

Summary of: Attention  
deficit hyperactivity  
disorder: diagnosis and  
management (NG87)

# NG87

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# Attention deficit hyperactivity disorder: diagnosis and management

## Recognition

- Be aware that the following groups may have an increased prevalence of ADHD:
  - people born preterm
  - looked-after children and young people
  - children and young people diagnosed with oppositional defiant disorder or conduct disorder
  - children and young people with mood disorders (for example, anxiety and depression)
  - people with a close family member diagnosed with ADHD
  - people with epilepsy
  - people with neurodevelopmental disorders
  - adults with a mental health condition
  - people with a history of substance misuse
  - people known to the Youth Justice System or Adult Criminal Justice System
  - people with acquired brain injury.

## Identification and referral

- Referral from the community to secondary care may involve health, education and social care professionals and care pathways can vary locally. The person making the referral to secondary care should inform the relevant GP.
  - When a child or young person presents in primary care with behavioural and/or attention problems suggestive of ADHD, primary care practitioners should determine the severity

of the problems, how these affect the child or young person and the parents or carers, and the extent to which they pervade different domains and settings.

- If the child or young person's behavioural and/or attention problems suggestive of ADHD are having an adverse impact on their development or family life, consider:
  - a period of watchful waiting of up to 10 weeks
    - offering parents or carers a referral to group-based ADHD-focused support (this should not wait for a formal diagnosis of ADHD).
    - if the behavioural and/or attention problems persist with at least moderate impairment, the child or young person should be referred to secondary care (that is, a child psychiatrist, paediatrician, or specialist ADHD CAMHS) for assessment.
  - If the child or young person's behavioural and/or attention problems are associated with severe impairment, referral should be made directly to secondary care.
  - Primary care practitioners should not make the initial diagnosis or start medication in children or young people with suspected ADHD.
  - Adults presenting with symptoms of ADHD in primary care or general adult psychiatric services, who do not have a childhood diagnosis

of ADHD, should be referred for assessment by a mental health specialist trained in the diagnosis and treatment of ADHD, where there is evidence of typical manifestations of ADHD (hyperactivity/impulsivity and/or inattention) that:

- began during childhood and have persisted throughout life
- are not explained by other psychiatric diagnoses (although there may be other coexisting psychiatric conditions)
- have resulted in or are associated with moderate or severe psychological, social and/or educational or occupational impairment.
- Adults who have previously been treated for ADHD as children or young people and present with symptoms suggestive of continuing ADHD should be referred to general adult psychiatric services for assessment. The symptoms should be associated with at least moderate or severe psychological and/or social or educational or occupational impairment.

### Diagnosis

- A diagnosis of ADHD should only be made by a specialist psychiatrist, paediatrician or other appropriately qualified healthcare professional with training and expertise in the diagnosis of ADHD, on the basis of:
  - A full clinical and psychosocial assessment of the person; this should include discussions about behaviour and symptoms in the different domains and settings of the person's everyday life and
  - A full developmental and psychiatric history and
  - Observer reports and assessment of the person's mental state.
- A diagnosis of ADHD should not be made solely on the basis of rating scale or observational data. However, rating scales are valuable adjuncts, and observations (for example, at school) are useful when there is doubt about symptoms.

- For a diagnosis of ADHD, symptoms of hyperactivity/impulsivity and/or inattention should:

- meet the diagnostic criteria in DSM5 or ICD10 (hyperkinetic disorder) and
- cause at least moderate psychological, social and/or educational or occupational impairment based on interview and/or direct observation in multiple settings and
- be pervasive, occurring in two or more important settings including social, familial, educational and/or occupational settings.

### Managing ADHD

**Note:** *The following recommendations are for healthcare professionals with training and expertise in diagnosing and managing ADHD.*

*Children aged 5 years and over and young people*

- Give information about ADHD and offer additional support to parents and carers. The support should be ADHD focused, can be group based and as few as 1 or 2 sessions. It should include:
  - education and information on the causes and impact of ADHD
  - advice on parenting strategies
  - with consent, liaison with school, college or university
  - both parents and carers if feasible.
- Offer medication for children aged 5 years and over and young people only if their ADHD symptoms are still causing a persistent significant impairment in at least one domain after environmental modifications have been implemented and reviewed they and their parents and carers have discussed information about ADHD a baseline assessment has been carried out.
- Consider a course of cognitive behavioural therapy (CBT) for young people with ADHD who have benefited from medication but whose symptoms are still causing a significant impairment in at least one domain.



### Adults

- Offer medication to adults with ADHD if their symptoms are still causing a significant impairment in at least one domain after environmental modifications have been implemented and reviewed.
- Consider non-pharmacological treatment for adults with ADHD who have:
  - made an informed choice not to have medication
  - difficulty adhering to medication
  - found medication to be ineffective or cannot tolerate it.
- Consider non-pharmacological treatment in combination with medication for adults with ADHD who have benefited from medication but whose symptoms are still causing a significant impairment in at least one domain.
  - When non-pharmacological treatment is indicated for adults with ADHD, offer the following as a minimum:
    - a structured supportive psychological intervention focused on ADHD
    - regular followup either in person or by phone.

### Dietary advice

- Do not advise elimination of artificial colouring and additives from the diet as a generally applicable treatment for children and young people with ADHD.
- Ask about foods or drinks that appear to influence hyperactive behaviour, and:
  - if there is a clear link, advise parents or carers to keep a diary of food and drinks taken and ADHD behaviour
  - if the diary supports a relationship between specific foods and drinks and behaviour, offer referral to a dietitian
  - ensure that further management is jointly undertaken by the dietitian, mental health specialist or paediatrician, and the parent or carer and child or young person.
- Do not advise or offer dietary fatty acid supplementation for treating ADHD.
- Advise the family members or carers of children with ADHD that there is no evidence about the long-term effectiveness or potential harms of a 'few food' diet for children with ADHD, and only limited evidence of short-term benefits.

### Medication

**All medication for ADHD should only be initiated by a healthcare professional with training and expertise in diagnosing and managing ADHD.**

#### Medication choice – children aged 5 years and over and young people

- Offer short acting or long acting methylphenidate as the first-line pharmacological treatment for children aged 5 years and over and young people if their ADHD symptoms are still causing a persistent significant impairment in at least one domain after their parents have received ADHD-focused information, group-based support has been offered and environmental modifications have been implemented and reviewed.
- Consider switching to lisdexamfetamine

for those who have had a 6-week trial of methylphenidate at an adequate dose and not derived enough benefit in terms of reduced ADHD symptoms and associated impairment.

- Consider dexamfetamine for those whose ADHD symptoms are responding to lisdexamfetamine but who cannot tolerate the longer effect profile.
- Offer atomoxetine or guanfacine if:
  - they cannot tolerate methylphenidate or lisdexamfetamine or
  - their symptoms have not responded to separate 6-week trials of lisdexamfetamine and methylphenidate, having considered alternative preparations and adequate doses.

#### *Medication choice – adults*

- Offer lisdexamfetamine or methylphenidate as first-line pharmacological treatment.
- Consider switching to lisdexamfetamine for adults who have had a 6-week trial of methylphenidate at an adequate dose but have not derived enough benefit.
- Consider switching to methylphenidate for adults who have had a 6-week trial of lisdexamfetamine at an adequate dose but have not derived enough benefit.
- Consider dexamfetamine for adults whose ADHD symptoms are responding to lisdexamfetamine but who cannot tolerate the longer effect profile.
- Offer atomoxetine to adults if:
  - they cannot tolerate lisdexamfetamine or methylphenidate or
  - their symptoms have not responded to separate 6-week trials of lisdexamfetamine and methylphenidate, having considered alternative preparations and adequate doses.

#### *Shared care for medication*

- After titration and dose stabilisation, prescribing and monitoring of ADHD medication should be carried out under Shared Care Protocol arrangements with primary care.

#### **Maintenance and monitoring**

- Monitor effectiveness of medication for ADHD and adverse effects.
- Ensure that children, young people and adults receiving treatment for ADHD have review and followup according to the severity of their condition, regardless of whether or not they are taking medication.
- Ensure the following are considered in monitoring:
  - Height and weight
  - Heart rate and BP
  - Tics
  - Sexual dysfunction
  - Seizures
  - Sleep
  - Worsening behaviour
  - Stimulant diversion

#### **Review of medication and discontinuation**

- A healthcare professional with training and expertise in managing ADHD should review ADHD medication at least once a year and discuss whether medication should be continued.
- Consider trial periods of stopping medication or reducing the dose when assessment of the overall balance of benefits and harms suggests this may be appropriate.
- A young person with ADHD receiving treatment and care from CAMHS or paediatric services should be reassessed at school-leaving age to establish the need for continuing treatment into adulthood. If treatment is necessary, arrangements should be made for a smooth transition to adult services. Precise timing of arrangements may vary locally but should usually be completed by the time the young person is 18 years.

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prolonged-release methylphenidate tablets

Indicated in children **aged 6 years and over** as part of a comprehensive treatment programme for Attention Deficit Hyperactivity Disorder (ADHD) when remedial measures alone prove insufficient. Treatment must be under the supervision of a specialist in childhood behavioural disorders.\*

\*Xaggitin XL treatment is not indicated in all children with ADHD and the decision to use the medicinal product must be based on a very thorough assessment of the severity and chronicity of the child's symptoms in relation to the child's age.



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