

ADHD

Reference Number: RDF1444-23

Date of Response: 05/05/2023

Further to your Freedom of Information Act request, please find the Trust's response(s) below:

Please be aware that the Royal Devon University Healthcare NHS Foundation Trust (Royal Devon) has existed since 1st April 2022 following the integration of the Northern Devon Healthcare NHS Trust (known as Northern Services) and the Royal Devon and Exeter NHS Foundation Trust (known as Eastern Services).

A1) Do you use screening before referring individuals to be assessed for ADHD.

Definition being as per

Screening: a triage process, using standardised tools and/or agreed processes and carried out by experienced Liaison and Diversion practitioners.

Assessment including specialist assessment: carried out by someone with a specific professional mandate, i.e. with requisite professional skills.

Yes, for children only. Please find attached our Trust ADHD guideline.

Please email the following for any information relating to ADHD for adults:

dpt.saferinformation@nhs.net

<https://www.dpt.nhs.uk/contact>

A2) If yes, when did you introduce screening?- Screening and triage of referrals is standard practice for all clinical teams, for all reasons for referrals. This is done as part of routine practice and there is not a start date.

B) For the years 2018, 2019, 2020,2021 and 2022 please provide the following broken down by calendar year.

- i) Number of people who sought/referred for an ADHD diagnosis.
- ii) Number of individuals who received screening
- iii) Number of individuals who were then referred for assessment.
- iiii) Number of those assessed who were given an official diagnosis.

The Trust has looked into your requests under question B,i,ii,iii and iiiii. The Trust issues a refusal notice under Section 17 of the Freedom of Information Act and in doing so applies the following Exemption:

Section 12 (1)

The Trust has considered your request, however, to provide you with the information requested would require the manual extraction and manipulation of information from various sources. To carry out this work would exceed the appropriate cost limit as set out in Section 12 (1) of the Freedom of Information Act 2000 and is therefore exempt.

This is not routine data that is currently monitored as a clinical team so we would rely on what could be extracted from A&G and EPIC searching for ADHD to get some data. Every child's notes would then need to be clinically reviewed to confirm date or diagnosis or date of decision diagnosis of ADHD was not appropriate. All of the searches would have to be done for each year requested in these questions.

We could search epic for 'ADHD' diagnosis and crosscheck with date of first appointment, however, this will not be accurate as it sometimes takes more than one appointment to agree a diagnosis. We do screening of referrals currently through A&G and prior to that via EPIC but it would not be recorded if a referral for possible ADHD.

Under the Freedom of Information Act 2000 Section 12 (1) and defined in the Freedom of Information and Data Protection (Appropriate Limit and Fees) Regulations 2004, a public authority is not obliged to comply with a request for information if it estimates the cost of complying would exceed the appropriate limit. The limit of £450 represents the estimated cost of one person spending two and a half days in determining whether the Trust holds the information, locating, retrieving and extracting that information.

**Clinical Guideline for:
Assessment and Management of ADHD in Community
Paediatric and Neuro-disability team**

Authors of Clinical Guideline	RDE Community Paediatrics, Child Health
Division/ Department responsible for Clinical Guideline	Community Paediatrics
Contact details	
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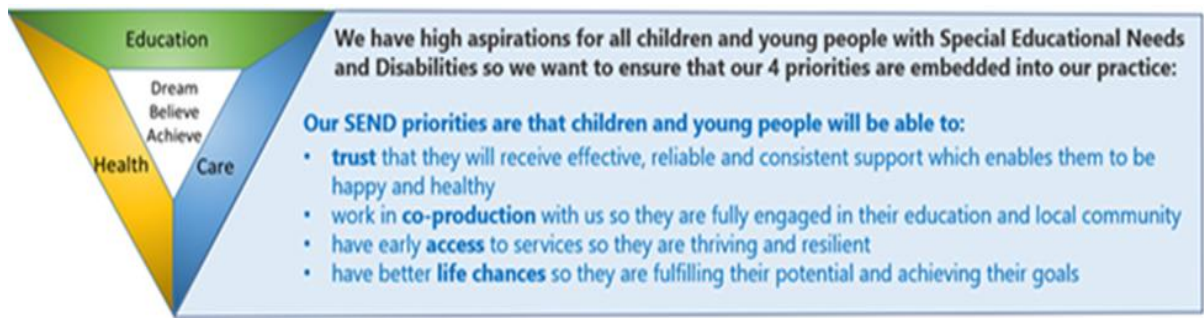
SUMMARY

This guideline outlines the process of assessment, diagnosis and management of possible ADHD within RDE Community Paediatric Department. **This may be in the context of wider neuro-developmental assessment.**

It includes guidance for each stage of the pathway/clinical guideline:

1. Pre-referral
2. Referral
3. Assessment
4. Management
5. Transition

Community Paediatric and Neuro-disability team provide specialist assessment, investigation, diagnosis and support for children with complex health needs associated with long term neurodevelopmental disorders and / or neuro-disabilities. These needs significantly impact on that child's ability to access and participate in aspects of daily living. We would expect that other professionals from health, education and social care will already have been involved in supporting the child and their family prior to referral to our team.



KEY POINTS

Attention Deficit Hyperactivity Disorder (ADHD) is a childhood-onset disorder characterised by **inattention, hyperactivity and/or impulsivity** demonstrated across 2 or more settings (such as home and school).

Some impairment must be present by 12 years of age and 60% to 70% of patients have persistent functional impairment into adulthood.

ADHD is diagnosed by clinical history and observation, which should include information from multiple sources, including parents, carers, and teachers.

Mainstay of medical treatment is stimulant medication, which can be effective in 85% of patients; non-stimulants are less often effective, but may have other advantages in terms of duration of action or in special populations.

Stimulant medications have been associated with cardiovascular side effects. These should be monitored in children with heart conditions.

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1. INTRODUCTION

1.1 This clinical guideline is designed to provide advice, guidance and direction to staff whilst leaving room for professional judgement, and adaptation, to fit individual circumstances.

ADHD is a persistent pattern of inattention, hyperactivity and impulsivity that is more extreme than is typically observed in individuals at a similar stage of development. It is evident at a young age and is pervasive across different settings e.g. home, school and with friends.

ADHD affects about 3-5% of children and 2% of adults and is more commonly identified in males than females (4:1).

Girls with ADHD may present with less hyperactivity than boys and subsequently may be less easily identified in primary care settings (NICE, 2008, 2013).

Certain groups have increased prevalence including people born pre-term, looked after children and young people, those with close family history of ADHD and people with neurodevelopmental disorders (for example, autism spectrum disorder, tic disorders, learning disability [intellectual disability] and specific learning difficulties or acquired brain injury).

1.2 How might ADHD affect children and young people?

- Hyperactivity – e.g. Unable to sit still, fidgety, fiddling with things and problems with sleep
- Inattention –e.g. Difficulties concentrating, disorganised, forgetful and struggle to complete tasks
- Impulsivity – e.g. Speaking out and acting without thinking, interrupting others, difficulties waiting their turn

While ADHD-like symptoms are found in many people some of the time, in people with ADHD they are **severe, persistent over time and lead to clinically significant impairments in functioning.**

About two-thirds of young people with ADHD have another disorder, most commonly behaviour problems (e.g. oppositional defiant difficulties and conduct difficulties). Other associated disorders include; tics, obsessive compulsive disorder, depression, substance misuse, autistic spectrum disorders and learning difficulties (NICE, 2008, 2013).

Impairments can impact on an individual in many ways including: low self-esteem, educational and occupational problems, problems in social interactions and relationships, antisocial behaviour, greater risk-taking and accidents and the development of co-morbid psychiatric disorders (NICE, 2008, 2013).

1.3 What causes ADHD?

The causes of ADHD are not fully understood but a number of risk factors are associated with the condition. Genetic factors can have an influence, with family members frequently affected. The diagnosis of ADHD in older family members such as parents may have previously been missed and should be considered.

ADHD is considered to be a neurobiological disorder linked to an imbalance of brain chemicals (dopamine and noradrenaline) with some evidence that there are also some structural brain changes in children and adults with ADHD (Purper-Ouakil et al., 2011).

Other factors suggested as potentially having a role in ADHD include:

- being born prematurely (before the 37th week of pregnancy)
- having a low birthweight
- smoking or alcohol or drug abuse during pregnancy

1.4 Long-term outcomes

ADHD is associated with long term adverse outcomes for many young people (NICE, 2008, 2013). The disorder impacts upon the young person's development and ability to gain adaptive skills to help with independence in everyday living. There is increasing evidence that problems related to childhood ADHD can persist into early adulthood and that they can act as a risk factor for the development of additional problems including other psychiatric disorders, substance misuse difficulties and problems with employment and relationships. An increased risk of premature mortality has also been found in adults (Dalsgaard et al., 2015).

ADHD has also been shown to be associated with anti-social behaviour in both young people and adults. Prevalence rates of ADHD in young offenders was found to be high (12%-19%) in comparison to 3-5% in the general adolescent population (Hughes et al., 2012). There is also evidence that ADHD medication treatment can reduce the risk of reoffending in adults by a third (Lichtenstein et al., 2012).

2. BACKGROUND

2.1 This document was drawn up following a departmental audit of ADHD management against NICE Guidance NG87 in March 2018 in order to clarify referral pathway and best utilise the skill mix within the department of community child health.

3. DEFINITIONS AND EVIDENCE BASE RESOURCES

3.1 ADHD – Attention Deficit Hyperactivity Disorder

Attention-deficit/hyperactivity disorder (ADHD) is a neurodevelopmental condition described in diagnostic classification systems (ICD-10, DSM-5 [1, 2]).

It is characterised by difficulties in two subdomains: inattention, and hyperactivity-impulsivity. Three primary subtypes can be identified: predominantly inattentive, hyperactive-impulsive, and combined presentations. Symptoms persist over time, pervade across situations and cause significant impairment

Key articles

- Attention deficit hyperactivity disorder: diagnosis and management
NICE guideline [NG87] Published: 14 March 2018 Last updated: 13 September 2019
<https://www.nice.org.uk/guidance/ng87>
- American Psychiatric Association. Diagnostic and statistical manual of mental disorders, 5th ed.,(DSM-5). Washington, DC: American Psychiatric Publishing; 2013.
- World Health Organization. International classification of diseases: 10th revision, second edition. Geneva, Switzerland: World Health Organization; 2004.
- Pliszka S, AACAP Work Group on Quality Issues. Practice parameter for the assessment and treatment of children and adolescents with attention-deficit/hyperactivity disorder. J Am Acad Child Adolesc Psychiatry. 2007 Jul;46(7):894-921.
- Wolraich M, Brown L, Brown RT, et al; Subcommittee on Attention-Deficit/Hyperactivity Disorder; Steering Committee on Quality Improvement and Management. ADHD: clinical practice guideline for the diagnosis, evaluation, and treatment of attention-deficit/hyperactivity disorder in children and adolescents. Pediatrics. 2011 Nov;128(5):1007-22.

4. MAIN BODY OF GUIDELINE

ADHD guideline summary flowchart:



PRE-REFERRAL

See Referral Guideline at <https://northeast.devonformularyguidance.nhs.uk/>

- Evidence of an Early Help , graduated and holistic approach to the concerns/needs
- Summary of impact of Early Help Assessment and/or support already instigated
- For ADHD: Evidence of behavioural management and intervention, either universal or targeted from the Locality Team based on child's needs.
- Information and interventions regarding any home or environmental factors which may have an impact on that child's behaviour and/or functioning, if not already included on the referral letter or early help assessment.

REFERRAL

See Referral Guideline at <https://northeast.devonformularyguidance.nhs.uk/>

- Referrals should be made by a health professional (school nurse / GP/ CAMHS professional) through A&G or direct referral to RDE community paediatricians,

Supporting evidence for referral should include the following areas:

- Evidence of the school using a graduated response, and following a clear cycle of 'Assess, Plan, Do, Review' with outcome measures of appropriate strategies and interventions used. This may include reports of assessments by Educational Psychology and/or Communication Interaction Team.
- Involvement of the school SENCo
- TAF meeting, SEN Support or EHCP reports describing needs and progress.
- Assessment of a child's current academic attainment – specifying child/young person's progress against age expected norms particularly where there are concerns about cognition and learning.
- Information from allied professionals, primarily SLT and OT or Babcock advisory teachers who have been working with the child and setting.
- Evidence of ADHD symptoms presenting across at least two settings e.g. home and school, with supporting information from school and /or other professionals supporting the child and family

Advice regarding children under 6 years:

- Young people presenting with ADHD symptoms below the age of 6 years should access support within the community using the iThrive framework, whereby children have access to strategies within school and parents are signposted to support /specialist parenting groups.
- Those with mild symptoms should be monitored (watchful waiting) while those with moderate-severe symptoms should access community based strategies to support early intervention (Department of Health, 2015). Primary care services (GPs and schools) should monitor the response to these strategies initially and if symptoms persist seek advice through consultation with specialist services regarding further assessment.
- The rationale for referring young people from the age of 6 years and above (age of 5 years in exceptional circumstances) for specialist ADHD assessments include:
 - Poorer reliability of diagnosis in pre-school children, particularly for those with other developmental needs.

- Research on preschool children suggests that some may manifest the symptoms of ADHD as part of that developmental period and that they may remain for periods of 3-6 months (Campbell, 1990; Palfrey et al,1985). Additional information from teachers about the child's presentation in more structured classroom settings and outcome of the Early Years Foundation Profile (end of reception year) can provide valuable clinical information including information on co-morbid developmental needs.
- Clinicians may be reluctant to diagnose ADHD in young children with other developmental difficulties which have not yet been identified, contributing to a delayed diagnosis and intervention.
- Diagnostic uncertainty when working with children under 6 can lead to increased out-patient appointments during the clinical assessment process thereby reducing cost-effective service delivery.
- SNAP-IV (Swanson, 1992) a frequently used ADHD symptoms rating scale in clinical assessment, has validity as an assessment tool for children from 6 years of age.
- Qbtest (Qbtech Ltd) has been developed and validated for use with children and young people from the age of 6years (FDA; Ref- k133382).Not currently available in RDE.
- Commonly used medication treatment for children with ADHD is licensed from 6 years of age (British National Formulary, 2017).

REFERRAL TRIAGE

Inadequate Evidence in initial referral – triage as reject and send a letter requesting additional information as above

Adequate evidence of appropriate pre-referral management/support and relevant information is complete then a decision is made at EPIC triage to

EITHER : accept

- Book a new Neurodevelopmental Assessment Pathway NAP patient appointment with member of our team (Paediatrician or Clinical Nurse Specialist)

OR: Consider alternative options

- At this stage it may be apparent that an assessment for ADHD is NOT indicated because the information suggests an alternative explanation – Rejected with Advice and Guidance to GP / referrer to re-direct and / or relevant signposting
- Or reject for GP to refer to CAMHS – evidence of complexity/co-morbidities and/or mental health concerns /already known to CAMHS.

ASSESSMENT

Outpatient appointment

An ADHD specialist assessment should include 3 key features;

- 1) **Semi-structured clinical interview**; usually 1 hour (can be over video) with parent/carer
- 2) Additional Information gathering including **validated ADHD rating scales and observational reports** from school / other settings (see below)
- 3) Face to face appointment with child including **physical examination**

The clinical interview should include;

- Discussion with parent/carer (+/- child dependent on age and appropriateness) regarding referral information, their concerns and the child's strengths and needs.
- Medical, developmental history and review of risk factors
- Psychosocial and history of any co-existing neuro-diverse /mental health /behavioural concerns which may be impacting on presentation
- Family history (including history of parental mental illness and current presentation)
- Observation and clinical examination of the young person
- An example of a semi-structured interview focusing on ADHD is available at

[Resources \(psychology-services.uk.com\)](http://Resources(psychology-services.uk.com))

Menu of information gathering and screening tools that can be used: P:\PAEDS_SHARED\Community Child Health\ADHD Resources and P:\PAEDS_SHARED\Community Child Health\Community Resource File

- School aged background information -parent/carer
- School report for paediatric appointment
- Strengths and difficulties Questionnaires

Consideration given to co-morbidities/other neuro-developmental conditions

- Home/ School ASD screeners if indicated

Find at:

P:\PAEDS_SHARED\Community Child Health\ASD resources\ASD-Screener April 2019 C&FHD.docx

- School / referrer to submit and CCH will review reports from other professionals e.g. Speech and Language and Educational Psychology.

Don't forget to ask about any co-morbid concerns including learning levels

ADHD Rating Scales:

Behaviour rating scales can be used to aid with the diagnosis and to follow response to treatment. Commonly used scales include:

- 1) Conners parent/ teacher and self-report questionnaire gathers information regarding a range of behaviours and symptoms. The scores indicate whether the symptoms observed are out of proportion to those expected for a child of the same age. T-scores > 60 for attention and hyperactivity/impulsivity indicate that the symptoms are significant. Paper copies Sent by post.

P:\PAEDS_SHARED\Community Child Health\NDevelopmental Resources\ADHD\ADHD rating scales\Conner's

- 2) ADHD Rating Scale IV is an 18-item scale based on the DSM criteria for ADHD. It is useful for both diagnosing ADHD in children and adolescents and for measuring improvements with treatment.

P:\PAEDS_SHARED\Community Child Health\NDevelopmental Resources\ADHD\ADHD rating scales\ADHD Rating Scale 1V

- 3) SNAP IV is included in many research trials, including the Multimodal Treatment Study of AD/HD (MTA). It is a 90-item scale that screens for ADHD and other diagnoses. [SNAP-IV rating scale] [SNAP-IV Teacher, Parent and Youth Rating Scale

4) Vanderbilt Scale is a 55-item scale, which assesses ADHD, comorbid conditions, and performance. [NICHQ Vanderbilt Assessment Scale]<P:\PAEDS SHARED\Community Child Health\ADHD Resources\Vanderbilt forms>

Objective information from informants or school reports :

- Use all available reports from allied health , education and social care colleagues
- Use validated Rating tools completed by professionals who know CYP well
- Review their SEN support plan or EHCP plan
- Review any educational psychology reports
- Request specific observations from SENCO/teacher if necessary – this should be done in a collaborative manner with consent. Useful prompts [ADHD Resources](#)

Reaching a Diagnosis: [DSM V checklist](#)

Diagnosis should follow DSM V or ICD – 10 criteria and the severity (moderate or severe) should also be documented based on functional impairment (NICE 2018). Parents should receive confirmation of the diagnosis in writing.

Written information (leaflet or clinic letter) should outline follow-up arrangements provided locally. It should include information on who is providing follow-up, frequency and purpose of appointments and expectations of families (for example attendance at regular medication clinic reviews) to provide transparency regarding the roles of service providers and service users.

With parental consent, schools should also be informed in writing of the outcome of the assessment with information regarding management strategies within the classroom (NICE, 2018).

Practical advice and support regarding strategies including self-help information, environmental changes which provides young people and their families with the tools to enable them to thrive and harness the positive aspects and effects of ADHD (NICE, 2018).

Potential Outcomes Post Specialist Assessment:

ADHD diagnosis

- Complete DSM V checklist
- Feedback diagnosis
- Share ADHD resource pack
- Follow on management: A post diagnostic ADHD session with young person and family and/ or TAF in school with a member of CCH team
- Clinical management / interventions as detailed in the section below

ADHD diagnosis with co-morbidities

- Co-morbid Autism: Send out ASD screeners following initial appointment, then if supportive refer on to CFHD ASD assessment Team to complete Autism Assessment.
- Other common co-morbidities E.g. Tics / Tourettes / Learning /Intellectual Disability / Genetic Syndrome / Mental Health needs - Arrange further assessment or onward referral as clinically indicated.

Other:

- Not ADHD
- Complex Presentation

- Consider referral for multi-service discussion Eg: monthly MDT meeting with CAMHS / Locality Pathway meeting (CFHD) / SEND Hub
- Discharge with onward referral and / or signposting to other agencies

MANAGEMENT

ADHD often affects many areas of functioning, including school, family relationships, friendships, activities, and self-esteem.

Support available:

- Psycho-education - Community Paediatric Service ADHD information for packs and carers – sleep, resources, transition, diet, reading lists, website. Local and national support organisations

Find at:

<P:\PAEDS SHARED\Community Child Health\ADHD Resources\ADHD Parent Resource Pack 11.4.19.docx>

- CCH team can signpost to a range of psycho-education including behaviour, sensory, education, practical tips and inform education - based planning / EHC stat assessment

Discussion of the following with child, parent and carers may be relevant:

Pre-school:

- Parenting programmes for preschool children
- The positive impacts of receiving a diagnosis, such as: – improving their understanding of symptoms – identifying and building on individual strengths – improving access to services
- Parent/carer support interventions, where people can meet and share experiences with others

Primary School Aged:

- Parent/ carer mediated interventions, Triple P or Incredible Years (for parents of school age children with ADHD and comorbid conduct disorder) - parenting a child with ADHD requires resilience and extra skills – investment in this at the earliest possible stage prevents the embedding of negative behaviours and relationships within the family unit, in particular the development of low self-worth and oppositional difficulties
- Psycho-education – school aged children:
 - 1) Young S, Smith J. Helping Children with ADHD. A CBT Guide for Practitioners, Parents and Teachers. Chichester: Wiley; 2017.
<https://download.e-bookshelf.de/download/0009/8431/93/L-G-0009843193-0019385811.pdf>
 - 2) A group intervention: Young S. The STAR Detective Facilitator Manual: A Cognitive Behavioral Group Intervention to Develop Skilled Thinking and Reasoning for Children with Cognitive, Behavioral, Emotional and Social Problems. London: Jessica Kingsley; 2017.
 - 3) Young S. Becoming a STAR Detective!: Your Detective's Notebook for Finding Clues to How You Feel. London: Jessica Kingsley; 2017
- Addressing allied issues e.g. Sleep strategies
- Principles of healthy diet
- Group social skills or problem solving training
- School based behavioural strategies
- For young people with co-morbid conduct and antisocial behaviour, practitioners should reference NICE guidance on Antisocial Behaviour and Conduct Disorders in Children and Young People (NICE, 2018) which emphasizes the role of parenting programmes, as well as multimodal and multi-systemic interventions

Secondary School Aged:

- As a child reaches secondary school age the focus of psychoeducation will alter – and may include info about a drop off in medication adherence. Parents and carers need to be aware of the elevated risk of deliberate self-harming behaviour (e.g. cutting), eating disorders, substance abuse, risk-taking behaviours, and vulnerability to exploitation in teenagers with ADHD
- May need interventions to support executive function (e.g. improving skills to address problems with time management, focus, sustaining attention, organisation and planning) which may in turn support their coping

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Approved by: Paediatrics Business and Governance Group, 09/03/2022

Review date: 08/12/2025

in secondary schooling. Teenage girls may particularly benefit from treatment aimed at improving self-concept and identity. rates of early pregnancy are higher in girls with ADHD

- Providing advice to school setting: ADHD is classified as a disability under the UK Equality Act reasonable adjustments to education provision are mandated (examples may include: additional examination time, academic coaching, rest-breaks during examination, or possibility for part-time study). Research suggests that simple interventions, including physical adjustments (table set-up, creating a time-out corner), and behaviour management techniques, as well as joint goal setting with primary age children, can help to improve ADHD symptoms, social and emotional functioning, and reduce conduct problems in the classroom. Proactive planning regarding educational transitions should be made with the student with ADHD, the school and others involved.
- Differences in girls with ADHD <P:\PAEDS SHARED\Community Child Health\ADHD Resources>
- Link with any local ADHD training e.g. Bis-net
[BisNet Training and Workshops - CEDA, Disability Action](#)

MEDICATION

- Medication is indicated for those who are severely impaired by their ADHD, or for those who moderately impaired by their ADHD and who have not responded to non-pharmacological interventions
- Practitioners should discuss with the young person and family different medication options, as well as the benefits and side-effects of medication (NICE, 2008).
- Information on medication should also be provided within a written format or families directed to web-based sources. <https://www.medicinesforchildren.org.uk/> provides practical and reliable information to parents and carers about giving medicines to their child
- Treatment should be comprehensive as well as flexible over time as presenting symptoms and necessary supports will change as development progresses.
- Treatment should be designed for the individual patient so that efficacy, tolerability, compliance, and affordability are maximised.
- Patients should be monitored with regular follow-up to monitor target symptoms, outcomes, and adverse effects. Follow up questionnaires available <P:\PAEDS SHARED\Community Child Health\ADHD Resources>
- Use Shared Care prescribing for joint care with Primary care

<https://devonccg.nhs.uk/download/methylphenidate-shared-care-guideline-devon>

<https://devonccg.nhs.uk/download/lisdexamfetamine-children-scg-devon>

<https://northeast.devonformularyguidance.nhs.uk/formulary/chapters/4.-central-nervous-system/4-4-cns-stimulant-and-drugs-for-adhd>

- Comorbid conditions should be actively assessed and relevant evidence based treatment accessed as appropriate
- Current management options including flow chart for medication options are available at <http://www.nice.org.uk/guidance/NG87>
- Best Practice BMJ Management of ADHD in children [BMJ best practice downloaded 7.10.20](#)

Before starting medication there needs to be a review of physical health, including:

- A medical history, taking into account conditions that may be contraindications for specific medicine
- Height and weight (measured and recorded against the normal range for age, height and sex)
- Baseline pulse and blood pressure (measured with an appropriately sized cuff and compared with the normal range for age)
- Cardiovascular assessment. NB: An electrocardiogram (ECG) is not needed before starting stimulants, atomoxetine or guanfacine, unless the person has any of these features, when a referral for cardiology opinion would also be recommended:

- a) History of congenital heart disease or previous cardiac surgery
- b) History of sudden death in a first-degree relative under 40 years suggesting a cardiac disease
- c) Shortness of breath on exertion compared with peers
- d) Fainting on exertion or in response to fright or noise
- e) Palpitations that are rapid, regular and start and stop suddenly
- f) Chest pain suggesting cardiac origin
- g) Signs of heart failure
- h) A murmur heard on cardiac examination
- i) Blood pressure that is classified as hypertensive

- The recommendation from NICE guidelines is the first line should be Methylphenidate (short or long acting), second line either lisdexamfetamine or dexamfetamine and third line atomoxetine or guanfacine
- Practitioners should use once daily prescribing (extended release preparations) where possible to increase compliance (NICE, 2018).
- Practitioners should request symptom and side-effect questionnaires to be completed by parent/carers and school and returned for the medication review appointment within 6 weeks ideally, but minimum of 3 months after starting medication (NICE, 2018).

First line: STIMULANT: Methylphenidate (MP) once daily long-release preparations

Drug	Form	Delivery	Short:Long % MP	Duration of action [#]	Notes
Concerta XL*	Tablet	Swallow whole	22:78	10-12h	
Equasym XL	Capsule	Can be sprinkled	30:70	8-10h	
Medikinet XL	Capsule	Can be sprinkled	50:50	6-8h	bd use possible

*alternative brands include Xenidate XL, Matoride X

[#]approximate duration at optimal dosing

Alternative first line

Drug	Form	Delivery	Notes
Methylphenidate Immediate release I/R	Tablet	Swallow whole	1. 2-3x daily, useful in establishing efficacy 2. Can be added to XL regime in afternoon to extend cover
Atomoxetine Non-stimulant	Capsule	Can be sprinkled	1. First line where stimulants contra-indicated 2. Requires continuous dosing/no breaks

Second line

Drug	Notes

Alternative MP preparations	It can be useful to try alternative MP-XL preparations or I/R, as above. Some children may respond better to a different brand/preparation
Lisdexamfetamine Mesilate	<i>Elvanse</i> – long-acting dexamfetamine preparation. Stimulant, similar side-effect profile to MP class. Capsule – can also be sprinkled
Atomoxetine	As above

Third line – may require additional specialist advice or peer case discussion	
Drug	Notes
Guanfacine Hydrochloride	<i>Intuniv</i> . Non-stimulant. Establishing its place in ADHD management, useful with co-existent tics. Side effect of hypotension. Alternative to Atomoxetine if stimulants contra-indicated. Not currently in Devon formulary
Clonidine	Useful with co-existing challenging behaviour or sleep issues
Dexamfetamine	Alternative stimulant to long-acting <i>Elvanse</i> . Similar regime to I/R methylphenidate.

Additional advice about medication and treatment options
<p>Practitioners should consult with another Consultant Child Psychiatrist/ Paediatrician or tertiary centre in the following circumstances (NICE 2018):</p> <ul style="list-style-type: none"> • If considering higher than British National Formulary limits of licensed medication • If considering combination medication • If considering unlicensed medication - parents/carers should also be informed if Medication usage is unlicensed and consent documented in notes <p><u>Practitioners should review the need for on-going medication use annually with the young person and parents/carers.</u></p> <p>Children and families should be aware that they can contact clinicians if there are concerns or difficulties before their scheduled appointments. Drug holidays are not routinely recommended as long as there is evidence to support the benefits of ongoing medication treatment, for example through the impact of missed or reduced medication doses (NICE, 2018).</p> <p>Co-morbid conditions such as depression, anxiety, self-harm, oppositional defiant disorder, developmental delays, autistic spectrum disorder, tic disorders and substance misuse are common amongst children and adolescents. During any treatment review, care should be given to actively elicit these difficulties so that relevant evidence based treatment pathways for these co-morbid conditions can be accessed. When prescribing ADHD medications in children and young people who have substance misuse needs, non-stimulant medications should be considered first.</p> <p>During outpatient review appointments, the young persons' goals of care should be understood and regularly reviewed. Additionally, practitioners should obtain written feedback from the young person's school, and family about their ADHD symptoms and general progress. Standardised and validated questionnaires including; ADHD symptom scales (e.g. SNAP-IV and Connors), general emotional and behavioural rating scales (SDQ; Strengths and</p>

Difficulties Questionnaire - Goodman, 1997) or quality of life questionnaires (WFIRS; WEISS Functional Impairment Rating Scale) should be regularly used to support the implementation of routine outcome measures (ROM). This is important to demonstrate treatment response and general progress (Department of Health, 2015).

Follow up clinic and shared care ADHD monitoring of CYP on medication

Refer to section in NICE guidance about planning treatment for detailed advice

Non- medicated:

- use patient or health professional initiated follow up options

Medicated:

- Shared care guidelines with primary care should be followed (see above) but use clinical judgement regarding increased frequency during periods of drug dose or type modification
- Standard is for 6 month GP baseline observations plus annual paediatric appointment
- Use an ADHD medication letter to obtain information prior to the follow up clinic appointment
- the possible effect on driving (for example, ADHD symptoms may impair a person's driving and ADHD medication may improve this; people with ADHD must declare their diagnosis to the DVLA if their ADHD symptoms or medication affect their ability to drive safely)

Tools:

- Medication side effect reviews
- Short SNAP symptom reviews or Vanderbilt follow up forms parent and teacher available

TRANSITION

Start 6 months before the point of transition to adult services by reviewing the young person's needs and support required following transition. Information should be communicated to all relevant agencies (primary care and specialist services) including details of the young person's needs, risk and care plan. If needs are severe or complex, the care programme approach should be considered (NICE,2018).

- A formal meeting involving CAMHS and/ or paediatrics and adult psychiatric services should be considered
- Transition to adult services use Ready Steady Go tool from aged 13 years www.rdehospital.nhs.uk/transition
- (DAANA) Devon Adult Autism and ADHD Service provides a diagnostic and advisory role for the assessment of high functioning autism/Asperger's disorder and Attention Deficit Hyperactivity Disorder (ADHD) for adults <https://www.dpt.nhs.uk/locations/devon-adult-autism-and-adhd-service-daana>
- Email address is dpn-tr.asc@nhs.net
- Referral forms are accessible on the DPT website above
- P:\PAEDS SHARED\Community Child Health\ASD resources\Signposting pack adults with an ASC and ADHD in Devon version 6.pdf
- [Preparing for adulthood Team Devon CC](#)
- Transition clinics with DPT and other adult services to be arranged

NICE guidelines (2018) note the need for adult services to reassess young people following transition. This can provide an opportunity to identify new co-morbid difficulties, discuss medication choices and direct young people towards advice regarding other issues, for example substance misuse services or family planning etc.

5. MONITORING COMPLIANCE WITH THIS GUIDELINE

- 5.1 Undertake repeat clinical audit as part of departmental audits as part of service improvements and to contribute to wider CFHD alliance pathways. This can be done via retrospective use of MYCare clinical records against DSM 5 ADHD criteria.

6. ASSOCIATED CLINICAL GUIDELINES OR POLICIES/PROCEDURES

Other Community Child Health guidelines including ASD, Learning disability, Sleep, FASD will be useful as may exist as co-morbid conditions.

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