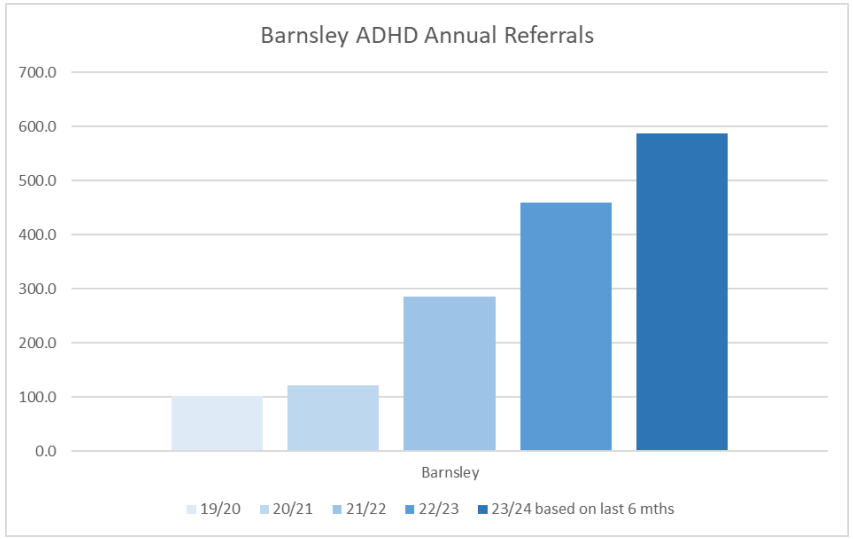
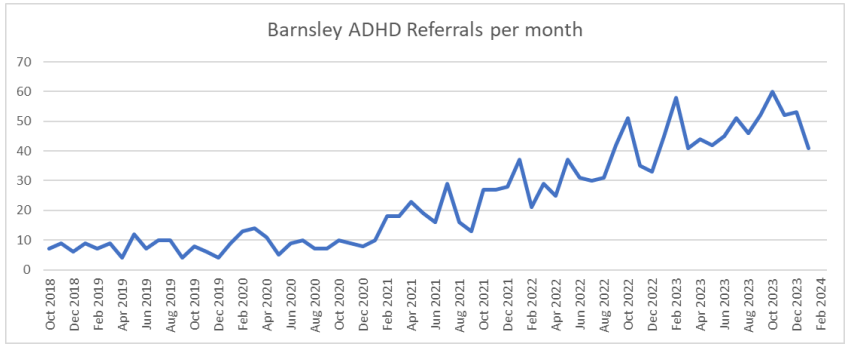
Adult ADHD: Assessment and Diagnosis

Professor Marios Adamou OBE

The Service receives approx. 50 referrals per month for ADHD

Projected total for 2023/24 is 590. This is almost six times higher than 5 years ago.





ADHD

Capacity & Waiting Times

- The commissioner funds approx 90 new cases each year, there has not been further investment to offset the increase in demand. This impacts on waiting times and numbers waiting.

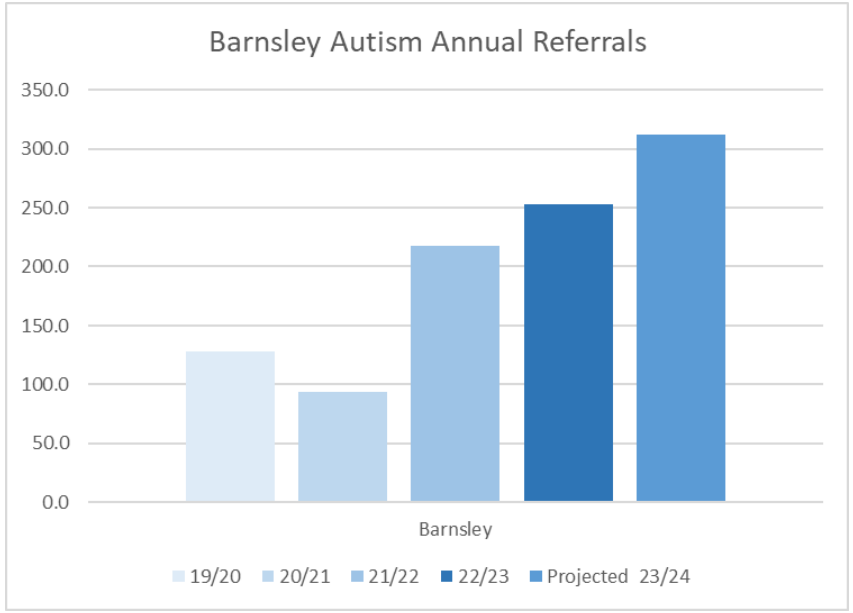
- There are currently 839 people waiting for an assessment, the longest wait is from Sept 2021. Note that patients are not necessarily seen in chronological order based on referral date, some are expedited based on clinical needs relating to ADHD.

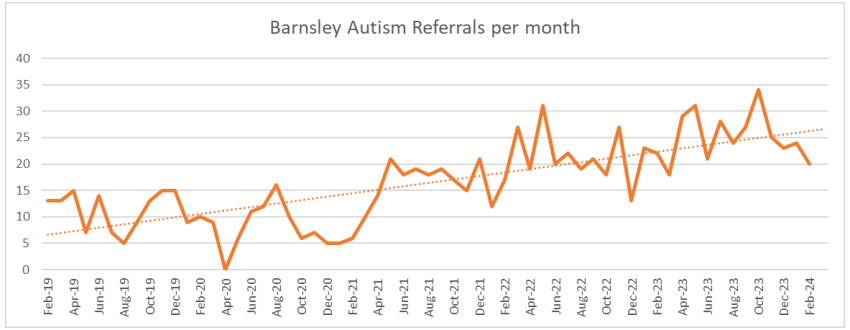
2023/24 Activity

- The Service is meeting the required number of assessments each year. Since 1st April 2023:
- 149 people have been invited start the assessment/treatment process, 28 (19%) did not engage and were discharged. 86 have already had a first appointment and a further 9 have appointments booked in the next four weeks (@19/3/24).
- The diagnostic rate in Barnsley is 53%. This is based on recorded diagnoses in the 12 months to 29th Feb 2024.

The Service receives approx. 25 referrals per month for Autism

Projected total for 2023/24 is 312. This is almost 2.5 times higher than 5 years ago.





Autism

Capacity & Waiting Times

There is no 'target' for new cases each year. The Service is commissioned to triage all referrals to determine clinical appropriateness and to offer assessment to those that are.

Although referral rates have increased, there is only a slight increase in the number of people being offered an assessment. This is typical of all areas.

There are currently 8 people waiting for assessment. On average, people are offered an appointment within 11 weeks of referral date. It can be as quick as 26 days but for others who are accepted for assessment but do not opt to be assessed straight away, it can be 3 months+.

2023/24 Activity

Since 1st April 2023:

42 people have been invited for assessment, 4 (10%) did not engage and were discharged. 29 have already had a first appointment and a further 6 have an appointment booked in the next four weeks (@19/3/24).

The diagnostic rate in Barnsley is 19%. This is based on recorded diagnoses in the 12 months to 29th Feb 2024.

Introduction and Context in adult ADHD

Useful Definitions and Categorisation

Basic Aetiology and Course of ADHD

Basics of diagnosis- diagnostic approach

Collecting a history for ADHD

Diagnosis and Treatment of Minimal Brain Dysfunction in Adults

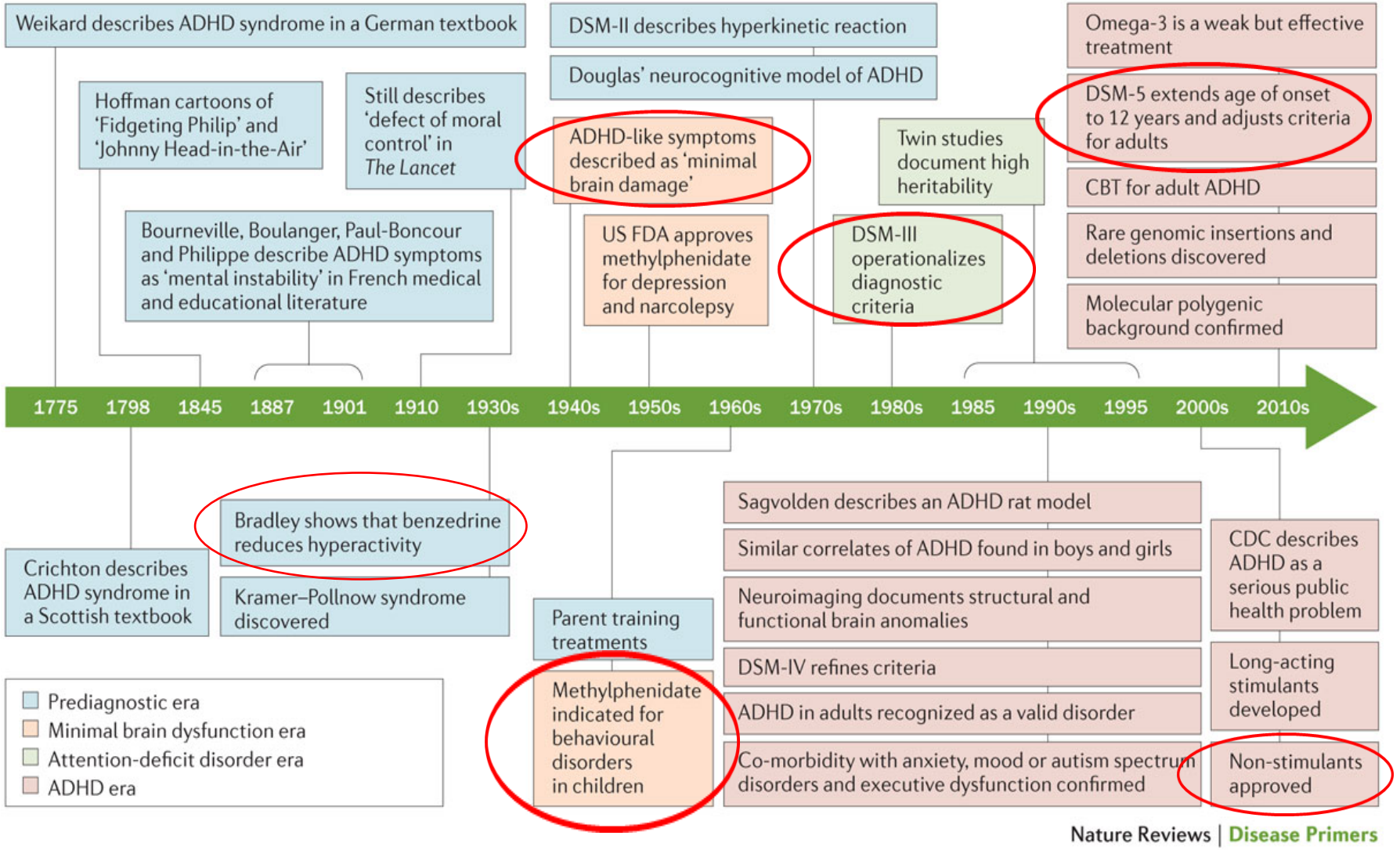
A Preliminary Report

David R. Wood, MD; Frederick W. Reimherr, MD; Paul H. Wender, MD; Glen E. Johnson, MD

The persistence of MBD-related behaviors into adulthood may be explicable in at least two ways. The adult abnormal behaviors may represent learning that occurred in childhood, although the putative biological problem underlying MBD may have been outgrown, or the aberrant physiology may have persisted into adulthood. In the latter instance, one might anticipate that MBD adults would respond to medicines in the same way that MBD children do. One then would expect to see behavioral improvement in adults when they are treated with stimulants or tricyclic antidepressants.

Archives Gen Psychiatry 1976

History of ADHD



Faraone, S. V. *et al.* (2015) Attention-deficit/hyperactivity disorder *Nat. Rev. Dis. Primers* doi:10.1038/nrdp.2015.20

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ADHD

ADHD is a neurodevelopmental disorder starting in childhood

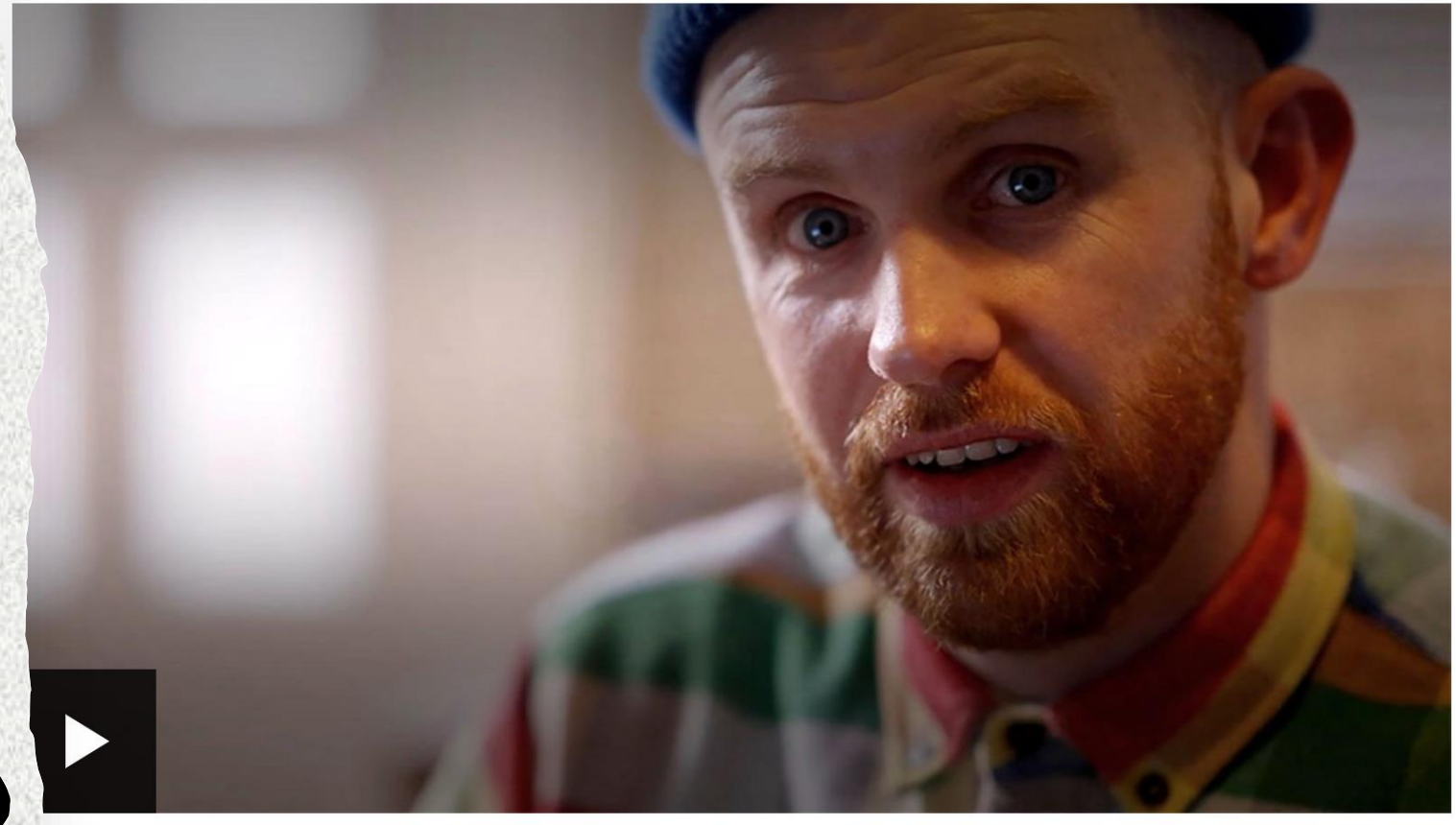
ADHD affects around 4-5 % of the population.

Until recently it was believed that children outgrew ADHD in adolescence. However, it is now known that the disorder can continue into adulthood.

People with ADHD may *vary in how their symptoms present* depending on the level of demand on them and characteristics of the environment they are working in (e.g. levels of noise etc).

ADHD: Private clinics exposed by BBC undercover investigation

15 May 2023



VATCH: BBC reporter's ADHD diagnosis with Harley Psychiatrists

anorama team

BC News

Can J Psychiatry. 2022 Dec; 67(12): 899–906.
Published online 2022 Feb 23. doi: 10.1177/07067437221082854

PMCID: PMC9659797
PMID: 35196157

Language: English | French

Journal Article

TikTok and Attention-Deficit/Hyperactivity Disorder: A Cross-Sectional Study of Social Media Content Quality

Anthony Yeung, MD, FRCPC,[1,2] Enoch Ng, MD, PhD,[3] and Elia Abi-Jaoude, MD, PhD, FRCPC[3,4]

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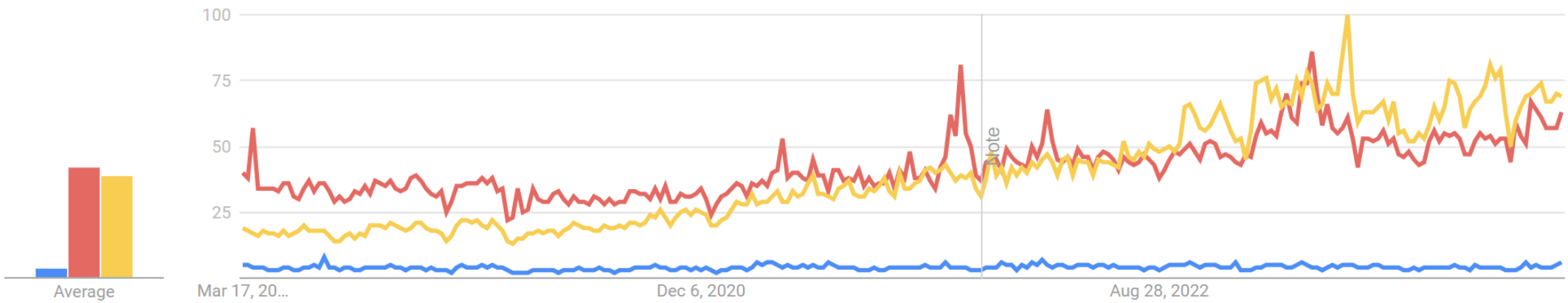
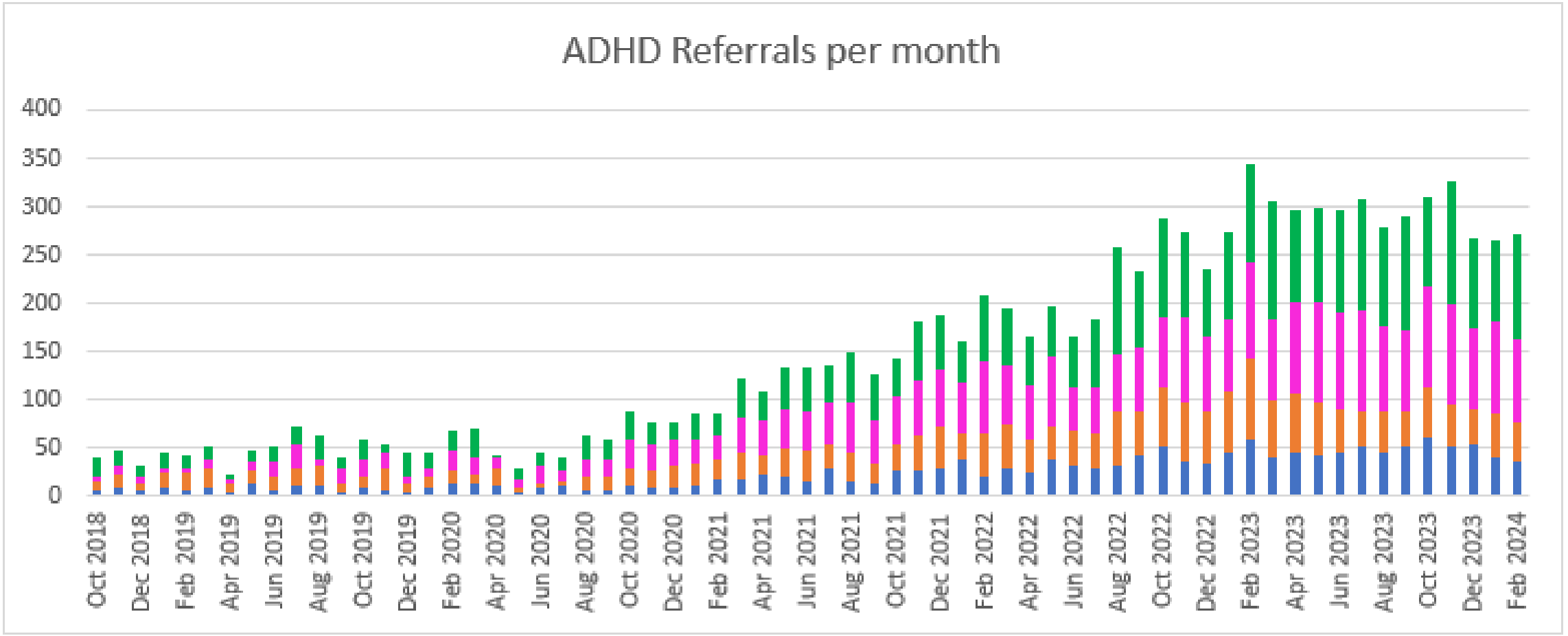
United Kingdom | Past 5 years | All categories | Web Search

Interest over time



Referral Rates



BJPsych Bulletin

UK adult ADHD services in crisis

Published online by Cambridge University Press: **07 December 2023**

Michael C. F. Smith, Raja A. S. Mukherjee, Ulrich Müller-Sedgwick, Dietmar Hank, Peter Carpenter and Marios Adamou

Show au

British Journal of General Practice
bringing research to clinical practice

Clinical Practice

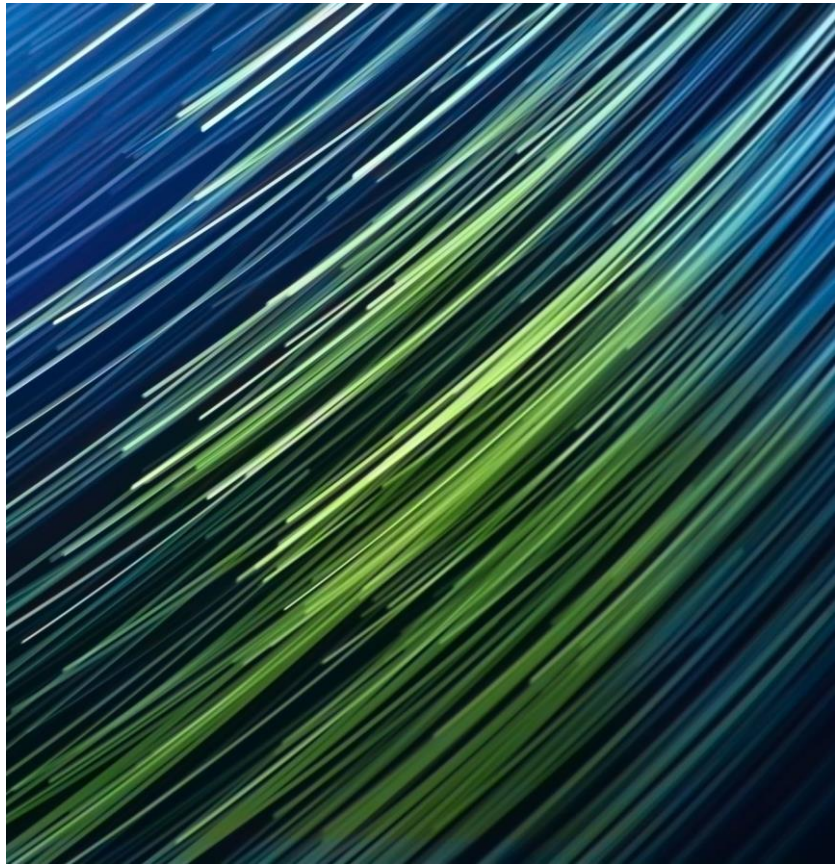
Assessments for adult ADHD: what makes them good enough?

Laurence Leaver, Kobus van Rensburg, Marios Adamou, Muhammad Arif, Philip Asherson, Sally Cubbin, James Kustow, Ulrich Müller-Sedgwick and Jane Sedgwick-Müller

British Journal of General Practice 2023; 73 (735): 473-474. **DOI:** https://doi.org/10.3399/bjgp23X735213

The Dangers of Self-Diagnosis: Misinterpreting Symptoms

Misinterpretation of Symptoms	•Mood swings: bipolar disorder vs. depression •The risk of incorrect self-assessment
Overlooking Medical Conditions	•Psychological symptoms masking medical issues •Examples: Panic disorder vs. hyperthyroidism, brain tumours
Undermining Doctor-Patient Relationship	•Importance of trust and open dialogue •Encourage discussing doubts openly
Missing Comorbidities	•Overlooking associated conditions •Example: Anxiety and major depressive disorder
Exacerbation of Anxiety and Misdiagnosis	•Overestimating health issues •The psychological impact of self-diagnosis
Denial and Minimisation of Symptoms	•Ignoring critical symptoms •Example: Generalized aches vs. coronary artery disease
Ignorance of Disruptive Syndromes	•Overlooking impactful disorders •Examples: Delusional disorder, personality disorders




North Yorkshire and York
Bradford and Airedale
Leeds
East Riding of Yorkshire
Hull
Calderdale
Kirklees
Wakefield
Barnsley
North Lincolnshire
North East Lincolnshire
Sheffield
Rotherham

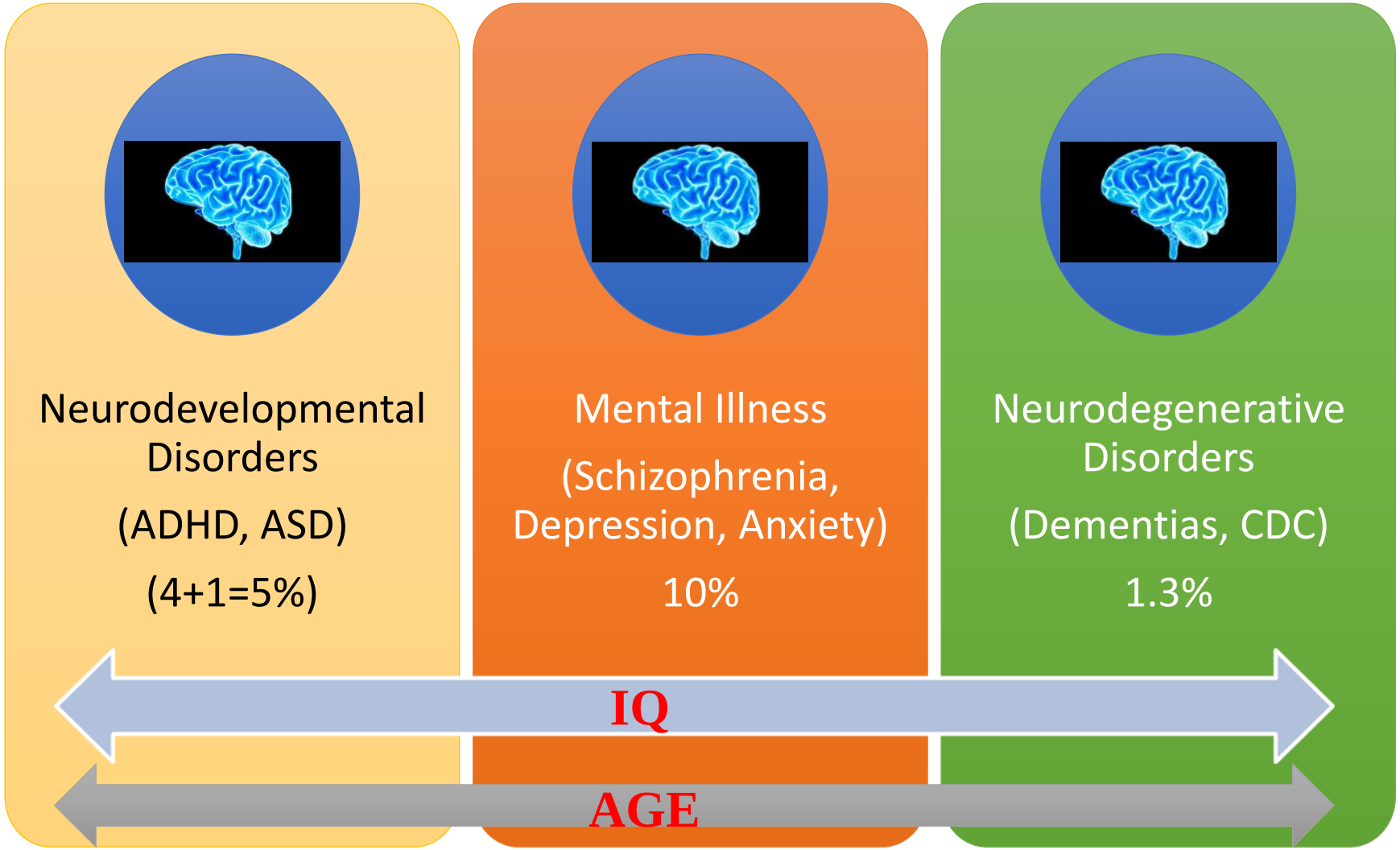
A PRACTICAL GUIDE TO SETTING UP AN ADULT ADHD CLINIC

Fulfilling the Need in Adult ADHD

Dr Marios Adamou MD, MA, MSc, LLM, MBA, PGCE, MRCPsych, DOccMed
Consultant Psychiatrist in Adult ADHD, South West Yorkshire Partnership NHS Foundation Trust

2009

Organisation of Mental Health Services



Definitions

Defining ADHD- what is it?

- ***A persistent pattern of inattention and/or hyperactivity that interferes with functioning or development***

- **Note:** DSM 5 states that the symptoms are not solely a *manifestation of oppositional behaviour, defiance, hostility,* or *failure to understand tasks or instructions*

- American Psychiatric Association: Diagnostic and Statistical Manual (DSM) of Mental Disorders, 5th Edition, 2013

Definition of trait

A personality trait is a relatively stable and enduring pattern of thoughts, feelings, and behaviours that distinguish one person from another.

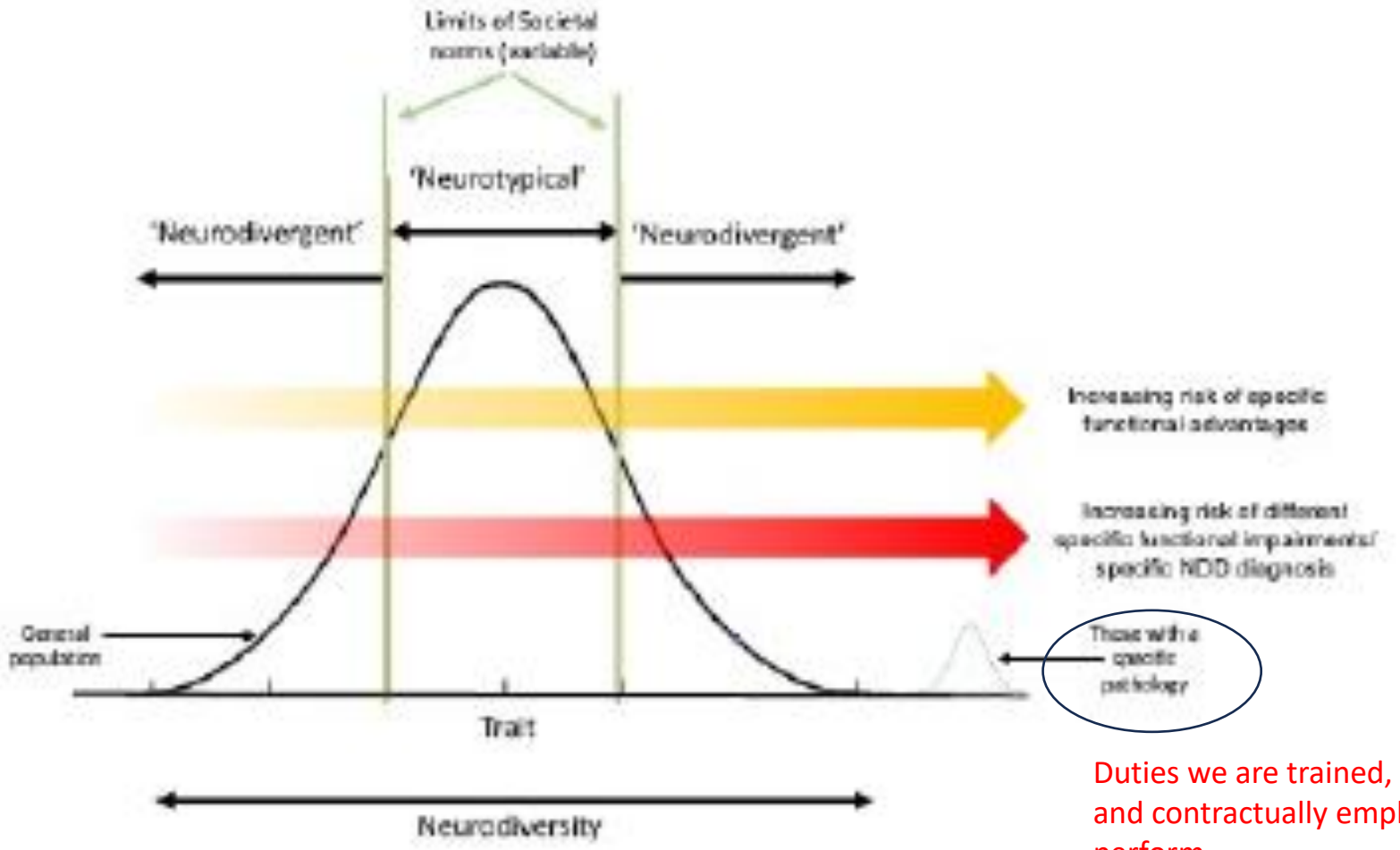
- **Consistency:** Personality traits exhibit consistency across different situations. While our behaviour will naturally vary to some extent, our underlying traits tend to influence how we react across a range of circumstances. For instance, a person high in extraversion is likely to be outgoing in both social gatherings and professional settings.
- **Stability:** Personality traits are relatively enduring over time. While there's room for development and some fluctuation, core traits tend to be present throughout a person's life in varying degrees.
- **Individual Differences:** Personality traits are what make us unique. People vary on a spectrum of different traits, and it's the particular combination and intensity of these traits that shape our distinct personalities

Neurodiversity

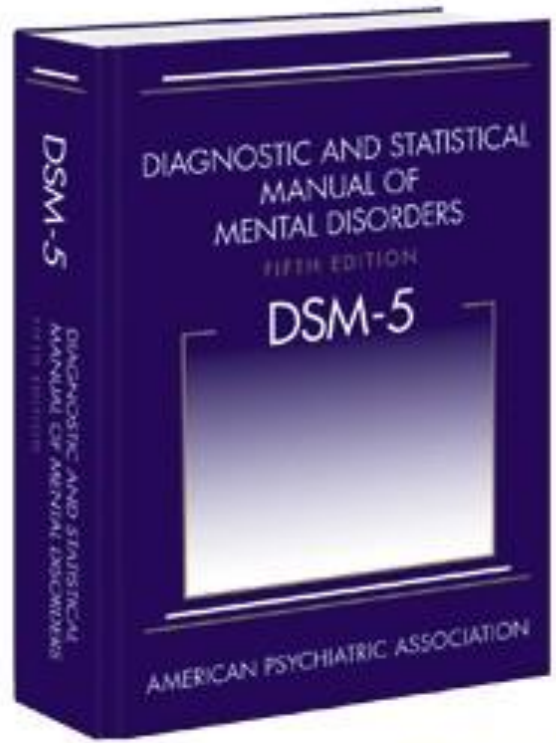
- The term "neurodiversity" was popularised by Judy Singer, an Australian social in her 1999 sociology honours thesis, drawing from online communities and personal experience.
- Neurodiversity originates from the autism rights movement and the social model of disability, advocating for the acceptance of neurological differences as natural variations.
- Advocates emphasise the strengths and abilities of neurodivergent conditions such as autism, ADHD, dyslexia, and others.
- The term was first used in print by American journalist Harvey Blume in 1998, highlighting the internet's role in fostering a global neurodiversity movement.
- The concept has gained traction, with increased media representation and social media playing a significant role in spreading awareness and connecting communities.
- The history of neurodiversity reflects a broader shift towards valuing cognitive differences as part of human diversity.

Aspect	Critical Psychiatry Movement	Neurodiversity Movement
Challenge to Dominant Norms	Questions the pathologisation of certain conditions as inherently negative, advocating for a broader understanding.	Argues against the negative view of neurodevelopmental conditions, promoting them as variations in brain function and information processing.
Empowerment and Self-Determination	Empowers individuals to have control over their treatment and challenges traditional power dynamics in mental health.	Advocates for self-determination and acceptance, allowing individuals to define their own experiences and identities.
Social Model of Disability	Draws on this model, highlighting that societal barriers create disability, advocating for more inclusive environments.	Utilises the social model to argue that disability stems from societal barriers, not neurological differences, pushing for inclusion.
Focus on Lived Experience	Values the experiences of those diagnosed with mental illness, pushing for their involvement in shaping care practices.	Prioritises the experiences of neurodivergent individuals, challenging medical perspectives with a neurodiversity-affirming approach.
Criticisms of Medicalisation	Concerned about the over-medicalisation of human behaviours, viewing some as natural responses to social stressors.	Critiques the medicalisation of human diversity, suggesting that experiences labelled as illness may be responses to lack of support.
Advocacy for Systemic Change	Advocates for systemic changes in societal, educational, and healthcare interactions with mentally ill individuals.	Promotes systemic reforms to better support neurodivergent individuals in society, education, and healthcare.
Educational and Employment Inclusion	Emphasises the importance of inclusive practices in educational and employment settings for mentally ill individuals.	Advocates for adjustments and accommodations that enable neurodivergent individuals to fully participate and succeed in these environments.
Critique of Diagnostic Frameworks	Critiques current diagnostic frameworks for oversimplifying and stigmatising the complexities of psychological experiences.	Encourages dialogue and research to develop more nuanced ways of conceptualising neurodevelopmental conditions, questioning diagnostic norms.
Interdisciplinary Collaboration	Promotes an interdisciplinary approach incorporating insights from various fields to understand and support mental health.	Values interdisciplinary collaboration to foster a holistic understanding and support system for neurodivergent individuals.
Global and Cultural Perspectives	Advocates for approaches that are sensitive to diverse cultural perspectives on mental health and treatment.	Recognises the impact of cultural and societal norms on the understanding and support of neurodivergence, promoting inclusive approaches.

Definitions

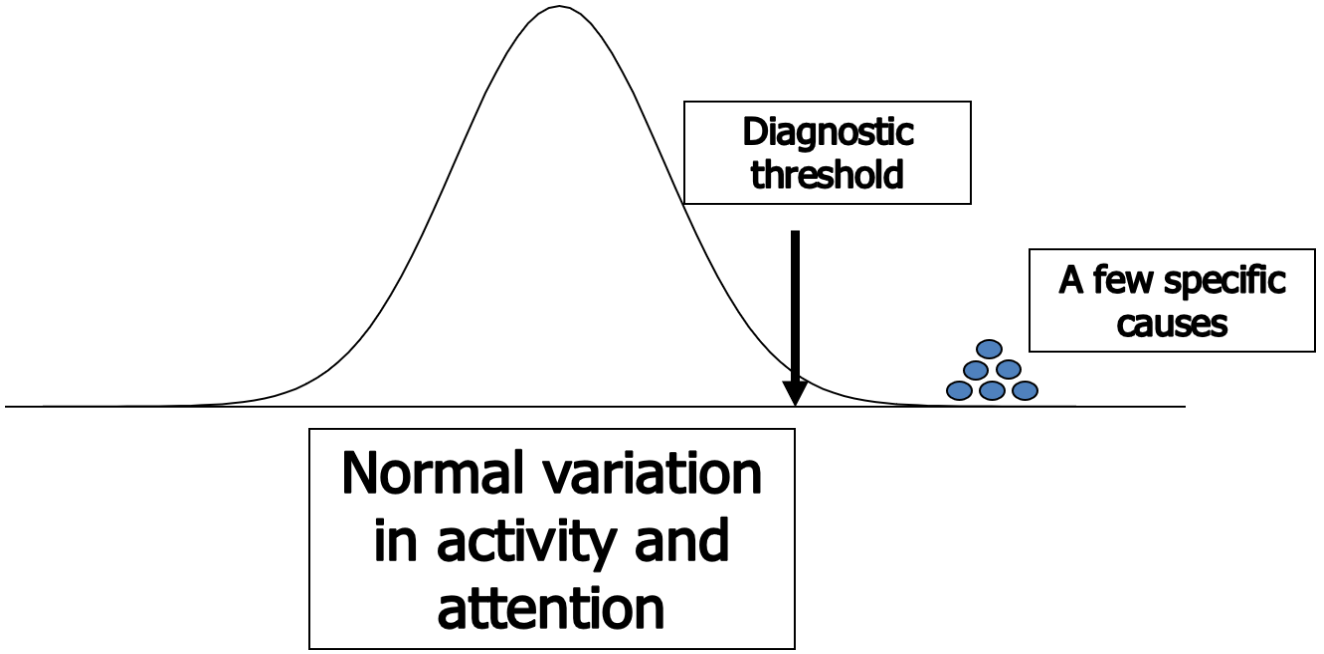


Duties we are trained, regulated and contractually employed to perform.


DSM-5
DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS
FIFTH EDITION
DSM-5
AMERICAN PSYCHIATRIC ASSOCIATION

DSM-5
2013

ADHD represents the extreme of a highly heritable quantitative trait



There is no natural cut-off in nature between those with trait levels of ADHD and those with the clinical disorder. The disorder defined on the basis of high levels of symptoms and impairments that cause real life problems for people and for which they need interventions.

Middeldorp et al, JAACAP, 2016: 10, 896-905

ADHD features/traits are not symptoms

All ADHD symptoms are common as *features/traits* in the general population, therefore sufficient, detailed information is needed to establish (through careful probing and open-ended questioning). The traits become symptoms if:

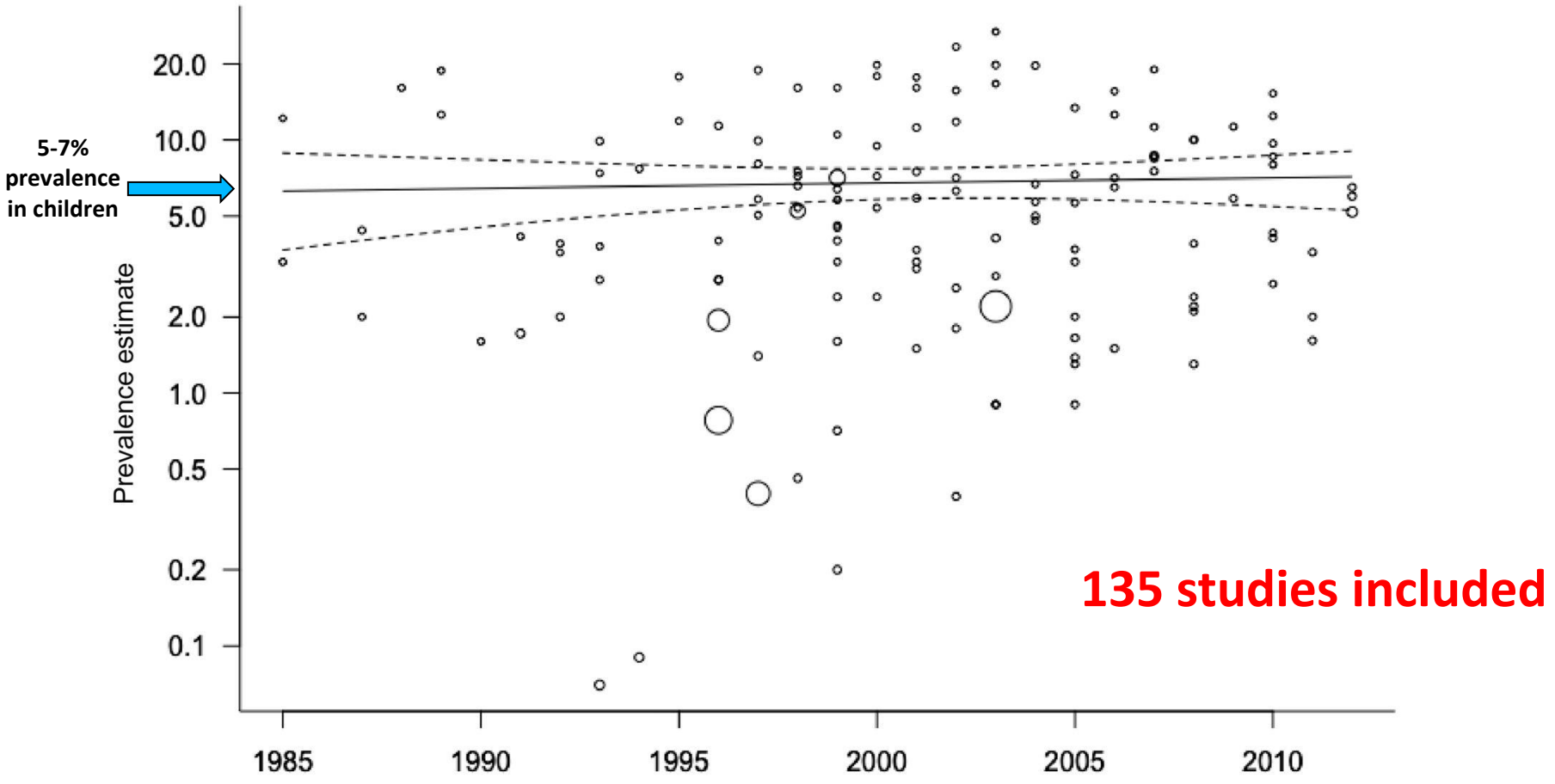
- present in the past,
- persistent in the present (day to day, week to week),
- pervasive across situations,
- and a problem which impacts significantly on daily functioning

***P**ast + **P**ersistent + **P**ervasive + **P**roblem = **P**roof of symptom of ADHD*

Basic Aetiology and Course

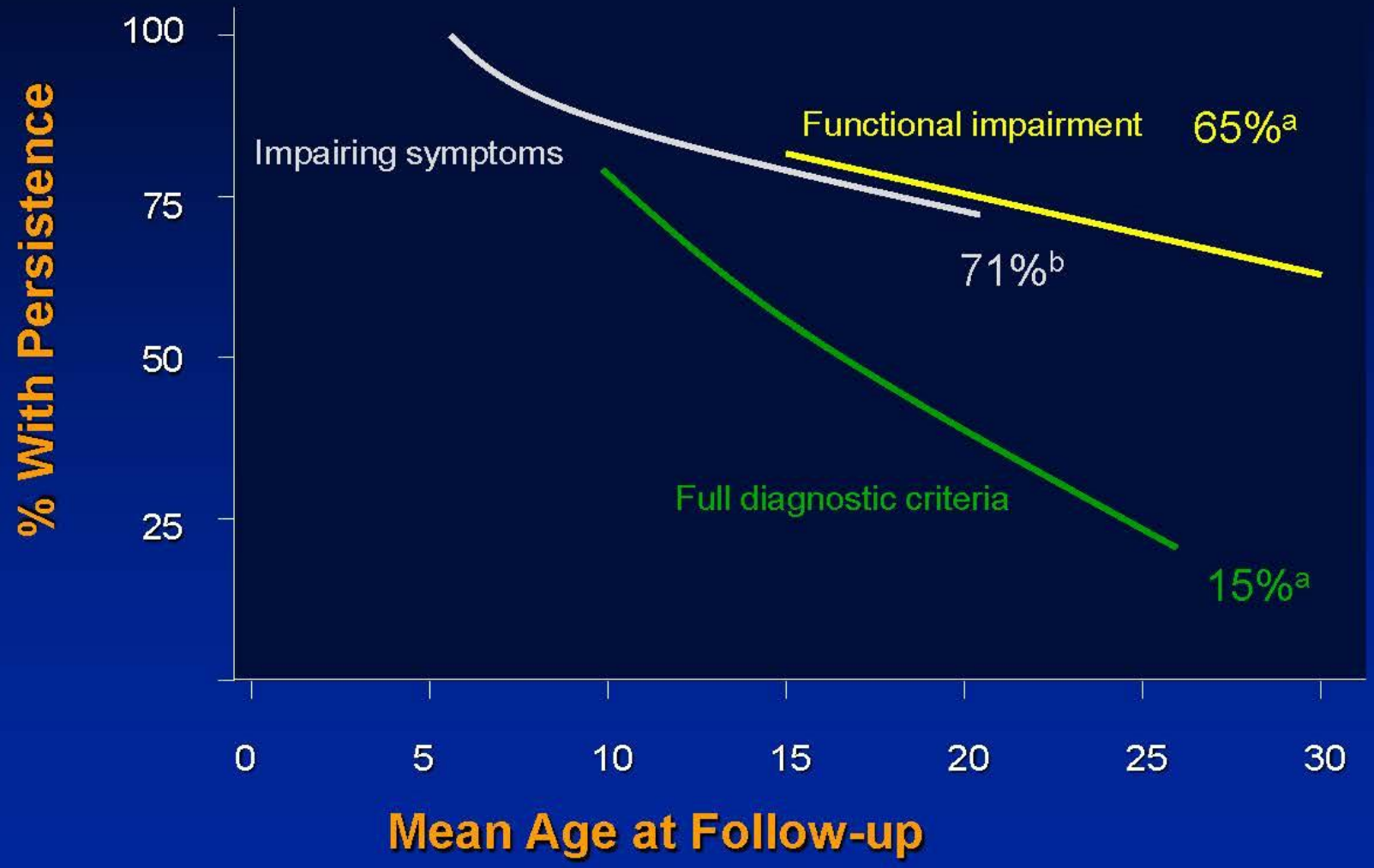
ADHD prevalence estimates across three decades:

updated systematic review and meta-regression analysis



ADHD prevalence estimates as a function of year of study publication

Polanczyk et al., Int J Epidemiol 2014; 43: 434-442



[a] Faraone et al. 2006, [b] Biederman et al., 2000

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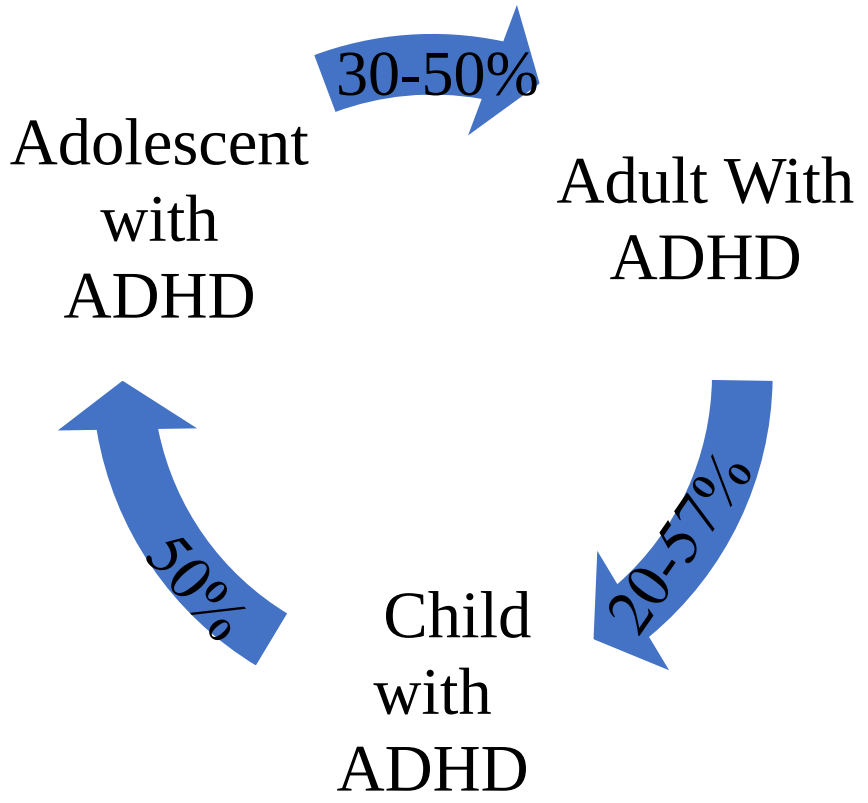
Lifetime of ADHD



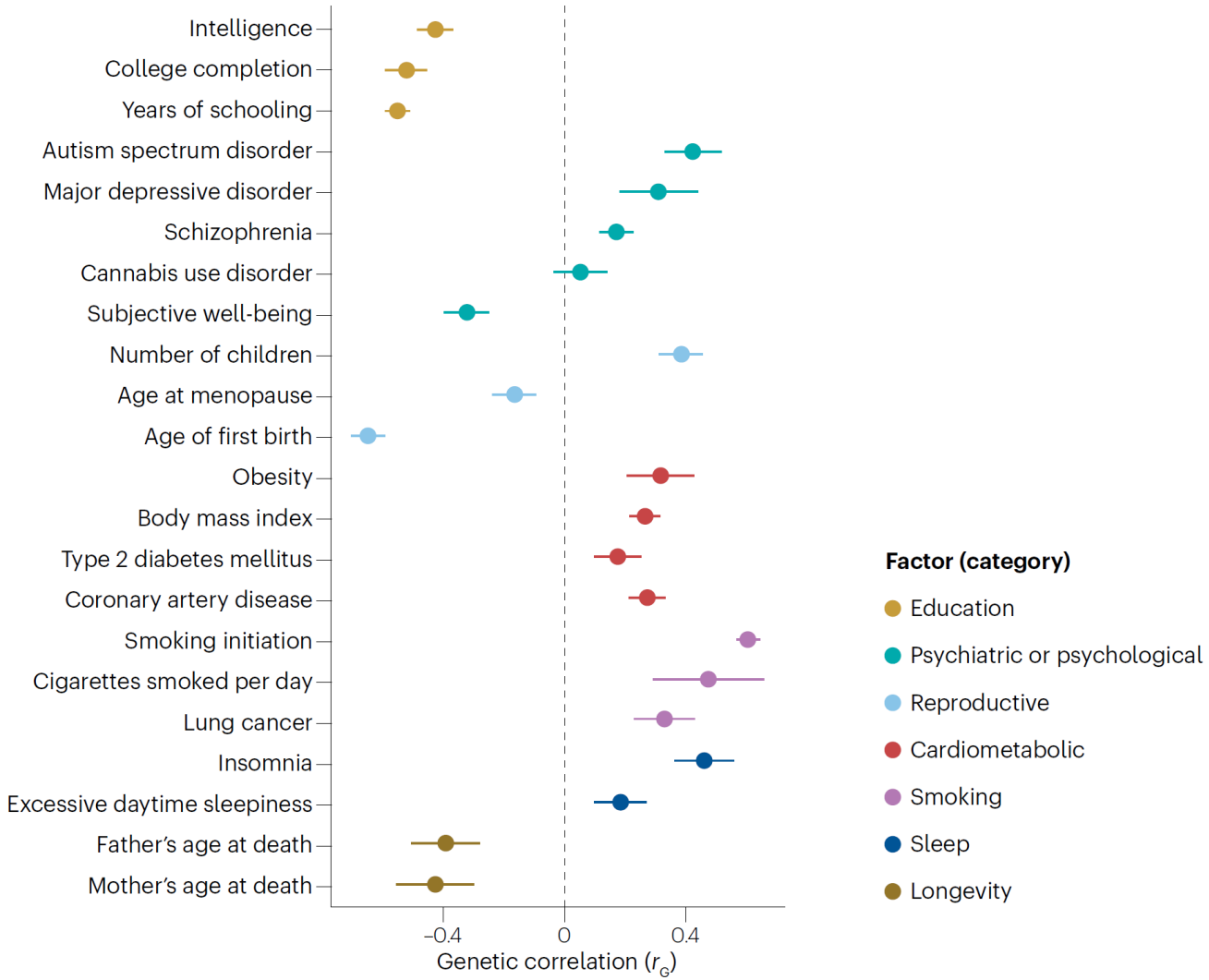


Fig. 2 | Genetic correlations of disorders and traits with ADHD. Genetic correlations show pronounced genetic overlap of attention-deficit/hyperactivity disorder (ADHD) with traits in the educational, psychiatric or psychological, reproductive, cardiometabolic, smoking-related, sleep-related and (parental) longevity domains. The horizontal bars indicate 95% confidence intervals. Data from ref. 71.

Environment: established causal associations

Environmental risk	Study design	Causal	Comments
Severe early deprivation	Romanian adoptee study	Yes	Dose response curve
Food additives	RCT in child population sample	Yes	Small but significant toxic effect on ADHD
Hostile parenting	Adoption at birth/conception	Yes	Evoked and causal pathways
Smoking during pregnancy	Adoption at conception	No	Genetic correlation between mothers smoking and offspring ADHD

Basics of diagnosis-diagnostic approach

Validated diagnostic criteria - NICE

The ADHD diagnosis predicts:

- Characteristic *clustering* of symptoms
- Clinical and psychosocial *impairments*
- *Course* and *outcome*
- *Genetic risk*
- *Environmental risks*
- *Cognitive impairments*
- Altered *brain structure, function and development*

NICE Clinical Guideline 72. 2008.
http://guidance.nice.org.uk/cg72

Validated diagnostic criteria - NICE

The ADHD diagnosis predicts:

- Characteristic *clustering*
- Clinical and ps
- *Cour*
- *structure, function and development*

Clinical response to pharmacological treatments

NICE Clinical Guideline 72. 2008. http://guidance.nice.org.uk/cg72

DSM-5

- Requires ‘several inattentive or hyperactive-impulsive symptoms’ are present prior to age 12 years rather than 7 years
- Requires six inattentive or six hyperactive-impulsive symptoms to be present for 6 months in two or more settings.
- For older adolescents and adults, the DSM-5 requires at least five symptoms.
- Clear evidence ‘that the symptoms interfere with, or reduce the quality of, social, academic or occupational functioning’.
- The predominantly inattentive, pre-dominantly hyperactive-impulsive and combined subtypes were retained.
- Symptoms are not better accounted for by another mental disorder
- DSM-5 also allows an ADHD diagnosis in the presence of Autism

ICD-11

Several symptoms of inattention that are persistent, and sufficiently severe that they have a direct negative impact on academic, occupational, or social functioning

Several symptoms of hyperactivity/impulsivity that are persistent, and sufficiently severe that they have a direct negative impact on academic, occupational, or social functioning.

Evidence of significant inattention and/or hyperactivity-impulsivity symptoms prior to age 12,

Manifestations of inattention and/or hyperactivity-impulsivity must be evident across multiple situations or settings

Symptoms are not better accounted for by another mental disorder

Symptoms are not due to the effects of a substance (e.g., cocaine) or medication (e.g., bronchodilators, thyroid replacement medication)

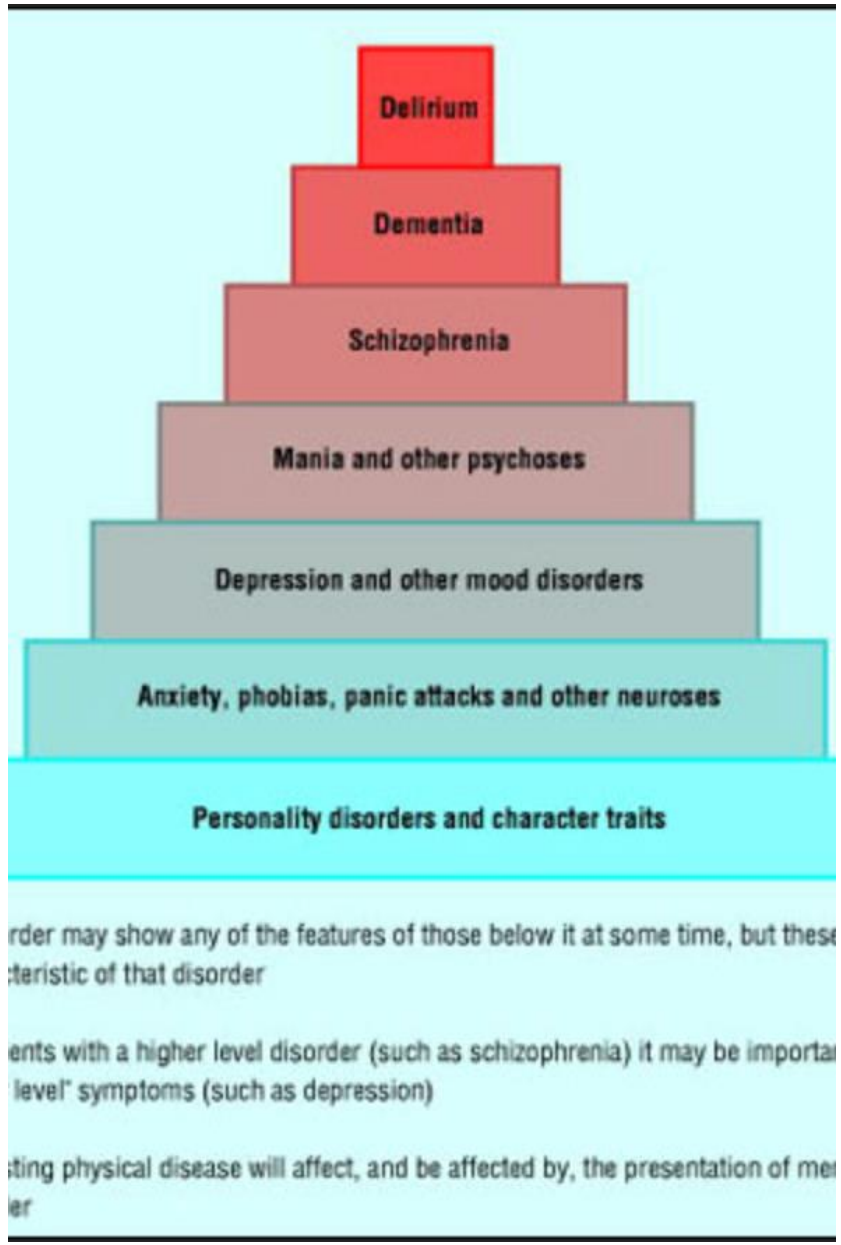
Threshold: Inattention, hyperactivity and impulsivity symptoms are present in many children, adolescents and adults, especially during certain developmental periods (e.g., early childhood). The diagnosis of Attention Deficit Hyperactivity Disorder requires that these symptoms be persistent across time, pervasive across situations, significantly out of keeping with developmental level, and have a direct negative impact on academic, occupational, or social functioning.

cal Medicine, 1975, **5**, 181–192

Hierarchy of classes of personal illness

G. A. FOULDS AND A. BEDFORD

m the Medical Research Council Unit for Epidemiological Studies in Psychiatry, Unive
Department of Psychiatry, Royal Edinburgh Hospital, Edinburgh



rder may show any of the features of those below it at some time, but these
teristic of that disorder

ents with a higher level disorder (such as schizophrenia) it may be importa
level' symptoms (such as depression)

ting physical disease will affect, and be affected by, the presentation of me
er

DSM 5: ADHD symptoms

- **INATTENTION (9 symptoms)**

(a) Lack of attention to details, makes careless mistakes

(b) Difficulty sustaining attention

(c) Does not listen when spoken to directly

(d) Trouble completing or finishing jobs or tasks

(e) Problems organising tasks and activities

(f) Avoids or dislikes sustained mental effort

(g) Loses and misplaces things

(h) Easily distracted

(i) Forgetful in daily activities

DSM 5: ADHD symptoms

- **HYPERACTIVITY (6 symptoms)**

(a) Fidgetiness (hand or feet) or squirming in seat

(b) Leaves seat when not supposed to

(c) Restless or overactive

(d) Difficulty engaging in leisure activities quietly

(e) Always "on the go"

(f) Talks excessively

- **IMPULSIVITY (3 symptoms)**

(g) Blurts our answers before questions have been completed

(h) Difficulty waiting in line or taking turns

(i) Interrupts or intrudes others when they are working or busy

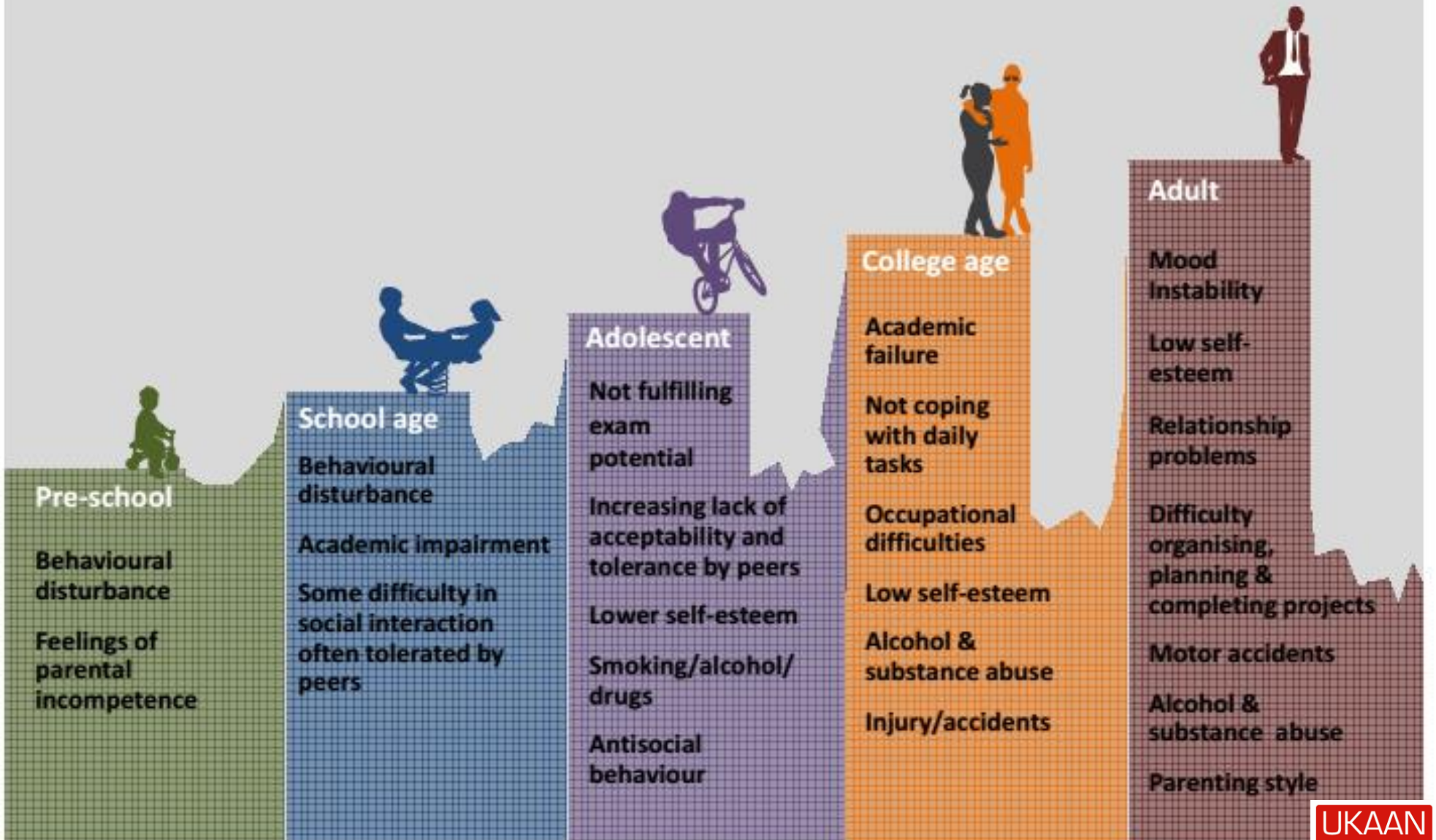
DSM-5: Associated features supporting diagnosis of ADHD

Development traits	Mild delays in language, motor or social development are not specific to ADHD but often co-occur.
Emotional symptoms	Low frustration tolerance, irritability, mood lability
Education problems	Even in the absence of a specific learning difficulty, academic or work performance is impaired
Cognitive deficits	May exhibit cognitive problems on tests of attention, executive function or memory – although tests are not sufficiently sensitive or specific to serve as diagnostic indices

American Psychiatric Association: Diagnostic and Statistical Manual (DSM) of Mental Disorders, 5th Edition, 2013

Developmental impact of ADHD

Slide from Mina Fazel (based on figure from UKAAN's Handbook of Adult ADHD)



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Domains of 'IMPAIRMENT'

1. *Work Functions
2. *Social relationships
3. *Coping with daily activities
4. Driving accidents
5. *Behavioural problems
6. *Distress from the symptoms
7. *Low self-esteem
8. Emotional lability
9. Sleep problems
10. *Risk for comorbid disorders (addiction, anxiety, depression, personality disorder)
11. Cognitive impairments, including specific learning difficulties

Psychosocial

Psychiatric

Neurodevelopmental

(** NICE definition of impairment 2008)*

NICE Clinical Guideline 72. 2008. http://guidance.nice.org.uk/cg72;

Asherson P, Expert Rev Neurotherapeutics. 2005 Jul;5(4):525-39.

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Defining ‘Impairment’ (NICE 2008)

Impairment to a degree that most people would consider requires some form of medical, social or educational intervention

Without a specialist professional or higher level of intervention to ameliorate the problems, there is likely to be long-term adverse implications for the person affected, as well as problems in the short and medium term

Impairment should be pervasive, occur in multiple settings and be at least of moderate severity

Significant impairment should not be considered where the impact of ADHD symptoms are restricted to academic/work performance alone, unless there is a moderate to severe impact in other domains

How patients present when requesting an ADHD assessment

Inattention	Hyperactivity	Impulsivity
•*Disorganisation and inefficiency* •*Procrastination* •*Failure to plan ahead* •*Forgetfulness* •*Difficulty in multi-tasking* •*Misjudging how long it takes to perform tasks* •*Inability to complete tasks* •*Distractibility* •*Poor ability to follow long explanations* •*Ceaseless mental activity - mind wandering*	• *Inability to relax* • *Restless sleep* • *Excessively active lifestyle* • *Constant purposeless motion of extremities* • *Constantly talking too much* • *Linked to constant stimulus seeking behaviour*	• *Disinhibited behaviour* • *May be linked to substance misuse - alcohol, cannabis, cocaine, tobacco, caffeine* • *May be linked to overeating* • *May be linked to aggressive behaviour / violence* • *Speaking out or making decisions without considering others* • *Impatient and unable to wait in queues*

Components of Excessive Mind Wandering in ADHD

- *Thoughts on the go all the time*
- *Thoughts jumping or flitting from one topic to another*
- *Multiple lines of thoughts at the same time*

Mowlem, et al., JAD, 2016

Mind Wandering in ADHD

- *Strong predictor of impairment*
- *Thought content is 'normal' – not driven by anxious/depressive rumination*
- *May reduce when engaged in salient activities (can focus on salient tasks)*

Aims of an ADHD diagnostic assessment

- To establish if all the criteria (A-E) for ADHD in DSM 5 are met before confirming a diagnosis
- To provide the best possible treatment for the patient based on a comprehensive assessment which identified all possible comorbidities

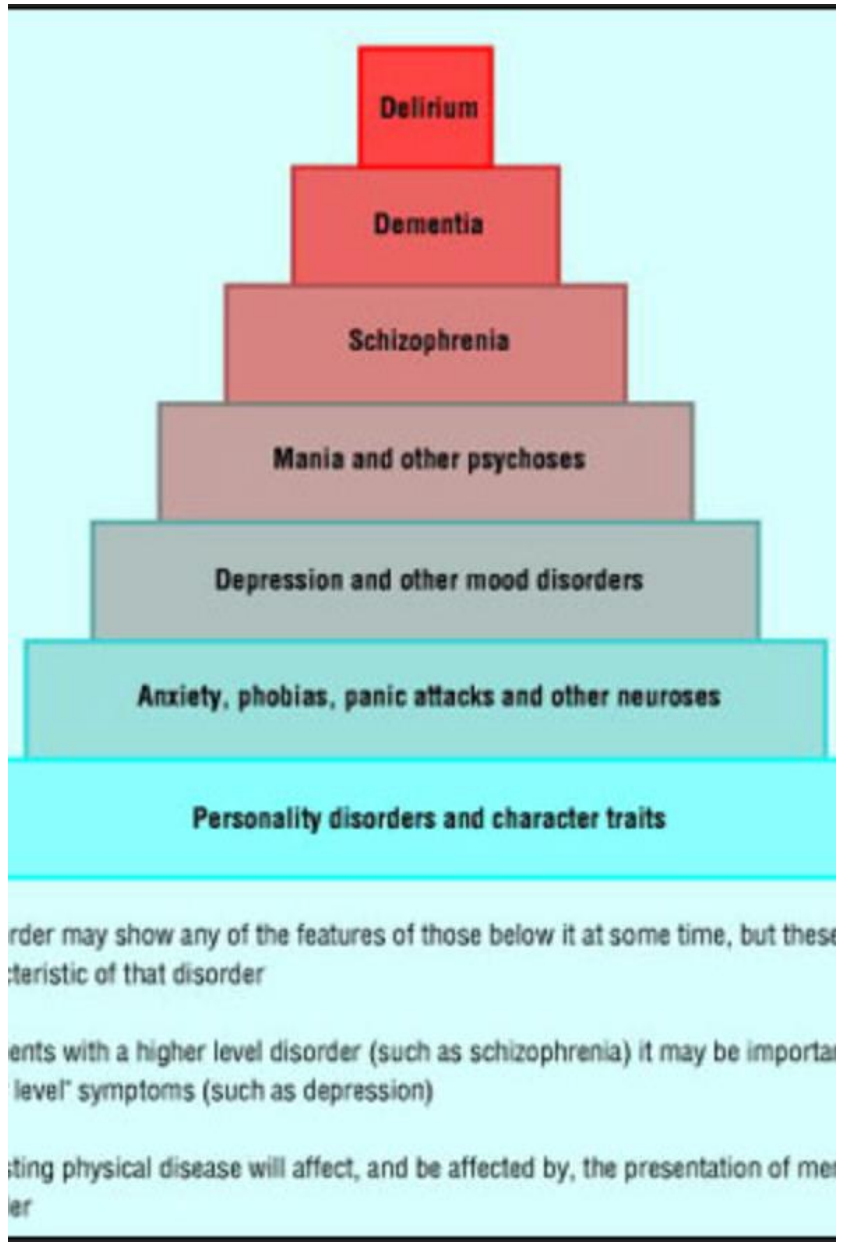
Diagnostic Approach

cal Medicine, 1975, **5**, 181–192

Hierarchy of classes of personal illness

G. A. FOULDS AND A. BEDFORD

m the Medical Research Council Unit for Epidemiological Studies in Psychiatry, Unive
Department of Psychiatry, Royal Edinburgh Hospital, Edinburgh



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level' symptoms (such as depression)

ting physical disease will affect, and be affected by, the presentation of me
er

Approach to assessment

PERFORM GENERAL PSYCHIATRIC ASSESSMENT

FOCUS ON IDENTIFYING PRESENCE OF ADHD

ASSESS SEVERITY OF ADHD

CONSIDER TREATMENT

Components of the assessment

A. Referral process

B. Assessment consultation(s)

1. *Reason for referral, presenting problems*
2. *Early Developmental History (pregnancy/birth complications/developmental milestones/early temperament)*
3. *Detailed Childhood History to establish the presence of "several" ADHD symptoms (B-criteria of DSM V)(academic progress, exclusions/expulsions, behaviour in class, peer group/family relationships, antisocial behaviour, activity level)*
4. *Further Education (academic/social challenges)*
5. *Employment History (task/distractions management/dealing with authority)*
6. *Daily Functioning (home admin/chores/shopping/finances)*
7. *Family Life/Activities (leisure/holidays/appointments)*
8. *Relationship History*
9. *Drug and Alcohol History – including misuse and diversion*

Components of the assessment

10. *Medical History*
11. *Psychiatric/neurodevelopmental History*
12. *Family History*
13. *Forensic History*
14. *Current Mental Health/Neurodevelopmental Difficulties*
15. *Collateral information*
16. *Observations*

C. Rating Scales
D. Formulation and sharing outcome of assessment
E. Patient reflection on outcome (essential)
F. If diagnosis of ADHD confirmed
   - *Psycho-education (see NICE guidelines)*
   - *Treatment (medical & psychosocial) options explored*

General guidelines

Avoid asking leading or closed questions to establish whether ADHD symptoms are present now/were present in the past. Therefore, it is not recommended to send symptom list questionnaires focusing solely on ADHD symptoms prior to screening or first appointment.

Avoid going through the DSM-5 ADHD symptoms in a linear (one after the other) way. Attempt to establish the presence of a symptom by asking open-ended questions when focusing on areas of life within the assessment e.g. the presence of some inattention symptoms will become evident when you ask about your patient's strategies to manage paperwork, function at work, watching movies, going shopping, organising a party etc.

General guidelines

Many services have implemented a **multi-disciplinary** model for adult ADHD diagnostic assessments, carried out over two (or more) consultations with the diagnostician attending the last consultation.

Obtain a **collateral perspective** whenever possible – therefore, request parent/carer, older sibling or partner to attend consultations to obtain childhood and current perspective.

Review **school reports** or other formal assessments if available.

PERFORM GENERAL PSYCHIATRIC ASSESSMENT

FOCUS ON IDENTIFYING PRESENCE OF ADHD

ASSESS SEVERITY OF ADHD

CONSIDER TREATMENT

Identifying ADHD Symptoms
(as described in DSM V)

Inattention Symptoms

A1 Often fails to give close attention to detail or make careless mistakes at work or during other activities[1]

How do you manage paperwork/responding to emails?

When you need to complete a form/questionnaire, how do you approach this? Following instructions such as making a flat pack?

Examples during adulthood:[2]

- □ Makes careless mistakes
- □ Works slowly to avoid mistakes
- □ Does not read instructions carefully
- □ Difficulty working in a detailed way
- □ Too much time needed to complete detailed tasks
- □ Gets easily bogged down by details
- □ Works too quickly and therefore makes mistakes

[1]APA. DSM V (2013); [2]DIVA 5

A2 Often has difficulty sustaining attention in tasks[1]

What do you read? How do you watch movies? How do you stay on task? How do you manage distractions?

When can you concentrate/ focus?

Examples during adulthood[2]:

□ Not able to keep attention on tasks for long

□ Quickly distracted by own thoughts or associations

□ Finds it difficult to watch a film through to the end, or to read a book

□ Quickly becomes bored with things

□ Asks questions about subjects that have already been discussed

*Unless the subject is found to be really interesting (e.g. computer or hobby)

[1]APA. DSM V (2013); [2]DIVA 5

A3 Often does not seem to listen when spoken to directly[1]

How do you manage conversations?

How do you stay focused in meetings?

What do others say? (”Are you listening to me?”)

Observed: patient asks for question to be repeated

Examples during adulthood[2]:

□ Dreamy or absent-minded

□ Difficulty concentrating on a conversation

□ Afterwards, not knowing what a conversation was about

□ Often changing the subject of the conversation

□ Others saying that your thoughts are somewhere else

[1]APA. DSM V (2013); [2]DIVA 5

A4 Often does not follow through on instructions and fails to finish chores, or duties in the workplace[1]

How do you remain on task?

What will make you stop an activity you've started?

Do you have many (bright) ideas? What happens next?

Observed during online appointments: patient shows unfinished DIY at home

Examples during adulthood[2]:

□ Does things that are muddled up together without completing them

□ Difficulty completing tasks once the novelty has worn off

□ Needing a time limit to complete tasks

□ Difficulty completing administrative tasks

□ Difficultly following instructions from a manual

[1]APA. DSM V (2013); [2]DIVA 5

A5 Often has difficulty organising tasks and activities[1]

How do you organise yourself at work/home?
How do you stay on top of your chores?
How do you plan ahead for something e.g. weekend/holiday?
Observed: arrived late for appointment, did not return forms

Examples during adulthood[2]:

□ Difficultly with planning activities of daily life
□ House and/or workplace are disorganised
□ Planning too many tasks or non-efficient planning
□ Regularly booking things to take place at the same time (double-booking)
□ Arriving late
□ Not able to use an agenda or diary consistently
□ Inflexible because of the need to keep to schedules
□ Poor sense of time
□ Creating schedules but not using them
□ Needing other people to structure things

[1]APA. DSM V (2013); [2]DIVA 5

A6 Often avoids, dislikes or is reluctant to engage in tasks which require sustained mental effort[1]

How do you deal with post/emails that needs responding to?

How do you manage tasks at work that involve reading?

How do you prioritise/put enough time aside to complete tasks?

How do you plan ahead for handing in assignments on time (students)?

Examples during adulthood[2]:

□ Do the easiest or nicest things first of all

□ Often postpone boring or difficult tasks

□ Postpone tasks so that deadlines are missed

□ Avoid monotonous work, such as administration

□ Do not like reading due to mental effort

□ Avoidance of tasks that require a lot of concentration

[1]APA. DSM V (2013); [2]DIVA 5

A7 Often loses things necessary for tasks or activities[1]

How do you know where you've put something down?

What strategy do you have for your valuables?

How sure are you about where your (e.g. keys, glasses, etc.) are right now?

Examples during adulthood[2]:

□ Mislays wallet, keys, or agenda

□ Often leaves things behind

□ Loses papers for work

□ Loses a lot of time searching for things

□ Gets in a panic if other people move things around

□ Stores things away in the wrong place

□ Loses notes, lists or telephone numbers

[1]APA. DSM V (2013); [2]DIVA 5

A8 Often easily distracted by external stimuli[1]

How do you manage external distractions?
What distracts you? How do you stay on task?
What happens when you are distracted by something?
Could also be observed during consultations

Examples during adulthood[2]:

□ Difficulty shutting off from external stimuli

□ After being distracted, difficult to pick up the thread again

□ Easily distracted by noises or events

□ Listening in the conversations of others

□ Difficulty in filtering and/or selecting information

[1]APA. DSM V (2013); [2]DIVA 5

A9 Often forgetful in daily activities[1]

How did you remember today's appointment?
What's your strategy for remembering appointments?
How do you plan for (grocery) shopping?
What goes in your diary?

Examples during adulthood:

□ Forgets appointments or other obligations
□ Forgets keys, agenda etc.
□ Needs frequent reminders for appointments
□ Returning home to fetch forgotten things
□ Rigid use of lists to make sure things aren't forgotten
□ Forgets to keep or look at daily agenda

[1]APA. DSM V (2013); [2]DIVA 5

Hyperactivity Symptoms

H/I 1 Often fidgets with, or taps hands or squirms in seat[1]

Should be able to observe this in a clinic setting, but also look out for attempts to inhibit this e.g., sitting on hands, hands in pockets.

Occasionally fidgety in daily life but not during assessment so also enquire about this.

Online consultation: ask "what is in your hand?"

Examples during adulthood[2]:

□ Difficulty sitting still

□ Fidgets with the legs

□ Tapping with a pen or playing with something

□ Fiddling with hair or biting nails

□ Able to control restlessness, but feels stressed as a result

[1]APA. DSM V (2013); [2]DIVA 5

H/I 2 Often leaves seat in situations when remaining seated is expected[1]

For how long can you remain seated in social situations? How does this compare to other people?

What's it like watching TV/going out for a meal with others?

(people with ADHD typically can't sit down for long)

What do you do when on a phone call?

(people with ADHD typically "pace and talk" whilst on the phone

Examples during adulthood[2]:

□ Avoids symposiums, lectures, church etc.

□ Prefers to walk around compared to sit

□ Never sits still for long, always moving around

□ Stressed owing to the difficulty of sitting still

□ Makes excuses in order to be able to walk around

[1]APA. DSM V (2013); [2]DIVA 5

H/I 3 Often feels restless[1]

How often can you do nothing?

What do you do to relax?

During a typical week, when do you switch off and relax?

What do you do in between tasks?

What do you do at lunch time (at work)?

What do you do when you get home after work?

Examples during adulthood[2]:

□ Feeling restless or agitated inside

□ Constantly having the feeling that you have to be doing something

□ Finding it hard to relax

[1]APA. DSM V (2013);
[2]DIVA 5

H/I 4 Often unable to engage in leisure activities quietly[1]

If present, might observe this (although less common in adults).

How do you manage silence?

Has anyone ever commented on the volume of your speech? What did they say?

Examples during adulthood[2]:

□ Talks during activities when this is not appropriate

□ Becoming quickly too cocky in public

□ Being loud in all kinds of situations

□ Difficulty doing activities quietly

□ Difficultly in speaking softly

[1]APA. DSM V (2013); [2]DIVA 5

H/I 5 Often on the go as if "driven by a motor" [1]

Similar to H/I 3

What do you do to relax?

How do you feel when you stop doing something and try to relax?

During a typical week, when do you switch off and relax?

What do you do on your holidays? How is this different to the rest of the family/friends (also on holiday)?

How does your energy/activity levels compare to those of others?

Examples during adulthood[2]:

□ Always busy doing something

□ Has too much energy, always on the move

□ Stepping over own boundaries

□ Finds it difficult to let things go, excessively driven

[1]APA. DSM V (2013); [2]DIVA 5

H/I 6 Often talks excessively[1]

Often able to observe this during appointments when present (whether in a clinic setting or online).

How do you manage conversations?

Compared to your friends, who is the most talkative?

Describe your level of engagement in conversations with people you know well.

Examples during adulthood[2]:

□ So busy talking that other people find it tiring

□ Known to be an incessant talker

□ Finds it difficult to stop talking

□ Tendency to talk too much

□ Not giving others room to interject during a conversation

□ Needing a lot of words to say something

[1]APA. DSM V (2013); [2]DIVA 5

Impulsivity Symptoms

H/I 7 Often blurts out an answer before questions have been completed[1]

If present, often able to observe this during appointments (whether in a clinic setting or online).

How do you manage conversations?

What happens when a thought comes into your mind? (people with ADHD typically say they worry that they will forget what they wanted to say)

How do you compare your pace (of speech) to that of others? (people with ADHD typically want others to speed up/get to the point)

Examples during adulthood[2]:

□ Being a blabbermouth, saying what you think

□ Saying things without thinking first

□ Giving people answers before they have finished speaking

□ Completing other people's words

□ Being tactless

[1]APA. DSM V (2013); [2]DIVA 5

H/I 8 Often has difficulty waiting their turn[1]

How do you manage standing/waiting in a queue? (people with ADHD might let others queue for them or shop at quieter times, e.g., late at night)

How do you manage traffic? (people with ADHD will very often take a detour/ side road in order to keep moving, even if the journey takes longer)

What is your approach to ordering items online? (people with ADHD typically want next day delivery and will sometimes be willing to pay substantially more in order not to wait longer)

How do you feel when you have to wait for something?

Examples during adulthood[2]:

□ Difficulty waiting in a queue, jumping the queue

□ Difficulty in patiently waiting in the traffic/traffic jams

□ Difficulty waiting your turn during conversations

□ Being impatient

□ Quickly starting relationships/jobs, or ending/leaving these because of impatience

[1]APA. DSM V (2013); [2]DIVA 5

H/I 9 Often interrupts or intrudes on others[1]

When you make decisions affecting others, how do you manage this?

When you need to ask someone else a question, what do you do if they are busy at that moment?

How do you react if someone annoys you?

Examples during adulthood[2]:

□ Being quick to interfere with others

□ Interrupts others

□ Disturbs other people's activities without being asked

□ Comments from others about interference

□ Difficulty respecting the boundaries of others

□ Having an opinion about everything and immediately expressing this

[1]APA. DSM V (2013); [2]DIVA 5

Impairment domains in the DIVA

Work and education

Partner and family relationships

Social contacts

Free time and hobbies

Self-confidence and self-image

- **2 or more required for diagnosis**

Impairment: Work/Education

- **Adulthood**
- □ Did not complete education/training needed for work
- □ Work below level of education
- □ Tire quickly of a workplace
- □ Pattern of many short-lasting jobs
- □ Difficulty with administrative work/planning
- □ Not achieving promotions
- □ Under-performing at work
- □ Left work following arguments or dismissal
- □ Sickness benefits/disability benefit as a result of symptoms
- □ Limited impairment through compensation of high IQ
- □ Limited impairment through compensation of external structure

- **Childhood**
- □ Lower educational level than expected based on IQ
- □ Staying back (repeating classes) as a result of concentration problems
- □ Education not completed / rejected from school
- □ Took much longer to complete education than usual
- □ Achieved education suited to IQ with a lot of effort
- □ Difficulty doing homework
- □ Followed special education on account of symptoms
- □ Comments from teachers about behaviour or concentration
- □ Limited impairment through compensation of high IQ
- □ Limited impairment through compensation of external structure

Impairment: Relationship and/or Family

- **Adulthood**
- □ Tire quickly of relationships
- □ Impulsively commencing / ending relationships
- □ Unequal partner relationship owing to symptoms
- □ Relationship problems, lots of arguments, lack of intimacy
- □ Divorced owing to symptoms
- □ Problems with sexuality as a result of symptoms
- □ Problems with upbringing as a result of symptoms
- □ Difficulty with housekeeping and/or administration
- □ Financial problems or gambling
- □ Not daring to start a relationship

- **Childhood**
- □ Frequent arguments with brothers or sisters
- □ Frequent punishment or physical bashing
- □ Little contact with family on account of conflicts
- □ Required structure from parents for a longer period than would normally be the case

Impairment: Social contacts

- **Adulthood**
- □ Tire quickly of social contacts
- □ Difficultly maintaining social contacts
- □ Conflicts as a result of communication problems
- □ Difficulty initiating social contacts
- □ Low self-assertiveness as a result of negative experiences
- □ Not being attentive (i.e. forget to send a card/empathising/phoning, etc)

- **Childhood**
- □ Difficultly maintaining social contacts
- □ Conflicts as a result of communication problems
- □ Difficultly entering into social contacts
- □ Low self-assertiveness as a result of negative experiences
- □ Few friends
- □ Being teased
- □ Shut out by, or not being allowed, to do things with a group
- □ Being a bully

Impairment: Free time / hobbies

- **Adulthood:**
- □ Unable to relax properly during free time
- □ Having to play lots of sports in order to relax
- □ Injuries as a result of excessive sport
- □ Unable to finish a book or watch a film all the way through
- □ Being continually busy and therefore becoming overtired
- □ Tire quickly of hobbies
- □ Accidents/loss of driving licence as a result of reckless driving behaviour
- □ Sensation seeking and/or taking too many risks
- □ Contact with the police/the courts
- □ Binge eating
-
- **Childhood**
- □ Unable to relax properly during free time
- □ Having to play lots of sport to be able to relax
- □ Injuries as a result of excessive sport
- □ Unable to finish a book or watch a film all the way through
- □ Being continually busy and therefore becoming overtired
- □ Tired quickly of hobbies
- □ Sensation seeking and/or taking too many risks
- □ Contact with the police/courts
- □ Increased number of accidents

Impairment: Self confidence / self-image

- **Adulthood**
- □ Uncertainty through negative comments of others
- □ Negative self-image due to experiences of failure
- □ Fear of failure in terms of starting new things
- □ Excessive intense reaction to criticism
- □ Perfectionism
- □ Distressed by the symptoms of ADHD

- **Childhood**
- □ Uncertainty through negative comments of others
- □ Negative self-image due to experiences of failure
- □ Fear of failure in terms of starting new things
- □ Excessive intense reaction to criticism
- □ Perfectionism

cal Medicine, 1975, **5**, 181–192

Hierarchy of classes of personal illness

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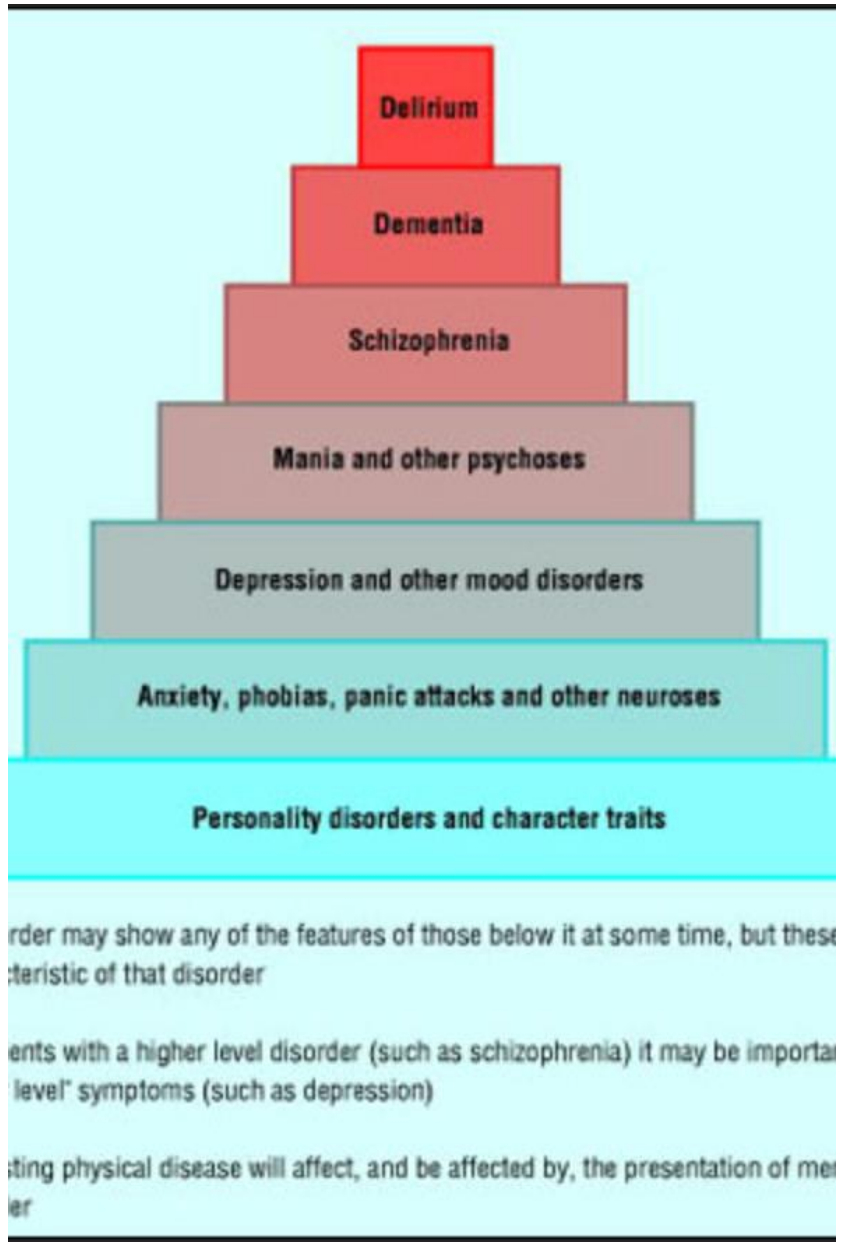

rder may show any of the features of those below it at some time, but these
teristic of that disorder

ents with a higher level disorder (such as schizophrenia) it may be importa
level' symptoms (such as depression)

ting physical disease will affect, and be affected by, the presentation of me
er

Finally: Review all DSM 5 criteria for adult ADHD

- Criteria A: 5 or more symptoms of inattention or hyperactivity-impulsivity
- Criteria B: Several symptoms present by the age of 12
- Criteria C: Several symptoms present in two or more settings
- Criteria D: Symptoms interfere with or reduce quality of social, educational or occupational functioning
- Criteria E: Symptoms are not better explained by another condition, such as mood disorder

- American Psychiatric Association. Diagnostic and Statistical Manual (DSM) of Mental Disorders. 5th Edition 2013

Presentation subtypes in DSM-5

- *Combined*
- *Predominantly inattentive*
- *Predominantly hyperactive-impulsive*
- *ADHD in 'partial remission'*

Competencies of Assessor

Who can diagnose?

Clinical judgement
Ability to carry out **Differential Diagnosis** is central to making a diagnosis
Ability to assess for **Comorbidities**: psychiatric and physical conditions
Ability to assess the **impact** • of each condition on the other • of each treatment on the other condition and the drug-drug interactions

UKAAN
UK ADULT ADHD NETWORK

Who can diagnose independently?

Competent in assessing a range of psychiatric and common physical conditions
Able to carry out a comprehensive assessment to enable safe prescribing
In ***'mental health'*** clinical practice for at least several (5+) years
At least at Band 7/8A level with relevant ADHD diagnostic training and evidence of numerous supervised cases – ongoing 1:1 or peer supervision essential

ADHD Co-morbidity

- At least 3/4 of adult ADHD patients meet criteria for a comorbid condition
- Up to 20% of patients have 2 or more comorbid disorders
- Affective disorders, including bipolar disorder, anxiety, substance abuse, and learning disabilities are the most common
- Comorbidity contributes to the failure in diagnosis of ADHD in adults
- Comorbid symptoms are generally less responsive to stimulants

Biederman (1993) Am J Psychiatry 150(12):1792-1798; Brown TE, ed. (2000), Washington, D.C.: American Psychiatric Press

Quality Standards- ADHD assessment

Standard Number	Description	Essential/Optional	Status	Comments
1	Professional information (optional)	Optional	N/A	
2	Duration of assessment (essential)	Essential	N/A	
3	Outline of assessment process (essential)	Essential	N/A	
4	Third-party information (essential)	Essential	N/A	
5	Inclusion of all standard psychiatric history sections (essential)	Essential	N/A	
6	Detailed account of individual symptoms (essential)	Essential	N/A	
7	Use of semi-structured interview format (optional)	Optional	N/A	
8	Semi-structured interview in-person (optional)	Optional	N/A	
9	Scores from interviews and questionnaires (essential)	Essential	N/A	
10	Narrative with life history examples (essential)	Essential	N/A	
11	Reference to diagnostic criteria and evidence (essential)	Essential	N/A	
12	Exploration of complex factors (essential)	Essential	N/A	
13	Formulation of ADHD presence with comorbidities (essential)	Essential	N/A	
14	Rationale for ADHD medication initiation (essential)	Essential	N/A	

Introduction and Context in adult ADHD

Useful Definitions and Categorisation

Basic Aetiology and Course of ADHD

Basics of diagnosis- diagnostic approach

Collecting a history for ADHD

Take home messages

ADHD is a Disorder not a Diversity

ADHD diagnosis is not for life

ADHD diagnosis is one of exclusion

ADHD assessment should follow a mental health assessment

No impairment – No diagnosis