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Psychological & Educational

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PECS' Example Comprehensive ADHD Report:

John Smith

This report was prepared for the purpose of the client's clinical and/or educational management.

The report is not intended for, and is unsuitable for, use in legal proceedings.

The information contained in this report is sensitive and confidential and must be treated accordingly.

The results should only be interpreted by an appropriately trained professional.

This PECS' Example Comprehensive ADHD Report is provided to act as an example of the breadth and thoroughness of an assessment performed by Psychological & Educational Consultancy Services (PECS).

The assessment components provide practitioners with assessment evidence to complement their clinical opinion when addressing the Department of Health / Stimulant Committee requirements for ADHD.

This example report also reflects changes relating to the release of the DSM-5-TR (APA, 2022).

This example report reflects one produced for an adult client. A child ADHD assessment and report is almost identical, with the only difference being the use of assessment tools relevant to a child.

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BIOGRAPHICAL DETAILS

Name:	John Smith
Date of Birth:	30/01/1991
Age:	33
Gender:	Male

REFERRAL INFORMATION

John was self-referred to Psychological and Educational Consultancy Services (PECS) for a *Comprehensive Psychological Assessment* and an indication of whether the results are reflective of an individual with Attention-Deficit/Hyperactivity Disorder (ADHD).

Additional screening for disorders commonly associated with ADHD (e.g., anxiety, depression) was also conducted to identify any possible comorbidity and/or differential diagnosis implications that may be present.

INFORMED CONSENT

John was 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 indicated that he understood all that was conveyed to him and signed a Consent Form acknowledging that he consented to the administration of the assessment; and for the report to be generated and disseminated accordingly.

RELEVANT BACKGROUND INFORMATION

1. Pregnancy, Birth, and Development:

John's mother did not experience any significant illnesses during her pregnancy with him. John reported that there were no concerns in relation to maternal consumption of alcohol and/or substances during his mother's pregnancy with him.

John was born with no apparent complications and did not require assistance with breathing nor time in the neonatal intensive care unit. John reached all the major developmental milestones (e.g., walking, speaking, toileting) within the expected age ranges.

2. Speech and Language:

John has a history of speech sound problems and underwent speech therapy when aged 5. John reported that he had a lisp when younger but this was resolved through the speech therapy he received.

3. Handedness and Coordination:

John is solely right-handed and right-footed.

John is of the opinion that he does not have any fine or gross motor movement problems, nor does he have any hypermobility.

4. Sight and Hearing:

Normal auditory and visual acuity were reported; however, the most recent testing was more than 3 years ago.

5. Sleep Quality:

John has difficulty falling asleep, staying asleep during the night, and finds it difficult to wake up in the morning. As a result, John reports a continuous feeling of being tired.

6. Peer Relations:

John reported that he has no issues with forming and maintaining good friendships or getting along with work colleagues.

7. Academic / Educational/Occupational:

John had difficulty with literacy when at school and this has continued into adult life. John's handwriting is often messy. His school reports often mentioned that he was intelligent, however, he did not put in enough effort during school and needed to maintain more focus.

John completed the STAT when he was 21 and did extremely well in the problem-solving section but poorly on the English section.

John has attempted to complete a degree at university three times but keeps failing due to issues with concentration and difficulty absorbing what he has read.

John reported that he is not reaching his full potential at work and is struggling to keep up with his work demands due to his poor attention, concentration, and disorganisation. John reported that he has really good staff who assist him with the tasks that require organisational skills.

8. Memory:

John reported that he has concerns with his short-term memory, but not long-term memory.

9. Behaviour:

John reported that he has issues with attention, concentration, memory, hyperactivity, sitting still, following instructions, and being able to relax.

John reported that he is easily distracted, and he is unable to stay on task most of the time (e.g., often starting one thing then moving onto another before finishing the first task). John also reported that he has random outbursts of energy, cannot sit still, is very fidgety, and is disorganised.

10. Health/Mental Health/Medical/Medication:

John reported that he has no major medical or neurological conditions. John has been diagnosed with anxiety and depression and is currently prescribed Lexapro which is proving effective. John first experienced anxiety and depression when he was 16 years of age. John is not currently receiving counselling, however, he has in the past and found it helpful.

John has no previous history of self-harm and reported that he is not currently at risk of engaging in any self-harming behaviours.

11. Family History of Mental Health Conditions:

There is a family history of depression, anxiety, and Attention Deficit / Hyperactivity Disorder (ADHD) on both sides of his family.

Screening Tests Administered:

(1) *Adult PsychProfiler* (APP v5; Langsford, Houghton, & Douglas, 2024)

APP Outline:

The APP is a reliable and valid instrument that utilises two separate global screening forms; the Self-report Form (SRF: 177 items) and Observer-report Form (ORF: 177 items) for the simultaneous screening of the 17 most prevalent disorders in adults aged 18 years and above.

The APP comprises screening criteria that mirror the symptom counts and diagnostic criteria of the *Diagnostic and Statistical Manual of Mental Disorders–Fifth Edition, Text Revision* (DSM-5-TR: American Psychiatric Association, 2022). For example, a positive screen for Attention-Deficit/Hyperactivity Disorder: Predominantly Inattentive Presentation indicates that the symptom count was 5 or more of the 9 DSM-5-TR Inattentive items.

For more information about the PsychProfiler, please see www.psychprofiler.com

APP Results:

In order to provide more comprehensive information, both John and his wife completed separate APP Forms.

John self-reported positive screens for the following disorders:

- Generalised Anxiety Disorder
- Attention-Deficit/Hyperactivity Disorder: Combined Presentation
- Language Disorder
- Persistent Depressive Disorder
- Specific Learning Disorder – with Impairment in Reading
- Specific Learning Disorder – with Impairment in Written Expression

John's wife reported positive screens on John's behalf for the following disorders:

- Generalised Anxiety Disorder
- Attention-Deficit/Hyperactivity Disorder: Predominantly Inattentive Presentation
- Persistent Depressive Disorder
- Specific Learning Disorder – with Impairment in Reading
- Specific Learning Disorder – with Impairment in Written Expression

Please note that any indication of a positive screen on the APP does not constitute a formal diagnosis.

A positive screen merely indicates that the individual has met sufficient criteria for a disorder to warrant further investigation by an appropriate professional.

The full list of 17 disorders screened for is available at www.psychprofiler.com

ADHD BEHAVIOURAL ASSESSMENT

Checklists Administered:

(1) Conners Adult ADHD Rating Scales 2nd Edition (CAARS 2; Conners, Erhardt, and Sparrow, 2023)

CAARS 2 Overview:

The CAARS 2 is an instrument that assesses core and associated symptoms of ADHD in adults aged 18 years and older. It also screens for four associated clinical concerns, namely, Suicidal thoughts/attempts, Self-injury, Anxiety/worry, and Sadness/Emptiness.

Checklist Results:

(1) CAARS 2 Self-Report:

CAARS 2 Self-Report Subscales	Percentile	Classification
Inattention/Executive Dysfunction	95	Very Elevated
Hyperactivity	95	Very Elevated
Impulsivity	93	Elevated
Emotional Dysregulation	98	Very Elevated
Negative Self-Concept	95	Elevated
DSM ADHD Inattentive Symptoms	95	Very Elevated
DSM ADHD Hyperactive-Impulsive Symptoms	94	Elevated
DSM Total ADHD Symptoms	93	Very Elevated

CAARS 2 Self-Report ADHD Index	% Probability	Guideline
Likelihood of ADHD	99%	Very High

The ADHD Index score is a probability % figure derived from the 12 items within the checklist that the author believes best differentiate individuals with ADHD from those in the general population.

DSM-5 Symptom Scale: Self-Report	Symptom Count
DSM ADHD Inattentive Symptoms	9
DSM ADHD Hyperactive-Impulsive Symptoms	6

CAARS 2 Self-Report Clinical Concerns	Guideline
Suicidal thoughts/attempts	Immediate follow-up is critical
Self-injury	Immediate follow-up is critical
Anxiety/worry	Follow-up is recommended
Sadness/emptiness	Follow-up is recommended

(2) CAARS 2 Observer-Report: Completed by John's wife.

CAARS 2 Observer-Report Subscales	Percentile	Classification
Inattention/Executive Dysfunction	96	Very Elevated
Hyperactivity	97	Very Elevated
Impulsivity	92	Slightly Elevated
Emotional Dysregulation	99	Very Elevated
Negative Self-Concept	99	Very Elevated
DSM ADHD Inattentive Symptoms	99	Very Elevated
DSM ADHD Hyperactive-Impulsive Symptoms	96	Elevated
DSM Total ADHD Symptoms	96	Very Elevated

CAARS 2 Observer-Report ADHD Index	% Probability	Guideline
Likelihood of ADHD	99%	Very High

The ADHD Index score is a probability % figure derived from the 12 items within the checklist that the author believes best differentiate individuals with ADHD from those in the general population.

DSM-5 Symptom Scale: Observer-Report	Symptom Count
DSM ADHD Inattentive Symptoms	9
DSM ADHD Hyperactive-Impulsive Symptoms	6

CAARS 2 Observer-Report Clinical Concerns	Guideline
Suicidal thoughts/attempts	Immediate follow-up is critical
Self-injury	Immediate follow-up is critical
Anxiety/worry	Follow-up is recommended
Sadness/emptiness	Follow-up is recommended

CAARS 2 ADHD BEHAVIOURAL ASSESSMENT SUMMARY:

ADHD:

Subscales classified as “Slightly Elevated”, “Elevated” and “Very Elevated” “indicate a problem in that area. Furthermore, the greater number of subscales that show ‘elevation’, the greater likelihood that the CAARS 2 scores indicate a moderate to severe problem.

John's scores exceeded the cut-off for **8** Subscales on the Self-report CAARS 2 checklist and **8** on the Observer-report.

John's self-report score on the ADHD Index indicates that there is a **99% probability** that he has ADHD, (unless another factor/diagnosis better explains the behaviours reported).

John's observer-report score on the ADHD Index indicates that there is a **99% probability** that he has ADHD, (unless another factor/diagnosis better explains the behaviours reported).

Associated Clinical Concerns:

The Suicidal thoughts/attempts and Self-injury subscale results warrant further investigation and/or intervention.

The Anxiety/worry and Sadness/emptiness subscale results suggest that Anxiety and Depression warrant further investigation and/or intervention.

ADHD DSM-5-TR CRITERIA CHECKLIST ASSESSMENT

Checklists Administered:

(1) ADHD DSM-5-TR Criteria: Self-Report Checklist (American Psychiatric Association, 2022)

INATTENTION (Only behaviours occurring for 6 months or more are ticked)		Yes (✓)
A1	Often fails to give close attention to details or makes careless mistakes	✓
A2	Often has difficulty sustaining attention in tasks or play activities	✓
A3	Often does not seem to listen when spoken to directly	✓
A4	Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace	✓
A5	Often has difficulty organizing tasks and activities	✓
A6	Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	
A7	Often loses things necessary for tasks or activities	✓
A8	Is often easily distracted by extraneous stimuli	✓
A9	Is often forgetful in daily activities	✓
YES TOTAL		8

HYPERACTIVITY AND IMPULSIVITY (Only behaviours occurring for 6 months or more are ticked)		Yes (✓)
A10	Often fidgets with or taps hands or feet or squirms in seat	✓
A11	Often leaves seat in situations when remaining seated is expected	✓
A12	Often runs about or climbs in situations where it is inappropriate, or feels restless	✓
A13	Often unable to play or engage in leisure activities quietly.	
A14	Is often “on the go,” acting as if “driven by a motor	✓
A15	Often talks excessively.	✓
A16	Often blurts out an answer before a question has been completed	
A17	Often has difficulty waiting their turn	
A18	Often interrupts or intrudes on others	
YES TOTAL		5

Clinically significant symptoms		Yes	No	NA
B	Have the several inattentive or hyperactive-impulsive symptoms been present prior to age 12 years?	✓		
C	Are the several inattentive or hyperactive-impulsive symptoms present in two or more settings	✓		
D	Is there clear evidence that the inattentive or hyperactive-impulsive symptoms interfere with, or reduce the quality of, social, academic, or occupational functioning?	✓		
E	Do the symptoms occur exclusively during the course of schizophrenia or another psychotic disorder; and/or are not better explained by another mental disorder			

DSM-5-TR ADHD CHECKLIST CONCLUSION:

Total number of Inattention criterion met = 8

Total number of Hyperactive-Impulsive criterion met = 5

John meets the DSM-5-TR criteria for Attention-Deficit/Hyperactivity Disorder: Combined Presentation (ADHD-CP) on this checklist.

Any comorbidity and/or differential diagnosis implications are to be considered by a Medical Specialist.

COGNITIVE ASSESSMENT

Cognitive Tests Administered:

<i>Test</i>	<i>Date of Administration</i>
Wechsler Adult Intelligence Scale-Fourth Edition (WAIS-IV, 2008)	02/02/2024

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. Please see Appendix for Index and Subtest descriptions.

Examiner's Details:

TEST ADMINISTRATOR:	Dr Shane Langsford
QUALIFICATIONS:	Bachelor of Psychology (1994, UWA) Bachelor of Education with First Class Honours (1996, UWA) Doctor of Philosophy in Educational Psychology (1999, UWA)
REGISTRATION:	AHPRA/PBA Fully Registered Psychologist (PSY0001578191)

Test Behaviour:

The examiner was able to establish good rapport with John.

John was observed to have put in an appropriate amount of effort throughout the assessment, and he displayed a normal affect which remained consistent throughout the assessment.

No behaviours that would affect the test results were observed during the testing.

Psychological Test Results:

Age at Testing: 33 years

Table 1: WAIS-IV Composite Score Summary

WAIS-IV Scale	Composite Score	Percentile Rank	95% Confidence Interval	Qualitative Description
Verbal Comprehension Index (VCI)	114	82	108-119	High Average
Perceptual Reasoning Index (PRI)	131	98	123-136	Very Superior
Working Memory Index (WMI)	98	45	93-102	Average
Processing Speed Index (PSI)	95	37	90-100	Average
Full Scale IQ (FSIQ)	111	77	106-116	High Average
General Ability Index (GAI)	122	93	117-127	Superior

Index scores have a mean Composite Score of 100 (50th percentile) and a standard deviation of 15.

Percentile Rank refers to individual's standing among 100 individuals of a similar age.

Therefore, a Percentile Rank of 50 indicates that they performed exactly at the average level for their age.

If there is a one standard deviation or more difference between any of the Index Composite Scores, often an Index rather than the FSIQ (e.g., GAI, FRI, etc) is deemed to provide a better estimate of the individual's true underlying natural cognitive ability.

Composite Scores are intentionally removed from client copies of the report as per APS policy

Below is a set of characteristic difficulties relevant to lower ability in each Index. These are generic difficulties and are not provided as an illustration of the individual's difficulties.

Verbal Comprehension weaknesses can cause difficulty learning and performing to ability in exams/performing in the workplace by:

- Trouble understanding verbal directions and/or instructions. This will be more so with complex language, or when multiple steps are included in an instruction.
- Struggling in written exams, especially when also faced with added time pressures.
- Being seen as a 'poor listener'. These individuals can appear to be easily distracted and inattentive at times, especially when faced with high verbal task demands.
- Being more likely to be working in environments that are more practical, hands-on or require knowledge of maths, science, artistic skills etc.
- Improved learning and skill acquisition from charts, visual materials, diagrams, videos, or hands-on on the job training.
- Difficulty in terms of reading comprehension – they may need to re-read a given text in order to fully understand the meaning (i.e. filling out forms or completing paperwork may be particularly time consuming).
- Difficulty in understanding abstract concepts, particularly when asked to perform tasks that rely heavily on verbal abstract reasoning.
- Difficulty in understanding social conventions (i.e. what should you do if you find a wallet in a store).

Working Memory weaknesses can cause difficulty learning and performing to ability in exams/performing in the workplace by:

- Difficulty absorbing instructions, particularly if they contain more than one step.
- Wide ranging difficulties in both maths and reading, both of which are activities that place high demand on working memory ability.
- These individuals will be slower than their peers in being able to pick up new skills, or in developing new concepts.
- Difficulty performing mental maths calculations, being able to recall names or phone numbers without prompts.
- Frequent errors across tasks that involve the individual needing to recall small amounts of information, while at the same time performing another task.
- Difficulty performing tasks with a number of steps, they may miss out steps or make mistakes in terms of not carefully paying attention to the details.
- Appearing to have a relatively short attention span, they may appear inattentive or distractible.

Processing Speed weaknesses can cause difficulty learning and performing to ability in exams/performing in the workplace by:

- Difficulty processing large amounts of information, or being able to understand long, complex instructions.
- Poorer performances when given deadlines or are under time pressure. They simply need longer to complete a given task.
- Written work is very time consuming, it takes these individuals a long time to write. They are likely to have a preference for using a computer to complete the majority of their work.
- Easy to fatigue; these individuals need to use more cognitive resources to complete the same amount of work as their peers.
- Difficulty following conversations, or keeping track of the plot in books/movies

Table 2: WAIS-IV Subtest Scaled Scores

Subtests	Scaled Score	Percentile Rank
Verbal Comprehension Index		
Similarities	11	63
Vocabulary	13	84
Information	14	91
Perceptual Reasoning Index		
Block Design	16	98
Matrix Reasoning	15	95
Visual Puzzles	15	95
Working Memory Index		
Digit Span	10	50
Arithmetic	9	37
*Letter-Number Sequencing	10	50
Processing Speed Index		
Symbol Search	10	50
Coding	8	25

See Appendix for complete subtest descriptions *Non-core subtest

Table 3: 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	11	12.67	-1.67	1.91	Low
Vocabulary	13	12.67	0.33	1.58	
Information	14	12.67	1.33	1.64	High

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

Table 4: 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	16	15.33	0.67	2.05	
Matrix Reasoning	15	15.33	-0.33	1.92	
Visual Puzzles	15	15.33	-0.33	1.99	

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

Table 5: WMI and PSI Subtest Discrepancies From GAI 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	GAI Mean Score	Difference From GAI Mean	Nominal Critical Cut-off	Strength or Weakness
Working Memory					
Digit Span	10	14	-4	2.50	Weakness
Arithmetic	9	14	-5	2.50	Weakness
*Letter-Number Sequencing	10	14	-4	2.50	Weakness
Processing Speed					
Symbol Search	10	14	-4	2.50	Weakness
Coding	8	14	-6	2.50	Weakness

Scores referred to as 'High' or 'Low' falls close to the critical value for statistical significance *Non-core subtest.

CONCLUSIONS AND STATEMENT OF DIAGNOSIS

ADHD:

John's background information, interview information, positive PsychProfiler screens for ADHD, high Conners Rating Scale behavioural results, high ADHD DSM-5-TR Criteria checklist results, and cognitive profile (i.e. depreciated Working Memory and Processing Speed) suggest ADHD is a possibility and warrants further investigation/consideration by a Medical Specialist.

Please note, although suitably trained Psychologists are permitted to diagnose ADHD, traditionally it is formally diagnosed by either a Paediatrician, Psychiatrist, or Clinical Neurologist. Therefore, if an individual's cognitive and/or behavioural results suggest that ADHD is a possibility, it is deemed appropriate of PECS to recommend that the appropriate Medical Specialist be consulted for their expert opinion. PECS does not make the recommendation on the basis that they believe the individual definitely has ADHD.

ANXIETY:

The existing diagnosis of anxiety is supported by the background information, interview information, PsychProfiler results, and Conners-2 results.

DEPRESSION:

The existing diagnosis of depression is supported by the background information, interview information, PsychProfiler results, and Conners-2 results.

Based on the past history reported by John, and information gathered during the interview, John is considered to be at low risk of self-harm.

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.

PSYCHIATRIC INVOLVEMENT:

- (1) Due to the background information, PsychProfiler results, DSM-5-TR ADHD Criteria Checklist results, Conners results, and WAIS-IV profile all suggesting possible ADHD, it is recommended that John be seen by a Psychiatrist for the purpose of a formal decision on the presence of an ADHD.

Please note that a GP referral is required to see a Medical Specialist.

Please ensure that you notify PECS of which Medical Specialist you book in with so this report can be forwarded to them.

ADHD COACHING:

- (1) John may wish to contact an ADHD Coach for assistance with ADHD management and behavioural strategies.

ADHD Coaches Australasia

www.adhdcoachesaustralasia.online

Please note that strategies to assist with poor concentration, low attention and distractibility are beneficial to people with these characteristics even if they are not formally diagnosed with ADHD

ADHD SELF-HELP ORGANISATIONS:

- (1) John would benefit from accessing ADHD information/resources from the following organisations.

ADHD WA

109 Montgomery Avenue, MT CLAREMONT WA 6010
(08) 6255 8880 hello@adhdwa.org www.adhdwa.org

ADHD WA is a support, information, and advocacy agency, founded in 1993 for people with ADHD. They aim to support individuals and families in Western Australia whose lives are impacted by ADHD, along with those who treat, teach, and work with people living with ADHD.

ADHD Australia

info@adhdaustralia.org.au www.adhdaustralia.org.au

ADHD Australia aims to be a voice for positive change for people living with ADHD and to help build a community that fully supports, understands, and accommodates ADHD.

ADHD Foundation

support@adhdfoundation.org.au www.adhdfoundation.org.au National Support Helpline: 1300 39 39 19

ADHD Foundation in Australia is a not-for-profit registered charity aiming to make the lives of people with ADHD better, easier and simpler. Whether it's accessing much-needed support, speaking to a trusted and professional community which can provide advice or simply being a safety network.

ADHD Support Australia

vivian@adhdsupportaustralia.com.au www.adhdsupportaustralia.com.au

ADHD Support Australia is a social enterprise which aims to build a thriving community for people and families with ADHD and to provide person-centred support, guidance, and information to enhance life outcomes.

Please note, these resources also assist individuals that display similar traits to an individual with ADHD, and not just those that are formally diagnosed with ADHD.

PSYCHOLOGICAL INVOLVEMENT:

- (1) John would benefit from re-engaging in on-going psychological counselling given the levels of anxiety and depression being self-reported.

For assistance with locating a suitable Psychologist in their local area, John may wish to utilise the 'Find a Psychologist' function available via the Australian Association of Psychologists' and/or Australian Psychological Society's websites.

AAPi = <https://www.aapi.org.au/FindaPsychologist>

APS = <https://psychology.org.au/find-a-psychologist>

To get a Medicare rebate for counselling, a referral from a Paediatrician, Psychiatrist, or General Practitioner is required. A GP must have generated a Mental Health Treatment Plan. <https://www.healthdirect.gov.au/mental-health-treatment-plan>

- (2) John's schooling history highlighting difficulties with literacy, PsychProfiler screens for a SLD in reading and writing, and a relatively depreciated WAIS-IV VCI, indicate that an educational test should be conducted to investigate the possibility of a Specific Learning Disorder with impairment in Reading and/or Written Expression.

ANXIETY/DEPRESSION SELF-HELP ORGANISATIONS:

- (1) John would benefit from accessing the following organisations for assistance with anxiety and/or depression resources. If immediate assistance is required, please contact Lifeline.

Lifeline (24/7 crisis support)

www.lifeline.org.au

Chat online – www.lifeline.org.au/crisis-chat

Text – 0477 131 114 Call - 13 11 14

The Black Dog Institute

www.blackdoginstitute.org.au

(08) 9382 2991 clinic@blackdog.org.au

beyondblue

www.beyondblue.org.au

beyondblue National Information Line - 1300 22 4636

headspace

www.headspace.org.au

headspace Nation Support Line - 1800 650 890

Helping Minds

www.helpingminds.org.au

(08) 9427 7100

HEALTH & WELL-BEING:

- (1) It is recommended that John continues his/implements regular exercise and maintains a healthy diet.

Please note, the above is a generic recommendation that should be followed by all and is not a recommendation specific to John due to any of his results or reported behaviours.

Dr Shane Langsford Managing Director -PECS Registered Psychologist APS College of Educational & Developmental Psychologists Academic Member	Date of Report
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WHAT IS A COMPREHENSIVE PSYCHOLOGICAL REPORT?

A Comprehensive Psychological Assessment (CPA) is the systematic collection and analysis of developmental, behavioural, socioemotional, cognitive and/or educational information for the purpose of making inferences about underlying brain function.

These inferences are achieved by investigating an individual's strengths and weaknesses across the aforementioned areas and identifying any patterns that may exist.

Ultimately, the investigation's aim is to rule out the presence of any clinically significant conditions, or if indeed present, to facilitate diagnosis of the core underlying problem, identify its aetiology and impact on the individual, and identify any comorbid concerns that may also exist.

Most conditions are genetic, hereditary and familial in nature, with a significant minority being environmental/experiential in origin.

A Comprehensive Psychological Report (CPR) contains the information garnered from the CPA and is primarily compiled to convey the information to other medical, health, and educational professionals (often the referrer) for the purpose of specialist diagnosis, and/or the implementation of intervention/treatment.

WHY SPECIFIC LEARNING DISORDER vs DYSLEXIA / DYSGRAPHIA / DYSCALCULIA?

PECS aligns its diagnostic approach with the DSM-5-TR (APA, 2022) as this is the classification system that the educational organisations in Western Australia (e.g., School Curriculum Standards Authority, WA Department of Education, Catholic Education Office, Association of Independent Schools, etc) align with.

The DSM-5 (APA, 2013) Neurodevelopmental Work Group, who were responsible for the decision to use the term Specific Learning Disorder (SLD) in the DSM-5 (APA, 2013), "concluded that the many definitions of dyslexia and dyscalculia meant those terms would not be useful as disorder names or in the diagnostic criteria".

Specific Learning Disorder (SLD) has been maintained as the disorder name in the DSM-5-TR (APA, 2022), therefore, PECS only uses the term Specific Learning Disorder (SLD) throughout this report.

However, in simplistic terms, Dyslexia=a SLD in Reading (and often Spelling); Dyscalculia=a SLD in Mathematics; and Dysgraphia=a SLD in Written Expression.

IS IT CALLED ADD OR ADHD?

As mentioned above, PECS aligns with the DSM-5-TR which allows for one of the following three diagnoses.

- 1. Attention-Deficit/Hyperactivity Disorder: Predominantly Hyperactive/Impulsive Presentation*
- 2. Attention-Deficit/Hyperactivity Disorder: Predominantly Inattentive Presentation*
- 3. Attention-Deficit/Hyperactivity Disorder: Combined Presentation*

Therefore, the correct acronym if aligning with the DSM-5-TR (APA, 2022) is ADHD, not ADD.

ADHD Combined Presentation refers to an individual who has both Hyperactive/Impulsive and Inattentive traits.

ADULTS WITH UNTREATED ADHD EXPERIENCE:

- Increased comorbidity of at least one psychiatric disorder¹
- Higher self-reported rates of anxiety and depression²
- Higher risk of substance abuse^{3 4}
- Lower frequency of regular jobs⁵
- Higher rates of unemployment⁶
- Significantly more externalizing behaviours, including abuse and criminality⁵
- Lower work performance and change jobs more frequently^{7 8}
- Lower occupational functioning^{9 10}
- Decreased overall educational achievement level¹¹
- Decreased average household incomes, regardless of academic achievement¹²
- Report significantly poorer marital adjustment and family functioning¹³
- More divorces^{14 15 16}
- Higher prevalence of oppositional, conduct, and substance abuse disorders¹⁶
- Higher rate of risky driving behaviour and suspension of driving license¹⁶
- Decreased social–emotional competence & reduced salience of emotion in interpersonal interaction¹⁷
- Difficulty engaging others in conversation¹⁷
- Decreased tactfulness or ability to adjust their behaviour to be appropriate for the situation¹⁷
- Heightened emotional reactivity, especially to contempt and disgust¹⁷
- Less awareness of emotional cues made by others¹⁷
- Lower self esteem²⁶

CHILDREN WITH UNTREATED ADHD EXPERIENCE:

- Higher risk for lifetime and 1-year prevalence of antisocial, addictive, mood, and anxiety disorders¹⁸
- Higher rates of frequent school disciplinary action against them¹⁶
- Functional impairments persisting through to adulthood^{19 20}
- Significantly lower academic achievements^{7 21}
- Lower educational attainment, grade retention,²² and suspension²⁵
- Increased likelihood of dropping out of school²²
- Inattentive symptoms at constant levels throughout their life²³
- More impairment in social competence, behavioural and emotional adjustment²⁴
- Lower quality of life, as measured by self-report²⁴
- Early pregnancy²⁵
- Behavioural disturbance²⁶
- Feeling of parental incompetence²⁶
- Lower social esteem²⁶
- Antisocial behaviour²⁶

¹ Biederman et al., 2004

² Halmoy, Fasmer, Gillberg, & Haavik 2009

³ Biederman et al., 1997;

⁴ Mannuzza et al., 1991

⁵ Rasmussen & Levander, 2009

⁶ Halmoy, Fasmer, Gillberg, & Haavik, 2009

⁷ Barkley et al., 2006

⁸ Weiss & Hechtman, 1993

⁹ Barkley, Murphy, & Fischer, 2007

¹⁰ Sobanski et al., 2007

¹¹ Halmoy, Fasmer, Gillberg, & Haavik, 2009

¹² Biederman & Faraone, 2006

¹³ Eakin L et al. 2004

¹⁴ Biederman et al., 1993

¹⁵ Biederman et al., 1994

¹⁶ Murphy & Barkley, 1996

¹⁷ Friedman et al. 2003

¹⁸ Biederman et al., 2006

¹⁹ Biederman, Mick, & Faraone, 2000

²⁰ Rasmussen & Gillberg, 2000

²¹ Mannuzza, Klein, Bessler, Malloy, & LaPadula, 1993

²² Biederman & Faraone, 2006

²³ Biederman, Mick, & Faraone, 2000

²⁴ Barkley et al., 1991

²⁵ Erskine et al., 2016

²⁶ UKAAN Handbook Adult ADHD

APPENDIX 3: WAIS-IV SUBTEST DESCRIPTIONS

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. The GAI should be interpreted with caution if there is a 15+ difference between the VCI and PRI.

The **Full-Scale IQ (FSIQ)** score is the overall 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. The FSIQ should be interpreted with caution if there is a one or more standard deviation (15+) difference between the VCI, PRI, WMI, or PSI.

VERBAL COMPREHENSION INDEX	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.
Vocabulary	The Vocabulary subtest required the individual to explain the meaning of words presented in isolation, both visually and orally. As a direct assessment of word knowledge, the subtest is one indication of their overall verbal comprehension and fund of knowledge. Performance on this subtest also requires abilities to verbalise meaningful concepts as well as to retrieve information from long-term memory.
Similarities	On the Similarities subtest, the individual was required to respond orally to a series of word pairs by explaining the similarity of the common objects or concepts they represent. This subtest examines their ability to abstract meaningful concepts and relationships from verbally presented material. As well as involving crystallised intelligence, abstract reasoning, auditory comprehension, memory, associative and categorical thinking, distinction between nonessential and essential features and verbal expression.
Information	The Information subtest required the individual to respond verbally to a series of orally presented questions that assess knowledge about common events, objects, places, and people. The subtest is primarily a measure of their fund of general knowledge. Performance on this subtest also may be influenced by their cultural experience, as well as their ability to retrieve information from long-term memory.
Comprehension (supplementary subtest)	The Comprehension subtest required the individual to provide oral solutions to everyday problems and to explain the underlying reasons for certain social rules or concepts. This subtest provides a general measure of verbal reasoning and conceptualisation, verbal comprehension and expression. In particular, this subtest assesses comprehension of social situations and social judgment, as well as knowledge of conventional standards of social behaviour.
PERCEPTUAL REASONING INDEX	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.
Block Design	The Block Design subtest required the individual to use two-colour cubes to construct replicas of two-dimensional, geometric patterns. This subtest assesses ability to mentally organize visual information. More specifically, this subtest assesses the ability to analyse part-whole relationships when information is presented spatially. Performance on this task also may be influenced by visual-spatial perception and visual perception-fine motor coordination, as well as planning ability.
Matrix Reasoning	The Matrix Reasoning subtest involves a series of incomplete gridded patterns that the individual completes by pointing to or saying the number of the correct response from 5 possible choices. This subtest assesses fluid intelligence, broad visual intelligence, classification and spatial ability, as well as the individual's knowledge of part-whole relationships and perceptual organisation abilities.
Visual Puzzles	The Visual Puzzles subtest requires the individual to view a completed puzzle and to then select three response options, which when combined will form the completed puzzle. This is a measure of an individual's non-verbal reasoning ability and their ability to both analyse and synthesise abstract visual stimuli.
Picture Completion * (supplementary subtest)	The Picture Completion subtest required the individual to identify the important missing part in each of a series of pictures of common objects, events, or scenes. An indication of their ability in visual discrimination, the Picture Completion subtest assesses the abilities to detect essential details in visually presented material and to differentiate them from nonessential details. Performance on this task also may be influenced by an individual's general level of alertness to the world around them and long-term visual memory.
Figure Weights (supplementary subtest)	The Figure Weights subtest involves viewing a scale, which is missing weight(s) and then selecting the response option which balances that scale. This is a measure of quantitative and analogical reasoning, which involves reasoning processes that can be expressed mathematically. The task emphasises the use of deductive and inductive logic.

WORKING MEMORY INDEX	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.
Arithmetic	The individual was required to mentally solve a series of orally presented arithmetic problems on the Arithmetic subtest. A direct measure of their numerical reasoning abilities, the subtest requires attention, concentration, short-term memory, and mental control. The Arithmetic subtest also measures logical reasoning, quantitative knowledge and sequential processing.
Digit Span	The Digit Span subtest is a series of orally presented number sequences that the individual must repeat verbatim (Digit Span Forward), in reverse order (Digit Span Backwards) or recall the numbers in ascending order (Digit Span Sequencing). A direct assessment of their short-term auditory memory, the Digit Span subtest requires attention, concentration, and mental control and can be influenced by their ability to correctly sequence information. The Digit Span Sequencing task increases the working memory demands of the task.
Letter-Number Sequencing (supplementary subtest)	The Letter-Number Sequencing subtest involves a series of orally presented sequences of letters and numbers that the individual simultaneously tracks and orally completes, with the numbers in ascending order and the letters in alphabetical order. This task is a measure of sequential processing ability, short term auditory memory span, mental manipulation, attention, and concentration. Letter-Number Sequencing also assesses an individual's underlying information processing abilities, cognitive flexibility and fluid intelligence.
PROCESSING SPEED INDEX	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.
Symbol Search	On the Symbol Search subtest, the individual was required to inspect several sets of symbols and indicate if special target symbols appeared in each set. A direct test of speed and accuracy, the subtest assesses scanning speed and sequential tracking of simple visual information. Performance on this subtest also may be influenced by visual discrimination and visual-motor coordination.
Coding	The Coding subtest required the individual to use a key to associate a series of symbols with a series of shapes and to use a pencil to draw the symbols next to the shapes. A direct test of speed and accuracy, the Coding subtest assesses ability in quickly and correctly scanning and sequencing simple visual information. Performance on this subtest also may be influenced by short-term visual memory, attention, or visual-motor coordination.
Cancellation (supplementary subtest)	The Cancellation subtest asks the individual to scan a structured arrangement of shapes, for a specified target shape, which they will mark. The Cancellation subtest is a direct measure of processing speed, as well as visual selective attention, vigilance, perceptual speed and visual motor ability. The inclusion of a decision-making component (selection is based on both shape and colour) places more complex demands upon them.

Please note:

Supplementary Subtests are only administered on an as needed basis when there is a significant discrepancy between the scaled scores of the Primary Subtests within an Index.

APPENDIX 4: BRIEF BIOGRAPHY OF THE AUTHOR

- Dr Shane Langsford is a highly qualified and very experienced psychologist who has conducted more than 9000 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 in Educational Psychology.
- 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), ADHDWA, and the School Psychologist's Association of Western Australia (SPAWA).
- 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 5000 ADHD assessments for various General Practitioners, Psychiatrists and Paediatricians; and in 2014 was asked to be on the National Shire ADHD Expert Panel for the "A Snapshot of ADHD: A Consumer and Community Discussion".

In April 2018, Dr Langsford was the only Psychologist from Australia participating in the ADHD Institute's "Meeting of the Minds" forum in Madrid – which is an invite-only meeting "providing a forum for ADHD scientists and clinicians to discuss the latest scientific evidence and share best practice in the management of ADHD". Dr Langsford was once again the only Psychologist from Australia invited to the 2019 Forum in Munich (Germany), the 2020 Forum in Stockholm (Sweden), and after a conference COVID hiatus, has been invited to the 2023 Forum in Berlin (Germany). www.adhd-institute.com.

- Dr Langsford is on the Management Board of ADHDWA. (For more information, see www.adhdwa.org/about-us/management-board)
- Dr Langsford has been a Member of the AFL Players' Association Network of Practitioners since 2020. This Network is coordinated by the AFLPA Mental Health & Wellbeing Team and involves the provision of psychological services to past and present players and their families.
- 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-TR and has been the most widely used Australian global psychiatric/psychological/educational assessment tool since 2004. (For more information, see <https://www.psychprofiler.com>)