Managing attention deficit/hyperactivity disorder: unmet needs and future directions

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The management of attention deficit/hyperactivity disorder (ADHD) requires a multimodal approach. Although shared-care protocols are suggested, uptake by general practice has been tentative. Behavioural management, both on its own and in combination with pharmacotherapy, reduces core symptoms and associated behaviours, such as oppositional defiant disorder (ODD). Links with education and social support are also important for helping children and their families. Psychostimulants have shown to be effective in the treatment of ADHD, however, their short duration of action highlights potential limitations. Other drugs used in the management of ADHD and comorbid disorders include antidepressants, clonidine and its analogues, newer atypical neuroleptics, and atomoxetine, a novel, non-stimulant therapy that has potential to fulfil some unmet treatment needs. Further research is needed in preschool children, girls, those with epilepsy, young adults, and in those with associated sleep disturbance. Selected rating scales and careful history taking, allied to close links with schools, are vital for the initial and ongoing assessment of ADHD and its comorbidities.

This article aims to provide an overview of current treatments for attention deficit/hyperactivity disorder (ADHD) and comorbid disorders from the perspective of a UK based clinician who, in common with many colleagues, sees and manages large numbers of children and young people with this challenging condition. The evidence base is discussed where relevant, highlighting gaps in knowledge, treatment provision, and research. The paper is not intended as an in-depth review of evidence based technologies, but seeks to complement other articles in this supplement.

ADHD represents a common developmental disorder of children and young people, often persisting into adulthood. Comorbid problems are common,1,2 therefore long term management invites a so called “multimodal” approach that helps to reduce ADHD symptoms, but also allows treatment of these associated areas of difficulty (figs 1 and 2). The cornerstones of long term multimodal management are:

- “Psychoeducation”—information, explanation, and counselling about ADHD for children, parents, and others.

...
strong evidence base, and can be taught for home and school use. In comparison, individualised cognitive behavioural therapy does not appear to be as effective.

Following the Multimodal Treatment study of ADHD (MTA) there was a risk that behavioural treatments for ADHD would be downgraded in importance, or even abandoned. However, there were significant improvements in the behavioural treatment arm of this study, and when used alongside pharmacotherapy, “combined” treatment was more acceptable to parents and allowed lower doses of medication. Other social, behavioural, and educational gains were also seen, emphasising the importance of “multimodal” management. Adherence to “combined” treatment, avoiding the temptation for parents to neglect behavioural approaches and become too reliant on medication (“Doctor, your pills aren’t working!”), is less likely if adequate time is invested in psychoeducation. Recent research does, however, add fuel to the debate regarding the relative importance of pharmacotherapy versus behavioural and other supports for ADHD. A two year, dual centre, randomised study of 7–9 year old children with methylphenidate responsive ADHD found no “extra” improvement in behaviour, academic, social and emotional adjustment, or parental practices following intensive add-on multimodal psychosocial treatments.

Further studies of similar design would be of considerable interest to examine these important questions further.

Behavioural support for ADHD is expensive, time consuming, and potentially burdensome for many children and families and, in practice, compliance and adherence are often poor. The evidence base for effectiveness remains significantly weaker than for medication approaches.

**SOCIAL SUPPORT AND COMMUNITY INTERVENTION**

On a day to day basis, the families of children and young people affected by ADHD are subjected to considerable stress and pressure associated with the disorder, particularly when ODD or conduct disorder are also present. Families show differing capacities to cope and this often changes over time. Provision of support beyond both the extended family and friends frequently forms an important part of multimodal management. The need for social support must be considered on an individual basis and may include befriending, self help groups, respite, and financial help. All too often in clinical practice in the UK we witness a shortfall in such provision; we need to continue to press for and advocate increased support.
Quality.27 Over time, however, a sufficient number of boys and girls (fig 3). Reports suggest that the pattern of ADHD within the school setting, particular attention may need to be paid to girls (fig 3). Furthermore, where necessary they can advocate on behalf of individual children. Within the school setting, particular attention may need to be paid to girls (fig 3). Reports suggest that the pattern of ADHD girls in association with intellectual impairment, lower levels of hyperactivity and less challenging behaviour; thus there is a risk of these children being ignored or overlooked because they are not causing trouble in classes.24 25 Lastly, children and young people should be afforded adequate privacy within the school environment for receiving their medication. Anecdotal evidence suggests that this is not always the case, with potential for embarrassment, increased anxiety, and reduced compliance.

PHARMACOTHERAPY

Psychostimulants

Research into the effectiveness and safety of psychostimulants is distinguished overall by quantity26 rather than quality.27 28 Over time, however, a sufficient number of studies of adequate design have provided strong evidence that short acting stimulants are effective in reducing core ADHD symptoms and that side effects are predictable and seldom serious.3 29 30 Although long term, placebo controlled studies are not feasible, there is some evidence that behavioural and cognitive gains are sustained over the longer term.31 32 33 Accordingly, at the time of writing, NICE (2000) and SIGN (2001) guidelines recommend stimulants as “first line” treatment for core ADHD symptoms in children and young people.4 They approach is also supported by the recently upgraded European Guidelines for the management of Hyperkinetic Disorder.35

The limitations of currently available short acting stimulant preparations are well documented.3 34 35 These include appetite suppression, potential long term growth concerns,36 insomnia, headache, dizziness, and abdominal pain. Less frequent side effects include anxiety, irritability, proneness to crying, and emergence of, or increase in, motor tics. Stimulant side effects are generally predictable and often relatively minor. If present, they can be tolerated by some children over a number of years.37 However, in other children (probably up to around 30%) medication will prove to be ineffective, or side effects will lead to withdrawal of treatment.

Compliance with short acting stimulants may be adversely affected by the requirement for multiple dosing through the day;37 additionally, observed “acute tolerance” results in potential loss of effectiveness and a need to give larger doses (for example, at lunchtime and late afternoon).38 Practical problems with regard to storage and administration of medication in school, concerns about diversion of medication supplies, and pupil embarrassment all contribute to a risk of medication being missed. Other relevant and potentially important treatment gaps occur in the early morning before medication is given or can take effect, and in the evening, when the re-emergence of ADHD behaviours has a particular impact on life and relationships at home. Abuse potential with stimulants looms large in the media, but it is infrequent, and has been overstated. Indeed, evidence strongly suggests that long term stimulant treatment may be a protective factor against substance abuse in adolescence and early adulthood.39 Unfortunately, parental, public, and professional concern regarding stimulant use remain, as does the dismissal of ADHD as a valid diagnosis.40 Consequently, the so called “Ritalin Wars” continue.41 Robust media skills are important if clinicians are to convey the importance of early recognition and proper management of ADHD, backed by reasoned scientific argument.42 43

Sustained release methylphenidate preparations available in the UK include an osmotic controlled release formulation (OROS-methylphenidate (Concerta XL)), and beaded release system (Equasym XL; currently only available on a special license basis). These products offer advantages over their short acting equivalent, with evidence of equal efficacy and tolerability in clinical trials.38 45–47 The pharmacokinetic profiles of the two preparations differ,48 with more methylphenidate released early in the day with the beaded release preparation and more available later in the day with the osmotic preparation. Once-daily dosing removes the requirement to seek and receive medication in school, removing much potential embarrassment and stigma,49 it is also likely to improve compliance. Moreover, issues surrounding storage, safety, and diversion in school are also removed. Unfortunately, the efficacy and advantages of these medications do not extend beyond a maximum of 8–12 hours. Thus, treatment gaps remain in the early morning and evening, and the risk of disrupted sleep persists.

Other drugs used in the management of ADHD and comorbid disorders

In the UK, tricyclic antidepressants (TCAs) are presently recommended as a second line treatment for the reduction of ADHD symptoms in patients where stimulants are ineffective or poorly tolerated.50 Extensive use has possibly been limited because of concern about side effects and potential cardiotoxicity, reflecting the narrow therapeutic index of this class of drugs.51 A number of alternative medications have been investigated for effectiveness in ADHD management; those most frequently used in clinical practice are summarised in table 1. Comorbid disorders, such as anxiety, depression, tics, and/or poor response to stimulants or TCAs, support consideration of these drugs, albeit mostly “off license” either as monotherapy or as part of rational combined treatment under relevant specialist supervision.52 The use of...
selective serotonin reuptake inhibitors (SSRIs), risperidone, and atomoxetine deserves special mention.

The paediatric use of SSRIs in the UK is now restricted to the prescription of fluoxetine, at a time when the evidence base and role of this class of medication for the treatment of depression (often comorbid with ADHD) is being questioned.63–65

Although there are no systematic studies of the atypical neuroleptic risperidone for the treatment of ADHD, anecdotal evidence suggests that it is used by clinicians in many specialist centres, particularly for treating aggression in ADHD, Tourette’s Syndrome, and for children with autism. Such use is supported by an increasing number of controlled trials.54–55

The use of atomoxetine, a novel, non-stimulant, noradrenergic reuptake inhibitor is discussed more fully elsewhere in this supplement. Trial evidence and clinical experience in the USA supports the effectiveness of atomoxetine in reducing ADHD symptoms in children and adolescents, with benefits that include once-daily dosing, “whole day” action, and positive effects on mood, anxiety, and sleep. Recent studies have shown that a once-daily dose of atomoxetine can offer symptom relief late into the evening and the following morning.60 This continuous symptom relief promises to close some of the treatment gaps referred to earlier in the discussion of stimulant therapy. Furthermore, this broader efficacy may have an associated positive impact on self esteem, and social and family functioning, without a requirement for combined treatments.54–65 Atomoxetine was approved by the US Food and Drug Administration in November 2002 for treatment of children, adolescents and adults with ADHD, and was licensed for use in the UK in May 2004.

**Table 1** Alternative medications for ADHD and comorbid disorders in children and young people

<table>
<thead>
<tr>
<th>Medication</th>
<th>Putative mechanism</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clonidine, guanfacine, and lofexadine</td>
<td>Alpha-noradrenergic agonists (Guanfacine and lofexadine are less sedating)</td>
<td>Limited studies, some when in combination with methylphenidate. May be useful for tics, aggression, and sleep problems.16–18</td>
</tr>
<tr>
<td>Buproprion</td>
<td>Dopamine/noradrenaline agonist</td>
<td>Very limited studies. Antidepressant effects; risk of seizure exacerbation.19–21</td>
</tr>
<tr>
<td>SSRIs</td>
<td>Serotonin reuptake inhibition</td>
<td>Limited studies in ADHD with comorbid depression. Now limited to fluoxetine in the UK (see text).22–24 Beware of increased agitation with fluoxetine.</td>
</tr>
<tr>
<td>Venlafaxine</td>
<td>Serotonin/noradrenaline reuptake inhibition</td>
<td>Very limited studies. Possible indication for comorbid mood and anxiety.25</td>
</tr>
<tr>
<td>Risperidone</td>
<td>Dopamine receptor blocker</td>
<td>No studies in ADHD, but supported by RCPCH’s Medicines for Children. Emergent literature supports effectiveness for control of aggression, tics, and in autism (see text). Appetite stimulation and weight gain common.</td>
</tr>
<tr>
<td>Atomoxetine</td>
<td>Long acting selective noradrenergic reuptake inhibition with parallel effects on prefrontal cortex dopamine pathways</td>
<td>Recent placebo controlled studies (see text). Positive effects on mood, anxiety, and sleep possible. Slow onset of action but 24 hour effect.</td>
</tr>
</tbody>
</table>

SSRI, selective serotonin reuptake inhibitor. Please note that all medications noted above are currently unlicensed for use in ADHD, although a UK license for atomoxetine was granted in May 2004.

Studies of dietary effects on behaviour pose significant methodological challenges and at the present time it would be inappropriate, for example, to extrapolate results obtained in preschool children and apply them to the general older population of children and young people with ADHD.67 The same scientific rigour applied to research into medications needs to be applied to dietary research.

The prospect of long term medication, however, continues to make many patients uneasy and results in a search for treatments perceived as “natural”, or “safer” than drugs.68 Special diets require extra work and often expense for a family who may already be hard pressed on account of their child’s behaviour. Taking into account the present paucity of evidence and the difficulty often experienced in persuading children and adolescents to comply with restricted diets, dietary management is not recommended, except possibly in a relatively small number of preschool children; in some of this age group, a diagnosis of ADHD may not in any event have been definitely confirmed. If so persuaded, for example, in response to parental pressure, and in some cases motivated by a need to maintain trust and a “therapeutic alliance”, a food diary approach allied to regular review can be helpful to identify those children in whom continuing dietary manipulation is justified.69 This is an area where fads abound, but where further large scale unbiased study is necessary to inform future practice.

**OTHER CHALLENGES IN ADHD MANAGEMENT IN CHILDREN AND YOUNG PEOPLE**

ADHD typically begins in early childhood, but unfortunately it has not been widely studied in preschool children. Increased attention to accurate and early diagnosis may improve long term outcome. There is also increasing evidence for effectiveness of neurostimulants in ameliorating core symptoms in this age group, at a time when medication remains off license for children under 6 years of age.69–71

Further research and treatment guidance for this age group is needed.

In addition to showing a complex association with behavioural and learning difficulties, children and young people with epilepsy also show increased rates of reported ADHD symptoms.72 Potential contributions include psychological adjustment to epilepsy, learning difficulty, anti-epileptic drug effects, and the type of underlying epilepsy or...
brain disorder. This is an area of clinical practice that would benefit considerably from more research and treatment guidance. Present evidence does not indicate that neurostimulants should be withheld from patients with epilepsy and confirmed ADHD.72

For adolescents and young adults who outgrow paediatric clinics, there is a national shortage of adequate diagnostic and treatment facilities for ADHD, in spite of strong evidence for the persistence of this disorder into adulthood and the value of ongoing treatment, including medication.71 72 It is incumbent on our colleagues in adult services to make good this shortfall as a matter of urgency. Previously, there were no licensed medications for the management of adult ADHD. However, atomoxetine is licensed for adults, as well as children and adolescents, and offers treatment across the lifespan.

Sleep disturbance, although not a diagnostic requirement, is common in ADHD, with a prevalence of up to 50%.75 Recent studies stress the variability and instability of sleep in ADHD, noting that reported difficulties are multifactorial, resulting from behavioural and psychological effects, such as ODD, anxiety, mood disorders, and potential medication effects associated with prescribed neurostimulants.76–80 In practice, neurostimulants may need to be reduced or discontinued in the face of persistent insomnia. It is important to take time to identify the pattern and causes of sleep problems in individual cases to allow the most appropriate and effective treatment.81–83 Evidence based treatment guidelines for the management of sleep in ADHD are lacking at present.

HOW ADHD IMPROVEMENTS ARE MONITORED AND ASSESSED

At initial outpatient review, any changes in ADHD and associated behaviours as a result of treatment are often very clear (one way or the other) by observing general appearance, demeanour, and interaction—particularly between child and parents.84 Further careful history taking is, however, necessary for clarification, supplemented by selective use of appropriate rating scales. When time allows, these can be useful for patient monitoring, audit, and accountability, but they are not a substitute for clinical intuition, experience, or history taking.85

Although there are many to choose from,86 frequently used rating scales based on DSM-IV criteria include the ADHD Rating Scale (ADHD-RS),87 88 and Conners’ Parent and Teacher Rating Scales revised versions.89 90 Conners’ Scales also allow exploration of other domains including oppositionality, learning difficulties, somatic symptoms, socialisation, and anxiety. A similar range of extended difficulties can be identified using the “Strengths and Difficulties Questionnaire”, popular in the UK.91

Other diagnostic and monitoring questionnaires are increasingly used in research to examine broader issues such as physical, emotional, and social wellbeing, including self esteem and family function. The use of devices that attempt to address these questions promises to significantly increase our insight into the overall impact of ADHD and its management on the quality of life for both children and their families. Examples include the Child Health Questionnaire,92 Child Health and Illness Profile-Child Edition (CHIP-CE),93 Harter Self Esteem scale,94 and a new rating scale under evaluation, the Daily Parent Rating of Evening and Morning Behaviours-Revised (DPREMB-R), which addresses specific behaviours in the evenings and early mornings.95

Successful completion of ongoing trials, such as the multicentre Attention Deficit hyperactivity disorder (ADHD) for child, family, and professionals.96

CONCLUSIONS

A summary of the key points from this paper is shown in box 2. Briefly, proper “psychoeducation”, allied to properly resourced multiagency and “multimodal” management remain pivotal if long term outcomes in ADHD are to improve.9 It is also important to avoid regarding currently available pharmacological approaches as a single or satisfactory solution to complex difficulties, focusing on the relief of daytime core ADHD symptoms, particularly in school. Significant treatment gaps persist, even with adequately applied multimodal approaches. In the future, a broader approach to symptom control (for example, through advances in psychopharmacology) to provide extended treatment effects, alongside consistent behavioural approaches may prove more effective and lead to further improvements in self esteem, social relationships, family functioning, sleep patterns, and overall quality of life. Continuing audit and good quality research will help to make this happen. There is a huge need for more UK based research into ADHD, at a time when recommendations for the management of hyperkinetic disorder in Europe are beginning to resemble more closely approaches to ADHD management in North America. Increased networking and collaboration between centres and clinicians with an interest and expertise in ADHD, from child and adolescent mental health services and paediatrics, would help to generate research of adequate power and quality in the future. Enhanced training opportunities, such as the recent popular
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