Irish Journal of Psychological Medicine (2018), **35**, 245–246. © College of Psychiatrists of Ireland 2017
doi:10.1017/ipm.2017.65

PERSPECTIVE PIECE

Reflections on developing an ADHD assessment service

N. Farrelly*

College Health Service, Trinity College Dublin, Dublin, Ireland

Clinicians in adult mental health services are coming under increasing pressure to respond to requests for Attention Deficit Hyperactivity Disorder assessment and management both from those who are to no longer eligible for treatment in the Child and Adolescent services and those seeking a new assessment. The challenges in responding to such requests are discussed in this reflection.

Received 14 February 2017; Revised 29 September 2017; Accepted 3 October 2017; First published online 23 November 2017

Key words: Adult ADHD, treatment, service.

On arrival in my position as Consultant Psychiatrist at Trinity College Dublin in May 2008 I was expecting to take over a general adult practice looking after the care needs of young university going adults treating a range of disorders including mood and anxiety disorders, emerging psychotic illness, etc. This was quickly met and I felt that my training both basic specialist training and higher specialist training and consultant experience had prepared me adequately for this role. That was until a number of referrals for assessment of Attention Deficit Hyperactivity Disorder (ADHD) landed on my desk. I had not bargained for this and yet the referrals kept coming. I was repeatedly being asked by GPs to give advice on patients who were already well maintained on ADHD treatment but could no longer access care as they had turned 18. I'd nothing to offer. Eventually I had to confront my convenient belief that ADHD was a disorder of childhood that magically disappeared on turning 18.

When the opportunity to attend a continuing professional development training day came up I decided I'd see what the 'believers' were saying. There I was bombarded with slide upon slide outlining the neurobiological and genetic evidence supporting ADHD and theories around maturing prefrontal cortices. My interest was piqued. My dilemma of inexperience and absence of supervision prevailed. Without any great plan, I happened upon a Professor of Child and Adolescent Psychiatry, Fiona Mc Nicholas, and spoke of my predicament. She very graciously agreed to provide advice and clinical supervision and I set about drawing up referral criteria and settling on a standardised assessment and follow-up protocol.

Having trialled a number of assessment tools including the adult Connors (expensive), the ASRS and Browne (too narrow for my population), I eventually settled on the DIVA (DIVA Foundation, 2008) in combination with the CADDRA (Canadian Attention Deficit Hyperactivity Disorder Resource Alliance, 2010) assessment protocols both of which are freely available online. The CADDRA pack provides a standardised assessment and a plethora of follow-up and symptom rating scales as well as medication fact sheets and driving assessment considerations. My concerns ranged from becoming known as 'Dr Ritalin' to drawing the derision of my colleagues so it was important to me that the referral pathway was clear and that the assessment was standardised. I decided to cast the net as narrowly as possible and to have a working relationship with referring agencies, therefore only referrals from external psychiatrists or internal college GP's were accepted initially. Additional precautions included not seeing patients for assessment between February and May (exam term) and advising referring agencies that the provision of collateral information in terms of history and supporting documentation (school reports) was mandatory to support a diagnosis.

Over the past 6 years the clinic has assessed over 90 patients for ADHD over two-thirds of whom have satisfied clinical criteria for adult ADHD. Most but not all patients have gone on to have a trial of medication either stimulant or non-stimulant as per the NICE Guidelines (NICE, 2016) and students are routinely offered Occupational Therapy support by a team of experienced therapists employed by the College Disability Service. Referrals are largely split equally between those with a pre-existing diagnosis from

* Address for correspondence: Dr N. Farrelly, Consultant Psychiatrist, College Health Service, Trinity College Dublin, House 47, Dublin 2, Ireland.
(Email: farreln5@tcd.ie)

childhood and first time assessments. Individuals with pre-existing diagnoses, most of whom are graduates of the Child and Adolescent Mental Health Services are still required to complete a full assessment prior to continuation of treatment to establish if the clinical criteria for ADHD are still met.

The lessons I have learned have been many and varied. The two most salient lessons being that ADHD exists in adulthood and is associated with significant functional impairment and, second, that treatment works. There are few conditions in my clinical practice that offer such consistent clinical reward for effort and this is not just reflected in the reduced rates of attrition from university but also improvements in social and occupational performance and self-esteem. More pragmatic lessons have been a realisation that patients with ADHD do not turn up to appointments unless they have reminders both the day before and the day of the appointment whilst my expectation of being inundated by the 'study aid' drug-seeking population has not come to pass in the manner than I had dreaded. The insistence on collateral information and school reports is especially important in these cases. In reality it is much easier to obtain Ritalin on the street at an affordable cost than it is to wait for at least 8–18 weeks for an assessment that takes on average two consultations, at least 3 hours out of your life.

As my caseload has grown I have become increasingly mindful of the enduring negative messages patients with ADHD receive throughout childhood with recurrent negative comments on school report cards. I am also cognisant of the significant role parents play in scaffolding their children through childhood and adolescence and for it all to come tumbling down once this is removed on leaving home. Specific enquiries about communication by social media is revealing and stories abound of great difficulty responding to messages in a timely fashion and of frustrated partners and friends left waiting in the rain. An audit of the rates of lost phones compared to the non-ADHD population would be interesting.

College life has changed significantly over the past 15 years with 5% of third-level students having a registered disability (Trinity College Dublin Disability Service, 2017). The need to provide appropriate support on campus for such students is evident. The existence of the Disability Access Route to Education (DARE) (a third-level alternative admissions scheme that offers reduced points places to school leavers whose disabilities have had a negative impact on their second-level education) tells us that the number of students registering with ADHD as a diagnosis has risen year on year, rates now appear to be plateauing. Students with ADHD are equally dispersed across all major faculties in college. Increasing diversity and access to college for all is laudable and reflects a growing awareness of, and access to assessment for neurodevelopmental disorders at second-level education. What happens on turning 18 is anyone's guess. In Ireland, the quality of life, morbidity and economic cost associated with adult ADHD in the larger community is largely unknown as the provision of ongoing care or access to new assessment is negligible. Adult ADHD exists and not just in the rarefied world of a university student. Our continued insistence on convenient beliefs about the absence of evidence to support adult ADHD and citations of lack of training can only hold water for so long.

Ethical Standards

The author asserts that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committee on human experimentation with the Helsinki Declaration of 1975, as revised in 2008.

Conflicts of Interest

Dr Farrelly reports non-financial support from National ADHD Conference, non-financial support from Lilly Adult ADHD Academy 2015, during the conduct of the study; and I have attended and presented at clinical meetings that were in part sponsored by companies including Shire and Lily.

Financial Support

None.

References

Canadian Attention Deficit Hyperactivity Disorder Resource Alliance (CADDRA) (2010). *CADDRA Practice Guidelines 3rd Edition*. Canadian ADHD Resource Alliance.

DIVA Foundation (2008). *DIVA 2.0 – Diagnostic Structured Interview for Adults with ADHD*. (http://www.divacenter.eu/DIVA.aspx?id=465) Accessed February 2016.

National Institute for Health and Care Excellence - NICE (2016). *Attention Deficit Hyperactivity Disorder: Diagnosis and Management - Clinical Guideline [CG72]*. September 2008, Last updated: February 2016. (https://www.nice.org.uk/guidance/cg72). Accessed February 2016.

Trinity College Dublin Disability Service (2017). *Disability Service Annual reports & KPI's*. (https://www.tcd.ie/disability/policies/annual-report-stats.php). Accessed February 2016.

https://doi.org/10.1017/ipm.2017.65 Published online by Cambridge University Press