EXAMPLE REPORT

Psychological & Educational
Consultancy Services

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www.pecs.net.au

Intellectual Disability Assessment:

John Smith

Strictly Confidential

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BIOGRAPHICAL DETAILS

Name:	John Smith
Date of Birth:	25/02/2003
Gender:	Male
Age:	17 years
Grade:	11
School:	Subiaco High School
Address:	123 Example Street SUBIACO WA 6008
Parent's Phone Number:	0411 111 111
Parent's Email Address:	janesmith@hotmail.com

REFERRAL INFORMATION

John was referred to Psychological and Educational Consultancy Services (PECS) by Dr James Brown (Consultant Paediatrician) for a *Cognitive and Adaptive Behaviour Assessment* to assess for an Intellectual Disability.

INFORMED CONSENT

John's parent(s) were informed of the reason for the assessment, the assessment components, and that the results would be used to compile a report which would be provided to them and the referrer (if applicable).

John's parent(s) indicated that they understood all that was conveyed to them and signed a Consent Form acknowledging that they consented to the administration of the assessment; and for the report to be generated and disseminated accordingly.

BRIEF BACKGROUND INFORMATION AND CLINICAL PRESENTATION

Relevant information reported during the initial interview session with John's mother:

- Was born with no apparent complications
- Reached all of the major developmental milestones (e.g., walking, speaking, toileting) later than the expected age ranges
- John wears a nappy because he is not toilet trained
- John uses orthotic inserts to address his balance and tone issues
- John had surgery to fix a squint at Princess Margaret Hospital
- Normal visual and auditory acuity reported (last tested in 2015)
- No prescription medication use
- Is solely right-handed/right-footed
- Has fine and gross motor coordination problems
- Because of John's fine motor difficulties, he needs help to eat smaller foods
- Things such as buttons and zips are too difficult for John to manipulate
- John finds writing and holding scissors very difficult
- John's awareness of danger with scissors is non-existent
- At present, John is unable to walk alone, so he uses a walking frame
- John appears to be unaware of others in his path, and often hits people with his walker
- John was diagnosed with a Global Developmental Delay at age 1
- John's cousin has a Global Developmental Delay
- John is part of the NDIS
- John has had several interventions to address his difficulties; such as, OT, speech therapy, physiotherapy, eye tests, hip X-ray's, genetic blood tests, and an MRI
- John has been with Senses Australia since he was 18 months old, doing physio, speech, and OT
- John has participated in play group and hydrotherapy
- John needs full time assistance
- John is unable to dress himself or blow his nose
- John is severely behind his peers in all areas
- John has had an Educational Assistant (EA) in the classroom
- John is a very happy and social boy who loves school, but is often distracted by others
- John's sister has been diagnosed with ADHD
- John appears to be more entertained by watching others than joining in; however, he likes to join in when he is capable of doing the activities
- John tries really hard to fit in and be part of everything, so he can get very frustrated when he can't physically do what others are doing
- John has a very limited vocabulary (50-70 words), and consequently uses short sentences (3-4 words)
- John says T or D for the 'G', 'C', and 'K' sounds

Information reported in Dr Jill White's Paediatric Neurologist Report (May 2007 - at age 4 years):

- John presented at the age of 6 months with a serious form of epilepsy known as West Syndrome, which refers to a combination of "infantile spasms" (a type of brief tonic seizure), "hypsarrhythmia" (a very irregular electro-encephalogram with very frequent multifocal epileptic activity) and arrest of neurodevelopmental progress.
- Current working diagnosis is cryptogenic West syndrome.
- John's epilepsy has responded well to treatment. However, West syndrome is commonly associated with significant learning difficulties and impairment of frontal lobe executive functions and unfortunately John has shown significant delays in both linguistic and fine motor skill development, as well as impaired concentration and reading ability.
- He has been assessed by and received therapy from educational psychologists, speech pathologists and occupational therapists.
- Previous trials of stimulant medication have been unhelpful for his short attention span and have not improved his academic performance.

Please note that only a brief overview was obtained due to John and his parents already having provided more detailed background information to Dr Brown.

See checklists for more behavioural information.

COGNITIVE ASSESSMENT

Cognitive Tests Administered:

Test	*Date of Administration*
Wechsler Adult Intelligence Scale-Fourth Edition (WAIS-IV, 2008)	03/09/2020

WAIS-IV Overview:

The Wechsler Adult Intelligence Scale-Fourth Edition (WAIS-IV) is a test designed to measure intelligence in older adolescents and adults (aged 16 years and above). It is composed of 10 core subtests and five supplemental subtests, with the 10 core subtests comprising the Full-Scale IQ. The WAIS-IV has been language adapted for Australia and New Zealand.

WAIS-IV Subtests:

Please see Appendix for full subtest descriptions.

WAIS-IV Indexes:

The **Verbal Comprehension Index (VCI)** is a measure of verbal acquired knowledge and verbal reasoning incorporating the 3 core Verbal subtests of Information, Similarities, and Vocabulary and one supplemental subtest Comprehension.

The **Perceptual Reasoning Index (PRI)** is a measure of fluid reasoning, spatial processing, attentiveness to detail, and visual-motor integration comprising the 3 core Performance subtests of Visual Puzzles, Block Design, and Matrix Reasoning and two supplemental subtests; Figure Weights and Picture Completion.

The **Working Memory Index (WMI)** comprises the two core subtests of Arithmetic, Digit Span, and one supplemental subtest; Letter-Number Sequencing. The subtests provide a range of verbally presented tasks that require the individual to attend to information, to hold briefly and process that information in memory, and then to formulate a response.

The **Processing Speed Index (PSI)** is an indication of an individual's ability to process simple or routine visual information quickly and efficiently and to quickly perform tasks based on that information. Good speed of simple information processing may free cognitive resources for the processing of more complex information and ease new learning. The PSI comprises two core subtests; Coding and Symbol Search and one supplemental subtest; Cancellation.

The **General Ability Index (GAI)** is an optional summary score that is less sensitive to the influence of working memory and processing speed. As working memory and processing speed are vital to a comprehensive evaluation of cognitive ability, it should be noted that the GAI does not have the breadth of coverage as the FSIQ. GAI is not considered to be valid if there is an 18+ difference between the VCI and PRI.

The **Full-Scale IQ (FSIQ)** score is the overall summary score that estimates an individual's general level of intellectual functioning. It is usually considered to be the score that is most representative of global intellectual functioning. FSIQ is not considered to be valid if there is an 18+ difference between the VCI, PRI, WMI or PSI.

WAIS-IV Qualitative Descriptions:

Standard Score	Percentile	WAIS-IV-Qualitative Description
<70	<2	Extremely Low
70-79	2-8	Very Low
80-89	9-23	Low Average
90-109	25-73	Average
110-119	75-90	High Average
120-129	91-97	Very High
130+	98+	Extremely High

Examiner's Details:

TEST ADMINISTRATOR: Dr Shane Langsford

QUALIFICATIONS: Bachelor of Psychology
Bachelor of Education with First Class Honours
Doctor of Philosophy

REGISTRATION: Psychology Board of Australia and AHPRA Registered Psychologist

Test Behaviour:

John was observed as having a lively affect and he seemed to genuinely enjoy completing the various tasks.

The examiner was unable to understand several of the answers given by John during the Information and Similarities subtest.

John had difficulty remembering instructions.

The manner and sophistication of John's interaction with the examiner was judged as being reflective of a person with cognitive deficiencies.

Psychological Test Results:

Age at Testing: 17 years

Table 1: WAIS-IV Composite Score Summary

WAIS-IV Scale	Composite Score	Percentile Rank	95% Confidence Interval	Qualitative Description
Verbal Comprehension Index (VCI)	66	1	62-73	Extremely Low
Perceptual Reasoning Index (PRI)	73	4	68-81	Borderline
Working Memory Index (WMI)	69	2	64-78	Extremely Low
Processing Speed Index (PSI)	76	5	70-87	Borderline
Full Scale IQ (FSIQ)	**65**	**1**	**62-70**	**Extremely Low**
General Ability Index (GAI)	67	1	63-73	Extremely Low

Index scores have a mean Composite Score of 100 (50th percentile) and a standard deviation of 15.
Percentile Rank refers to John's standing among 100 adults of similar age.
Therefore, a Percentile Rank of 50 indicates that John performed exactly at the average level for his chronological age.
Composite scores are intentionally removed from client copies of the report as per APS policy

Table 2: WAIS-IV Index Level Discrepancy Comparisons

WAIS-IV Index	Difference	Critical Value 0.05	Significant Difference (exceeds 0.05)	Base Rate
Verbal Comprehension – Perceptual Reasoning	-7	9.74	No	31.8
Verbal Comprehension – Working Memory	-3	10.60	No	41.5
Verbal Comprehension – Processing Speed	-10	12.47	No	26.4
Perceptual Reasoning — Working Memory	4	10.18	No	39.7
Perceptual Reasoning – Processing Speed	-3	12.12	No	43.9
Working Memory — Processing Speed	-7	12.82	No	32.5
Full Scale IQ – General Ability Index	-2	3.96	No	37.6

Statistical Significance (Critical Values) at the .05 level
Base rate refers to the clinical significance (vs Ability Sample) - <15% = clinically significant

Table 3: WAIS-IV Subtest Scaled Scores

Subtests	Scaled Score	Percentile Rank
Verbal Comprehension Index		
Similarities	4	2
Vocabulary	5	5
Information	3	1
Perceptual Reasoning Index		
Block Design	5	5
Matrix Reasoning	5	5
Visual Puzzles	6	9
Working Memory Index		
Digit Span	4	2
Arithmetic	5	5
Processing Speed Index		
Symbol Search	5	5
Coding	6	9

See Appendix for complete subtest descriptions **Non-core subtest*

Table 4: Differences Between VCI Subtest Scores and Mean of VCI Subtest Scores

VCI Subtests	Scaled Score	VCI Mean	Difference From Mean	.05 Critical Value	Strength or Weakness
Similarities	4	4.00	0	1.91	
Vocabulary	5	4.00	1	1.58	
Information	3	4.00	-1	1.64	

"High" or "Low" is indicated when the score falls within 20% of the critical value required for reaching statistical significance
Statistical Significance (Critical Values) at the .05 level
**Non-core subtest*

Table 5: Differences Between PRI Subtest Scores and Mean of PRI Subtest Scores

PRI Subtests	Scaled Score	PRI Mean	Difference From Mean	.05 Critical Value	Strength or Weakness
Block Design	5	5.33	-0.33	2.05	
Matrix Reasoning	5	5.33	-0.33	1.92	
Visual Puzzles	6	5.33	0.67	1.99	

"High" or "Low" is indicated when the score falls within 20% of the critical value required for reaching statistical significance
Statistical Significance (Critical Values) at the .05 level
**Non-core subtest*

Table 6: WMI and PSI Subtest Discrepancies from FSIQ Index Subtest Mean

Please note, the statistics provided in this table are not standard WAIS-IV analyses and are provided as a guide only

Subtest	Subtest Scaled Score	FSIQ Mean Score	Difference From FSIQ Mean	Nominal Critical Cut-off	Strength or Weakness
Working Memory					
Digit Span	4	4.8	-0.8	2.50	
Arithmetic	5	4.8	0.2	2.50	
Processing Speed					
Symbol Search	5	4.8	0.2	2.50	
Coding	6	4.8	1.2	2.50	

Scores referred to as 'High' or 'Low' fall within 20% of the critical value for statistical significance **Non-core subtest.*

ADAPTIVE BEHAVIOUR ASSESSMENT

Adaptive Behaviour Tests Administered:

Test	*Date of Administration*
Adaptive Behaviour Assessment System–Second Edition (ABAS-II, 2008)	17/09/2020

ABAS-3 Overview:

The Adaptive Behaviour Assessment System – Third Edition provides a comprehensive, norm-referenced assessment of adaptive skills for individuals ages birth to 89 years. The ABAS-3 may be used to assess an individual's adaptive skills for diagnosis and classification of disabilities and disorders, identification of strengths and limitations, and to document and monitor an individual's progress over time.

ABAS-3 Qualitative Descriptions:

Standard Score	Scaled Score	Qualitative Range
120 and above	≥15	High
110-119	13-14	Above Average
90-109	8-12	Average
80-89	6-7	Below Average
70-79	4-5	Low
69 and below	≤3	Extremely Low

ABAS-3 Test Results:

(1) Parent/Primary Caregiver Form (Ages 5-21) – Completed by John's Mother

Table 1: Sum of Scaled Scores to Composite Score Conversions

Composite	Standard Score	Percentile Rank	95% Confidence Interval	Qualitative Range
General Adaptive Composite (GAC)	**64**	**1**	**60-68**	**Extremely Low**
Conceptual	63	1	57-69	Extremely Low
Social	56	0.2	49-63	Extremely Low
Practical	75	5	68-82	Low

Adaptive Domain scores have a mean of 100 (50th percentile) and a standard deviation of 15.
Percentile Rank refers to John's standing among 100 individuals of a similar age.

Table 2: Raw Score to Scaled Score Conversions

Skill Areas	Scaled Scores	Qualitative Range
Communication	5	Low
Community Use	7	Below Average
Functional Academics	2	Extremely Low
Home Living	1	Extremely Low
Health and Safety	9	Average
Leisure	2	Extremely Low
Self-Care	5	Low
Self-Direction	3	Extremely Low
Social	1	Extremely Low

Scaled scores have a mean of 10 (50th percentile) and a standard deviation of 3.
Percentile Rank refers to John's standing among 100 individuals of a similar age.

(2) Teacher Provider Form (Ages 5-21) – Completed by John's Teacher

Table 1: Sum of Scaled Scores to Composite Score Conversions

Composite	Standard Score	Percentile Rank	95% Confidence Interval	Qualitative Range
General Adaptive Composite (GAC)	**43**	**<0.1**	**40-46**	**Extremely Low**
Conceptual	53	0.1	49-57	Extremely Low
Social	58	0.3	54-62	Extremely Low
Practical	45	<0.1	41-49	Extremely Low

Adaptive Domain scores have a mean of 100 (50th percentile) and a standard deviation of 15.
Percentile Rank refers to John's standing among 100 individuals of a similar age.

Table 2: Raw Score to Scaled Score Conversions

Skill Areas	Scaled Scores	Qualitative Range
Communication	1	Extremely Low
Community Use	1	Extremely Low
Functional Academics	1	Extremely Low
Home Living	1	Extremely Low
Health and Safety	1	Extremely Low
Leisure	2	Extremely Low
Self-Care	1	Extremely Low
Self-Direction	2	Extremely Low
Social	1	Extremely Low

Scaled scores have a mean of 10 (50th percentile) and a standard deviation of 3.
Percentile Rank refers to John's standing among 100 individuals of a similar age.

Adaptive Behaviour Summary:

John's overall level of adaptive behaviour is best described by his ABAS-3 General Adaptive Behaviour Composite (GAC) score, both of which fell in the **Extremely Low** category (Parent = 1st percentile; Teacher = <0.1st percentile).

SUMMARY

REASON FOR REFERRAL:

John was referred to Psychological and Educational Consultancy Services (PECS) by Dr James Brown (Consultant Paediatrician) for a *Cognitive and Adaptive Behaviour Assessment* to assess for an Intellectual Disability.

COGNITIVE ASSESSMENT:

WAIS-IV Scale	Composite Score	Percentile Rank	95% Confidence Interval	Qualitative Description
Verbal Comprehension Index (VCI)	66	1	62-73	Extremely Low
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Full Scale IQ (FSIQ)	**65**	**1**	**62-70**	**Extremely Low**
General Ability Index (GAI)	67	1	63-73	Extremely Low

ADAPTIVE BEHAVIOUR SUMMARY:

John's overall level of adaptive behaviour is best described by his ABAS-3 General Adaptive Behaviour Composite (GAC) score, both of which fell in the **Extremely Low** category (Parent = 1st percentile; Teacher = <0.1st percentile).

CONCLUSION AND SUMMARY OF INTELLECTUAL DISABILITY DSM-5 CRITERIA

Intellectual Disability (Intellectual Developmental Disorder) is a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains. (DSM-5 Definition, p.33).

As per the DSM-5, the following three criteria must be met:

Criterion A. **Deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgement, academic learning, and learning from experience, confirmed by both clinical assessment and individualised, standardised intelligence testing.**	
A1: Clinical Assessment.	**Criterion Met** (see Background and Clinical Presentation Information and Test Behaviour section)
A2. Intellectual Assessment	**Criterion Met** (as per FSIQ/Index/ Subtest scores in Cognitive Assessment section)
Criterion B. **Deficits in adaptive functioning that result in failure to meet developmental and socio-cultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community.**	
B. Adaptive Functioning	**Criterion Met** (see Background and Clinical Presentation Information and Adaptive Behaviour section)
Criterion C. **Onset of intellectual and adaptive deficits during the developmental period**	
C. Onset prior to age 18	**Criterion Met** John is currently 17 years of age
Severity: **The various levels of severity are defined on the basis of adaptive functioning, and not IQ scores, because it is adaptive functioning that determines the level of supports required. Levels of severity are Mild, Moderate, Severe, and Profound.**	
Severity.	**Moderate** (see Background and Clinical Presentation Information, Adaptive Behaviour section, and Adaptive Behaviour Table in Appendix)

As indicated in the summary table above, John meets the criteria for a diagnosis of an Intellectual Disability, which can be described as being of a "Moderate" nature.

RECOMMENDATIONS

Please note, PECS does not provide micro-strategies (e.g., sit student at front of classroom, etc) as part of their recommendations. PECS's provides recommendations on what further assessment is required, what intervention is necessary, and who is the most appropriate to provide the assessment/intervention recommended.

SCHOOL INVOLVEMENT:

(1) A case-conference involving John's parents and the key Department of Education personnel should be held to discuss John's individual learning requirements.

NDIS:

(1) John's parents should provide a copy of this report to the NDIS.

DEPARTMENT OF HUMAN SERVICES / CENTRELINK:

(1) John's parents should provide a copy of this report to the DHS/Centrelink as he is likely eligible for a Disability Support Pension.

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Dr Shane Langsford **Date of Report**
Managing Director -PECS
Registered Psychologist
APS College of Educational & Developmental Psychologists Academic Member

APPENDIX 1: ADAPTIVE BEHAVIOUR SEVERITY SUMMARY TABLE

Severity	Conceptual domain	Social domain	Practical domain
Mild	For preschool children, there may be no obvious conceptual differences. For school-age children and adults, there are difficulties in learning academic skills involving reading, writing, arithmetic, time or money with support needed in one or more areas to meet age-related expectations. In adults, abstract thinking, executive function (i.e., planning, strategizing, priority setting, and cognitive flexibility), and short-term memory, as well as functional use of academic skills (e.g., reading, money management), are impaired. This is a somewhat concrete approach to problems and solutions compared with age mates.	Compared with typically developing age-mates, the individual is immature in social interaction. For example, there may be difficulty in accurately perceiving peers' social cues. Communication, conversation, and language are more concrete or immature than expected for age. There may be difficulties regulating emotion and behaviour in age-appropriate fashion; these difficulties are noticed by peers in social situations. There is limited understanding of risk in social situations; social judgement is immature for age, and the person is at risk of being manipulated by others (gullibility).	The individual may function age-appropriately in personal care. Individuals need some support with complex daily living tasks in comparison to peers. In adulthood, supports typically involve grocery shopping, transportation, home and child-care organising, nutritious food preparation, and banking and money management. Recreational skills resemble those of age-mates, although judgement related to well-being and organisation around recreation requires support. In adulthood, competitive employment is often seen in jobs that do not emphasize conceptual skills. Individuals generally need support to make health care decisions and legal decisions, and to learn to perform a skilled vocation competently. Support is typically needed to raise a family.
Moderate	All through development, the individual's conceptual skills lag markedly behind those of peers. For pre-schoolers, language and pre-academic skills develop slowly. For school-age children, progress in reading, writing, mathematics and understanding of time and money occurs slowly across the school years and is markedly limited compared with that of peers. For adults, academic skills development is typically at an elementary level, and support is required for all use of academic skills in work and personal life. Ongoing assistance on a daily basis is needed to complete conceptual tasks of day-to-day life, and others may take over these responsibilities fully for the individual.	The individual shows marked differences from peers in social and communicative behaviour across development. Spoken language is typically a primary tool for social communication but is much less complex than that of peers. Capacity for relationships is evident in ties to family and friends, and the individual may have successful friendships across life and sometimes romantic relations in adulthood. However, individuals may not perceive or interpret social cues accurately. Social judgement and decision-making abilities are limited, and caretakers must assist the person with life decisions. Friendships with typically developing peers are often affected by communication or social limitations. Significant social and communicative support is needed in work settings for success.	The individual can care for personal needs involving eating, dressing, elimination, and hygiene as an adult, although an extended period of teaching and time is needed for the individual to become independent in these areas, and reminders may be needed. Similarly, participation in all household tasks can be achieved by adulthood, although an extended period of teaching is needed, and ongoing supports will typically occur for adult-level performance. Independent employment in jobs that require limited conceptual and communication skills can be achieved, but considerable support from co-worker, supervisors, and others is needed to manage social expectations, job complexities, and ancillary responsibilities such as scheduling, transportation, health benefits and money management. A variety of recreational skills can be developed. These typically require additional supports and learning opportunities over an extended period of time. Maladaptive behaviour is present in a significant minority and causes social problems.

Severe	Attainment of conceptual skills is limited. The individual generally has little understanding of written language or of concepts involving numbers, quantity, time, and money. Caretakers provide extensive supports for problem solving throughout life.	Spoken language is quite limited in terms of vocabulary and grammar. Speech may be single words or phrases and may be supplemented through augmentative means. Speech and communication are focused on the here and now within everyday events. Language is used for social communication more than for explication. Individuals understand simple speech and gestural communication. Relationships with family members and familiar others are a source of pleasure and help	The individual requires support for all activities of daily living, including meals, dressing, bathing, and elimination. The individual requires supervision at all times. The individual cannot make responsible decisions regarding well-being of self or others. In adulthood, participation in tasks at home, recreation, ad work requires ongoing support and assistance. Skills acquisition in all domains involves long-term teaching and ongoing support. Maladaptive behaviour, including self-injury, is present in a significant minority.
Profound	Conceptual skills generally involve the physical world rather than symbolic processes. The individual may use objects in goal-directed fashion for self-care, work, and recreation. Certain visuospatial skills, such as matching and sorting based on physical characteristics, may be required. However, co-occurring motor and sensory impairments may prevent functional use of objects.	The individual has very limited understanding of symbolic communication in speech or gesture. He or she may understand some simple instructions or gestures. The individual expresses his or her own desires and emotions largely through nonverbal, non-symbolic communication. The individual enjoys relationships with well-known family members, caretakers, and familiar others, and initiates and responds to social interaction through gestural and emotional cues. Co-occurring sensory and physical impairments may prevent many social activities.	The individual is dependent on others for all aspects of daily physical care, health, and safety, although he or she may be able to participate in some of these activities as well. Individuals without severe physical impairments may assist with some daily work tasks at home, like carrying dishes to the table. Simple actions with objects may be the basis of participation in some vocational activities with high levels of ongoing support. Recreational activities may involve, for example, enjoyment in listening to music, watching movies, going out for walks, or participating in water activities, all with the support of others. Co-occurring physical and sensory impairments are frequent barriers to participation (beyond watching) in home, recreational, and vocational activities. Maladaptive behaviour is present in a significant minority.

BRIEF BIOGRAPHY OF THE AUTHOR

- *Dr Shane Langsford is a highly qualified and very experienced psychologist who has conducted more than 4000 child and adult assessments since establishing Psychological & Educational Consultancy Services in 1999.*

- *Dr Langsford's qualifications include a Bachelor of Psychology, a Bachelor of Education with First Class Honours, and a PhD.*

- *Dr Langsford is fully registered with the Psychology Board of Australia (PBA) and the Australian Health Practitioners Regulation Agency (AHPRA).*

- *Dr Langsford is a Full Member of the Australian Psychological Society (APS), Australian Association of Psychologists (AAPi), Australian ADHD Professionals Association (AADPA), and ADHD Australia.*

- *Dr Langsford is also an APS College of Educational & Developmental Psychologists Full Academic Member. To be awarded Full Academic Member status, an individual must have completed a PhD in psychology, have at least two years' experience as a researcher or educator in psychology in the College specific area of practice, and have published a notable body of relevant research in the College-specific area of practice.*

- *In 2015, Dr Langsford was personally selected from a shortlist by the then Federal Minister of Health (the Hon Sussan Ley) to be part of the 13-member Mental Health Expert Reference Group (MHERG). The group was formed to provide advice to the Commonwealth Department of Health in relation to the government's response to the National Review of Mental Health Programmes and Services. Dr Langsford was the only practising psychologist in Australia appointed to the group, and the only member in the group from Western Australia. (For more information, see https://www.pecs.net.au/pecs-profile)*

- *With regards to ADHD, Dr Langsford has conducted over 1500 ADHD assessments for various Psychiatrists and Paediatricians, was asked in 2014 to be on the National Shire ADHD Expert Panel for the "A Snapshot of ADHD: A Consumer and Community Discussion", and in April 2018 was the only Psychologist from Australia invited to the ADHD Institute's "Meeting of the Minds" Forum in Madrid (Spain). Dr Langsford was for the second year running once again the only Psychologist from Australia invited to the Forum, which was held in Munich (Germany) in November 2019. (For more information, see https://www.adhd-institute.com)*

- *Dr Langsford's extensive knowledge of a wide range of disorders led to the creation of the PsychProfiler, which is a reliable and valid instrument oriented to the DSM-5 and has been the most widely used Australian global psychiatric/psychological/educational assessment tool since 2004.*
  (For more information, see https://www.psychprofiler.com)