Attitudes towards attention deficit hyperactivity disorder in child and adolescent mental health services teams

Attention deficit hyperactivity disorder (ADHD) is a distressing condition that has a great impact on children and their families, reflected in the increasing numbers presenting to child and adolescent mental health services. Sandra Bailey and Alan Simpson discuss findings from a study that highlights differing approaches to the treatment and management of ADHD and calls for staff training and consistency in the delivery of clinical services.

Attention deficit hyperactivity disorder (ADHD) is one of the most common psychiatric disorders of childhood and is characterised by elevated levels of inattentive and/or hyperactive and impulsive behaviour (Anderson et al 1987). In the USA it is present in 3 to 10 per cent of children (Spencer et al 2002) whereas in the UK prevalence has been estimated at 1.7 per cent of children (Esser et al 1990). Differences in the assessment and treatment of children with ADHD have been reported (Daugherty and Quay 1991). Studies conducted in the US demonstrated that a large number of children presenting with ADHD symptomatology did not receive systematic assessments or comprehensive treatment that was well co-ordinated across home and school environments (McNeal et al 2000). This has serious implications for children and families because evidence suggests that early detection and appropriate treatment alters the likelihood of a negative developmental trajectory (Magyary and Brandt 2002).

Despite the early view that ADHD was a time-limited disorder of pre-puberty, prospective studies in psychiatric clinic samples revealed ADHD to be a chronic disorder in a substantial majority of children who receive the diagnosis, with anti-social behaviour, substance misuse, and family, interpersonal or occupational difficulties persisting into adolescence and adulthood (Klein and Manuzza 1991, Weiss and Hechtman 1993).

The co-morbid and associated conditions add to the clinical complexity of ADHD. Interactions of ADHD children and adolescents with their parents are frequently disturbed and conflictual, characterising family life with a degree of discord and disharmony (Anderson et al 1987). The difficulties within families tend to relate to poor compliance with parental instructions with parents often experiencing increased stress and a decreased sense of parenting self-competence. Evidence from longitudinal studies suggests that for some ADHD adolescents, dysfunction in parenting may play a role in the origins of ADHD (Pierce et al 1999).

Targets of treatment
Various theories exist about the aetiology of ADHD including genetic, neurological, environmental, dietary and psychosocial factors, but there is still no consensus about causal mechanisms. This has led to clinical researchers evaluating treatments targeted at the clinical and prognostic characteristics of the syndrome, its symptoms, comorbidities, functional impairments and long-term risk factors. This
would explain why the literature on treatment has focused on psychopharmacology, parenting, family and school-based interventions (Anastopoulos et al 1992). Numerous studies have been conducted on the use of stimulant medication to treat ADHD. Major findings are consistent in showing that stimulant medications have large, immediate salutary effects on a range of primary and comorbid symptoms, and some functional domains in children and young people with ADHD (Wolraich et al 2001). Evidence from randomised controlled trials suggests that methylphenidate, a central nervous system stimulant licensed for use in the treatment of children with ADHD, is effective in reducing hyperactivity, inattention and impulsiveness (Wells et al 2000). Stimulant medications have also had positive effects on the social behaviours and interactions of children and young people with ADHD. Despite this, it is widely recognised that there are limitations to the sole use of pharmacology in the treatment of ADHD (Pelham and Hinshaw 1992).

Swanson et al (1995) conducted a group of studies and demonstrated that 10 to 30 per cent of children showed an adverse or no response to a single stimulant. Moreover, as noted by Weiss and Hechtman (1993), there is little evidence that treatment with stimulant medication alters the poor long-term course of ADHD. Pelham and Waschbusch (1999) argued for stimulant medication to be an adjunct to behavioural used and felt that this should be implemented as first-line treatment.

Results from a number of studies suggest that behaviour therapy procedures may be useful in the treatment of ADHD (Hinshaw et al 2002). Specifically, behavioural parent-training and school interventions are two of the most widely reported interventions with proven efficacy where a marked decrease in school-based disruption, inattention and off-task behaviour have been noted (DuPaul and Eckert 1998). Even though significant improvements are obtained, neither stimulant medication nor behaviour therapy alone produces full normalisation of symptoms or reduces functional impairments. Therefore, investigators continue to ask whether a combination of medication and behaviour therapy will produce better effects, normalisation and long-term outcomes.

Study into staff attitudes

In the UK, in response to concerns over considerable variation in clinical practice, the National Institute for Health and Clinical Excellence (NICE) published guidelines on the use of methylphenidate in treatment (NICE 2000). These guidelines also recommend that the management of children with ADHD requires a seamless, consistent multidisciplinary approach to ensure the delivery of effective services, and that a child and adolescent psychiatrist, or paediatrician with experience in the field, should lead assessment and management of children with ADHD. This has fuelled debates about which professional discipline should take the lead responsibility in directing clinical pathways for children with ADHD (Magyary and Brandt 2002). This being the case, it is important to establish whether the stipulations from the guidelines have had any effect on staff attitudes and approaches to ADHD and multidisciplinary working in child and adolescent mental health services (CAMHS).

A review of the research literature revealed studies concerning the attitudes of primary care practitioners (Shaw et al 2003) and teachers (Barbaraesi et al 2002), but no studies were found regarding the attitudes of CAMHS professionals towards the diagnosis and management of ADHD. It is in this context that we chose to conduct a study to explore CAMHS staff attitudes to children and adolescents with ADHD and to look at the influence of clinical guidelines on practice.

**Aim:** The study set out to explore the attitudes of child and adolescent mental health workers towards the identification, conceptualisation, assessment and treatment of ADHD and the use of the NICE clinical guidelines in practice.

**Method:** A semi-structured interview survey of multidisciplinary members of three CAMHS teams was used.

**Sample:** Ten multidisciplinary staff members were purposively sampled to provide representatives from three different CAMHS teams, several different professions and to reflect the gender and age balance of the teams.

**Ethics**

Ethical considerations were fully explored in undertaking this study and the approval of the local research ethics committee was obtained. Issues relating to confidentiality, anonymity, storage, information sharing, impact on participants, consent and dissemination of findings were fully discussed with each participant before gaining their consent to participate. They were also informed that they were within their rights to withdraw from the study at any time and that this would not affect their employment rights.

**Procedure**

A semi-structured interview guide was designed, focusing on various aspects pertinent to ADHD and the aims of the study, and drawn from a review of the relevant literature and clinical experience. This included demographic details and questions about classification of the disorder, clinicians’ roles in identifying ADHD, views on treatment strategies and how they are applied in clinical practice. Views were also sought on the importance of diagnosis and the use of clinical guidelines in enhancing service delivery. The interview guide was piloted and refined before use in the study and was found to be acceptable to clinicians and useful in focusing and directing the discussion. Potential participants were contacted by telephone or in person and invited to take part in the study. All staff who were approached agreed to participate. A suitable time for the interviews was agreed. These were then conducted and tape-recorded between December 2004 and March 2005. On average, interviews lasted one hour.

**Data analysis**

Responses from the interviews were transcribed and analysed using interpretative phenomenological analysis. This method of analysis is used to identify specific themes in the acquired data systematically and objectively (Nachmias and Nachmias 1994). The procedure involved selecting one interview and reading the transcript several times. Following this, sub-themes that were similar were grouped together and those that were different were placed in a separate group. Clusters of themes were then formulated where similar topics or issues were identified and a master list of themes was produced, each containing a number of categories. These major themes captured most strongly the participants’ concerns on the topic. After analysis of the first transcription the master list was used with subsequent transcriptions exploring the recurrence of the themes, which were identified from the first interview. New themes or categories were

There is little evidence that treatment with stimulant medication alters the poor long-term course of ADHD
Findings

Eight women and two men were interviewed. Four participants were based in an inner-city service and six were based in two separately located urban services. The majority of participants were aged 41 to 60 and had on average 8.5 years of service in CAMHS. There was representation from five professional disciplines: nursing, psychiatry, family therapy, psychology and psychotherapy. These demographic data were representative of the teams studied. Clinical leadership and practice were also proportionally represented at different levels, reflecting varying levels of responsibility and role in the service. The key themes that emerged from analysis of the interviews were:

- Clinical presentation of ADHD.
- Role of participants in the multidisciplinary teams.
- Use of stimulant medication.
- NICE clinical guidelines.

Clinical presentation of ADHD

In general there was a consensus of knowledge base in all the responses suggestive of participants’ understanding of classifications and clinical presentations of ADHD. Common and consistent responses included the following:

- ‘I would expect a child to have over-activity, impulsivity and inattentiveness’ (psychiatrist).
- ‘I’d be looking and observing in terms of inattentive behaviour. I would be looking to see whether they are able to sit in the chair and pay attention to the teacher, listen to what the teachers say and if there are impulsive type behaviours. Can he keep himself still and settled and not jump up and not react to things?’ (psychologist).
- ‘Well, distractibility, not being able to sit still, fidgety, maybe more constantly looking around or looking for something else to do’ (family therapist).

However, views concerning the aetiology of ADHD varied. Medical staff were more likely to proffer biological explanations, whereas non-medical staff referred to factors such as social construction theory, family dynamics and psychoanalytic theories, which appeared to reflect professional background and training. A number of respondents offered these differing views:

- ‘I am ambivalent about ADHD. Any model or framework is only a hypothesis. Although it may be biological there is still a social construction’ (family therapist).
- ‘They may feel abnormal, mad and crazy, and this leads to feelings of low self-esteem, unhappiness, and there may be difficulty in how their parents conceptualise them in diagnosis. I think that because similar mental health conditions can be produced from accumulative traumas this is represented in ADHD children’ (psychotherapist).

Box 1. Cluster group identified from themes relating to medication and other treatments

- Medication was mainly over-prescribed in some services
- Positive experience of use of medication in some services
- Use of CBT/behaviour therapy can be effective if combined
- Psychotherapy is an effective but expensive treatment
- Cultural influences exist in families/services
- Beliefs about the existence of ADHD influence treatment choice
- Family’s ability to manage child’s behaviour influences treatment

Findings

Eight women and two men were interviewed. Four participants were based in an inner-city service and six were based in two separately located urban services. The majority of participants were aged 41 to 60 and had on average 8.5 years of service in CAMHS. There was representation from five professional disciplines: nursing, psychiatry, family therapy, psychology and psychotherapy. These demographic data were representative of the teams studied. Clinical leadership and practice were also proportionally represented at different levels, reflecting varying levels of responsibility and role in the service. The key themes that emerged from analysis of the interviews were:

- Clinical presentation of ADHD.
- Role of participants in the multidisciplinary teams.
- Use of stimulant medication.
- NICE clinical guidelines.

Clinical presentation of ADHD

In general there was a consensus of knowledge base in all the responses suggestive of participants’ understanding of classifications and clinical presentations of ADHD. Common and consistent responses included the following:

- ‘I would expect a child to have over-activity, impulsivity and inattentiveness’ (psychiatrist).
- ‘I’d be looking and observing in terms of inattentive behaviour. I would be looking to see whether they are able to sit in the chair and pay attention to the teacher, listen to what the teachers say and if there are impulsive type behaviours. Can he keep himself still and settled and not jump up and not react to things?’ (psychologist).
- ‘Well, distractibility, not being able to sit still, fidgety, maybe more constantly looking around or looking for something else to do’ (family therapist).

However, views concerning the aetiology of ADHD varied. Medical staff were more likely to proffer biological explanations, whereas non-medical staff referred to factors such as social construction theory, family dynamics and psychoanalytic theories, which appeared to reflect professional background and training. A number of respondents offered these differing views:

- ‘I am ambivalent about ADHD. Any model or framework is only a hypothesis. Although it may be biological there is still a social construction’ (family therapist).
- ‘They may feel abnormal, mad and crazy, and this leads to feelings of low self-esteem, unhappiness, and there may be difficulty in how their parents conceptualise them in diagnosis. I think that because similar mental health conditions can be produced from accumulative traumas this is represented in ADHD children’ (psychotherapist).
- ‘In thinking of ADHD we know from literature and from clinical experience that ADHD really exists. It is a constellation of symptoms to do with hyperactivity, attention deficit and impulsivity, which in the medical model not only recognises biological factors, but also family, environmental and social factors as well’ (consultant psychiatrist).
The relationship between the role of participants and their professional background caused conflict for a number of non-medical participants. Some of the views expressed demonstrated a level of role conflict that might affect collaborative team-working:

‘As family therapists we have to find some way of being useful and take a pragmatic position about the medical system. It is important for us to develop our roles in helping families to cope rather than developing expertise in assessing. This may put us in the position of being junior doctor look-alikes’ (family therapist).

‘I hold a different point of view from the psychiatrists. A child who displays fidgety behaviour and who finds it difficult to sit still may be diagnosed with ADHD; however, in my opinion this may not necessarily be the case. Recently I was involved in jointly assessing a boy with the psychiatrist. We had a long debate about his behaviour because I felt that other factors were contributing to his behaviour such as school context and his creativity. This led to a very difficult situation in the team because of our different views and required input from other team members who also had differing views’ (family therapist).

‘Obviously I am aware of what the symptoms of ADHD are and if my formulation fitted I would ask the psychiatrist to join me to make the diagnosis. Don’t forget that I don’t really see the psychologist’s role as making a diagnosis. This is a medical function so my role would be to focus on the whole range of family and emotional issues. This stance has often led to difficulties in my role as a psychologist in the team’ (psychologist).

The findings demonstrated that ADHD was predominantly defined as a medical condition that needed diagnosis and treatment. Therefore it was conceptualised as such, leading to reluctance in assessment and treatment by most non-medical participants. Consequently, the role of the consultant psychiatrist was central:

‘I partly see the psychiatrist’s role as prescription of medication and making a diagnosis of ADHD’ (psychiatrist).

‘I have always involved the psychiatrist in any ADHD-type assessments so that they can make the diagnosis’ (family therapist).

‘I would ask the psychiatrist to join me to make a diagnosis of ADHD’ (psychologist).

However, recognition of the core involvement of psychiatrists in the diagnosis of ADHD was not without tensions, with implications for teamwork:

‘My role in the team is to provide support to the children and their parents. The psychiatrist and the other doctors do the assessment and diagnosis of ADHD from the outpatients’ team, as well as the specialist registrars who see cases to gain experience. This arrangement is not totally acceptable because I may not always agree with that diagnosis being made if there isn’t full evidence of the steps taken to reach that diagnosis. This cannot be a medical diagnostic service as it has wider implications for the families and for the resultant treatment package. I think that the high numbers of children being diagnosed and treated is becoming a real issue for the service, as shown in the recent audit, and needs further exploration’ (nurse).

‘Other factors such as early development, stress, trauma and attachment may be contributory factors. There may be a specific cognitive deficit or a stressful incident in infancy which may cause these behaviours. Therefore I am not always convinced that we can accept the medical diagnostic labelling of these children. Of course, this difference in professional viewpoint does not always lead to good MDT (multidisciplinary) working’ (psychologist).

**Use of stimulant medication**

There was a consensus among most participants that stimulant medication was over-prescribed in the treatment of ADHD and that there should be more caution in prescribing it. There was also an understanding that stimulant medication should always be used in combination with other psychological therapies:

‘I think that medication should never be used on its own but should always be used in conjunction with psychological therapies’ (psychologist).

‘Some children may need medication plus diet plus the attention training and behaviour management. And I suppose when I put it in that context I see it very differently, so I do think that what we need to do is to make sure that it is absolutely necessary’ (nurse).

‘With regards to medication we know from findings in the States that it does seem as if medication is increasingly prescribed. We know from literature in this country that medication prescribing has also increased’ (consultant psychiatrist).

**NICE clinical guidelines**

Participants were asked about the clinical guidelines produced by NICE and their usefulness in clinical practice. Few participants were aware of the contents of the guidelines and the majority had not read them:

‘I have not read them, which is unusual for me’ (psychologist).

‘I will confess at this precise moment I do not know the ins and outs of what the guidelines are saying in relation to ADHD but having heard the NICE guidelines in relation to other conditions I am sure they will be very beneficial’ (nurse).

Despite the lack of first-hand knowledge of the guidelines, several people expressed the view that they were typically ‘medically orientated’ guidelines and did not relate to the work of non-medical clinicians. In addition to this, strongly held views were expressed by participants who felt that their

**ADHD was predominantly defined as a medical condition that needed diagnosis and treatment**
own knowledge base and that of others with whom they were working was sufficient in identifying children with ADHD and they did not need to rely on the guidelines. However, there was some recognition of the benefits of guidelines:

“Well, I haven’t read them – no, I don’t think they are helpful. I don’t think they’ve made a difference to me on the ground. I’m fairly experienced in seeing a whole range of behaviour difficulties and so therefore I think I would know what to do when I saw something which looked like ADHD’ (family therapist).

‘I’m not sure if it greatly affects our practice to be honest, in that NICE guidance wasn’t really about ADHD in its entirety; it was about prescribing methylphenidate and what it talked about is the need to be cautious up to the age of six and also the need for it to be a part of a package of care’ (psychiatrist).

‘It’s very limited in terms of usefulness. I’ve read some of it and I’ve not read all of it, but I’m very pleased that there are guidelines around medication and controlling that and the use of that’ (psychotherapist).

Discussion
This was a limited study of ten professionals across just three CAMHS teams, so caution is required when considering the wider relevance of the findings. However, this exploratory study provides a useful indication of areas requiring further investigation and possible transformations in practice development, education and training.

There are certain significant findings that have arisen from this study. First, there appeared to be agreement among participants about the core symptoms and the resultant effect of the condition on children with ADHD, with wide recognition of core symptoms of inattention, impulsivity and excessive motor activity. This is in line with the international diagnostic classification of ADHD (American Psychiatric Association 1994) that has formed the basis of clinical practice over a number of years and leads to the diagnosis of a syndrome with high inter-rater reliability, good face validity, high predictability of course and medication responsiveness (Goldman et al 1998).

However, the findings suggest much less agreement over the way ADHD is conceptualised, resulting in differing approaches to treatment of the condition.

Exploring issues relating to participants’ roles in identifying ADHD, it was evident that there was some influence of professional training and perhaps socialisation as identified in multidisciplinary teams for adult populations (Mistral and Velleman 1997). It became evident that there were conflicts in relation to participants’ roles within services, which were being driven by their underlying conviction and knowledge of ADHD.

The views expressed by most participants from a non-medical background suggested that the belief about the existence of ADHD was based on a number of factors such as their professional discipline, the culture within the service, scepticism about ADHD’s existence, lack of knowledge relating to available evidence and, most importantly, barriers created by ADHD being an identified medical condition. This can best be understood by some of the discussions that took place in the interviews where participants expressed doubts, cynicism and a lack of acceptance of the existence of the condition. Instead, some of those children presenting with symptoms of ADHD were being conceptualised in the participants’ own framework related to their professional background.

This is consistent with the other evidence available, which highlights the controversy relating to labels used to describe the disorder, as well as the theories regarding its aetiology and primary deficits (Connors and Erhardt 1998). Goldman et al (1998) explored this further and highlighted the areas of difficulties that continue to exist in practice and society in general. Therefore, despite an enormous body of research into this disorder, various aspects of ADHD have continued to generate controversy over the years. Debate has centred on the inappropriate assessment and labelling of children and whether diagnosis is merely applied to control children who exhibit unwanted behaviours in the classroom or home environment, with medication being used to control such behaviour.

Efforts have been made to label the whole idea of ADHD being an illness as a ‘myth’ and to brand the use of stimulants in children as a form of mind control (Safer and Krager 1994). These often widely held public views have created a climate of fear among practitioners, parents and educators, and have caused anxiety and confusion among the general public (Pierce et al 1999). It is therefore important to separate legitimate concerns raised by scientific studies from distorted information. Clinicians must acknowledge and discuss their own perspectives, and recognise and address the views and beliefs held by parents and young people attending CAMHS to ensure that these do not present a barrier to engagement and treatment.

Another important area for reflection is that of treatment modalities and the perception among participants that stimulant medication is over-prescribed. A study by Safer and Krager (1994) found no evidence of over-diagnosis of ADHD or over-prescribing of stimulants, findings which they suggested were the result of early identification and comprehensive assessments. More recent evidence suggests that stimulant medication in the ADHD population is simply being used more broadly for longer periods and without interruptions (Spencer et al 2002). Other possible explanations for greater treatment with stimulant medication may include increased knowledge, awareness and acceptance of the condition, use of a broader case definition and lengthier periods of treatment. However, this is not a view apparently supported by the majority of experienced clinicians in this study.

Other findings from the study suggest that child and adolescent mental health clinicians continue to practise in accordance with their own professional training, knowledge and clinical approach with very little multidisciplinary consensus in the overall management of ADHD.
continuing professional developments participants will need to cultivate insight and self-awareness (Hutchings et al. 2003). Recent studies suggest that interprofessional education and training can be beneficial (Reeves 2001).

The lack of concurrence between different CAMHS professionals drew even greater attention to the finding that most staff had not read the national clinical guidelines on the treatment of ADHD (NICE 2000). There appeared to be a reluctance or resistance to consider any potential benefits of such guidelines or, even worse, a dismissive assumption about their contents. Such a failure to engage with key recommendations pertinent to an important area of participants’ clinical endeavours was surprising and concerning, given the role that such guidelines can play in prompting consistency in working practices and enhancing good standards of care. A quality framework for the delivery and standardisation of services is necessary and the management of children and adolescents taking stimulant medication should be guided by the NICE guidelines. Failure to consider the value of such guidelines suggests professional defensiveness at the expense of ensuring high-quality clinical care (Box 2).

### Box 2. Recommendations for practice

**Teams need to explore differences in conceptualisations and attitudes, and work towards achieving consistency in approach to the care and treatment of children and young people with ADHD**

Teams need to engage in team-building exercises to achieve common understandings and develop protocols in meeting the needs of this client group.

Regular auditing of prescribing practices should be conducted to ensure practice is in accordance with national and local policies and clinical guidelines.

A common assessment framework is recommended to ensure that all children and young people with ADHD receive consistent assessments despite the differing views, attitudes and philosophies of team members.

Assessments and interventions should draw on the range of knowledge and skills available in multidisciplinary teams.

All staff in this area of clinical practice should become conversant with the NICE guidelines and should implement the recommendations in their clinical practice.

---

**Conclusion**

This exploratory study of the views of multidisciplinary staff working in CAMHS has identified a lack of consistency and some interprofessional tensions in the conceptualisation and treatment of children and young people with ADHD, and apparent resistance to the use and implementation of clinical guidelines. Further research with a larger sample of staff and teams is required to explore this further with a view to implementing interprofessional education and training that will provide consistent, high-quality treatment of people with ADHD and their families.

---

**References**


---

**Sandra Bailey RGN, RMN, Dip Nursing, MSc is lead nurse, West London Mental Health Trust**

**Alan Simpson PhD, RMN is senior research fellow, City University, London**

---

**Acknowledgements**

We would like to thank the staff who kindly agreed to take part in this study.