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Assessments for adult ADHD:

what makes them good enough?

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Submitted: 20 August 2023; **Editor's response:** 3 September 2023; **final acceptance:** 3 September 2023.

DOI: https://doi.org/10.3399/bjgp23X735213

INTRODUCTION

Concerns have been raised in the media[1] over the quality of assessments for adult attention deficit hyperactivity disorder (ADHD) and the role of the private sector.[2] Patients who feel unable to accept long NHS waiting lists and NHS commissioning bodies (including via 'right to choose') may pay significant sums for ADHD assessments, often without knowing how valid or cost-effective they are. Patients subsequently expect GPs to prescribe medication (mainly stimulants, which are controlled drugs) when primary care staff may have questions about the rigour of the diagnostic assessment or treatment. The patient may then be referred for a long awaited new NHS assessment, with difficulties if the diagnosis is rescinded. A published framework of what expert consensus deems a high-quality assessment would be useful to patients, GPs, commissioners, psychiatrists, and others. This could help GPs to have more confidence to challenge poor assessments and accept good ones. It might help patients to decide where they spend money and commissioners to consider service-level agreements.

The UK Adult ADHD Network (UKAAN, www.ukaan.org), was founded in 2009 and provides training courses, education, support, and research for professionals working with adults with ADHD. UKAAN has been working for over a year to produce an expert consensus statement for an Adult ADHD 'Assessment Quality Assurance Standard (AQAS)'. Boxes 1 and 2 provide a summary from the AQAS of what a quality assessment should constitute.

APPROACH TO HISTORY-TAKING

Assessment of adult ADHD should not be seen in isolation but as only part of a full psychiatric and neurodevelopmental review. The assessor must keep an open mind to the differential diagnosis: ADHD may be one of several potential diagnoses contributing to the impairment experienced over the patient's lifespan. Very high rates of comorbidity with ADHD can make this a considerable task, and ADHD should not be diagnosed when another condition better explains symptoms and impairments. The assessor must be familiar with autism spectrum, mood/bipolar, personality, and substance use disorders, and other comorbidities and differential diagnoses. It is also important to consider physical comorbidity, particularly conditions that have a bearing on prescribing medication for ADHD or may cause symptoms resembling those of ADHD.

THE 'THREE Ps': PERSISTENT, PERVASIVE, AND PROBLEMATIC

ADHD is a 'lifespan condition'. To meet DSM-5-TR criteria for ADHD,[3] symptoms must be 'trait-like'. Symptoms must *persist* over time, with at least several symptoms since childhood. They must not be episodic. Symptoms must be *pervasive*, that is, occur in different settings. They must be a significant *problem*, that is, impairment from symptoms is at least moderate in two domains, for example, education, work, relationships, or leisure activities.

SKILLS NEEDED FOR ASSESSMENT

The assessor needs to have good interview skills. A semi-structured interview must allow open questions with appropriate elaboration and reflection. Probing is required to elicit real-life examples of symptoms and impairments in the individual's daily life. Assessments that rely on a checklist of closed questions ('tick boxes') based on the DSM-5-TR list of 18 symptoms of inattention, hyperactivity, and impulsivity run the risk of confirmation bias, and may fail to properly consider important differential diagnoses. Relying excessively on rating scales and pre-test questionnaires for evidence of symptoms may play into this.

Objective or third-party information, where possible, should be used to corroborate the nature of symptoms and severity of impairment. The report should give examples that illustrate how diagnostic criteria apply and provide sufficient description of the

Box 1. Essential components for diagnostic assessment

- Presenting complaint(s).
- Full psychiatric history.
- Neurodevelopmental evaluation.
- Past medical history for potential contraindications to treatment.
- Semi-structured interview with open questions and elaboration; not merely a checklist; not simply 'yes or no' questions; careful use of, not reliance on, questionnaires or rating scales – with adequate probing during the interview. All relevant areas of life (for example, education, employment, leisure, relationships, daily task and health management) need to be reviewed in detail to establish the presence of ADHD traits, avoiding a linear (symptom after symptom) approach.
- Explicit detailing of which DSM-5-TR symptoms of inattention, hyperactivity, and impulsivity are persistent, pervasive, and problematic; and how they cause at least moderate impairment in two domains, with detailed illustrative examples.
- Discussion of independent evidence, including informant questionnaires, used to support the diagnosis.
- Consideration of differential diagnoses and comorbidity.

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symptoms and impairments, to allow other stakeholders to have confidence in the diagnosis.

Some of the skill in performing ADHD assessments is in ascertaining when ADHD is not present. The patient may report symptoms appearing to be ADHD, which upon further enquiry might be subthreshold, or better explained by another condition. This may be difficult when a patient strongly believes they have ADHD and they have paid significant sums to 'confirm' it.

AFTER DIAGNOSIS

After diagnosis, it is important to provide the patient with a detailed explanation and psychoeducation about ADHD, in understandable language. The assessor must allow the patient to reflect on the diagnosis and the opportunity to ask follow-up questions. Psychosocial issues should be discussed, including educational, occupational, and social impacts (including driving).[4]

It can be useful to focus on a small number of measurable goals before starting treatment. The treatment should be focused on reducing symptoms and real-life impairments. All available treatment options[5] must be discussed, including non-pharmacological ones, and the reasons for preferring a particular treatment must be made clear. Potential side effects and contraindications should be considered. This takes time and may work better in a separate consultation.

Follow-up should be arranged and there should be liaison with the GP about ongoing treatment, including whether the GP is willing to take over prescribing when the patient has finished titrating doses and has been stable. It can help if specialists understand that 'shared' care, in England, is a euphemism for transferring extracontractual work to primary care, typically unfunded, with continuing access to specialist oversight when indicated.

TRAINING AND RESOURCE ISSUES

Such assessments require significant skill, which may require learning through dedicated courses, shadowing adult ADHD specialists, and continuing professional education involving ongoing peer supervision and case discussions. The skills of assessors are more important than their primary professional qualification. While it would be preferable for adult ADHD assessments, particularly for straightforward cases, to move into mainstream services[6] rather than a small number of tertiary clinics, this must not compromise the quality of assessment and accuracy of diagnosis. It is accepted that resource constraints can make it difficult to offer an ideal assessment or treatment in every case, but this should not detract from the essence of a high-quality assessment.

The direct contact time of the diagnostic assessment is likely to be at least 2 hours, in most cases, conducted over single or multiple sessions; this includes the assessment, discussion of the diagnosis and treatment, and initial psychoeducation. Timing may be longer depending on the complexity of the case and the skill of the assessor. The complexity of case-mix may depend on the nature of referral pathways, including self-referral, thresholds for referral, and how cases are screened prior to formal assessment. Information obtained from referral letters, previous medical notes, questionnaires, and so on can be important.

Box 2. Essential components post-diagnosis

- Detailed feedback, explanation, and psychoeducation about ADHD, in clear language.
- A discussion about psychosocial issues, including education or occupation and driving.
- Time to reflect on the diagnosis and ask questions.
- A discussion to allow shared decision making about available treatment options, consideration of contraindications, and reasons for preferring one treatment to others.
- Consideration of measurable treatment goals before starting treatment.
- Physical monitoring for medication (clinical examination, blood pressure, pulse, and weight) at baseline and during treatment.
- Liaison with the GP to ascertain whether the GP is willing to take over future prescribing, while recognising there may be different patterns of 'shared' care.

Provenance

Freely submitted; not externally peer reviewed.

Competing interests

The UK Adult ADHD Network has accepted pharmaceutical company sponsorship for some educational meetings from Janssen-Cilag Ltd, Lilly, Shire Pharmaceuticals, Flynn Pharma Ltd, The Waterloo Foundation, and Alcobra. These were small sums, were not the main source of funding, and the companies had no input into the nature or content of the meetings.

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