SASC Guidance on the assessment and identification of the characteristics of an Attention Deficit Hyperactivity Disorder (ADHD)

This guidance has been updated by SASC

Under the guidance of

Philip Asherson, Professor of Neurodevelopmental Psychiatry
at the Institute of Psychiatry, Psychology and Neuroscience
King's College, London

working with
Katherine Kindersley, Director, Dyslexia Assessment & Consultancy
SASC Board member

Dr Anna Smith, Lead Psychologist, Dyslexia Action
SASC Board member

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Guidance related to the characteristics of ADHD

Introduction

The development of this guidance began in 2013 when the SpLD Assessment Standards Committee (SASC) convened the ADHD Consensus Meeting in Oxford, chaired by Philip Asherson (Professor of Neurodevelopmental Psychiatry, King's College London). Development of this guidance has continued following consultations over the intervening years from a range of interested parties.[1] However, we recognise the need for this guidance to be updated in response to changes in the field of assessment of ADHD.

This guidance focuses on the identification of characteristics of ADHD in individuals of any age but will lead to different courses of action depending upon their age at the time of the assessment.

- If the assessment is of a **child under the age of 16,** the young person should be referred to Child and Adolescent Mental Health Services (CAMHS), or in some regions to the Paediatric Services, so that a full multi-disciplinary assessment can make a detailed evaluation. These referrals are usually via the general practitioner (GP), but they may also be directly referred to CAMHS if there is an established link with the school and the educational psychologist.

  However, as in any diagnostic assessment, the report will detail the reasons for referral and the current concerns of the school, the parent/carer and the young person him/herself and this information would support the decision for onward referral into the medical services.

- For individuals **between the ages of 16 years and 17 years 11 months** with the characteristic features of ADHD, there should still be a referral to Child and Adolescent Mental Health Services (CAMHS), or in some regions to the Paediatric Services, so that a full multi-disciplinary assessment can make a detailed evaluation. However, an assessment report carried out by a specialist teacher or psychologist should also detail the characteristics of ADHD that support the need for educational interventions and, potentially, medical treatment.

- For **individuals aged 18 or over**, the key purpose of identification of characteristics of ADHD should be to allow them the opportunity to access support for their study or employment, and appropriate medical management if required.

[1] The minutes of that meeting and participants are available on the SASC website.

Therefore in the case of individuals with the characteristic features of ADHD, a description of these characteristics supporting the need for educational or workplace support, and potentially medical treatment, ~~s~~should be detailed in the report.

1. Overview

ADHD is a neurodevelopmental disorder with worldwide prevalence of approximately 5% in children and 3% in adults (Fayyad et al, 2017, Faraone et al 2021). ADHD is more common in males than females during childhood (Gaub and Carlson, 1997), but this gender difference is less pronounced during the adult years (Fayyad et al, 2017). There are multiple genetic and environmental risk factors that accumulate in various combinations to cause ADHD (Faraone et al 2021).

The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) defines ADHD as a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with normal functioning or development. In adults, an individual must have at least five out of a list of nine symptoms of inattention (for example, difficulties sustaining attention when working or during play, or not paying attention when being spoken to directly), and/or five out of a list of nine hyperactivity/impulsivity symptoms (for example, excessive talking, fidgeting with hands or feet, or impatience when waiting). During childhood the symptom threshold is increased to six or more in either the inattentive or hyperactive/impulsive domain. The symptoms of ADHD should reflect sustained difficulties with attention, activity levels or impulsive behaviour, and should not occur exclusively during periods of anxiety, or other episodic mental health disorders. The symptoms of ADHD start in childhood with at least several symptoms in either the inattentive or hyperactive/impulsive domain present by the age of twelve years.

There are three main ways that ADHD can present: a predominantly inattentive, a predominantly hyperactive/impulsive or a combined presentation where both types of symptoms are prominent. In practice most people with ADHD present with predominantly inattentive or combined inattentive and hyperactive/impulsive symptoms. The predominantly inattentive presentation is often referred to as ADD (attention deficit disorder). However, many people with the inattentive type of presentation show sub-threshold levels of hyperactive/impulsive symptoms. These patterns of symptoms should be present in multiple settings (e.g., home, school, work) and interfere with, or reduce the quality of social, academic or occupational functioning.

ADHD has features relating to both mental health and specific learning difficulties. It frequently results in learning challenges for the individuals concerned, with a measurable impact on educational and occupational outcomes (Fredriksen et al, 2014, Sciberras et al, 2009). Given its impact on learning and education, ADHD can be conceptualised as a specific

learning difficulty (Snowling and Maughan, 2006). However, learning difficulties reflect only one aspect of ADHD, which include a wider range of psychosocial (e.g. occupational failure, behavioural problems, driving accidents) and mental health problems (e.g. sleep difficulties, low self-esteem, emotional instability, development of comorbid anxiety/depression).

Although ADHD is a categorical diagnosis made by following the diagnostic criteria in DSM-5, ADHD symptoms and associated difficulties are continuously distributed throughout the general population. Many people can experience from time to time, depending on the context, inattentiveness, hyperactivity, and impulsiveness. However these behaviours can be impairing when there is significant deviation from a normal range. This means that there is no clear distinction between those that just meet ADHD diagnostic criteria, and those that are just subthreshold to the full diagnostic criteria. It is therefore essential to delineate the areas of impairment, in addition to the symptoms of ADHD. Establishing the diagnosis can sometimes be difficult in high functioning individuals with ADHD who have developed effective coping strategies, or are well supported, but may nevertheless struggle with learning and underperform. However, in most cases there is a clear description of characteristic ADHD symptoms and associated difficulties.

ADHD is strongly linked to learning difficulties, yet there are many examples of high functioning individuals who go onto higher education and may even excel in aspects of their work. Indeed, many individuals with ADHD can function well in one or more aspects of their lives. This may be linked to neurodevelopmental differences. ADHD can therefore be viewed as a neurodiversity, in which individuals can show considerable strengths, as well as relative weaknesses. These strengths may be associated with characteristics of ADHD such as the ability to focus, or even hyperfocus, on tasks that are highly salient or have a high level of immediate stimulation, increased creativity linked to mind wandering, and high levels of activity that may be useful under certain circumstances. An important approach when supporting people with ADHD is therefore to understand and build upon their strengths, as well as managing difficulties that arise from inattention or hyperactive or impulsive behaviour.

2. CHILDHOOD: establishing sufficient evidence to identify characteristics of ADHD

SpLD assessors and psychologists should not attempt to diagnose ADHD in individuals under the age of 16. (Also see Page 2). Following recognition of suspected ADHD, these individuals should be referred into the medical services, as described above (see section 1).

Onward referral is important. In addition to evaluating the potential impact of specific learning difficulties (e.g. dyslexia, Developmental Coordination Disorder (DCD)), there are several possible differential and co-existing conditions that need to be considered when evaluating the manifestations of ADHD. These include: (1) neurodevelopmental disorders:

e.g. Autistic Spectrum Disorder, Tic Disorders (including Tourette's), Traumatic Brain Injury; (2) behavioural problems: e.g. Oppositional Defiant Disorder, Conduct Disorder; (3) mental health disorders: e.g. emerging Personality Disorders (borderline, antisocial), Post-traumatic Stress Disorder, Anxiety or Depression, Obsessive Compulsive Disorder, Substance Misuse, Psychosis, and Bipolar Disorder. The evaluation of ADHD in the presence of symptoms of these other disorders, or high levels of behavioural, emotional, mood or anxiety symptoms, can be complex and require a high level of expertise by an expert with relevant experience in the co-occurring condition(s).

However, SpLD assessors and psychologists should in any assessment carried out prior to onward referral, describe in detail the suspected features of ADHD; observed or reported by the child assessed, their parents, carers and teachers. The aim is to describe the features of ADHD that are impacting upon learning and to support the identification of learning difficulties due to ADHD. To support the process of the referral, assessors are encouraged to use a template referral letter (see below for a suggested template for children, students and adults that can be adapted as required).

All assessors should collect background information in advance of any assessment. They should question parents and/or carers carefully about attentional difficulties, as well as restless, overactive or impulsive behaviour, noted *before* the date of the assessment. The assessor will then be aware in advance of the areas that they may need to explore and describe characteristics of ADHD in detail. If characteristics of ADHD are recognised, but the assessor does not have appropriate training, they must refer these children and their families to another assessor [2] who does.

SpLD assessors and psychologists can make use of parent and teacher rated **scales** and other **screening materials,** in addition to accessing school reports, for an initial evaluation of the characteristics of ADHD in children. See recommendations below.

3. ADULTHOOD: establishing sufficient evidence to identify characteristics of ADHD

Adults with ADHD generally present with problems related to the inattentive symptoms of ADHD as these tend to have the main impact on learning and performance. Problems with sustaining attention, excessive uncontrolled mind wandering, getting bored quickly and being unable to focus, difficulty following lectures or reading, distractibility, disorganisation and forgetfulness, procrastination and poor time management are all common. The hyperactive-impulsive symptoms are usually (but not always) less obvious in adults or may

[2] For individuals of 16 years and over there is a necessity to formally describe ADHD characteristics since this report may be used in adulthood for DSA or other purposes. Where children are under 16, DSA decisions will be based upon the outcome of referrals to CAMHS or Paediatric Services.

have less impact on their functioning. However subtle signs of motor restlessness are often present, such as impatience when waiting and a tendency to talk over people, and some adults will still present with severe and impairing levels of hyperactive/impulsive behaviours (Asherson et al., 2012; Kooij et al., 2010).

Within educational and occupational settings, a number of individuals will present with and describe marked difficulties with sustaining attention, paying attention during lectures or when reading, distractibility, organising and planning, initiating and completing tasks, timekeeping, forgetfulness, impulse control and self-regulation of behaviour. These problems may be due to ADHD, and if so, they may have a marked impact upon learning practices and function in their education and work. In many cases, ADHD was not recognised or diagnosed in childhood, or they were previously diagnosed during childhood with no information available on their current diagnostic status.

There has been some confusion over the evidence required for the diagnosis of ADHD needed to access to Disabled Student's Allowance (DSA), even where individuals meet criteria for DSA due to learning difficulties caused by ADHD. In particular, it is not clear who can diagnose ADHD for this purpose, and whether a medical assessment is required. Waiting lists for medical assessments can be very long (months or several years) in many parts of the country, and some regions still do not provide a diagnostic or treatment service for adults with ADHD. Furthermore, they were established for the medical treatment of ADHD rather than provision of diagnostic assessments for educational support (NICE 2018). Waiting for a medical assessment may therefore not be appropriate when there is an urgent need to provide educational support due to learning difficulties from ADHD.

To address the need for ADHD assessments for DSA funding, SASC recommend that practitioner psychologists and specialist teacher assessors holding current registration (HCPC and APC) and who have **relevant training** (see below) can identify learning difficulties and patterns of behaviour that together indicate the presence of characteristic features of ADHD. In this situation they can make relevant recommendations for support at Further and/or Higher Education institutions and in the workplace on the basis that the person presents with above threshold symptoms and impairments according to the DSM-5 criteria for ADHD. Such assessments should be accepted by Student Finance England (SFE) in support of an application for the Disabled Students' Allowance or for Access to Work funding.

A conclusion that characteristics of ADHD are present should only be arrived at by an individual who has undertaken **appropriate training** (see below). Reports should provide details of the evidence for the identification of the characteristic features of ADHD and recommendations for the level/type of educational or occupational support required. It is also a requirement that the report provides guidance on possible future action which may

include information on how to seek a medical diagnosis and access to pharmacological and talking therapies.

4. Who can assess characteristics of ADHD in adulthood?

A Specialist Assessor who intends to make diagnostic judgements about ADHD symptoms and impairments should have an Assessment Practising Certificate (APC) or be a practitioner psychologist registered with Health and Care Professions Council (HCPC). Further to these qualifications, they must have completed additional appropriate training on ADHD. This training should include: the manifestations of ADHD and what might alert an assessor to apply recognised screening scales and diagnostic assessment tools; taking a developmental history including developmental course of ADHD symptoms and impairments; interplay of ADHD and other medical and mental health conditions; use of a diagnostic interview for the assessment of ADHD; psychometric tests and what they might reveal (although not a requirement when establishing the diagnosis of ADHD); distinction between ADHD and SpLDs; appropriate recommendations in an educational setting; how to include important diagnostic information in an assessment report; the pathway forward. Preferably, those assessors who choose to work in this field should seek supervision when writing initial reports, ongoing peer support/co-supervision and relevant continuous professional development (CPD).

5. How to identify characteristics of ADHD in adulthood

a) When first evaluating learning difficulties, enquire about sustained problems with inattention, hyperactive restless and impulsive behaviour.

b) Use screening instruments to screen for ADHD characteristics: This is good practice before embarking on an interview. Two screening questionnaires that are available for use are as follows:

- Barkley ADHD rating scale for DSM-IV (same items as DSM-5)
- The Adult ADHD Self Report scale for DSM-5 (ASRS-5) developed in the US by the World Health Organization (WHO) and the Workgroup on Adult ADHD.

These screening questionnaires are NOT diagnostic tools, but are useful for initial screening, monitoring change over time and making decisions about further referrals.

c) Undertake a structured diagnostic interview (e.g. ACE+/DIVA-5/CAADID-3). This process is strongly recommended as the core evaluation procedure for each of the 18 DSM items both currently and retrospectively, and the additional criteria required for the diagnosis of DSM-5 ADHD.

d) Evaluate impairments/needs: Matching symptoms to impairments is an essential part of the diagnostic process and it is therefore essential to include an assessment of all key areas of impairment. These will not be restricted to academic impact or impact at work and assessors would expect to see moderate to severe impact in other domains (e.g. work/education, relationships/family, social contacts, free time/hobbies, self-confidence/self-image) and associated features of ADHD (e.g. sleep problems, emotional dysregulation). Sometimes individuals display symptoms without impairment and in these cases identification of ADHD characteristics and recommendation for DSA support is not appropriate. Significant impairment from the symptoms is essential to the definition of ADHD as a disorder.

e) Gather a detailed history with an emphasis on developmental and childhood history, screening for other disorders, family history, social development and particularly educational development. Regarding the impact on educational difficulties, documenting a life history should, when ADHD is suspected, cover the following key issues: the individual's experience of reading, essay writing, course work, revision, examinations, and lectures, and experiences within the workplace. Care should be given to issues related to sustaining attention, procrastination, time management and level of distractibility. When there is a significant practice element (e.g. music students), attitudes towards taking part in regular, repetitive exercises should be investigated. As poor sleep patterns also impact on educational or occupational performance and/or attendance, any identified sleep difficulties should also be documented. A common characteristic of the attention deficit in ADHD is the ability to focus (or hyperfocus) on tasks that are highly salient to the individual, giving rise to a pattern of inconsistent attention to salient tasks only, or only focusing at the last moment under the pressure of critical deadlines. Some students with ADHD do well under pressure of examinations but fail on course work, while others are too distracted or restless to focus sufficiently during examinations.

f) Wherever possible, self-report should be supplemented by collateral/informant accounts of:

[3] Using a structured interview is a way to ensure that the criteria used to define ADHD in DSM-5 are met and is recommended practice. Details of these interviews are given below.

- history and description of ADHD symptoms and impairments in childhood (e.g. by parent/carer account of childhood symptoms/difficulties);
- review of school reports if available;
- informant/partner account of current symptoms and impairment;
- informant rating scales for DSM-5 ADHD can be used as an additional screen for current and childhood symptoms.

Identification of ADHD can be made based on self-report alone if a detailed account of symptoms and impairments can be obtained. This should be based on real life examples of ADHD related difficulties in daily life, and detailed descriptions of underlying problems such as excessive uncontrolled mind wandering, distractibility and forgetfulness. However, whenever possible this should be supplemented by additional information from friends, family, tutors or colleagues, and clear evidence of impairments such as educational failure and poor or inconsistent performance relative to the developmental age of the student. In some cases impairment in childhood may be limited if compensated for by high general cognitive ability and structured family and school support, with impairment emerging in the adult years.

g) **Cognitive performance and other evaluations (optional):** Collecting cognitive performance information from testing procedures can be useful but is not a requirement for establishing the diagnosis of ADHD. While there is no valid cognitive test for the disorder, qualitative observations gathered during tests can be useful to support conclusions and identify specific areas of cognitive performance impairments. Measures of general cognitive ability are helpful in identifying performance deficits relative to general ability.

Characteristic cognitive performance deficits associated with ADHD include: variable response times on speeded reaction time tasks (e.g. Continuous Performance Task, Sustained Attention to Response Task (SART)), response inhibition (e.g. stop task, commission errors on SART or other go/no tasks); variable working memory performance, and observed motor restlessness, distractibility and poor maintenance of attention during the assessment. However, it is important to note that performance test results are neither necessary nor sufficient for the diagnosis (although deficits in task performance are common, they are not always present). Task performance can fall in the normal range, particularly for tasks that are fast or rewarded. More consistent deficits compared to normative groups are seen for measures of reaction time variability or response inhibition during slow continuous boring tasks. Motor restlessness during computer tasks us a useful additional measure.

Observed behaviours such as distractibility or restlessness may not be apparent due to high motivation and novelty in the assessment situation, as ADHD symptoms and behaviours can be very sensitive to the saliency of the task environment for the individual. Some of the observed deficits may emerge over time as novelty and saliency of the situation and task wane. It is always important to evaluate ADHD on the basis of the presence of core ADHD symptoms in daily life. Do not exclude the diagnosis of ADHD based only on the absence of performance deficits and behavioural observations during office assessments.

ADHD is often referred to as a disorder of Executive Functions. This is particularly true for behavioural measures of ADHD which can be measured using self-ratings from the Behaviour Rating Scale for Executive Functions (BRIEF). This reflects real life difficulties which are characteristically seen in individuals with ADHD.

h) Consider the presence of specific learning difficulties e.g. dyslexia, Developmental Coordination Disorder (DCD) and dyscalculia by asking relevant questions and using screening tools. Note that ADHD will commonly co-exist with specific learning difficulties.

i) Consider whether ADHD traits might be better explained by other conditions and/or environmental factors. This is usually noted when ADHD symptoms only emerge at times of high stress or during episodes of anxiety or depression. The hallmark of ADHD symptoms are persistent trait-like symptoms that are present regardless of the presence or absence of other mental health conditions.

j) Emotional dysregulation (reports of irritability, temper control, emotional over-reactions) in daily life is a characteristic feature of ADHD and can be used to support the diagnosis of ADHD (APA 2013). However, because emotional dysregulation is often seen in other neurodevelopmental and mental health disorders it is not considered one of the core symptoms used in the diagnostic criteria for ADHD.

6. Evidence that needs to be included in an assessment report Post 16

a) presence of *several* symptoms of inattention and/or hyperactivity-impulsivity in childhood by the age of 12. In the DIVA-5 assessment *several* is defined as three or more symptoms in either the inattentive or hyperactive/impulsive symptom domains.

b) inattentive **and/or** hyperactive-impulsive symptoms in more than one domain (e.g. in education, work and everyday life) and various settings within the domains.

c) the adverse impact of such symptoms, particularly with reference to educational or workplace performance, but also on social interactions and activities when not working. Assessors should select pertinent examples of difficulties that provide robust evidence to give confidence in the conclusions.

d) positive achievement data; including examples of coping and adaptive skills in the management of ADHD symptoms and their impact, as well as potential strengths linked to core ADHD symptoms.

e) the administration and reporting of a diagnostic interview (e.g. ACE+, DIVA-5, CAADID-3) (see below);

f) awareness that ADHD is frequently associated with other specific learning difficulties (particularly DCD and dyslexia) and a range of mental health issues (e.g. low self-esteem, anxiety, depression, emotional instability, drug/alcohol misuse);

g) reference to qualitative observations of performance throughout the assessment as described above; but note that observed performance and behaviour can fall in the normal range during office assessments.

h) whenever possible, corroboration of symptoms and educational difficulties by contact with informant (e.g. face-to-face or telephone review with parent/partners/teachers) and/or review of educational reports;

i) It should be made clear in assessors' reports that they have taken a careful history and, whenever possible, collected direct additional evidence as noted. The information should be summarised with examples;

j) A history showing impairments across domains, linked to the symptoms of ADHD, is very important;

k) Understanding both strengths and weaknesses is fundamental to helping individuals cope and leads to strategies and altering behaviour. To identify characteristics of ADHD, there should be a significant impact of the symptoms of ADHD on performance and/or quality of life in at least one significant aspect of everyday life, as well as in education.

l) Following educational support and/or environmental modifications (including effective self-management) impairment sufficient for identifying characteristic characteristics of ADHD may be limited to one domain (e.g., significant impact on education).

7. Recommendations Post 16

a) If the assessor believes ADHD to be present, then he/she should:

- maintain professional boundaries of training and expertise when offering advice and counselling to the individual thus ensuring that professional indemnity insurance or equivalent company insurance contractual agreements remain unaffected.
- report evidence for the presence of ADHD and other possible SpLDs that may be present; and make relevant educational or workplace recommendations.

b) In cases where the individual does not already have a medical diagnosis of ADHD, advise that one can be requested via their GP or student medical service should they choose (see template letter). If there is no local service or long waiting times it is possible to request referral to an alternative NHS commissioned service under the NHS 'Right To Choose' Legislation.

c) Advise individuals that the medical route may provide access to:

- specific medications for ADHD that can help to control impairing levels of inattention, hyperactivity, impulsivity and associated emotional lability. Several medications are safe and effective for treating ADHD and for preventing many adverse outcomes (Faraone et al, 2021). These are recommended by NICE (2008, 2018) as first line treatments for the reduction of impairing levels of ADHD symptoms and may have a considerable impact on improving educational performance and other aspects of ADHD.

- an NHS referral to a suitably qualified psychologist who could help them with changing unhelpful thought patterns and behaviours. This is important as many individuals think that the medical route will result only in their being offered medication but the National Institute for Health and Care Excellence (NICE) guidance recommends a holistic approach when planning treatment and highlights the importance of discussing strengths and weaknesses of both pharmacological and alternative interventions with people with ADHD.

However, it should be noted that currently there are few NHS resources in this area.

d) Signpost individuals to local support groups and/or universities' disability or neurodiversity support groups, including national Patient Organisation website information (e.g. AADD-UK and ADDISS) and the Neurodiversity In/And Creative Research Group. These organisations would provide the possibility for peer support and further information.

e) Consider signposting individuals for expert support from qualified ADHD coaches with experience of working with students. Referral to suitable qualified expert ADHD coaches can be funded by DSA.

f) Notwithstanding (c) above, be aware that symptoms of possible ADHD may, in fact, be signs of other medical complaints, and recommend that individuals seek a consultation with their GP or student medical services. The GP or medical service will also be required to liaise with or make the referral for a specialist medical assessment. This would also be essential if the student or adult appears to be distressed or medically ill.

g) Assessors should include a statement that assessment findings confirm the presence of specific learning difficulties that are affecting an individual's ability to cope with academic demands in college, university or the workplace. If the assessor considers that the specific learning difficulties result from the interference of ADHD characteristics on performance this should be specifically stated. If the assessor considers that characteristics of ADHD are present, they should state this.

Although it is implied, it should be noted that this guidance does not preclude medical evidence from a suitably qualified health care professional and routes for onward referral should be given.

8. Links to screening questionnaires and interviews

ADHD Child Evaluation (ACE) and ADHD Evaluation for Adults (ACE+)
https://www.psychology-services.uk.com/adhd

The Adult ADHD Self Report scale for DSM V

Ustun, B., Adler, L.A., Rudin, C., Faraone, S.V., Spencer, T.J., Berglund, P., Gruber, M.J. and Kessler, R.C., 2017. The World Health Organization adult attention-deficit/hyperactivity disorder self-report screening scale for DSM-5. *Jama psychiatry*, *74*(5), pp.520-526.

https://www.hcp.med.harvard.edu/ncs/ftpdir/adhd/ASRS-5_English.pdf

Barkley Adult ADHD Rating Scale IV (BAARS-IV)
Barkley Russell A., 2011

https://www.guilford.com/books/Barkley-Adult-ADHD-Rating-Scale-IV-BAARS-IV/Russell-Barkley/9781609182038
And
https://www.guilford.com/browse/assessment-scales

Conners Adult ADHD Diagnostic Interview (CAADID)
Epstein, J.N. and Kollins, S.H., 2006. Psychometric properties of an adult ADHD diagnostic interview. Journal of Attention Disorders, 9(3), pp.504-514.

https://www.mhs.com/MHS-Assessment?prodname=caadhf

Diagnostic Interview for ADHD in Adults (DIVA 5)
Ramos-Quiroga, J.A., Nasillo, V., Richarte, V., Corrales, M., Palma, F., Ibáñez, P., Michelsen, M., Van de Glind, G., Casas, M. and Kooij, J.S., 2019. Criteria and concurrent validity of DIVA 2.0: a semi-structured diagnostic interview for adult ADHD. Journal of attention disorders, 23(10), pp.1126-1135.

http://www.divacenter.eu/DIVA.aspx

Strengths and Difficulties Questionnaire (SDQ)
Goodman, R., 2001. Psychometric properties of the strengths and difficulties questionnaire. Journal of the American Academy of Child & Adolescent Psychiatry, 40(11), pp.1337-1345.

https://www.sdqinfo.com

Weiss Functional Impairment Rating Scale
Behaviour Rating Inventory of Executive Function
Jarratt, K.P., Riccio, C.A. and Siekierski, B.M., 2005. Assessment of attention deficit hyperactivity disorder (ADHD) using the BASC and BRIEF. *Applied Neuropsychology*, *12*(2), pp.83-93.

https://www.caddra.ca/wp-content/uploads/WFIRS-S.pdf

9. References and suggested reading

Asherson, P., Akehurst, R., Kooij, J.S., Huss, M., Beusterien, K., Sasané, R., Gholizadeh, S. and Hodgkins, P., 2012. Under diagnosis of adult ADHD: cultural influences and societal burden. Journal of Attention Disorders, 16(5_suppl), pp.20S-38S.

Stephen V Faraone, Neuroscience and Biobehavioural Reviews, https://doi.org/10.1016/j.neurobiorev.2021.01.022

Fayyad, J., Sampson, N.A., Hwang, I., Adamowski, T., Aguilar-Gaxiola, S., Al-Hamzawi, A., Andrade, L.H., Borges, G., de Girolamo, G., Florescu, S. and Gureje, O., 2017. The descriptive epidemiology of DSM-IV Adult ADHD in the world health organization world mental health surveys. *ADHD Attention Deficit and Hyperactivity Disorders*, *9*(1), pp.47-65.

Faraone, S.V., Banaschewski, T., Coghill, D., Zheng, Y., Biederman, J., Bellgrove, M.A., Newcorn, J.H., Gignac, M., Al Saud, N.M., Manor, I. and Rohde, L.A., 2021. The world federation of ADHD international consensus statement: 208 evidence-based conclusions about the disorder. *Neuroscience & Biobehavioral Reviews*.

Fredriksen, M., Dahl, A.A., Martinsen, E.W., Klungsoyr, O., Faraone, S.V. and Peleikis, D.E., 2014. Childhood and persistent ADHD symptoms associated with educational failure and long-term occupational disability in adult ADHD. ADHD Attention Deficit and Hyperactivity Disorders, 6(2), pp.87-99.

Gaub, M. and Carlson, C.L., 1997. Gender differences in ADHD: a meta-analysis and critical review. Journal of the American Academy of Child & Adolescent Psychiatry, 36(8), pp.1036-1045.

Kooij, S.J., Bejerot, S., Blackwell, A., Caci, H., Casas-Brugué, M., Carpentier, P.J., Edvinsson, D., Fayyad, J., Foeken, K., Fitzgerald, M. and Gaillac, V., 2010. European consensus statement on diagnosis and treatment of adult ADHD: The European Network Adult ADHD. BMC psychiatry, 10(1), p.67.

Moncrieff, J. and Timimi, S., 2013. The social and cultural construction of psychiatric knowledge: an analysis of NICE guidelines on depression and ADHD. Anthropology & medicine, 20(1), pp.59-71.

National Institute for Health and Care Excellence. ADHD Diagnosis and Management https://www.nice.org.uk/guidance/ng87
Neurodiversity in/and Creativity Research Group
https://www.jiscmail.ac.uk/cgi-bin/webadmin?A0=NEURODIVERSITY

Polanczyk, G., De Lima, M.S., Horta, B.L., Biederman, J. and Rohde, L.A., 2007. The worldwide prevalence of ADHD: a systematic review and metaregression analysis. American journal of psychiatry, 164(6), pp.942-948.
Saul, R., 2014. Doctor: ADHD Does Not Exist. TIME. com.

Sciberras, E., Roos, L.E. and Efron, D., 2009. Review of prospective longitudinal studies of children with ADHD: mental health, educational, and social outcomes. Current Attention Disorders Reports, 1(4), pp.171-177.

Snowling, M.J. and Maughan, B., 2006. Reading and other learning disorders. A clinician's handbook of child and adolescent psychiatry, pp.417-446.

Timimi, S., 2017. Non-diagnostic based approaches to helping children who could be labelled ADHD and their families. International Journal of Qualitative Studies on Health and Well-being, 12(sup1), p.1298270.

Timimi, S. and Taylor, E., 2004. ADHD is best understood as a cultural construct. *The British Journal of Psychiatry*, *184*(1), pp.8-9.

Appendix 1: Referral letter template

Your name, qualifications and contact details

Date

To (Whom It May Concern, Name of GP if known)

CC: Parent(s)/ Carer(s)/Teacher and/or school as relevant

Re: Name of child/young person/student

DOB:

On (**give date**) X was referred to me (**give reason as appropriate** e.g. for an assessment to investigate a suspected specific learning difficulty / because of concerns about progress at school / college/ university because of concerns about the development of inattentive, impulsive and hyperactive behaviour [delete as required])

A full developmental history was taken at the assessment, including questions about attention, impulsivity and hyperactivity. X's parent(s)/carer(s)/teacher(s) contributed information about difficulties with these characteristics at school and the age at which they began.

The following difficulties associated with inattention, impulsivity and hyperactivity [delete as required] were described by X and parent(s)/carer(s)/teacher(s): (Briefly list/bullet point difficulties)

During my assessment X: (give examples of difficulties noted at assessment, e.g. attentional, impulsive and hyperactive [deleted as required] behavioural style).

Briefly list any **other relevant results of assessment** and **relevant contextual information**

I am making this referral because X would benefit from a **medical assessment** to determine accurate diagnosis/diagnoses and provide recommendations for medical treatment or support. Ideally this would involve an inter- or multi-disciplinary assessment by a paediatrician or clinical psychologist.

In making this referral I am following the **SASC Guidance on the assessment and identification of Attention Deficit/Hyperactivity Disorder,** which can be found via the Downloads tab at www.sasc.org.uk. There is further information at: https://www.nhs.uk/conditions/attention-deficit-hyperactivity-disorder-adhd/

Yours sincerely/faithfully