NHS
North West London

Adult Attention-Deficit/Hyperactivity Disorder (ADHD) Assessment and Treatment

Service Specification

between

NHS North West London Integrated Care Board

and

Any Qualified Provider

January 2024

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National context

Attention deficit hyperactivity disorder (ADHD) is a neurodevelopmental condition characterised by core symptoms and persistent patterns of inattention and/or hyperactivity and impulsiveness. NICE Clinical Guidelines NG87[1] defines the condition as:

"Attention deficit hyperactivity disorder (ADHD) is a heterogeneous disorder characterised by the core symptoms of hyperactivity, impulsivity and inattention, which are judged excessive for the patient's age or level of overall development. The diagnosis is made on the basis of observed and reported behavioural symptoms. Two main diagnostic systems are in current use, the International Classification of Mental and Behavioural Disorders 10th revision (ICD-10) and the Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM-5). Both systems require that symptoms are present in several settings such as school/work, home life and leisure activities. Symptoms should be evident in early life, if only in retrospect; for ICD-10, by age 7 years and for DSM-5, by age 12 years. ADHD may persist into adult life."

ADHD is under-diagnosed and under-treated. There is no specific mention of expectations around adult ADHD diagnosis and treatment in the NHS Long Term Plan. It can cause significant functional impairment in over half of people into adulthood. There are a range of adverse outcomes as a result of untreated ADHD including long term personal, social, health and economic costs. People with ADHD are:

- More prone to accidents
- Have a higher mortality rate compared to the rest of the population, including increased risk of suicidality
- Are more likely to be involved with the criminal justice system and/or substance misuse
- Have higher rates of unplanned pregnancy
- More likely to experience academic failure
- Have difficulty coping with daily tasks
- More likely to be unemployed or have employment difficulties
- More likely to have lower self esteem
- More likely to experience mood instability
- More likely to experience difficulties with interpersonal relationships

Many adults, children and their families living with ADHD may have developed a range of coping strategies which may work for them. However, there are occasions where these strategies fail, and this is when they and their families seek help. They may struggle with the following:

- Being able to concentrate for longer periods
- Forgetfulness and short-term memory issues
- Being disorganised
- Have difficulty maintaining daily routines
- Impulsive behaviour which is often interpreted by others as being thoughtlessness
- Impulsive and angry outbursts
- Low self-esteem which can lead to depression
- Poor social skills
- Poor time management
- Feeling overwhelmed by everyday tasks
- Difficulty moving from planning a task to 'doing' a task
- Having trouble completing a task

[1] Overview | Attention deficit hyperactivity disorder: diagnosis and management | Guidance | NICE

Treatment includes medications, talking therapies and treatment for any mental health conditions that occur along with ADHD. Psychiatric comorbidity is common in the adult ADHD population. Common co-existing conditions in adults include personality disorders, bipolar affective disorder, obsessive-compulsive disorder and substance misuse.

Local context

ADHD in the UK has a prevalence rate of just over 3-4% of the general adult population. Traditionally it was thought that prevalence was more common in males, however, based on current referral patterns for females this appears to be changing. For North West (NW) London this would equate to approximately 32,000 adults. Waiting times for assessment in NW London have increased in the past few years with demand mirroring the lengthy waiting times across London and the country. Most services have a lengthy waiting list and/or have to close their services to new referrals for a period of time. Demand from young adults in particular is evident and patients are exercising their 'Right to Choose'[2], most significantly in Hammersmith & Fulham from patients registered with 'GP at Hand'. Over 2,000 assessments in total were carried out in NW London in 2022/23 by a range of providers but with many more left waiting.

This service specification sets out to ensure that every provider of adult ADHD assessment, treatment and follow up operating in NW London has an agreement with the ICB and clear standards and expectations set out on service quality requirements. The intention is to stimulate and support a mixed provider market so that patients have access to the best quality and most appropriate service with parity of offer. It offers the possibility for providers to work together to offer a combination of coordinated services to patients and better meet demand. As per National Health Service (Procurement, Patient Choice and Competition) (No2) Regulations 2013, services must be consultant led, referral made by a GP and deemed clinically appropriate.

Aims and objectives of the service

- To provide a specialist assessment and diagnostic service to adults with a suspected ADHD registered with a GP within Brent, Hillingdon, Harrow, Westminster, Kensington & Chelsea, Hammersmith & Fulham, Ealing and Hounslow as defined by the ICB commissioning boundaries, aligned to Who Pays[3] guidance.
- To enable adults with suspected ADHD to obtain a timely diagnosis of their condition.
- To prioritise those cases where the impact on daily functioning including academic attainment, relationships and employment outcomes is most impacted.
- To provide virtual and/or face to face clinics, for the review and ongoing treatment of complex and non-complex patients, to include prescribing and monitoring.
- To signpost patients with ADHD to other agencies and sources of support as appropriate including local and national support organisations and cognitive behavioural therapy for ADHD
- To provide guidance on self-help strategies and recommendations for patients in support of self-care.
- To signpost patients with an unconfirmed diagnosis to appropriate local services and support networks where practicable.

[2] Your choices in the NHS - NHS (www.nhs.uk)
[3] NHS England » Who Pays?

NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	✓
Domain 2	Enhancing quality of life for people with long-term conditions	✓
Domain 3	Helping people to recover from episodes of ill-health or following injury	✓
Domain 4	Ensuring people have a positive experience of care	✓
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	✓

Locally defined outcomes

- Minimise patient waiting time; diagnosis and treatment would take place within 18 weeks from the date of referral and 12 weeks from pre-assessment.
- Timely assessment, diagnosis and prescribing of medication in order for individuals to feel more in control of their life.
- To provide a structured and supportive psychological intervention or psycho education focused on ADHD where the need for medication is not indicated.
- To provide advice and guidance on self-help strategies and recommendations for patients in support of self-care.
- To provide advice and guidance on strategies to support patients, families and education settings who support the patient on a day-to-day basis.
- Signposting to organisations/support networks to enable patients to access the right support.

Exclusion criteria

- Those under 18 years of age.
- Those who are not registered with a GP that falls under the geographic area of NW London ICB.
- Those with a moderate to severe learning disability.

Location of work

The Service must be accessible, offering patient choice of face to face or virtual (camera on) appointments where practicable and depending on complexity of presentation (see pre-assessment triage).

The Service shall offer bookable appointment slots and use an appropriate electronic appointment booking system and confirm the date, time with the patient, parent/carer once booked. Reminder texts shall be provided, with consent, prior to the appointment. DNAs shall be reported to the referrer and the patient's GP and another appointment will be offered.

Where the Service cancels the appointment, this shall be rebooked as appropriate with the patient.

Operational hours

The Service shall inform the ICB of the days and times of the service's working hours. Service delivery changes shall be communicated to the ICB with immediate effect.

Service scope

The Service shall provide:

- A single point of access for all referrals to be submitted on the standard NW London ADHD referral form in primary care systems by email or via a secure portal aligned to data protection requirements as defined in the wider contract.
- An assessment and diagnosis service to support patients with suspected ADHD and those with a diagnosis of ADHD to include prescribing which is NICE compliant.
- A treatment plan personalised for the patient including:
    - ADHD medication as appropriate
    - A structured and supportive psychological intervention focused on ADHD where the need for medication is not indicated. Service users will also have a choice of psychological approach as a first step rather than medication
    - Advice and guidance on self-help strategies.
    - Signposting to organisations/support networks to enable patients to access the right support
- The Service shall aim to complete an assessment within 18 weeks of receiving a referral for an individual and within 8-12 weeks if the patient is a priority case.
- Feedback on the outcome of the consultation to the GP and patient in the form of a letter, to include recommendations for the patient in support of self-care, appropriate care interventions and possible additional needs and onward referrals to local services to be considered.
- Prescribing of drugs for the central nervous system in line with the NW London Adult ADHD guidance for GPs (Appendix 2).
- The Service shall be required to undertake Shared Care in relation to prescribing medication with the patient's GP, the service will need to facilitate the patient's GP in following the NW London guidance (Appendix 2). The Service will support and guide primary care clinicians for medication queries and prioritise these patients. There will be clear contact information and offer to GPs. As part of shared care the GP is required to undertake annual medication reviews including physical health monitoring.
- The Service will continue to hold clinical oversight of the patient's diagnosis and any treatment the service undertakes until the patient is passed to their GP with mutual agreement.
- The Service will work collaboratively with other providers of adult ADHD assessment and treatment operating in NW London to ensure no duplication of activity/waiting lists and that patients who are known to secondary mental health care services are supported in the service most able to meet their overall needs.

Referrals

The Service shall accept referrals from:

- General Practitioners on the standard NW London ADHD referral form.
- Secondary healthcare/ A&E psychiatric liaison teams.

The Service is required to collate detailed development information from birth through early and later childhood (utilising a Childhood Screening Questionnaire) and if relevant into adulthood. This must therefore be clearly stated on referral forms.

It is expected this referral information will include:

- Contact details for the patient's GP and confirmation they are a patient registered with a GP in the NW London ICB boundary.
- The patient's history including current medications.
- Childhood Screening questionnaire to confirm lifelong symptoms (more useful than general screening questionnaires).
- If the patient is known to secondary mental health care.
- Any risk issues or areas of particular high need related to the possible diagnosis warranting prioritised referral.
- A notification if the patient poses a risk to others. For example, those involved with the criminal justice system, or who are under Multi-Agency Public Protection Arrangements, Care and Treatment Orders etc.
- A questionnaire of global functioning (to support prioritising of cases).
- A copy of the patient's crisis plan if in place.
- Any other relevant information available e.g. Education Health and Care Plans (EHCPs), Occupational Therapy reports.
- Baseline investigations including pulse, BP, BMI, ECG and bloods - FBC, U+E, LFTs, TFTs (these may be forwarded by the GP after the referral has been accepted for funding).

The Service provider is expected to offer a **pre-assessment triage service.** which will:

1. Ensure the above information is complete before proceeding with the assessment pathway. The following factors will be considered:
    - There are enough clinical indicators that a full diagnostic assessment is indicated i.e. that there are several features suggestive of ADHD such as difficulties with attention, hyperactivity or impulsivity
    - That these are lifelong developmental issues
    - The difficulties the patient is experiencing have a sufficient impact on their level of functioning to be a barrier to daily living e.g. attaining academic qualifications and/or employment and sustaining interpersonal relationships

2. Patients with the highest need or risk are prioritised for assessment. Factors to consider may include the following, though this remains a clinical decision:

    - Patients already known to secondary mental health services
    - Patients who have been known to CAMHS
    - Pregnant women
    - Patients known to NHS Talking Therapies
    - Patients aged 18-25 years
    - Patients who have previously been diagnosed with ADHD and need to have their medication reviewed or restarted including patients diagnosed abroad (these patients need less assessment time so can be seen more quickly)
    - Patients who are transitioning from childhood to adulthood and who need a review
    - Patients who have previously been diagnosed by independent providers who have self-funded or who have been discharged by that provider prior to this specification been in place
    - Patients who have several of the presenting factors below that increase severity of presentation:
        - Patients who are at high risk of losing their education or employment because of their symptoms
        - Patients whose close relationships or social circumstances are severely affected by their symptoms
        - Patients whose mood is severely affected by their symptoms or who are considered at risk of harm to self or others as a result of their symptoms
        - Patients whose presentation is complex due to co-morbid conditions including neurodevelopmental disorders or substance misuse
        - Patients where there are safeguarding issues related to their symptoms including where an adult's diagnosis of ADHD is impacting dependent children or vulnerable adults in their care or where their ADHD is contributing to them being vulnerable to abuse from others

3. Where cases are of a more complex nature and/or there is a co-existing mental health need that may be present, these patients should receive a face to face assessment. Where there are no such concerns related to a patient (lower clinical risk/complexity) and when they may benefit from an online psychoeducational approach then these patients may be assessed virtually.

4. Where relevant: request information about presentation and need from their education provider.

5. Where relevant: request a statement from the person who knows the patient best providing information about presentation and need. This may not be needed if this person is able to attend the assessment with the patient.

A significant proportion of those treated in childhood for ADHD will require on going treatment at 18yrs+ though this requirement tends to decline with increasing age. There must be sufficient attention given to robust transition between childhood and adult treatment services for those who

level of need remains high at 18yrs of age. Where these needs are complex, including other co-morbidities, transition to adult community mental health services rather than to an adult ADHD only service may be appropriate to ensure holistic care.

Assessment and diagnosis

The Service will offer sufficient direct clinical time with the patient to obtain detailed developmental information and make in-consultation observations.

The Service will follow a semi-structured interview process which avoids closed questioning.

The Service will be delivered aligned to NICE guidance.

The Service is required to provide a clear formulation and reason for the diagnostic outcome.

The Service must allow sufficient time for the patient to reflect on the diagnostic outcome prior to treatment/ support.

Impairment

The Service is required to establish if at least a moderate level of impairment is present. The level of impairment is a key factor in confirming neurodevelopmental diagnosis. Without impairment (even when symptom criteria are met) diagnosis should not be confirmed. Providers are required to identify at least a moderate psychological, social and/or educational or occupational impairment and it must be related to the diagnosis considered. e.g. for an ADHD diagnosis the impairment seen needs to be ADHD related and not for example relationship related.

Symptom Overlap

Symptom Overlap is known to be high (differential diagnosis), and the service will deliver an in-depth assessment as required to produce a differential diagnosis.

a) A careful developmental history is important to distinguish between symptoms such as Autism and Reactive Attachment Disorder.
b) ADHD Symptoms are highly prevalent in the general population and are also seen in other conditions including mood disorders, personality disorders and other neurodevelopmental disorders.

Comorbidity and dual diagnosis

The Service is expected to recognise that a range of comorbidities (including dual diagnosis of ADHD, mental health issues and/or substance misuse) may be present and any associated clinical risks with starting on medication and/or safeguarding concerns:

a) Mental health disorders e.g. mood or personality disorders, other neurodevelopment disorders. Diagnoses are often first seen in educational settings e.g. dyslexia and developmental coordination disorder, and consideration should also be given to a growing number of possible medical comorbidities such as hypermobility.

b) Certain comorbid conditions that need treating prior to assessment e.g. Bipolar affective disorder to ADHD treatment commencing.

c) If someone is diagnosed with ADHD and comorbid Autism, the titration of medication is usually different i.e. 'a start low and go slow' process should be followed. Therefore, it is

important that comorbidities are considered to ensure medication is prescribed in the safest possible way.

d) Substance misuse, which will not be an exclusion to assessment.

Note that the Service is not expected to take a lead role in care coordination in instances of co-morbidity, this will be carried out by the most appropriate service and in the majority of cases this will be the community mental health team.

Interdependency with other services

It is recognised that patients may have other co-morbidities e.g. anxiety which may need separate treatment and may be suspected during the diagnostic assessment this may include:

1. Academic/educational needs e.g. dyslexia
2. Other neurodevelopment conditions e.g. autism
3. Mental health needs e.g. anxiety
4. Physical health conditions e.g. hyper-mobility
5. Substance misuse

Where this is suspected, the Service is expected to document this in their final report back to the GP and/or referrer. The Service is expected to work alongside a range of other services and agencies to provide advice and support to colleagues to enable other teams and services to work effectively with patients who have a diagnosis of ADHD.

These will include:

- Community mental health teams (MINT and Community Mental Health Hubs), including Crisis Teams and mental health trust single points of access.
- Pharmacists
- Primary Care
- Talking Therapies services
- Substance misuse services
- Social Care teams
- VCSE organisations
- Independent Sector agencies

Treatment

Prior to treatment and support the Service shall provide essential psychoeducation.

Before starting any treatment for ADHD, the Service shall discuss the following with the patient, and their family or carers as appropriate:

- Clarification of all the treatment/support options available.
- The benefits and harms of non-pharmacological and pharmacological treatments (for example, the efficacy of medication compared with no treatment or non-pharmacological treatments, potential adverse effects and non-response rates).

- The benefits of a healthy lifestyle, including exercise.
- The service user's preferences and concerns (it is important to understand that a patient's decision to start, change or stop treatment may be influenced by media coverage, teachers, family members, friends and differing opinion on the validity of a diagnosis of ADHD).
- What another mental health or neurodevelopmental conditions might mean for treatment choices.
- The importance of adherence to treatment and any factors that may affect this (for example, it may be difficult to take medication at school or work, or to remember appointments).

The Service shall consider non-pharmacological treatment for adults with ADHD who have:

- made an informed choice not to have medication;
- difficulty adhering to medication; and/ or
- found medication to be ineffective or cannot tolerate it.

When non-pharmacological treatment is indicated for adults with ADHD, this must be clearly indicated in the report and treatment made available to the patient at that time or at a later stage if preferred. It is important that patients are made aware that if they wish to pursue a change to their treatment plan in the future, they can discuss that with their GP and have a follow up appointment arranged with the specialist service.

When non-pharmacological treatment is offered this should be:

- a structured supporting psychological intervention focused on ADHD; and/ or
- regular follow-up either in person or by phone.

Treatment may involve elements of or a course of CBT. Where a patient has co-existing anxiety and depression referral to NHS Talking Therapies may be appropriate.

Before starting medication for ADHD, patients with ADHD shall have a full assessment, which should include a review:

- To confirm they continue to meet the criteria for ADHD and need treatment
- Of mental health and social circumstances, including:
    - presence of coexisting mental health and neurodevelopmental conditions;
    - current educational or employment circumstances;
    - risk assessment for substance misuse and drug diversion; and
    - care needs.
- Of physical health, to be obtained from their GP (who will have pre-approved their input at the point of referral). This should be requested from the GP 6-8 weeks prior to assessing the patient to ensure that the results are current and up to date if the patient has been waiting longer for assessment. It will include:
    - a medical history, taking into account conditions that may be contraindications for specific medicines;
    - current medication;

- height and weight (measured and recorded against the normal range for age, height and sex);
- baseline pulse and blood pressure (measured with an appropriately sized cuff);
- a cardiovascular assessment; and
- an ECG if the treatment may affect the QT interval.

Following a diagnosis of ADHD, there shall be a structured discussion with patients (and their families or carers as appropriate) about how ADHD could affect their life. This could include:

- The positive impacts of receiving a diagnosis, such as:
  - improving their understanding of symptoms;
  - identifying and building on individual strengths; and
  - improving access to services.
- The negative impacts of receiving a diagnosis, such as stigma and labelling.
- A greater tendency for and risks of impulsive behaviour.
- The importance of environmental modifications to reduce the impact of ADHD symptoms
- Education issues (for example, reasonable adjustments at college).
- Employment issues (for example, impact on career choices and rights to reasonable adjustments in the workplace).
- Social relationship issues.
- The challenges of managing ADHD when a patient has coexisting neurodevelopmental or mental health conditions.
- The increased risk of substance misuse and self-medication.
- The possible effect on driving (for example, ADHD symptoms may impair a patient's driving and ADHD medication may improve this; patients with ADHD must declare their diagnosis to the DVLA if their ADHD symptoms or medication affect their ability to drive safely).

This structured discussion should inform the shared treatment plan.

The Service shall provide a report and treatment plan to those diagnosed with ADHD (and their families and carers as appropriate) having followed the content of diagnostic assessments defined in Appendix 1. The plan will be in a form that:

- Takes into account the patient’s developmental level, cognitive style, emotional maturity and cognitive capacity (referral exclude patients with moderate to severe learning disabilities, but the service will accept patients with mild learning disabilities), sight or hearing problems, delays in language development or social communication difficulties.
- Takes into account any coexisting neurodevelopmental and mental health conditions.
- Is tailored to their individual needs and circumstances, including age, gender, educational level and life stage.
- Gives guidance and strategies that the patient, referrer, family and education provider could make to support the patient in their day-to-day life.

Patients who receive a diagnosis of ADHD (and their families or carers as appropriate) will be pointed to national information available about sources of information and where the ICB has provided local area information this will be provided. All young adults up to the age of 25 with a diagnosis will fall under the Special Education Needs and Disabilities umbrella and so should be signposted to their borough's Local Offer website for further information on support and services available.

Patients who have had an assessment but whose symptoms and impairment fall short of a diagnosis of ADHD may benefit from similar information, this should be provided at the discretion of the service.

Care planning

The Service will record the patient's preferences and concerns in their care and treatment plan.

The Service shall ensure that patients with a diagnosis of ADHD have a comprehensive, holistic shared treatment plan that addresses psychological, behavioural and occupational or educational needs. Taking into account:

- The severity of symptoms and impairment, and how these affects or may affect everyday life (including sleep).
- Their goals around education, employment, relationships etc.
- Their resilience and protective factors.
- The relative impact of other neurodevelopmental or mental health conditions.

Care pathway

Patients who are very stable, with any medications optimised, can be discharged to their GP but with an easily accessible pathway to get consultant advice, or a face to face appointment, when needed for medication changes or queries. Aligned to the NW London guidance to GPs (Appendix 2), handover to local services is required. In the event this is not possible the clinical responsibility for review remains with the Service.

Annual Reviews

It is expected that annual reviews will be carried out by primary care[4] with the support and guidance of the provider that made the initial diagnosis. The GP will review ADHD medication annually and discuss with the patient (and their families and carers as appropriate) whether medication should be continued. The review should include a comprehensive assessment of the:

- Preference of the person with ADHD (and their family or carers as appropriate).
- Impact on education and employment.
- Benefits, including how well the current treatment is working throughout the day.
- Clinical need and whether medication has been optimised.
- Adverse effects of medication.

[4] Complex reviews in primary care can be covered by payments for complex common mental illness patients as part of the SMI physical health check enhanced service including mental and physical health check and medications review.

- Effects of missed doses, planned dose reductions and periods of no treatment.
- Effect of medication on existing or new mental health, physical health or neurodevelopmental conditions.
- Need for support and type of support (for example, psychological, educational, social) if medication has been optimised but ADHD symptoms continue to cause a significant impairment.

Complex cases

Patients with complex cases will not be rejected and there will be full support for GPs. Patients who are treatment resistant and do not respond to first line management of ADHD would be reviewed under special arrangements, as many times as needed to optimise medication, by the consultant or the specialist nurse.

Where complex patients are under the care of other mental health services, such as a community mental health team, then the service will liaise with that service to ensure holistic care for the patient. In these cases, it may be in the best interests of the patient if assessment is carried out by the same provider that is also supporting their mental health needs and at a face to face appointment.

Service user feedback

The Service will undertake service reviews and seek the input from service users and carers and use this information in the further development of the service.

Reporting and monitoring

The Service shall be required to organise an electronic record keeping information exchange system to record information. A reporting schedule will be provided.

To include:

- Demographics of the cohort (age, gender, ethnicity, borough)
- NHS Numbers (to enable cross checking across providers for duplicates on waiting lists)
- Referring organisation/borough.
- Number of referrals.
- Number of appointments issued each month by type (medication review, new assessment).
- Number seen in month period, and number remaining on waiting lists.
- Inappropriate referrals defined as referrals declined, including those who did not meet the criteria during screening.
- DNAs and lost to follow ups (cases closed as patient has not engaged).
- Number diagnosed with ADHD/overall diagnosis rate
- Number requiring prescribing/ medication titration.
- Number of follow ups.
- Referrals requiring follow up by other service.
- Numbers discharged.
- Patient satisfaction survey results.
- Incident reporting.
- Service developments introduced.

Applicable national standards

https://www.nice.org.uk/guidance/ng87/chapter/Recommendations#recognition-identification-and-referral

https://www.nice.org.uk/guidance/NG87

- Mental Health Act code of Practice (1983)

Applicable local service standards

- It is expected that the Service shall ensure appropriate policies are in place in line with current health and safety and risk management guidance together with appropriate mechanisms for recording, auditing and monitoring feedback on service provision and actions taken to resolve issues. All activities shall have a risk assessment.
- Assessment should be conducted by appropriately trained and qualified practitioner(s) with experience in the use of the evidenced based assessment tools and who is trained in the assessment of ADHD for adults.
- The Service must provide high levels of supervision for new staff and ongoing supervision for all staff.
- Clear feedback on the outcomes of diagnosis, should be made verbally at the point of diagnosis and reinforced in writing (in the language or format of the patient's choice including easy read or visual) within one working month.
- The Service must monitor access to services by all nine protected characteristics in the Equality Act 2010, (Age, Disability, Gender reassignment, Marriage and civil partnership, Pregnancy and maternity, Race, Religion or belief, Sex, Sexual orientation) and will be required to work with commissioners to ensure that access to services is as equitable as possible.
- The Service asks those referred for feedback on the services received and engage people with ADHD and their families in future service planning and delivery.

Safeguarding

Professional(s) working with people with a suspected ADHD must consider whether there are any safeguarding concerns relating to the service user, or other people in the environment. Where there is concern for their safety, or that of others then it is the responsibility of the professional identifying the concern to notify the appropriate authority.

Professionals at the Service shall follow local procedures to commence the referral process to ensure that the correct local safeguarding process is adhered to for the protection of identified adults and young people.

The Service shall ensure all staff/ volunteers receive relevant training, including, but not limited to:

- Adult Protection
- Mental Capacity Act
- Deprivation of Liberty Safeguards on a multi-agency basis and Advocacy
- Child Protection
- Local Safeguarding training.

Appendix 1

Diagnostic Assessments

Well established adult ADHD services indicate that around 2.5 to 3 hours of direct clinical time is required to complete a thorough ADHD diagnostic assessment. This could take the form of a single or two session consultation.

In both instances, additional time will be required to review previous clinical records, self-report, or informant-completed questionnaires (with scoring), clinical notetaking/ report writing, feeding back the outcome, and discussing management and follow up options.

Additional time may be required for liaison or more detailed history taking in cases with complexity, such as those with comorbid mental or neurodevelopmental conditions.

Content of adult ADHD diagnostic assessments: direct clinical time

1. Orientation to process
2. General history taking including:
3. Presenting problems.
4. Developmental/personal history.
    - Pregnancy-related detail, birth and infancy (i.e. birth complications, developmental milestones, early temperament).
    - Childhood and adolescence (i.e. academic progress, exclusions/expulsions, behaviour in class, peer group relationships, antisocial behaviour, personal/family relationships). Utilising a Childhood Screening Questionnaire.
5. Assessment of ADHD-related impairment and the presence of ADHD in different areas of life (further education, employment, leisure/free time, relationships, self-esteem) – therefore, the presence of many ADHD symptoms are identified here through open-ended questions as opposed to following an 18-symptom list one after the other.
    - Health related areas (physical health, sleep, appetite) – current/past.
    - Medication/ allergies – current/ past.
    - Mental health comorbidities (mood, past/current treatment, coping strategies, etc.).
    - Neurodevelopmental comorbidities (e.g., ASD, Tourette's, Dyslexia, DCD).
    - Addiction/ drug/ alcohol history.
    - Risk assessment.
    - Forensic history (if relevant).
6. Review of Diagnostic and Statistical Manual of Mental Disorders (DSM V) symptoms (mainly those not addressed elsewhere in assessment) using a semi- structured interview e.g. the Diagnostic Interview for ADHD in Adults (DIVA).
7. Formulation and sharing of diagnosis (clear explanation what the DSM V criteria is, why diagnosis is given/not given, subtype, level of impairment, informant information/ life-long symptoms, etc.).
    - Sufficient time for patient to reflect on diagnostic outcome.
    - Structured post-diagnostic psychoeducation interview according to NICE Guidelines (not optional).
    - Detailed discussion of all treatment options and key elements of best possible outcome.

Obtaining developmental information for ADHD assessment:

If an informant is available (e.g., parent, older sibling) they should be asked to attend the consultation(s). Alternatively, the informant needs to be asked to complete informant questionnaires. School reports could be reviewed if available.

Appendix 2

North West London Adult ADHD Guidance for GPs

The following is guidance produced by North West London Integrated Care System to guide GPs in the management of patients with possible or confirmed Attention Deficit Hyperactivity Disorder. It aims to clarify prescribing principles, particularly whilst awaiting further assessment by a specialist ADHD clinic.

The following treatment situations are included:

1. Patients previously diagnosed in childhood who require on-going treatment in adulthood.
2. Patients requesting a new diagnosis/treatment in adulthood
3. Patients who may have had treatment initiated in adulthood outside of the UK requesting on going NHS prescribing.
    a. Different diagnostic criteria and treatment regimens are sometimes used abroad so the patient may need to be referred to a specialist service for UK confirmation prior to ongoing prescribing in primary care, however, this at the discretion of the GP depending on their confidence to continue prescribing. The Service will give advice to primary care whilst on the waiting list for assessment.
    b. GPs may consider prescribing based on foreign diagnosis and initiation of treatment where there is adequate documentation available (in English) to demonstrate that a thorough assessment process has taken place.
    c. In the absence of this it is advised that patients continue to obtain their medication from abroad whilst waiting to be assessed.

Childhood diagnosis

A significant proportion of those treated in childhood for ADHD will require on going treatment at 18yrs+ though this requirement may decline with increasing age. There must be sufficient attention given to robust transition between childhood and adult treatment services.

Prescribing and management can be continued in primary care alone as the risks of disordered growth are no longer applicable. Continue the last CAMHS dosage.

Regular monitoring of BP, pulse and weight every 6-12 months is required.

Usual treatment (see BNF for dosage guidance):

1st line – **methylphenidate** - CD, taken 2-3 times per day or once daily if MR

Or - **Lisdexamfetamine** - CD, pro-drug of dexamfetamine so less potential for abuse, good 1st choice or alternative when methylphenidate is not tolerated.

2nd line – **atomoxetine** - SNRI or **guanfacine** – alpha 2A agonist, neither are CDs (guanfacine is only licenced for <18yr but is used off licence in adults following advice from a specialist service)

3rd line – **dexamfetamine** - rarely used, now extremely expensive and most abuse potential

Ongoing need for treatment should be reviewed annually through assessing the response to treatment breaks or missed doses. There is no need to wean down medication to do this except with atomoxetine and guanfacine. These medications should have the dose reduced over 3 weeks prior to stopping as with other SNRIs.

See also NICE guidance: https://www.nice.org.uk/guidance/cg72/resources/guidance-attention-deficit-hyperactivity-disorder-pdf

New Adult Diagnosis

NICE guidance recommends that new diagnoses in adulthood should **ONLY** be made in **secondary care**, with medication initiated and stabilised before transferring back to primary care for on-going prescribing and monitoring.

The referral route is direct to any specialist ADHD clinic on a specialist ADHD referral form or the general adult community mental health referral form on the referral system. If the patient has a complex mental health history it may be appropriate to refer via the CMHT to exclude other causes of the symptoms first. Unfortunately, there can be a wait for assessment in the specialist ADHD clinics.

Online questionnaires are not a reliable diagnostic tool due to poor specificity though are still encouraged as part of the referral process. Diagnosis also needs to take into account the patient's mental state, childhood history, substance misuse and social factors. These factors can also help clinic staff to prioritise the most urgent cases for assessment.

Response to stimulant medication is also not indicative of the diagnosis as many patients with depressive or personality disorders feel better on stimulants.

GPs are asked to provide **baseline metrics** before the patient will be assessed in the ADHD clinic (these need to be arranged shortly before the assessment appointment). They should include **pulse, BP, BMI and an ECG and the following bloods: FBC, U+E, LFTs, TFTs**. Note that payments to primary care for this can be covered under Complex Common Mental Illness as part of the Enhanced service specification.

GPs may consider referral for a **cardiology opinion** or investigations such as echocardiogram and/or making a cardiology advice and guidance request where there is clinical concern. The following may indicate a need for further investigation prior to commencing ADHD medication:

- history of congenital heart disease or previous cardiac surgery
- history of sudden death in a first-degree relative under 40 years suggesting a cardiac disease
- shortness of breath on exertion compared with peers
- fainting on exertion or in response to fright or noise
- palpitations that are rapid, regular and start and stop suddenly (fleeting occasional irregular beats are usually ectopic and do not need investigation)
- chest pain suggesting cardiac origin
- signs of heart failure
- a murmur heard on cardiac examination
- blood pressure that is classified as hypertensive for adults

GPs should also signpost appropriately to local social prescribing offers and offer self-help/self-care advice.

All treatment will be initiated and adjusted by the specialist ADHD clinic as is appropriate. Patients may contact the ADHD clinic directly for a review if they are within 6 months of discharge from the clinic. The clinic must give clear instructions to the GP at point of discharge, including contact details for queries (phone number and email for each provider) and an expected timescale for responding to these. If there are queries after that a new GP referral is required though these will be prioritised for appointments. It is NOT expected that GPs will adjust ADHD medications.

GPs should be able to seek support and guidance for patients transitioning from childhood to adulthood where there are concerns though not all patients will require review at this stage.