Position Statement 55
Attention Deficit Hyperactivity Disorder in Childhood and Adolescence

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Definition

Attention Deficit Hyperactivity Disorder (ADHD) is a clinical syndrome of pervasive inattention and/or hyperactivity and impulsivity in excess of that typical for developmental age that adversely affects learning, socio-emotional development and overall functioning. Studies generally show that between 2% - 5% of school-aged children have ADHD, with boys three to five times more likely to be affected. [1, 2] Symptoms and associated impairments of ADHD continue to affect the individual in adolescence and sometimes into adulthood (see www.ranzcp.org/Resources/Statements-Guidelines/Adult-ADHD-practice-guidelines.aspx). Medication and therapy can moderate symptoms, but there is no proven cure for the condition.

Evidence

ADHD is a significant family and community issue, as it is associated with higher rates of behavioural and conduct problems, accidents and injuries, school and learning difficulties, alcohol and drug abuse and family conflict.

As many as two-thirds of clinically referred children with ADHD in US studies have additional problems; 30% - 50% will have Conduct problems, and 20% - 25% will have anxiety problems [1, 3-5]. These problems are also influenced by parenting, discipline strategies, and social environment.

Comorbid disorders can make finding the proper diagnosis and the right overall treatment more costly and time-consuming [6]. ADHD with comorbid behavioural disorder will typically still respond to monotherapy with an approved treatment such as a psychostimulant or the noradrenergically active drug atomoxetine. The comorbid behavioural disorder will likely require parent behavioural management training, and in some circumstances the addition of another medication such as an alpha-2 agonist. ADHD in the presence of comorbid emotional disorder requires thoughtful selection of pharmacotherapy, and will usually require additional individual or family focussed therapy.

Research suggests that genetic and neurobiological factors contribute to the disorder. Parents and siblings of people affected by ADHD have a two to eight fold increased risk of having the condition compared with the relatives of unaffected controls [7]. Environmental factors such as maternal smoking and exposure to lead and certain pesticides make an additional small contribution to the disorder. Psychosocial adversity does not cause ADHD, but can affect the development, presentation, course and response to treatment of the syndrome [8].

Recommendations

- Symptoms of ADHD appear early in a child's life. Because many normal children may have these symptoms, but at a low level, or the symptoms may be caused by another disorder, it is important

that the initial assessment or diagnosis of ADHD is conducted by a well-qualified professional, such as paediatrician or child and adolescent psychiatrist.

- Diagnosis of ADHD should be based on a comprehensive multimodal assessment which includes accounts of the child's functioning in a variety of situations. It is important to exclude developmentally appropriate levels of inattention and hyperactivity-impulsivity. ADHD symptoms can overlap, co-occur and exacerbate autistic- spectrum disorders, learning disorders, mood and anxiety disorders, behavioural disorders, attachment disorders, sequelae of trauma, neglect and abuse. Assessment should seek to identify/ exclude this extensive comorbidity and comorbidity should be addressed in treatment planning. Psychometrics, language and developmental assessments provide additional information which may contribute to diagnostic clarification. Physical health assessment should be undertaken and neurological examination is specifically relevant in the presence of developmental delay, autistic features, neurological signs or disorder.

- Families and schools of children being treated for ADHD should be educated about the appropriate use and limitations of psychotropic medication, including possible side effects and need for non-pharmacologic treatments and behavioural management. Children with ADHD should be assessed and monitored for presence of depressive and anxiety symptoms, which may be induced or exacerbated by some treatments.

- Continuing review and monitoring of learning, socioemotional development and behaviour should occur utilising direct observation and school and family reports. Monitoring of medication, particularly efficacy and presence of side effects and effects on growth should occur at least every six months. Aims of management are to support socioemotional development, minimise behavioural disorders and to avoid polypharmacy. Coordination of services and support of primary care and school-based interventions is integral to ongoing care.

- Management of ADHD should involve the family, school and social network, and should be tailored to the needs of the individual child.

Resources

- The National Health and Medical Research Council (NHMRC) developed clinical practice points on the Diagnosis, Assessment and Management of ADHD in Children and Adolescents (http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/mh26_adhd_cpp_2012_120903.pdf).

- The Royal Australasian College of Physicians has also developed Draft Australian Guidelines on Attention Deficit Hyperactivity Disorder, which were not endorsed by the NHMRC, but are a useful reference (http://www.racp.edu.au/index.cfm?objectid=393DD54A-04C5-85AC-B35FE82BA4849595)

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