ADHD Child Evaluation

A diagnostic interview of ADHD in children

ACE

English

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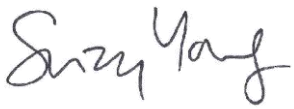
Preface

I started working with young people with Attention Deficit/Hyperactivity Disorder (ADHD) over 20 years ago. The clinical picture has changed over these years due to research, which has considerably advanced our scientific knowledge and understanding about the aetiology, presentation, treatment and prognosis of ADHD. ADHD is now recognised to be a lifespan condition yet, despite international guidelines on the assessment, treatment and management of ADHD, too many young people reach adulthood with undiagnosed ADHD. This means that the diagnosis is being missed or that they are misdiagnosed in childhood. It also means that these young people will not receive the optimal treatment for their symptoms and associated problems; many will not reach their potential and for some the future is bleak. The good news is that there are large treatment effects for ADHD interventions and one can intervene at any age, but if children with ADHD are to mature into confident young adults who experience psychological wellbeing and have a good quality of life we need to intervene as early as possible. I therefore developed the ADHD Child Evaluation (ACE) in the hope that this semi-structured interview will support healthcare practitioners across the world in their assessment and diagnosis of ADHD in childhood.

I thank all of my colleagues who have kindly given feedback on previous drafts of the ACE interview, in particular Cornelius Ani, David Coghill, Eric Taylor, Isaac Szpindel, Jade Smith, Nader Ali Perroud, Tammi Kramer, Tony Rostain and Paul Ramchandani. Special thanks go to Hannah Mullens for her support in the creation and development of the project and design of ACE interview.



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Introduction to ADHD

ADHD

Attention Deficit Hyperactivity Disorder (ADHD) is a neurodevelopmental disorder characterised by symptoms of inattention, impulsivity and hyperactivity that are inconsistent with the child's developmental level. For a diagnosis, the behaviours and difficulties associated with ADHD must interfere significantly with an individual's functioning. As a result, ADHD is associated with a variety of problems including poor academic performance, interpersonal relationship problems and, later in life, employment problems (Shaw et al., 2012). Early diagnosis will provide an opportunity for early intervention, which in turn will improve the young person's quality of life across the lifespan.

For some individuals symptoms remit with age (most commonly overt hyperactive and impulsive symptoms), while others experience persistent symptoms and associated impairment into adulthood. The prevalence of ADHD is suggested to be around 5% in children and 2.5% in adults (American Psychiatric Association, 2013). In childhood up to four times more boys than girls are diagnosed with ADHD, whereas in adulthood females are just as likely to be diagnosed as males (Ford et al., 2003; Kessler et al., 2006). This may be because young boys present with greater hyperactivity than girls, and thus they are more likely to be noticed and referred for assessment. ADHD is a treatable condition, and this interview focuses on the assessment of ADHD.

Diagnostic criteria

There are two diagnostic criteria in common use, the Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM-5) and the International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10). These criteria differ in their classification of ADHD. DSM-5 and ICD-10 were developed as guidance for healthcare practitioners and not a specific algorithm.

The DSM-5 criteria, defined by the American Psychiatric Association (2013), include three subtypes of ADHD: predominantly inattentive, predominantly hyperactive/impulsive, and combined presentation. DSM-5 criteria require onset of symptoms by age 12 (but not necessarily causing impairment). For children, six (or more) symptoms from each subtype are required for a diagnosis, whereas for older adolescents and adults (age 17 and older), at least five current symptoms are required. Symptoms must have persisted for at least six months to a degree that is inconsistent with the child's developmental level and have caused impairment directly on social and academic/occupational activities. These criteria are widely used and included in the SNAP-IV (Swanson, 1992), BAARS-IV (Barkley, 2011), ADHD Rating Scale-IV (DuPaul et al, 1998), and Kiddie-Sads-Present and Lifetime Version (K-SADS-PL; Kaufman et al., 1996).

The ICD-10 criteria, defined by the World Health Organization (1992), diagnoses ADHD under the title Hyperkinetic Disorder. The symptoms remain the same as in the DSM-5, however the nine hyperactivity/impulsivity symptoms of the DSM-5 are separated into their constituent parts, with five hyperactivity symptoms and four impulsivity symptoms. The ICD-10 requires onset of symptoms by the age of seven years (but not necessarily causing impairment). For a diagnosis of Hyperkinetic Disorder to be made, children must present with at least six inattention symptoms, in addition to at least three

hyperactivity symptoms and at least one impulsivity symptom. The number of symptoms required for a diagnosis is not age dependent in the ICD-10, and this is the same for both children and adults. Similar to the DSM-5, the ICD-10 requires symptoms to have been present for at least six months to a degree that is inconsistent with typical developmental levels of that age, and to cause impairment across more than one situation. In contrast to the DSM-5, the ICD-10 does not outline different subtypes of Hyperkinetic Disorder, instead stating that many authorities will still recognise the condition if an individual is sub-threshold in only one area of the diagnosis, e.g. if a child falls below threshold for hyperactivity but presents as highly inattentive.

Whilst ADHD can be diagnosed in children under the age of five (there is no minimum age proposed by the diagnostic systems), symptoms can be hard to distinguish from the variation seen in normative behaviours during pre-school years. Thus it is recommended that assessors exercise caution when conducting an assessment of ADHD in children younger than five.

Co-existing problems and disorders

For a diagnosis of ADHD, symptoms must not be better explained by another mental disorder (e.g. substance use, anxiety, depression), which involves an assessment for differential diagnoses. However, children with ADHD often present with a second psychiatric disorder; it is reported that up to two-thirds of children with ADHD have one or more co-existing conditions. Common comorbidities include oppositional defiant and conduct disorder, anxiety and mood disorders, tic disorders and autistic spectrum disorders (Biederman et al, 1991; Goldman et al, 1998; Pliszka, 1998; Elia, et al, 2008). Hence the assessor must distinguish between primary (i.e. differential) and secondary (i.e. co-existing) conditions.

The classification systems differ on this criterion. The DSM-5 recognises and allows for comorbidities, whereas they are exclusion criteria in the ICD-10. This contributes to the preference among practitioners of the broader DSM-5 criteria as this fits more closely with clinical practice and experience.

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ACE Administration

The ADHD Child Evaluation (ACE) is a tool designed to support healthcare practitioners to assess for ADHD in children aged 5-16 years. The ACE interview leads the assessor through the diagnostic process by assessing the core symptoms of ADHD and the extent to which they impair functioning. ACE sets out a series of questions that correspond with the core symptoms of inattention, hyperactivity and impulsivity, and typical examples of the manifestation of these symptoms are provided which can be used to prompt the assessor and guide clinical judgement. In order to assess whether the core symptoms are causing significant interference in two or more settings, ACE prompts the investigation of each symptom in both home and school situations. Examples are given for each setting. Out of school activities should be noted as an example from home.

Interviewee

ACE is a clinical interview that should be administered by a healthcare practitioner to individuals who are close to the child and have known him/her for a considerable time. They must be familiar with the child's functioning in different settings. Typically parents/carers or other family members who are familiar with the home setting are interviewed. Usually, the child is also invited to contribute to the interview as this provides the opportunity to obtain the child's perspective, as well as the opportunity to observe their behaviour in the assessment setting. Whenever possible, independent evidence should be obtained from school (i.e. a teacher interview and/or examination of school reports). For older children in their mid-teens, ACE can be administered directly to the child; nevertheless, it is advisable to gain corroborative information from appropriate informants and to obtain school reports if possible.

Introduction to the ACE interview

Prior to administering the interview, the assessor should establish rapport with the interviewee in order to make them feel comfortable, settled and at ease. It is recommended that the assessor begins by finding out about the child and the family using general open-ended questions, for example *"I'm here to learn as much as I can about your child and their behaviours. Could you tell me a little bit about your child and the concerns that you have?"*. It is useful to establish what daily life is like for the child and those around them, and to understand what is expected of the child at home (i.e. behaviours, chores) and how the child is progressing at school. When beginning administration of the ACE interview, it is important to 'set the scene' by explaining to the interviewee that you will ask specific questions that relate to the symptoms within the diagnostic criteria, and they will be invited to consider whether these symptoms have been present over the past six months. Ask the interviewee to provide examples (as many as possible) of how the symptoms manifest at home, school or other activities. You should also ask the interviewee to consider whether the symptoms seem to occur with greater frequency compared with other children their age (e.g. with siblings or peers).

Administering the ACE interview

Begin the interview by completing the background information section. In addition to demographic information, this section enquires about the presence of early risk factors in the child's life, their

medical history, educational history, peer relationships and family background. It is important to take time over these questions as these details are necessary for understanding the context of the child's behaviour and may provide insight regarding impairment.

There follows items relating to the symptom criteria of inattention (nine items), hyperactivity (five items) and impulsivity (four items). First read out the question and prompt the interviewee to consider the presence of this symptom at home and at school. The assessor is guided by a brief description that summarises the common presentation of children with ADHD in these respective settings. This written guidance serves as a prompt to the assessor and it should not be read aloud to the interviewee. Prompt the interviewee to describe specific situations and/or to give specific examples of when the symptom or problem is present, the onset of the symptom or problem, its contextual presentation, its frequency, severity and mediating factors. It is particularly important to consider the degree of impairment experienced by the child due to this symptom/problem and whether it occurs more frequently than would be expected for a child of a similar age and developmental level. Make notes in the corresponding home/school boxes; the notes should be written in sufficient depth to guide and support the assessor's decision about whether the symptom is present or absent.

From this in-depth exploration of each symptom, the assessor will judge whether a symptom is present and if it is impairing. If there are uncertainties that prevent a clear decision being made, it may be helpful to refer to documents for collateral information (such as school reports) and/or to seek the perspective of others involved in the child's care and/or extra-curricular activities.

An observation section is provided after the symptom evaluation section where the assessor can make notes regarding their observations of the child if they are present during the interview (and/or for observations made in another setting).

Co-existing problems and disorders

Following the observation section, the assessor is steered to consider the issue of differential or co-occurring presentations by referring to a list of alternative and/or common co-existing problems. These include neurodevelopmental/cognitive, behavioural, emotional, physical and medical disorders, and each include a brief description that aims to prompt the assessor to consider the presentation of the child from a different perspective. This section lists potential co-existing problems and disorders, however when conducting the assessment it is not recommended that the problems and disorders are disclosed (as labelled) to the individual. Preferably, the assessor should lead with general questions that relate to the condition before focusing on specific symptoms. A space is provided to make notes and classify whether the condition has been previously diagnosed or whether further investigation is required. It is important to note that the DSM-5 criteria allows for comorbid diagnoses, however the ICD-10 does not. This section is not intended to make a diagnosis; rather it aims to identify behaviours that should be considered as potential differential or co-existing conditions that require further investigation.

Scoring the interview

Instructions for scoring the ACE interview are provided at the end of the interview; one based on the DSM-5 diagnostic criteria and the other on the ICD-10 diagnostic criteria.

INTERVIEW - Background

Name of child:

Date of birth: ___ /___ /___

Gender: Male Female

Informant's name(s):

Relationship to child:

Date of interview: ___ /___ /___

Name of assessor:

Additional Notes:

Early Risk Factors Present (tick those that apply and make notes below):

- ☐ Premature birth*
- ☐ Low birth weight*
- ☐ Early trauma (e.g. physical, sexual emotional abuse)*
- ☐ Head injury involving loss of consciousness*
- ☐ Parental mental health issues*
- ☐ Maternal smoking and/or substance use during pregnancy (including alcohol)*

*Please detail:

Has the child had their cognitive ability assessed? ☐ Yes* ☐ No

*Please detail:

Medical History

Does the child have any medical diagnoses? ☐ Yes* ☐ No

*Please detail:

Is the child currently taking any medication? ☐ Yes* ☐ No

*Please detail:

Education

What is the child's current educational level? (i.e. year of schooling)

Does the child attend a mainstream school? ☐ Yes ☐ No*

*Please detail:

Does the child have special educational needs? ☐ Yes* ☐ No

*Please detail:

Does the child receive extra support or help at school? ☐ Yes* ☐ No

*Please detail:

Has the child ever been excluded from school? ☐ Yes* ☐ No

*How many times? ☐ Once ☐ Twice ☐ More than twice

*Why?

Has the child ever failed a grade or repeated a subject class? (i.e. not achieved an expected target) ☐ Yes* ☐ No

*Please detail:

Peer Relationships

Describe the quality of the child's friendships (both inside and outside of school)

Family Background

Do any family members have diagnosed or suspected ADHD?

☐ Yes - diagnosed (Relationship to child:_____)

☐ Yes - suspected (Relationship to child:_____)

☐ No

Do any family members have other neurodevelopmental conditions (e.g. Autism spectrum disorder, Intellectual impairment)?

☐ Yes (Relationship to child and condition:_____)

☐ No

Do any family members have a specific learning difficulty?

☐ Yes (Relationship to child and learning difficulty:_____)

☐ No

Do any family members have a history of a psychiatric disorder?

☐ Yes (Relationship to child and disorder:_____)

☐ No

Mother's educational history (including highest level of education):

Father's educational history (including highest level of education):

Mother's occupational history:

Father's occupational history:

Symptom Ratings

Questions 1-9 enquire about the child's ability to pay attention.
Questions 10-14 enquire about the child's restlessness and hyperactivity.
Questions 15-18 enquire about the child's impulsive behaviours.

When conducting the interview bear in mind and note the following points:

- **Onset:** When did this symptom first appear? (Symptoms must be present prior to age seven for ICD-10 criteria and prior to age 12 for DSM-5 criteria)

- **Duration:** Has this symptom been present for six months or more?

- **Pervasiveness:** Is this symptom appearing in more than one context (e.g. at school and home)?

- **Persistence:** Is this symptom occurring more frequently than that typically expected for the child's age and development level? This requires the symptom to be present 'often', i.e. the usual style of the child and occurring much or most of the time. However, this will depend on the situation and is not invariant.

- **Impairment:** To what extent does this symptom impair the child's functioning and development?

When interviews are conducted with parents/carers or other family members who are familiar with the home setting, it is recommended that independent evidence is obtained for the school section (i.e. with a teacher interview and/or by examination of school reports). Usually, the child is also invited to contribute to the interview as this provides the opportunity to obtain the child's perspective, as well as the opportunity to observe their behaviour in the assessment setting. For older children in their mid-teens, ACE can be administered directly to the child; nevertheless, it is advisable to gain corroborative information from appropriate informants and to obtain school reports if possible.

1. Does the child *often* fail to give close attention to details or make careless errors?

Criterion Met:
- ☐ At Home
- ☐ At School

Home

The child may complete tasks inefficiently, e.g. by missing out steps in chores or other activities which then need repeating, not paying attention to instructions, or breaking items due to rushing (not paying attention to what they are doing). The child may make lots of mistakes in their homework even when they understand what to do, and homework may be presented as messy with lots of corrections. The child may not notice important information in the environment, such as road crossings or signs of danger.

*Is this symptom present? If yes, give examples and probe about <u>how</u> it causes impairment at **home***

School

The child may hand in incomplete work and/or poorly presented work that looks rushed and contains many errors. On test papers, children may skip questions and/or not think to check whether there are more questions on the other side of the paper (leading the child to achieve a lower mark/grade). Children may find tasks that require a lot of detail particularly stressful and time consuming.

*Is this symptom present? If yes, give examples and probe about <u>how</u> it causes impairment at **school***

2. Does the child *often* fail to sustain attention in tasks or play activities?

Criterion Met:
- ☐ At Home
- ☐ At School

Home

At home or clubs this symptom can be observed by the child frequently changing the toy they are playing with or the activity they are doing. They may only stay on task for a few minutes. This may be because they have become bored or because something more engaging has caught their eye. Children may struggle to complete activities and tasks, even with adult support. They may avoid reading books or sitting through a movie, for example. They may also lose their train of thought when engaged in conversation.

*Is this symptom present? If yes, give examples and probe about <u>how</u> it causes impairment at **home***

School

The child may find tasks that are repetitive and/or require sustained mental effort notably difficult compared to their peers, for example the child may complain and/or struggle with essay based tasks. Teachers may comment that the child needs frequent reminders and redirection to return to the task. The child may state the task is boring and seem to lack the motivation to reach the end, becoming irritable, frustrated and/or disruptive. By contrast, they may struggle less (or not at all) with tasks they enjoy. The child may not appear to settle during break or lunch times; they may frequently change who they play with and the toys they play with.

*Is this symptom present? If yes, give examples and probe about <u>how</u> it causes impairment at **school***

3. Does the child *often* appear not to listen to what is being said to him or her?

Criterion Met:
- ☐ At Home
- ☐ At School

Home

It may seem that the child is not paying attention or is daydreaming. Family and visitors to the home may comment on this. Alternatively, the child may appear to listen, but subsequently forget or be unable to repeat instructions. In sports, for example, the child may appear to listen to the coach but fail to follow through on instructions.

*Is this symptom present? If yes, give examples and probe about <u>how</u> it causes impairment at **home***

School

Teachers may comment that the child is not listening in class. They may comment that the child requires instructions to be repeated many times and/or broken down into small steps in order to successfully complete a task. Teachers may move the child to sit at the front of the class or next to an assistant. Some teachers may misperceive the child's presentation to be defiant behaviour.

*Is this symptom present? If yes, give examples and probe about <u>how</u> it causes impairment at **school***

4. Does the child *often* fail to follow through on instructions or to finish tasks?

Criterion Met:
- ☐ At Home
- ☐ At School

Home

When given chores to do at home, the child may miss out some tasks and/or not finish everything they set out to do. Common examples are not completing their self-care routine, including dressing; forgetting items when going to shops and/or returning with random items; leaving taps running; and needing many reminders to complete an activity. Even when following written instructions, the child may miss out steps, for example when putting together a toy, resulting in errors and toys being incorrectly assembled.

*Is this symptom present? If yes, give examples and probe about how it causes impairment at **home***

School

The child may have difficulty following and remembering instructions, leading to incomplete tasks and unmet goals. For example, the child may be observed to start a practical activity but forget or miss out steps or go off-task and leave it prematurely. Children may receive warnings or detentions for oppositional behaviour due to incomplete classwork and homework.

*Is this symptom present? If yes, give examples and probe about how it causes impairment at **school***

5. Does the child *often* appear impaired in organising tasks and activities?

Criterion Met:
- ☐ At Home
- ☐ At School

Home

The child may seem to always be in a rush, or running late to clubs or activities. The child may undertake tasks in an order that seems illogical to others due to poor planning and organising skills. Children may be untidy and have difficulty finding their toys or clothes. Older children may find it hard to balance homework and leisure activities, not due to a disregard for their homework but due to poor time management and organisational skills. They may have impaired relationships due to missing events or letting down friends.

*Is this symptom present? If yes, give examples and probe about <u>how</u> it causes impairment at **home***

School

The child may miss deadlines as they have not organised or planned their work efficiently. They may appear to be generally messy and untidy (in their appearance and with their belongings). They may make notes during lessons that lack structure. When the timetable becomes more complicated during the transition to secondary school, children may frequently turn up late for lessons and become stressed by the higher expectation of autonomy. They may leave things behind at home, such as their bus pass, locker key, snack box, sports kit and homework.

*Is this symptom present? If yes, give examples and probe about <u>how</u> it causes impairment at **school***

6. Does the child *often* avoid or strongly dislike tasks that require sustained mental effort?

Criterion Met:
- ☐ At Home
- ☐ At School

Home

The child may avoid or delay tasks requiring mental effort. They may not persevere on tasks they find hard and/or repetitive. The child may procrastinate and put off homework tasks. When asked to do a chore, the child may complete smaller tasks first and put off more intensive tasks, and/or protest a lot about having to complete the task. The child may join clubs but disengage from activities that lack physical stimulation or activity. The child may avoid games they perceive to be long, repetitive and/or educational, becoming oppositional at these times as they find the task aversive.

Is this symptom present? If yes, give examples and probe about how it causes impairment at ***home***

School

The child may try to avoid specific lessons that they find particularly intensive and require mental effort, such as maths, writing and essays. During lessons, the child may protest or lack effort and become frustrated and irritable. They may become restless and/or oppositional. The child may make excuses to leave the classroom, including feigning illness. In extreme cases the child may feign illness to stay at home and avoid attending some classes, and/or truant from school.

Is this symptom present? If yes, give examples and probe about how it causes impairment at ***school***

7. Does the child *often* lose things necessary for certain tasks or activities?

Criterion Met:
- ☐ At Home
- ☐ At School

Home

The child may lose or misplace items such as their bus pass, keys, clothing, schoolwork and toys, and have no inclination of where or when they last had the item. This means that they may turn up for activities unprepared and/or without the equipment or materials that they need, for example without their coat, scarf, football, tennis racket, USB stick and/or paperwork.

*Is this symptom present? If yes, give examples and probe about <u>how</u> it causes impairment at **home***

School

The child may lose or misplace their school bag, books, school uniform, bus pass and sports kit. The child may often be checking lost property at school to search for lost clothing, pencil cases and school books. Teachers report the child often attends lessons without the equipment or materials required for lessons.

*Is this symptom present? If yes, give examples and probe about <u>how</u> it causes impairment at **school***

8. Does the child *often* appear easily distracted by external stimuli?

Criterion Met:
- ☐ At Home
- ☐ At School

Home

The child may appear to frequently be daydreaming and/or observed to quickly shift focus to another (more stimulating) task. The child may be easily distracted by their surroundings, including activities and/or background noise (such as the television) that others seem to be able to block out or ignore. Multitasking may be particularly challenging. The child may apply coping strategies that mask this symptom, such as preferring to do homework in a quiet room.

*Is this symptom present? If yes, give examples and probe about <u>how</u> it causes impairment at **home***

School

The child may appear to be distracted by their surroundings to a greater extent than their peers. They may be distracted by noise and activity in the classroom, as well as noise and activity from outside such as children in the playground or any outside sports. Teachers may report that they go off-task because they chatter to peers, or are seen to be daydreaming and require prompting to return to the task. It may be reported that they work better one-to-one or in small groups.

*Is this symptom present? If yes, give examples and probe about <u>how</u> it causes impairment at **school***

9. Does the child *often* appear forgetful in the course of daily activities?

Criterion Met:
- ☐ At Home
- ☐ At School

Home

The child may frequently forget where they left something, and spend a lot of time searching for objects, toys, clothes etc. The child may forget to attend appointments, meetings or clubs. They may forget to communicate important information and/or letters from school to parents/carers (which remain at the bottom of their school bag). When visiting friends or relatives, the child may not collect all of their property, even items or toys that are important to them. They may need reminders to do routine tasks, such as brushing their teeth.

*Is this symptom present? If yes, give examples and probe about <u>how</u> it causes impairment at **home***

School

The child may regularly forget their timetable and/or leave items at home that they need for class. They may forget to collect all of their belongings as they move from classroom to classroom. The child may forget when their homework is due and fail to hand it in on time, even if it has been completed. They may forget to attend meetings and appointments, or even detentions, despite knowing the consequence.

*Is this symptom present? If yes, give examples and probe about <u>how</u> it causes impairment at **school***

10. Does the child *often* fidget with their hands or feet or squirm on their seat?

Criterion Met:
- ☐ At Home
- ☐ At School

Home

The child may be observed to be fidgety and restless, even when watching television, at the dinner table and/or in the car. The child may fidget even when engaged on a task or activity they find interesting, or when feeling tired. They are frequently being told to stop rocking back on their chair, kicking their legs and/or fiddling with objects. These behaviours may cause problems in the cinema, in church and/or in restaurants.

*Is this symptom present? If yes, give examples and probe about <u>how</u> it causes impairment at **home***

School

Teachers may comment that the child is fidgety and restless in class, irrespective of the topic or activity, and that their fidgeting disturbs other children. The child may shuffle about in their seat, kick their legs, rock back on their chair, fiddle with items on the table, and/or doodle on their books. The child may be perceived as clumsy because they often fall over or knock over items.

*Is this symptom present? If yes, give examples and probe about <u>how</u> it causes impairment at **school***

11. Does the child *often* leave their seat in situations in which remaining seated is expected?

Criterion Met:
- ☐ At Home
- ☐ At School

Home

The child may have difficulty settling down. In particular, the child may struggle to stay seated even when this is compulsory or important, getting up multiple times. This may be observed by the child wandering around the room when watching television and/or leaving their seat at the dinner table. The child may need constant engagement to help them remain seated on public transport and they may struggle to cope with long journeys.

*Is this symptom present? If yes, give examples and probe about <u>how</u> it causes impairment at **home***

School

Despite frequent reminders and redirection, the child may struggle to stay seated. The child may swing back on their chair or leave their seat and sit on the floor. When engaged in floor work, the child may roll about on the floor and disrupt peers. The child may find excuses to get up and move around, such as to go to the toilet, to go and talk to someone, or to look at something. The child may be unable to modify their behaviour, even when redirected or reprimanded.

*Is this symptom present? If yes, give examples and probe about <u>how</u> it causes impairment at **school***

12. Does the child *often* run about or climb excessively in situations in which it is inappropriate?

Criterion Met:
- ☐ At Home
- ☐ At School

Home

The child may run around and climb on objects despite attempts by parents/carers to manage this behaviour. The child may have damaged furniture through these activities, or hurt themselves. They may run or climb in areas where this is not permitted and/or engage in behaviours that are risky or dangerous, such as climbing up on roofs, cars, trees, and running across the street or track lines. Older children may channel the urge to run and climb into sporting activities.

*Is this symptom present? If yes, give examples and probe about <u>how</u> it causes impairment at **home***

School

The child may appear restless and eager for break time and physical activities when they can engage in boisterous play and climbing activities. They may need time to calm down when returning to the classroom. The child may be reprimanded for running in corridors. On class trips they may need additional supervision to ensure they stay with the group or walk safely. Older children may appear more restless and fidgety than overtly active.

*Is this symptom present? If yes, give examples and probe about <u>how</u> it causes impairment at **school***

13. Does the child *often* appear unduly noisy in playing or have difficulty engaging quietly in leisure activities?

Criterion Met:
- ☐ At Home
- ☐ At School

Home

The child may be rarely observed to engage in quiet activities, instead being described as loud, on the go and overly active. When asked to play quietly, the child may go off-task because they get up, run around, and/or make a lot of noise. The child may struggle to adhere to social norms and control behaviour in settings such as museums, galleries or church. The child may disturb others by talking throughout television programmes or at the cinema.

*Is this symptom present? If yes, give examples and probe about <u>how</u> it causes impairment at **home***

School

The child may talk or shout when it's quiet time or during activities that require concentration. They may ask lots of questions, talk over others, and distract their peers. Reminders to be quiet and/or reprimands don't seem to help. Given the choice, the child may avoid quiet activities, preferring to choose physically active or noisy ones. Older children may be reprimanded for chatting and disturbing their peers during individual work and/or have difficulty settling down during tests.

*Is this symptom present? If yes, give examples and probe about <u>how</u> it causes impairment at **school***

14. Does the child *often* exhibit a persistent pattern of excessive motor activity that is not modified by context?

Criterion Met:
- ☐ At Home
- ☐ At School

Home

The child may be described as being constantly on the go from morning to night and struggling to settle at bedtime. Young children may seem like a whirlwind, moving from task to task, running around, and not engaging with activities. On public transport the child may require additional supervision to ensure that they stay seated and safe. Parents/carers may report feeling worn out by the child. Older children may present as less chaotic but still struggle to settle and fully engage. The child may report a desire to relax but feel unable to 'switch off', even when they go to bed.

Is this symptom present? If yes, give examples and probe about how it causes impairment at ***home***

School

The child may be seen as a whirlwind, running, climbing, and moving aimlessly between activities. The child may appear to be always on the go. At the end of the day the child may not seem to be tired but instead presents as irritable or overwhelmed. The child may favour anticipated break times and physical activities rather than class work. Given the choice, extra-curricular activities involve physical activities rather than less active pursuits.

Is this symptom present? If yes, give examples and probe about how it causes impairment at ***school***

15. Does the child *often* blurt out answers before questions have been completed?

Criterion Met:
- ☐ At Home
- ☐ At School

Home

The child may have difficulty waiting for their turn to speak and instead blurt things out or interrupt others. They may struggle to follow the 'turn-taking' rules of conversation but instead seem motivated to say immediately what is on their mind (even if this is unrelated to the topic of conversation). The child may seem to be impatient for others to finish speaking. Older children may finish other people's sentences for them.

*Is this symptom present? If yes, give examples and probe about <u>how</u> it causes impairment at **home***

School

The child may be frequently reminded or reprimanded for talking in lessons. The child may seem to dominate the class by frequently calling out or talking over others. The child may have difficulty waiting for their turn to speak and/or answer questions. Older children may have some awareness of this difficulty but struggle to inhibit their behaviour. These behaviours may irritate peers and lead the child to be unpopular.

*Is this symptom present? If yes, give examples and probe about <u>how</u> it causes impairment at **school***

16. Does the child *often* fail to wait in lines or await turns in games or group situations?

Criterion Met:
- ☐ At Home
- ☐ At School

Home

The child may be observed to find waiting aversive and become quickly impatient. The child may become overly emotional when something that they want is not available. They may avoid standing in line in a queue or push to the front, speak out of turn, and snatch items. The child may attempt to wait but becomes unmanageable, disruptive, or embarrassing. Parents/carers may report having to leave situations, for example when shopping in the supermarket. This may even be the case when queuing for something the child desires, such as a ride at a theme park.

*Is this symptom present? If yes, give examples and probe about <u>how</u> it causes impairment at **home***

School

The child may be reprimanded for queue jumping and/or not taking turns in class activities or when playing with friends. The child may appear to be oppositional and/or become distressed or agitated, even for activities that require a short wait and/or waiting for a desired activity. Teachers may comment that the child has good intentions but becomes overly enthusiastic and/or has peer relationship problems due to perceived self-centred behaviour.

*Is this symptom present? If yes, give examples and probe about <u>how</u> it causes impairment at **school***

17. Does the child *often* interrupt or intrude on others?

Criterion Met:
- ☐ At Home
- ☐ At School

Home

The child may intrude on the conversations, private space, or activities, of others. The child may understand the social boundaries, but lack the patience to manage them. They might interrupt private conversations and their behaviour may be perceived as attention seeking. The child may not seem to respect the privacy of parents/carers or siblings, using the possessions of others without asking. They may act without thinking through the consequences of their behaviour. Reprimands may have had limited effect.

Is this symptom present? If yes, give examples and probe about how it causes impairment at ***home***

School

Teachers may notice that the child tends to interrupt others, speak out in assembly, use things that do not belong to them, and/or appear to monopolise and take over the personal space and time of others (both children and staff). They may act without thinking through the consequences of their behaviour. The child may have little appreciation of how their behaviour is perceived by others and this may lead to interpersonal conflict with peers.

Is this symptom present? If yes, give examples and probe about how it causes impairment at ***school***

18. Does the child *often* talk excessively without appropriate response to social constraints?

Criterion Met:
- ☐ At Home
- ☐ At School

Home

The child may be persistently chattering, even when they know the situation calls for quiet. The child may jump from topic to topic, having an endless narrative, and dominate conversations as they struggle to stop talking. They may interrupt the conversations of others, even when they are on the phone. Parents/carers may report having to frequently remind the child to be quiet or settle down.

Is this symptom present? If yes, give examples and probe about how it causes impairment at ***home***

School

The child may chatter to peers in class, even when they have been asked to work quietly or during tests. They may not respond to reminders or reprimands. They may dominate conversations, talk over others (even teachers) and give tangential responses to questions.

Is this symptom present? If yes, give examples and probe about how it causes impairment at ***school***

Observations

Please use this space to detail any observations of the child's behaviour and interactions. Make sure to note the observed levels of inattention, hyperactivity and impulsivity displayed across the timespan. Typical behaviours may present as: prematurely breaking off from activities before they are finished and not returning to them; going off-task completely; disorganisation of activities, such as starting to draw without gathering all of the crayons needed beforehand; fidgeting, as well as motoric activity; and acting without thinking.

Date of observation: ___ /___ /___

Time of observation: ___ : ___

Observation setting:

Duration of observation: ___ hours ___ minutes

Co-existing Problems and Disorders

Common differential and co-existing conditions are presented below. The assessor should consider each in turn and decide whether it is a primary (i.e. differential diagnosis) or secondary (i.e. co-existing condition). It is important to establish whether the presenting problem is chronic or whether it has a recent onset. When applying the ICD-10 criteria, note that this classification system does not recognise comorbid conditions. It is recommended that the assessor DOES NOT disclose (as labelled) the disorder being discussed. Preferably, the assessor should lead with general questions that relate to the condition before focusing on specific symptoms.

Autism Spectrum Disorder

Is there evidence of speech delay, problems with forming and maintaining social relationships, social communication, rigidity, repetitive behaviours and sensory hypersensitivity?

Notes:

Previously Diagnosed: ☐ Yes ☐ No

Further investigation required: ☐ Yes ☐ No

Cognitive Impairments

Is there evidence of generalised or specific learning difficulties such as reading, writing or arithmetic difficulties?

Notes:

Previously Diagnosed: ☐ Yes ☐ No

Further investigation required: ☐ Yes ☐ No

Speech and Language Impairments

Is there evidence of specific expressive and receptive language delay?

Notes:

Previously Diagnosed: ☐ Yes ☐ No

Further investigation required: ☐ Yes ☐ No

Tics Disorder (Including Tourette's)

Is there evidence of motor and/or vocal tics?

Notes:

Previously Diagnosed: ☐ Yes ☐ No

Further investigation required: ☐ Yes ☐ No

Other Developmental Disorders

Is there evidence of gross motor or fine motor developmental difficulties?

Notes:

Previously Diagnosed: ☐ Yes ☐ No

Further investigation required: ☐ Yes ☐ No

Traumatic Brain Injury

Is there evidence of a history of severe head trauma or recurrent head injuries (e.g. falls, sport accidents, motor vehicle related injuries)? Note any loss of consciousness.

Notes:

Previously Diagnosed: ☐ Yes ☐ No

Further investigation required: ☐ Yes ☐ No

Oppositional Defiance Disorder or Conduct Disorder

Is there evidence of oppositional behaviour and refusal to comply with authority, or more serious antisocial behaviours?

Notes:

Previously Diagnosed: ☐ Yes ☐ No

Further investigation required: ☐ Yes ☐ No

Interpersonal Problems

Is there evidence of peer relationship problems, mixing with much younger/older children, and/or disrupted relationships with teachers and/or other adults?

Notes:

Previously Diagnosed: ☐ Yes ☐ No

Further investigation required: ☐ Yes ☐ No

Post-Traumatic Stress Disorder

Has the child experienced any significant physical, sexual or emotional trauma?

Notes:

Previously Diagnosed: ☐ Yes ☐ No

Further investigation required: ☐ Yes ☐ No

Anxiety Disorders

Is there evidence of phobia, panic, separation and/or generalised anxiety?

Notes:

Previously Diagnosed: ☐ Yes ☐ No

Further investigation required: ☐ Yes ☐ No

Obsessive Compulsive Disorder

Is there evidence of obsessions, compulsions or other ritualistic or stereotyped behaviour?

Notes:

Previously Diagnosed: ☐ Yes ☐ No

Further investigation required: ☐ Yes ☐ No

Depression

Is there evidence of low mood, negative thinking, low self-esteem, fluctuating mood, and irritability? Note if there has ever been suicidal ideation or behaviour.

Notes:

Previously Diagnosed: ☐ Yes ☐ No

Further investigation required: ☐ Yes ☐ No

Disruptive Mood Dysregulation Disorder

Is there evidence of excessive irritability and/or anger, either in intensity, frequency, and/or ease of provocation?

Notes:

Previously Diagnosed: ☐ Yes ☐ No

Further investigation required: ☐ Yes ☐ No

Substance Misuse

Is there evidence of the child using or misusing substances including alcohol, cigarettes, prescription medication and/or illicit drugs?

Notes:

Previously Diagnosed: ☐ Yes ☐ No

Further investigation required: ☐ Yes ☐ No

Other Medical Conditions

Does the child have any other diagnoses or suspected inherited or acquired conditions (e.g. hearing impairment, sleep apnea, nutritional deficiency, obesity, foetal alcohol syndrome, and genetic, metabolic or endocrine disorders)?

Notes:

Previously Diagnosed: ☐ Yes ☐ No

Further investigation required: ☐ Yes ☐ No

Other Mental Health Problems

Does the child have any other mental health problems (e.g. eating disorder, Bipolar disorder, psychosis)?

Notes:

Previously Diagnosed: ☐ Yes ☐ No

Further investigation required: ☐ Yes ☐ No

DSM-5 Scoring Sheet

Using the DSM-5 criterion, individuals must have six or more symptoms of inattention and/or hyperactivity/impulsivity for a diagnosis of ADHD. Some of these symptoms must be present across settings (e.g. at home and school) and have persisted and significantly negatively impacted on the child's social and academic functioning for the past six months. ADHD must be considered to be the primary diagnosis and onset of symptoms must have been prior to the age of 12. Place a '✓' in the boxes for each symptom that was met at home and/or school.

Inattention Domain

Question	Symptom present at home and/or school
1	☐
2	☐
3	☐
4	☐
5	☐
6	☐
7	☐
8	☐
9	☐
Total number of symptoms met:	☐
Inattention Domain 6 or more symptoms met at home and/or school	**Yes / No**

Hyperactivity/Impulsivity Domain

Question	Symptom present at home and/or school
10	☐
11	☐
12	☐
13	☐
14	☐
15	☐
16	☐
17	☐
18	☐
Total number of symptoms met:	☐
Hyperactivity/Impulsivity Domain 6 or more symptoms met at home and/or school	**Yes / No**

Are these symptoms found in more than one setting?	**Yes** ☐	**No** ☐
Were these symptoms present before the age of 12?	**Yes** ☐	**No** ☐
Have these symptoms been present for six or more months?	**Yes** ☐	**No** ☐
Are these symptoms impairing the child's functioning and development?	**Yes** ☐	**No** ☐
Are these symptoms better explained by another condition?	**Yes** ☐	**No** ☐

DSM-5 Diagnosis

☐ **Predominantly Inattentive Classification (314.00)**
Inattention criterion met but hyperactivity/impulsivity criterion not met
(i.e. Yes in the inattention domain only)

☐ **Predominantly Hyperactive/Impulsive Classification (314.01)**
Hyperactivity/impulsivity criterion met but inattention criterion not met
(i.e. Yes in the hyperactivity/impulsivity domain only)

☐ **Combined Classification (314.01)**
Both the inattention and hyperactivity/impulsivity criterion met
(i.e. Yes in both the inattention and hyperactivity/impulsivity domains)

ICD-10 Scoring Sheet

Using the ICD-10 criterion, individuals must have six or more symptoms of inattention, plus three or more symptoms of hyperactivity, plus one or more symptoms of impulsivity for a diagnosis of Hyperkinetic Disorder. Some of these symptoms must be present across settings (e.g. at home and school) and have persisted and significantly negatively impacted on the child's social and academic functioning for the past six months. ADHD must be considered to be the primary diagnosis and onset of symptoms must have been prior to the age of seven. Place a '✓' in the boxes for each symptom that was met at home and/or school.

Inattention Domain

Question	Symptom present at home and/or school
1	☐
2	☐
3	☐
4	☐
5	☐
6	☐
7	☐
8	☐
9	☐
Total number of symptoms met:	☐
Inattention Domain 6 or more symptoms met at home and/or school	**Yes / No**

Hyperactivity Domain

Question	Symptom present at home and/or school
10	☐
11	☐
12	☐
13	☐
14	☐
Total number of symptoms met:	☐
Hyperactivity Domain 3 or more symptoms met at home and/or school	**Yes / No**

Impulsivity Domain

Question	Symptom present at home and/or school
15	☐
16	☐
17	☐
18	☐
Total number of symptoms met:	☐
Impulsivity Domain 1 or more symptoms met at home and/or school	**Yes / No**

Are these symptoms found in more than one setting? **Yes** ☐ **No** ☐

Were these symptoms present before the age of 7? **Yes** ☐ **No** ☐

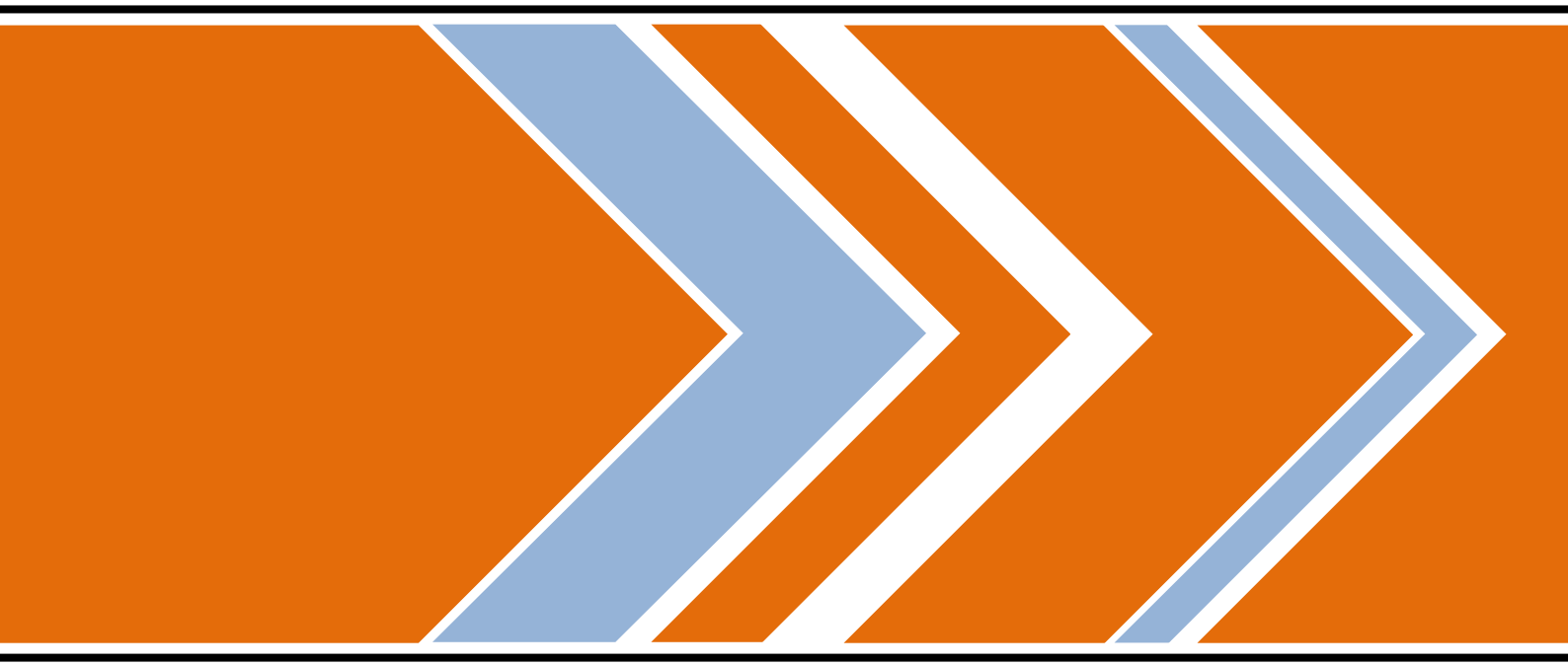
Have these symptoms been present for six or more months? **Yes** ☐ **No** ☐

Are these symptoms impairing the child's functioning and development? **Yes** ☐ **No** ☐

Are these symptoms better explained by another condition? **Yes** ☐ **No** ☐

ICD-10 Diagnosis

☐ **Hyperkinetic Disorder (F90.0)**
The inattention, hyperactivity and impulsivity criterion are all met (i.e. Yes in all three domains)



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