POSITION STATEMENT ON THE USE OF RATING SCALES IN THE DIAGNOSIS OF ADHD IN CHILDREN AND ADOLESCENTS

Position Statement on the use of rating scales in the diagnosis of ADHD in children and adolescents

The South African Society of Psychiatrists (SASOP) Child and Adolescent Psychiatry special interest group (CAPSIG) believes in and promotes the comprehensive clinical evaluation of a young patient by an adequately-trained and skilled healthcare professional, preferably a specialist psychiatrist, pediatrician or other appropriately qualified healthcare professional with training and expertise in the diagnosis of Attention Deficit Hyperactivity Disorder (ADHD), prior to initiating treatment (which may include, but is not limited to medication). The SASOP CAPSIG wishes to emphasize that a diagnosis of ADHD is exclusively made on clinical grounds and shall follow either DSM-5 (American Psychiatric Association, 2013) or WHO ICD-10 (World Health Organization, 1993) diagnostic criteria after a comprehensive clinical assessment outlined in established guidelines (ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-De?cit / Hyperactivity Disorder in Children and Adolescents, American Academy of Pediatrics, 2011; Attention deficit hyperactivity disorder: diagnosis and management, Clinical Guideline -National Institute for Health and Care Excellence – NICE, 2008.)

These guidelines should be utilized in conjunction with other guidelines, as well as the responsibility of practitioners to maintain a high level of personal knowledge, expertise and ethical standards.

The core triad of symptoms of ADHD is a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning. This is accompanied by associated behavioural, cognitive, emotional and social problems which can lead to academic and interpersonal difficulties. The child's developmental stage must be considered in clinical evaluation as well as symptom pervasiveness (occurrence in more than one environment, like home and school) and clear evidence of clinically significant impairment in social, academic, or occupational functioning. The inclusion of an assessment by an Educational Psychologist, Occupational Therapist and Speech and Language Therapist may be advised where possible depending on clinical presentation. In younger children it is essential to assess the family environment; where there is chaotic or inconsistent parenting, abuse or neglect, children often respond with behaviour in ways very similar to that found in ADHD. Ignoring this possibility can easily lead to misdiagnosis.

Irrespective of the pervasiveness criterion (presence of symptoms in at least two different settings), it is necessary to have more than one source of information, usually parents and teachers. This is because informants (either parents or teachers) observe the child in different contexts, which may influence the occurrence of symptoms, and informants may be susceptible to a variety of biases.

This additional information may be obtained through direct, (semi-) structured interviews, school or home observations, social functioning or psychometric assessments, telephonic contacts and/or the use of rating scales.

Commonly used rating scales for screening childhood ADHD include the following scales freely available in the public domain: Swanson, Nolan and Pelham Teacher and Parent Rating Scale (SNAP-IV), the Strengths and Weaknesses of ADHD Symptoms and Normal Behaviour Rating Scales (SWAN) and the Strengths and Difficulties Questionnaire (SDQ). The Conner's Comprehensive Behaviour Rating ScalesTM are subjected to copyright which may restrict their use.

While a diagnosis cannot be made based on a rating scale alone, using rating scales is good clinical practice for screening purposes, to measure symptom severity and to monitor response to treatment and outcome as a useful adjunct in a comprehensive assessment. A rating scale can aid a diagnosis, but no rating scale can be used in isolation to diagnose ADHD. General community screening using rating scales as the only diagnostic measure is discouraged due to a high yield of false positive results.

The clinical assessment remains the cornerstone of the diagnostic process for childhood ADHD. Although various standardized, structured interviews and rating scales are available, these cannot replace the clinical assessment but may add a standardization and a quantifiable dimension in the areas being evaluated. Assessing for a differential diagnosis and comorbid medical and mental health disorders remains mandatory.

REFERENCES:

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