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ADHD is everybody's business

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Attention Deficit Hyperactivity Disorder (ADHD) and Attention Deficit Disorder (ADD) remains a controversial area for clinicians and patients across the world and the UK, despite evidence of effective treatment options and the likelihood of lives being changed for the better. Hence in the UK, The National institute for Health and Care Excellence (NICE), have recommended interventions for ADHD and have recently updated its guidance on diagnosis and management (March 2018). The latest iteration of the NICE guidelines specifically mentions recognition of the condition and appropriate services to diagnose and support patients with this disorder [1].

The prevalence of the condition varies across the world and one estimate suggest 5% of school-age children could suffer from the same with a significant cost burden to society [2]. With persistence of ADHD symptoms in to adulthood being posited to be as high as 78% [3], it is important the patients are supported, and clinicians are familiar with the phenotype and able to appropriately manage the significant comorbidity that exists with ADHD/ADD (http://adhd-institute.com/burden-ofadhd/epidemiology/comorbidities/).

There is on-going reluctance to diagnose this condition, due to a variety of factors (https://www.birmingham.ac.uk/research/perspective/adhd.aspx). Some consider the condition as an American import, medicalising a variance of the norm, and are concerned about the use of stimulant medication in patients, making them potentially addicted to it. However, if ADHD and ADD are not diagnosed early on, it can lead to significant morbidity and mortality [4].

Despite the condition being classically defined as neurodevelopmental disorder, it is not always the case that children can be easily diagnosed with the condition. With the revision of the DSM V criteria (symptoms now need to be evident before the age of 12 and no longer before the age of 7 as in DSM IV) [5], it is hoped parents, teachers and clinicians do not miss identifying the patients due to the above restriction. However, it is also clear to clinicians working in the field, that individuals are often first diagnosed with ADHD/ADD in adulthood. A supportive family environment would compensate for the organisational difficulties etc and problems would only become evident once the client is no longer in a structured environment and the compensation from the family is no longer possible.

It is imperative all professionals (especially mental health clinicians) have this condition in their sphere of differential diagnosis, as they could be very well faced primarily with comorbidity. Mental health services are increasingly nurse led at the front line, who are responsible in carrying out initial assessments in most teams, be this access/assessment teams, crisis and home treatment, and even in early intervention services. This article is aimed at up skilling nurses and allied health professionals such that it is easier to identify and intervene early on, for symptoms of undiagnosed ADHD/ADD.

The symptom cluster for this condition can be viewed as a specific phenotype but often masked by compensatory actions. For example, poor focus and concentration could be masked by a very high IQ and spending long hours in pursuing goals in a distraction free environment. These patients could come across as very hard working and diligent, due to numerous compensations, like repeated checking, and rechecking. Hence, they might not present with classical ADHD/ADD symptoms of repeated careless mistakes, procrastination, incomplete task completion or coming in late to work. Patients may be regarded as perfectionists due to significant increase in anxiety levels and at a cost to their social functioning. Many patients can be in very successful roles which adapt around their skill sets. They are usually blue-sky thinkers, but poor in admin or tasks they find boring and need support for mundane day to day tasks. In their social lives, they could be overwhelmed with simple tasks like paying bills, organisation of flights, shopping etc and could only manage with significant compensatory strategies, which might not be clearly evident.

Where hyperactive / impulsive symptoms have been evident in childhood, it is not uncommon to see the overt phenotype being minimised in patients who have developed an early understanding of social behaviour. However, the impulsivities might continue beneath the surface, leading to binge eating disorders, addictions (shopping, gambling, video games, alcohol, illicit drugs, sex, porn etc) and frequent changes in intimate relationships, due to extreme boredom. It is vital we delve behind the compensations to accurately highlight the true costs in juggling all the different responsibilities [6].

Looking at the recent trends in ADHD/ADD medication use [7], the prevalence of ADHD medication use among children and adults has increased over time in all countries and regions, but large variations exist. However, evidence-based guidelines need to be followed consistently in clinical practice and this might reduce this variation.

In a major 2018 Lancet psychiatry article, Samuele Cortese and co [8] looked at the comparative efficacy and tolerability of medications for attention-deficit hyperactivity disorder in children, adolescents, and adults via a systematic review and network meta-analysis. With respect to ADHD core symptoms, all drugs were superior to placebo. With respect to tolerability, in children and adolescents, only guanfacine and amphetamines were less well tolerated than placebo. In adults, modafinil, amphetamines, methylphenidate, and atomoxetine were inferior to placebo. The medications were shown to be highly efficacious. In children and adolescents, all compounds were superior

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to placebo on the Clinical Global Impression scale, except for clonidine (OR 2.78, 95% CI 0.91–8.53). In adults, amphetamines (4.86, 3.30–7.17), bupropion (3.43, 1.45–8.14), and methylphenidate (3.08, 2.04–4.65) were superior to placebo on the CGI-I scale.

A fear of using stimulant medication due to it causing increased cardiovascular and cerebrovascular adverse events has not been borne out (https://onlinelibrary.wiley.com/doi/abs/10.1111/jcpp.12036). There is incontrovertible evidence from the seminal MTA study that early treatment with stimulant medication does not lead to an increase in substance use disorder [9]. Moreover, a recent 2018 article suggested growth retardation in children might not be the case [10]. Finally, a word in terms of clients with an ADHD diagnosis in prison population. The article from Ylva Ginsberg [11] clearly highlights this significant consequence of having untreated ADHD and the impact on their trajectory of life. Also, ADHD is over represented in accidents and hence untreated ADHD has significant public health consequences as well (https://www.sciencedirect.com/science/article/pii/S1054139X04000552).

A take home message for professionals who do not deal with ADHD on a daily basis is that we need to identify these phenotypes very early on to make a significant change to the lives of our clients. We need to also trust the availability of non-stimulant/stimulant medication (along with psychological and social interventions) and the effectiveness and safety of the same.

Summary

I take this opportunity to highlight that early identification is the key which can lead to a successful outcome. The pharmacological interventions are safe and are well tolerated across the world and use of stimulants is gradually increasing across the globe. The risks with stimulants medication are usually hyped up but it is exceptionally safe, though the risk of diversion remains [12]. The latter could be minimised easily by close supervision and use of long acting stimulants. It is important clinicians recognise this phenotype and direct clients to help as soon as possible, as early intervention can change the trajectory of life [13].

Of course, there are co-morbid conditions co-existing, which can very well mask the presence of ADHD and the fact of getting prescribed stimulants is difficult in certain situations to accept. However stimulants are increasing being researched in the roles of treating depression (http://journals.sagepub.com/doi/abs/10.1177/0004867416634208) and eating disorder (https://www.researchgate.net/publication/320545167), making it increasingly more main stream.

Hence instead of vilifying ADHD, we should encourage both patients and clinician to embrace the need for immediate treatment (biological, psychological and social) and hence improve outcomes for the future. The condition is acknowledged in the UK, as a disability under the Equalites Act of 2010 and hence allows the support and adjustments needed to be put in place for clients to achieve their full potential.

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