Assessment of attention deficit hyperactivity disorder

ONE OF the main drains on child and adolescent mental health services (CAMHS) is the input required for the assessment and treatment of children who have possible attention deficit hyperactivity disorder (ADHD). Forth Valley Primary Care NHS Trust is no exception: of the 1,162 referrals received between April 2001 and April 2002, a large number were suspected of having hyperactivity and/or ADHD. In addition, the service already had a large caseload of children diagnosed with ADHD.

Historically, children who were referred with suspected ADHD went straight to psychiatrists for assessment, since it is the psychiatrists who are responsible for prescribing and monitoring any medication that is needed.

However, the large number involved meant the psychiatrists’ caseloads were being filled by young people with possible ADHD. The knock-on effect was that children with other mental health problems were at risk of waiting longer to be seen, these included patients with depression, anorexia or those who were suicidal.

Staff at Forth Valley Primary Care NHS Trust decided to develop multidisciplinary assessment and treatment interventions that would make the most of the service’s resources. It was hoped that these interventions would alleviate the above pressures and shape the service delivery for this client group.

**Patient assessment**

When a child presents to the CAMHS for assessment, clinical nurse specialists or nurse therapists carry out an initial interview with the child’s parents or carers. This interview forms the foundation of the assessment. A history is obtained relating to the young person’s presentation in order to help reach a diagnosis and assist with the formulation of a treatment plan.

It is important to establish whether there were any obstetric or perinatal complications associated with the birth of the child. Complications, including pre-term delivery and maternal tobacco, drug and alcohol misuse have all been associated with ADHD. A chronological picture of the child’s difficulties is extremely useful, so a full developmental history, including the acquisition of developmental milestones should be sought.

There is some evidence to support a genetic link to ADHD (Biederman et al, 1990), so details of the child’s immediate and extended family should be obtained, including any history of psychopathology. Gaining a clear understanding of family function is important for almost all cases that are referred to CAMHS, and Offord et al (1992) saw this as being no different when assessing for ADHD. They assert that an assessment of family function, including relationships within the family, communication patterns between family members, parental management techniques and any marital discord should be explored.

Regardless of the presenting complaint or difficulty, it can be useful to see the child or young person alone. This can give the assessment another dimension and help the practitioner to gain an understanding of the difficulties from the child’s perspective. Hinshaw (1994) supports this, stating that children and young people are often more reliable than their parents in reporting the internalisation of symptoms, such as anxiety or depression.

Questionnaires and other scales are often used in the CAMHS to assist with assessment and to monitor the efficacy of interventions. The main scales used with ADHD are the Conners’ Teachers, Conners’ Parent and Conners’ Self-Rating Scales (Conners, 1973).

Assessing the child’s academic ability is important, as a high percentage of children with ADHD also have co-morbid learning difficulties. This may affect educational attainment and long-term prognosis (Silver, 1990).

**Treatment of ADHD**

The overwhelming choice for first-line treatment of ADHD is the use of pharmacological therapy. Barclay (1977) demonstrated that the use of psychostimulants led to a reduction of core symptoms of ADHD in 70 per cent of children. Stimulants also improved cognitive ability and behaviour, compliance and parent-child relationships, as well as reducing fidgeting, impulsive behaviour and aggression. Schachar and Tannock (1993) indicated that psychostimulant treatment was superior to non-pharmacological interventions.

Other longer-term studies (Multimodal Treatment Study of Children With Attention-Deficit/Hyperactivity Disorder (MTA) Cooperative Group, 1999; Greenhill, 1998) found psychostimulants to have a persistent positive impact on the core features and symptoms of ADHD over time. The main psychostimulant of choice in the UK is methylphenidate.

There is also an important role for behavioural interventions in the treatment of ADHD, while parenting interventions have been found to be useful in improving compliance as well as improving parental well-being (Anastopoulos et al, 1993).

**Developing ADHD assessment and care at Forth Valley**

In order to make efficient and effective use of the CAMHS’s resources and spread the workload while ensuring high standards of care, two developments were proposed:

- The production of guidelines that would allow nurses to share the responsibility for assessment and treatment of this client group;

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**ABSTRACT**


Increasing numbers of referrals of children with possible attention deficit hyperactivity disorder (ADHD) for psychiatric assessment are significantly adding to psychiatrists’ workloads. In Forth Valley Primary Care NHS Trust the situation had reached a point where children with other mental health problems were having to wait longer for appointments. Two developments were implemented that aimed to ameliorate the problem by making better use of the skills of clinical nurse specialists and nurse therapists. Guidelines were drawn up for nurse assessment of children with suspected ADHD, and a dedicated active behaviour clinic was established to diagnose and review children with the condition. The developments have improved the services for children with ADHD and have given psychiatrists more time to spend with other client groups.
The implementation of a multidisciplinary and dedicated clinic to assist in the assessment and treatment of children and young people with ADHD.

Assessment and treatment guidelines
Clinical nurse specialists (H grades) and nurse therapists (G grades) working in child and adolescent psychiatry outpatients are case managers, responsible for their own cases from initial referral through to discharge. Historically, where a diagnosis of ADHD has been likely, the cases were handed over to a psychiatrist. This needed to change. Psychiatrists’ caseloads were becoming overloaded with ADHD cases, restricting their input to other clinicians’ cases and delaying their involvement in cases that required their opinion. At the same time nurses working at a specialist level within CAMHS had the skills to assess, treat and manage these cases. Developing guidelines that would enable nurse specialists to assist in the assessment and treatment of ADHD was an obvious way forward.

Most importantly, by spreading the workload of ADHD cases, we would be in a better position to improve existing interventions and develop specialist and adolescent mental health services, as outlined by the Health Advisory Service (1995). Given the finite resources within the CAMHS, we hoped the guidelines would help us to deliver a better quality of service for this patient group.

Carrying out the assessment
During the assessment a full history is taken, ensuring that the following points are covered:

- History of presenting problems;
- Obstetric and perinatal history;
- Detailed developmental history;
- Family history;
- Psychosocial history;
- Educational history.

The initial interview normally takes place with the family present. Hoare (1993) emphasises the importance of involving the child in the initial interview with the whole family. This gives the clinician the opportunity to hear how the child sees his or her difficulties in the context of the family. It is recognised that although children and young people are not always reliable in reporting their externalising behaviour, they are more reliable than their parents at reporting internalised symptoms such as anxiety and/or depression. This is important when considering comorbidity (Hinshaw, 1994).

A private interview with the child or adolescent on their own is also carried out. This is an important way of engaging the child or young person within the therapeutic process. It helps by:

- Establishing trust and confidence between the child and the nurse;
- Allowing the nurse to show concern and interest in the child as a person and to value the child’s point of view;
- Giving the child the opportunity to talk separately about their own views of the problem;
- Providing the opportunity to elicit the child’s feelings or worries (Hoare, 1993).

Further steps in the assessment process include the completion of the Conners’ Parents’ Questionnaire and the Conners’ Teacher’s Questionnaire. It can be useful to go through these questionnaires with the parents and the teacher, to hear examples of specific types of behaviour being described, particularly if the scores given on the questionnaires are high.

The child’s class teacher is also interviewed. The purpose of this is to help give the nurse an understanding of the child’s academic ability, presentation in the classroom and playground, and ability to relate to and interact with his or her peers.

The child will be observed in the classroom (by a clinician the child does not know). If observed in the school by a nurse whom the child has previously met, the child will invariably behave differently from normal – either being more boisterous and attention-seeking or trying hard to control his or her behaviour in order to impress ‘the visitor’. It is better, therefore, to have the child observed by an unknown nurse. The nurse will be able to see how much the core features of ADHD – such as inattention, impulsiveness and hyperactivity – impact on the child during school hours.

Throughout the process the nurse involved in the case will liaise with other agencies (health visitor, social worker, paediatrician, educational psychologist, school and GP) as appropriate to gain a full picture of the child or young person with suspected ADHD.

After carrying out all of the above, the case is discussed with the team, including the consultant psychiatrist. At this point, the team may suggest further preliminary work to be carried out by the nurse. If no further work is required the nurse and consultant psychiatrist meet the child and family. Towards the end of this meeting, the nurse and the consultant psychiatrist will have a further discussion regarding diagnosis and treatment options.

If a diagnosis of ADHD has been confirmed and a trial of methylphenidate agreed, the family is informed of the diagnosis and the psychiatrist and/or nurse discuss with the family the possible benefits of the trial. From this point the nurse carries on with case management and has responsibility for the case, but will meet with the psychiatrist at agreed intervals to discuss the medication.

Treatment
The nurse has a number of roles/responsibilities in respect of methylphenidate treatment:

- Monitoring blood pressure, height and weight;
- Monitoring for adverse side-effects;
- If required, advising the patient/family to change the time of the dose;
- If required, advising the patient/family to increase or decrease the dose (by no more than 10mg).

The latter two responsibilities are optional and prior discussion and agreement must take place between the psychiatrist and the nurse. The psychiatrist will then clearly state the changes that can be made to the pre-

REFERENCES


For related articles on this subject and links to relevant websites see. www.nursingtimes.net
Agree to any changes in medication per protocol.

2.00–5.00pm

Patients are reviewed. Each child is given a half-hour appointment and the last appointment is at 4.30pm. A clinical nurse specialist, nurse therapist, consultant psychiatrist and occasionally a senior house officer on rotation review patients independently. This means that up to four patients can be seen in the clinic at one time. Therefore, 20 in total can be reviewed at an ABC clinic. The appointment is only to discuss medication, that is dose or side-effects. If the clinician is alerted to any other issues that fall outside the remit of the ABC, an early appointment can be arranged for the patient to see his or her own case manager.

10.15am

Clinicians screen the interview in another room via a video link.

The interview stops and the two clinicians who were interviewing discuss the interview with those who have been screening. The family is left in the screening room with the video equipment off. All information from the case manager’s assessment is considered as well as how the child presented on the day. Usually a consensus is reached regarding diagnosis or the need for further assessment.

10.45am

The family is given feedback by the clinicians who interviewed them.

11.00am

Coffee.

11.15am

Discuss Case 2.

11.30am

As at 9.30am.

12.15pm

As at 10.15am.

12.30pm

As at 10.45am.

12.45pm

Business lunch. The nurse and psychiatrist discuss all the review cases to be seen in the afternoon and

Reflection on this service development

Given the limited resources in the service and the ever-increasing demands placed on it, an overhaul of service delivery for children with ADHD was necessary. Undertaking change is often difficult for teams and services. After careful negotiation and compromise between all clinicians directly affected, we agreed to implement the protocol and the ABC.

With all the ongoing changes to nurse prescribing we were cautious with the guidelines. There was no reference to ‘supplementary prescribing’, as methylphenidate is a controlled drug and can only be prescribed by medical staff. The UKCC’s Scope of Professional Practice (1992) was used in considering the role the nurses were taking on with the protocol – this emphasised the importance of working within our limitations. The view of the team – and the trust – is that nurses at G-grade level and above were easily capable of working to the guideline.

The workload throughout the service is now more evenly distributed and as a result standards of care have improved for young people with ADHD. They are now being seen sooner and once treatment has started, they are reviewed on a more regular basis.

These developments are not perfect, but the service is now able to assess and review more children with ADHD than ever before and the view from those delivering the service is that it has improved. Importantly, the ABC and protocol have helped to raise staff morale and improved the profile of the nurses involved, as their clinical practice has been raised to a higher level.

Overall, the ABC and the protocol are regarded by staff as helpful models of working and, anecdotally, the consensus is that a diagnosis of ADHD is arrived at or excluded via a very detailed assessment process.