Bournemouth, Dorset and Poole Prescribing Forum

Pharmacological Intervention in Attention Deficit Hyperactivity Disorder (ADHD)

Diagnosis by a secondary care specialist (Child and Adolescent Psychiatrist or Paediatrician)

For a diagnosis of ADHD, symptoms of hyperactivity/impulsivity and/or inattention should:
– meet the diagnostic criteria in DSM-IV or ICD-10 (hyperkinetic disorder)1 **and**
– be associated with 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.
As part of the diagnostic process, include an assessment of the person's needs, coexisting conditions, social, familial and educational or occupational circumstances and physical health. For children and young people there should also be an assessment of their parents' or carers' mental health.

Treatment options

Methylphenidate, atomoxetine and **dexamfetamine** are recommended, within their licensed indications.

- When a decision has been made to treat children or young people with ADHD with drugs, healthcare professionals should consider:
  – methylphenidate for ADHD without significant comorbidity
  – methylphenidate for ADHD with comorbid conduct disorder
  – methylphenidate or atomoxetine when tics, Tourette's syndrome, anxiety disorder, stimulant misuse or risk of stimulant diversion are present
  – atomoxetine if methylphenidate has been tried and has been ineffective at the maximum tolerated dose, or the child or young person is intolerant to low or moderate doses of methylphenidate.
- Drug treatment for adults with ADHD should always form part of a comprehensive treatment programme that addresses psychological, behavioural and educational or occupational needs.
- Following a decision to start drug treatment in adults with ADHD, methylphenidate should normally be tried first.

Treatment should be initiated by *secondary care specialist*, and prescribed in line with the relevant Dorset shared care guideline (access via the extranet: nww.dorset.nhs.uk)

For further information please refer to the individual SPCs; NICE Clinical Guideline 72

Discontinuation by a secondary care specialist

For either a stimulant or atomoxetine, when improvement has occurred and the child's condition is stable, treatment can be discontinued at intervals. Monitor progress and need for continuation of therapy.

Stimulant: Where appropriate discontinue treatment at intervals, in order to assess both the child's progress and the need for continuation of therapy. (Most children can be weaned off the drug by their mid-teens and could certainly be tried on school day only medication).

GP's should make **urgent** arrangements for re-referral in the event of the following (in line with shared care): failure to thrive/retardation of growth; persistent sleep disturbance; persistent problems with poor attention; pronounced change in mental state.

Atomoxetine: no distinct withdrawal symptoms have been described. In cases of significant adverse events, it may be stopped abruptly; otherwise it may be tapered off over a suitable period of time. Treatment should not usually be discontinued during school holidays because of the time taken to achieve a full clinical response.

Transfer to adult care

Stimulant/Atomoxetine: in adolescents, whose symptoms persist into adulthood, and who have shown clear benefit from treatment, it may be appropriate to continue treatment into adulthood. A full review should be performed by the CAMHS psychiatrist or paediatrician before transferring to the care of an adult psychiatrist. This should include a trial without medication.

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