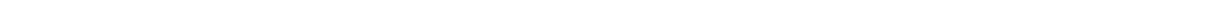




Guidelines for Documentation of Psychiatric Disabilities in Adolescents and Adults

Second Edition – 2012



Contents

Preface	2
Definition.....	2
Confidentiality Statement.....	2
Introduction	3
I. A Qualified Professional Must Conduct the Evaluation	5
II. Documentation Necessary to Support the Diagnosis and Accommodations Must Be Comprehensive	6
III. The Currency Requirements of Documentation and Documentation Updates ...	8
IV. Psychotropic Medications and Documentation Requirements.....	10
V. Rationale for Each Requested Accommodation Must Be Provided	11
VI. Multiple Diagnoses.....	12
VII. Additional Sources of Information.....	12
Appendix A: A Primer for Test Takers on Psychotropic Medications and Testing Accommodations	14
Appendix B: Recommendations for Consumers	16
Appendix C: Assessing Adolescents and Adults with Psychiatric Disorders	17
Appendix D: Resources and Organizations	20

Preface

This document updates the 2001 first edition of the ETS Policy Statement for the Documentation of Psychiatric Disorders in Adolescents and Adults. In the last decade, ETS has experienced a threefold increase in the number of requests for testing accommodations from this population. The intent of this document is to synthesize current knowledge about psychiatric and psychological disabilities and to outline the necessary criteria for documenting the need for reasonable accommodations based on test takers' psychiatric disorders. It reflects the most recent research on psychiatric disabilities and represents more than 10 years' experience reviewing documentation intended to support our test takers' requests for accommodations. These guidelines are intended for use by many constituent groups, including test takers requiring documentation to establish eligibility for appropriate accommodations as well as professionals who produce psychiatric documentation, postsecondary personnel, and licensing and testing agencies.

Definition

"Psychiatric disabilities" is a generic term referring to a range of syndromes and conditions characterized by different types and degrees of emotional, developmental, cognitive, and/or behavioral manifestations. The terms "psychological disabilities" and "psychiatric disabilities" are used interchangeably by professionals in the field and within this document. The source for understanding the exact nature of these conditions is typically the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases: Classification of Mental and Behavioural Disorders (ICD). Common subtypes of psychiatric disorders include but are not limited to obsessive-compulsive, bipolar, generalized anxiety, mood, and post-traumatic stress disorders.

Confidentiality Statement

ETS takes the confidential, private, and sensitive nature of psychiatric information very seriously. ETS will not release any information regarding an individual's diagnosis or medical condition without his or her informed written consent or under compulsion of legal process. Information will be disclosed only on a "need to know" basis, except where otherwise required by law. Furthermore, to safeguard the confidentiality of individuals with disabilities, evaluators may withhold or redact any portion of

the documentation that is not directly relevant to ETS's criteria for establishing both (1) a disability as defined by the Americans with Disabilities Act Amendments Act (ADAAA) and (2) a rationale for all requested testing accommodations. If a section of a report has been redacted, the evaluator should provide an acknowledgment and rationale for this action.

ETS recognizes that misconceptions still exist about individuals with psychiatric disabilities and that special care needs to be taken to protect this sensitive psychological information and related disclosures. Consequently, ETS encourages all institutions to provide secure storage for confidential and sensitive student and employee information that may be used in support of requests for testing accommodations.

Introduction

ETS provides testing accommodations to individuals with a broad range of psychiatric disabilities under the ADAAA and Section 504 of the Rehabilitation Act. In order to receive testing accommodations, a test taker needs to provide ETS with current and comprehensive documentation that supports the need for reasonable accommodations that allow equal access to the testing environment without fundamentally altering an essential component of the test. According to the law, an impairment must “substantially limit a major life activity.” Major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, working, concentrating, thinking, communicating, and the operation of bodily functions. Individuals with psychiatric disabilities, in particular, may experience difficulties with remembering, learning, reading, concentrating and/or thinking, which may interfere directly with the test-taking process. Given that the regular and intermittent use of psychotropic medications has become increasingly common, it is important to document the side effects of these medications. The side effects of associated medications also may impact an individual's performance during clinical and standardized testing and should be addressed in the documentation.

Individuals with psychiatric disabilities often experience co-occurring disabilities such as attention-deficit hyperactivity disorder (ADHD), learning disabilities (LD), and/or physical or chronic health conditions along with the primary diagnosis. In instances where there may be multiple diagnoses including LD and/or ADHD,

evaluators should consult the appropriate ETS companion documentation guidelines as found at <http://www.ets.org/disabilities>.

This revised Policy Statement includes the following eight elements:

- I. Evaluator qualifications
- II. Documentation necessary to support the diagnosis and accommodations must be comprehensive evidence to establish the functional limitations of the psychological condition
 - A. Historical information, diagnostic interview and/or psychological assessment
 - B. Documentation must include a specific diagnosis or diagnoses
 - C. Alternative diagnoses or explanations should be ruled out
- III. The currency requirements of documentation and documentation updates
- IV. Psychotropic medication management and side effects
- V. Rationale for each requested accommodation must be provided
- VI. Multiple diagnoses
- VII. Additional sources of information
- VIII. Appendices A, B, C, and D, respectively, provide the following: a primer on psychotropic medications, recommendations for consumers, suggestions for assessment measures, and a listing of resources and organizations.

I. A Qualified Professional Must Conduct the Evaluation

Professionals conducting evaluations, rendering diagnoses of psychiatric disorders, and making recommendations for accommodations of individuals with disabilities must be qualified to do so. It is essential that professional qualifications include information about both (1) comprehensive training and relevant expertise in diagnosis of psychiatric disorders, and (2) appropriate licensure/certification.

Qualified evaluators are defined as those licensed individuals who are competent to evaluate and diagnose psychiatric disorders or who may serve as members of the diagnostic team. These individuals or team members may include:

- licensed psychologists
- neuropsychologists
- psychiatrists
- other relevantly trained medical doctors
- clinical social workers
- school psychologists
- psychiatric nurse practitioners

Documentation may be provided from more than one source when a clinical team approach consisting of a variety of educational, medical and mental health professionals has been used.

Diagnoses of psychiatric disorders by a family member will not be accepted due to professional and ethical considerations, even when the family members are otherwise qualified by virtue of their training and licensure/certification.

The name, title, credentials, and signature of the licensed qualified professional writing the evaluation must be included. Information regarding license or certification, as well as the area of specialization, employment, and state or province in which the individual practices must also be clearly stated in the documentation. All reports should be in written in English, typed or printed on professional letterhead, and dated.

II. Documentation Necessary to Support the Diagnosis and Accommodations Must Be Comprehensive

In most cases, documentation should be based on a comprehensive diagnostic/clinical evaluation that adheres to the guidelines outlined in this document. It is recommended that the diagnostic report include the following components:

- specific diagnosis or diagnoses
- description of current symptoms in the testing environment as well as across other settings (e.g., college or employment)
- relevant information regarding psychotropic medications expected to be in use during test administration and the anticipated impact (“side effects”) on the test taker in this setting (see Section IV)
- relevant information regarding current treatment
- specific recommendations for accommodations with an accompanying rationale (see Section V)

A. Historical Information, Diagnostic Interview, and/or Psychological Assessment

Behavioral observations, combined with the clinician’s professional judgment and expertise, are often critical in helping to formulate a diagnostic impression. The evaluator should specifically indicate, in detail, the relevant test-taking behaviors that impact upon the examinee’s performance. The evaluator should indicate if the behaviors noted during testing are consistent with the diagnosis, and if not, why not.

The information collected for the diagnostic interview should include, but not be limited to, the following:

- history of presenting symptoms of the disability when active (e.g., palpitation, sweaty palms, disoriented thinking, mental fatigue);
- onset of the disorder and duration and severity of the symptoms (including discussion that separates common test-taking anxiety from a diagnosed condition);

- relevant developmental, historical and familial data (including any hospitalization, outpatient treatment, and visits to counseling and mental health services);
- relevant medical and medication history, including the individual's current medication regimen compliance, side effects (if relevant), and positive and negative response(s) to medication;
- a description of current functional limitations in academic testing or employment settings with the understanding that a psychological disorder usually presents itself across a variety of settings other than just the academic domain and that its expression is often influenced by context-specific variables (e.g., school-based performance, work or job performance);
- if relevant to test-taking performance, a description of the expected progression or stability of the impact of the condition over time;
- if relevant to test-taking performance, information regarding type of treatment received, its effectiveness, and the duration and frequency of the therapeutic relationship; and
- if relevant, information regarding sleep hygiene and possible impact on functioning in a test-taking situation.

B. Documentation Must Include a Specific Diagnosis or Diagnoses

The report must include at least one specific diagnosis based on the latest edition of the DSM or the ICD, preferably listed in a specific diagnostic section of the report with the nominal diagnosis and accompanying numerical code. Evaluators are encouraged to also provide meaningful contextual information (e.g., associated medical diagnoses, current stressors and sociocultural factors, as well as statements regarding general level of functioning) as has been the standard set forth in recent editions of the DSM. Citing the specific objective measures used to help substantiate the diagnosis along with scores can be quite helpful in documenting a reasonable need for accommodations. The evaluator should use definitive language in the diagnosis of a psychiatric disorder, avoiding such wording as "is consistent with," "has problems with," or "may indicate emotional problems."

Given that many individuals benefit from prescribed medications and therapies, a positive response to medication in and of itself does not confirm a diagnosis, nor does the use of medication in and of itself either support or negate the need for accommodations.

C. Alternative Diagnoses or Explanations Should Be Ruled Out

To the extent possible, the evaluator should investigate and rule out the possibility of other potential diagnoses that may alter the expression of a disability. These diagnoses, such as neurological and/or medical conditions or substance abuse, as well as educational, linguistic, sensori-motor and cross-cultural factors, may result in symptoms that mimic, exacerbate, or otherwise complicate determinations of the true nature of the purported psychiatric disability.

III. The Currency Requirements of Documentation and Documentation Updates

Due to the changing nature of psychiatric disabilities, it is essential that a test taker provide recent and appropriate documentation. Since reasonable accommodations are based upon the current impact of the disability, the documentation must address the individual's present level of functioning and the need for accommodations in the test-taking situation. This is important because an individual's presentation and performance may vary over time even if the diagnosis remains unchanged. It is difficult to provide hard-and-fast rules regarding the currency of psychiatric documentation, but ETS endeavors to be reasonable when reviewing the totality of information provided.

In most instances, the recency requirement for psychiatric documentation is that an evaluation has been conducted within six months of the requested accommodations. However, there is room for flexibility, depending on the following variables: a) the nature and type of disability, including its stated or implied course; b) the severity of the disability; c) the history of onset and/or duration of the disability; and d) other conditions at the time of last assessment, such as treatment status and stability of functioning.

After considering these variables, together with the standard of a six-month guideline, the evaluator should ask himself or herself the following about the documentation:

1. Does the information submitted for review present a reasonably comprehensive picture regarding the disability and the rationale for the requested accommodation(s)?
2. Is the information provided still applicable at the time of documentation submission?

The answers to these two essential questions should help determine whether there is a need to update information that is more than six months old and, if so, what specific information should be provided. In some situations a clinical update may be used. A clinical update is typically a letter from the treating clinician(s) specifically addressing current symptomatology or disability status, as well as response to a previously documented recommendation for intervention as it relates to a condition that is of more recent onset. Sometimes a more comprehensive workup will be necessary. This is referred to as a documentation update.

A documentation update is a report by a qualified professional that includes a summary of the original disability documentation findings, as well as additional clinical data necessary to establish the candidate's current need for the requested testing accommodation(s).

A summary in a documentation update should include:

- restatement of the current diagnosis, including date(s) for all prior diagnoses and data that were used to establish each diagnosis (evidence regarding the diagnosis should be more than a self-report by the test taker);
- verification of continuing weaknesses in those areas identified in prior evaluation(s);
- discussion of current functional limitations due to the disability, including information regarding its frequency, duration, and impact on academic performance in general and on test taking in particular;
- observational data gathered during the evaluation, including affect, concentration, attentional fatigue, executive functioning, personal hygiene, and response to questions;

- types of accommodations received and used in the past, consistency and circumstances of use (e.g., the type of test for which accommodations were most helpful), or an explanation of why no accommodations have been used prior to the current request but are needed now; and
- discussion of the appropriateness of the requested accommodations for ETS tests.

Additional evaluation data for a psychiatric update may include achievement measures that substantiate the ongoing impact of the disability on academic performance. The updated evaluation need not include a full battery of tests but may include selected academic tests and subtests deemed appropriate to support requested accommodations. Furthermore, there should be an explanation of why certain subtests were selected for the update, interpretation of the reported scores, and a discussion of how error patterns in the candidate's performance reflect a substantial limitation to learning and/or test taking.

IV. Psychotropic Medications and Documentation Requirements

Any test taker applying for accommodations for a psychiatric disability who is being treated with psychotropic medications (PMs) should provide the following basic information as part of his/her submitted documentation: the name (generic or trade) of each specific agent, along with the dosing regimen and any actual side effects experienced. Physicians or other prescribers providing documentation should verify the basic parameters of the medication treatment: rationale, agent(s) used, dosing regimens, duration of treatment, compliance, therapeutic benefit, side effects, and adverse effects, if any. Please see Appendix A, "A Primer for Test Takers on Psychotropic Medications and Testing Accommodations," for more details.

Some test takers may be tempted to go off medications before the diagnostic evaluation to more readily demonstrate the existence of a disabling condition. This is often misguided. If a formal psychological assessment is undertaken to help document the presence of functional limitations, it is important that the test taker undergo such clinical testing while taking the medication. Although the ADAAA prevents considering a therapeutic response to medication to deny the presence of a disabling condition, taking into account the impact of the treatment regimen is relevant to the granting of appropriate accommodations for this population.

V. Rationale for Each Requested Accommodation Must Be Provided

The evaluator must describe the degree of current impact of the diagnosed psychiatric disorder on a specific major life activity as well as the degree of impact on the individual. A link must be established between the requested accommodations and the manifested symptomatology of the disorder that is pertinent to the anticipated testing situation. Accommodations can be provided only when a convincing rationale is made for their necessity to create a level playing field. A diagnosis in and of itself does not automatically warrant approval of requested accommodations. For example, test anxiety alone is not a sufficient diagnosis to support requests for accommodations. Given that many individuals may perceive that they might benefit from extended time in testing situations, evaluators must provide specific rationales and justifications for the accommodation. A prior history of accommodations, without demonstration of current need, does not in and of itself warrant the provision of accommodations. If there is no prior history of accommodations, the evaluator and/or the test taker must include a detailed explanation of why accommodations were not needed in the past and why they are currently being requested. Psychoeducational, neuropsychological, or behavioral assessments often are necessary to support the need for testing accommodations based on the potential for psychiatric disorders to interfere with cognitive performance. The documentation should include a comprehensive discussion of the individual circumstances supporting the request for any accommodation based upon psychiatric disabilities.

Undergoing neuropsychological, psychological, or psychoeducational testing often can be a critical step in establishing or reconfirming a diagnosis and documenting its impact on an individual's current academic functioning. Obtaining standardized measures of performance on a range of academically relevant tasks can guide the accommodation-granting process by objectively demonstrating the need for accommodations and identifying the type and extent of formal assistance that is likely to be effective. Beyond the issue of qualifying for accommodations, such testing can also provide insights into one's profile of cognitive strengths and vulnerabilities and help students compensate more effectively and better advocate for themselves. However, not all applicants with psychiatric disabilities will need to undergo such psychometric assessments or achievement testing in order to qualify for testing accommodations. ETS will determine the adequacy of submitted documentation on a case-by-case basis and base accommodation decisions on the totality of information provided.

VI. Multiple Diagnoses

Multiple diagnoses may require a variety of accommodations beyond those typically associated with the impact of a single diagnosis. For example, when accommodations are requested based on multiple diagnoses (e.g., a psychological disability with an accompanying learning disability), documentation should also comply with the ETS policy statements pertaining to the documentation of these specific disabilities. In such instances, an evaluator should consult ETS's policies and guidelines for documentation. The ETS guidelines for documentation of psychiatric disabilities as well as policy statements pertaining to LD and ADHD can be found at <http://www.ets.org/disabilities>. If the accommodations requested cannot be supported by the current evaluation and multiple diagnoses are suspected, the evaluator should recommend/refer the individual to another qualified professional for additional testing.

VII. Additional Sources of Information

Other sources of documentation can be used to corroborate symptoms of the disorder and support the need for the requested accommodation(s). Relevant information from these sources should be summarized by the evaluator in the current disability documentation and/or included as an attachment by the applicant.

Depending on the degree and scope of the information it contains, a school-based document such as an Individualized Education Program (IEP), a Section 504 Plan, a Summary of Performance (SOP), or transition documentation can be included as part of a more comprehensive documentation packet. Prior evaluation reports should be reviewed by the evaluator and summarized in the history section or attached to the documentation packet. Such documents may provide useful supplemental information about a test taker's educational history, history of eligibility for services, history of limitations to academic achievement, and history of accommodation use.

Other supplemental forms of documentation may include evidence of a reduced course load or the number of incompletes or dropped courses, a copy of an accommodation letter to faculty, a letter from a content area teacher, and/or official scores with or without accommodations from national standardized tests (e.g., SAT®, ACT®). A detailed letter from a college disability services provider, a vocational rehabilitation counselor, or a human resources professional describing current limitations and use of accommodations also can be helpful to supplement comprehensive documentation.

A personal letter from the applicant in his/her own words explaining academic difficulties and coping strategies used also may be helpful. The evaluator's and/or the applicant's personal letter should highlight the relevant information from these other forms of documentation that add further information to support the current need for accommodations. The personal letter should not exceed one page and may include information regarding the date of the initial diagnosis, accommodations history in a variety of settings, a statement explaining the need for accommodations that are presently requested, and any additional supporting information for the requested accommodations.

For additional information contact:

ETS
Disability Services
P.O. Box 6054
Princeton, NJ 08541-6054

Phone: **1-866-387-8602** (toll free) from U.S., U.S. Territories* and Canada
1-609-771-7780 (all other locations)

TTY: **1-609-771-7714**

Fax: **1-973-735-1893**

Email: **stassd@ets.org**

*Includes American Samoa, Guam, Puerto Rico and U.S. Virgin Islands.

Appendix A

A Primer for Test Takers on Psychotropic Medications and Testing Accommodations

Psychotropic medications (PMs) are pharmaceutical agents that alter mental functioning. PMs are commonly prescribed for the treatment of a wide range of psychiatric conditions. Most PMs have a generic (or chemical) name as well as a trade (or brand or commercial) name. For example, the generic drug fluoxetine also is marketed under the trade name Prozac. This does not mean that all such agents are equivalent, since there may be differences in how they are formulated. In addition to name, three common ways of classifying PMs are:

- by the conditions they are used to treat (antidepressants, antipsychotics)
- by their main intended therapeutic effect or target action (mood stabilizers, stimulants)
- by their primary neurochemical mode of action (serotonin reuptake blockers, antihistamines)

The intended action of some drugs can positively impact cognition in everyday life as well as performance on formal testing, including school-based examinations, clinical assessments, and high-stakes standardized tests. The intended therapeutic effect of a drug is to be distinguished from unwanted side effects that often accompany an attempt to directly alter the physiology of the brain. When side effects are harmful, they are known as adverse effects. In some instances side effects may be beneficial — for example, an antidepressant that causes sedation may actually help a patient get to sleep at night. When side effects occur, the prescribing professional should work with the patient to analyze the costs and benefits of staying on the medication, discontinuing it or trying a different agent. Other options include an alteration in the dosing regimen (e.g., amount, timing) or the form of the agent (e.g., short-acting, sustained-release) that might minimize the side effect or allow the patient to better tolerate it.

Side effects can occur at any time in the course of treatment: at the initiation of a new medication, when a dosing regimen is changed, during maintenance on a stable dose when personal health or circumstances change, or upon discontinuation. Some side effects can negatively affect cognitive function in ways that directly impact test-taking performance. Examples include sedation, mental and physical slowing, diminished concentration, and restlessness. Other side effects have the potential to indirectly impede test performance through distracting or incapacitating discomforts such as thirst, dry mouth, nausea, frequent urination, lightheadedness, dizziness, or headache.

Individual reactions to PMs are highly variable. It is not possible to predict ahead of time either their therapeutic or their side effects with an acceptable degree of confidence. One therefore cannot assume which particular benefit(s) or side effect(s) a given drug will produce in a particular person. A trial of a PM is often called “empirical” because its impact only becomes known as the user’s experience with the drug unfolds. It is important to expect that each individual will experience a PM uniquely — in terms of both its positive and negative effects.

Given that different individuals may experience the same PM agent differently, and that both positive and negative effects of these medicines could impact test-taking performance, it is important to consider some of the variables that determine how these effects are experienced. How long an active ingredient of a medication stays in the body depends on what parts of the body absorb it, how strongly it binds to parts of the body

(such as proteins), and how effectively enzymes break it down. Sometimes a medication is designed to be released more slowly to allow more of the active ingredient to linger in the body. How long an agent lasts in the system depends on the particulars of how it gets into, stays in, and is removed from the body. For some agents, this duration of action varies greatly among individuals. When and how much medication is taken, and how long its effects last, will determine what level of the agent is in a person's system at a given time. How long it takes for medication to take effect and for effects to wear off also is variable, as biological effects differ among individuals. Ending a medication can result in withdrawal symptoms in some cases. PMs also can produce longer-term changes in neural circuitry that persist after the agent itself is cleared from the body. With knowledge of the specific properties of the agent(s) involved, a strategy for tapering dosages can often be devised, along with a "Plan B" if one is having difficulty tolerating being off the PM in question. Any contemplated change in one's medication usage should be discussed with and approved by an appropriate expert medical provider.

In some cases, an agent will have different effects over the course of the day. Some agents will produce, for example, discomforts such as nausea, headache, mood distress, or sedation either as they peak in the system or as they wear off. It may take careful tracking of symptoms for someone on medication to appreciate such patterns.

Polypharmacy is the term used when an individual is taking multiple PMs for a condition. This common situation adds an additional layer of complication to the process of establishing the positive and negative effects of individual PMs. The presence of other medical conditions that affect the way one's body absorbs and excretes a PM is yet another factor to consider in evaluating drug effects and in making treatment decisions.

The list of specific PMs is lengthy and ever-changing. Information about duration of drug effects, side effects, and discontinuation effects is available from expert sources. ETS recommends consulting a range of trusted sources, such as:

- www.accessdata.fda.gov/scripts/cder/drugsatfda/index.cfm
- www.webmd.com/drugs/
- www.nlm.nih.gov/medlineplus/druginformation.html
- www.pdrhealth.com

Disclaimer

The information above is provided specifically for the purpose of guiding ETS consumers with psychiatric disabilities in making informed choices regarding their requests for accommodations. This information should not be construed as an attempt to offer or substitute for professional counseling or medical advice.

(M. Greenberg, 2011)

Appendix B

Recommendations for Consumers

1. If you are currently not under the care of a qualified professional and need assistance in identifying one, contact:
 - a. your primary care physician to discuss obtaining a referral;
 - b. the disability services coordinator or college counselor and/or mental health service provider at a college or university for possible referral sources;
 - c. a high school guidance office and/or counselor; or
 - d. a physician who may be able to refer you to a qualified professional with demonstrated expertise in psychological disorders.
2. In selecting a qualified professional, ask:
 - a. what experience and training he or she has had diagnosing adolescents and adults;
 - b. whether he or she has training in differential diagnosis and the full range of psychological disorders. Clinicians typically qualified to diagnose psychiatric disabilities include psychologists, neuropsychologists, psychiatrists, neuropsychiatrists, other relevantly trained medical doctors, clinical social workers, licensed counselors, and psychiatric nurse practitioners;
 - c. whether he or she has ever worked with a postsecondary disability service provider, a high school guidance counselor, or the agency to which you are providing documentation; and
 - d. whether you will receive a comprehensive written report.
3. In working with the professional:
 - a. take a copy of these guidelines to the professional; and
 - b. be prepared to be candid and thorough in providing requested information.
4. As a follow-up to the assessment by the professional:
 - a. schedule a meeting to discuss the results, recommendations and possible treatment;
 - b. request additional resources, support group information and publications if you need them;
 - c. maintain a personal file of your records and reports, and keep a copy of any reports or documentation you submit to a testing agency; and
 - d. be sure to discuss the issues of confidentiality with the professional at the outset of the evaluation as well as during the follow-up meeting.

Appendix C

Assessing Adolescents and Adults with Psychiatric Disorders

This appendix contains selected examples of tests and instruments that may be used to supplement the clinical interview and support the presence of functional limitations. All tests used should be current and have sufficient reliability, validity, and utility for the specific purposes for which they are being employed. All tests also should be normed on relevant populations, and the results should be reported in standard scores and/or percentile ranks. Tests that have built-in validity scales or indicators are preferred over those that do not.

- 1.** Rating scales: Self-rater or interviewer-rated scales for categorizing and quantifying the nature of the impairment may be useful in conjunction with other data, but no single test or subtest should be used solely to substantiate a diagnosis.

Acceptable instruments include but are not limited to:

- Beck Anxiety Inventory
 - Beck Depression Inventory-II
 - Brief Psychiatric Rating Scale (BPRS)
 - Burns Anxiety Inventory
 - Burns Depression Inventory
 - Children’s Depression Inventory
 - Hamilton Anxiety Rating Scale
 - Hamilton Depression Rating Scale
 - Inventory to Diagnose Depression
 - Multidimensional Anxiety Scale for Children (MASC)
 - Profile of Mood States (POMS)
 - State-Trait Anxiety Inventory (STAI)
 - Symptom Checklist-90-Revised
 - Taylor Manifest Anxiety Scale
 - Yale-Brown Obsessive Compulsive Scale (Y-BOCS)
- 2.** Neuropsychological and psychoeducational testing: Cognitive, achievement, and personality profiles may uncover attention or information-processing deficits, but no single test or subtest should be used solely to substantiate a diagnosis.

Acceptable instruments include, but are not limited to:

- Kaufman Adolescent and Adult Intelligence Test
- Stanford-Binet, Fifth Edition
- Wechsler Adult Intelligence Scale – IV (WAIS-IV)
- Woodcock-Johnson® III – Tests of Cognitive Abilities

Academic Achievement

- Scholastic Abilities Test for Adults (SATA)
- Stanford Test of Academic Skills (TASK)
- Wechsler Individual Achievement Test-III (WIAT-III)
- Woodcock-Johnson® III – Tests of Achievement

Subject-specific Measures

- Nelson-Denny Reading Test
- Stanford Diagnostic Mathematics Test
- Test of Written Language-4 (TOWL-4)
- Woodcock Reading Mastery Tests - Revised

Information Processing

- California Verbal Learning Test-II
- Category Test
- Comprehensive Test of Phonological Processing (CTOPP)
- Continuous Performance Test
- Delis Kaplan
- Detroit Tests of Learning Aptitude-Adult (DTLA-A)
- Detroit Tests of Learning Aptitude-3 (DTLA-3)
- Halstead-Reitan Neuropsychological Test Battery
- Rey-Osterrieth Complex Figure Test
- Stroop Interference Test
- Test of Memory Malingering (TOMM)
- Trail Making Test
- Wechsler Memory Scale III (WMS-III)
- Wisconsin Card Sorting Test

Information from subtests on the WAIS-IV or Woodcock-Johnson III – Tests of Cognitive Abilities, as well as other relevant instruments, may be useful when interpreted within the context of other diagnostic information.

3. Personality Tests:

Acceptable instruments may include, but are not limited to:

- Millon Adolescent Personality Inventory (MAPI)
- Millon Clinical Multiaxial Personality Inventory-III (MCMI-III)
- Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A)
- Minnesota Multiphasic Personality Inventory-2 (MMPI-2)
- NEO Personality Inventory-Revised (NEO-PI-R)
- Personality Assessment Inventory (PAI)
- Personality Diagnostic Questionnaire-4 (PDQ)
- Sixteen Personality Factor Questionnaire (16PF)
- Thematic Apperception Test (TAT)

4. Anxiety/Depression:

Acceptable instruments may include, but are not limited to:

- Anxiety Sensitivity Index (ASI)
- Beck Depression Inventory II (BDI-II)
- Patient Health Questionnaire (PHQ-9)
- Satisfaction with Life Scale (SWLS)
- State-Trait Inventory for Cognitive and Somatic Anxiety (STICSA)
- Perceived Stress Reactivity Scale (PSRS)
- The Yale-Brown Obsessive Compulsive Scale (Y-BOCS)

5. Eating Disorders:

- Eating Disorder Examination-Questionnaire (EDE:Q)

6. Sleep:

- Insomnia Severity Index Test

Appendix D

Resources and Organizations

Anxiety Disorder Association of America (ADAA)

8730 Georgia Avenue
Silver Spring, MD 20910

1-240-485-1001 voice

1-240-485-1035 fax

<http://www.adaa.org>

The ADAA is the leader in advocacy, education, training, and research for anxiety and stress-related disorders.

Association on Higher Education and Disability (AHEAD)

107 Commerce Center Drive, Suite 204
Huntsville, NC 28078

1-704-947-7779 voice

1-704-948-7779 fax

<http://www.ahead.org>

AHEAD is a professional membership organization for individuals involved in the development of policy and in the provision of quality services to meet the needs of persons with disabilities involved in all areas of higher education.

Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD)

8181 Professional Place, Suite 150
Landover, MD 20785

1-800-233-4050 voice – toll free

1-301-306-7070 voice

1-301-306-7090 fax

<http://www.chadd.org>

CHADD is the nation's leading nonprofit organization serving individuals with ADHD and their families. CHADD has more than 16,000 members in 200 local chapters throughout the United States. Chapters offer support for individuals, parents, teachers, professionals, and others.

Council for Exceptional Children (CEC)

2900 Crystal Drive, Suite 1000
Arlington, VA 22202-3557

1-888-232-7733 voice

1-866-915-5000 TTY

<http://www.cec.sped.org>

The CEC works to improve the educational success of children and youth with disabilities and/or gifts and talents.

Depression and Bipolar Support Alliance (DBSA)

730 N. Franklin Street, Suite 501
Chicago, IL 60654-7225

1-800-826-3632 toll free

1-312-642-7243 fax

<http://www.dbsalliance.org>

The DBSA provides support to improve the lives of people living with mood disorders. DBSA pursues and accomplishes this mission through peer-based, recovery-oriented, empowering services and resources when people want them, where they want them, and how they want to receive them.

International OCD Foundation (IOCDF)

112 Water Street, Suite 501
Boston, MA 02109

1-617-973-5801 voice

1-617-973-5803 fax

<http://www.ocfoundation.org>

The IOCDF is an international not-for-profit organization made up of people with obsessive-compulsive disorder (OCD) and related disorders, as well as their families, friends, professionals and others.

The Internet Mental Health Web page

<http://www.mentalhealth.com>

Internet Mental Health is a free encyclopedia of mental health information created by a Canadian psychiatrist, Dr. Phillip Long.

Learning Disabilities Association of America (LDA)

4156 Library Road
Pittsburgh, PA 15234-1349

1-412-341-1515 voice
1-412-344-2240 fax

<http://www.ldanatl.org>

LDA is the largest nonprofit volunteer organization advocating for individuals with learning disabilities. LDA has more than 200 state and local affiliates in 42 states and Puerto Rico. Membership, composed of individuals with learning disabilities, family members and concerned professionals, advocates for the almost three million students of school age with learning disabilities and for adults affected with learning disabilities.

National Center for Learning Disabilities (NCLD)

381 Park Avenue South, Suite 1401
New York, NY 10016

1-212-545-7510 voice
1-212-545-9665 fax
1-888-575-7373 toll free

<http://www.nclld.org>

NCLD's mission is to ensure success for all individuals with learning disabilities in school, at work and in life. NCLD provides essential information to parents, professionals and individuals with learning disabilities, promotes research and programs to foster effective learning, and advocates for policies to protect and strengthen educational rights and opportunities.

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