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Caregiver Perceptions of the Impact of Psychoeducational Reports on Children with Learning Disabilities and ADHD

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Abstract

The present study aimed to investigate caregiver perceptions of the role of psychoeducational reports in facilitating positive educational and psychosocial outcomes for children identified with learning disabilities (LD) or attention-deficit-hyperactive-disorder (ADHD). Participants were twenty parents of children who previously received private psychoeducational assessments from a university-based teaching clinic in Southwestern Ontario. Data on children's educational experiences and parents' concerns for their children's functioning were collected through an online mixed-methods questionnaire. Findings suggested that psychoeducational reports facilitated a widespread increase in educational services and significantly addressed parent worries about children's futures and autonomous, academic, and emotional functioning. However, the findings also revealed that some parents perceived their children's educational services as inadequate for promoting successful outcomes. Taken together, the findings point to a need for further outcome data and enhancing collaboration between parents, clinicians, and educators to maximize the benefits that psychoeducational reports can have for children with LD and ADHD.

Keywords

psychoeducational reports, psychoeducational assessments, learning disabilities, attention-deficit-hyperactive-disorder (ADHD), caregivers, parents, children, education, school

Summary for Lay Audience

For children with LD and ADHD, meeting the required goals of their academic coursework can be especially difficult. These children might also experience more social and behavioural challenges, especially when their need for support is unfairly judged. Repeatedly failing to meet expectations can hurt children's self-esteem, potentially leading to disengagement from learning. However, these children have the potential to succeed in school with appropriate educational support. This involves setting manageable expectations that meet learning needs and maximize children's capabilities.
Research shows that receiving adequate support in a timely manner results in lower school dropout rates, better post-secondary and career prospects, more stable relationships, and fewer emotional problems. Psychologists can use psychoeducational assessments to identify children's unique strengths and needs. Their findings are documented in a psychoeducational report, which can be shared with parents and teachers and includes recommendations for how to best support children. Although psychoeducational reports are assumed to help children access support, few studies have investigated whether these reports indeed result in improved children's outcomes.

The aim of the current research was to investigate parent perspectives on how useful psychoeducational reports were for accessing appropriate support for their children and addressing concerns around academic, behavioural, social, and emotional development. The methodology involved a survey with twenty parents or caregivers whose children had received psychoeducational assessments at a university clinic in Southwestern Ontario. The results revealed a marked increase in educational services provided to children after their psychoeducational assessments. Parents' concerns for their children's futures, independence, and academic and emotional development were significantly reduced after their children's assessments. However, the results did not reveal meaningful changes in parents' concerns for their children's social or behavioural development. Some parents also perceived their children's support as inadequate.

Overall, the results suggested that psychoeducational reports have an important role to play in supporting children with LD and ADHD. However, the findings also highlighted a

need for more consistent implementation of these tools in school settings, raising implications for how educators, caregivers, and clinicians can better collaborate to fully realize the benefits that psychoeducational reports can have on children's educational experiences and development.

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I want to begin by acknowledging the participants who dedicated time to sharing their perspectives. Thank you for allowing me the opportunity to hear your voices and document your experiences.

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1 Introduction

The provision of timely and essential educational interventions plays a crucial role in promoting favourable outcomes for children with learning disabilities (LD) and attention-deficit/hyperactivity disorder (ADHD) (Goldberg et al., 2003; Hamre & Pianta, 2001; Keogh & Weisner, 1993; Pesova et al., 2014; Torgensen et al., 1999; Werner, 1993). Evidence from research and clinical practice indicates an elevated risk of academic struggles, emotional and behavioural challenges, as well as difficulties in social regulation for this population. Such outcomes can potentially hinder these children's inclusive engagement in education and their ability to participate in meaningful opportunities within their communities (Barbaresi et al., 2013; Fabiano et al., 2022; Waber, 2010). Addressing these challenges through educational supports that promote emotional regulation, self-advocacy, and social skills is crucial (Keogh & Weisner, 1993; Sorensen et al., 2003; Werner, 1993), as it can enhance children's self-esteem, foster independence in learning, and support their successful transition to higher education or the workforce (Goldberg et al., 2003; Keogh & Weisner, 1993).

A psychoeducational report details key findings of a child's psychoeducational assessment and accompanying recommendations from the clinician (Hass & Carriere, 2014). This resource is intended to be a valuable tool for tailoring interventions to a child's unique strengths and needs and can serve as a key tool to accessing formal educational supports (Mastoras et al., 2011). Caregivers of children with LD and ADHD frequently rely on psychoeducational reports to aid in their child's academic, social, and emotional development (Waber et al., 2017). However, the assessment process to generate these reports can be arduous and costly for those seeking these services (Wakeman, 2022). Nevertheless, the families that can access these services consider them worthwhile if the reports lead to meaningful changes in their children's lives (Waber et al., 2017).

Perceived benefits of obtaining a psychoeducational report include providing guidelines for individualized education planning, offering psychoeducation for families, supporting

advocacy in educational settings, monitoring progress, and enhancing collaboration among the stakeholders who are involved in the child's development (Dombrowski, 2015; Fletcher et al., 2015; Waber et al., 2017; Wakeman, 2022). While these assumptions are widely accepted, there is limited empirical evidence on whether psychoeducational reports indeed result in meaningful changes in children's lives, highlighting the need for further research in this area.

Accordingly, the main objective of this thesis is to address the gap in understanding the outcomes of obtaining psychoeducational reports for school-aged children with LD and ADHD in Canada, aiming to contribute to evidence-based practices. The ensuing literature review will commence with an exploration of the developmental implications of LD and ADHD, provincial inclusive education policies, and the significance of timely educational interventions. This will be followed by an overview of previously identified challenges in accessing these interventions, the role of psychoeducational reports in securing resources for families, and barriers to accessing psychoeducational assessment services. Finally, I will introduce a novel study aiming to investigate caregivers' perceptions regarding the impact of these reports on children's functioning within the school environment.

2 Literature Review

2.1 Learning Disabilities and ADHD

Learning disabilities (LD) and attention deficit hyperactivity disorder (ADHD) rank among the most frequently diagnosed disabilities during childhood (Barberesi et al., 2013; Statistics Canada, 2008). The Learning Disabilities Association of Canada (LDAC) estimates that 1 in 10 Canadians have an LD (LDAC, 2017). However, the exact prevalence rates in Canada are difficult to ascertain, largely due to provinces lacking a uniform definition of what constitutes an LD. Some provinces, including Ontario, have adopted the LDAC's definition for LD: a broad term encompassing several lifelong neurobiological conditions that impact learning processes in individuals with otherwise average cognitive abilities. Specific LDs, which vary in severity, are characterized by

difficulties with oral language, reading, writing, and mathematics, and are often associated with acquiring, organizing, interpreting, or utilizing information effectively. LDs are commonly accompanied by difficulties in social functioning (LDAC, 2017).

While the LDAC definition informs educational policymaking in Ontario to determine who qualifies for LD school supports, clinicians utilize the definition delineated in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) to identify a diagnosis (D'Intino, 2017). The LDAC's definition is a broader extension of the DSM-5, which identifies three specific LD categories, differing based on their relevance to difficulties in reading, writing, or mathematics (American Psychiatric Association, 2013). Diagnosis for specific learning disabilities involves a psychoeducational assessment, which determines children's key areas of strengths and needs.

In Ontario schools, the intelligence-achievement discrepancy model, which compares the child's cognitive abilities to their achievement scores, is commonly utilized to identify LD. Therefore, LD is predominantly identified in children exhibiting poor academic performance or requiring significant support (D'Intino, 2017; Ontario Human Rights Commission, 2022). Although several studies have noted that initial concerns relating to children's learning difficulties emerge early on when the child is in preschool or entering primary school (Denton et al., 2022; Kelley, 2022; Miech, 2020; Silverstein, 2015), the intelligence achievement model may delay the identification of LD for Ontario students, especially for children with mild LDs. Identifying specific LDs enables policymakers, clinicians, and educators to determine which supports are appropriate for addressing the child's learning strengths and needs. Some supports, such as additional time to complete work, can be more broadly applicable to any LD. Other supports are more targeted, such as text-to-speech software that reads instructions to a child with a reading-specific LD (e.g., dyslexia).

ADHD, which involves challenges relating to attention, hyperactive behaviour, and impulse control is the most identified behavioural disorder in childhood, with prevalence rates estimated at around 5% (Barbaresi et al., 2013; Froehlich et al., 2007; Sayal et al., 2018). There are three ADHD subtypes (predominantly inattentive presentation,

predominantly hyperactive-impulsive presentation, and combined inattentive and hyperactive presentation), and the types of educational supports children receive will depend on the strengths and needs emerging from their subtype. Children with hyperactive or combined presentations may feel less supported in school, as previous research indicates that educators can have greater difficulties in implementing behavioural management interventions in the classroom setting (Borghese & Cole, 1994).

Like LD, ADHD is a lifelong condition, and the severity of both disabilities is influenced by environmental demands (Turgay et al., 2012). Moreover, the comorbidity of ADHD with LD is significant, although inconsistent LD definitions result in substantial variation in prevalence rates reported across studies (DuPaul et al., 2013). However, in a review of 17 studies that reported comorbidity rates, DuPaul and Stoner (2003) found a median rate of 31.1% across the samples, indicating that an average of one in three children with ADHD were also diagnosed with an LD. The authors additionally reviewed seven studies that reported prevalence rates for ADHD in children with LD. The median rate found across the samples was 38.2%, and the authors noted that, on average, children with LD were seven times more likely to have ADHD than children without LD. With respect to the impact of ADHD on learning, some definitions of LD include ADHD. However, the Ontario Ministry of Education does not consider ADHD as an LD; moreover, ADHD is excluded from the Ministry's definition of formal educational exceptionalities (Ontario Ministry of Education, 2017).

Psychoeducational assessments may reduce the barriers to learning that both children with LD and ADHD experience by informing targeted interventions, although their specific impact on driving early intervention strategies remains to be fully elucidated. To understand the role that psychoeducational reports can play in shaping children's educational experiences, it is important to first understand how they might supplement inclusive educational practices in Canada.

2.2 Inclusive Education Practices

An inclusive and accessible education is crucial for children of all abilities to thrive in their educational environments and participate in their communities (UNESCO, 1994). In Canada, the Charter of Rights and Freedoms (1982) acknowledges the essentiality of inclusive education by constitutionally protecting a student's right to an inclusive education that denounces discrimination based on disability. In Ontario, several legislations further reinforce students' access to an education that appropriately meets their needs (e.g., Accessibility for Ontarians with Disabilities Act, 2005; Advancing Inclusion in Ontario Classrooms Act, 2008; Ontario Human Rights Code, 1990).

The Education Amendment Act (1980) outlined the first clear demarcation of Canadian inclusive education objectives, emphasizing the importance of parents' involvement in educational planning and collaboration between parents, educators, and other relevant stakeholders involved in children's development. A cornerstone of the Act was the formulation of Individualized Education Plans (IEPs), which involve targeted accommodations and support strategies for students with different learning needs (Dombrowski, 2015).

In Ontario, several subsequent legislations further reinforced students' access to an education that appropriately meets their needs (e.g., Accessibility for Ontarians with Disabilities Act, 2005; Advancing Inclusion in Ontario Classrooms Act, 2008; Ontario Human Rights Code, 1990). Today, preferred educational practices in Canada also emphasize the inclusion of students with different learning needs into mainstream classrooms and utilizing Universal Design Learning (UDL) and Differentiated Instruction (DI) to limit barriers to learning (Friesen et al., 2023; Ontario Ministry of Education, 2017).

UDL and DI involve providing students of all abilities with choice and flexibility in their educational programs, emphasizing developing opportunities for students to utilize their learning strengths to demonstrate their learning. A key consideration of strengths-based inclusive practices like UDL and DI is that while they are essential for some students,

they benefit all (Ontario Ministry of Education, 2013). While IEPs involve more targeted interventions, such as specific accommodations and modifications, UDL and DI enable educators to develop more holistically supportive learning environments for students with LD and ADHD, reducing their need for targeted interventions.

Thus, effective inclusive education transcends mere integration by promoting an inclusive ethos in educational practices that appreciate and address every student's distinct needs and abilities. Psychoeducational reports can be an important tool for cultivating an inclusive environment, assuming they can provide parents and other stakeholders with a shared understanding of the child's strengths and needs, facilitating effective collaboration. Moreover, they might provide valuable insight to inform the development of UDL, DI, and IEP supports, which are essential to facilitating positive educational and developmental outcomes for children with LD and ADHD.

2.3 Importance of Educational Supports for LD and ADHD

Timely supports play a critical role in promoting successful developmental outcomes for children with LD and ADHD (Goldberg et al., 2003; Sorensen et al., 2003). The ramifications of LD and ADHD can extend beyond the classroom and across the lifespan, impacting various aspects of children's developmental trajectories, elevating their risk for experiencing negative scholastic, emotional, behavioural, and social outcomes (Fernández-Alcántara et al., 2017; Huntington & Bender, 1993; Wilson et al., 2007). A key reason why children experience negative psychosocial outcomes is that misinterpretation of a child's needs can result in parents, teachers, and peers forming negative perceptions of them (Fernández-Alcántara et al., 2017; Sorensen et al., 2003).

Accurate attributions for learning difficulties acknowledge that external forces beyond the child's control are impacting their ability to succeed. In contrast, misattributions rely on internal factors, such as laziness or lack of effort, to explain the child's behaviour. Over time, the child may internalize those negative perceptions, leading to feelings of shame or guilt and harming self-concept (Sorensen et al., 2003). This outcome can

contribute to a self-perpetuating cycle of disengagement and failure to meet expectations (Goldberg et al., 2003). In their review of 31 studies investigating how adolescents with LD compare to their peers without disabilities on indices of psychosocial adjustment, Huntington and Bender (1993) found abundant converging evidence associating LD with anxiety, depression, and significantly poorer self-concept. The review found that adolescents with LD who failed to meet expectations engaged in more internal attributions (e.g., self-blame) and fewer external attributions (e.g., the impact of forces beyond their control). In another study investigating psychosocial adjustment and psychiatric co-morbidity in a sample of 118 adults with ADHD, Sobanski and colleagues (2008) found that all three ADHD subtypes were significantly associated with undereducation, underemployment, depressive disorders, substance use disorders, and eating disorders, with the highest prevalence rates found amongst those in the combined subtype group. Similar patterns of results have been reported in other studies (e.g., Barkley, 2002; Biederman et al., 1993; Fayyad et al., 2007).

Self-concept, which influences a host of maladaptive outcomes, becomes more rigid with age (Goldberg et al., 2003; Huntington & Bender, 1993), underscoring the necessity of early intervention strategies that promote adaptive self-beliefs and behaviours for children with LD and ADHD. Promising evidence from longitudinal research has indicated that timely educational interventions can significantly reduce adverse outcomes, such as school dropout rates, unemployment, caregiver dependence, relationship instability, and psychiatric comorbidities (Goldberg et al., 2003; Sorensen et al., 2003; Wilson et al., 2007).

Educational services are especially crucial to promoting better adjustment outcomes, as the school context is an arena where many of the academic, social, emotional, and behavioural experiences impacted by LD and ADHD are most salient. Interestingly, although Sorensen and colleagues (2003) found that increased educational services were not directly related to improved academic achievement scores for children with LD across a two-year period, they were associated with improved self-concepts and social skills, fewer conduct issues, and more positive learning attitudes, which were independently related to better academic scores. The most substantial improvements in

psychosocial factors were observed for the youngest children in the sample who received early intervention and support. Notably, the teachers involved in the study reported setting more appropriate academic tasks that matched the students' abilities.

Other studies confirm that academic support and setting manageable and accurate expectations for students can promote adaptive coping strategies, self-esteem, and classroom engagement (e.g., Goldberg et al., 2003; Pekrun et al., 2011; Sorensen et al., 2003; Waber et al., 2017). Taken together, the previous literature strongly supports the necessity of providing appropriate educational supports early and without significant barriers. Psychoeducational assessments are assumed to help children, parents, and educators form more positive constructions for children's behaviour by identifying unique areas of strength and need, which are central to developing appropriate targeted interventions.

2.4 Psychoeducational Assessments

Psychoeducational assessments offer a comprehensive evaluation of an individual's cognitive, emotional, and behavioural functioning within an educational context (Dombrowski, 2015). These evaluations are crucial for identifying both strengths and areas requiring support. Utilizing standardized testing, observations, interviews, and an assortment of norm-referenced assessment tools, clinicians can benchmark a student's performance against age- or grade-specific standards (Dombrowski, 2015). Such a detailed approach facilitates a deep understanding of a child's cognitive capabilities, academic skills, executive functions, socio-emotional health, and other factors affecting educational outcomes. The culmination of these findings is encapsulated in a comprehensive psychoeducational report. Designed to be accessible for caregivers, educators, and other interested parties, this report acts as a guide for navigating the most effective strategies to support a child's learning trajectory while maximizing their strengths (Hass & Carriere, 2014).

Assessment encompasses more than merely collecting data; it requires the synthesis and analysis of information to construct insightful and meaningful descriptions that prioritize

the client's best interests (Dombrowski, 2015). A clinician's feedback conference and a comprehensive psychoeducational report summarize and disseminate these insights to families, providing recommendations to effectively support their children's educational endeavours. Such information serves as a pivotal resource for educators in developing educational plans. By presenting a clear and structured summary of the assessment findings, these reports aim to foster a collective understanding of the child's educational requirements. This understanding, in turn, enhances the communication among parents, teachers, school administrators, and other stakeholders involved in the child's developmental journey (Hass & Carriere, 2014).

Nevertheless, the efficacy of these reports in enabling school personnel to devise appropriate accommodations and interventions for students with LDs or ADHD remains ambiguous. A study with a U.S. sample of teachers revealed that 88% of the respondents disagreed that the reports contained relevant information for aiding children in the classroom, and 55% contested the usefulness of these documents in formulating interventions (Rahill, 2018).

On the contrary, research conducted by Friesen et al. (2023) with pre-service teachers in Canada indicated a majority found psychoeducational reports to be accessible and beneficial for their practice. However, the results might have been influenced by participants' shared educational background in psychology, which some participants identified as useful in helping them interpret the more technical sections of the report and effectively utilize those sections to develop IEPs and UDL lesson plans. Alternatively, pre-service teachers might have rated reports more favourably due to their relative inexperience with implementing clinician recommendations in classrooms. Indeed, in an earlier study, Hagborg and Aeillo-Coultier (1994) noted that more experienced teachers from their sample of U.S. elementary teachers rated reports as less relevant to their practice than less experienced respondents. Thus, the utility of these reports in reducing barriers to learning remains a topic of debate.

2.5 Barriers to Accessing Supports

In Ontario, children with identified exceptionalities are guaranteed access to an IEP. Although this means that children formally identified with LD are guaranteed support, those who are awaiting a diagnosis and IEP are not. While those children without formal identification may receive an IEP, this service is not guaranteed and can be removed at the school board's discretion. As a result, many school boards do not offer individualized education without formal identification (OHRC, 2022). Additionally, students with significant learning needs just below the diagnostic threshold may have access to fewer resources. Moreover, despite the legal requirements supporting their right to inclusive education in Ontario, even students formally identified as having an LD or ADHD frequently experience significant barriers to accessing necessary resources. This may be especially true for children with ADHD, who are not included in Ontario's definition of students with exceptionalities and are therefore not guaranteed access to an IEP (Ontario Ministry of Education, 2017).

In 2003, the Ontario Human Rights Commission (OHRC) conducted an extensive investigation into human rights complaints relating to the provision of those services for students with disabilities, including learning disabilities and ADHD. The OHRC documented their findings in a report entitled "The Opportunity to Succeed: Achieving Barrier-free Education for Students with Disabilities" (2003), which includes feedback from consultees (e.g., students, educators, parents) from across the province. The report identified key barriers to inclusive education for children with disabilities, including inadequate funding for services, time-consuming and cumbersome accommodation processes, negative attitudes and social stigma, and a lack of understanding amongst relevant parties about their rights and responsibilities under the Ontario Human Rights Code.

The OHRC report (2003) also summarized concerns about Individual Education Plans (IEPs) in elementary and secondary schools, noting delays, inaccuracies, and inconsistent implementation. Moreover, the Commission learned from consultees that resources were ineffectively utilized. For instance, the delivery of assistive technologies to schools often

went unused due to educators and students lacking training on how to use those technologies. Additionally, the report noted concerns from families that students with LD requiring moderate support faced longer wait times and limited access to resources; a lack of qualified professionals resulted in further delays in identifying learning disabilities. Of note, the report identified underperformance in Grade 9 Education Quality and Accountability Office (EQAO) and Grade 10 Literacy tests for students with LD and other disabilities affecting cognitive processing (e.g., ADHD). The report attributed lower test scores to inadequate educational supports in previous school years.

The recently released Right to Read report (2022) echoed similar findings, outlining challenges faced by parents in securing supports for their children with reading disabilities. The report noted similar concerns of delayed provision of accommodations, inconsistent implementation of IEPs, and the need for persistent advocacy and private evaluations. Both OHRC reports also highlighted students' and educators' experiences with barriers to accessing or providing support. Students frequently cited the need to self-advocate and dismissive attitudes from educators, while educators cited financial constraints, lack of resources, and inadequate training as impediments to providing adequate services.

In a previous study, Borghese and Cole (1994) noted similar concerns reported by a sample of twenty-five teachers, with only 61% of participants reporting the successful implementation of clinicians' suggestions in the classroom. The authors noted that the type of recommendation and how closely it aligned to the classroom environment significantly influenced teachers' success rates. For instance, teachers reported that vague, time-consuming recommendations or those requiring the management of students' behavioural concerns were particularly challenging to implement. Friesen and colleagues (2023) observed similar statements from some pre-service teachers who reported uncertainty on how to effectively integrate the information provided in the behavioural section of psychoeducational reports into their lesson plans. In another study, Barrett (2019) found that 74.5% of Canadian teachers successfully implemented clinician recommendations, but the author noted that potential self-selection biases and a small sample size of eight teachers may have potentially inflated those results.

In general, the OHRC's reports underscored the persistent barriers faced by students with LD and ADHD, with particular emphasis on delayed or insufficient provision of services. Notably, both reports underscored the impact of socioeconomic status and indigenous backgrounds on access to educational supports, indicating that some families experience disproportionately greater barriers and have fewer resources available to advocate on behalf of their children.

Psychoeducational assessments are not mandatory for accessing resources but can constitute a beneficial tool for supporting parental advocacy efforts to secure appropriate and timely educational supports for their children. Therefore, parents who can access private evaluations may have greater chances of successfully securing timely supports for their children. However, more evidence is required to support that assumption.

2.6 Barriers to Accessing Psychoeducational Assessments

Access to psychoeducational assessments may empower families to advocate for their children's educational needs within the school system. Yet, barriers such as protracted wait times, inconsistent referral criteria, school board policies, and the high cost of private evaluations often hinder widespread access to these crucial evaluations (Anthony et al., 2023; OHRC, 2003; 2022; Waber et al. 2017; Wakeman, 2022).

Extended wait periods for assessments have been noted as a key obstacle to obtaining timely support (OHRC 2003; 2022). This challenge is exacerbated in certain regions by a dearth of qualified professionals available to conduct these assessments, a situation attributed to insufficient resources and funding for the training and retention of such professionals (OHRC, 2003; 2022). Although the Ontario Ministry of Education provides schools with funds to support students with diverse learning needs, not all schools can afford to allocate these funds towards forming an in-house team of trained evaluators (OHRC, 2022). Consequently, several students are either left waiting years for an assessment or must pursue expensive private evaluations to meet their needs in a timely manner.

A second identified barrier is the lack of uniform referral criteria across school boards. The OHRC (2003; 2022) highlights that the discretion used by boards in the referral process could lead to bias, such as the more frequent overlooking of students who are struggling in silence or managing to meet curriculum expectations through exceptional effort. Additionally, the absence of centralized waitlists and a mechanism for tracking wait times leaves families uncertain about when they might access an assessment (OHRC, 2022). Furthermore, while referral for assessments of LDs and ADHD varies widely across schools, a consistent policy amongst most Ontario boards is delaying referrals for suspected reading disabilities until Grade 3. This delay means students may not be assessed until Grade 5 or 6. Concerningly, the OHRC (2022) notes that by this stage, children have missed the opportunity for more intensive instruction in areas of need (e.g., reading instruction). Private assessments, although an alternative to publicly funded services within school boards, are financially prohibitive for many families and are not covered by the Ontario Health Insurance Plan (OHIP). As a result, only families of higher socioeconomic status (SES) or those who allocate a substantial part of their family budget toward these assessments can pursue private evaluations (Dawson et al., 2013; Waber et al., 2017).

Cultural and linguistic barriers further complicate access for students and families from diverse backgrounds, with a notable lack of culturally sensitive assessment tools and professionals skilled in administering assessments in languages beyond English or French (OHRC, 2022). These obstacles to inclusivity further impede the timely and accurate assessment of students from marginalized communities or those with complex needs, compounding the intersectional barriers affecting these students' educational outcomes.

2.7 Need for Outcome Data

A psychoeducational report can be viewed as a catalyst for accessing necessary educational supports. Such reports are lauded for their multiple purported benefits, which include enhancing stakeholder collaboration, empowering advocacy efforts, and facilitating the creation of individualized education plans (Dombrowki, 2015; Hass & Carriere, 2014; Waber et al., 2017). Those who encounter systemic barriers or invest

significant resources in acquiring a report often harbour considerable expectations that it will catalyze significant improvements in their child's educational journey. Consequently, gathering and analyzing outcome data is imperative to ensuring that families achieve the anticipated benefits.

Presently, the literature on this subject is scant, with few studies examining the implementation of report recommendations and the resultant functional outcomes. Fisher and colleagues (2022) highlighted a notable gap in the research, pointing out that most studies focus on proximal outcomes of assessments, such as client satisfaction, rather than distal impacts, such as impact on children's functional development. Although the literature indicates client satisfaction with the insights gained from assessments (Allott et al., 2011; Bodin et al., 2007; Smith et al., 2007; Temple et al., 2006; Waber et al., 2017; Watt & Crowe, 2018), this does not necessarily correlate with satisfaction regarding the impact of evaluation recommendations on children's outcomes (Bodin et al., 2007).

Moreover, the limited studies that have explored the long-term functional outcomes for children post-assessment reported mixed findings. In one study exploring 117 parents' satisfaction with both proximal and distal outcomes following their children's neuropsychological evaluations, Bodin and colleagues (2007) found that 45% of parents endorsed that they were either unsure or did not believe that the evaluation facilitated overall improvements to their child's life. Additionally, this study uncovered disparities between parental satisfaction with the assessment process and their contentment with the resultant impacts. Although 82% of participants rated the evaluation service favourably, only 57% of parents reported that the evaluation resulted in improved educational services for their children. One reason for this discrepancy may be that families often face obstacles to implementing clinician recommendations (Wakeman, 2022), underlining the need for further investigation into family satisfaction with the implementation of these recommendations.

In contrast, Waber et al. (2017) noted that the majority of parents whose children received increased educational services following neuropsychological assessments endorsed the evaluations' utility as a tool for supporting their children's development.

Nevertheless, parents who struggled to secure adequate support reported that the assessments were less beneficial, underscoring the necessity of accessing meaningful support post-assessment.

Although parents in previous studies have reported increased school services post-assessment (Farmer & Brazeal, 1998; Waber et al., 2017), Wakeman (2022) discovered that 80% of parents encountered at least one barrier to implementing clinician recommendations. Parent-reported barriers included difficulties in navigating the school system and advocating effectively for their child. Additionally, teachers have previously cited challenges in integrating clinical recommendations into their lesson planning and classroom practices as a key barrier to implementation (Borghese & Cole, 1994; OHRC, 2022).

It is important to note that despite mixed results for other variables amongst previous findings, there remains a strong consensus within the literature that families from lower socioeconomic backgrounds face more significant hurdles in obtaining educational support after a formal evaluation (Elias et al., 2020; OHRC, 2022; Waber et al., 2017; Wakeman, 2022). In summary, further research is essential to determine the role psychoeducational reports play in overcoming barriers to educational support and effecting meaningful changes for children with LDs and ADHD.

3 The Present Study

Prior research suggests that children with LD and ADHD who receive appropriate and timely educational supports tend to exhibit higher self-concepts, improved career prospects, enhanced relationship stability, better income status, and increased ability to function autonomously, ultimately leading to an improved quality of life (Goldberg et al., 2003; Hamre & Pianta, 2001; Sorensen et al., 2003; Wilson et al., 2007). Considering the breadth of positive outcomes that are associated with accessing appropriate support, upholding these children's legislated rights to an inclusive education is essential. Psychoeducational reports may play a meaningful role in supporting children's access to equitable educational opportunities by providing key insights into the strengths and areas

of need for children with LD and ADHD. However, the literature is scarce on outcome data to substantiate the belief that psychoeducational reports translate into the successful implementation of clinician recommendations, acquisition of necessary and appropriate educational resources, and functional impacts.

Accordingly, this study aims to investigate caregiver perceptions regarding the impact of psychoeducational reports on accessing educational support and fostering meaningful changes in their child's emotional, social, behavioural, and academic growth. To facilitate the primary research objective outlined above, this study will trace the trajectory of the psychoeducational report, including whom the report was shared with and caregiver perceptions of what role the document served in supporting their children's outcomes.

Next, the study will identify whether changes were made to children's IEP status following their psychoeducational assessment, as well as explore the nature of the accommodations and modifications provided to students before and after their psychoeducational assessments to identify whether students experienced meaningful changes in educational support. Subsequently, potential barriers to implementing report insights will be explored. Additionally, key parent concerns relating to their children's academic, developmental, behavioural, social, and emotional functioning will be identified. Finally, this study will investigate parent perceptions relating to the utility of the report in addressing those key concerns, as well as how useful the report was for accessing appropriate educational services for their children.

4 Method

4.1 Participants

Twenty parents or caregivers of children aged 5-17 participated in this study. Their child were previously assessed for learning or attention difficulties at a university-based teaching clinic in Southwestern Ontario, and had received a psychoeducational assessment and report. Most respondents were the child's mother or stepmother (n = 17), with the remaining being the child's father or stepfather (n = 3). As a proxy for

socioeconomic status, data were collected for participants' highest level of education. 5% of participants reported earning a secondary school diploma, 50% earned a university or college degree, 35% earned a master's degree, and 10% held doctoral degrees.

The current mean age of the respondents' children was 12.45 (*SD* = 2.19, range: 8-17). When respondents initially suspected their child had challenges related to learning, the children's mean age was 5.2 (*SD* = 2.75, range: 1-11). The mean age at the time of assessment was 9.55 (*SD* = 2.19, range: 6-14). Nine respondents' children identified as male, and 11 identified as female. Seventeen participants referred their child for a psychoeducational assessment. Physicians made referrals for two children, and one was referred by an educator. Following their psychoeducational assessment, eighteen children received a diagnosis, and two did not.

Amongst the children who received a diagnosis, sixteen (89%) were diagnosed with an LD and ten (55%) were diagnosed with ADHD. Nine children (50%) received co-occurring diagnoses for both LD and ADHD. Three of those nine children each received one additional co-morbid diagnosis (obsessive-compulsive disorder) or identification eligible for educational recognition in the schools (giftedness and mild intellectual disability). One child received co-morbid diagnoses for LD and autism. Five children received a diagnosis of LD only, and one child received a provisional diagnosis of ADHD only. One respondent's child received a diagnosis of global developmental delay but was not diagnosed with LD or ADHD.

4.2 Measures

4.2.1 Impact of Psychoeducational Reports Questionnaire

The questionnaire comprised a series of quantitative and qualitative questions. The quantitative component examined changes in caregiver perceptions of educational support levels before and after their child's assessment. Additionally, data were collected on parents' pre-assessment and current ratings of the relevancy of their concerns for their children's future and academic, emotional, social, behavioural, and self-autonomous functioning. The qualitative data were collected through open-ended questions, allowing

participants to share their experiences and perspectives. The qualitative component investigated the barriers to participants' ability to secure educational supports for their children, the types of support provided, and factors that impacted satisfaction with their children's outcomes. All study questions were developed in response to gaps in outcome data identified by the extant literature.

Table 1 provides an overview of the questionnaire's format and content. To review the full questionnaire, see Appendix C.

Table 1

Overview of Study Questionnaire

Section #	**Section title**	**Format**	**Content**	**Total # of Questions**
1	Introductory Questions	Multiple choice; open-ended	Demographics; child diagnosis; referral source	12
2	Educational Experiences	Multiple choice; open-ended	IEP; accommodations; modifications	16*
3	Utilizing Psychoeducational Report	Multiple choice; open-ended	Challenges accessing supports; report stakeholders	5*
4	Concerns	Sliding scale; open-ended	Parental concerns related to child's functioning	6

**Note: Due to the usage of decision trees for question prompts in this section, the actual number of questions that participants*

4.3 Procedure

The recruitment period was held in June 2023. 130 eligible families were identified through the clinic's research database. This database comprised former clients' caregivers who consented to be contacted for research studies. An administrative assistant at the clinic distributed a recruitment email to eligible participants, inviting them to participate in the study. The email included a brief study description in lay terms, participation instructions, an attached Letter of Information and Consent (see Appendix B), and a link to the study survey.

All participation was electronic with no in-person participation required. Participants were informed that they could access the survey link in the recruitment email on a convenient day or time to participate. The link re-directed participants to the University's Qualtrics platform to complete the study. The estimated time for completing the survey was approximately 30 minutes. Participation was voluntary, and participants could withdraw from the study or refuse to answer individual questions at any time. At the end of the study, participants were provided the option to withdraw their data from the study. After completing the study, participants were provided debriefing information through the Qualtrics platform. Participants who completed the study were compensated with a $20 gift card.

4.4 Analysis

Descriptive (e.g., means, frequency counts) and inferential (e.g., t-tests) statistics were employed for force choice items (e.g., scales). The analysis of open-ended responses began with a data-driven, inductive approach that allowed themes to emerge from the frequency and content of similar responses rather than imposing preconceived categories (Terry et al., 2021). The first phase of this process involved familiarizing myself with data, which involved the careful reading and rereading of responses to identify recurring semantic expressions and patterns related to each other in terms of their explicit meaning and context (Braun & Clarke, 2006; Terry et al., 2021). The next phase involved latent

analysis of participant responses to identify the implicit shared meanings between responses from which themes emerged (Braun & Clarke, 2006; Terry et al., 2021).

Data were then manually sorted into emergent thematic categories for report stakeholders, types of reported accommodations and modifications, and types of reported challenges parents experienced securing support for their children. These categories were used to understand the most pressing concerns and prevalent needs of children and families, as expressed by the participants. Narratives were additionally utilized to enrich the quantitative findings, providing a more nuanced understanding of the data. This comprehensive methodological approach allowed for a robust analysis, integrating both the richness of qualitative data and the clarity and precision of quantitative findings (Cresswell, 2009; Vasileiou et al., 2018).

5 Results

5.1 Report Stakeholders

Of the survey's 20 respondents, 19 parents reported sharing their child's report with other stakeholders, and one did not share the report. Five groups of stakeholders emerged from participants' responses. The most frequently mentioned group was school staff (e.g., administrators, teachers, learning support or special education teachers; $n = 17$), followed by medical professionals (e.g., family doctors, physicians, pediatricians; $n = 8$), community partners (e.g., agencies supporting children's speech and language development, developmental services, learning disabilities supports); $n = 6$), specialized support workers (e.g., speech and language pathologists, occupational therapists, ADHD specialists; $n = 4$), and mental health support workers (e.g., psychologists, psychotherapists, social workers; $n = 3$). Parents reported sharing their child's report with an average of 2.00 stakeholder groups ($SD = 1.11$).

5.2 Individualized Education Plan (IEP)

Table 2 reports frequency counts for the number of children who had an IEP both before and after assessment. Note that before the assessment, most children did not have an IEP.

However, following the assessment, an additional 13 students were being supported with an IEP. Additionally, four parents reported that their child's IEP was updated to include further information and supports following the assessment. The participant who reported that their child did not currently have an IEP indicated that the IEP was in development following their child's recent assessment.

Table 2

Comparison of IEP Frequency Counts Before vs. After Assessment

	No IEP	IEP in place
Before Assessment	14	6
After Assessment	1	19

5.3 Accommodations

Most participants in the study (*n* = 18), confirmed that their children were currently receiving accommodations in school. When asked if their child was receiving these accommodations prior to their psychoeducational assessment, 50% of these parents (*n* = 9) reported that their child's accommodations were only initiated following the assessment. A further 30% (*n* = 6) of the parents reported that while their child received some universal accommodations before the assessment, they did not receive a full range of accommodations until after the evaluation (e.g., covering instructional, environmental and/or assessment accommodations). The remaining 20% (*n* = 3) said that their child had already been receiving all the current accommodations before undergoing the psychoeducational assessment.

Additionally, 17 of these parents provided responses for which types of accommodations their child was currently receiving. All respondents, except one, indicated that their child received all three categories of accommodations (i.e., Instructional, Environmental and

Assessment). The remaining parent indicated that their child was receiving environmental accommodations only. In their open-ended responses, participants elaborated on the key accommodations included in their child's IEP. Responses containing similar wording (e.g., more time, additional time) were combined to identify the most frequently reported key accommodations. Participant responses are reported below in Table 3.

Table 3

Frequency Counts for Commonly Reported Key Accommodations

Instructional	*n*	Environmental	*n*	Assessment	*n*
additional time	14	quiet work space	13	assistive technology	12
scribe support	5	preferential seating	9	additional time	8
reduced workload or altered expectations	5	assistive technology and tools	3	assistance with instructions	5
assistive technology	5	more frequent breaks	2	simplified assessments	3
support with instructions	2	separate room for assessments	2	quiet space to complete assessments	2
teacher support	2	slow start to the day	1	scribe support	2

Some accommodations (e.g., scribe support) were noted in participant responses for more than one accommodation type (e.g., instructional and assessment). A tally of similarly worded responses across the three accommodation types revealed that the most

frequently reported accommodation was additional time (*n* = 22), followed by assistive technology (*n* = 20) and a quiet or separate workspace (*n* = 17).

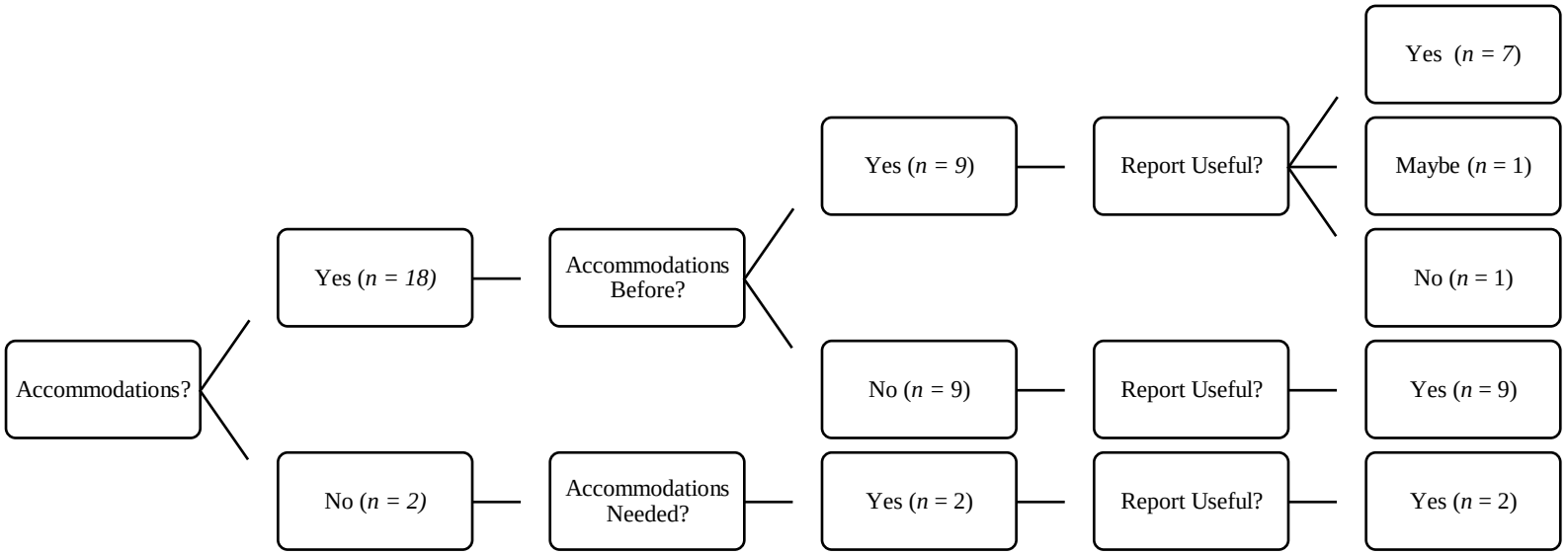
Finally, two participants reported that their children were not currently receiving any accommodations. One of these parents verified that their child had an IEP, whereas the other reported that their child was not receiving support via an IEP. Of note, when queried on whether their child required accommodations, both parents selected the response *definitely yes*, indicating a discrepancy between desired and achieved level of access to accommodation support.

5.4 Report Usefulness for Accommodations

Participants reported how useful their child's psychoeducational report was for securing accommodations. Overall, parents rated the usefulness of their child's report favourably, with most participants (*n* = 15) selecting the response that their child's psychoeducational report *definitely was useful – it would be very challenging to secure the necessary accommodations without a formal report.* Of note, all participants who reported that their child is now receiving accommodations that were not previously provided also endorsed the statement that their child's report was definitely useful for securing accommodations. A further three parents indicated that the report probably was useful for securing accommodations. Figure 1 illustrates variations in how useful participants considered their child's report to be for securing accommodations relative to their responses regarding whether their child was previously receiving accommodations.

Figure 1

Comparison of Participant Perceptions of Psychoeducational Report Usefulness for Securing Accommodations Relative to Status of Accommodations Access



Interestingly, the two participants whose children are not currently receiving accommodations nonetheless reported perceiving their child's report as useful. Notably, only one participant endorsed that their child's report was not useful for securing accommodations.

5.5 Modifications

Compared to accommodations, fewer parents reported that their child was currently receiving academic modifications (i.e., changes are made to age-appropriate grade level expectations for a subject to meet the needs of the student) (n = 7). Four of these parents reported that their children's curricula had been adjusted to reflect a lower grade level. Two parents reported modified expectations for their children, who were receiving additional time to complete a reduced volume of work, and one parent reported that their child was placed in a different class for developmental learning. Over half of these parents (n = 4) reported that their child began receiving modifications only after their child completed the psychoeducational assessment, while two parents said that their child was already receiving their current modifications before the assessment. The remaining parent reported that their child was receiving some, but not all, of their current modifications before assessment. This parent elaborated that their child's previous modifications included assessment at lower grade expectations. Following their child's psychoeducational assessment, those modifications were updated to assess the child at grade level.

The other thirteen participants reported that their children were not currently receiving curriculum modifications. These parents provided varied responses to whether they believed their child required modifications to coursework at school. While six parents responded that their child definitely does not require modifications, two parents endorsed the statement that their child definitely requires modifications, and another two parents said their child probably requires modifications. An additional three parents selected the response *might or might not* to indicate their uncertainty regarding whether their child

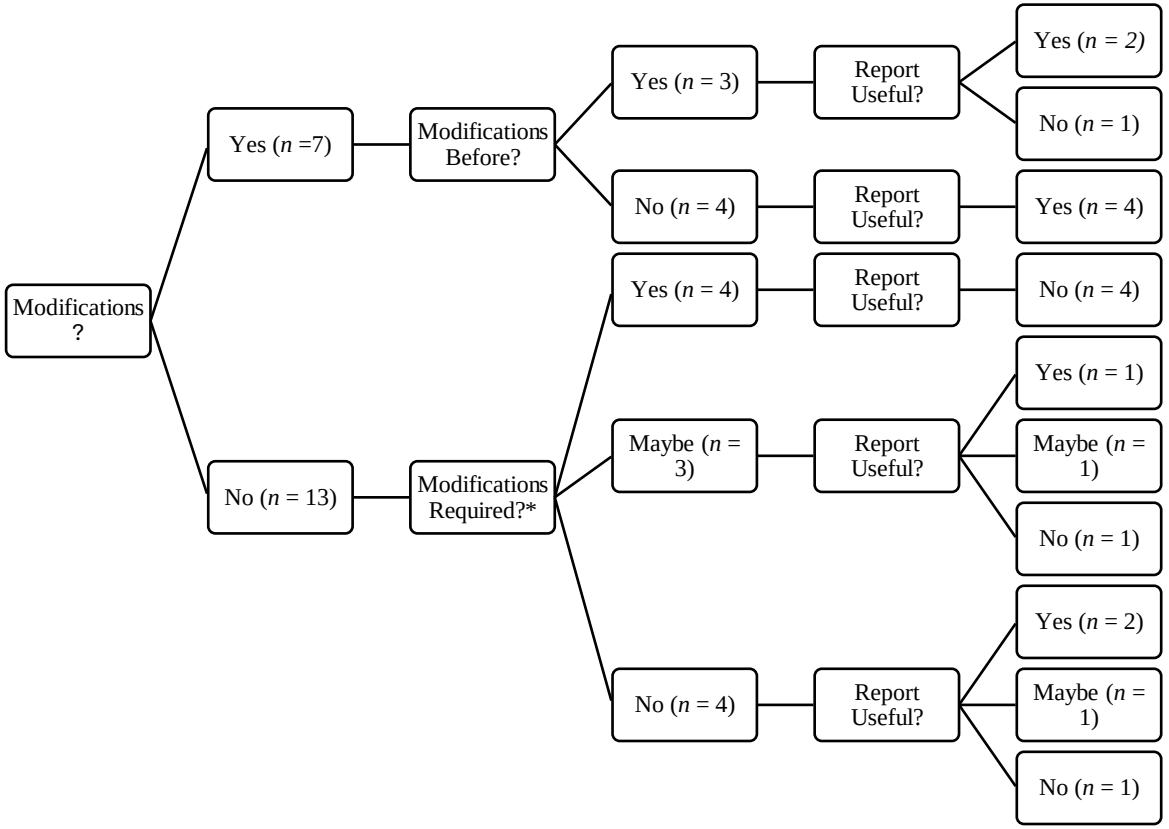
requires modifications. Thus, there appears to be a gap between some parents' desired and achieved levels of modifications provided to their children.

5.6 Report Usefulness for Modifications

Compared to how many parents rated their child's report as useful for securing accommodations, fewer parents rated their child's report as useful for securing modifications. As a group, participants whose children were currently receiving modifications (n = 7) provided more favourable ratings for the report's usefulness, with most selecting the response that their child's psychoeducational report *definitely was useful* for securing modifications (n = 5). In contrast, the participants whose children were not receiving modifications (n = 13) rated their child's report less favourably as a group, with four participants endorsing the statement that their child's report *definitely was not useful* for securing modifications (n = 4) and one parent reporting that their child's report *probably was not useful*. Figure 2 further illustrates variations in participant responses regarding their child's access to or need for modifications and how useful their child's psychoeducational report was with respect to securing modifications for their child.

Figure 2

Comparison of Participant Perceptions of Psychoeducational Report Usefulness for Securing Modifications Relative to Status of Modifications Access



**Note: two participants did not provide answers for whether their children required modifications*

Notably, all parents whose children were currently receiving modifications not previously provided also endorsed the statement that their child's report was useful for securing those modifications. Conversely, all parents who reported their child requires modifications that are not currently being provided also indicated that their child's report was not useful in regard to securing modifications.

5.7 Challenges in Securing Supports

Parents were asked whether they experienced challenges related to securing necessary supports for their children before and after their child's psychoeducational assessment. Table 4 reports participants' responses.

Table 4

Frequency Counts Comparison for Reported Challenges Experienced Before and After Assessment

		After Assessment		
		Yes	No	**Total**
Before Assessment	Yes	7	4	**11**
	No	2	7	**9**
	Total	**9**	**11**	

Overall, the number of participants who reported experiencing challenges before (n = 11) and after (n = 9) the assessment was about the same, with close to half of participants experiencing challenges securing supports for their children. One participant whose challenges were resolved following receiving their child's report shared their experience securing support for their child before the assessment:

Teachers saying they were not able to help without documentation, school ignoring concerns, child getting brushed to the side or forgotten – P9

For this parent, obtaining their child's assessment report may have been the key for unlocking necessary support and advocating for their child within the school system. In contrast, some parents' challenges were not resolved despite procuring a private assessment for their child. Quotes from two participants illustrate some of the challenges these parents encountered before seeking their child's assessment:

She requires use of technology for writing and spelling support, access to audiobooks, text-to-speech. It has been impossible to establish these accommodations without a formal report. No remedial support is offered for spelling and writing gaps even with the report. Needed report to access interventions such as Lexia/Power-Up. We just received the report in […]2023, IEP is in development but I've been advised will not formally be in place until the next school year even with the report. – P7

The school did not pursue further assessment despite evidence that my child had special needs. There was no curiosity as to why she had large gaps on her academic assessment or why she was struggling – P17

These same parents reported experiencing sustained challenges relating to advocating for their child and accessing adequate and timely supports even after receiving and sharing the results of their child's psychoeducational report with educators:

Zero remedial support for areas of need - really only offered tech to accommodate and that will not be provided until the next school year due to ordering delays. – P7

The school often does not provide accommodations listed in IEP; no reading intervention has been offered other than Lexia which the school does not support my child in doing. I have had to advocate endlessly for supports and I get nowhere. The school does little to nothing to support the academic achievements of my daughter. It is a constant fight and I never get anywhere. – P17

Interestingly, two parents reported that the challenges they experienced in securing supports for their children initiated after their child's assessment. For instance, one parent shared:

> *Challenges related to going to high school from […] school with better 1:1 contact. Continued challenges related to […] support with learning challenges related to reading and writing, gifted in […], adhd means this all manifests as either boredom or moving too fast* – P11

Thus, it appears that while the psychoeducational report was useful for addressing some parents' challenges, several parents nonetheless continued experiencing difficulties procuring adequate support for their children even after sharing the document with relevant school staff.

Altogether, thirteen parents provided responses to open-ended questions inquiring about specific challenges they experienced before and after receiving their child's report. Eight key types of challenges were identified in participant responses. Parents who responded to this question, reported on average experiencing 2.8 types of key challenges (*SD* = 1.24). Table 5 outlines the eight key challenges parents reported with example participant quotes to illustrate parents' experiences.

Table 5

Key Identified Challenges in Securing Supports

Challenge	*n*	Example
Lack of support	8	*Support below what was needed for success*
Documentation required	4	*No school support until I sought assessment*
Inappropriate expectations of child	2	*Lack of appropriate expectations*
Assistive-tech only support	3	*Really only offered tech to accommodate*
Lack of 1:1 support	2	*No person-to-person […] support*
Inconsistent administration of support	2	*Inconsistency with administration of IEP*
Delays	3	*She would not be assessed by school psychologist for 2-3 yr wait*
Advocacy-related challenges	4	*School did not pursue further assessment despite evidence that my child had special needs*

5.8 Parent Concerns

Table 6 reports means and standard deviations for parental concerns scores before and after assessment. Parents rated the relevancy of each concern statement (e.g., I worry about my child's social development) on a scale of 0-10, with 10 indicating the highest level of concern.

Table 6

Comparison of Parental Concern Scores Before Assessment vs. Current Beliefs

Concern	*N*	Before Assessment	Current Beliefs
		M (SD)	*M* (SD)
Future	19	8.11 (2.16)	6.74 (2.62)
Academic success	19	8.11 (2.45)	6.68 (2.91)
Autonomous development	18	7.11 (3.12)	5.72 (3.10)
Behavioural functioning	14	3.42 (3.48)	3.14 (2.93)
Social development	15	5.67 (4.01)	5.73 (3.89)
Emotional development	18	6.89 (3.51)	5.56 (3.81)

Numerically speaking, parents' highest-rated concerns related to worries about their child's future and academic success, while behavioural functioning was the lowest-rated concern. To determine if any of these observed mean differences were statistically significant, a series of paired samples t-tests were performed. Parent's current level of concern for their children decreased significantly relative to before the assessment in the following areas: concerns about their child's future *[t(18) = 2.858, p = .010]*, academic success *[t(18) = 2.545, p = 0.020],* and autonomous development *[t(17) = 3.651, p = 0.002]*. The difference in mean scores for parent concerns about their child's emotional development was just beyond the threshold for significance with a 2-tailed test *[t(17) = 2.015, p = 0.06]*. No significant mean differences were observed for prior and current parent concerns about their child's behavioural functioning or social development.

6 Discussion

The purpose of the current study was to investigate whether caregivers perceived psychoeducational reports as useful for facilitating meaningful changes to their children's education and development. On average, parents reported that obtaining their children's psychoeducational reports resulted in greater access to educational services at school. Parents reported on the nature of their children's IEPs, accommodations, modifications, and challenges encountered in accessing educational services. Additionally, parents opined on whether their children's reports were useful in addressing key concerns relating to their children's functioning. The ensuing discussion contextualizes the interpretation of these findings within the literature, as well as potential implications for educators and clinicians, study limitations, and future directions for research.

6.1 Children's Assessment History

Two key findings of this study related to children's history of difficulties and eventual diagnoses that were received. First, several years elapsed on average between the time of initial concern and the time of assessment. Second, there was a high co-occurrence rate between LD and ADHD in this sample. This section overviews the implications of those findings for children's development.

6.1.1 Age of Children

Children in this study were, on average, around 5 years old when parents first suspected the presence of an LD or ADHD. This finding was consistent with the literature, which has noted that children's learning requirements are typically observed in early primary school (Denton et al., 2022; Kelley, 2022; Miech, 2020; Silverstein, 2015). At the time of the psychoeducational assessment, the children in this sample were, on average, 9.55 years old, with ages ranging from 6 to 14 years. Consistent with the findings of Anthony and colleagues (2023), most parents in this study identified themselves as the referral source for their children's assessments. The interval between the time of initial concern and psychoeducational assessment averaged 4.35 years. This delay may reflect prolonged

wait times, as documented in the literature (OHRC, 2002; 2022). Several study participants noted prolonged waiting periods as a barrier to accessing educational support for their children.

Furthermore, there may have been hesitations in recommending assessments until later educational stages for certain students. For instance, the OHRC (2022) noted a persistent misbelief amongst stakeholders that children should be at least in Grade 3 before being assessed for reading disabilities. Of note, children in this study were, on average, enrolled in grades 4 to 5 at the time of assessment. Moreover, several parents reported their children had reading-based disabilities. However, the duration of wait times and the nature or severity of suspected disabilities were not specifically measured in this study. Therefore, the current results cannot speak to how those factors impacted access to support.

Nonetheless, several participants in this study reported waiting periods as a barrier, which likely factored into these parents' decisions to seek private assessments. Some participants noted that the COVID-19 pandemic further exacerbated wait times for both school-based and private evaluations. Concerningly, the time elapsed between the initial concern and assessment could have had an impact on sequential learning. The findings of this study support the conclusion that greater effort must be devoted to prompt service delivery to ensure children are not missing opportunities for more intensive instruction in areas of need.

6.1.2 Co-occurrence of LD and ADHD

Following assessment, most children in the sample received more than one diagnosis, which is consistent with the literature (DuPaul & Stoner, 2003; Joyner & Wagner, 2020; Moll et al., 2020). The most striking co-occurrence was between LD and ADHD, with nine children identified as having both diagnoses. This finding corroborated DuPaul and Stoner's (2013) observation of a marked association between LD and ADHD in the extant literature. It is important to note that children with co-occurring LD and ADHD experience more substantial barriers to learning (Wakeman, 2022). This issue raises questions about how educational service delivery can be improved to support children

with multifaceted learning needs. Recent research by Friesen and colleagues (2023) found that pre-service teachers prioritized the use of a strengths and challenges summary in psychoeducational reports for their lesson planning over the provision of specific diagnoses. This focus on individual learning needs rather than diagnostic labels indicates the usefulness of a child-centred approach for supporting children with complex needs.

While the limited sample size impacts the generalizability of current results, the finding that 90% of children with ADHD had LD is worth highlighting. This finding points to the necessity for ongoing research that looks to refine and advance service accessibility in educational settings for children with complex learning needs.

6.2 Impact of Psychoeducational Reports on Access to Educational Services

The results of this study underscore the relevancy of psychoeducational reports in educational contexts. Schools emerged as the most widespread consumer of children's reports, with all but one participant reporting that they shared their child's report with educators. This finding highlights the importance of report recommendations leading to actionable results within the school context.

In discussing key educational services findings, it is important to consider the potential impact of the COVID-19 pandemic on parent perceptions. The current mean age for children in this sample was three years older than the mean age at the time of assessment. This suggests children were, on average, assessed three years before the study. Accordingly, is possible that some children's educational services were updated shortly prior to or during the pandemic. Frequent interruptions to learning schedules, administrative delays, distance learning, and the pandemic's emotional toll on educators could have impacted service delivery (Whitley, 2021). Although this study did not investigate the specific impact of COVID-19 on children's experiences, it is important to keep it in mind when discussing parents' perceptions of children's IEPs, accommodations, and modifications.

6.2.1 Individualized Education Plans

A key finding of the current research was the role of psychoeducational assessments for IEP development. All parents reported that following the assessment, their children either received new or updated IEPs (*n* = 19) or had one in development (*n* = 1). For those parents who reported their children's school required a psychoeducational report for IEP access, the report proved to be a critical tool for unlocking support. Notably, psychoeducational reports helped facilitate the development of an IEP even for two children not formally identified with a disability or diagnosis. This suggested that, regarding IEP access, the thorough documentation of children's strengths and needs was useful in lieu of formal identification.

Not all children required documentation to access support—about a third of children in this sample (*n* = 6) had pre-existing IEPs. This finding points to potential variations among schools in their policies on IEP provision for students awaiting assessment. Nevertheless, most of these students' plans were updated with additional support post-assessment, indicating the utility of psychoeducational reports in enhancing educational support. The generalizability of these findings might be impacted by the focus on one metropolitan area, with many children likely attending the same school board(s). Still, the patterns align with previous results from Waber and colleagues (2017) and Wakeman (2022), which also noted increases in educational services post-assessment.

Despite the widespread increase in access to educational services, some parents expressed dissatisfaction with IEP accommodations or modifications. These parents reported a perceived mismatch between the services provided and the children's actual needs. It is plausible that the COVID-19 pandemic exacerbated some parents' perceptions of services provided. Children in this sample were, on average, three years older than the mean age at the time of assessment. This finding raises the possibility that several children in this study had their educational services updated shortly before or during the pandemic. A deeper examination of the specific accommodations and modifications reported can help elucidate these concerns.

6.2.2 Accommodations

Most parents reported their children's IEPs included accommodations, with additional time, assistive technology, and separate or quiet workspaces being the most commonly listed accommodations. These results mirror D'Intino's (2017) previous identification of the top three accommodations across Canada. This trend suggests that accommodations requiring lesser differentiation to classrooms or direct teacher involvement are favoured, possibly due to their ease of implementation and low resource demand. Notably, the least commonly reported accommodation was one-on-one teacher time, which is plausibly one of the most resource-intensive supports available.

There is a caveat, however, regarding the use of assistive technology. Despite its hands-off nature post-training, the initial instructional phase for students necessitates greater educator involvement. The Ontario Human Rights Commission (OHRC, 2022) reported some schools did not utilize provided assistive technologies due to a lack of educator training. This study supports the OHRC's findings, with some reports of equipment provided without appropriate training for students. When students are not adequately supported in using these tools, the effectiveness of these tools is compromised. The widespread reliance on assistive technology as an accommodation underscores the critical need for adequate training to effectively support students.

It is also possible that clinicians recommend these accommodations more frequently. The generalizable nature of these accommodations might target a broader range of learning requirements. Moreover, Ontario's educational policies explicitly permit such accommodations and offer clear guidelines on the acceptable use of these supports (D'Intino, 2017). The literature supports educators' preference for accommodations with clearly delineated parameters (Mastoras et al., 2011; Pelco et al., 2009). However, it is important to note that the effectiveness of these common accommodations remains uncertain. Despite their prevalence, there is a lack of empirical support for their impact on student progress (D'Intino, 2017).

Some parents expressed concerns about the perceived adequacy of supports, opining that the accommodations fell short of what was perceived for their children's success. These

concerns underscore the necessity for ongoing research to evaluate the effectiveness of common accommodations to ensure students are receiving evidence-based support. It is worth noting, however, that these parents' definitions of success were unspecified. It is difficult to ascertain whether the provided accommodations could reasonably address parents' concerns without a clear understanding of how these parents define success.

Another consideration is that parents, educators, and children may vary in how they define success or perceive student progress. For instance, Sorensen and colleagues (2003) found that children reported increased self-concept after two years of receiving LD interventions, a marker of internal progress that was unobserved by their parents. Nevertheless, it is important to ensure parents' concerns are heard, as achieving successful outcomes for their children is the central goal for seeking psychoeducational assessments. Despite these concerns, the overwhelming consensus amongst parents was that the report was valuable for accessing accommodations. Most parents indicated their child's report was "definitely useful" and none of the parents endorsed the statement that the report was not useful for securing accommodations. Taken together, these findings support the conclusion that psychoeducational reports fulfill parents' goals for accessing accommodations.

6.2.3 Modifications

Several parents found their child's psychoeducational report unhelpful for securing modifications, which contrasted with their beliefs about accommodations. This difference may be attributed to Ontario's educational policies, which recommend modifications only as a last resort. This policy is intended to protect student outcomes, as "modifications to grade-level expectations from a lower grade are a form of streaming: they place students below the standard grade level of their peers and can interfere with students' access to future learning at the same level as their peers" (OHRC, 2022, p.317). Children with LD and ADHD possess at least average cognitive abilities (LDAC, 2017), which supports the premise that appropriate supports can help these students engage with grade-level curriculum. Accommodations leverage children's strengths and address their needs

without altering curriculum expectations, aligning with the goal of helping students reach their potential.

Modifications are only considered when accommodations have not sufficiently supported the child's learning requirements after a certain period (Ontario Ministry of Education, 2014). The nature of this approach may have contributed to dissatisfaction among parents if they expected reports would result in prompt access to modifications. Moreover, these parents may not have been fully aware of the potential ramifications of modifications on their child's educational trajectory. Other parents might have simply rated reports as less useful because modifications were not an intended goal for seeking assessment. Of note, the study found that parents whose children did receive modifications after the assessment found the reports exceptionally useful, underscoring psychoeducational evaluations as vital for securing these more intensive supports. This finding points to a potential reluctance among educators to initiate modifications without substantial clinical or assessment evidence demonstrating the necessity for such measures.

In sum, while psychoeducational reports are valuable tools in accessing educational services, parents might encounter more obstacles in obtaining modifications than accommodations. These findings suggest a need for clearer communication between clinicians, schools, and parents to better align expectations and support student progress.

6.2.4 Challenges in Accessing Supports

The study found that as a group, the proportion of parents experiencing barriers to accessing educational services did not meaningfully change after assessment. Both before and after the assessment, approximately half of the sample reported facing challenges. Overall, 70% of parents encountered difficulties at one or both time points, echoing Wakeman's (2022) finding that 80% of parents reported barriers at some stage in their efforts to secure services.

On an individual level, some parents reported that their challenges were resolved post-assessment. These parents' challenges were primarily related to advocacy efforts and the requisites of some schools for formal reports to access specific or specialized services.

This finding corroborated previous parent reports to the OHRC (2002; 2022) that some children required assessments to access formal supports. For these parents, the psychoeducational report proved central to resolving their concerns. Conversely, other parents only began facing obstacles after the assessment. This group of participants were predominantly concerned with whether provided supports were sufficient for facilitating successful outcomes for their children.

In summary, while psychoeducational reports were critical for resolving some families' challenges, other parents encountered new or ongoing challenges. High hopes of reports guaranteeing seamless access to desired supports may result in disappointment for some families. Nevertheless, while some parents may experience ongoing challenges relating to support access, psychoeducational reports may still prove valuable in addressing other concerns they have for their children's overall functioning.

6.3 Concerns

The most relevant concerns for parents included worries about their children's academic success and future. This finding aligns with existing literature indicating these are central concerns among parents of children with LD and ADHD regarding their children's educational outcomes and future opportunities (e.g., Fernandez-Alcantara et al., 2017). A positive result of this study was the significant decrease in parents' concerns regarding their children's academic success, future, autonomous development, and emotional development following a psychological assessment. This shift suggests a newfound optimism among parents, indicating the beneficial impact of psychoeducational assessments in addressing some of their chief worries. Moreover, if parent concern levels can serve as a proxy for child functioning, these findings might suggest the possibility of assessments facilitating meaningful changes in children's development.

Various interpretations may explain the reduction in parental concerns across these four domains. Prior research supports the view that elements of the assessment process, such as feedback conferences with clinicians and the insights provided in diagnostic reports, can assuage concerns related to children's independence, educational aspirations, and

future opportunities (Fernandez-Alcantara et al., 2017; Levi, 2017; Porter et al., 2020). Pre-assessment, parents of children with LD and ADHD often grapple with negative emotions like shame, guilt, and doubts about their parenting efficacy. Some parents might unintentionally project those negative emotions onto their children, impacting relationship closeness and lowering self-concepts for both parent and child (Fernandez-Alcantara et al., 2017).

In this context, receiving a diagnosis can bring relief (Porter et al., 2020), allowing both parents and children to reframe challenges positively and shift focus onto the child's strengths and needs (Levi, 2017; Wilmot et al., 2022). Such reframing can positively impact the child's self-esteem and self-efficacy. A higher self-concept can encourage more learning engagement and independent behaviour in the child. Thus, a diagnosis can catalyze a reciprocal cycle of adaptive behaviours that impact several different areas of functioning.

An important outcome of assessments is that they can serve as a pathway to interventions and resources (Porter et al., 2020), which can tangibly impact children's functional outcomes. In this study, all parents reported increased access to educational services post-assessment, suggesting the possibility that those services helped alleviate some concerns. While this study did not collect specific data on changes to academic achievement (e.g., grades, test scores), its focus lay in examining the extent to which psychoeducational reports addressed families' desired outcomes.

Notably, most parents in this study emphasized the importance of accessing educational resources for their children, with no references to grades or test scores. It is, therefore, reasonable to assume that accessing educational services for their children was of greater concern to these parents than achievement scores. This underscores the value of focusing on enhancing access to educational services rather than fixating solely on performance outcomes, as posited by Waber and colleagues (2017). This assumption does not discount the possibility that their children's performance improved after receiving educational services. However, this study did not collect data on children's achievement scores.

Therefore, the current results cannot address assumptions regarding performance improvement.

In contrast to the previous findings, the current results did not reveal significant changes in parental worries about their children's behavioural and social functioning. One plausible explanation for this finding could be that, on average, the children in the sample did not exhibit pronounced challenges in these domains. If parents' ratings can be used as a proxy for determining children's functioning, then that could indeed be the case – on average, parents rated worries about their children's behavioural and social functioning as their least relevant concerns.

The lower concern for these behavioural concerns contradicted the previous results that indicated parents of children with ADHD are more likely to have concerns about their children's behaviour (e.g., Fernandez-Alcantara, 2017). The lower concern for social functioning was also surprising, considering that both LD and ADHD are associated with social difficulties (LDAC, 2017; Fernandez-Alcantara, 2017). Nonetheless, it is possible that these children's ADHD did not manifest with substantial challenges in behavioural functioning. Parents' descriptions of their children's accommodations support this assumption, as most interventions were academic-focused. Finally, considering that children's behavioural and social difficulties are often most salient within the school environment (Sorensen et al., 2003), distance learning during the COVID-19 pandemic may have reduced the relevancy of these concerns.

In summary, psychoeducational assessments promisingly appear to play a role in mitigating several key parental concerns about children's functioning. Future research may elucidate reasons why assessments are less likely to impact parent concerns about children's behavioural and social functioning.

6.4 Implications for Clinicians

Overall, this study found evidence to support the conclusion that psychoeducational reports played a role in facilitating meaningful changes to children's educational experiences and development. Nonetheless, there are a few implications worth

considering for enhancing clinical services for families with LD and ADHD. First, linking recommendations to parents' concerns for their children's functioning across the key domains discussed in this study can help ensure parents' goals for assessment are met (Mastoras et al., 2011).

Second, the present study found that schools were one of the primary consumers of children's psychoeducational reports, which is consistent with previous research (e.g., Weiner, 1985, 1987), This finding underscores the necessity for clinicians to produce reports that translate to feasible classroom interventions. Previous research has identified a myriad of factors that limit the effective implementation of clinical recommendations. Educators have cited their level of experience utilizing reports and interventions, clarity of report recommendations, and resource constraints as key factors impacting implementation (Mastoras et al., 2011; OHRC, 2022; Pelco et al., 2009).

Enhancing collaboration between clinicians and educators is a key consideration for improving the usefulness of psychoeducational reports in school contexts. Writing clear and concise psychoeducational reports that precisely feed into IEPs can enhance educators' abilities to support students (Mastoras et al., 2011; Pelco et al., 2009). Mastoras and colleagues (2011) posited that psychoeducational reports should explicitly link assessment results and interpretations with referral questions to ensure that the recommended solutions aptly address initial concerns and improve consumer satisfaction. Clinicians can build further upon this approach by also considering the resources and barriers specific to individual schools. While the initial approach is likely to produce precise client-centred solutions, the recommendations are only feasible if they also consider all factors impacting stakeholders' abilities to implement them (Brenner, 2003). In other words, the needs of the child, parents, and educators should all be factored into the clinician's selection of recommended interventions (King et al., 2023).

To gather this information from schools, clinicians can solicit direct feedback from the client's teachers, conduct feedback sessions, and organize workshops for educators (King et al., 2023). Workshops for educators can involve training on utilizing psychoeducational reports. They can also serve as an opportunity for clinicians to hear

from educators about the barriers and facilitators specific to different schools. Such mutual professional development opportunities can be beneficial for both the producers and consumers of psychoeducational reports. While teachers may have more opportunities for informal interaction with in-house specialists (King et al., 2023), private clinicians are likely less accessible. Therefore, enhancing interprofessional collaboration is an especially pertinent consideration for clinicians working in private settings.

6.5 Implications for Educators and School Boards

The study's findings pointed to some discrepancies perceived by caregivers regarding the alignment between report recommendations and their actual implementation in the classroom. While these reports led to an increase in IEPs, some parents expressed concerns that inconsistent implementation or insufficient support hindered positive outcomes for their children. These findings raise some implications for improving educational practices. First, educators and school-based teams can ensure that parents are made aware of educational policies, timelines, and anticipated outcomes for various intervention strategies. Prioritizing clearer communication between educators and families can better align the expectations of all parties.

Second, increasing training opportunities for teachers is a key consideration for bolstering the efficacy of interventions within school settings. In their review of student placement literature, the Canadian Council of Learning (2009) identified teachers' capacity to educate students with additional learning needs as a salient predictor of student success. Enhancing teachers' self-efficacy and confidence through tailored training programs is foundational to developing educator capacity (Canadian Council of Learning, 2009). Central to this process is incorporating inclusive educational coursework in pre-service teacher education (Friesen & Cunning, 2020; Stanovich & Jordan, 1998), alongside continuous professional development opportunities (Canadian Council of Learning, 2009). These opportunities could include workshops that focus on collaboration with parents and other professionals and the effective use of psychoeducational reports. Such training can notably improve teachers' confidence in integrating insights from these reports into actionable lesson plans and interventions (Friesen & Cunning, 2020).

Ensuring that teachers can effectively support their students requires addressing systemic barriers to inclusive education. Updating the definition of students with exceptionalities to include ADHD can yield more accurate estimates for students with additional learning needs (D'Intino, 2017). Better estimates can ensure adequate resources are devoted to supporting all students who require further supports. Moreover, it is essential that investments into key resources, such as assistive technology equipment, are effectively utilized (OHRC, 2022). Finally, adopting a top-down approach that begins with training for school administrators and principals promotes inclusive educational environments, as positive attitudes towards inclusion at higher administrative levels have been associated with teachers' engagement in inclusive practices (Stanovich & Jordan, 1988).

6.6 Limitations and Future Directions

The current study provided insights into caregiver perceptions concerning the usefulness of psychoeducational reports in promoting positive outcomes for their children. However, it is important to acknowledge several potential limitations of the current study that could be addressed by future research. First, all participants' children were evaluated at the same clinic. While this was advantageous for controlling for clinician approaches and report writing styles, the overall homogeneity restricts the generalizability of findings to broader populations.

Furthermore, the sample was predominantly highly educated. If education level can serve as an indicator of SES status, then this study might not capture the experiences of families from lower SES backgrounds. Importantly, the families in this study were able to cover the financial cost of private evaluation. Therefore, these families' experiences are unrepresentative of those who are unable to access financially prohibitive services. The lack of data on parental income and cultural, linguistic, or ethnic backgrounds further hinders a comprehensive understanding of how these factors may influence parental perceptions and children's educational experiences. Future studies could benefit from larger, more diverse samples to capture a wider range of experiences. Future studies could also benefit from exploring the viewpoints of more parties involved in the child's education, such as clinicians, educators, administrators, and children themselves. This

would enable future researchers to triangulate responses to facilitate a more comprehensive understanding of how psychoeducational reports impact children's outcomes.

Another limitation of the study was the reliance on retrospective parental reports, introducing potential recall bias. Longitudinal designs could aid in mitigating this limitation, and incorporating interviews in future studies could provide deeper insights from qualitative responses. Finally, the study did not extensively consider the age and developmental stages of the children, possibly overlooking age-specific challenges that could affect the effectiveness of educational accommodations and parental advocacy efforts, such as transitioning to higher education.

7 Conclusion

This study contributes to our understanding of caregiver perceptions regarding the impact of psychoeducational reports in shaping children's educational experiences. Taken together, the findings indicate that caregivers derived value from the reports. The reports facilitated widespread increases in services for most families. Furthermore, the evidence suggests that the assessment process, insights provided in the reports, and resultant outcomes effectively addressed several key worries of parents for their children's functioning. However, a critical takeaway from this study was that, for many parents, the existing level of support provided remained below what they felt their children required to thrive in their educational programs. Thus, while psychoeducational reports removed some barriers to children's learning, there is apparent room for improvement in terms of the utility of these reports. Future research should endeavour to collect longitudinal outcome data from larger and more diverse samples and enlist inputs from various stakeholders involved in children's education to cultivate a more holistic understanding of how psychoeducational reports influence children's developmental trajectories.

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Appendices

Appendix A: Ethics Approval Letter

Western Research

Date: 26 May 2023 **To:** Dr Colin King **Project ID:** 120558

Study Title: Understanding the impact of psychoeducational assessments

Application Type: NMREB Initial Application

Review Type: Delegated

Full Board Reporting Date: 07/Jul/2023 **Date Approval Issued:** 26/May/2023 10:15 **REB Approval Expiry Date:** 26/May/2024

Dear Dr Colin King

The Western University Non-Medical Research Ethics Board (NMREB) has reviewed and approved the WREM application form for the above mentioned study, as of the date noted above. NMREB approval for this study remains valid until the expiry date noted above, conditional to timely submission and acceptance of NMREB Continuing Ethics Review.

This research study is to be conducted by the investigator noted above. **All other required institutional approvals and mandated training must also be obtained prior to the conduct of the study.**

Documents Approved:

Document Name	Document Type	Document Date	Document Version
Questionnaire	Online Survey	11/May/2023	2
Debriefing Study	Debriefing document	11/May/2023	2
Recruitment follow-up_CYDC Parents	Recruitment Materials	07/May/2023	2
Qualtrics Link for the LOI	Implied Consent/Assent	11/May/2023	1
Study Procedures Document_CYDC	Protocol	23/May/2023	3
Letter of Information and Consent_CYDC Parents	Implied Consent/Assent	23/May/2023	3
Recruitment Email_CYDC Parents	Recruitment Materials	23/May/2023	3

The Western University NMREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), the Ontario Personal Health Information Protection Act (PHIPA, 2004), and the applicable laws and regulations of Ontario. Members of the NMREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB. The NMREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000941.

Please do not hesitate to
contact us if you have any
questions.

Sincerely,

Ms. Katelyn Harris , Research Ethics Officer on behalf of Dr. Randal Graham, NMREB Chair

Note: This correspondence includes an electronic signature (validation and approval via an online system that is compliant with all regulations).

Appendix B: Ethics Approval Letter

Western Education

Letter of Information and Consent

Project Title: *Understanding the Impact of Psychoeducational Assessments*

Principal Investigator: Colin King, Ph.D., C. Psych., Education, Western University (Child & Youth Development Clinic Director)

Co-Investigator: Deanna Friesen, Ph.D., Education, Western University

Co-Investigator: Rafia Junaid, Education, Western University

Invitation to Participate

You are invited to participate in a research study conducted as part of a master's thesis project because you are a parent of a child between the ages of 5-17 who is a client of the Child & Youth Development Clinic & who received a psychoeducational assessment for a learning or attention concern.

Purpose of Letter

The purpose of this letter is to provide you with information that you require in order to make an informed decision in terms of your participation in this research.

Purpose of this Study

The purpose of the present study is to collect insights from parents of children who have received a psychoeducational report about how this report impacted the services received by their child.

Inclusion Criteria

You are eligible to participate in this study if you are 18 years of age (or older) and the parent/guardian of a child between the ages of 5-17 who is a client at the Child & Youth Development Clinic, and who received a psychoeducational report for a learning or an attention concern.

Exclusion Criteria

You are not eligible to participate in this study if you are not 18 years of age (or older) and/or not the parent of a child (or children) between the ages of 5-17 who is a client at the Child & Youth Development Clinic.

Study Procedures

To participate you would complete the questionnaire about the services that you received before and after the psychoeducational assessment. Questions also include information on any benefits or drawbacks from assessment, the nature of the report and your child's current functioning.

All participation is electronic, therefore no in-person visits are required. Your participation will take place via an online survey link you can access at a day & time that is most convenient for you. To participate, you will need access to a computer, tablet, or phone device that can connect to the internet. However, we recommend using a computer or a tablet rather than a phone. The time it takes to complete the questionnaire will vary based on each participant, but we estimate that it will take you approximately 30 minutes.

Potential Risks and Harm

There are no known major risks associated with participation in this study. However, it should be noted that we cannot guarantee with that information provided via the internet is 100% secure.

Possible Benefits to Participation

Your participation in this study will assist researchers in understanding the outcomes associated with receiving a psychoeducational report. An understanding of both the

positive and negative outcomes will enable the researchers to inform policy & practice within the clinic and can also be shared with other relevant stakeholders to influence policy.

Compensation

For completing this study, you will be offered the option of receiving a 20$ gift card from the vendor of your choice from one of the following: Tim Horton's, Starbucks, Indigo OR the option to have 20$ donated to the London and Area Learning Disabilities Association. Once you have completed the questionnaire, you will be redirected to a secure Qualtrics link to make your choice. If you select to receive a gift card, you will be asked to input your name and email address. We will provide your name and email address to the company and the gift card will be sent to your email address through the business' online purchasing system. You will receive this compensation within 2 business days of completing the study. If you select the donation, then we will not ask for your contact information and will make a donation on your behalf.

Voluntary Participation

Implied consent is being collected; therefore, you will indicate your consent directly in the survey link. If based on the Letter of Information you decide *not* to participate, you can select "I do not agree to participate" and no information will be collected.

Participation in this study is completely voluntary, and your decision on whether or not to participate in the study will in no way affect your previous, current, or future interactions and/or support with the CYDC. This project is separate from the CYDC services provided and it is completely up to you if you would like to support this research by completing the questionnaire. You do not waive any legal right by consenting to this study.

While completing the questionnaire, you may withdraw from the study or refuse to answer any of the individual questions at any time. If you decide to withdraw from the study, you may do so at any time by exiting the survey window. However, to be compensated for your participation,

you must move through to the end of the study. At the end of the survey, you will have the opportunity to withdraw your data. However, once your survey responses have been submitted, the researchers will not be able to withdraw your data because it is anonymous.

Confidentiality

The researchers will keep all data in a secure and confidential location for 7 years. All questionnaire data collected will remain accessible to members of the research team on secured servers and will be accessed both onsite at Western and remotely from home. While we will do our best to protect your information, there is no guarantee that we will be able to do so. When the results are published, aggregated data and direct quotes will be incorporated within a thesis or publication but will not be identifiable to you.

No identifying details about you and/or your child (name, address, etc.) will be shared with researchers by CYCD staff, and all your personal information is kept on a secure, private computer at the CYDC. However, if you choose to receive compensation for your time, at the end of the study, you will be asked for your name and email address on a different link. This information will not be associated with your questionnaire responses. It will be collected by a research team member (Dr. Deanna Friesen) who has no role in providing services at CYCD and she will use this information only to send compensation.

The Questionnaire responses will be collected anonymously through a secure online survey platform called Qualtrics whose server is located in Ireland. Qualtrics uses encryption technology and restricted access authorizations to protect all data collected **https://mysurveys.uwo.ca/general_information1/qualtrics_security.pdf**. The data will then be exported from Qualtrics and securely stored on Western University's server. Representatives of The University of Western Ontario Non-Medical Research Ethics Board require access to your study-related records to monitor the conduct of the research.

Open Access Data

Only the anonymized numerical data (multiple-choice responses) will be made accessible by the study investigators to the broader scientific community through on online repository (Open Science Framework: OSF | Home). The study investigators may re-analyze the anonymized data to gain knowledge and understanding for different research questions.

Contacts for Further Information

If you have any questions or concerns about your rights as a research participant or the ethical conduct of this study, you may contact **The Office of Human Research Ethics (1-844-720-9816),** email: ethics@uwo.ca. You may also choose to direct any questions about this research or to address any concerns about your participation to **Dr. Deanna Friesen** at the University of Western Ontario.

You are encouraged to keep a copy of this letter of information for your records (see recruitment email attachment).

Consent Form

Participants who agree to participate will select the box that states, "I have read the Letter of Information, understand the nature of the study, and I agree to participate" and will be directed to the study's questionnaire for completion.

☐ I have read the Letter of Information, understand the nature of the study, and I agree to participate.

☐ I do NOT agree to participate

Appendix C: Impact of Psychoeducational Reports Questionnaire

Section 1: Introductory Questions

1. Who referred your child for a psychoeducational assessment?
    - Parent or Guardian (self-referred)
    - Educator / School
    - Physician
    - Other

2. What is your role in relation to your child?
    - Mother/Step-Mother
    - Father/Step-Father
    - Guardian

3. Please select the option that best reflects the highest education level you have completed
    - Primary School
    - Secondary School
    - University/College
    - Graduate
    - Post-Grad/Doctoral

4. What are your child's pronouns?
    - She/Her
    - He/Him
    - They/Them
    - Other

5. Please provide your child's pronouns:

6. What is the **current** age of your child?

7. In what grade level is your child **currently** enrolled?

8. What was the age of your child at the **time of initial assessment**?

9. In what grade level was your child enrolled in at the **time of initial assessment**?

10. What was your child's age when you first suspected theymay have challenges related to learning?

11. Following the assessment, did your child receive a formal diagnosis? This may include, but is not limited to: Learning Disability (Dyslexia; Dyscalculia; Dyspraxia), ADHD, Intellectual Disability.
    - Yes
    - No

12. Please specify your child's diagnosis (e.g., learning disability, ADHD). If your child received more than one diagnosis (e.g., learning disability **and** ADHD), please list all diagnoses.

Section 2: Educational Experiences

In this section, you will be asked to comment on your child's educational experiences at home and at school. The aim of this section is to identify what you believe your child's educational needs are and how effective you think your child's psychoeducational report has been in meeting those needs.

13. On average, how many hours per week does your child spend completing homework at home?

14. Does your child typically require assistance to complete homework assignments?
    - Never
    - Sometimes
    - Half the time
    - Most of the time
    - Always

15. Who typically assists your child with their homework?

16. Is your child enrolled in any academic or personal support programmes (e.g., after-school programme, homework support, mentoring programme, tutoring)?
    - No
    - Yes

17. Please specify what programmes your child is enrolled in:

18. Is your child currently on an IEP?
    - No
    - Yes

19. Prior to receiving a psychological assessment, was your child on an IEP (Individualized Education Plan)?
    - No
    - Yes

20. Following the psychological assessment, were any changes made to your child's IEP?
    - No
    - Yes

21. Following the psychological assessment, did your child receive an IEP?

- No
- Yes

22. Does your child receive formal academic **accommodations** at school? (Some examples of accommodations are extra time for completing tests and assignments, peer note-takers, quiet study spaces, preferential seating, and assistive technologies).
    - No
    - Yes

23. In your opinion, does your child require accommodations at school?
    - Definitely yes
    - Probably yes
    - Might or might not
    - Probably no
    - Definitely no

24. Please list key accommodations that are provided to your child in each of the following areas:
    - Instructional accommodations – (e.g., peer note-taker, additional time)
    - Environmental accommodations – (e.g., preferential seating, quiet study space)
    - Assessment accommodations (e.g., additional time, assistive technology)

25. Was your child provided any of those accommodations before the psychoeducational assessment?
    - No - the accommodations were provided after the psychoeducational assessment
    - Yes - they received some of those accommodations
    - Yes - they received all of those accommodations

26. What were the key accommodations that were provided to your child before the assessment?

27. In your opinion, was your child's psychoeducational report useful or necessary for securing academic accommodations for your child?
    - Definitely was not useful
    - Probably was not useful
    - Might or might not have been useful
    - Probably was useful
    - Definitely was useful -- it would be very challenging to secure the necessary accommodations without a formal report

28. Does your child receive formal ***modifications*** to coursework at school? (Some examples of modifications are reductions to content difficulty and/or complexity, changes to rubrics or grading criteria, focusing on content from a different grade level, etc.).
    - No
    - Yes

29. In your opinion, does your child require modifications to coursework?
    - Definitely yes
    - Probably yes
    - Might or might not
    - Probably no
    - Definitely no

30. What modifications have been made to your child's coursework?

31. Were those modifications made before the psychoeducational assessment?
    - No - the modifications were made after the psychoeducational assessment
    - Yes - some of those modifications were made before the assessment

- Yes - all of those modifications were made before the assessment

32. What modifications were made before the psychoeducational assessment?

33. In your opinion, was your child's psychoeducational report useful or necessary for securing modifications to your child's coursework?
    - Definitely was not useful
    - Probably was not useful
    - Might or might not have been useful
    - Probably was useful
    - Definitely was useful – it would be very challenging to secure the necessary modifications without a formal report

Section 3: Utilizing Psychoeducational Report

34. **Prior** to receiving your child's psychoeducational report, did you experience any challenges in securing necessary supports for your child?
    - No
    - Yes

35. Please describe the challenges you experienced

36. **After** receiving your child's report, did you experience challenges securing supports for your child?
    - No
    - Yes

37. Please describe the challenges you experienced

38. Who has your child's psychoeducational report been shared with?

Section 4: Concerns

Below is a list of commonly reported concerns that parents have for their child when seeking psychoeducational assessments. The items are not listed in any particular order.

39. Please use the slider to indicate how relevant each concern was for you and your child, **prior to seeking assessment**. (Note: a score of 0 indicates the concern is not at all relevant, and a score of 10 indicates the concern is highly relevant).

I worry about my child's future	0	1	2	3	4	5	6	7	8	9	10
I worry about my child's academic success (e.g., grades in school)	0	1	2	3	4	5	6	7	8	9	10
I worry about my child's autonomous development (e.g., ability to be self-sufficient)	0	1	2	3	4	5	6	7	8	9	10
I worry about my child's behavioural functioning (e.g., defiant behaviour)	0	1	2	3	4	5	6	7	8	9	10
I worry about my child's social development (e.g.,relationships with peers)	0	1	2	3	4	5	6	7	8	9	10
I worry about my child's emotional development (e.g., self-esteem)	0	1	2	3	4	5	6	7	8	9	10

40. If you had other concerns for your child (prior to assessment) that are not listed above, please comment below.

41. Please use the slider to indicate how relevant each concern is **currently** for you and your child. (Note: a score of 0 indicates the concern is not at all relevant, and a score of 10 indicates the concern is highly relevant).

I worry about my child's future	0	1	2	3	4	5	6	7	8	9	10
I worry about my child's academic success (e.g., grades in school)	0	1	2	3	4	5	6	7	8	9	10
I worry about my child's autonomous development (e.g., ability to be self-sufficient)	0	1	2	3	4	5	6	7	8	9	10
I worry about my child's behavioural functioning (e.g., defiant behaviour)	0	1	2	3	4	5	6	7	8	9	10
I worry about my child's social development (e.g.,relationships with peers)	0	1	2	3	4	5	6	7	8	9	10
I worry about my child's emotional development (e.g., self-esteem)	0	1	2	3	4	5	6	7	8	9	10

42. If you currently have any other concerns for your child that are not listed above, please comment below.

43. Did the psychoeducational report provide information about supporting your child in the following areas? Please use the sliding scales below to record your response. (Note: a score of 0 indicates the report did not provide any information, and a score of 10 indicates the report provided a great deal of information).

How to support my child's future	0	1	2	3	4	5	6	7	8	9	10
How to support my child's academic success	0	1	2	3	4	5	6	7	8	9	10
How to support my child's autonomy	0	1	2	3	4	5	6	7	8	9	10
How to support my child's behavioural functioning	0	1	2	3	4	5	6	7	8	9	10
How to support my child's social development	0	1	2	3	4	5	6	7	8	9	10
How to support my child's emotional development	0	1	2	3	4	5	6	7	8	9	10

44. If you found that the report was especially useful or not useful at all in addressing the concerns you have for your child, please elaborate below.

Curriculum Vitae

Name:	Rafia Junaid
Post-secondary Education and Degrees:	Western University London, Ontario, Canada 2021-present M.A. Counselling Psychology
	Carleton University Ottawa, Ontario, Canada 2018-2020 H.B.A. Psychology
	Carleton University Ottawa, Ontario, Canada 2012-2016 H.B.A. History co-minor English & Philosophy
Honours and Awards:	Carleton University Dean's List 2013-2014, 2014-2015, 2015-2016, 2018-2019, 2019-2020
Related Work Experience	Focused Family Therapy Intern Vanier Children's Services 2022-2023
	Research Assistant Carleton University 2018-2020