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360 Treatment Tools & Tips
An ADHD 360 3T's paper

The Challenges that can be helped with a solid ADHD diagnosis

The rise in awareness of ADHD has inevitably led to commentary from onlookers regarding the associated increases in diagnosis and treatment. Some of this commentary is negative, marginalising those that have suffered with ADHD over time, maybe even through generations. Some of the commentary, regrettably for modern society, is fuelled by a need to restrict investment in mental health by those charged with a responsibility to provide adequate services for those in need.

This short paper in the ADHD 360 T3 series, examines the key question that can challenge the frustrating negative commentary, discussing what it means to have a compliant, safe and world class assessment and diagnosis, enabling not only the 'patient' to go on to lead their best life, but also to enable the ADHD community to rise up and proudly sustain the changes needed to amend the developing negative narrative.

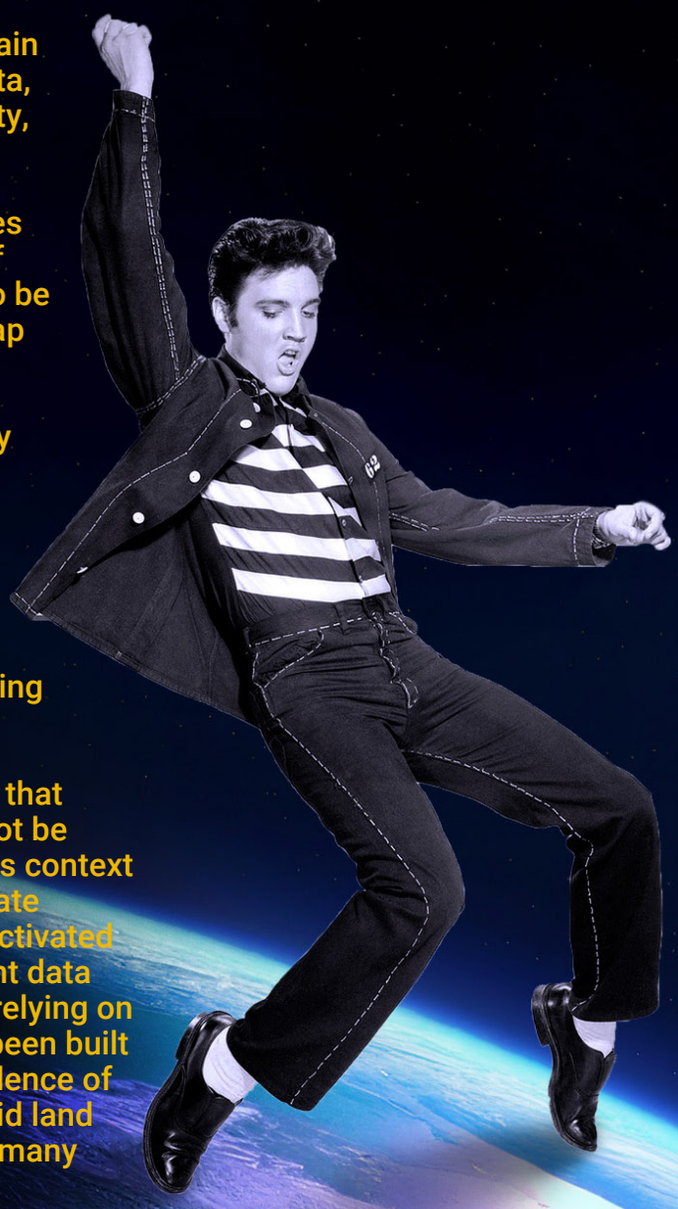
The Story So Far...

‘Back in the day’ ADHD was fundamentally mis-understood, not just within the domestic setting but throughout medicine and society as a whole. Believed to be something that children ‘grew out of’ and that it mostly centred around boys, the scene was set to provide inappropriate decision making, strategy writing and funding decisions that would reverberate for decades, reaching far deeper than could simply be rectified by new science and new data.

Cast in stone, the beliefs of many influential commentators had a background to rely on, a narrative that could (some say *would*) support those that champion preventing what is required becoming the new reality, and provide consistent, seemingly incomprehensible barriers to change.

Elements of our society still debate if Elvis is actually dead, did man land on the moon and at an extreme, is the earth flat. Similarly, despite the overwhelming evidence to the contrary, ADHD is not all about boys, children and importantly, does not require emotional dysregulation to be present, harmful and a preventative factor in people being sad, dangerously anxious, and for them to fail in life, through no fault of their own.

Generally, society lobbies for change, seeks a dynamic that can accept evidence and rationalised data, and brings about development and growth through established mechanisms that in the main, work. But what if the main protagonists for that change, those presenting the data, come from a body that maybe suffers with high anxiety, dysregulated emotions, and cannot possibly present the data in a manner that will overturn the mindset, remember, a mindset that is cast in stone with decades of reassuring false information for encouragement, of the very professionals charged with a responsibility to be progressive and focused on the individual, not the wrap around process and system.



We refer of course to GP’s and Teachers, who are easy targets for this commentary. But we should probably review those that we are quick to condemn in this context, and shift the lens further up the supply chain to policy makers, funders and strategic decision makers of local, regional and national influence. We should ask ‘Is my GP trained to understand ADHD?’ and ‘Why is it that my child’s Teacher cannot do anything for my child, they MUST see they have ADHD?’

Also, we MUST present the new data regarding ADHD that is required to influence change in a manner that cannot be challenged, is robust, fair and credible. We refer, in this context to the data that can and will emerge from an appropriate assessment and diagnosis of the patient, that when activated in a world class treatment plan, WILL provide sufficient data and information to change the narrative. Rather than relying on challenging the fact that the premise that ADHD has been built on over decades is flawed, we should present the evidence of positive change for the individual as proof that man did land on the moon, the earth is not flat and sadly Elvis died many years ago, but his memory lives on.

What is an appropriate diagnosis that can be described as ‘solid’?

Something that is best described as solid is ‘firm, stable and not fluid’. These simply strung-together words form the basis of this discussion, whereby we provide assessment and treatment regimes that cannot be challenged by those who believe the earth is flat, cannot be pulled apart to provide the disbelievers with credibility and allow the patient to receive the care, attention, and funding they require to go forward and lead ‘their best life’.

Internationally, the two main ‘manuals’ for understanding ADHD and an ADHD assessment are the ICD-11 and DSM 5. Regardless of which manual is taken off the shelf for use, the fundamentals remain the same. Whilst many consider that those fundamentals are flawed, we have to work with what we have got. National guidelines are often layered over the DSM / ICD framework providing a more localised set of considerations aimed at taking the broad theoretical framework into a more pragmatic set of directives. Perhaps they too are flawed, but they are what we have, and what we need to work with. In the UK, the national, overlaid guidelines are produced by the National Institute for Health and Care Excellence (NICE) in the form of NICE NG87. These guidelines emerged in 2018 and are considered already to be dated, representative of a very historical perspective and requiring change. What is concerning is that those making the changes may well rely on evidence that doesn’t consider the evidence of positive change from solid assessment and treatment, and unless this evidence is presented with vigour and energy ahead of being called for, the chance for growth and change may well pass us all by.

Interpretation opportunities frustrate accurate definitions of what ‘excellence’ looks like in the environment under discussion. This is the case within the DSM / ICD / NICE landscape as much as anywhere, a couple of examples may assist us in understanding how hard the battle may be:

- **A diagnosis of ADHD should only be made by a specialist Psychiatrist, Paediatrician or other appropriately qualified healthcare professional with training and expertise in the diagnosis of ADHD …(NICE NG87)**

- **… recommends that healthcare providers ask parents, Teachers and other adults who care for the child about the child’s behaviour in different settings, like at home, school, or with peers…(DSM 5)**

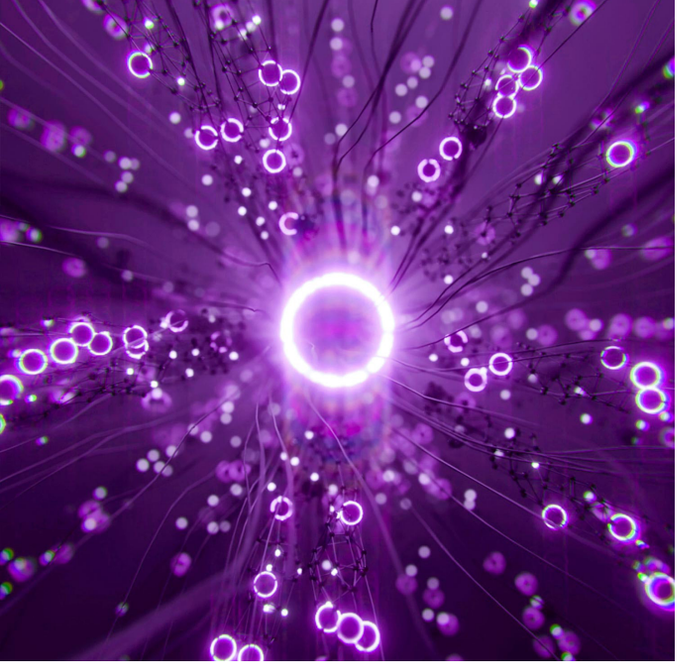
The latter recommendation, taken from the DSM, written and located on the first page, where perhaps some commentators may stop reading, is incredibly misleading. Let's just examine the challenges that paragraph presents, or to put this differently, let's look at the opportunities this gives the 'flat earth society' to find reasons to not move with the times.

- The role of the Teacher. Often, far too often, Teachers interpret this statement as a requirement that for a valid diagnosis, the Teacher MUST agree with the symptoms and impairments being claimed. That equates to requiring an airline pilot to fully understand how a boat floats and stays buoyant. If the professional is not trained, they cannot be a responsible decision maker for the relevant process. Sadly, most Teachers are not trained in understanding and recognising ADHD in their classroom, and therefore rely on jaundiced perspectives built on myths and untruths, it is far too easy to blame them for this as a body of professionals.

- 'The child's behaviour' brings about two main flaws. Reinforcement of the 'child' as the ADHD patient, excluding from the 'get go' the adult that suffers and needs help, and then compounding that mindset error with a discussion being opened about behaviour. Emotional dysregulation is an often found byproduct of poorly managed or non-diagnosed ADHD but it is not a prerequisite, many people with ADHD can 'behave' in accordance with societal norms consistently, and it is a mistake to assume that an absence of poor behaviour would dismiss the chances of the patient having ADHD. Imagine coupling both the Teacher's belief that they are the decision maker, and then having a person with ADHD who doesn't misbehave in the classroom, no matter how hard that is for them, and we have two rationales, believed valid, to dismiss the ADHD diagnosis.

The NICE NG87 comment is an incredible cause of debate throughout the ADHD community. Expectations are often set on historical perspectives, and national rules and regulations can frequently support those dated viewpoints. The woolly nature of the definitions in this paragraph reverberates in policy making and patient belief mechanisms worldwide. Again, examination yields commentary that may help us understand:

- When medication for depression first came to market, only suitably trained specialist Psychiatrists could administer it. Over time, as learning became more widespread, medication protocols provided evidence of safety for the patient, the medical responsibility was deescalated, and now the community based general practitioner, GP can, and indeed should take responsibility for treating depression for the majority of 'normal' cases. This example demonstrated both progress, and increased accessibility, required to keep society functioning.



- When ADHD first came into medical practice, it was collectively grouped into Psychiatry, after all, it revolves around those processes in part of the brain. Perhaps we should therefore look at what a Psychiatrist is. Are they frequently generalists in matters of human behaviour and the brain, or are they specialists in acute elements of the vast subject matter contained in the DSM? I favour that experience dictates more than often, a well meaning professional Psychiatrist is a generalist and the badge (of honour) as a Psychiatrist does not lead to a natural conclusion that they are an expert in a subject such as ADHD.

- But of course the guideline provides further clarification, or this further opportunity for mis-information and poor interpretation, often to reinforce the jaundiced / required perspective to fit a particular need. A Paediatric Doctor, qualifies under the guideline. Of course, here there is no need to understand the brain to the level of a Psychiatrist, the clinician in these circumstances could be an expert in the growth of a child, or gastro issues, but still be 'qualified' under this definition.

- What is next in the guideline is a statement that has caused national and international debate, consistently. What, or who, is an 'appropriately qualified healthcare professional' and what is 'with training and expertise in the diagnosis of ADHD'? Modern practice in UK healthcare, and to some extent USA healthcare, provides for other professional clinicians, such as suitably qualified Nurses and Pharmacists to be classed and accepted as a healthcare professional. We use the word 'modern' here to demonstrate up-to-date thinking, but it was in 2006 that the UK changed the rules to allow Nurses to prescribe medication and take more responsible roles throughout medicine. Hardly modern, but due to the nebulous wording of NICE, not specifically listing these professionals, open to translation and interpretation to meet the needs of the commentator. As a fact, a material fact backed up with evidence, most specialist ADHD Nurses the author has worked with, can run rings around a generalist Psychiatrist or Paediatrician regarding suitable assessment and treatment processes for ADHD. When suitably trained and with the appropriate support, role should not be a determinant of competence.

- That leads, in this short synoptic analysis, to examining 'with training and expertise'. Again woolly, perhaps this time as *'woolly as a Herdwick sheep with a jumper on'*, comes to mind as a descriptor. Who decides what training is suitable, who makes the appropriate decision to claim that expertise is valid? In the absence of 'real' guidance, well, you can imagine the commentary emerging from those that believe Elvis lives on. This lack of structural definition provides excuses, 'validity' for those that feel a need to refuse to accept a diagnosis and treatment plan for a person with ADHD. **That is wrong.**

Providing the required evidence to prove that the earth is in fact round, we did land on the moon and Elvis sadly passed away in 1977.

Despite the rather nebulous regulatory framework we must accept that adherence and 'best effort' interpretation is the order of the day. 'Best effort' in this context is about striking the balance between the regulations and the most appropriate interpretations. Those interpretations will not always, maybe even not often, suit the diverse needs of the audience that will scrutinise those outcomes.

- The commissioning health provider will probably have a view on what can be funded and how the regulations can be interpreted to facilitate their requirements appearing rationale
- The patient wanting change in a school for their child who they believe will benefit from appropriate accommodations will naturally challenge the Teacher who doesn't see any poor behaviour or emotional outbursts in the classroom and who dismisses the claim of inattentiveness
- The Psychiatrist who has built their professional reputation on the gravitas of the role may challenge the suitability of a Nurse or Pharmacist to provide suitable safe treatment for a patient with ADHD
- The policy makers will listen to voices that meet their needs and align with the intended outcome, it takes a brave policy maker to truly take a holistic perspective that may well lead to a funding requirement that is clearly over budget

The standard of treatment, from diagnosis through to treatment outcomes should always be focused on the patient, and that focus should acknowledge the failings of the system, and the requirements of those that may challenge the outcome and not place the patient in the middle of an unintended squabble about what the regulations state. That's the provider's role, not that of the patient.

- **Ensure that the provider's interpretations of the regulations are valid**
- **Ensure that the assessment framework and tools used are validated and appropriate**
- **Ensure that treatment plans are formulated with the patient at the centre**
- **Believe in your perspective that someone you are close to who needs help, should get help, and configure the thinking of those around you to provide that**

The views of the author expressed in this paper are reinforced by his belief that man did land on the moon (he has met astronauts that confirm this), that the world is not flat (he has documentary evidence to that effect), that Elvis did pass away (he has visited the house and seen the grave as well as discussing the post mortem with a clinician present at the time) and he believes that new understanding is required ahead of the next iteration of the DSM, ICD and NICE guidelines to truly effect change for the better of the worlds ADHD population, which remains sadly under nourished.

Eldrin 'Buzz' Aldrin
Mare Tranquilitatis, The Moon
July 20, 1969
Image courtesy of NASA/MSFC