap*, save for an additional ‘conduct’ criterion.

The definition of *severe mental impairment* is identical to that of *severe mental impairment* in both the Mental Health Act 1983 and the Mental Health (Scotland) Act 1984 but unlike these two Acts, the Northern Ireland Order does not contain a category of *mental impairment*.

Since a Treatment Order in Northern Ireland can be invoked only in a case of *severe mental impairment* (with its attendant severe impairments of both intelligence and social functioning), this makes it crucial for accurate operational distinctions between *significant* and *severe* impairments to be agreed in that particular context.

2.1.4 ABNORMALLY AGGRESSIVE OR SERIOUSLY IRRESPONSIBLE CONDUCT

Abnormally aggressive or seriously irresponsible conduct are behaviours which must be associated with ‘a state of arrested or incomplete development of mind’ in order to meet the criteria for categorisation as *mental impairment* under the Mental Health Act 1983 and the Mental Health (Scotland) Act 1984, or in order to meet the criteria for categorisation as *severe mental impairment* under the Mental Health Act 1983, the Mental Health (Scotland) Act 1984 and the Mental Health (Northern Ireland) Order 1986.

These behaviours are not further defined within the Acts or the Order, but the Mental Health Act 1983 Memorandum⁴¹ comments that they were included in the formulation of *mental impairment* and *severe mental impairment* so as:

to ensure that people with learning disabilities are not subject to long-term compulsory powers unless the behaviour which is part of their condition in that particular case justifies the use of those powers. [s.9]

⁴¹ Department of Health and Welsh Office (1998).

In seeking to operationalise these terms, therefore, it is appropriate to bear in mind that they should constrain, rather than maximise, the extent to which people with learning disabilities can be compulsorily detained.

The Mental Health Act 1983, Code of Practice (1999) gives the following guidance on how to assess these behaviours:

- **Abnormally aggressive behaviour:** *Any assessment of this category should be based on observations of behaviour which lead to a conclusion that the actions are outside the usual range of aggressive behaviour, and which cause actual damage and/or real distress occurring recently or persistently or with excessive severity. [s.30.5]*
- **Irresponsible conduct:** *The assessment of this characteristic should be based on an observation of behaviour which shows a lack of responsibility, a disregard of the consequences of action taken, and where the results cause actual damage or real distress, either recently or persistently or with excessive severity. [s.30.5]*

Thus, the assessment of '*abnormally aggressive or seriously irresponsible conduct*' can be seen to have both observational (i.e. the actual behaviour) and judgement (i.e. the abnormality and/or seriousness) components. In this connection the previous recommendations (BPS, 1991) are developed here.

For both abnormally aggressive and seriously irresponsible conduct there should be direct observation of actual conduct/behaviour, or reported observation by at least two reliable witnesses (although in some instances no second person may be present, when this criterion for reliability cannot be met), and there should be recording of this conduct/behaviour in behavioural terms.

Abnormally aggressive conduct must be judged to be 'outside the usual range of aggressive behaviour' – unpredictability or unreasonableness *under the circumstances* will be factors which may establish the criterion.

Irresponsible conduct is that which shows a lack of responsibility and/or a disregard of the consequences of the action – it does not necessarily require the person to be capable of judging these consequences. In certain circumstances, *failure to act* can also be evidence of irresponsibility.

To meet the criteria for each, abnormally aggressive and seriously irresponsible conduct should result in actual damage and/or real distress (in some cases to the self), and should occur '*either recently or persistently or with excessive severity*'.

There is a lack of official guidance on how to decide when abnormally aggressive or seriously irresponsible conduct have ceased, although the importance of being able to do so is clear. It would not be appropriate to continue to regard a person who has a learning disability as being mentally impaired, if remission or treatment have eliminated their abnormally aggressive or seriously irresponsible conduct. In most circumstances, observed cessation of key behaviours, or clinically significant reductions in their frequency, will provide adequate evidence of change. In evaluating this, however, account must be taken of the extent to which characteristics of detention or a treatment regime are serving to render the problematical conduct temporarily impossible of execution. There may be similar difficulty in deciding whether infrequently occurring irresponsible conduct of extreme severity has ceased. Judgement in these circumstances is likely to be most readily optimised by drawing upon clinical experience of similar profiles.

2.2 CRIMINAL JUSTICE SYSTEM⁴²

There are a number of Statutes that are specifically relevant to people with learning disabilities, and for which psychological assessment and opinion may have some applicability. The following is not intended as an exhaustive list, but does include some legislative areas in which a psychologist's opinion or advice may be sought (see also Appendix II):

- **Sexual Offences Act 1956⁴³** – includes reference to unlawful (i.e. outside marriage) sexual intercourse with a woman who is a 'defective', and reference to indecent assault on a man or woman who is a 'defective'.
- **Mental Health Act 1959** – Section 128 deals with unlawful sexual intercourse between a male employee and a woman being treated for 'mental disorder'. The Act defines 'mental disorder'.
- **Sexual Offences Act 1967** – deals with male homosexuality, and includes reference to males with 'severe mental handicap'.
- **Mental Health (Amendment) Act 1982** – updated parts of the Sexual Offences Acts 1956 and 1967, amended the definition of 'defective' and 'severe mental handicap'.
- **Police and Criminal Evidence Act 1984 (PACE) and the Codes of Practice** – concerning the requirement for an 'appropriate adult' to be present at interviews related to suspects who have a 'mental handicap'.
- **Mental Health (Scotland) Act 1984** – Section 106 relates to unlawful sexual intercourse with a woman who has a 'mental handicap'.⁴⁴
- **Mental Health (Scotland) Act 1984** – Section 107 relates to unlawful sexual intercourse between a male employee and a woman being treated for 'mental disorder'.

Again, it is important to re-emphasise that clinical diagnoses/classifications are not the same as legal classifications. Gunn (1996) notes: *'It is important to understand the definitions used in each Act and to remember that these terms have a specific legal meaning which may not be the same as the meanings given to them in general or professional conversation.'*⁴⁵

However, within a legal context, clinical terminology may justifiably be used to assist the Court to make a judgement, with respect to legal classifications. The relationship between the clinical and the legal context has to be carefully considered. For instance, in drawing conclusions from one legal case, Gudjonsson and Haward (1998) note that '*... successful submissions under PACE might involve borderline IQ scores*', i.e. IQ scores of 70 to 79 (Wechsler, 1981). In the same case, trial judges were '*... not attracted to the concept that the judicial approach to submissions under... the Police and Criminal Evidence Act 1984 (PACE) should be governed by which side of an arbitrary line, whether 69/70 or elsewhere, the IQ falls.*' Equally the same authors stress the difficulties of generalising, even within the legal system, noting a case in which '*the Court of Appeal decided it was wrong to take the IQ scores from one case and apply them slavishly to another.*'

⁴² Some legislation across England and Wales, Scotland and Northern Ireland will differ.

⁴³ An 'unlawful sexual intercourse' clause appears, in Scotland, in the Mental Health (Scotland) Act 1984. [s.106] However, it is important to note that the *level* of disability criterion differs.

⁴⁴ This is a similar clause to that in the Sexual Offences Act 1956 under English Law. However, it should be noted, again, that the *level* of disability criterion, under the respective legislation, differs.

⁴⁵ Gunn (1996) cites a case in which the Court of Appeal decided that the words defining 'defective' were '*words of the ordinary English language*' and that whether someone is a 'defective' is to be measured by the '*standards of normal persons*' and is to be decided by the jury.

Finally, it is important to note that although, within English law, individuals identified as ‘defective’/’severely mentally handicapped’ within the Sexual Offences legislation are considered, in law, as not being able to consent to unlawful sexual relationships,⁴⁶ this should not be used as a generalised criterion for determining the ability to consent with respect to other issues, choices or situations. Again, any assessment addressing mental incapacity/capacity and issues of consent should not rely on generalised inferences relating to broad classification but should be conducted in the context of the particular issues in question and of the individual being assessed.⁴⁷

2.3 LOCAL GOVERNMENT/BENEFITS LEGISLATION

Classifications that are relevant to people with learning disabilities appear in local government/benefits legislation. Examples of associated definitions are given in Appendix II.

Benefits legislation is quite complex, and subject to frequent change, so in those instances when an opinion of a psychologist is sought, the psychologist should be fully aware of the context of the assessment, and of any recent changes within the legislation. It should also be noted that interpretations of the Regulations are subject to Commissioners’ decisions. As within the criminal justice system, the clinical diagnoses/classifications are not the same as the classifications within the specific Act/Regulation’ the latter will have their specific own meanings.⁴⁸

However, again, as within the criminal justice system, an expert opinion may be requested in order to make a judgement in any one particular case.

2.4 MISCELLANEOUS

Classifications with respect to people with learning disabilities occur in a variety of other contexts. Examples of associated definitions are given in Appendix II.

⁴⁶ Again, it should be noted that the *level* of disability criterion differs for Scotland. See the Mental Health (Scotland) Act 1984 (s. 106). See also McKay (1994).

⁴⁷ For further discussion on issues of incapacity and consent see Wong, J. (1997); British Medical Association and the Law Society (1995); Law Commission (1995); Command Papers Cm 3803 (1997) & Cm 4465 (1999).

⁴⁸ In the context of the Disability Living Allowance (higher rate mobility component) a Commissioner’s decision (CDLA/6219/97) has defined ‘severe impairment of intelligence’ as an IQ of 55 or less. However, as with other medico-legal judgements, it has also been argued that ‘intelligence’ is used in the ordinary sense of the word and has no *technical* meaning (Commissioner’s decision CDLA/12148/96) (cited in Paterson, 1999). Either way, a judgement should not be based on severe impairment of intelligence alone, but should take into account impairment of social functioning and, in this case, other aspects. The Court of Appeal Judgement – Megarry v CoA gives support for this. Additionally this same judgement (relating to a person with autism) concluded that whilst the claimant’s IQ is likely to be *‘the essential starting point for considering impairment of intelligence’* and that it was *‘reasonable to take an IQ of 55 or less’* as being severe impairment of intelligence, the IQ score would not necessarily prove decisive. Thus (certainly in the case of people with autism), where the IQ is over 55, all the available evidence should be considered when deciding if the severe impairment of intelligence is satisfied.

2.5 'GATE-KEEPING' – ACCESS TO SERVICES

There has been some debate regarding requests for psychological assessment which relate to a person's suitability or eligibility for access to learning disability services (i.e. a 'gate-keeping' function). Although the Society cannot be prescriptive regarding local responses, it is important to note that access to services will not depend solely on the characteristics of the individual service user but also on the extent and configuration of local service provision.⁴⁹

It is important to recognise that whilst some of these requests may be presented in terms of *assisting access* to specialist services, this may also imply *restricted* access to or *exclusion* from appropriate generic/mainstream services.

Psychologists should be aware of this risk and should avoid making a recommendation that, by implication or inference, might be used to restrict or exclude people from the most appropriate services available.

In responding to requests to classify people for service/administrative purposes, there is a danger that the unique characteristics of the individual will be lost. In such circumstances it is essential not simply to apply labels, but to focus the assessment on specific individual need, and to make recommendations on the type of service and supports that would best meet that need.^{50,51,52}

⁴⁹ Fox & Lamb (1998) have invited comments on the use of psychological assessments for potential administrative service functions. This issue has been considered by a number of clinical psychologists on behalf of local services e.g. Burton (1997), Dodd & Webb (1998) and Evers & Hill (1999).

⁵⁰ Within some areas, people with a learning disability receive high quality psychological primary care services like any other person. Unfortunately, however, there is also evidence that people with a learning disability may be marginalised, having little access to mainstream services (DoH, 1998; Band, 1998).

⁵¹ The AAMR (1992) avoids sub-classification, and emphasises a process which relates a person's needs with respect to '*... the intensities of supports necessary to enhance the person's independence/interdependence, productivity, and community integration.*'

⁵² Schalock *et al.* (1994).

Part 3: Appendices

APPENDIX I: CLINICAL DEFINITIONS

Organisation	Terminology	Definition/Criteria
ICD-10 ⁵³ The ICD-10 Classification of Mental and Behavioural Disorders ⁵⁴	Mental Retardation	<i>... a condition of arrested or incomplete development of the mind, which is especially characterised by impairment of skills manifested during the developmental period, which contribute to the overall level of intelligence, i.e. cognitive, language, motor and social abilities. ... Adaptive behaviour is always impaired ...</i>
AAMR The American Association on Mental Retardation (1992)	Mental Retardation	<i>... substantial limitations in present functioning. It is characterised by significantly sub average intellectual functioning, existing concurrently with related limitations in two or more of the following applicable adaptive skill areas: communication, self-care, home-living, social skills, community use, self-direction, health and safety, functional academics, leisure and work. Mental retardation manifests before age 18.</i>
DSM-IV Diagnostic and Statistical Manual of Mental Disorders ⁵⁵	Mental Retardation	<i>(a) Significantly sub-average intellectual functioning: an IQ of approximately 70 or below on an individually administered IQ test. (b) Concurrent deficits or impairments in present adaptive functioning (i.e. the person's effectiveness in meeting the standards expected for his or her age by his or her cultural group) in at least two of the following areas: communication, self-care, home-living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety. (c) The onset is before age 18 years.</i>
Department of Health (1998) ⁵⁶	Learning Disability	<i>... usually described as a significant impairment of intelligence and social functioning acquired before adulthood.</i>

⁵³ At the time of writing, *The International Classification of Impairments, Activities and Participation: a Manual of Dimensions of Disablement and Functioning* ICIDH-20 is being developed. The intellectual disability part of this manual is being trialed in Australia (Cooper, 1997).

⁵⁴ World Health Organisation (1992).

⁵⁵ American Psychiatric Association (1994).

⁵⁶ Department of Health (1998): *Signposts for Success...*

APPENDIX II: SAMPLE OF RELATED DEFINITIONS MENTAL HEALTH LEGISLATION

Act/Regulation	Terminology	Definition/Criteria
Mental Health Act 1983	Mental Disorder	<i>Mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind.</i>
	Arrested or incomplete development of mind	Not defined.
	Mental Impairment	<i>A state of arrested or incomplete development of mind ... which includes significant impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned.</i>
	Severe Mental Impairment	<i>A state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned.</i>
Mental Health (Scotland) Act 1984	Mental Disorder	<i>Mental illness or mental handicap however caused or manifested.</i>
	Mental Impairment/ Severe Mental Impairment	As for Mental Health Act 1983.
	Mental Handicap	<i>A state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning.</i>
	Mental Disorder	<i>Mental illness, mental handicap and any other disorder or disability of mind.</i>
Mental Health (N.Ireland) Order 1986	Mental Handicap	<i>A state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning.</i>
	Severe Mental Handicap	<i>A state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning.</i>
	Severe Mental Impairment	<i>A state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned.</i>

LOCAL GOVERNMENT/BENEFITS LEGISLATION

Act/Regulation	Terminology	Definition/Criteria
Local Government Finance Act 1992 (Relates to Council Tax)	Severely Mentally Impaired	<i>Severe impairment of intelligence and social functioning (however caused) which appears to be permanent. This includes people who are severely mentally impaired as a result of a degenerative brain disorder such as Alzheimer's Disease, a stroke or other forms of dementia.</i>
Social Security (Disability Living Allowance) Regulations 1991; Social Security Contributions and Benefits Act 1992 sec. 73 (Relates to the higher rate mobility component of the Disability Living Allowance)	Severely Mentally Impaired	<i>A state of arrested development or incomplete physical development of the brain, which results in severe impairment of intelligence and social functioning.⁵⁷ 'Arrested development or incomplete physical development of the brain' must take place before the brain is fully developed. In most cases this will be by the late twenties, and invariably before age 30. (R(DLA)2/96).</i> Note: Degenerative diseases such as Alzheimer's Disease that begin after the brain is fully developed do not satisfy the severely mentally impaired criteria. Criteria for higher rate mobility component of Disability Living Allowance includes a 'severe behavioural problem' criteria which includes (extreme) disruptive behaviour ... regularly requires another person to intervene and physically restrain ... so unpredictable that another person [must] be present and watching over him whenever he is awake. Reg 12(5), (6) DLA Regs.
Social Security (Incapacity for Work) General Regulations 1995; Social Security (Incapacity Benefit) (Transitional) Regulations 1995	Severe Learning Disability	<i>A condition which results from the arrested or incomplete physical development of the brain, or severe damage to the brain, and which involves severe impairment of intelligence and social functioning. (This is less restrictive than 'severely mentally impaired' as defined in some Regulations in that it includes conditions that arise later in life, e.g. a later head injury.)</i>
Disability Discrimination Act 1995	Disability	<i>A physical or mental impairment which has a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities. 'Mental impairment' includes learning disabilities and mental illness (if recognised by a respected body of medical opinion).</i>

⁵⁷ For further discussion, see footnote 48, page 18.

CRIMINAL JUSTICE SYSTEM⁵⁸

Act/Regulation	Terminology	Definition/Criteria
Police and Criminal Evidence Act 1984; Police and Criminal Evidence (N.Ireland) Order 1989	Mentally Handicapped (person)	<i>A state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning.</i>
Sexual Offences Act 1956	Defective	<i>A state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning. [As amended by the Mental Health (Amendment) Act 1982].</i>
Sexual Offences Act 1967	Severe Mental Handicap (males)	<i>A state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning. [As amended by the Mental Health (Amendment) Act 1982].</i>

MISCELLANEOUS

Act/Regulation	Terminology	Definition/Criteria
Registered Homes Act 1984	Mental Handicap	<i>A state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning.</i>
Residential Care Homes Regulations 1984	Mental Handicap	<i>A state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning.</i>
Road Traffic Act 1988	Mild to Moderate Mental Handicap	<i>If stable, it may be possible to hold a licence but he/she will need to demonstrate functional ability at the wheel and be otherwise stable [No other definition is given].</i>
	Severe Mental Handicap	<i>A state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning.</i>

⁵⁸ The section refers to legislation in England and Wales. Although comparable legislation in Scotland may exist, this may appear in different Statutes. The difference in the level of disability criterion for unlawful sexual intercourse between Sexual Offences Act 1956 [England] and Mental Health (Scotland) Act 1984 (s. 106) is particularly important. A useful reference on Scottish law relevant to personal relationships is McKay (1994).

APPENDIX III: CONFIDENCE LIMITS IN PSYCHOMETRIC ASSESSMENT

Confidence intervals for any score can be calculated from the standard error of measurement (SEM) statistic. This indicates the probable extent of error in any score in the set to which it applies. The range of error depends on test reliability, so the higher the reliability, the narrower the range of error. Most test manuals should provide either the SEM statistic directly or, at the very least, reliability figures from which it can be calculated. Where such information is not available for a particular test, the use of results from that test is severely constrained.

If a particular test does provide this statistic, it is possible to derive the 95 per cent probability of the limits (i.e. the confidence limits) within which a particular score might be expected to lie. Assuming that the test has been standardised on a large sample, this can be done by multiplying the SEM by 1.96.

The WAIS-R (Wechsler, 1981), which can be used with persons over 16 years of age, gives SEM figures for IQ scores which vary depending on the age group concerned. For *Full Scale* IQ scores, SEM figures range from 2.20 to 2.96, with an average of 2.53.⁵⁹ This latter figure gives confidence limits of ± 4.96 (i.e. approximately ± 5).

The WAIS-III^{UK} (Wechsler, 1999) provides 90 per cent and 95 per cent confidence intervals for each level of observed score for IQ and Index scores. These have been calculated slightly differently – being based on the estimated true score and standard error of estimation for each observed score level.

Figures for other tests will obviously vary and it should be noted that, as a general rule, intelligence tests are least reliable at their extremes, and the SEM figures published in the test manuals may contain an underestimate of the size of measurement error in the case of those with greater intellectual disability.

At transition points of classification (e.g. between significant and severe impairment of intellectual functioning) it will be necessary to treat IQ figures with caution. To make allowance for the possibility of measurement error, the limits within which the IQ score probably lies should be stated. The chartered psychologist will be guided by proper use of psychometric information in determining whether or not a particular individual is functioning above, at, or below a given transition point.

There has been some debate about the interpretation of scores around the transition points for the age bands of particular tests (Murray & McKenzie, 1999).⁶⁰ Some caution is needed when the age of the person being assessed is close to the age transition points.

⁵⁹ Figures for Verbal IQ and Performance IQ differ.

⁶⁰ See also Collerton (1999) and Leyin (2000).

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Afterword

From the presented discussions on the definitions of learning disabilities – and of the rather formal contexts in which they may occur – it is important, as stated in the Introduction to this document, that the reader does not infer that psychometric testing is sufficient, or always necessary, to produce a meaningful assessment of a person with learning disability. Indeed without a broader framework, any assessment based solely on psychometric assessment – and any resultant classification – would miss many important aspects of the person who is being assessed. This general view cannot, perhaps, be expressed more eloquently than by the sentiment expressed in the following:

Rebecca

‘When I first saw her – clumsy, uncouth, all-of-a-fumble – I saw her merely, or wholly, as a casualty, a broken creature, whose neurological impairments I could pick out and dissect with precision: a multitude of apraxias and agnosias, a mass of sensorimotor impairments and breakdowns, limitations of intellectual schemata and concepts similar to those of a child of eight. A poor thing, I said to myself ...

‘The next time I saw her, it was all very different. I didn’t have her in a test situation, ‘evaluating’ her in a clinic. I wandered outside, it was a lovely spring day, with a few minutes in hand before the clinic started, and there I saw Rebecca sitting on a bench, gazing at the April foliage quietly, with obvious delight. Her posture had none of the clumsiness which had so impressed me before. Sitting there, in a light dress, her face calm and slightly smiling, she suddenly brought to mind one of Chekov’s young women – seen against the backdrop of a Chekovian cherry orchard. She could have been any young woman enjoying a beautiful spring day. This was my human, as opposed to my neurological, vision ...

‘As I approached, she heard my footsteps and turned, gave me a broad smile, and wordlessly gestured. ‘Look at the world’, she seemed to say. ‘How beautiful it is’ ...

‘She had done appallingly in the testing – which, in a sense, was designed, like all neurological and psychological testing, not merely to uncover, to bring out deficits, but to decompose her into functions and deficits. She had come apart, horribly, in formal testing, but now she was mysteriously ‘together’ and composed.’

Sacks, O. (1985)

Rebecca in The Man who Mistook his Wife for a Hat.



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