

02 - 6A00 Disorders of intellectual development

6A00 Disorders of intellectual development

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders In addition, three categories from the grouping of primary tics and tic disorders in Chapter 8 on diseases of the nervous system are cross-listed here, with diagnostic guidance provided, because of their high co-occurrence and familial association with neurodevelopmental disorders. These include: 8A05.00 Tourette syndrome 8A05.01 Chronic motor tic disorder 8A05.02 Chronic phonic tic disorder General cultural considerations for neurodevelopmental disorders • The evaluation of the essential features of most of the disorders in this section either depends on or is informed by standardized assessments. The cultural appropriateness of tests and norms used to assess intellectual, motor, language or social abilities should be considered for each individual. Test performance may be affected by cultural biases (e.g. reference in test items to terminology or objects not common to a culture) and limitations of translation. Language proficiency must also be considered when interpreting test results. Where appropriately normed and standardized tests are not available, assessment of the essential features of these disorders requires greater reliance on clinical judgement based on appropriate evidence and assessment. Disorders of intellectual development Essential (required) features • The presence of significant limitations in intellectual functioning across various domains such as perceptual reasoning, working memory, processing speed and verbal comprehension is required for diagnosis. There is often substantial variability in the extent to which any of these domains are affected in an individual. Whenever possible, performance should be measured using appropriately normed, standardized tests of intellectual functioning and found to be approximately 2 or more standard deviations below the mean (i.e. approximately less than the 2.3rd percentile). In situations where appropriately normed and standardized tests are not available, assessment of intellectual functioning requires greater reliance on clinical judgement based on appropriate evidence and assessment, which may include the use of behavioural indicators of intellectual functioning (see Table 6.1, p. 101). • The presence of significant limitations in adaptive behaviour, which refers to the set of conceptual, social and practical skills that have been learned and are performed by people in their everyday lives, is an essential component. Conceptual skills are those that involve the application of knowledge (e.g. reading, writing, calculating, solving problems and

making decisions) and communication; social skills include managing interpersonal interactions

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93 Neurodevelopmental disorders and relationships, social responsibility, following rules and obeying laws, and avoiding victimization; and practical skills are involved in areas such as self-care, health and safety, occupational skills, recreation, use of money, mobility and transportation, as well as use of home appliances and technological devices. Expectations of adaptive functioning may change in response to environmental demands that change with age. Whenever possible, performance should be measured with appropriately normed, standardized tests of adaptive behaviour and the total score found to be approximately 2 or more standard deviations below the mean (i.e. approximately less than the 2.3rd percentile). In situations where appropriately normed and standardized tests are not available, assessment of adaptive behaviour functioning requires greater reliance on clinical judgement based on appropriate assessment, which may include the use of behavioural indicators of adaptive behaviour skills (see Tables 6.2–6.4, pp. 104–111).

- Onset occurs during the developmental period. Among adults with disorders of intellectual development who come to clinical attention without a previous diagnosis, it is possible to establish developmental onset through the person's history (retrospective diagnosis). Severity specifiers The severity of a disorder of intellectual development is determined by considering both the individual's level of intellectual ability and level of adaptive behaviour, ideally assessed using appropriately normed, individually administered standardized tests. Where appropriately normed and standardized tests are not available, assessment of intellectual functioning and adaptive behaviour requires greater reliance on clinical judgement based on appropriate evidence and assessment, which may include the use of behavioural indicators of intellectual and adaptive functioning provided in Tables 6.1–6.4. Generally, the level of severity should be assigned on the basis of the level at which the majority of the individual's intellectual ability and adaptive behaviour skills across all three domains – conceptual, social and practical skills – fall. For example, if intellectual functioning and two of three adaptive behaviour domains are determined to be 3–4 standard deviations below the mean, moderate disorder of intellectual development would be the most appropriate diagnosis. However, this formulation may vary according to the nature and purpose of the assessment, as well as the importance of the behaviour in question in relation to the individual's overall functioning.

Disorder of intellectual development, mild

- In mild disorder of intellectual development, intellectual functioning and adaptive behaviour are found to be approximately 2–3 standard deviations below the mean (approximately 0.1–2.3 percentile), based on appropriately normed, individually administered standardized tests. Where standardized tests are not available, assessment of intellectual functioning and adaptive behaviour requires greater reliance on clinical judgement, which may include the use of behavioural indicators provided in Tables 6.1–6.4. People with mild disorder of intellectual development often exhibit difficulties in the acquisition and comprehension of complex language concepts and academic skills. Most master basic self-care, domestic and practical activities. Affected people can generally achieve relatively independent living and employment as adults, but may require appropriate support.

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Disorder of intellectual development, moderate

- In moderate disorder of intellectual development, intellectual functioning and adaptive behaviour are found to be approximately 3–4 standard deviations below the mean (approximately 0.003–0.1 percentile),

based on appropriately normed, individually administered standardized tests. Where standardized tests are not available, assessment of intellectual functioning and adaptive behaviour requires greater reliance on clinical judgement, which may include the use of behavioural indicators provided in Tables 6.1–6.4. Language and capacity for acquisition of academic skills of people affected by moderate disorder of intellectual development vary but are generally limited to basic skills. Some may master basic self-care, domestic and practical activities. Most affected people require considerable and consistent support in order to achieve independent living and employment as adults.

Disorder of intellectual development, severe • In severe disorder of intellectual development, intellectual functioning and adaptive behaviour are found to be approximately 4 or more standard deviations below the mean (less than approximately the 0.003rd percentile), based on appropriately normed, individually administered standardized tests. Where standardized tests are not available, assessment of intellectual functioning and adaptive behaviour requires greater reliance on clinical judgement, which may include the use of behavioural indicators provided in Tables 6.1–6.4. People affected by severe disorder of intellectual development exhibit very limited language and capacity for acquisition of academic skills. They may also have motor impairments and typically require daily support in a supervised environment for adequate care, but may acquire basic self-care skills with intensive training.

Severe and profound disorders of intellectual development are differentiated exclusively on the basis of adaptive behaviour differences because existing standardized tests of intelligence cannot reliably or validly distinguish among individuals with intellectual functioning below the 0.003rd percentile.

Disorder of intellectual development, profound • In profound disorder of intellectual development, intellectual functioning and adaptive behaviour are found to be approximately 4 or more standard deviations below the mean (approximately less than the 0.003rd percentile), based on individually administered appropriately normed, standardized tests. Where standardized tests are not available, assessment of intellectual functioning and adaptive behaviour requires greater reliance on clinical judgement, which may include the use of behavioural indicators provided in Tables 6.1–6.4. People affected by profound disorder of intellectual development possess very limited communication abilities and capacity for acquisition of academic skills is restricted to basic concrete skills. They may also have co-occurring motor and sensory impairments and typically require daily support in a supervised environment for adequate care.

Severe and profound disorders of intellectual development are differentiated exclusively on the basis of adaptive behaviour differences because existing standardized tests of intelligence cannot reliably or validly distinguish among individuals with intellectual functioning below the 0.003rd percentile.

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Disorder of intellectual development, provisional • Provisional disorder of intellectual development is assigned when there is evidence of a disorder of intellectual development but the individual is an infant or child under the age of 4 years, making it difficult to ascertain whether the observed impairments represent a transient delay. Provisional disorder of intellectual development in this context is sometimes referred to as “global developmental delay”. The diagnosis can also be assigned in individuals 4 years of age or older when evidence is suggestive of a disorder of intellectual development but it is not possible to conduct a valid assessment of intellectual functioning and adaptive behaviour because of sensory or physical impairments (e.g. blindness, prelingual deafness), motor or communication impairments, severe problem behaviours, or symptoms of another mental, behavioural or neurodevelopmental disorder that interfere with assessment.

Disorder of intellectual development, unspecified Additional clinical

features • No single physical feature or personality type is common to all individuals with disorders of intellectual development, although specific etiological groups may have common physical characteristics. • Disorders of intellectual development are associated with a high rate of co-occurring mental, behavioural and neurodevelopmental disorders. However, clinical presentations may vary depending on the individual's age, level of severity of the disorder of intellectual development, communication skills and symptom complexity. Some disorders – such as autism spectrum disorder, depressive disorders, bipolar and related disorders, schizophrenia, dementia and attention deficit hyperactivity disorder – occur more commonly among individuals with disorders of intellectual development than in the general population. Individuals with a co-occurring disorder of intellectual development and other mental, behavioural and neurodevelopmental disorders are at similar risk of suicide as individuals with mental disorders who do not have a co-occurring disorder of intellectual development. • Problem or challenging behaviours such as aggression, self-injurious behaviour, attentionseeking behaviour, oppositional defiant behaviour and sexually inappropriate behaviour are more frequent among those with disorders of intellectual development than in the general population. • Many individuals with disorders of intellectual development are more gullible and naive, easier to deceive, and more prone to acquiescence and confabulation than people in the general population. This can lead to various consequences, including greater likelihood of victimization, becoming involved in criminal activities and providing inaccurate statements to law enforcement. • Significant life changes and traumatic experiences can be particularly difficult for a person with a disorder of intellectual development. Whereas the timing and type of life transitions vary across societies, it is generally the case that individuals with disorders of intellectual

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Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders development need additional support adapting to changes in routine, structure, or educational or living arrangements. • Many medical conditions can cause disorders of intellectual development and are, in turn, associated with specific additional medical problems. A variety of prenatal (e.g. exposure to toxic substances or harmful medications), perinatal (e.g. labour and delivery problems) and postnatal (e.g. infectious encephalopathies) factors may contribute to the development of disorders of intellectual development, and multiple etiologies may interact. Early diagnosis of the etiology of a disorder of intellectual development, when possible, can assist in the prevention and management of related medical problems (e.g. frequent thyroid disease screening is recommended for individuals with Down syndrome). If the etiology of a disorder of intellectual development in a particular individual has been established, the diagnosis corresponding to that etiology should also be assigned. • Individuals with disorders of intellectual development are at greater risk of a variety of health (e.g. epilepsy) and social (e.g. poverty) problems across the lifespan. Boundary with normality (threshold) • In disorders of intellectual development, a measure of intelligence quotient (IQ) is not an isolated diagnostic requirement to distinguish disorder from normality, but should be considered a proxy measure of the “significant limitations in intellectual functioning” that partially characterize disorders of intellectual development. IQ scores may vary as a result of the technical properties of the specific test being used, the testing conditions and a variety of other variables, and also can vary substantially over the individual's development and life-course. The diagnosis of disorders of intellectual development should not be made solely based on IQ scores but must also include a comprehensive evaluation of adaptive behaviour. • Scores on individually administered

standardized tests of intellectual and adaptive functioning may vary considerably over the course of an individual's development, and it is quite possible that, during the developmental period, a child may meet the diagnostic requirements of disorders of intellectual development on one occasion but not another. Multiple testing on different occasions during the developmental trajectory is necessary to establish a reliable estimate of functioning.

- Special care should be taken in differentiating disorders of intellectual development from normality when evaluating people with communication, sensory or motor impairments; those exhibiting behavioural disturbances; immigrants; people with low literacy levels; people with mental disorders; people undergoing medical treatments (e.g. pharmacotherapy); and people who have experienced severe social or sensory deprivation. If not adequately addressed during the evaluation, these factors may reduce the validity of scores obtained on standardized or behavioural measures of intellectual and adaptive functioning. For example, the reliable use of standardized measures of intellectual functioning and adaptive behaviour may pose particular challenges among individuals with motor coordination and communication impairments, and assessments must be selected that are appropriate to the individual's capacities.
- What is sometimes termed "borderline intellectual functioning", defined as intellectual functioning between approximately 1 and 2 standard deviations below the mean, is not a diagnosable disorder. Nonetheless, such individuals may present many needs for support and interventions that are similar to those of people with disorders of intellectual development.

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- Disorders of intellectual development are lifespan conditions that typically manifest during early childhood and require consideration of developmental phases and life transitions whereby periods of relatively greater need may alternate with those where less support may be necessary.
- Disorders of intellectual development may show individual as well as etiology-specific variation in developmental trajectories (i.e. periods of relative decline or amelioration in functioning). Intellectual functioning and adaptive behaviour can vary substantially across the lifespan. Results from a single assessment, particularly those obtained during early childhood, may be of limited predictive use, as later functioning will be influenced by the level and type of interventions and support provided.
- People with disorders of intellectual development typically need exceptional support throughout the lifespan, although the types and intensities of required support often change over time depending on age, development, environmental factors and life circumstances. Most people with disorders of intellectual development continue to acquire skills and competencies over time. Providing interventions and support – including education – assists with this process and, if provided during the developmental period, may result in lower support needs in adulthood.

Developmental presentations

- There is wide variability in the developmental presentation and developmental trajectories of individuals with disorders of intellectual development. Tables 6.2–6.4 provide clinicians with some of the key areas of strengths and weaknesses typically observed at different time points across development (i.e. early childhood, childhood, adolescence and adulthood) in individuals with disorders of intellectual development.
- Conditions related to disorders of intellectual development may be suspected during the first days and months of life due to the presence of certain physical signs such as facial dimorphisms, congenital malformation, micro- or macrocephalia, low weight, hypotonia, physical growth retardation, metabolic problems and failure to thrive, among others.
- In older children, disorders of intellectual development may manifest as problems in acquiring academic knowledge and abilities such as reading, writing and arithmetic. Many children with mild disorder of intellectual development may not be referred for evaluation until they reach school age.

Some individuals may remain undiagnosed until much later, during adolescence or adulthood. • The manifestations of disorders of intellectual development during late adolescence and the first years of adulthood may be strongly influenced by the presence of challenges related to assuming adult roles, such as postsecondary education, employment, independent living and adult relationships. • Older adults with disorders of intellectual development may present with a more rapid onset of dementia or declining skills than older adults in the general population. They also have significantly more difficulty gaining access to necessary support and appropriate health care for medical problems. Neurodevelopmental disorders | Disorders of intellectual development

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders Culture-related features • The cultural appropriateness of tests and norms used to assess intellectual and adaptive functioning should be considered for each individual. Test performance may be affected by cultural biases (e.g. reference in test items to terminology or objects not common to a culture) and limitations of translation. • In evaluating adaptive functioning (i.e. the individual's conceptual, social and practical skills), the expectations of the individual's culture and social environment should be considered. • Language proficiency must also be considered when interpreting test results, in terms of both its impact on verbal performance and whether the individual understood the instructions. Sex- and/or gender-related features • The overall prevalence of disorders of intellectual development is slightly higher in males. The prevalence of some etiologies of disorders of intellectual development differs between males and females (e.g. X-linked genetic conditions such as fragile X syndrome are predominantly diagnosed in males, whereas Turner syndrome occurs exclusively in females). • A number of associated features of disorders of intellectual development differ between males and females – for example, in the expression of problem behaviours and co-occurring mental, behavioural and neurodevelopmental disorders. Males are more likely to exhibit hyperactivity and conduct disturbances, whereas females are more likely to exhibit mood and anxiety symptoms. • Reduced social value and expectations placed on females compared to males in some societies may negatively affect the accurate identification and provision of support for females with disorders of intellectual development. Boundaries with other disorders and conditions (differential diagnosis) Boundary with developmental speech and language disorders In developmental speech and language disorders, individuals exhibit difficulties in understanding or producing speech and language, or in using language in context for the purposes of communication that is markedly below what would be expected given the individual's age and level of intellectual functioning. If speech and language abilities are significantly below what would be expected based on intellectual and adaptive behaviour functioning in an individual with a disorder of intellectual development, an additional diagnosis of developmental speech and language disorder may be assigned. Neurodevelopmental disorders | Disorders of intellectual development

99 Neurodevelopmental disorders Boundary with autism spectrum disorder Autism spectrum disorder is characterized by persistent deficits in reciprocal social interaction and social communication, and by a range of restricted, repetitive, inflexible patterns of behaviour and interests. Although many individuals with autism spectrum disorder present with the significant limitations in intellectual functioning and adaptive behaviour observed in disorders of intellectual development, autism spectrum disorder can also present without general limitations in intellectual functioning. In cases of autism spectrum disorder where there are significant limitations in intellectual functioning and adaptive behaviour (i.e. 2 or more standard deviations below the mean

or approximately less than the 2.3rd percentile) both the diagnosis of autism spectrum disorder using the with disorder of intellectual development specifier and the diagnosis of a disorder of intellectual development at the corresponding level of severity should be assigned. The diagnosis of autism spectrum disorder in individuals with severe and profound disorders of intellectual development is particularly difficult, and requires in-depth and longitudinal assessments. Because autism spectrum disorder inherently involves social deficits, assessment of adaptive behaviour as a part of the diagnosis of a co-occurring disorder of intellectual development should place greater emphasis on the conceptual and practical domains of adaptive functioning than on social skills.

Boundary with developmental learning disorders Developmental learning disorders are characterized by significant and persistent difficulties in learning academic skills including reading, writing and arithmetic, with performance in these areas markedly below what would be expected based on chronological age or intellectual level. Individuals with disorders of intellectual development often present with limitations in academic achievement by virtue of significant generalized deficits in intellectual functioning. It is therefore difficult to establish the co-occurring presence of a developmental learning disorder in individuals with a disorder of intellectual development. However, developmental learning disorders can co-occur in some individuals with disorders of intellectual development if, despite adequate opportunities, acquisition of learning is significantly below what is expected based on established intellectual functioning. In such cases, both disorders may be diagnosed.

Boundary with developmental motor coordination disorders In developmental motor coordination disorder, individuals exhibit significant delays during the developmental period in the acquisition of gross and fine motor skills, and impairment in the execution of coordinated motor skills that manifest in clumsiness, slowness or inaccuracy of motor performance. Individuals with disorders of intellectual development may also display such motor coordination difficulties that affect adaptive behaviour functioning. In contrast to those with developmental motor coordination disorder, individuals with disorders of intellectual development have accompanying significant limitations in intellectual functioning. However, if coordinated motor skills are significantly below what would be expected based on level of intellectual functioning and adaptive behaviour, and represent a separate focus of clinical attention, both diagnoses may be assigned.

Boundary with attention deficit hyperactivity disorder In attention deficit hyperactivity disorder, individuals show a persistent and generalized pattern of inattention and/or hyperactivity-impulsivity that emerges during the developmental period. If all diagnostic requirements for a disorder of intellectual development are met, and inattention and/or hyperactivity-impulsivity are found to be outside normal expected limits based on age and level of intellectual functioning, with significant interference in academic, occupational or social functioning, both diagnoses may be assigned.

Boundary with dementia In dementia, affected individuals – usually older adults – exhibit a decline from a previous level of functioning in multiple cognitive domains that interferes significantly with performance of

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Boundary with other mental and behavioural disorders Other mental and behavioural disorders such as schizophrenia and other primary psychotic disorders may include symptoms that interfere with intellectual functioning and adaptive behaviour. A disorder of intellectual development should not be diagnosed if the limitations are better accounted for by another mental and behavioural disorder. However, other mental and behavioural disorders are at least as prevalent in individuals with disorders of intellectual development as in the general population, and co-occurring diagnoses should be assigned if warranted. In evaluating mental and behavioural disorders in individuals with disorders of intellectual development, signs and symptoms must be assessed using methods that are appropriate to the individual's level of development and intellectual functioning, and may require a greater reliance on observable signs and the reports of others who are familiar with the individual.

Boundary with sensory impairments If not addressed, sensory impairments (e.g. visual, auditory) can interfere with opportunities for learning, resulting in apparent limitations in intellectual functioning or adaptive behaviour. If the observed limitations are solely attributable to a sensory impairment, a disorder of intellectual development should not be assigned. However, prolonged sensory impairment throughout the critical period of development may result in the persistence of limitations in intellectual functioning or adaptive behaviour, despite later intervention, and an additional diagnosis of a disorder of intellectual development may be warranted in such cases.

Boundary with effects of psychosocial deprivation Extreme psychosocial deprivation in early childhood can produce severe and selective impairments in specific mental functions such as language, social interaction and emotional expression. Depending on the onset, level of severity and duration of the deprivation, functioning in these areas may improve substantially after the child is moved to a more positive environment. However, some deficits may persist even after a sustained period in an environment that provides adequate stimulation for development, and a diagnosis of a disorder of intellectual development may be appropriate in such cases if all diagnostic requirements are met.

Boundary with neurodegenerative diseases Neurodegenerative diseases can be associated with disorders of intellectual development but only if they have their onset in the developmental period (e.g. mucopolipidosis type I, Gaucher's disease type III). If a neurodegenerative disease co-occurs with a disorder of intellectual development, both diagnoses should be assigned.

Boundary with secondary neurodevelopmental syndrome If the diagnostic requirements of a disorder of intellectual development are met and the symptoms are attributed to medical conditions with onset during the prenatal or developmental period, both disorder of intellectual development and the underlying medical conditions should be diagnosed. If the diagnostic requirements of a disorder of intellectual development are not met (e.g. limitations in intellectual functioning without limitations in adaptive functioning) and the symptoms are attributed to medical conditions with onset during the prenatal or developmental period, a diagnosis of secondary neurodevelopmental syndrome should be assigned, together with the diagnosis corresponding to the underlying medical condition.

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101 Neurodevelopmental disorders | Disorders of intellectual development Table 6.1. Behavioural indicators of intellectual functioning

Severity level	Early childhood	Childhood and adolescence	Adulthood
Mild	By the end of this developmental period, there is evidence of the emergence or presence of the abilities listed below.	• Most will develop language skills and be able to communicate needs. Delays in the acquisition of language skills are typical, and once acquired the skills are frequently less developed than in typically developing peers (e.g. more limited vocabulary). • Most can tell or identify their gender and age. • Most can attend to a simple cause-	

effect relationship. • Most can attend to and follow up to 2-step instructions. • Most can make one-to-one correspondence or match to sample (e.g. organize or match items according to shape, size, colour). • Most can communicate their immediate future goals (e.g. desired activities for the day). • Most can express their likes and dislikes in relationships (e.g. who they prefer to spend time with), activities, food and dress. Literacy/numeracy • Most will develop emergent reading and writing skills. • Most will be able to recognize letters from their name, and some can recognize their own name in print. During this developmental period, there is evidence of the emergence or presence of the abilities listed below. • Most can communicate effectively. • Most can tell or identify their age. • Most can initiate/invite others to participate in an activity. • Most can communicate about past, present and future events. • Most can attend to and follow up to 3-step instructions. • Most can identify different denominations of money (e.g. coins) and count small amounts of money. • Most can cross street intersections safely (look in both directions, wait for traffic to clear before crossing, obey traffic signals). In contexts without busy intersections, most can follow socially acceptable rules necessary to ensure personal safety. • Most can communicate their future goals and participate in their health care. • Most can identify many of their relatives and their relationships. • Most can apply existing abilities in order to build skills for future semi-skilled employment (i.e. involving the performance of routine operations) and in some cases skilled employment (e.g. requiring some independent judgement and responsibility). • Most are naive in anticipating full consequences of actions or recognizing when someone is trying to exploit them. • Some can orient themselves in the community and travel to new places using familiar modes of transportation. Literacy/numeracy • Most can read sentences with five common words. • Most can count and make simple additions and subtractions. Neurodevelopmental disorders • Most can communicate fluently. • Many can tell or identify their birth date. • Most can initiate/invite others to participate in an activity. • Most can communicate about past, present and future events. • Most can attend to and follow up to 3-step instructions. • Most can identify different denominations of money (e.g. coins) and count money more or less accurately. • Most can orient themselves in the community and learn to travel to new places using different modes of transportation with instruction/training. • Some can learn the road laws and meet requirements to obtain a driver's license. Travel is mainly restricted to familiar environments. • Most can cross residential street intersections safely (look in both directions, wait for traffic to clear before crossing, obey traffic signals). In contexts without busy intersections, most can follow socially acceptable rules necessary to ensure personal safety. • Most can communicate their decisions about their future goals, health care and relationships (e.g. who they prefer to spend time with). • Most can apply existing abilities in the context of semi-skilled employment (i.e. involving the performance of routine operations) and in some cases skilled employment (e.g. requiring some independent judgement and responsibility). • Most remain naive in anticipating full consequences of actions or recognizing when someone is trying to exploit them. • Most have difficulty in handling complex situations such as managing bank accounts and long-term money management. Literacy/numeracy • Most can read and write up to approximately a level expected for someone who has attended 7-8 years of schooling (i.e. start of middle/secondary school), and read simple material for information and entertainment. • Most can count, understand mathematical concepts and make simple mathematical calculations.

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders Table 6.1. contd Severity level Early childhood Childhood and adolescence Adulthood Moderate • Most will develop language skills and be able to communicate

needs. Delays in the acquisition of language skills are typical, and once acquired the skills are often less developed than in typically developing peers (e.g. more limited vocabulary).

- Most can follow 1-step instructions.
- Most can self-initiate activities and participate in parallel play. Some develop simple interactive play.
- Some can attend to a simple cause-effect relationship.
- Most can distinguish between “more” and “less”.
- Some can make one-to-one correspondence or match to sample (e.g. organize or match items according to shape, size, colour).
- Many can express their likes and dislikes in relationships (e.g. who they prefer to spend time with), activities, food and dress.

Literacy/numeracy

- Most can recognize symbols.
- Most can tell or identify their age and gender.
- Most can initiate/invite others to participate in an activity.
- Most can communicate immediate experiences.
- Most can attend to and follow up to 2-step instructions.
- Some can cross residential street intersections safely (look in both directions, wait for traffic to clear before crossing, obey lights and signal signals). In contexts without busy intersections, some can follow socially acceptable rules necessary to ensure personal safety.
- Some can go independently to nearby familiar places.
- Most can communicate preferences about their future goals when provided with options.
- Most can express their likes and dislikes in relationships (e.g. who they prefer to spend time with), activities, food and dress.
- With support, most can apply existing abilities in order to build skills for future semi-skilled employment (i.e. involving the performance of routine operations).
- Most are naive in anticipating full consequences of actions or recognizing when someone is trying to exploit them.

Literacy/numeracy

- Most will develop emergent reading and writing skills.
- Most can recognize their own name in print.
- Most can choose the correct number of objects.
- Some can learn to count up to 10.
- Most can initiate/invite others to participate in an activity.
- Most can communicate immediate experiences.
- Most can attend to and follow up to 2-step instructions.
- Most can cross residential street intersections safely (look in both directions, wait for traffic to clear before crossing, obey lights and signal signals). In contexts without busy intersections, some can follow socially acceptable rules necessary to ensure personal safety.
- Some can travel independently to familiar places.
- Most can communicate their preferences about their future goals, health care and relationships (e.g. who they prefer to spend time with), and will often act in accordance with these preferences.
- Some can apply existing abilities in the context of semi-skilled employment (i.e. involving the performance of routine operations).
- Most remain naive in anticipating full consequences of actions or recognizing when someone is trying to exploit them.

Literacy/numeracy

- Most can read sentences with three common words and can achieve a reading and writing level up to that expected of someone who has attended 4–5 years of schooling (i.e. several years of primary/elementary school).
- Most can choose the correct number of objects.
- Most can count to 10 and in some cases higher.

Severe

- Most will develop various simple nonverbal strategies to communicate basic needs.
- Some can self-initiate activities.
- Most can attend to and respond to others.
- Most can separate one object from a group upon request.
- Most can stop an activity upon request.
- Most can use communication strategies to indicate preferences.
- Most can self-initiate activities.
- Most can attend to and recognize familiar pictures.
- Most can follow 1-step instructions and stop an activity upon request.
- Most can distinguish between “more” and “less”.
- Most can separate one object from a group upon request.
- Most can use communication strategies to indicate preferences.
- Most can self-initiate activities.
- Most can attend to and recognize familiar pictures.
- Most can follow 1-step instructions and stop an activity upon request.
- Most can distinguish between “more” and “less”.
- Most can separate one object from a group upon request.

103 Severity level Early childhood Childhood and adolescence Adulthood • Most can express their likes and dislikes in relationships (e.g. who they prefer to spend time with), activities, food and dress when given concrete choices (e.g. with visual aids). Literacy/numeracy • Most can make rudimentary marks that are precursors to letters on a page. • Most can differentiate locations and associate meanings (e.g. car, kitchen, bathroom, school, doctor's office). • Most can express their likes and dislikes in relationships (e.g. who they prefer to spend time with), activities, food and dress when given concrete choices (e.g. with visual aids). • With support, some may be able to apply existing abilities in order to build skills for future unskilled employment (i.e. involving performing simple duties) or semiskilled employment (i.e. involving performing routine operations). Literacy/numeracy • Most can recognize symbols. • Many can recognize own name in print. • Most can differentiate locations and associated meanings (e.g. car, kitchen, bathroom, school, doctor's office). • Most can communicate their preferences about their future goals, health care and relationships (e.g. who they prefer to spend time with) when given concrete choices (e.g. with visual aids). • Some can apply existing skills to obtain unskilled employment (i.e. involving performing simple duties) or semi-skilled employment (i.e. involving performing routine operations) with appropriate social and visual/verbal support. Literacy/numeracy • Most can recognize common pictures (e.g. house, ball, flower). • Many can recognize letters from an alphabet. Profound • Many will develop nonverbal strategies to communicate basic needs. • Most can attend to and respond to others. • Most can start or stop activities with prompts and aids. • Many can express their likes and dislikes in relationships (e.g. who they prefer to spend time with), activities, food and dress when given concrete choices (e.g. with visual aids). Literacy/numeracy • Children with profound disorders of intellectual development will not learn to read or write. • Most will develop strategies to communicate basic needs and preferences. • Most can recognize familiar people in person and in photographs. • Most can perform very simple tasks with prompts and aids. • Some can separate one object from a group upon request. • Some can differentiate locations and associated meanings (e.g. car, kitchen, bathroom, school, doctor's office). • Many can express their likes and dislikes in relationships (e.g. who they prefer to spend time with), activities, food and dress when given concrete choices (e.g. with visual aids). • Most will develop nonverbal strategies and some utterances/ occasional words to communicate basic needs and preferences. • Most can attend to and recognize familiar pictures. • Most can perform very simple tasks with prompts and aids. • Some can separate one object from a group upon request. • Some can differentiate locations and associated meanings (e.g. car, kitchen, bathroom, school, doctor's office). • Many can communicate their preferences about their future goals, health care and relationships (e.g. who they prefer to spend time with) when given concrete choices (e.g. with visual aids). Table 6.1.

contd Neurodevelopmental disorders Neurodevelopmental disorders | Disorders of intellectual development Note: the presence or absence of particular behavioural indicators listed in the table is not sufficient to assign a diagnosis of disorder of intellectual development. Clinical judgement is a necessary component in determining whether an individual has a diagnosable disorder, and diagnosis relies on the following key assumptions being met: • Limitations in present functioning have been considered within the context of community environments typical of the individual's age peers and culture. • Valid assessment has considered cultural and linguistic diversity, as well as differences in communication, sensory, motor and behavioural factors. • Within an individual, limitations are recognized to often coexist alongside strengths and both were considered during the assessment. • Limitations are described, in part, to develop a profile of needed support. • It is recognized that with appropriate support over a sustained period, the life functioning of the affected person generally will improve. • Please consult the CDDR for disorders of intellectual

development and, if applicable, autism spectrum disorder for guidance on how to determine the severity level.

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders Table 6.2. Behavioural indicators of adaptive behaviour, early childhood (up to 6 years of age) Severity level Conceptual Social Practical Mild • Most can perform basic listening skills with a 15-minute attention span. They will need help to sustain their attention for 30 minutes. • Most are able to follow simple 2-step instructions. They will need help following a 3-step or “if-then” type of instruction. • Most can state their age and name and identify close family members when asked. • Many will have a 100-word vocabulary. Most will ask “wh” question (who, what, where, why), but will need help using pronouns and tense verbs. • Most are not able to give a detailed account of their experiences. • Most will understand the simple concepts of time, space, distance and spatial relationships. Literacy • Many will not learn reading/ writing skills. If present, reading skills will be limited to identifying some letters of the alphabet. Only some will be able to recognize their own name in print. • Most can perform independently basic skills related to social interaction – such as imitation and showing affection to familiar people, as well as friend-seeking behaviour – expressing emotions and answering basic questions. • Most will need frequent encouragement and assistance in offering help to others, sharing interests or perspective taking. They are able to engage in play with others, even with minimal supervision, although they will need assistance taking turns, following rules or sharing. • Most are able to demonstrate polite behaviour (saying “please”, “thank you”), although they may need help apologizing, demonstrating appropriate behaviour with strangers or waiting for the appropriate moment to speak in a social context. • Most will need help to modify their behaviour in accordance with changing social situations or when there is a change in their routines. • Most will learn the majority of basic eating, washing face and hands, toileting and self-care skills. • Most will acquire independence in dressing (but may need help to button/fasten clothes) and night-time continence. • Most can use simple household devices. • Most will need support with bathing, using utensils, toileting such as cleaning after passing stools, and brushing teeth. • Most can learn the concept of danger and avoid hot objects. • Most will be able to help with simple household chores independently, but will often need assistance with more complex tasks such as putting away clothes or cleaning up their rooms. • With some assistance, most can learn the concept of money (although they will be unable to learn the value of the different denominations, e.g. coins), can count to 10, and can follow basic rules around the home. • Most will be unable to learn days of the week, and learn and remember phone numbers. Moderate • Most will independently point to common objects when asked and follow 1-step instructions. Some will need support to perform basic skills such as following simple 2-step instructions. • Most can state their own name. • Most will have basic communication skills such as formulating one-word requests, using simple phrases and using other people’s customary forms of address (mommy, papa, sister), but will need help with full names. • Most will speak at least 50 words and name/point to at least 10 objects when asked. • Most are not able (or will need considerable support) to use past tense verbs, pronouns or “wh” questions. Literacy • Most will not learn reading or writing skills, but will know how to use pens and pencils and make marks on a page. • Most are able to perform independently some of the basic skills related to social interaction, although they might need some help making new friends, answering basic social questions or expressing their emotions. • Most are able to play with peers and show interest in, play or interact with others, but may need more supervision/support to play cooperatively with others, play symbolically, take turns, follow rules of a game and share objects. • Most will not be

able to perform more complex social skills involving interpersonal interactions such as offering help to others, empathy, sharing their interests with others or perspective taking. • Most can learn the majority of basic eating skills, but may need more assistance than their sameage peers with toilet training and dressing themselves (some help needed to button/fasten). • Most will learn to ask to use the toilet, drink from a cup, feed themselves with a spoon, and some may become toilet trained during daytime. Most will often need support with brushing teeth, bathing and using utensils. • With some support, most can learn to use simple household devices and carry out simple chores such as putting away their footwear. • Most can learn the concept of danger, although some assistance will be needed when using sharp objects (e.g. scissors). • Many will be able to help with very simple household chores such as cleaning fruits and vegetables. • Most will not acquire understanding of the concept of money and time. Neurodevelopmental disorders | Disorders of intellectual development

105 Severity level Conceptual Social Practical Severe • Most can perform independently the most basic skills such as wave goodbye, identify parent/caregiver, point to a desired object and point or gesture to indicate their preference, and understanding the meaning of yes and no. • Most will need support to point to/identify common objects, follow 1-step instructions, and sustain their attention to listen to a story for at least 5 minutes. • Most will not be able to state their age correctly and will speak less than 50 recognizable words. They may need help formulating 1-word requests and using first names or nicknames of familiar people, naming objects, answering when called upon, and using simple phrases. Literacy • Most will not learn reading and writing skills. • Most will need help to perform basic social skills such as imitation or showing interest and preferences in social interactions with their peers. • Most are able to show interest when someone else is playful and to play simple games. • Most will need significant support to play in a cooperative way, play symbolically or seek others for play/leisure activities. • Most will need significant help with transitions – changing from one activity to another or an unexpected change in routine. • Most will need significant help using polite social responses such as “please” and “thank you”. • Most will not be able to engage in turn-taking, following rules or sharing objects. • Most can learn many of the basic eating skills but will need substantially more assistance than their same-age peers with toilet training, learning to use a cup and spoon, and putting on clothes. • Most can learn to use simple household devices with consistent support. • Most will have difficulty learning to master many selfcare skills, including using the toilet independently. • Most will not be able to learn the concept of danger, and will require close supervision in areas such as the kitchen. • Some may learn basic cleaning skills such as washing hands but will consistently need assistance. • Most will not learn the concept of money, time or numbers. Profound • Most will master only the most basic communication skills such as turning their eye gaze and head towards a sound. • Children with profound disorders of intellectual development will typically need prompting to orient towards people in their environment, respond when their name is called, and understand the meaning of yes and no. • Children with profound disorders of intellectual development are typically able to cry when hungry or wet, smile and make sounds of pleasure, but it may be difficult to get their attention. Literacy • Children with profound disorders of intellectual development will not learn to read or write. • Most may be able to perform only the most basic social skills such as smiling, orienting their gaze, looking at others/objects, or showing basic emotions. • Some might be able to perform other basic social skills with considerable support/ prompting, such as showing preference for people or objects, imitating simple movements and expressions, or engaging in reciprocal social interactions. • Some can show interest when someone else is playful, but will need considerable

support to play simple games. • Most will have difficulty adapting to changes and transitions in activity/location. • Most will be unable to follow rules of a social game. • Most will need help performing even the most basic eating, dressing, drinking and bathing skills. • Most will be unable to learn to be independent using the toilet, being dry during the day, bathing or washing self at the sink, and using a fork and knife. • Most will need constant supervision around potentially dangerous situations in the home and community. • Most will be unable to clean up after themselves and will need help with even basic chores, such as picking up belongings to put away. • Most will not be able to learn to use the telephone or other simple devices around the home independently. Note: the behavioural indicators in the table are intended to be used by the clinician in determining the level of severity of the disorder of intellectual development, either as a complement to properly normed, standardized tests, or when such tests are unavailable or inappropriate given the individual's cultural and linguistic background. Use of these indicators is predicated on the clinician's knowledge of and experience with typically developing individuals of comparable age. Unless explicitly stated, the behavioural indicators of intellectual functioning and adaptive behaviour functioning for each severity level are what are typically expected to be mastered by the individual by 6 years of age. Please consult the CDDR for disorders of intellectual development and, if applicable, autism spectrum disorder for guidance on how to determine the severity level. Table 6.2. contd Neurodevelopmental disorders Neurodevelopmental disorders | Disorders of intellectual development

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders Table 6.3. Behavioural indicators of adaptive behaviour, childhood and adolescence (6–18 years of age) Severity level Conceptual Social Practical Mild • Most will need some help to sustain their attention for a 30-minute period. • Most can follow 3-step instructions. • Most will acquire sufficient communication skills to use pronouns, possessives and regular tenses, as well as be able to ask “wh” question (e.g. who, what, where, when or why). • Many will need support to tell a narrative story or to give someone simple directions. They will also need assistance to explain their ideas using multiple examples, detail short-term goals and steps to achieve them, stay on the topic in group conversations and move from one topic to another. Literacy • Most will have reading and writing skills that are limited to approximately those expected of someone who has attended 3–4 years of primary/elementary school. • Some may have a more concrete understanding of social situations, and may need support understanding some types of humour (e.g. teasing others), making plans and knowing to let others know about these plans as needed, controlling their emotions when faced with disappointment, and knowing to avoid dangerous activities or situations that may not be in their best interest (e.g. taken advantage of or exploited). • Some may need some support initiating conversation, organizing social activities with others or talking about shared interests with peers/friends. • Some may need substantial support to talk about personal things and emotions or understand social cues. • Most are able to play outdoor sports or other social games in groups, although they need help to play games with more complex rules (e.g. board games). • Most will learn to perform independently most dressing, toileting and eating skills. • Most will learn to manage activities of daily living independently, such as brushing teeth, bathing and showering. • Most will need some support getting around the community and being safe (e.g. although they will know to stay to the side of routes with car traffic, they may continue to need support to check for traffic before crossing a street). • Many may be vulnerable to being taken advantage of in social situations. They may continue to need some support for telling time, identifying correct day/dates on calendar, making and checking the correct

change at the store, and being independent with basic health-maintaining behaviours. • If available, many can learn to use computers and cell phones for school and play. • Most will learn basic work skills at nearly the same pace as their same-age peers, but will require greater repetition and structure for mastery. Moderate • Most will need help performing skills such as following instructions containing “if-then”, and sustaining their attention to listen to a story for at least a 15-minute period. • Most can say at least 100 words, use negatives, use simple sentences and state their first and last name and their locality/place of residence. • Some may need help using pronouns, possessives or past tense verbs. • Some may need support telling basic parts of a story or asking “wh” questions (e.g. when, where, why, who). • Most will not learn complex conversation skills (i.e. expressing their ideas in an abstract manner or in more than one way). • Some may need support expressing their emotions or concerns, knowing when others might need their help, showing emotions appropriate to the situation/context, or knowing what others like or want. • Most will need considerable help initiating a conversation, waiting for the appropriate moment to speak, meeting friends and going on social outings or talking about shared interests with others. • Most will need help following rules when playing simple games or going out with friends. • Some will need support when changing routines and transitioning between activities/places. • Most can learn to feed themselves, use the toilet and dress (including putting shoes/ footwear on the correct feet). • Most will often continue to need support to attain independence for bathing and showering, brushing teeth, selecting appropriate clothing, and being independent and safe in the home and community. • Most will continue to have difficulty using a knife to cut food, using cooking appliances safely, using household products safely, and doing household chores. Neurodevelopmental disorders | Disorders of intellectual development

107 Severity level Conceptual Social Practical Literacy • Most will have reading and writing skills that will be limited to approximately those expected of someone who has attended 2 years of primary/elementary school. • Most may need support with reading simple stories, writing simple sentences, and writing more than 20 words from memory. • Most will be able to say the names of a few animals, fruits and foods prepared in the home. • Some will need support in behaving appropriately in accordance with social situations, and knowing what to do in social situations involving strangers. • Most individuals will not be able to share information with others about their past day’s events/activities, and will need support managing conflicts or challenging social interactions and recognizing/avoiding dangerous social situations. • Most will not acquire an understanding of taking care of their health. • Most will learn basic work skills but later than same-age peers Severe • Most will be able independently to make simple one-word requests, use first names of familiar individuals and name at least 10 familiar objects. • Some may need help following instructions, and will not be able to use pronouns, possessives or regular past tenses, or state their age. • With help, some may be able to ask “wh” questions (e.g. when, why, what, where), use at least 100 recognizable words, use negatives, and relate their experiences in simple sentences. Literacy • Most will have reading and writing skills that will be limited to identifying some letters of the alphabet. • Most will be able to count up to 5. • Some may need support demonstrating friend-seeking behaviour, or engaging in reciprocal social interactions. • Most will need help expressing their emotions or showing empathy. • Most will not know that they should offer help to others without cues or prompting, show appropriate emotions in social situations, engage in conversations or ask others about their interests. • Most will need support to play cooperatively. • Most will need help with transitions – changing from one activity to another, or an unexpected change in routine. • With considerable help, some might be able to start/end a

conversation appropriately, and say “please” and “thank you” when appropriate. • Most will have difficulty following social rules, as well as rules associated with games such as turn-taking or sharing toys. Most will be unable to participate in social or other games with complex rules. • Most can learn to independently put on and take off clothing, feed themselves with hand or a spoon, and use the toilet. • They will often continue to need support to attain independence for putting shoes or other footwear on the correct feet, buttoning and fastening clothing, bathing and showering. • Most individuals will not learn the rules and safe behaviours in the home and community, doing household chores or checking for correct change when purchasing items. • Some will learn basic work skills but later than same-age peers. Table 6.3. contd Neurodevelopmental disorders

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Severity level	Conceptual	Social	Practical	Profound
• Most will have basic communication skills such as orienting their eye gaze and turning their head to locate a sound, responding to their name, getting a parent/caregiver’s attention, expressing their needs, and demonstrating an understanding of the meaning of yes and no. • With significant support, some will be able to wave goodbye, use their parent/caregiver’s name, and point to objects to express their preferences. • Most indicate when there are hungry or wet by making a vocalization or crying, smile, and make sounds to indicate they are happy/sad. • Some may not be able to effectively use communication to get the attention of others in their environment. Literacy • Most will not learn to read or write. • Most will need some help to perform basic social skills such as showing interest and affection for people familiar to them, engaging in social interactions, or discriminating between acquaintances. • Some can perform certain social skills such as imitation, showing interest in peers or empathy. • For some, transitioning between social contexts and activities will elicit negative reactions if not done with support. • Most will not be able to engage in cooperative social play, and will need a lot of help moderating their behaviour to different social cues. • Most will need exceptional support with basic hygiene and washing, picking up after themselves, clearing their place at the kitchen table, being safe in the kitchen, and using hot water. • Most will be unable to learn to prepare foods or assist in the kitchen, or use simple household devices (e.g. switches, stoves, microwaves). • Most will not learn rules and safe behaviours in the home and community. • Most will require a lot of supervision to remain on task and be engaged in basic vocational or pre-vocational skills. Table 6.3. contd Note: the behavioural indicators in the table are intended to be used by the clinician in determining the level of severity of the disorder of intellectual development, either as a complement to properly normed, standardized tests, or when such tests are unavailable or inappropriate given the individual’s cultural and linguistic background. Use of these indicators is predicated on the clinician’s knowledge of and experience with typically developing individuals of comparable age. Unless explicitly stated, the behavioural indicators of intellectual functioning and adaptive behaviour functioning for each severity level are what are typically expected to be mastered by the individual by 18 years of age. Please consult the CDDR for disorders of intellectual development and, if applicable, autism spectrum disorder for guidance on how to determine the severity level.				

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109 Table 6.4. Behavioural indicators of adaptive behaviour, adulthood (18 years of age and over)

Severity level	Early childhood	Childhood and adolescence	Adulthood	Mild
• Most will master listening and communication skills, although some may need help to stay on topic in group				

conversations, move from one topic to another, express ideas in more than one way or state their complete home address. • Most will probably not be able to give complex directions and describe long-term goals. Literacy • Most can read and understand material up to that expected of someone who has attended 3 or 4 years of primary/elementary school, and will master some writing skills, although they may have difficulty writing reports and long essays. • Most can meet others independently for the purpose of making new friends, participate in social outings on a regular basis, and talk about personal feelings. • Most can initiate a conversation independently and talk about shared interests with others. • Most can understand social cues, and are able to regulate their conversation based on their interpretation of other people's feelings. • Most are able to play complex social games and team sports, although they may need support with understanding the rules. • Most can learn to weigh the possible consequences of their actions before making a decision in familiar situations but not in new or complex situations, and will know right from wrong. • Most will need help recognizing when a situation or relationship might pose dangers or someone might be manipulating them for their own gain. • Most can initiate planning of a social activity with others. Some can be engaged in an intimate relationship, whereas others might need more support to do so. • Most will be independent in household chores, be safe around the home, and use the telephone and TV; some will learn to operate a gas or electric stove. • Most will often continue to need some support to attain independence with more complex domestic skills (e.g. small household repairs), comparative shopping for consumer products, following a healthy diet and being engaged in health-promoting behaviours, caring for themselves when sick or knowing what to do when they are sick/ill. • Many can learn to live and work independently, working at a part-time or full-time job with competitive wages – support at work will depend on the level of complexity of the work, and may fluctuate with life transitions. • Some can learn to drive a motor vehicle or a bicycle, manage simple aspects of a bank account, prepare simple meals and, if available, use a computer or other digital devices. Many will learn to use public transport with minimal help. • Most will continue to need support with more complex banking needs, paying bills, driving on busy roads and parenting skills. Moderate • Most will need considerable support to be able to attend to various tasks for more than a 15-minute period and to follow instructions or directions from memory (i.e. with a 5-minute delay). • Most will master simple descriptions, using “wh” questions (e.g. what, when, why, where) and relating their experiences using simple sentences. • With help, most are able to follow 3-step instructions. • Most will continue to need help frequently with using language containing past tenses and describing their experiences in detail. • Most will not learn more complex conversation skills (e.g. expressing ideas in more than one way). • Some will need help learning how to share interests or engaging in perspective taking. • Some may need support initiating conversations and introducing themselves to unfamiliar people. • Most will need significant support engaging in regular social activities, planning social activities with others, understanding social cues, and knowing what are appropriate or inappropriate conversation topics. • Most will need significant support engaging in social activities requiring transportation. • Most are unable to be engaged in more social or other games with complex rules (e.g. board games). • Some will learn to master dressing (but may need some help selecting appropriate clothing to wear for weather), washing, eating and toileting needs. • Most are able to be safe around the home, use the telephone, use the basic features of a TV and use simple appliances/ household articles (e.g. switches, stoves, microwaves). • Some may continue to need support with bathing and showering, using more complex household appliances (e.g. stoves) safely, meal preparation, or using cleaning products safely. • Many will understand the function of money but will struggle with making change, budgeting and making purchases without being told

what to buy. Neurodevelopmental disorders Neurodevelopmental disorders | Disorders of intellectual development

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Severity level Early childhood Childhood and adolescence Adulthood

Literacy • Most will acquire some reading and writing skills, such as letters of the alphabet, writing at least three simple words from an example, and writing their own first and last name. They will need significant support to write simple sentences or read simple stories at about the level expected of someone who has attended 2 years of primary/elementary school. • Most will need help providing socially polite responses such as “please” and “thank you”. • Most are unable to recognize when a social situation might pose some danger to them (e.g. potential for abuse or exploitation). • Most will need support being safe in the community and living independently. They will need substantial support for employment, including finding and keeping a job. • Most will not be able to travel independently to new places, have a developed concept of time sufficient to tell time independently and know when they are late. Severe • Most will often need lifelong support to recall and comply with instructions given 5 minutes prior, and sustain their attention to a story for a 15-minute period. Most are able to listen and attend to a story for a period of at least 5 minutes. • Most can make sounds or gestures to get the attention of individuals in their environment, and can make their needs known. • They may need help using simple phrases, describing objects and relating their experiences to others, speaking at least 100 recognizable words, and using negatives, possessives and pronouns, and asking “wh” questions. Literacy • Reading and writing skills will be limited to identifying some letters of the alphabet, copying simple words from an example and attempting to write their name. • All will need help in social situations, showing and expressing their emotions in an appropriate manner, and engaging in a reciprocal conversation with others. • Most can play simple social games such as catching and throwing a ball, but may need help choosing friends to play with. They will need considerable help to play symbolically and follow the rules while playing games, such as turn-taking or sharing toys. • Most will need help with transition – changing from one activity to the next or an unexpected change in routine. • Most will not spontaneously use polite forms such as “please”, “excuse me”, “thank you” and so on, or respectful/customary ways of addressing others. They will need significant support starting, maintaining and ending conversations with others. • Most will not recognize when a social situation might pose a danger to them (e.g. potential for abuse or exploitation) or discern dangers potentially associated with strangers. • Most will need some support for even basic personal hygiene, domestic skills, home and community skills. • Most will be able to drink independently from a cup and learn to use basic utensils for eating. Some may continue to need support getting dressed. • Many may learn independent toileting if provided an established routine. Most will be unable to care for their own belongings, perform household chores independently, cooking or care for their health. • Most will need substantial support to travel independently, plan and do shopping and banking of any sort. • Most will require significant support to be engaged in paid employment. Profound • Most are able to turn their head and eye gaze towards sounds in their environment and respond to their name when called. • Most will use sounds and gestures to get a parent/caregiver’s attention or express their wants, and some will have an understanding of the meaning of yes and no. Some are able with prompting to wave goodbye, use their parent’s/caregiver’s name / customary ways of addressing others, and point to objects to express their preferences. • Most will not spontaneously show interest in peers or unfamiliar individuals. • With significant support, most are able to imitate simple actions/behaviours or show concern for others. • Most will not engage in

reciprocal/ back-and-forth conversation. • Most will not spontaneously use polite forms such as “please”, “excuse me”, “thank you” and so on. • Most will need support performing even the most basic self-care, eating, washing and domestic skills. • Some may learn independent toileting during the day, but night-time continence will be more difficult. • Most will have difficulty picking out appropriate clothing, and zipping and snapping clothes. • Most will need supervision and support for bathing, including safely adjusting water temperature and washing/drying. Table 6.4. contd
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111 Table 6.4. contd Severity level Early childhood Childhood and adolescence Adulthood Profound

- Most will cry or make vocalizations when hungry or wet, smile, and make sounds of pleasure. • Most are not able to follow instructions or story being told. • Most will have only rudimentary knowledge of moving around within their house. Literacy • Most will not learn to read or write. • Most are unable to anticipate changes in routines. Social interactions with others will be very basic and limited to essential wants and needs. • Most are unable to recognize when a social situation might pose some danger to them (e.g. potential for abuse or exploitation). • Most will be unable to clean or care for their living environment independently, including clothing and meal preparation. • All will need substantial support with health matters, being safe in the home and community, and learning the concept of days of the week and time of day. • Most will be extremely limited in their vocational skills, and engagement in employment activities will necessitate structure and support.

Note: the behavioural indicators in the table are intended to be used by the clinician in determining the level of severity of the disorder of intellectual development either as a complement to properly normed, standardized tests, or when such tests are unavailable or inappropriate given the individual’s cultural and linguistic background. Use of these indicators is predicated on the clinician’s knowledge of and experience with typically developing individuals of comparable age. The behavioural indicators of intellectual functioning and adaptive behaviour functioning for each severity level are what are typically expected to be mastered by the individual as an adult. Please consult the CDDR for disorders of intellectual development and, if applicable, autism spectrum disorder for guidance on how to determine the severity level. Neurodevelopmental disorders
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