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Implementation of the Adult ADHD Self-Report Scale in a Mental Health Clinic

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Executive Summary

Introduction of the Problem

Attention deficit hyperactivity disorder (ADHD) is the most common neuropsychiatric disorder diagnosed among children. Long-time assumptions have suggested that children outgrow ADHD, limiting diagnosis, treatment, and the overall impact as an adult (Pawaskar et al., 2019). Approximately sixty percent of children diagnosed with ADHD continue to meet the diagnostic criteria for ADHD into adulthood, with less than twenty percent of those diagnosed receiving continued treatment (Ohnishi et al., 2019).

The impact of adult ADHD impairs various daily functions, including psychosocial functioning, academic and occupational performance, socioeconomic status, relationships, and mental health (Bitter et al., 2019). ADHD is often unrecognized and misdiagnosed in adults as comorbid psychiatric disorders, including depression and anxiety, due to overlapping symptomology (Bukstein, 2022). Diagnosis, treatment, and patient outcomes are often impacted due to inadequate screening for adult ADHD and misdiagnosis of comorbid psychiatric conditions.

This project was completed within a mental health community clinic based in Central Illinois. The population of patients was limited to adults diagnosed with depression or anxiety. Currently, there is no standardized process to screen for ADHD with a history of depression or anxiety.

Literature Review

ADHD is a neuropsychiatric, lifelong, chronic disorder that impacts daily functioning among people of all ages. ADHD affects around 9% of children and 4% of adults in the United States (Pawaskar et al., 2019). Only recently has research focused on the progression of ADHD

into adulthood. Longitudinal studies of children with ADHD have discovered that the disorder persists into adulthood in about 60% of patients. Factors that impact its persistence include its severity, comorbidities, and family history of mental health disorders (Bukstein, 2022). ADHD also impacts adults with no history of ADHD, with prospective studies demonstrating adults meeting the criteria for ADHD with no previous childhood history (Huang et al., 2020).

Adult ADHD is more commonly seen in men, but women report more concerns and impact on daily functioning (Adler et al., 2018). Adults with ADHD can display symptoms of inattention, restlessness, deficits in executive functioning, and mood lability (Bukstein, 2022). Impulsivity and hyperactivity are challenging symptoms to observe in appropriate settings, and diagnosis often relies on symptoms reported by the patient. Impulsivity symptoms in adults are associated with daily errors, employment concerns, termination, and relationship challenges (Bukstein, 2022). A study by Pawaskar et al. (2019) involving a representative sample of 69,000 adults in the United States noted a higher number of days missed at work, with decreased productivity. Individuals reporting symptoms of ADHD also reported impairment in social life, responsibilities in home life, and school or work (Pawaskar et al., 2019). ADHD and workplace concerns have contributed to a yearly economic burden of between 87 and 137 billion in the United States (Anbarasan et al., 2020). ADHD in adults also impacts relationships, with a noted divorce rate twice as high as that seen among those without ADHD (Tampi et al., 2020).

ADHD was once considered a standalone diagnosis, but based on updated data, 80% of adults with ADHD have at least one comorbid psychiatric diagnosis (Tampi et al., 2020). Many symptoms of ADHD and psychiatric conditions overlap, leading to incorrect diagnosis and treatment. Adults with ADHD often experience trouble regulating emotions, including impulsivity, overreaction, and mood changes (Anbarasan et al., 2020). Higher rates of

generalized emotional dysregulation are noted in adults with ADHD than in those with no diagnosis (Bukstein, 2022). Comorbidities with ADHD differ between adults and children, with anxiety, mood disorder, and substance use disorder seen most in the adult population. Comorbid disorders increase with age as symptoms become more evident (Bukstein, 2022). A multicenter cross-sectional study indicated that adults diagnosed with comorbid anxiety or depression had decreased quality of life compared to those without ADHD (Quintero et al., 2019).

Making a diagnosis of ADHD can be difficult due to the presence of psychiatric comorbidities, and it is often underdiagnosed in the adult population (Quintero et al., 2019). A diagnosis for adult ADHD is clinical, relying on the history reported by the patient and screening tools. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) is the gold standard for diagnosis, placing less emphasis on neuropsychological testing (Chamberlain et al., 2021). Using short screening tools and questionnaires to obtain information for those needing additional assessment for ADHD is recommended to screen high-risk groups in the general population (Brevik et al., 2021). Incorporating screening tools and questionnaires help prevent excessive and inappropriate specialist referrals for ADHD assessments while reducing healthcare costs (Chamberlain et al., 2021). Various screening tools are available, including the Wender Utah rating scale and the adult ADHD self-report scale (ASRS). These instruments help detect ADHD but are not considered diagnostic tools.

The Adult Attention-Deficit/Hyperactivity Disorder Self-Report Scale (ASRS) was developed assessing 18 DSM items and meant to take approximately 5 minutes to complete, providing a critical assessment to supplement the diagnostic process. The screening scale uses a five-point Likert-type scale assessing ADHD symptoms over the past six months (Anbarasan et al., 2022). This questionnaire has been found appropriate for specialty and primary care offices

to screen for adult ADHD used at baseline and during follow-up visits (Anbarasan et al., 2022). The ASRS questionnaire demonstrates deficits in executive functioning and emotional dysregulation (Anbarasan et al., 2020). The ASRS questionnaire was the most frequently used in the systemic review by Choi et al. (2022) due to the simplicity and cost-effectiveness of the screening tool. Ustun et al. (2017) found that 67.3% of patients in the general population screened positive for ADHD, while over 80% screened within specialty samples screened positive for ADHD, yielding few false positives. Huang et al. (2020) found the ASRS screening tool to have a negative predictive value of 98% and offered recommendations to assess further patients who screen positive. Individuals who screen positive should be evaluated using a comprehensive psychiatric, clinical interview, and assessment prior to diagnosis (Anbarasan et al., 2020).

Project Methods

The aim of this project was to increase the detection of ADHD among adults with a comorbid psychiatric diagnosis and ensure those who screened positive are adequately assessed for ADHD. The staff, including the certified psychiatric mental health nurse practitioner, registered nurses, social workers, and secretaries were educated and trained on the Adult ADHD Self-Report Scale (ASRS), which screens for ADHD. The project was conducted in a Decatur, Illinois, outpatient mental health clinic. The clinic serves veterans whose primary insurance is through the Veteran Insurance Program and averages ten to thirteen patients per day. This clinic was selected due to the need for routine screening of ADHD within the adult population. When the project was conducted, there was no standardized process to screen for adult ADHD.

Evaluation

Evaluation of this project was two-fold. Data collected on the number of patients screened for ADHD was compared to the initial number of patients screened for adult ADHD, which was zero, as no screening process was in place to screen adults for ADHD. One hundred fifty participants completed the adult ADHD self-report survey with six participants refusing. The survey results indicated that 90 participants screened positive for ADHD, suggesting additional ADHD evaluation. When comparing gender, 50% of males screened positive compared to 76% of females. Individuals aged 31-43 had the highest percentage of positive screening at 74%, although at least 50% of positive screenings were seen within all age groups. When comparing mental health comorbidities, 57% of individuals with a diagnosis of major depressive disorder screened positive, 59% of individuals diagnosed with generalized anxiety disorder screened positive, and 74% of individuals screened positive with a dual diagnosis of major depressive disorder and generalized anxiety disorder.

Second, the staff completed a survey using a Likert scale at the end of implementation to share feedback, improvements, and feasibility for long-term and expansion of the project. A five-point Likert scale, ranging from strongly agree to strongly disagree, was utilized to assess implementation and feasibility for long-term and expansion of the project. Five individuals participated in implementing the project and completed the survey. 100% of participants answered “Strongly Agree” regarding assessing the usefulness of the survey, the feasibility of continuing screening in daily practice, and appropriateness of the survey for the population.

Impact on Practice

The feasibility of this project, ease of use, and suggestions from participating staff resulted in routine screening for ADHD in patients with depression and anxiety. There were no patient complaints regarding the screening forms or process outside of the six patients who

refused to participate. By the end of the implementation, the screening process had become second nature to the staff with no reported concerns.

The screening process has continued for patients who are seen by the certified mental health nurse practitioner at the current location. This process could be easily implemented on a permanent basis for not only the participating provider in the project but for additional staff treating individuals for depression and anxiety, pending approval. Expansion of this project could include increased screening access in routine preventative health and specialty care visits. Incorporating ADHD screening within the practice resulted in the identification of 90 patients needing additional ADHD evaluation. Additional expansion may include evaluation of patient outcomes in those patients who were referred for additional ADHD evaluation and treatment. Incorporating and expanding routine screening for ADHD would improve mental health treatment outcomes.

Conclusion

Implementation of ADHD screening within the mental health clinic was positive, with hopes routine screening will be available for other providers working with individuals with depression and anxiety. This project demonstrated that a screening process could be successfully implemented in a mental health clinic. Future projects may focus on expanding screening to primary care locations.

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