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Date: 06-07-2020



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ADHD assessment

Assessment Date/Time: 06-07-2020 17:04:12

Psychologist’s Name: Lizaveta Zeldzina

Client name: Luke Peter Hassan

Client DOB: 1990-02-07

Client Address:

**Outline**

This Adult ADHD assessment is based on a clinical/structured expanded interview, conducted according to the guidelines set out by the National Institute for Health and Care Excellence, the Royal College of Psychiatrists, and the World Health Organisation. It includes the “gold standard” approved Rating Scales, such as DIVA-5 and Conners, and uses strict criteria as per DSM-5.

The assessment incorporates, inter alia, valuable information from the professional interview, information provided by the patient about themselves, and where applicable it also includes an
observer’s input, as well as various other collaborative tools.

The report contributes towards considering:

* A diagnosis of ADHD
* A diagnosis of related problems.
* Evaluating the treatment plan options

This report provides information about the patient’s scores, significance of specific symptoms in relation to accepted diagnostic thresholds, and summarises the interpretation of the main subscales as compared to diagnostic criteria.

The report is based on the individual's current functioning, incorporates the neurodevelopmental data, and includes the (childhood) onset of symptoms, as required for diagnosis by the leading authorities.

**Neurodevelopment and Patient History**

**DSM-5 Standards**

These results are based on the Diagnostic Interview for ADHD in Adults (DIVA-5), and confirmed by other components of the current assessment.

1. Criterion A (ADHD symptoms):
   1. The assessment confirmed that 3 or more symptoms of Attention Deficit and/or Hyperactivity/Impulsivity were present in childhood.
   2. There were 5 or more characteristics of Attention Deficit found in adulthood.
   3. There were 5 or more characteristics of Hyperactivity/Impulsivity found in adulthood.
2. Criterion B (age of onset): There are signs of a lifelong pattern of symptoms (starting before the 12th year of age)
3. Criterion C (pervasiveness) and D (impairment): The symptoms and the impairment are expressed in at least two domains of functioning, both in adulthood and childhood
4. Criterion E (exclusionary conditions): During the course of the assessment, the symptoms could not be better explained by the presence of another psychiatric disorder

**Summary of A1 and A2 symptoms**

The following table shows a summary of the DSM-5 criterions and presence during adulthood and childhood as found by DIVA, split by Attention Deficit and Hyperactivity/Impulsivity symptoms:

| **Criterion** | **Symptom** | **Adult** | **Child** |
| --- | --- | --- | --- |
| **A1a** | A1. Often fails to give close attention to details, or makes careless mistakes in schoolwork, work or during other activities |  |  |
| **A1b** | A2. Often has difficultly sustaining attention in tasks or play activities |  |  |
| **A1c** | A3. Often does not seem to listen when spoken to directly |  |  |
| **A1d** | A4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace |  |  |
| **A1e** | A5. Often has difficulty organizing tasks and activities |  |  |
| **A1f** | A6. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort |  |  |
| **A1g** | A7. Often loses things necessary for tasks or activities |  |  |
| **A1h** | A8. Often easily distracted by extraneous stimuli |  |  |
| **A1i** | A9. Often forgetful in daily activities |  |  |
|  | **Total number of criteria Attention Deficit** | **9/9** | **8/9** |
| **A2a** | H/I 1. Often fidgets with or taps hands or feet or squirms in seat |  |  |
| **A2b** | H/I 2. Often leaves seat in situations when remaining seated is expected |  |  |
| **A2c** | H/I 3. Often runs about or climbs in situations where it is inappropriate |  |  |
| **A2d** | H/I 4. Often unable to play or take part in leisure activities quietly |  |  |
| **A2e** | H/I 5. Is often “on the go” acting as if “driven by a motor” |  |  |
| **A2f** | H/I 6. Often talks excessively |  |  |
| **A2g** | H/I 7. Often blurts out an answer before a question has been completed |  |  |
| **A2h** | H/I 8. Often has difficulty awaiting his or her turn |  |  |
| **A2i** | H/I 9. Often interrupts or intrudes on others |  |  |
|  | **Total number of criteria Hyperactivity/Impulsivity** | **9/9** | **9/9** |

**Absolute/Relative representation of the Main Diagnostic
criteria subscales**

The following graph provides Luke Peter Hassan `s diagnostic indicators' comparative strength for each of the official
DSM 5 subscales and evidenced in relation to the required threshold values (in brackets where
applicable):

Attention Deficit in childhood  
  
Hyperactivity/Impulsivity in childhood  
  
DSM\* "A", childhood subset  
  
DSM\* "A", adult attention subset A1  
  
DSM\* "A", adult H/I subset A2  
  
DSM\* "B", lifelong pattern  
  
DSM\* "C" AND "D", childhood subset  
  
DSM\* "C" AND "D", adult subset  
  
DSM\* "C" AND "D",   
  
DSM\* "E", exclusionary conditions  
  
  
 (8)  
  
 (9)  
  
 8 (Threshold - 5)  
  
 9 (Threshold - 5)  
  
 9 (Threshold - 5)  
  
  
  
 2 ( Threshold - 2)  
  
 4 ( Threshold - 2)



Keys:

DSM\*- DSM-5 Criterion;

- equal or exceeding the threshold;   
 - threshold  
 - under the threshold or inconclusive values DSM 5   
 - Non-relational (absolute) values;



**General Examination of the Profile**

The DSM-5 diagnostic criteria for ADHD have been met. This implies positive
identification of symptoms' intensity and their life-cycle timing equal or beyond the required thresholds
as per official tests' guidelines. The main issues indicative for the ADHD are at scales related to
Hyperactivity/Impulsivity and/or attentional deficits. Specific information about the areas that are
elevated can be obtained from examining the subscale descriptions. Please note that the clinical
examination can override the formal tests' results.

**Summary of problem areas**

The following is a list of Luke Peter Hassan 's representative problem areas.

|  |  |
| --- | --- |
| **Main area** | **Example of highly probable problem issues usually related to the Main area:** |
| Work/education | Tire quickly of a workplace  Pattern of many short-lasting jobs |
| Relationship and/or family | Impulsively commencing/ending relationships  Relationship problems, lots of arguments, lack of intimacy |
| Social contacts | Difficultly maintaining social contacts  Difficulty initiating social contacts  Not being attentive (i.e. forget to send a card/ empathising/phoning, etc) |
| Free time / hobby |  |
| Self-confidence / self-image | Excessive intense reaction to criticism |

**Data Validity Assessment**

If the findings presented in this assessment contradict those obtainable from other sources of
information, then the reason(s) for the conflicting information should be considered. These findings
should be interpreted and considered together with such reasons.

Regarding the possible explanation of any such prospective inconsistency, there is potentially a wide
range of reasons, such as very subjective description of the problems, or existence of behaviour which is
situation specific (such as significant difference in attitude and behavioural patterns at home and at
work).

**Synopsis of Results**

Luke Peter Hassan `s presentation, history and diagnostic tools interpretation are indicative of the following diagnosis (DSM-5):

* 314.01 Combined presentation type

**Treatment Plan**

In accordance with widely accepted guidelines, and as applicable in Luke Peter Hassan ’s individual's circumstances,
the following Treatment Plan elements should be considered:

1. It is important to start with psychoeducation; review ADHD resources, behaviour modification
   and skills development.
2. Systemic Therapy in order to reduce the accompanying issues (comorbidities), to contain the
   ADHD symptoms and ultimately to significantly improve quality of life.
3. If Systemic Therapy is not viable for any reason, a course of short-term counselling and
   psychoeducation should be started without delay.
4. Medication could be considered in some cases following a Psychiatric Assessment, if required.

It is always advisable to engage and inform the GP in any health-related problems. We can send a summary to a GP or other specialist, if the client instructs us to proceed with this service.

**If the client experiences a worsening of symptoms or decline in their mental health**

In case of any severe symptoms or crisis, or any issues out-of-hours, the client should consider calling the emergency services or visit an A and E hospital without delay.

Also, Samaritans 24 hours, 7 days a week helpline (tel no. 116123) might be a useful resource in case of crisis.

If the client wishes to contact us, they can get in touch on 02081586650 or

admin@harleypsychiatrists.co.uk.

Yours Sincerely,

Lizaveta Zeldzina