

ADHD

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Communication and clarity pay off

“ Misconceptions about attention deficit hyperactivity disorder (ADHD) are not only found among the general public: I often come across teachers and even doctors who believe certain myths about ADHD. Improving knowledge of transitioning to adult care, co-morbidities and successful therapies, and breaking the silence about stigma is important for every new generation of patients, parents and care providers.

It is refreshing to read the article by Iliana Singh and Lauren Baker on the VOICES (Voices on Identity, Childhood, Ethics & Stimulants: Children join the debate) study, where children's thoughts on expectations, concerns, labelling and treatment are investigated. As professionals, we have to listen carefully to these opinions, as we try to work in the most effective and empathetic way on our patient's behalf. It is, therefore, astounding to read that the communication between doctor and patient is sometimes absent: like talking to the person pushing the wheelchair instead of communicating with the handicapped person themselves. I hope the results from this study can be replicated in other countries: the lessons are important, not only for professionals who care for children, but also for those who treat adolescents and adults.

In her article on transition, Noreen Ryan stresses the need for swift investigation into the possibilities of adolescent and adult ADHD services. Meanwhile, Nigel Humphrey reviews some of the more or less objective methods used to diagnose adult ADHD. Knowledge and available support are very different in various parts of the world. In some countries, ADHD children and adolescents are treated by their child psychiatrist or paediatrician well into their 20s, when they should be mature enough to

function as adults. In contrast, some decades ago, children were not treated past the age of 13. It would be useful to convey the messages in Nigel Humphrey's article to adolescents and young patients.

We are progressing slowly towards more comprehensive and evidence-based care for adolescents and adults, with long-term studies on the negative impact of delayed diagnosis and treatment recently published.^{1,2} Risk perception can be difficult to change in your own life and more effort should be put into adequate guidance. This also goes for other (difficult to manage) health risks such as obesity, drinking and smoking. The majority of ADHD cases will have one or more comorbid psychiatric or physical disorders, such as enuresis, obesity or atopic disease. Hervé Caci and Charles Lehéron conducted a small study on the presence of atopic dermatitis in ADHD patients and found a relationship between the two. However, the reason for this is not clear and more research is required.

Since the MTA (Multimodal Treatment of Attention Deficit Hyperactivity Disorder) study concluded, it has been common practice to treat ADHD patients with evidence-based therapy: psychoeducation and medication. Isabel Hernández Otero and Maria Jose Ortega Cabrera added emotional and cognitive components to the psychotherapeutic intervention for adolescents, introducing a more functional way of mediating conflicts between children and parents with the use of a reflective team. This method seems worth trying in more complicated adolescent cases. As ADHD is a complex and heterogenic disorder, it is important to consider treatment from an individual viewpoint. ”

Rob Rodrigues Pereira, Paediatrician

Declaration of interest
None declared.

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Call for articles!

ADHD in practice welcomes submissions of review articles, case studies, opinion pieces and original research covering all aspects of management of ADHD in children, adolescents and adults. We are particularly keen to hear from practitioners across Europe.

Articles should be original, topical and not previously published elsewhere. All articles must be submitted in English. Before submitting a full article, you may first wish to submit a brief outline to the Editor.



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ADHD and stigma: the role of environmental factors

The VOICES (Voices On Identity, Childhood, Ethics & Stimulants: Children join the debate) study investigated claims about the ethical harms of attention deficit hyperactivity disorder (ADHD) diagnosis and stimulant drug treatments. We focused on three ethical concepts: authenticity, moral agency and moral responsibility. We also investigated children's perspectives on broader societal concerns about behavioural norms and childhood experiences; schooling expectations and academic pressures; and stigma associated with ADHD.

In this article, we report on the finding that ADHD was viewed and experienced by diagnosed children in different ways in the USA and UK. We discuss the different forms of stigma experienced in these two countries and we show the close association between stigma and contextual understandings of ADHD. We argue that medical professionals should do more to directly engage with their paediatric patients to better understand, and to help combat, stigma.

Method

A total of 151 families in the USA and the UK were recruited into the study. Qualitative interviews were supported by quantitative measures and analyses. We held interviews of approximately one hour with all child participants, and we questioned parents and caregivers about the family context and the nature of support they had received from health-related and educational services. We gained a broad understanding of local educational, socioeconomic and political pressures by visiting support groups for parents of children with ADHD and by talking with local clinicians and teachers. We collected data on cur-

rent symptoms, self-perception and quality of diagnosis using standardised measures.

Three groups of children aged between nine and 14 years were included in the study: children who were taking stimulants for diagnosed ADHD, children who had a diagnosis of ADHD but were unmedicated and children without a psychiatric diagnosis as a comparison group. The average child in the VOICES study was an 11-year-old, lower-middle class white boy (see Table 1).

Families with diagnosed children were recruited through NHS clinics in the UK and through university and community clinics in several US states. Children without a diagnosis were recruited

through a market research firm and through the snowball recruitment technique. A brief behavioural screen was used to recruit undiagnosed children with some experience of behavioural difficulties, but who had not been referred for evaluation for ADHD.

Current ADHD symptoms were measured using the Conners Comprehensive Behavior Rating Scales, Parent Form. Overall, we found no significant differences between US and UK children on the Conners' test, but UK children scored significantly higher on the oppositional subscale (see Figure 1).

Assessment and treatment of ADHD in the USA and UK

Approaches to assessment and treatment of ADHD can differ between the USA and the UK.¹ In both countries, clinicians use child behaviour checklists that elicit information from multiple sources, such as the Conners Comprehensive Behavior Rating Scales.² However, in the USA, the mental health-related expertise of the diagnosing clinician can vary considerably: it is possible to obtain an ADHD diagnosis from a primary care physician (GP), a nurse, a paediatrician, a psychiatrist or a neurologist. In the UK, assessment for ADHD is usually performed in a specialist child psychiatric service. The VOICES study used a 'quality of diagnosis' questionnaire to ascertain that the diagnosis received by recruited children in both countries was broadly similar.

A recent analysis suggests that, in the USA, 15% of school-age boys and 7% of school-age girls have received a diagnosis of ADHD; approximately two-

Approaches to assessment and treatment of ADHD can differ between the USA and the UK

Table 1. Demographic characteristics of children in the study

Participants (n=151)	Gender	Mean age	Mean SES	Ethnicity
USA (n=69)	60.9% male, 39.1% female	11.41 years	Class III–IV (middle to lower-middle class)	66.7% white, 23.2% black, 10.1% other
UK (n=82)	80.5% male, 19.5% female	10.87 years	Class III–IV (middle to lower-middle class)	86.6% white, 3.7% black, 9.8% other

SES = socioeconomic background

thirds of those diagnosed receive pharmacological treatment. Approximately 3% of school-age children in the UK are thought to have ADHD. In the UK, the National Institute for Health and Care Excellence (NICE) recommends drug treatment as the first-line treatment for school-age children with severe ADHD, but recognises parent training as the first-line treatment for preschoolers.³ In both countries there is a lack of further, evidence-based alternative treatment options for children with ADHD.

Ecological niches: good performance versus good conduct

The VOICES study used the concept of the ecological niche to analyse the complex and subtle dynamics between a child and the surrounding environment.⁴ Two niches were discovered in the VOICES study, the 'performance niche' and the 'conduct niche'. These niches give rise to different experiences with ADHD diagnosis and stimulant drug treatments.

In a performance niche, children's cognitive achievements and successes are strongly emphasised, and ADHD is viewed as a disorder of academic performance. Children articulate the effects of stimulant drugs in relation to classroom behaviour, school work, intelligence and academic achievements.

We might say that in a performance niche, a dominant preoccupation is 'doing well':

Interviewer: Tell me about a time when you weren't very happy with how you behaved.

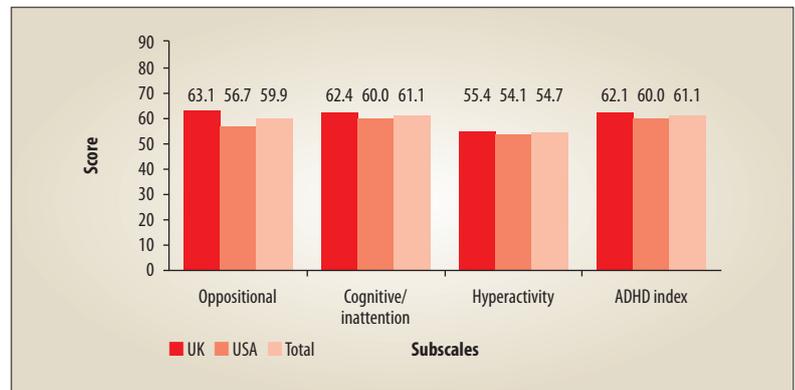
Child: I got my name on a board, and I got Fs on my report card, and my mom was really mad. And she told me that I need to do better ... I was really happy this year, that it's really good. But last year, I wasn't paying attention. (Rose, USA, aged 11)

In a conduct niche, children's social behaviours and social hierarchies are a dominant preoccupation among children and adults, and academic achievement does not outrank other obligations. ADHD is viewed as a disorder of anger and aggression, and stimulant drugs are seen by children to improve emotional self-control, aggressive behaviours, social status and moral decision-making.

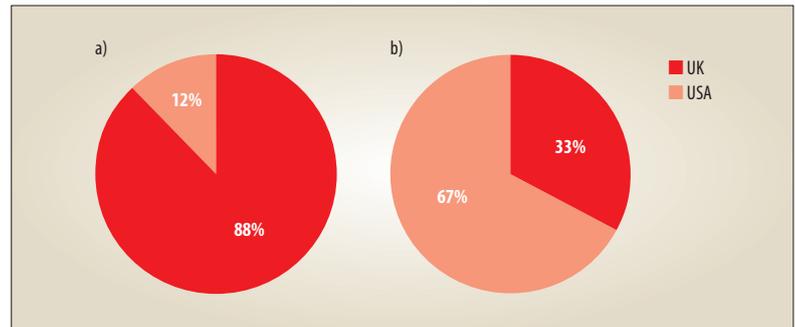
We might say that in a conduct niche, a main preoccupation is 'being good':

Interviewer: Tell me about a time when you felt good about your behaviour.

Child: I feel good about my behaviour if I've been, like, good all that time and if someone's, like, rewarded me at school, like and said how good I am, or they write ... to my parents saying how good I've been. Something like that would make my day. It's just like normal praise



■ Figure 1. Conners' test results by subscale and country (n=151)



■ Figure 2.
a) Proportion of children who spontaneously report that stimulants help to manage anger and aggressive behaviours.
b) Proportion of children who spontaneously report that stimulants help to improve classroom and academic performance

really. Like, if I do good on tests and everything, that is a bonus, but if I've been good because I've not been, like, disrupting or anything all day, because I've controlled my ADHD, that's like, even better. (Sean, UK, aged 12)

Alongside the association with anger and aggression, ADHD in a conduct niche was sometimes associated with being 'thick' or 'slow'. Some children wished they could be 'more clever', but far fewer associated stimulant drug treatment with academic achievement as compared with children in the performance niche.

These two niches are not exhaustive of all possible niches in an environment; nor are niches necessarily wholly distinct. More research to describe ecological niches and their contribution to ADHD behaviours and the experience of ADHD is needed.

In the VOICES study, these niches were associated with national differences. Among the US children we interviewed, the performance niche was the most common niche environment, while among the UK children, the conduct niche was the most common niche environment (see Figure 2).

The study did not specifically investigate the underlying reasons why, for example, the UK sample was found to be predominantly in the conduct niche. However, in any small, non-randomised sample, there is a recruitment bias. One source of bias is that our UK sample did not include children from public schools, where it is likely that more emphasis is placed on academic performance.

Epidemiological factors may also pertain; for example, the predominance of the conduct niche in the UK may reflect a socioeconomic class bias in

ADHD diagnoses. Although no difference was found in the average socioeconomic class status of US and UK children in the sample, there is (as yet unpublished) evidence that ADHD diagnosis in the UK is more likely among children of lower socioeconomic status.⁵

Finally, stigma (discussed below) is a relevant social driver that maintains biased social understandings of ADHD and may, therefore, impact on the way difficulties with self-control are identified and assessed by adults, as well as how they manifest themselves in children's behaviour.

Stigma and ecological niche

Children's experiences of stigma differed markedly across the two ecological niches. In the conduct niche, children with an ADHD diagnosis were frequently well known to others as having an 'anger problem'; they were a highly visible part of the social fabric. Most children did not try to keep their diagnosis a secret. In the conduct niche, many children with and without a diagnosis of ADHD reported experiences of active and persistent bullying. Many children with ADHD admitted that they were both victims and victimisers of others. As victims of bullying, children with ADHD were frequently targeted specifically for their behavioural difficulties. They were purposely 'wound up' by other children:

Because I told them about my ADHD, they thought if they could wind me up I'd get really upset and they love to do that ... [Teachers] know what I'm like, but I don't think they really know how hard it is for me to cope.
(Heidi, UK, aged 11)

In the performance niche, most children wanted to keep their ADHD diagnosis a secret – from friends, teachers (where possible) and even from family members outside immediate family.

No one knows [about my ADHD diagnosis] except my teacher. I don't want anyone to know I have ADHD. They'll spread it all around school and then everyone will laugh at me. (Brendan, USA, aged 11)

The consequences of secrecy

Secrecy was more possible in the performance niche because many children in that niche had less obtrusive symptoms than those in the conduct niche. Secrecy was also enabled by parents in the performance niche, who felt strongly that children should not tell peers about the diagnosis. Parents thought that the child might feel shame or embarrassment, or might be bullied by others. Par-

ents also worried about 'courtesy stigma' – that is, that they would be seen as bad parents for having pursued a diagnosis of ADHD and/or having accepted stimulant drug treatment for their child.

There were several consequences of this secrecy for diagnosed children. Many children worried about stigma, even though they had never had any stigmatising experiences and could not recall any child who had been bullied or teased for having a disability in their school. This is called 'expected stigma' and probably results, in part, from children's contact with the high level of parental anxiety around an ADHD diagnosis.⁶ National disability legislation has had an impact on ADHD children's stigma experiences; for example, US schools have strict rules about discriminatory behaviour by students and teachers (including bullying) on the basis of disability.⁷ In the UK, the Equality Act (2010) includes ADHD as a disability, but the act has not motivated a clearly enforced set of anti-bullying or anti-discrimination guidelines for ADHD pupils in UK schools.⁸

In addition, many performance niche children we interviewed did not know what ADHD is. Some children who had been diagnosed with ADHD, but were not taking stimulant medication, were unsure whether they had a diagnosis of ADHD.

I don't know what it [ADHD] means but I know it means lying and being nosy. (Ron, USA, diagnosed, aged 10)

ADHD is kind of like a cancer disease but you're not going to die from it. (Sylvia, USA, diagnosed, aged 11)

We hypothesise that children's lack of knowledge about ADHD may be due, in part, to the pervasive silence around the diagnosis. Children who are urged to keep ADHD a secret are unlikely to ask for clarification of what it is, or whether they have it. It is also possible that our findings represent how children manage their ADHD in public at a particular age. Older children may feel more confident about sharing the fact of their ADHD diagnosis with others.

Research suggests that silence and secrecy are not a good way to tackle stigma.⁹ These coping strategies are likely to encourage anxiety and shame in children, and to prevent them from accessing resources to respond to inaccurate or demeaning accounts of ADHD. Secrecy can also have a negative impact on friendships.

Research on stigma suggests that one of the best ways to combat stigma around mental disorder is to meet a person with that disorder.¹⁰ While conduct niche children report that peers, and even some teachers, engage in stigmatising and bullying behaviour around ADHD, diagnosed children

Research suggests that silence and secrecy are not a good way to tackle stigma

in the conduct niche have more opportunity to disprove stereotypes than children who keep their diagnosis a secret.

We think that the opportunity to have a say in what ADHD means, and to defy stigmatising assumptions, is profoundly important. Children should be actively supported in this opportunity by adult caregivers and medical professionals.

Medical professionals as a means of support for children with ADHD

US and UK children in the VOICES study reported that they had little meaningful contact with medical professionals. After the initial evaluation, clinic visits tended to focus on side effect checks, during which children were weighed and measured. Most children were not asked any questions, nor did they volunteer any questions during these visits:

When I see the doctor, he doesn't say anything to me. He just asks my mum questions and I go and get weighed. It's OK because it doesn't take long, but it's not helpful or anything. (Reese, UK, aged 11)

Sometimes he looks at me and, like, asks if I'm taking my pill, like regularly. But mostly it's just, um, stuff, like, about getting a prescription and talking to my parents. (Rhonda, USA, aged 12)

Given the ethical concerns that arise from ADHD diagnosis and stimulant drug treatment, it is imperative that children are able to openly discuss their experiences of ADHD behaviours, stigma and medication with medical professionals. The clinic visit should be a time when children are invited to speak and to ask questions. Follow-up visits should encompass discussion about how to manage potential problems the child is experiencing as a result of having ADHD. Children who had contact with medical professionals who provided an open, non-judgemental space for this discussion found it motivating and useful:

I feel like I can talk to Dr X. She's really nice and doesn't seem to think I'm doing stuff on purpose like other people do ... I mean, she's also helped me see that sometimes I can control myself better if I try. (Tony, USA, aged 10)

Conclusion

An important discovery of the VOICES study is that, with support, children with ADHD can be reflective about the inputs that help and hinder their capacity for self-control. Stimulant medication is reported to be helpful, but environmental factors such as stigma, bullying and support from teachers and medical professionals play an important role.

Our interviews with children have been made into an animated film that communicates the VOICES study findings in their own words, which you can view online (<http://youtu.be/yvaVKvuE-Bkk>). The film has already helped many parents, teachers and children to better understand ADHD and stimulant drug treatments.

The VOICES study also has a website with further information, including academic publications and a useful VOICES report created for parents, teachers and children (www.adhdvoices.com) ■

Declaration of interest
None declared.

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Key points

- The VOICES (Voices On Identity, Childhood, Ethics & Stimulants: Children join the debate) study investigated claims about the ethical harms of attention deficit hyperactivity disorder (ADHD) diagnosis and stimulant drug treatments.
- Two niches were discovered in the VOICES study that give rise to different experiences with ADHD diagnosis and stimulant drug treatments: in a performance niche, ADHD is viewed as a disorder of academic performance, while in a conduct niche, it is viewed as a disorder of anger and aggression.
- The VOICES study found that children's experiences of stigma differed markedly across the two niches.
- Given the ethical concerns that arise from ADHD diagnosis and stimulant drug treatment, medical professionals should do more to engage with their paediatric patients to help to them better understand, and combat, stigma.
- A series of animated short films of VOICES interviews with children can be viewed at: <http://youtu.be/yvaVKvuE-Bkk>.



PETER WAZELVIGTNY

What I tell young people about transitioning to adult services

■ The transition from child and young person's services to adult services can be complicated, particularly in those with attention deficit hyperactivity disorder

Preparing for the move from young people's to adult healthcare services can be a daunting task for many young people and their families. It has been found that young people's participation in this process is hindered,¹ but it is important for you to consider what services you need in order to stay in good health once you are no longer eligible to see child and adolescent mental health services (CAMHS). There are concerns that the high threshold of need required to access adult services can mean that there is no healthcare service available for young people after adolescence. This means it is important to begin the discussion and preparation as early as possible.

With the introduction of National Institute for Health and Care Excellence (NICE) guidelines² and the recognition that attention deficit hyperactivity disorder (ADHD) is not a childhood-limited disorder, there has been an increasing need for the provision of adult services. The transition of young people to adult services is common in many other disorders, such as diabetes and asthma; however, there are different considerations for transition when mental health and well-being are concerned.

This transition will come about at a time when there may be many other changes happening in your life; for example, changes in education, moving away

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from home and meeting new friends. Adult services tend to view young people as independent from their families and have different expectations of how you should participate in your own care. If you would like your family and friends to remain involved in your care, you should make this known to adult services.

What is transitioning?

Up until now you will have been cared for by young person-oriented health services. We use the term 'transition' to describe consideration of, and preparing and planning for, your future healthcare needs, which may require you to be cared for by adult services. The timing of this can vary depending on the service you are in, but can happen from the age of 16 and should be completed by the time you are 18 years old. This process is to ensure that there are no gaps in your care, that you have access to the appropriate healthcare services and that all of your needs are met.

It is important to determine if there are adult services for ADHD in your area, as these are not yet widely available everywhere in the UK. This is in spite of the recommendation from NICE, which expects transition between child and adult services to be smooth.² Your healthcare worker will know if there are local services, and will provide advice on contacting

your local commissioner for health services via your GP if there are none available. Differences in the thresholds of need for some services may leave some young adults without healthcare provision.³

The developmental course of ADHD

Frequently asked questions by young people include 'How long will I have ADHD?' and 'How long will I have to take treatment?'. Adequate preparation for transition is vital. You will need to discuss plans for ongoing treatment with your health worker, with whom you will make a joint decision. A review of the symptoms of ADHD that continue to impair your day-to-day functioning is also needed. This will determine whether ongoing treatment is required or, indeed, wanted.

In adolescence, young people develop increasing skills of independence and are able to make their own choices. You will have your own thoughts about ADHD and how it affects your life, and you will need to make decisions about the future. Sometimes it can be hard to see the effect ADHD has on your life and what choices are available to you. This is why it is important to discuss your understanding of your ADHD with your family and health worker. This increasing autonomy may cause conflict with those around you about the decisions you want to make for yourself.

The end of secondary education is a reasonable time to review the symptoms of ADHD and consider the choices that are available to you – especially whether to continue with medication. It is not unusual for young people to not always be able to see the problems and symptoms of ADHD and, therefore, not see the need for continuing treatment. However, it is known that ADHD symptoms can persist into your adult life; they may not be as severe as when you were a child, but can still cause problems with day-to-day aspects of life, affecting education, work and relationships.

What you need to consider

To help you make decisions about continuing with treatment and transitioning to adult services, there are a number of issues to consider.

- Decide who you need to discuss

Useful advice sheets

- www.dawsonmarketing.co.uk/youngminds/shop/PDF/YP-TRANS.PDF
- www.dawsonmarketing.co.uk/youngminds/shop/PDF/PARENT-TRANS.PDF
- www.youngminds.org.uk/assets/0000/1331/YM_Prof_Transitions_Guide_email_version.pdf

your care with: parents/carers, health workers, tutors and friends.

- Determine how well you understand ADHD and how it has changed from when you were first diagnosed. The treatments previously offered will have been for the management of your symptoms, to improve your concentration and to reduce

hyperactivity and impulsivity. You probably do not have severe symptoms of hyperactivity and these may have changed to feelings of inner restlessness. Understanding your ADHD as an adult requires you

to review your symptoms and how they have changed over time. Your parents and teachers will have been given advice about the symptoms of ADHD and how to manage behavioural issues. You may have received talking treatments to help you self-regulate your behaviour and get along with others. You need to decide what treatments were helpful and what you want to continue with.

- Get used to asking questions to your healthcare worker about decisions and ensure that, even from early on, you are encouraged to take part in your own care.
- Understand your medication, how it works, what the side effects are and how to order prescriptions from your GP.
- Find out how to contact your health worker (phone, text or email) should you require advice from them. Use your mobile phone, mobile apps and calendars to keep contacts and numbers, as well as appointments times.
- Discuss your thoughts for the future with your family and carers, and

Sometimes it can be hard to see the effect ADHD has on your life



Young people should be encouraged to take responsibility for their own healthcare; for example, by keeping track of their medication

decide if you want them to be involved in your ongoing care.

- Obtain advice from a young people's mental health charity, such as YoungMinds in the UK.⁴

Arranging transition

Your adolescent health worker will organise transition with the adult service, but the next steps will depend on the local protocol. You and your health worker will decide what information will be shared with the adult service about your previous care, as your health records will not be passed on in full, only summarised. It may be helpful to include the initial assessment and diagnosis information and subsequent important letters about treatment interventions, changes to medication regimens, any information about times when medication was withdrawn and the most recent review of symptoms. If you have been taking medication, then a copy of your growth charts showing your health development over the years will also be useful. You will have received this information from your health worker as part of your ongoing treatment, but it is useful to negotiate and agree on what information to forward on to adult services.

Organising a joint appointment with the adult team can help ensure the accurate transmission of information and needs, as being with health workers who know you well may help with the overall process. It is helpful to plan with your health worker what help you need to inform the transition process, work with them to put this in writing and discuss this at the transition appointment.

Not enough help: what next?

If you feel you are not getting the help you need, talk to your healthcare worker about this; it may be helpful to write your thoughts down so that you can be clear about them. Talk to your family and friends and see if they can be an advocate for you at your appointments. There may be other

Key points

- The transition from child and adolescent services to adult services can be particularly difficult for young people with attention deficit hyperactivity disorder (ADHD).
- There may not be adult services for ADHD in all areas; some young adults may be left without any further care.
- Discussions are required about ADHD symptoms, treatment and effect on a young person's everyday life, to determine the most appropriate future course of action.
- Young people, parents/carers and healthcare workers all need to interact and discuss a number of key issues about the process of transition.
- Young people should be encouraged to have independence and take responsibility for their own care. Support is on offer from a number of organisations and services to help them cope with living with ADHD as an adult.

Information for parents/carers

This is a time of many changes for your child, but it is also a time to allow them to develop independent living skills and become more proactive with their healthcare decisions. You may need to consider the following points.

- Acknowledge that your child now has the autonomy to make decisions for themselves, even though they may not be ones you agree with.
- Talk with your child, listen to their views and try to support them through this period of change – it may not be easy for either of you.
- Give your child responsibility for remembering medication, appointments and prescriptions to prepare them for adult life, as adult services will deal with them directly – you may feel excluded from this process and need to ensure that your child can manage this situation for themselves.

Information for healthcare workers

To prepare young people for transition, you need to encourage them from early adolescence to take control of their own healthcare.

- Self-care should be encouraged as appropriate, looking at safekeeping of medicines and making sure they do not run out of medication.
- Use clinic appointments to help develop the young person's sense of self-awareness and their inclusion in decisions about their healthcare.
- Write to the young person directly to begin to develop their sense of responsibility for their own care.
- In family negotiations, act as an advocate with the young person in the decisions that they wish to make.

agencies and services, aside from health services, that can offer help and support to you as an adult with ADHD: local ADHD support groups if they are available, the CONNEXIONS service to help young people (www.connexionslive.com) and the Adult ADHD network (www.ukaan.org/index.htm) ■

Declaration of interest

The author has received payment from Eli Lilly and Janssen for speaking on nurse prescribing.

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- The new 'Practical resources' section is intended as a tool to help ADHD specialists communicate complex matters simply and clearly to non-specialists – from patients and their parents to teachers and GPs. Download PDFs of the articles free of charge from the website:

www.adhdinpractice.co.uk

Assessment scales for adult ADHD

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The process of assessing attention deficit hyperactivity disorder (ADHD) in adults is fraught with concerns about subjectivity, as difficulties have been shown with self-reporting, both with over- and under-reporting, of symptoms.¹ There have been some shifts to more objective measures such as infrared tracking of eye movements, computerised continuous performance tests, functional MRI and quantitative electroencephalograms (qEEGs).²⁻⁵ As these can be expensive to set up, the majority of assessments still tend to rely on self-reporting and corroborative evidence. This article will review some of the more common adult assessment frameworks in use. All of the following tools have been validated empirically and cited widely in peer-reviewed research.⁶⁻¹⁰

Brown Attention-Deficit Disorder Scale for Adults

The Brown Attention-Deficit Disorder Scales (BADDs) are based on Thomas Brown's model of ADHD as an underlying difficulty in executive functioning. The scale for adults (18 years and up) comprises 40 questions, designed to elicit executive functioning deficits in the following areas:

- Organising, prioritising and activating to work
- Focusing, sustaining and shifting attention to tasks
- Regulating alertness, sustaining effort and processing speed
- Managing frustration and modulating emotions
- Utilising working memory and accessing recall.¹¹

The assessments also include a guided interview protocol and ask for the input of corroborative sources who know the individual well. They take 10–20 minutes to administer and provide 'normed' scores indicating the probability of ADHD. Software is available to purchase if a computer-generated report is required.

The strengths of the BADDs lie in their ease of administration, and the use of executive function helps those adults for whom the term 'ADHD' is mired in the stigma of a childhood condition. A few of the 40 questions can be hard to quantify in terms of frequency, as the tool aims to elicit how many times a week the various difficulties occur. The scores do not incorporate adjustments for age or gender.

Conners' Adult ADHD Rating Scales

The Conners' Adult ADHD Rating Scales (CAARS) are designed to assess the core symptoms of ADHD and related problems in adults ≥ 18 years of age. Separate self-report and observer report forms are available. The scales are based on the same underpinnings as the Conners' Rating Scales-Revised for children and adolescents, which have been in use for many years, and form part of the overall Conners' Adult ADHD Diagnostic Interview for DSM-IV (*Diagnostic and Statistical Manual of Mental Disorders*)™ (CAADID™). The CAARS have been modified to target the experience of ADHD in adults.

Both the self-report and observer report forms comprise multimodal assessments of the same behaviours and problems, and contain an identical set of scales, subscales and indexes. CAARS forms are available in long, short and screening versions. The test takes approximately 10–15 minutes to administer for the short form and approximately 30 minutes for the long form; it is hand-scored. A computerised report can be generated if the requisite software is purchased.

The long version has 66 items and assesses behaviour across the following domains:

- Inattention/memory problems
- Impulsivity/emotional lability
- Hyperactivity/restlessness
- Problems with self-concept.

Results are then compared with normative data.

The long form also includes:

- DSM-IV ADHD symptom measures – to help assess inattentive symptoms, hyperactive-impulsive symptoms and total ADHD symptoms
- ADHD index – 12 items that help identify respondents who may benefit from a more detailed clinical assessment
- Inconsistency index – to help identify random or careless responding.

Like the BADDs, the CAARS also include a guided interview format. The test's strengths lie in its ease of use and relatively short administration time. The self-concept domain provides useful information for further psychotherapy in addition to the core ADHD impairment features.

In 2003, Macey found that no information had been provided on the ethnic representation of the normative sample, and no studies had addressed issues of ethnic difference or bias, thus caution

should be exercised when using the CAARS with individuals from ethnic minorities.¹² However, they have been shown to have validity across a number of cultural variations within Europe, including Spain and Germany.⁷

Wender-Utah Rating Scale

The Wender-Utah Rating Scale (WURS) was originally developed by Paul Wender as a research instrument, but has subsequently been validated as a screening tool. It aims to capture the distinct features of the disorder in adults, but is also reliant on a retrospective rating of childhood ADHD symptoms. The tool consists of 61 questions that ask the adult patient to recall their childhood behaviour, with a subset of 25 questions relating to ADHD. Each question has five possible responses, scored from zero to four points. Using a cut-off score of 46, after scoring only the 25 questions related to ADHD, it has been shown to identify 86% of patients with ADHD.¹³

The WURS assesses behaviours across six categories: hyperactivity, attentional deficits, behavioural problems in school, impulsivity, overexcitability and temper. It takes 10–15 minutes to administer and, unlike the BADDs and CAARS, is completely free. One of its strengths is that it does go beyond the relatively limited perspective of the DSM-IV criteria and thus is able to target more areas for treatment. However, it can be difficult for adults with ADHD to correctly and objectively recall their adult functioning, let alone their childhood functioning,^{1,14} which highlights the importance of corroborative input.

Adult ADHD Self-Report Scale

The Adult ADHD Self-Report Scale version 1.1 (ASRS-v1.1) is a six-item self-reporting tool developed by the WHO. It looks at the adult ADHD symptoms that are the most predictive of having the disorder. The first four questions relate to inattentive symptoms and the last two questions apply to hyperactive/impulsive symptoms. Significant symptoms are shaded and rated either

‘sometimes’ or ‘often’. If four or more marks appear in the darkly shaded boxes, the patient has symptoms highly consistent with ADHD.

The ASRS-v1.1 only takes about one minute to complete and is more likely to be useful as a screening tool in a primary care setting to establish whether to refer the patient for a more comprehensive assessment.

Current Symptoms Scale

The Current Symptoms Scale (CSS) forms part of the Barkley Adult ADHD Rating Scale-IV (BAARS-IV) tool for assessing current ADHD symptoms and domains of impairment as well as recollections of childhood symptoms. It is directly linked to the DSM-IV diagnostic criteria.

The scale includes both self-report and observer report forms (the latter can be obtained, for example, from a spouse, parent or sibling). The long version takes an average adult five to seven minutes to complete, and the quick screen version takes three to five minutes. Additional features include a section of items assessing the symptoms of sluggish cognitive tempo, also known as the inattentive-only subtype of ADHD.

The CSS comprises 18 items that address the symptoms listed in the DSM-IV diagnostic criteria. Odd-numbered items assess the frequency of inattentive symptoms, and even-numbered items hyperactive/impulsive symptoms, using a 0–3 Likert-type frequency scale (0 = never or rarely, 1 = sometimes, 2 = often, 3 = very often). Sample items include ‘Leave my seat in situations in which seating is expected’ and ‘Avoid, dislike, or am reluctant to engage in work that requires sustained mental effort’. The scale also asks patients to report the age at onset of ADHD symptoms and to note how often their symptoms interfere with activities in social arenas (such as school, relationships, work and home). Finally, it addresses oppositional defiant disorder (ODD) co-morbidity with eight questions about symptoms of ODD.

Barkley also has a Childhood Symptoms Scale Self-Report Form, a Developmental Employment, Health and Social History Form, and a Work Performance Rating Scale Self-Report Form. All of these can be sent to the patient to complete before their first clinic visit.

As with the other scales reviewed here, the CSS and other Barkley forms provide scope for others who know the individual well to provide corroborative input – particularly parents of the adult. Corroborative input is very important but also prone to difficulties – not all adult patients have parents who are still alive or able to accurately

They should not be the sole defining assessment for a diagnosis of ADHD

Key points

- The majority of assessments for attention deficit hyperactivity disorder (ADHD) in adults tend to rely on self-reporting and corroborative evidence.
- Ease of use and short administration time are significant benefits in the use of scales to assess ADHD.
- Current scales will need to be adjusted under the new *Diagnostic and Statistical Manual of Mental Disorders-5* criteria.

reflect on what happened when their children were young.

Conclusions

All the scales discussed here are in strong agreement with one another in assessing ADHD symptoms. The question, thus, becomes which scale is the least time-consuming and most pragmatic for the evaluator to use. However, they all remain fairly reliant on subjective input and, thus, should not be the sole defining assessment for establishing a diagnosis of ADHD. They need to be combined with more objective measures, such as the subtest variability within the cognitive assessment of the Wechsler Adult Intelligence Scale, computerised concentration/impulsivity assessments or EEGs. A comprehensive assessment will also check for both comorbid conditions and differential diagnoses, as depression, anxiety and substance abuse can all mimic or mask the symptoms of ADHD.¹⁰ The data gained from the assessment scales are rich with information that psychotherapy can be used to modify self-concept and identify goals for ADHD coaching.

There is likely to be a need for a readjustment of these assessment scales under the new DSM-5 criteria. The DSM-5 adds symptoms and alters the diagnosis criteria for children and adults, which will affect the majority of assessment scales as they are reliant on DSM-IV criteria, with the possible exception of the BADDSS, which rely on the executive functioning framework instead. We are likely to see a new raft of assessment scales developed over the next few months ■

Declaration of interest

Nigel Humphrey does not receive funds from any company that develops or markets assessment scales.

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Update – nurse prescribing

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Nurses working with children and young people with attention deficit hyperactivity disorder (ADHD) have been anticipating a change in legislation that improves patient access to medicines for ADHD.

Before the change in legislation in April 2012, the independent prescribing of controlled

drugs (CDs) was restricted by law to a limited range of medicines. Independent nurse prescribers were only able to prescribe stimulant medication for ADHD as a supplementary prescriber. This required a voluntary prescribing partnership between an independent prescriber (doctor) and a supplementary prescriber (nurse) to implement an agreed clinical management plan (CMP) with the patient's agreement. Nurses were able to prescribe atomoxetine independently, as it is not a CD, but not methylphenidate or dexamphetamine. This restriction inhibited patient care and access to appropriate interventions. It also, as Warburton argues, did not recognise the educational skills and competences of nurses to prescribe safely and appropriately.¹

The amendment to the Misuse of Drugs Regulations allows appropriately trained and competent nurses to independently prescribe CDs for ADHD.² Independent nurse prescribers are now allowed 'to prescribe any Schedule 2–5 CDs for any medical condition, within their clinical competence, removing the previous limitations'. This change in legislation offers new ways of working and allows for the redesign of services for children and families with ADHD.

At Bolton NHS Foundation Trust (as at many others) we continue to use CMPs as a safeguard. The service is nurse-led: the nursing team initiates treatment regimens within the CMP, following the trust's standard operational policy for prescribing for ADHD, reviewing medicines and their effectiveness, titrating doses and changing medicines. This allows our medical colleagues to focus on different clinical tasks, such as prescribing for other needs, and makes more effective use of the clinical team. Children and families usually respond well to nurses prescribing and, to date, no one has requested a doctor to prescribe in place of a nurse.

However, nurses working with children and families with ADHD must seek local advice from their NHS trusts about how to implement this change safely: as ever, the practice of prescribing is granted to nurses as a privilege by legislation and their organisations, and these should ensure that the nurses have the adequate competences and skills to undertake this skilled task³ ■

Declaration of interest

The author has received payment from Eli Lilly and Janssen for speaking on nurse prescribing.

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ADHD and atopy

Attention deficit hyperactivity disorder (ADHD) is a frequent neurodevelopmental disorder characterised by both its clinical heterogeneity and co-existing comorbid disorders. The prevalence of these disorders is higher in patients with ADHD than in those without the condition and, conversely, ADHD is more prevalent in patients diagnosed with these comorbid conditions than in those without them. This can be observed, for example, with anxiety disorders, tics, reading disability, sleep disorders and enuresis.¹ In our department at Nice Paediatric Hospitals, we have drawn attention to some such comorbid disorders; namely, enuresis,² obesity and atopy.

Allergy and neuropsychiatric disorders

Atopy, a term derived from the Greek *atopia*, meaning 'different' or 'out of place', was originally proposed in 1923 to include asthma and allergic rhinitis. Eczema, or atopic dermatitis (AD), was added to the group in 1933. Its prevalence in children increased from 3% before 1960 to at least 16% in 2000,³ although this strongly varies according to local environmental conditions (air pollution, latitude, and so on). Atopic manifestations follow a typical sequence of progression, with clinical signs of AD predating the development of asthma and allergic rhinitis – a phenomenon known as the 'atopic march'.³

From an immunology point of view, atopy is defined as the propensity to develop immediate allergic reactions (mediated by IgE) to common environmental allergens. Clinical criteria have been developed for all three manifestations and, in addition, the World Allergy Organization defines atopy as the positivity of skin prick tests and/or the presence of serum IgE specifically directed toward environmental allergens. In most cases, atopic manifestations are conditions that cause lifetime impairment and may lead to depression, anxiety and stress-related disorders; that is, the spectrum of co-morbidity extends beyond allergy.

Studying the potential relationship

There is a long-lasting debate regarding the relationships between immunology and psychiatric disorders. We can cite the Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS) hypothesis described in the 2000s by Hamilton and Swedo



■ The link between atopic dermatitis (pictured) and ADHD is being explored, and physicians should screen for both conditions

in New York.⁴ Twenty years earlier, the Geschwind–Behan hypothesis had opened the question by suggesting a correlation between brain laterality (that is, left-handedness), immune disease, migraine and developmental learning disorder.⁵ Negative results were reported, which might have led to the definitive rejection of the Geschwind–Behan hypothesis,⁶ but the question persisted to be addressed in many studies, which were recently reviewed.⁷

This review of the literature retained 20 international studies published either in English or German and highlighted their numerous methodological flaws, which, in the end, precluded any meta-analysis. The central criticism was that, in most studies, clinical diagnoses (of asthma, AD and ADHD) did not rely on validated clinical criteria; for example, ADHD was clinically diagnosed in only three studies, and diagnosed on the basis of parental or teacher reports and ratings on non-specific scales in the other studies.

From a qualitative point of view, however, it can be noted that:

- Out of six studies that specifically assessed AD and ADHD, four reported a significant positive relationship between AD and ADHD, with odds ratio (OR) estimates of >2 for two studies. A mul-

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tivariate analysis to control for confounding variables such as asthma or rhinitis was conducted in only three studies. The OR remained significant in two of these studies, and in the three studies analysed, the significant relationship between asthma/rhinitis and ADHD disappeared in the multivariate model.

- Out of the 20 studies, all 12 studies focusing on the relationship between asthma and ADHD reported a significant result, with ORs ranging from 1.23 to 2.42. Unfortunately, AD was considered in only one of these 12 studies; the significant relationship disappeared when AD was added to the multivariate model.
- Out of the 20 studies, no significant result was reported in those two studies that investigated the relationship between rhinitis and ADHD.
- Sleep disorders were considered in a few studies only, even though AD is a recognised cause of sleeplessness and night respiratory symptoms are part of the diagnosis of asthma.

Two further studies were identified after the review – one in children⁸ and one in adults⁹ – but neither reported OR estimates for the association between AD and ADHD diagnosis or symptoms.¹⁰

Paediatric screening in Nice

In our paediatric department, all children referred to the first author of this article for ADHD diagnosis were systematically screened for atopy over a period of one year. The diagnosis of ADHD strictly followed *Diagnostic and Statistical Manual of Mental Disorders* (DSM)-IV criteria.

As part of our pre-treatment battery for those patients who needed pharmacological intervention, the Phadiatop[®] blood test was used to detect IgE specifically directed toward a set of the ten most common aeroallergens.¹¹ Out of 102 children screened, 63 (61.8%) had a positive result. Atopy was confirmed in all 40 positive children who underwent a subsequent allergy evaluation by the second author: all had at least one atopic disease. Out of 40 patients, 34 (85%) had rhinitis; for 14 (41.2%), this was of intermittent duration, and for 20 (58.8%) it was enduring. Eleven of the 34 patients (32.4%) experienced rhinitis of mild intensity, while for 23 the condition was of moderate-to-severe intensity (67.7%). Hence, an active drug for rhinitis was indicated for two-thirds of the sample.

Additionally, 21 patients (52.5%) had a history of conjunctivitis. AD was present in seven cases (17.5%) at the time of examination: three without rhinitis, one with intermittent rhinitis and three

with enduring rhinitis. Two patients (5%) had a food allergy – one to peanuts and one to apples (oral allergy syndrome). Finally, 15 patients (37.5%) presented with symptoms of bronchia hyperreactivity (one with conjunctivitis without rhinitis, six with intermittent rhinitis and eight with enduring rhinitis).

Out of these 40 ADHD patients with atopy, only nine (22.5%) had ever been examined by an allergy specialist. All these relationships were significant for ADHD only, not for oppositional defiant disorder or conduct disorder.

Our study suggests that the prevalence of atopy is up to three times higher in children with ADHD than in the general population. More research is warranted before atopy can be considered as a true comorbid condition or, perhaps, a true endophenotype of ADHD. However, we already encourage psychiatrists and paediatricians to screen their patients for atopy and ADHD, respectively ■

Declaration of interest

The authors declare that there is no conflict of interest.

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Key points

- Attention deficit hyperactivity disorder (ADHD) has a high prevalence of comorbid disorders.
- The link between atopic dermatitis and ADHD is currently being explored, and there is a long-lasting debate about the relationships between immunology and psychiatric disorders.
- One small study in France showed that atopy prevalence was up to three times higher in children with ADHD than in the general population.
- Clinicians should be encouraged to screen for atopic manifestations alongside ADHD.

■ ADDISS

ADDISS (Attention Deficit Disorder Information and Support Services) was established in the late 1990s by Andrea Bilbow in response to the clear gap in the understanding and social acceptance of what is now more commonly understood as attention deficit hyperactivity disorder (ADHD).

One of the problems identified was the lack of support for sufferers and their families. ADDISS exists to support these people, their friends and associated professionals. We act as a main point of contact for those directly affected by ADHD through our telephone service (operating from 10 am to 3 pm, Monday to Friday), and have an extensive selection of books, DVDs and reference materials available from our office and our website (www.addiss.co.uk). Our telephone service, the only one of its kind in the UK, receives over 300 calls (on average) each month. Funding for longer hours and more staff would enable us to respond to many more calls.

We are passionate about changing the social and professional perception of ADHD. We believe that early diagnosis is key to helping not only the sufferer and their close circle, but society as a whole. We also recognise the many adults who need our support.

How else do you support people?

ADDISS has seen an alarming increase in the number of parents getting in contact directly after their children have been threatened with exclusion from school. We can help them write clear, constructive letters to schools, objecting to exclusions, and often accompany parents at tribunals to act as an advocate for the child in question and help the panel understand the disability aspect of ADHD. In addition, we offer support to help the school understand ADHD, how it affects behaviour and how best to work with the child and family to improve their condition.

We are setting up a new pilot project supporting adults with ADHD. This will be a weekly drop-in offering support and skill building, including money management. We are also the UK licence holder for 1-2-3 Magic, a behaviour management programme designed to deal with the core symptoms of ADHD, and have now trained over 120 practitioners who are able to share this training with parents across the UK.

ADDISS is currently involved with the European WHAAM project, aimed at developing a web and phone application to support young people with ADHD and professionals working with them.

How wide is your reach?

As well as parents, ADDISS works with teachers and healthcare and youth justice professionals. We understand the importance of giving clear, factual

advice to people likely to deal with ADHD. We also give regular talks and dedicated training to user and professional groups across the country. CEO Andrea Bilbow is often requested to speak at conferences across the UK and Europe, and respond to the national press on topical news items as needed.

How big is your operation?

ADDISS is run using a limited but very dedicated number of staff and volunteers. Andrea Bilbow is supported by Colin McGee, a specialist in ADHD and education, and a psychotherapist with skills invaluable to the ADDISS helpline. We have several volunteers, including our trustees, who support the national phone line and assist at various training courses and conferences. Our quarterly newsletter is full of interesting and helpful articles and advice from contributors across the globe.

What is your vision for the future?

ADDISS has achieved a huge amount in the last 19 years in helping sufferers and their families, as well as starting to change the broader perception of ADHD. We hope to extend our helpline operating hours, as well as expand our number of staff and volunteers. We are proud of our achievements, and thankful to our supporters over the years. We are even more proud to announce that, in June, Andrea Bilbow was awarded the OBE for services to families affected by ADHD.

How can people get involved?

There are a number of ways to support ADDISS. As a professional, please encourage your patients to become members; the more we have, the stronger our voice will be when campaigning for change.

If you would like to get in touch or refer someone to us, you may contact us via email at info@addiss.co.uk, call 020 8952 2800, or access our website at www.addiss.co.uk ■

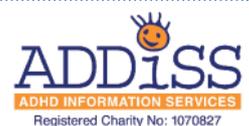
Events

■ 11th International ADDISS Conference

10–12 October 2013, Liverpool, UK

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Adolescent therapy: the role of the reflective team

Psychotherapy with adolescents is always a challenge, even more so when impulsivity and hyperactivity are associated with conduct disorders and lead to difficulties in socialisation. A combination of psychotherapy and medication has been broadly demonstrated to be the most effective intervention for attention deficit hyperactivity disorder (ADHD).¹

Among the most promising systemic models, the solution-focused therapy model described by Steve de Shazer has been suggested as being particularly indicated for ADHD.² However, this intervention may be unsuccessful in those adolescents who, in their quest for identity formation, sometimes question authority figures.³ In addition, poor social skills and poor moral development associated with psychopathology require a more balanced relationship between therapists and patients to facilitate co-responsibility.

This article aims to share our experience at the Department of Child and Adolescent Psychiatry at the University Hospital Virgen de la Victoria in Malaga, Spain. Our unit is a tertiary service that offers assistance to 1,000,000 people in Malaga and the Costa del Sol. The unit provides specialised interventions for children and adolescents with mental health disorders. Once patients have been evaluated in the outpatient clinic, they are referred to specific programmes at the day centre according to their needs.

The ADHD team offers individual therapy, psychoeducation, psychopharmacological interventions and group therapy. These interventions help to improve moral and cognitive development (grief, expression of feelings and introjections), which also contributes to the enhancement of self-esteem and social adjustment – key to building a successful adult identity. The team is multi-professional, including doctors, psychologists, nurses and therapists. Patients are seen in the outpatient clinic; once a diagnosis has been made and a therapeutic plan decided, they are referred to the day centre for group therapy with a reflective team.

The reflective team in group therapy

Children and adolescents with ADHD often find it difficult to have successful relationships that allow them to express their emotions and thoughts. Adults who support them often priori-

tise their need for a structured environment, with rules and actions to help them control their hyperactivity and self-manage.⁴ Our objective was to add emotional and cognitive components to the psychotherapeutic intervention, with the aim of helping participants to connect their emotions with a narrative and build their identity, and then implementing specific interventions for adolescents with ADHD. Using a reflective team allowed us to move closer to this objective, with successful results for therapists, patients and families.

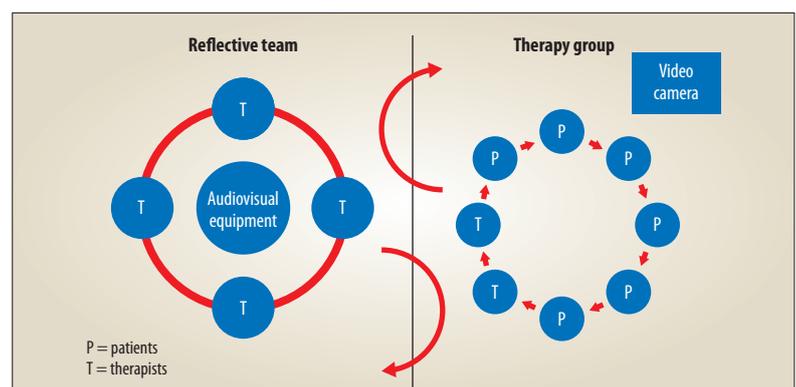
The reflective team is a modality within the systemic paradigm of family therapy.⁵ It is based around the idea of inverting the process of observation, to let the family and therapist listen to the comments and reflections from the team observing the group therapy.⁶ The frontiers between patients and therapists are less strict than in other interventions, providing a more equal relationship. The reflective team also helps participants to organise their thoughts through active listening.

We scheduled the intervention for between September and June, to coincide with the academic year. Patients and families came to our unit twice a month, and sessions were 90 minutes long. We worked with parents and adolescents simultaneously but separately, holding multi-family (parents and children) sessions at the beginning and end of the programme. With the adolescents, we incorporated extra multi-family sessions according to the reflective team's observations. The professionals involved had flexible roles.

We carried out the sessions in two different rooms (see Figure 1). The reflective team listened to and viewed the sessions, prioritising the adolescent group over the parent group. When the reflective team found it necessary to participate in the session, they used messages such as, 'When

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■ **Figure 1.**
Reflective team
and therapy group

Case studies

■ The invisible child who started to call for attention

M is 14 years old and has an average IQ, but his academic results are poorer than expected, in spite of the hours he spends studying. He is diagnosed with the inattentive subtype of ADHD and treated with atomoxetine. His test results improve, but he is not focused. He also has behaviour problems at home and is often punished.

M is the youngest of four siblings – ten years younger than the next youngest. The family is from Argentina and moved to Spain to find work. M's mother was depressed and did not want another pregnancy. There is talk of returning to Argentina, but the family decide to stay after M starts displaying difficulties.

Before M joined the therapy group, his parents' compliance with treatment was poor. They seem more focused on their own problems than M's difficulties. We worked with the parents on these issues, and the group was a safe atmosphere for M to express his feelings about his home situation. He was rewarded for his improvement and the group gave him advice.

■ The 'difficult' partner of the inattentive mother

L is a 15-year-old with an IQ of 113 who has a diagnosis of combined-subtype ADHD and emotional difficulties. He is on once-daily methylphenidate. His poor academic results are explained by ADHD, alongside his inability to accept limits and assume responsibility for his actions.

He is an only child and his parents divorced when he was six. He and his mother have a couple-like relationship, with L being given the role of a partner by his mother. He looks after her and makes decisions that should be made by her. His parents seem to be pleased with the diagnosis of ADHD, as they have a chance to hide their own difficulties with co-parenting behind the scientific narrative of their child having a mental disorder.

In the group session, the parents' failure to emotionally separate from each other and the conflict between them (in which L is entangled) is underlined. This gave L the opportunity to express his anger and to assume his own role, separate from the conflict his parents have been involved in.

you are ready we would like to say something', meaning that participation was not imperative. The therapist and co-therapist who were part of the therapy group felt free to contact the reflective team when they wished to do so, but always with agreement from the rest of the group.

In every session we started with a meeting where we established a space to introduce the key points for discussion, and ended by sharing our views with those of the adolescents.

What progress did the group make?

During the first sessions, the therapist in charge of the group session led the direction of the discussion and was asking the reflective team for their views. However, after a few sessions, the reflective team started to request more active participation.

Adolescents felt uncomfortable with the idea of having a reflective team at first, and it meant they displayed defiant behaviour; eventually, however, they requested the reflective team to participate. They mentioned that they identified the therapist as the authority figure and the reflective team as an opportunity to express their own views from a

more equal position. We thought this was probably the same model some families showed at home.

Conclusions

Using a reflective team alongside the therapy group, we found that:

- It was possible to create an atmosphere where emotions were expressed and discussed, revealing alternative narratives
- More functional ways of communicating could be used between adolescents and adults, and these could be generalised to the adolescents' relationships with parents, teachers and other authority figures
- Thoughts about the need to accept one's parents unconditionally to overcome difficulties were recognised, and families accepted the negative effect of unsolved conflicts in their children
- A dynamic, respectful and responsible relationship could be created, where each individual has to take care of what they do and say, with consideration of others
- Conflicts between parents and children and between adults could be successfully addressed ■

Key points

- Psychotherapy may be unsuccessful in adolescents with attention deficit hyperactivity disorder (ADHD), due to a propensity to question authority figures and poor social skills.
- At University Hospital Virgen de la Victoria in Malaga, Spain, a reflective team was used to add emotional and cognitive components to group therapy, and provide a more equal relationship between patients and therapists.
- Adolescents displayed defiance at first, but eventually viewed the reflective team as a way to express their own views.

Declaration of interest

Dr Hernández Otero has served as a speaker for Janssen-Cilag, Eli Lilly, Shire Iberica and Juste. She has received royalties from Rubió and Shire International and participated in clinical trials for Shire International, Forest, Roche and Sunovion. She has received research support from Alicia Koplowitz Foundation. María José Ortega Cabrera has declared no conflicts of interest.

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Your views on *ADHD in practice*

Last year, we invited you to share your thoughts about *ADHD in practice* via a reader survey. Here, we report on the results

Our readership

The European readership of *ADHD in practice* continues to grow, with the majority of respondents to the reader survey coming from the UK (37%), France (19%) and Italy (11%). There were also a sizeable portion of responses from Germany (7%), Sweden (6%) and Denmark (5%; see Figure 1).

Child and adolescent psychiatrists accounted for almost half of all respondents (44%), while there were also responses from paediatricians (21%), generalist adult psychiatrists (12%) and child and adolescent psychiatric nurses (8%; see Figure 2).

As for reading habits, 34% of respondents use the journal as a resource for reference, 31% to aid treatment of their patients, 29% to aid their own training and 14% to aid the training of others. Forty-three per cent read specific articles, while 41% prefer to read each issue in its entirety.

Print versus digital

Loyalty to print remains strong, with 77% of respondents stating a preference for reading *ADHD in practice* in print; 31% would like to view it online, while 44% would prefer to use a searchable archive. Seventy-two per cent of respondents expected to use an online archive at least once a month, if not more frequently.

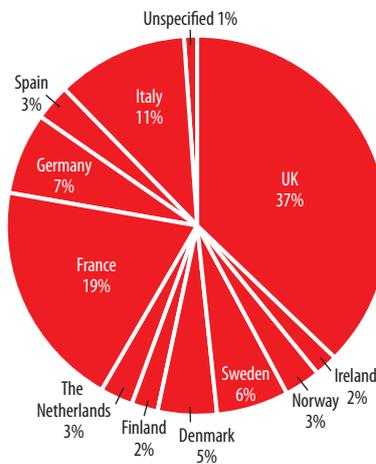
Most readers are happy with the frequency of publication, with 84% saying they would like to see the journal continued to be published quarterly; 14% would like it to be published more frequently, while only 3% would prefer fewer issues per year.

Almost three-quarters of respondents (72%) said they would be interested in completing online continuing professional development modules if they were offered on the *ADHD in practice* website.

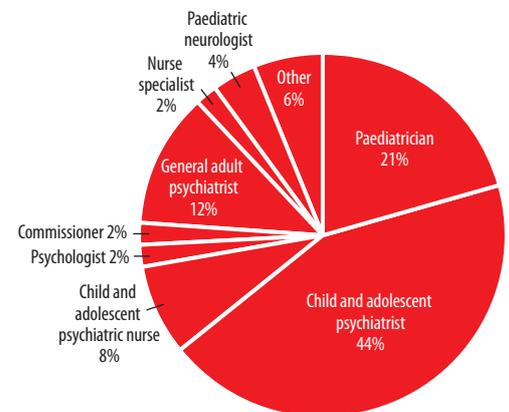
Suggestions for the future

Respondents' favourite aspects of *ADHD in practice* are that it is topical, that it features a broad range of topics and that it covers practical issues. Clinical reviews and practice-focused articles are generally found to be the most useful.

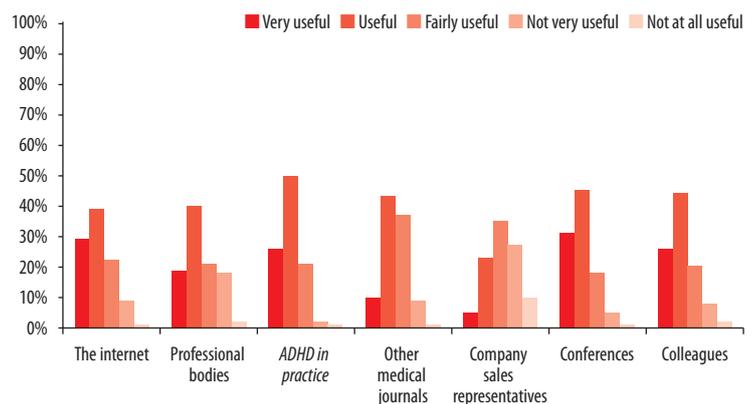
Topic suggestions for future issues included comorbidities; medication (and its side effects); and diagnosis, assessment and screening issues.



■ Figure 1. Respondents' countries of origin



■ Figure 2. Respondents' professions



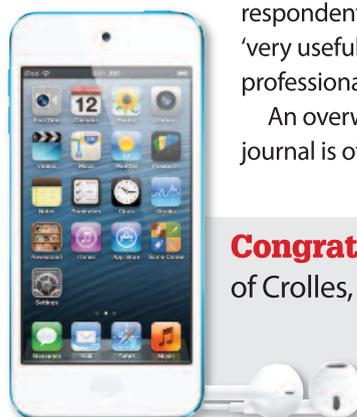
■ Figure 3. Usefulness of *ADHD in practice* in comparison with other sources

Informative and influential

Ninety-five per cent of readers agree that *ADHD in practice* is informative, while 77% say that information in the journal sometimes influences the way they care for their patients.

In fact, only conferences matched *ADHD in practice* in terms of utility as a source of information: 76% of respondents said that both sources were 'useful' or 'very useful', marking the journal above the internet, professional bodies and colleagues (see Figure 3).

An overwhelming majority – 98% – think that the journal is of some, or great, benefit ■



Congratulations to Nathalie Viard of Crolles, France, who is the winner of our prize draw and will receive an iPod touch ■



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