

ATTENTION DEFICIT HYPERACTIVITY DISORDER: ASSESSMENT AND MANAGEMENT

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ASSESSMENT OF THE CHILD IN THE CONTEXT OF FAMILY AND SCHOOL

In the assessment of a child or young person with suspected AND/MD, consideration should occur in four areas:

- general health
- developmental status
- mental health assessment
- range of behaviours, exhibited in a variety of environments (home, school and elsewhere)

Detailed assessment in these areas enables the diagnosis to be confirmed, the differential diagnoses to be excluded and comorbid disorders to be identified and assessed. The key features of assessment in each of these areas is outlined in Table A.

The child must be considered in the context of his family, school and local environment. Assessment of the family, the influence it has upon the child and the effect a child with

AD/MD has upon a family must be evaluated and should not be underestimated. A detailed history of the immediate and extended family may reveal a relevant history of similar difficulties or educational problems, especially in male family members.

The effects of social influences, ie housing or unemployment, upon the family are relevant and may influence decisions about management, especially in isolated or single-parent families with limited local family support networks.

Within the child's school, information is required from teachers who know him well, about educational progress: what are his current educational achievements as measured in school assessments and by statutory national assessment (SATs)? Is the child within the school's special educational needs system (and if so, at what stage?) What problems does the child experience, either in a teaching environment or in less structured times (playground, breaks etc)? Information is also required about the child's peer interaction and social interaction within the school.

Specific information regarding the key behaviours of AD/HD (inattention, impulsivity and motor restlessness) is sought by use of structured questionnaires – Connor’s questionnaires.

The school questionnaire, which contains 39 questions, identifies key behaviours and their frequency in 'classroom behaviour', 'group participation with peers' and 'attitude to authority'. A similar but more detailed family questionnaire has 97 questions and helps to identify key behaviours in the home environment. It also helps to define any other behavioural difficulties within the home which may require further assessment.

These Connor's questionnaires are scored with reference to the frequency of events and have a possible score of 1 to 3 for each question. This can give an impression of the severity of difficulties and can be useful as a means of evaluating response to management.

In the Lancaster district the assessment model currently used is a two-stage process, initially involving experienced staff grade doctors from the school health service. These doctors are the named 'school doctor' for the child's school and are often known to the family and know the local schools. The child and family are seen for a joint appointment when assessment of general health and developmental status occurs. Information is collected regarding the child's mental health status and Connor's questionnaires are completed by parents and teachers. Information is sought from educational psychologists in the Schools' Psychological Service. All this information is collected and analysed and the child is either

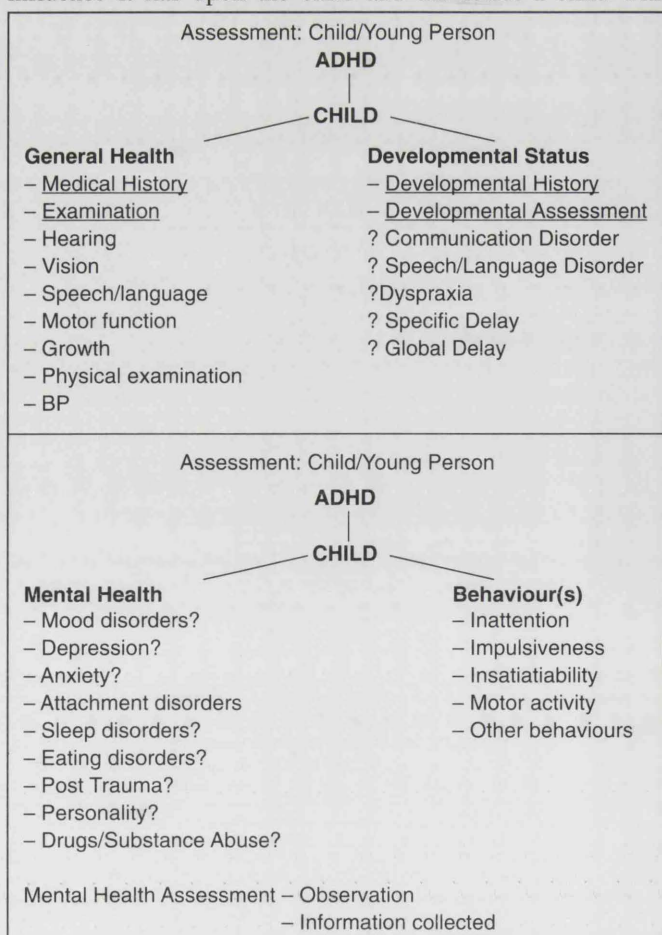
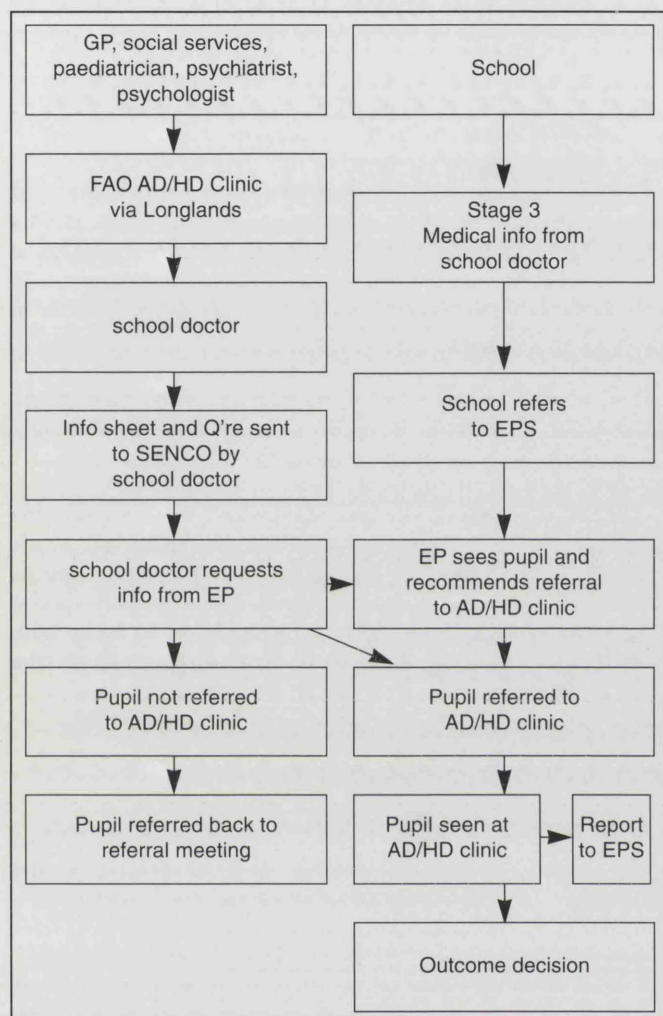


Table A

then referred to the designated AD/HD clinic for further assessment and appropriate management, or, if AD/HD does not appear to be a primary diagnosis, referred for a consultant opinion at a community paediatric clinic, child psychiatry or child psychology clinic. The child may be seen jointly by these disciplines within the context of the AD/HD clinic for further multidisciplinary assessment and advice.



AD/HD referral flowchart

Following assessment in the AD/HD clinic, subsequent regular review of the medical aspects of management, especially medication (dosage changes, side effects, effectiveness) and liaison with school is via the local school doctor. Referral back to the AD/HD clinic can occur at any time for advice or further consultation, particularly if medication is being stopped, or in late teenage years, for consideration of whether medication should continue into early adult life.

MANAGEMENT OF THE CHILD AND ADVICE TO FAMILIES

Detailed assessment may lead to several possible interventions.

Within the family, recognition, assessment and acknowledgement by professionals of the difficulties a child is experiencing, can in itself be helpful. A significant number of parents of children with AD/HD can consider themselves, or be considered by others, to be inadequate parents. Not all parents are seeking a diagnostic label of AD/HD and indeed many parents are unaware of the disorder, despite significant media coverage.

Education of the parents, wider family members and teachers about AD/HD is fundamental to helping these children. There is a useful range of appropriate parent booklets available from bookshops or on loan from local libraries.

Assessment of the child's interactions with others may identify areas of specific therapeutic work which may be beneficial, eg parenting skills groups, arranged through Child and Adolescent Mental Health Service staff, or other behaviour approaches concerned with parentchild or sibling-child interactions. Within the school, advice from the specialist school support services (Pupil Referral Service in Lancashire schools) may provide support on peer interaction, behavioural strategies for classroom difficulties or issues of self-esteem. Advice from specialist social workers working with children with mental health difficulties and their families (previously the Child and Family Consultation Service in Lancashire) may be helpful, as may family therapy, as practised in the department of Child and Adolescent Psychiatry.

Social work assessment and advice may be very helpful, especially if there are adverse social or environmental factors. Support for families by outreach support teams, family link schemes or short break (respite) opportunities may be very helpful to families under stress. School holiday times can be particularly difficult and playschemes can be very supportive. Social workers may also advise on the availability of benefits such as the Disability Living Allowance, reflecting requirements of greater levels of daytime care and supervision for children with AD/HD.

MEDICATION

The use of medication should only be considered as one possible management option following detailed assessment. Medication can, however, enable other strategies to be more effective and may prevent secondary handicaps developing as a result of educational failure, such as

- exclusion from school
- development of conduct disorders
- increasing family tensions, producing negativity
- potential family rejection.

Although the widespread use of medication in the UK is a relatively recent development, the use of amphetamine-based stimulants has been established for many decades in the USA and Australasia. The mechanism of action is understood to be by influence on neurotransmitter balance within the frontal lobe, increasing the inhibitory role of the frontal lobe in modifying behavioural responses. This may result in an observable increase in desirable behaviours such as improved attention control and concentration span or reduced impulsive behaviour and less excessive motor activity. Within the home this may result in more socially acceptable behaviour whilst in the classroom better 'on task' behaviours should result in increased educational productivity, associated with a reduction in inappropriate behaviours.

A significant and favourable response to medication is observed in 70-80% of children. Medication is usually used only over the age of five years. If no benefit is obtained with Ritalin (methylphenidate), which is usually the drug of first choice, then an alternative amphetamine-based stimulant ie Dexamphetamine (Dexedrine) may be more effective for that child.

The use of methylphenidate is summarized in Table 1.

Although the pharmacological half-life of medication is short (three to four hours) benefits can be observed within both school and home environments over longer periods.

onset	20-30 minutes
action	3 ¹ / ₂ -4 hours, may be shorter
dosage	¹ / ₂ -2 tablets: 5-20mg (10mg tablets) daily dosage: two or three times daily, with food 8am 12noon ?4pm
side effects	short term stomach ache nausea emotional liability – tearful headaches NB: BLOOD PRESSURE SHOULD BE MONITORED long term insomnia anorexia – monitor growth nervous tics (may be made worse)
cautions	can be used in children with epilepsy less predictable action with global delay or other neurological damage but can be very effective
other drugs	dexamphetamine (Dexedrine) rarely: Imipramine Clonidine

Table 1 The use of methylphenidate (Ritalin)

When starting medication, parents and children need to be aware that its use may be longterm and is likely to continue for a number of years, ie whilst beneficial effects are still being observed by parents, teachers and the child. A small proportion may continue to benefit from medication into young adult life. Drug-free periods may be helpful in deciding upon continued effectiveness. Problems with compliance may emerge during teenage years.

The potential beneficial effects of reducing the consequences of untreated AD/HD would appear significantly to outweigh the theoretical risk of drug misuse with amphetamine-based drugs.

There are significant issues regarding the use of controlled drug medication in school, shown in Table 2. Effective communication and liaison with schools in assessment and subsequent management are essential to help overcome these concerns. A defined and appropriate policy on medication in schools is required. Each school should have a policy on the use of medication on its premises. Advice has been given to schools by the Department of Education and Lancashire Education Authority, and the policy is the responsibility of the head teacher.

The School Health Service can give assistance in advising parents and schools on issues relating to the use of medication in the school environment.

CLINICAL PSYCHOLOGY INPUT TO THE AD/HD CLINIC

The clinical child psychologist provides flexible input to the clinic team, offering joint consultation with medical colleagues. Detailed psychological assessment is available to children whose neurological functioning may be affecting their behaviour.

information regarding medication and dosage supplied to school by parents
supervision of pupil
recording of medication given
refusal of medication by pupil
supply of medication to school by parents
safe storage in school of medication
effective communication between doctor, parents and school

Table 2 Medication in schools – issues

The clinical psychologist can provide developmental and behavioural strategies aimed at improving the child's compliance within the family or school environment. This is so particularly in the case of young children, or those who do not meet the diagnostic criteria of unmanageable behaviour in at least two life situations.

Psychological research is undertaken within the clinic setting, currently focussing upon the information-processing capacity of children referred for AD/HD assessment.

All schools work to the Code of Practice on the identification and assessment of special educational needs and use Lancashire's guidelines to it. This places responsibility on the school to identify pupils with special educational needs, to provide for those needs, to liaise with parents and outside agencies and to ensure access to the curriculum.

THE STAGED APPROACH

Special educational needs occur along a continuum. Pupils identified as having such needs will be placed at the appropriate stage of the special educational needs register.

Stage 1

The class or subject teacher, parent or other agency expresses a concern about a pupil. This concern is assessed and then registered as a special educational need by the teacher who takes the initial action.

Stage 2

At Stage 2, a pupil requires early intensive action through an individual educational plan (IEP). The special educational needs coordinator takes the lead responsibility for coordinating the special needs provision.

Stage 3

The school can call upon external specialist support. The pupil has a more complex IEP, which reflects Stage 3 needs.

Stage 4 and 5

The local education authority is involved in considering the need to make a statutory assessment, and at Stage 5 the LEA issues a statement of special educational needs which provides for additional support.

THE ROLE OF THE EDUCATIONAL PSYCHOLOGIST

Educational psychologists are primarily involved at Stages 3-5, but can give advice at Stages 1 and 2. Part of their role in schools is to help children and young people who have difficulties with learning or behaviour or both, through

assessment of the difficulties and the environment, advising teachers, parents and others, and by undertaking direct therapeutic work. Educational psychologists work in cooperation with families, teachers, doctors, social workers and other professionals.

Pupils with AD/HD-type behaviour which is causing significant difficulty will be referred to the educational psychologist at Stage 3. These pupils will be exhibiting behavioural difficulties linked to hyperactivity and impulsivity, but may also have learning difficulties. Pupils who have AD/HD symptoms without the hyperactivity component, ie mainly inattentive, may not be so easily identified.

It is expected that by this stage the school will have completed a Stage 3 request for medical assessment, and this may have identified the possibility of AD/HD via the school medical service. Educational psychologist assessment of the pupil can include observation in a range of settings, interview with staff and parents and individual assessment (cognitive, literacy, numeracy, self-esteem, personality).

When assessment is completed, the educational psychologist writes a report (EP2), summarising his

involvement and the child's background, assessment findings and results, special educational needs, objectives and recommended methods and approaches.

If there is evidence that the pupil may have AD/HD, with or without hyperactivity, this will have been discussed with the parents and permission obtained to send a EP2 report as a referral to the AD/HD clinic. Once the pupil has been seen at the clinic, a report of the outcome is sent to the referring educational psychologist, who will liaise with the school medical service and the school with regard to recommendations for strategies and future provision, and monitoring within the school setting.

In a small number of cases, a parent may raise concerns that the child has AD/HD, but the school does not consider the child a priority for referral to the educational psychology service. In these cases, the school may discuss the pupil with the educational psychologist and send a Stage 3 medical referral to the school doctor. Liaison should continue between the school, the medical service, parents and the psychology service to consider whether an educational psychologist's assessment is necessary in each case.