National Institute for Health and Clinical Excellence

Attention deficit hyperactivity disorder scope – stakeholder consultation table

31 January–28 February 2006

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Action for Sick Children			This organisation was approached but did not respond.	
Acute Care Collaborating Centre			This organisation was approached but did not respond.	
Addenbrookes NHS Trust			This organisation was approached but did not respond.	
adders.org			This organisation was approached but did not respond.	
ADDISS			This organisation was approached but did not respond.	
ADHD In Suffolk			This organisation was approached but did not respond.	
ADHD-Leicester Family Support Group			This organisation was approached but did not respond.	
Airedale Primary Care Trust			This organisation was approached but did not respond.	

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Assist Trauma Care			This organisation was approached but did not respond.	
Association for Continence Advice			This organisation was approached but did not respond.	
Association of Child Psychotherapists			This organisation was approached but did not respond.	
Association of the British Pharmaceuticals Industry (ABPI)			This organisation was approached but did not respond.	
Avon and Wiltshire Mental Health Partnership NHS Trust			This organisation was approached but did not respond.	
Barnardo's			This organisation was approached but did not respond.	
Barnsley Primary Care Trust			This organisation was approached but did not respond.	
Boehringer Ingelheim Ltd			This organisation was approached but did not respond.	
Bolton Salford & Trafford Mental Health			This organisation was approached but did not respond.	
Bristol North PCT	1	General	As a PCT we sought the views of practicing clinicians, which are	

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(Teaching)			reflected below. They may not be all structured as direct commentaries upon the scope, but we hope that the GDG will be able to take these comments into account.	
Bristol North PCT (Teaching)	2	4.3 b)	It is not clear where the diagnosis will be made (ie Primary care or Secondary care)	Thank you for your comments. Considering the evidence related to diagnosis will be part of the guideline development group's work, rather than being outlined in detail in the Scope.
Bristol North PCT (Teaching)	3	4.3.b)	I worry about the diagnostic criteria and would imagine the condition would be suspected in primary care and confirmed in secondary care after observations in different settings needing a lot of resources/manpower - it is likely to remain underdiagnosed if 10% of children in the UK are affected. Will the guideline offer criteria for prioritisation?	Thank you for your comments. Considering the evidence related to diagnosis will be part of the guideline development group's work, rather than being outlined in detail in the Scope.
Bristol North PCT (Teaching)	4	4.3 c)	Makes mention of early diagnosis of ADHD in children in primary care – but how realistic is this for a primary care clinician to make such a diagnosis? Especially as comorbidities accompany that would normally be treated in secondary care, and diagnostic criteria are primarily observational.	Thank you for your comments. Considering the evidence related to diagnosis will be part of the guideline development group's work, rather than being outlined in detail in the Scope.
Bristol North PCT (Teaching)	5	4.3 f)	It is not clear that "Appropriate use" includes the duration of treatment, and the discontinuation of treatment (assuming we won't end up with 10% of the population taking Strattera from	Thank you for your comments. Considering the specific evidence related to all aspects

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			cradle to grave…)	pharmacological interventions will be part of the guideline development group's work, rather than being outlined in detail in the Scope (see section 4.3g)
Bristol North PCT (Teaching)	6	4.3 f)	Also doesn't make mention of any monitoring required	Thank you for your comments. Please see comment above.
Bristol North PCT (Teaching)	7	General – may be 4.3d)	We are also likely to have adults approaching their GPs believing the diagnosis of ADHD was missed in their own cases. Where can we refer these individuals?	Thank you for your comments. Considering the evidence related to adult diagnosis will be part of the guideline development group's work, rather than being outlined in detail in the Scope (see section 3 a).
Bristol North PCT (Teaching)	8	3.e)	suggests that almost 1 in 10 school-age children in the UK meet diagnostic criteria! Is there good evidence to support either this statistic, or the diagnostic criteria, or their application and interpretation? And the robust evidence for the point at which treatment is initiated once diagnosis is made? Does the prevalence vary between countries because the diagnosis varies, or because of environmental variations, which points to greater non-pharmacological intervention? And why has the no. of scripts doubled since 1998, but the cost of those scripts increased almost three-fold? Has the unit dose cost increased, or the treatment dosage increased, or simply a move to more expensive modified-release dosage forms? Has this increased	Thank you for your comments. The information given in these sections of any NICE guideline scope are prepared by our technical team in collaboration with leading national and international experts. We do not normally reference the statements of need for any guideline. However, rest assured that when the full guideline is published all statements will be supported by references

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			investment improved outcomes?	wherever this is possible.
British and Irish Orthoptic Society			This organisation was approached but did not respond.	
British Association for Community Child Health	1	General	Is the proposed guideline intended to cover only the 'effectiveness of methylphenidate…and psychological interventions..for the treatment of attention deficit hyperactivity disorder' as stated in the 'referral letter' or are they meant to be 'broader' in the clinical context, including differential diagnosis, etc. as well? In the clinical Paediatric context, one needs to distinguish ADHD from 'normality' as well as other clinical conditions mimicking it e.g. Iron deficiency without anaemia (personal observation by RT backed by data), (adverse) social environmental consequences, attachment problem esp. in child protection contexts. For this reason, it is important to clarify the remit of the ADHD Guideline Development Group, and for the composition of the 'Group to reflect necessary expertise, should its remit be broader. BACCH would prefer the 'Group to adopt a broader remit.	Thank you for your comments, but the areas to which the guideline applies have already been determined by the Department of Health. However, where appropriate, the guideline will consider other associated conditions and the interface with non-NHS services (see section 4.2 b)
British Association for Community Child Health	2	2 (b)	While the NSF for Children (mental health chapter) gives a general guidance on child mental health issues, it does not specifically mention ADHD.	Thank you for your comments. In order to ensure that these issues are addressed a paediatrician will be represented on the Guideline

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			Nor is NSF specific about acknowledging the substantial role that paediatricians play in serving mental health needs of children and young people, at times without the support from specialist mental health professionals, e.g. clinical psychologists. This situation has been is a cause for great concern for paediatricians for several years, and we fear that 'going by the NSF' as it currently stands, would not really help bridge the current 'divide of provision' that is disadvantageous to 'paediatric-patients' as well as being stressful to paediatricians themselves!	Development Group.
British Association for Community Child Health	3	3 (b)	The apparent 'acknowledgement' of co-morbidities as 'the norm' in the literature, is more a reflection of the 'nature of literature' rather than the actual reality of ADHD as seen in the clinical paediatric context where a more 'balanced' spectrum of presentation (with a higher proportion of 'uncomplicated' ADHD) is encountered. We hope to collate in the near future, the clinical profile of ADHD in predominantly community- based paediatric practice in the UK. Would this 'evidence' (in the form of a peer-reviewed paper) be admissible in the proceedings of the 'Group, should it be available in the next two or three months? What is the likely 'cut-off date' for such material?	Thank you, we shall endeavour to make best use of all the available evidence and will consider your paper, along with other evidence once it is completed.
British Association for Community Child	4	3(c)	While there is a 'continuing debate' as to the 'cause' of ADHD, its essentially biopsychosocial nature ought to be highlighted by	Thank you for your comments.

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Health			the 'Group. In fact, the ' Group should take this opportunity to publicly settle, through its Report, the controversy around the 'existence' of ADHD (generated by some media and other vested interests) once and for all, so that children and their families can really get the necessary professional help without a sense of anxiety and even guilt!	
British Association for Community Child Health	5	3 (f)	There is probably a lesser gender imbalance in the profile of ADHD in clinical paediatric context (RCT personal data), given the close links between (community-based) paediatricians and teachers/educational psychologists. One way to minimise the avoidable part of the 'gender imbalance' would be to include an educational academic in the 'Group – suggest [X].	Thank you for your comments. We have already addressed this issue in the Guideline Development Group membership which will include an education expert.
British Association for Community Child Health	6	4.1.1 (a)	As implied in the opening 'general' comment, the ADHD Guideline Group should avail itself a wider range of professional expertise as regards interventions for children and young people with ADHD, instead of just focussing on pharmacological and psychological interventions	Thank you, this issue has already been addressed in the Guideline Development Group membership.
British Association for Community Child Health	7	4.2 (a)	Distinction should not be made between 'secondary care' and 'community' services. This is particularly relevant to 'community-based' consultant paediatricians who have the same level of expertise as their' hospital' based counterparts. In any case, the dividing line between hospital and community is getting less sharp, and so the terminology should focus on 'level	Thank you for your comments.

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			of expertise' rather than the setting of provision.	
British Association for Community Child Health	8	4.2 (b)	It is a pity that this is an NHS guideline; there is an urgent need for a 'joined-up' guideline so far as ADHD is concerned! Is it a final decision?	Thank you for your comments. This is an NHS clinical guideline and therefore does not cover services provided by other agencies. It will however comment on the interfaces with these agencies (see revised section 4.2 b)
British Association for Community Child Health	9	4.3 (g)	Would it cover 'EEG Neurofeedback based intervention, as being researched at the Imperial College?	Thank you for your comments. The guideline will cover all treatments routinely provided by the NHS.
British Association for Community Child Health	10	4.3 General	Would it clarify the issue of eligibility of ADHD sufferers for 'state benefits' (which bothers a lot of people)?	Thank you for your comments. This issue is beyond the remit of this guideline as laid down by the Department of Health.
British Association for Counselling and Psychotherapy			This organisation was approached but did not respond.	
British Association for Psychopharmacology	1	3 (a, c)	Both DSM IV and ICD 10 require 6 months duration of symptoms. We think this section would read better if it described hyperkinetic disorder first and then went on to describe the DSM IV concept as describing ADHD "more broadly". The different ways in which both systems deal with the presence or absence of comorbidity could be described more clearly in section 3 c.	Thank you, we shall amend the text in the light of the comments.

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British Association for Psychopharmacology	2	3 (b) & 4.11 (b)	While it is true that current diagnostic criteria (DSM-IV, ICD-10) prohibit the co-morbid diagnosis of PDD/ autism spectrum disorder many children with ASD/PDD present with impairing symptoms of overactivity, impulsivity and inattention which would meet the criteria for ADHD in the absence of ASD/PDD. The needs of these children are often not discussed as they fall out with the scope of reviews such as this. They are however a very important and at times complex clinical group who cause concern and for many clinicians. The management of children meeting criteria for both ADHD and ASD poses important clinical questions (e.g. response to medication and psychological interventions) and so we would recommend that PDD/ASD should be included under the management of co-morbidities (Section 4.11 (b).	Thank you for this information. We have amended the text to include consideration of all 'common' comorbities as far as they affect the treatment of ADHD. (See 4.1.1b)
British Association for Psychopharmacology	3	3 (c)	A first sentence could be added here along the lines "ADHD is a heterogeneous behavioural syndrome and the diagnosis does not imply any specific cause. However, various genetic and environmental risk factors…."	Thank you we will amend the text in the light of the comments.
British Association for Psychopharmacology	4	3 e	The section on ICD 10 should precede the section on DSM IV. Also there should be mention of the current under recognition of cases in the UK.	Thank you we will amend the text in the light of the comments.
British Association for Psychopharmacology	5	3 f	Diagnosis is traditionally around 9 times more common in males it is this that is inflated by referral bias. The epidemiological picture seems to be between 3 – 4 times greater in moles than females and is less likely to be inflated	Thank you we will amend the text in the light of the comments.

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British Association for Psychopharmacology	6	4.1.1 (a)	2nd sentence: specify "three DSM-IV ADHD subtypes…..together with ICD-10 hyperkinetic disorder".	Thank you we will amend the text in the light of the comments.
British Association for Psychopharmacology	7	4.2 (a-c)	The Guideline should ideally map onto the Tiered model of CAMHS specified in the NSF for Children (Standard 9). Within this model, tier 1 and 2 services may be delivered by multi agency teams commissioned by PCTs (or jointly commissioned) and managed outside the NHS by other agencies (e.g. social services or voluntary agencies with some specialist CAMHS input). Effective screening and early identification of ADHD will depend on implementation of the Guideline by groups not directly accountable to the NHS clinical governance procedures. Adoption of these standards by the Health Commission and their use by PCTs in performance management of service providers may be one possible mechanism to ensure the implementation of the Guideline within the CAMHS tier 1-4 structure. We would suggest that this section explicitly state that the guideline will cover "identification and care" as the second can't happen without the first.	Thank you we will amend the text in the light of the comments (see section 4.2 b). Nevertheless, some of the things you mention will need to be considered during guideline development by the GDG.
British Association for Psychopharmacology	8	4.3	Assessment is an essential precursor to accurate diagnosis and effective treatment. We would recommend that 'Assessment', including the use of interviews, questionnaires and cognitive testing, is listed as a separate item under 4.3.	Thank you we will amend the text in the light of the comments (see section 4.3 c).
British Association for Psychopharmacology	9	4.3	Differential diagnosis should also be included here. Diagnostic distinctions from attachment disorders and bipolar disorder (cross reference to NICE Bipolar Guideline) are highly relevant.	We will be addressing 'common' comorbidities in the overall management of children, young

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			The guideline should also stress the importance of the diagnosis of comorbid psychiatric and non-psychiatric comorbidities (e.g. axes 3 & 4 on the ICD 10 multiaxial system such as specific learning difficulties, motor coordination problems, epilepsy etc) and also the assessment of other difficulties associated abnormal psychosocial conditions (e.g. axis 5 on the ICD 10 multiaxial system)	people and adults with ADHD (see amended 4.1.1b).
British Association for Psychopharmacology	10	4.3 (f)	Use of pharmacological agents should include guidance on co-prescribing, drug interactions and monitoring.	Thank you for your comments. All aspects of pharmacological treatment will be considered during the development of the guideline (see revised section 4.3 g)
British Association for Psychopharmacology	11	4.3	Guidance should be given on establishing G.P./ specialist shared-care management protocols and transition to adult mental health services.	Thank you for your comments.
British Association for Psychopharmacology	12	4.3	Guidance should be given on the relationships between services caring for those with ADHD and those with other CAMHS or paediatric difficulties. This is important as the recent development of "ADHD teams" which at times can become relatively isolated has lead some children in some areas missing out on the more global mental health or paediatric specialist care they require (e.g. systemic therapy for family based problems, CBT for depression etc	Thank you for your comments.
British Dietetic			This organisation was approached but did not respond.	

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Association				
British National Formulary (BNF)			This organisation was approached but did not respond.	
British Paediatric Mental Health Group of the Royal College of Paediatrics and Child Health			This organisation was approached but did not respond.	
British Paediatric Neurology Association			This organisation was approached but did not respond.	
British Psychological Society, The			This organisation was approached but did not respond.	
Cactus Clinic The Steve Baldwin Foundation			This organisation was approached but did not respond.	
Camden and Islington Mental Health and Social Care Trust			This organisation was approached but did not respond.	
CASPE			This organisation was approached but did not respond.	
Cephalon UK Ltd			This organisation was approached but did not respond.	

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Chartered Society of Physiotherapy, The	1		The CSP has no comments to make at this stage.	
Cheshire & Wirral Partnership NHS Trust			This organisation was approached but did not respond.	
Children in Wales			This organisation was approached but did not respond.	
Chronic Conditions Collaborating Centre			This organisation was approached but did not respond.	
CIS'ters	1	general	We would wish to see the scope include a consideration of the possibility that there are other 'causes' that result in the "presentation" of the symptoms that are later diagnosed as ADHD.	Thank you for your comments. (Please see section 4.3c)
CIS'ters	2		The symptoms might, alternatively, be a childs unspoken distress as they attempt to alert others around them to the abuse that is taking place, now or in the past.	Thank you for your comments. (Please see section 4.3c)
CIS'ters	3		It is important to ensure that such considerations are in place and that there is a safe environment within which a child can build sufficient trust to make such a disclosure – without the caregivers present (as they may be the abuser or complicit).	Thank you for your comments.
CIS'ters	4		Medicating a child who "presents" with ADHD who is being sexually abused, means that they are then MORE at risk, as they are less able to say, physically, no to such abuse due to the slowing affect of the medication.	Thank you for your comments.

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CIS'ters	5		Remember > The problem is not the problem, it is a symptom of the problem, so 'what' is the problem ?	Thank you for your comments.
Clinovia Ltd			This organisation was approached but did not respond.	
College of Occupational Therapists	1	3 b	The identification and management of conditions which *comorbid* with ADHD is very important in the overall treatment of children with ADHD. In the SCOPE paper, only comorbid childhood mental health disorders have been mentioned. It is important to highlight that children with ADHD do have comorbid *Development Coordination Disorder (DCD).* Many studies have shown that there is a strong relationship between ADHD and DCD, and other perceptual-motor dysfunctions (ranged from 25% to 65%) (Whitmont and Clark, 1996; Piek, Pitcher and Hay, 1999; Kadesjo and Gillberg, 2001, and Steger, Imhof, Coutts, Gundelfinger, Steinhausen and Brandeis, 2001). In analysing different studies, Gillberg and Kadesjo (2000) concluded that the prevalence of comorbid ADHD and DCD is as high as 50%. In a recently published longitudinal study, Rasmussen and Gillberg (2000) found that the combination of ADHD and DCD appeared to carry a particularly gloomy outlook. For example, individuals with both ADHD and DCD tend to have a higher incidence of living off a pension / benefit, drug or alcohol abuse, a major personality disorder, chronic severe psychiatric disorder and conviction for a crime. Occupational therapists have specialist skills in the assessment and management of children with ADHD and DCD. Therefore, it	Thank you for this information. The Guideline Development Group will review all common comorbidities and where appropriate address their affect on the treatment of ADHD (see amended section 4.1.1 b) Where appropriate the Guideline Development Group will be assisted by special advisors.

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			is important to include occupational therapists as a member of a multidisciplinary team for children with ADHD. References: Gillberg, C. and Kadesjo, B. (2000). Attention-Deficit/Hyperactivity Disorder and Developmental Coordination Disorder. In: T.E. Brown (Ed.). *Attention-Deficit Disorders and Comorbidities in Children, Adolescents, and Adults.* Washington, DC: American Psychiatric Press, Inc. Kadesjo, B. and Gillberg, C. (2001). The comorbidity of ADHD in the general population of Swedish school-age children. *Journal of Child Psychology and Psychiatry*, 42(4), 487-492. Piek, J.P., Pitcher, T.M. and Hay, D.A. (1999). Motor coordination and kinaesthesis in boys with ADHD. *Developmental Medicine and Child Neurology*, 41, 159-165. Rasmussen, P. and Gillberg, C. (2000). Natural outcome of ADHD with Developmental Coordination Disorder at age 22 years: a controlled, longitudinal, community-based study. *Journal of the American Academy of Child and Adolescent Psychiatry,* 39(11), 1424-1431. Steger, J., Imhof, K., Coutts, E., Gundelfinger, R., Steinhausen, H-Ch., and Brandeis, D. (2001). Attentional and neuromotor deficits in ADHD. *Developmental Medicine and Child Neurology*, 43, 172-179.	

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			Whitmont, S. and Clark, C. (1996). Kinaesthetic acuity and fine motor skills in children with ADHD: a preliminary report. *Developmental Medicine and Child Neurology*, 38, 1091-1098.	
College of Occupational Therapists	2	3 c	According to the current diagnostic criteria in the DSM-IV, children with PDD will be excluded in the diagnosis of ADHD. Frazier, Biederman, Bellordre, Garfield, Geller, Coffey and Faraone (2001) challenged this exclusionary criterion and suggested children with PDD with concomitant symptoms of inattention, hyperactivity and impulsivity may have true comorbid ADHD. In recent clinical practice, there are children who have been given a *dual diagnosis of PDD and ADHD* as both sets of behavioural patterns are equally a hindrance in the child's life. Reference: Frazier, J.A., Biederman, J, Bellordre, C.A., Garfield, S.B., Geller, D.A, Coffey, B.J. and Faraone, S.V. (2001). Should the diagnosis of Attention Deficit Hyperactivity Disorder be considered in children with Pervasive Developmental Disorder? *Journal of Attention Disorders*, 4(4), 203-211.	Thank you for this comment. However the areas to which the guideline applies have already been determined by the Department of Health. Consideration of common comorbidities is dealt with (see 4.1.1b).

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College of Occupational Therapists	3	4.1.1 c	As discussed above (comments for section 3 c), the *specific management* of ADHD in those individuals who also have *DCD should be included* (besides learning disability and defined neurological disorder).	Thank you for this information. The Guideline Development Group will review all common comorbidities and where appropriate address their affect on the treatment of ADHD. If the Scope covers too much, which we believe is a risk if we specify too many comorbidities, the guideline will become unmanageably large.
College of Occupational Therapists	4	4.2 b	The interplay between educational, health and social factors is particularly pertinent in the context of the notion of ADHD. It is only through links between services and professionals that appropriate assessment and treatment can be ensured. It is well known in practice that successful management of children with ADHD requires good *multi-agency collaboration.* It is important to develop the guidelines with *input from DfES, educational and Social Services professionals.* We note from the list of stakeholders that the DfES are included and would urge the Institute to invite the Social Care Institute for Excellence to register as a stakeholder for this guideline.	Thank you for this comment. SCIE is one of the registered stakeholders for this guideline.
College of Occupational Therapists	5	4.2 c	The guideline should also cover educational settings. ADHD places children at serious educational risk (Barkley, 1994). *Children with ADHD pose particular challenges for their teachers (DuPaul and Stoner, 2003)*. Teachers will need to adapt the learning environment and their teaching style in order	Thank you for this comment. In order to ensure that these issues are addressed an education specialist will be represented on the Guideline Development Group.

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			to meet their specific needs for better behavioural organisation and successful educational outcomes. Just as the goal at home is to lessen the impact of ADHD and to encourage development of good habits, much the same is true at school. An ideal programme for a student with ADHD is one that prevents his or her attention or self-control problems from hindering learning (Wodrich, 1994). When ADHD symptoms adversely affect academic performance and success, educational accommodations will be necessary (Cohen, 1998). Therefore, it is important to *include educational settings in the guideline.* References:- Barkley, R.A. (1998a). *ADHD – a handbook for diagnosis and treatment* (2nd Ed.). New York: The Guilford Press. Cohen, M.W. (1998). *The Attention Zone – a parent's guide to ADHD*. Washington, DC: Taylor and Francis. DuPaul, G.J. and Stoner, G. (2003). *ADHD in the Schools: Assessment and Intervention Strategies (2nd Ed.)*. New York, NY: The Guilford Press. Wodrich, D.L. (1994). *ADHD – what every parent wants to know.* Baltimore: Paul H. Brookes Publishing Co.	
College of Occupational	6	4.3 b and c	Each child with ADHD has a unique constellation of problems and multiple domains of functioning may be affected (Whalen	Thank you for your comments.

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Therapists			and Henker, 1996). Therefore, it is important to adopt a *multi-dimensional assessment approach* in order to determine whether or not an ADHD is present and how it affects the child's development and performance in different areas of functions (Chu, 2003). A *team approach* of evaluation should be advocated in the guideline. Many studies have found that over 50% of individuals diagnosed with ADHD also meet the diagnostic criteria for one or more additional psychiatric and developmental disorders (Brown, 2000). The implication of high rates of comorbidity is that simply recognising features of ADHD is not enough and that a full appraisal of the child is necessary. Accardo (1999) highlighted that the failure to see the association between ADHD and these comorbid conditions remains one of the most frequent causes of misunderstanding and incorrect treatment. Occupational therapists are skilful in the identification of different developmental disorders that commonly comorbid with ADHD e.g. DCD. Therefore, occupational therapy evaluation should be an essential component in the processes of *differential diagnosis and the identification of comorbidity* in children with ADHD. References:- Accardo, P. (1999). A rational approach to the medical assessment of the child with attention deficit/hyperactivity	Where appropriate the Guideline Development Group will be assisted by special advisors.

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			disorder. *Pediatric Clinics of North America*, 46(5), 845-856. Brown, T.E. (2000). *Attention-Deficit Disorders and Comorbidities in Children, Adolescents, and Adults.* Washington, DC: American Psychiatric Press, Inc. Chu, S. (2003). Attention Deficit Hyperactivity Disorder (ADHD) part two: evaluation and intervention. *International Journal of Therapy and Rehabilitation*, 10(6), 254-262. Whalen, C.K. and Henker, B. (1996). Attention deficit / hyperactivity disorder. In: T.H. Ollendick and M. Hersen (Eds.). *Handbook of Child Psychopathology (3rd Ed.).* New York: Plenum Press.	
College of Occupational Therapists	78	4.3 d and f	Although much is known about certain benefits of medications and behavioural approaches (Jensen, 1999 and MTA Cooperative Group, 1999), much less is known about the optimal strategies for tailoring these treatments according to timing, dose, and combination for individual children with ADHD (Conners, 2000). It is undoubtedly clear that a diagnosis of ADHD should not constitute a recommendation of automatic drug treatment. As stated by Taylor and Hemsley (1995) *medication must not become the first line of treatment.* So far, no treatment has yet been proved to cure the condition of ADHD. In order to remediate the "roots" of the disorder, a *model of multi-faceted intervention* is essential to address different levels and aspects of the disorder. A model of multi-	Thank you for your comments.

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			faceted intervention for children with ADHD should include some of the following components (Chu, 2003):- 1. **Education and training** i.e. to promote the understanding of a child with ADHD, and to equip parents/teachers with necessary skills for managing the specific behavioural problems of a child with ADHD. 2. **Environmental adaptation** i.e. to provide advice on adapting and modifying the classroom and home environment in order to promote the child's functioning within these environments e.g. seating position within classroom, calming colour scheme and layout of the child's bedroom, etc. 3. **Behavioural and psychological management** i.e. to develop desirable behaviours by using different positive reinforcement and behaviour reduction strategies, and to treat certain neuropsychological dysfunctions e.g. attention training, impulse control training, and treatment of executive dysfunctions. 4. **Medication treatment** i.e. prescription of appropriate medication to change the brain mechanism responsible for behavioural inhibition, and to monitor the effect and side-effect of medication. 5. **Educational management** i.e. to provide advice to teachers	

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			on effective classroom organisation, curriculum modification and performance-promoting strategies. 6. **Social skill training** i.e. to promote the acquisition of appropriate social interactive behaviour by using structured social skills training programme. 7. **Sensory integrative approaches** i.e. to reduce the impacts of different sensory, perceptual and motor dysfunctions which may be the cause of different ADHD features or academic underachievement. 8. **Developmental approaches** i.e. to enhance the child's acquisition of different learning and daily life skills, e.g. handwriting skills, dressing skills, and to advise on the use of compensatory strategies and adaptive devices, e.g. the use of colour coding system in categorising information from different subjects. References:- Chu, S. (2003). Attention Deficit Hyperactivity Disorder (ADHD) part two: evaluation and intervention. *International Journal of Therapy and Rehabilitation*, 10(6), 254-262. Conners, C.K. (2000). Attention-Deficit/Hyperactivity Disorder – Historical Development and Overview. *Journal of Attention Disorders*, Vol. 3, No. 4, 173- 191.	

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			Jensen, P.S. (1999). Fact versus fancy concerning the multimodal treatment study for ADHD. *Canadian Journal of Psychiatry*, 44 (10), 975-980. MTA Cooperative Group (1999). A 14-month randomised clinical trial of treatment strategies for ADHD. *Archives of General Psychiatry*, 56, 1073-1086. Taylor, E. and Hemsley, R. (1995). Treating hyperkinetic disorders in children. *British Medical Journal*, 310, 1617 – 1618.	
College of Occupational Therapists	9	4.3 g	It is not clear what constitutes "*other therapies*". Does it refer to Allied Health Professions (AHPs) e.g. Occupational Therapy? In many different child psychiatry settings, occupational therapists are the key AHPs involved directly in the assessment, diagnosis, and treatment of children with ADHD.	The scope has now been amended to clarify this point. Thank you for your comments (See 4.3 h)
College of Occupational Therapists	10	4.3 General	It is important to include in the guideline the *assessment and treatment of sensory integrative functions / dysfunctions in children with ADHD.* Sensory Integration (SI) is the neurological process that organises sensation from one's own body and from the environment and makes it possible to use the body effectively within the environment (Ayres, 1989). Several researchers have noted an association between ADHD and Dysfunctions in Sensory Integration (Kimball, 1986; Lightsey, 1993; Mulligan, 1996; Parush et al, 1997). The association is hypothesised to	Thank you for this information.

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			be linked to the way in which the central nervous system regulates sensory information, especially in the brainstem level, through the process of sensory modulation (Cermak, 1988a & b). Recent research studies have provided evidence of the association between dysfunction in sensory modulation and ADHD (Mangeot et al, 2001 and Dunn and Bennett, 2002). Sensory modulation is the brain's capacity to regulate and organise the degree, intensity, and nature of responses to sensory input in a graded and adaptive manner, so that an optimal range of performance and adaptation to challenges from the environment can be maintained (Lane et al, 2000). Some children with ADHD have been identified as being hypo-reactive to various forms of sensory inputs e.g. they present sensory seeking behaviours, whereas other ADHD children have been identified as being over-reactive e.g. they present tactile defensive behaviours. The Sensory Profile developed by Dunn (1999) can be used to assess the sensory modulation function of a child with ADHD. It is a judgment-based caregiver questionnaire and consists of 125 items. Dunn (1999) found that children with ADHD present a profile of lower scores in 43 items distributed in the following 3 Factors and Processing Cluster i.e. Factor 1 – Sensory Seeking, Factor 2 – Emotionally Reactive, Factor 3 – Inattention/Distractibility, and the Visual/Tactile Processing Cluster. Further research by Dunn and Bennett (2002) indicated that children with ADHD differed significantly from	

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			children without disabilities in their sensory responsiveness based on the Sensory Profile results. They suggested that the Sensory Profile can contribute to diagnostic and programme planning processes and increase understanding of the nature of the disorder of ADHD. References: Ayres, A.J. (1989). *Sensory Integration and Praxis Tests Manual*. Los Angeles, CA: Western Psychological Services. Cermak, S. (1988a). The relationship between attention deficit and sensory integration disorders – Part I. *AOTA Sensory Integration Special Interest Section Newsletter*, 11(2), 1-4. Cermak, S. (1988b). The relationship between attention deficit and sensory integration disorders – Part II. *AOTA Sensory Integration Special Interest Section Newsletter*, 11(3). 3-4. Dunn, W. (1999). *Sensory Profile – User's Manual*. San Antonio, TX: The Psychological Corporation. Dunn,W. & Bennett, D. (2002). Patterns of sensory processing in children with attention deficit hyperactivity disorder. *Occupational Therapy Journal of Research*, 22(1), 4-15. Kimball, J.G. (1986). Prediction of Methylphenidate (Ritalin) Responsiveness through Sensory Integrative Testing. *American Journal of Occupational Therapy,* 40, 241-248.	

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			Lane, S.J., Miller, L.J. and Hanft, B.E. (2000). Toward a consensus in terminology in sensory integration theory and practice. II: sensory integration patterns of function and dysfunction. *Sensory Integration Special Interest Section Quarterly*, 23, 1-3. Lightsey, R.L. (1993). Tactile defensiveness in ADHD children. *Sensory Integration Quarterly*, 1993 (Summer), 6. Mangeot, S.D., Miller, L.J., McIntosh, D.N., McGrath-Clarke, J., Hagerman, R.J., and Goldson, E. (2001). Sensory Modulation Dysfunction in Children with Attention-Deficit/Hyperactivity Disorder. *Developmental Medicine & Child Neurology*, 43, 399-406. Mulligan, S. (1996). An analysis of score patterns of children with attention disorders on the Sensory Integration and Praxis Tests (SIPT). *American Journal of Occupational Therapy*, 50, 647-654. Parush, S. Suhmer, H., Steinberg, A. and Kaitz, M. (1997). Somatosensory functioning in children with ADHD. *Developmental Medicine and Child Neurology*, 39, 464-468.	
College of Occupational Therapists	11	4.3 General	The role and contribution of different *voluntary organisations and parent support groups* should be emphasised in the guideline.	Thank you for this comment. Service users and carers are full members of the Guideline Development Group.

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College of Occupational Therapists	12	General	We suggest that the guideline should address support for children with *"less severe" ADHD.*	Thank you for your comments.
College of Occupational Therapists	13	General	The guideline should also address *the interplay between child health and child psychiatry services.*	Thank you for this comment. This issue will be addressed through appropriate membership of the Guideline Development Group.
College of Occupational Therapists	14	General	The guideline should provide recommendations for *training* of parents, front-lined workers and other professionals involvement in the assessment and treatment of children with ADHD.	Thank you for your comments.
Community Practitioners' and Health Visitors' Association	1	3 a	This needs to include: ADHD sufferers represent a heterogeneous population who display considerable variations in the degree of their symptoms, in the situational pervasiveness of those symptoms, and in the extent to which other disorders occur in association with it.	Thank you for your comment. Please see section 4.1.1b which deals with this issue.
Community Practitioners' and Health Visitors' Association	2	3b	Bipolar disorder, somatisation disorder	Thank you for your comments.
Community Practitioners' and Health Visitors' Association	3	3d	Need to consider adolescence. Also, not aware of any studies that have looked at ADHD children who are functioning well in school, or ADHD adults who are functioning well in life.	Thank you for your comments.

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Community Practitioners' and Health Visitors' Association	4	3e	Consider cross- cultural differences. Although ADHD does exist, universally significant differences in the prevalence of ADHD across different countries have been reported. We need to consider cultural biases, especially as assessing ADHD is a highly subjective process.	Thank you for your comments. Cross-cultural difference will be considered as part of this guideline.
Community Practitioners' and Health Visitors' Association	5	3f	This needs to include that there are important differences in the nature of ADHD symptoms in girls and boys	This will be addressed in 4.3b.
Community Practitioners' and Health Visitors' Association	6	4.1.1 a	We welcome the recommendation that we should be looking at children as young as three, as well as young people and adults. However it will require a lot of education for all professionals as there is still many health professionals who work both in general practice and community mental health who do not accept that this condition exists. It will require adequate resources and time in order to ensure effective implementation	Thank you for your comments.
Community Practitioners' and Health Visitors' Association	7	4.1.1 b	Co-morbidities often get missed. As the child develops the frequency and intensity of these co-morbidies may also increase and at any time a specific condition may become more pronounced and subsequently for a period of time one or more of the other conditions may become less obvious	Thank you for your comments. Common comorbities (where they affect the treatment of ADHD) will be considered (see 4.1.1 b).

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Community Practitioners' and Health Visitors' Association	8	4.1.1 c	Often children with learning disabilities and other disorders are not seen and assessed comprehensively enough and so ADHD goes undiagnosed and/or untreated. It is often the parents/carers and the schools who need extra help with this	Thank you for your comments.
Community Practitioners' and Health Visitors' Association	9	4.2 a&c	There must be greater understanding, awareness and consensus about this condition. In a time when health visitor input to the under 5's is under review and many families only receiving the most minimal of universal services who will see the children and start the referral process? When diagnosis has been made there needs to be more monitoring of care given (especially medication) and greater provision of resources for all involved	Thank you for your comments.
Community Practitioners' and Health Visitors' Association	10	4.3 b	Can the Scope address the broad scepticism that surrounds this condition? The media focus on ADHD has not always been helpful in the past.	Thank you for this comment. The function of the Scope is to set down those areas which will / will not be considered as part of the Guideline Development Process, rather than addressing specific media issues associated surrounding ADHD.

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Community Practitioners' and Health Visitors' Association	11	4.3 c	One key issue is 'thresholds' .Different professionals seem to have very different ' tolerance' levels of behaviour i.e. what falls into normal and what does not. We need a clear multi-agency understanding of what ADHD is. Could this be addressed at national level so that a standardised definition can be agreed?	Thank you for this comment.
Community Practitioners' and Health Visitors' Association	12	4.3 d	There is often great disparity in the way some paediatricians and child psychiatrists treat ADHD issues in children. There is need for agreement between the Royal Colleges about what constitutes best practice and universally adopt that agreed model.	Thank you for this comment. This issue will be addressed through appropriate membership of the Guideline Development Group
Community Practitioners' and Health Visitors' Association	13	4.3 f	Need to consider: Side effects and their management Compliance.	Thank you for this comment. All aspects of the pharmacological treatment of ADHD will be considered as part of this guideline (see revised section 4.3 g)
Community Practitioners' and Health Visitors' Association	14	4.3 g	Lack of recognition of ADHD in school is a major issue for young people. Failure to accommodate children's differences within school can lead to exclusion for many young people. As the national drive is to move to Children's Trusts and pooled budgets can the scope seek to involve education colleagues in multi model assessment and support? Peer mediated conflict resolution programme.	Thank you for this comment. In order to ensure that these issues are addressed an education specialist will be represented on the Guideline Development Group.

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Community Practitioners' and Health Visitors' Association	15	4.3 k	Sensitivity and awareness to different beliefs/culture should receive more attention in this scope due to the apparent disparity in diagnosis rates in different cultures.	Thank you for this comment. Cross-cultural difference will be considered as part of this guideline.
Community Practitioners' and Health Visitors' Association	16	4.3 1	Siblings report that their needs are often overlooked; will the needs of all family members be considered? Parents and carers often request respite care; will parent/carers be consulted so that their expressed needs might be considered? Improvement in parenting skills have been shown to have a significant positive effect on the family life of sufferers hence deserves a subsection on its own.	Thank you for this comment. Carers are full representatives on the Guideline Development Group. The evidence associated with parent training / education programmes will be considered as part of this guideline.
Community Practitioners' and Health Visitors' Association	17	4.3 1	This organisation was approached but did not respond.	
Community Practitioners' and Health Visitors' Association	18	General	The following are some of the factors we believe will lead to better outcomes for the children affected and their families: • Early identification is important for all concerned as parents will feel listened to and so more inclined to work in partnership with professionals • .Children's behaviour can be monitored and helped with ongoing support • A clear and easy to understand pathway is required,	Thank you for your comments. Implementation issues will be considered during the guideline development process. The views of young people will be taken on board through the use of focus groups.

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			preferably standardised in all geographical areas • A clear understanding about medication for professionals and carers is needed as is regular monitoring. • A clear guideline outlining which professional is responsible and the frequency of contact is necessary. • There needs to be greater number and availability of psychological interventions. They should be easy to access and the waiting list "reasonable ". • Help should be available for parents/carers • The transition from children to adult services should be smooth. There is currently a gap in service provision between the ages of 16 and 18 where there is no clear delineation between adults or children. • Agreed outcome measures are required. Can the guidelines incorporate this? • Resources are always a major issue and whilst long term appropriate strategies may result in redistribution of some current resources, money will be required to 'pump prime' some initiatives. This should not be seen as short term funding for projects that then close due to lack of long term funding even when they have proved successful or a considerable time is spent on securing	

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			funding. In other words services need to be mainstreamed with secure funding, but may require initial set up costs. • Training is a major issue and needs to be multi-agency. Can there be a recommendation that training should be multi-agency, including raising awareness and putting networks in place to ensure implementation and long term support arrangements? • User involvement is paramount. How will young people be consulted and involved with the guidelines development?	
Community Practitioners' and Health Visitors' Association	19		Health Visiting Input: Health Visitors are almost always the first point of contact with children with ADHD and are in a key position to detect the condition at an early stage. Reference should be made to their key role in the guideline in relation to early detection and ongoing support for families otherwise this resource will be wasted as its capacity is already under threat from service redesign. Also the GDG should note that some Health visitors run clinics for children with ADHD and support groups for their families. These can be important additional services. There is an enormous amount of expertise within the HV profession in this area and the GDG needs to tap into it.	Thank you for your comments. Where appropriate, the Guideline Development Group will be assisted by special advisors.

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Conwy & Denbighshire NHS Trust			This organisation was approached but did not respond.	
Co-operative Pharmacy Association			This organisation was approached but did not respond.	
Cornwall Partnership Trust			This organisation was approached but did not respond.	
Counselling and Psychotherapy Trust			This organisation was approached but did not respond.	
Counsellors and Psychotherapists in Primary Care			This organisation was approached but did not respond.	
Critical Psychiatry Network	1	General	Pressures of time mean that this is a brief response that sets out some parameters that need thorough consideration in any NICE guideline on ADHD. This is a highly contested clinical area and the guidelines should attempt to encompass this rather than reaching for a homogonous meaningless 'middle' ground (where the middle ground lies of course changes over time and according to your particular perspective).	Thank you for your comments.
Critical Psychiatry Network	2	4.3 Comments	1. **Full range of care routinely made available by the NHS.** Care in the NHS is a lottery. This has been aggravated by the	Thank you very much for your comprehensive and detailed critique of the concept, diagnosis, classification and treatment of

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		related to areas that will be covered by the guideline	unscientific nature of the ADHD construct and its categorisation as a 'neurodevelopment' disorder despite the lack of evidence to support this categorisation. The result has been that the majority of ADHD clinics that have been set up in the NHS are run by paediatricians, who have no training in assessment or treatment of broader psychosocial factors, resulting in 'care' revolving around drug treatment only, with little or no access for the vast majority of those diagnosed to other treatments. There is a huge problem in the nature of the diagnostic process. There are no medical tests for ADHD. There are no specific brain functioning tests for ADHD. There are no specific psychological tests for ADHD. There are no specific observational tests for ADHD. A doctor, through that doctor's assessment of a child's history and reported behaviour problems, makes a diagnosis of ADHD. Rating scales, which the child's parents or carers and teachers fill out about the child concerned, are frequently used to assist the doctor when they are assessing a child for ADHD. These rating scales are questionnaires in which adults looking after the child (most usually a separate questionnaire for a parent/carer and a separate questionnaire for a teacher) are asked to decide on the frequency with which hyperactive, inattentive or impulsive behaviours are occurring in the child. They are not a test for ADHD as all a rating questionnaire can measure is an adult's opinion about a particular child's behaviour at a particular moment in time and in a particular setting.	ADHD and related categories. Unfortunately, we are unable to dismiss the diagnosis as we would be left without a guideline to undertake. Your points are, however, well taken and we will share all your comments with the guideline development group. It is important to us (the NCCMH and guideline developers) that critical views, even those that are critical to the very nature of psychiatry, are heard. Thank you again for your comments.

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			Common questions used in rating scales (which the person filling in the questionnaire has to rate for frequency or severity in the child) include: • Often fails to give close attention to details or makes careless mistakes in homework, work, or other activities. • Often has difficulties sustaining attention in tasks or play activities. • Often does not seem to listen when spoken to directly. • Often does not follow through instructions and fails to finish schoolwork, chores, or duties in the workplace. • Often has difficulties organizing tasks and activities. • Often avoids, dislikes or is reluctant to engage in tasks that require sustained mental efforts. • Often loses things necessary for tasks or activities (e.g. toys, school assignments, pencils, books). • Is often easily distracted by extraneous stimuli. • Is often forgetful in daily activities. • Often fidgets with hands or feet or squirms in seat. • Often leaves seat in classroom or in other situations in which remaining seated is expected.	

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			• Often runs about or climbs excessively in situations in which it is inappropriate. • Often has difficulty playing or engaging in leisure activities quietly. • Is often "on the go" or often acts as if "driven by a motor". • Often talks excessively. • Often blurts out answers before questions have been completed. • Often has difficulty waiting their turn. • Often interrupt or intrudes on others. Words such as "often", "seems", "difficulties", "reluctant", "easily", "quietly", and "excessively" that appear in these questionnaires are hard to define. For example the word "often" appears in every one of the above questions, but what does it mean? Does it mean that the child does those behaviours at least once a day or at least once a minute? These questionnaires can only rate a particular adult's perception of a particular child at a particular moment in time and in a particular setting. In other words they are measures of the *subjective* perception of the adult filling in the rating scale. What they cannot be is an *objective* factual piece of 'hard data' about a child.	

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			These days when making a diagnosis of ADHD, the doctor doing the evaluation does not need to observe the behaviours of hyperactivity, impulsivity or inattention in the child concerned during the assessment. Making the diagnosis is based on taking a history (to see if the behaviours, according to those giving the doctor the history, started early in a child's life, and to exclude any other medical reason that may be causing the behavioural problems) and evaluating a couple of rating questionnaires. Ultimately the making of the diagnosis (or not) rests on the beliefs of the doctor and how they interpret the history and questionnaires. It's an entirely subjective process. Hyperactivity, impulsivity and limited attention span are behaviours that occur on a continuum. All children, particularly boys will present with such behaviour in some settings at some point. They are not behaviours that would be interpreted as abnormal whenever they occur. Contrast this to a hallucination (such as hearing voices that are not there) or a delusion which, in Western culture at least, are viewed as abnormal in most circumstances (However, even with these symptoms that are psychiatrically categorised as 'psychotic' symptoms, in other words symptoms of someone deemed to be out of touch with reality, it is not as straight forward as many believe. For example, it is now recognized that many otherwise healthy and socially well functioning people sometimes hear voices). Without any medical tests to establish which individual has a physical problem causing the above behaviour problems,	

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			defining the cut off between normal and ADHD is arrived at by an arbitrary decision. Those who have argued that ADHD does not exist as a real disorder, start by pointing to the obvious uncertainty about its definition. Because of the uncertainty about definition it is hardly surprising that epidemiological studies (studies that measure how many have a disorder) have produced very different prevalence rates for ADHD or hyperkinetic disorders (ADHD's equivalent in the International Classification of Diseases (ICD) system of diagnoses) ranging from about 0.5% of school age children to 26% of school age children (see below). **2. Validity and reliability of existing diagnostic criteria and criteria that can be used to determine circumstances in which the guideline should be used.** So what is the evidence for the existence of this disorder? Is there a medical test that will diagnose it? No. Are there any specific cognitive, metabolic or neurological markers for ADHD? No. Those who have argued that ADHD does not exist as a real disorder, start by pointing to the obvious uncertainty about its definition (McGuinness, 1989). Because of this uncertainty it is hardly surprising that epidemiological studies have produced very different prevalence rates for ADHD (in its various forms), ranging from about 0.5% of school age children to 26% of school age children (Taylor and Hemsley, 1995; Green et al, 1999).	

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			There is a preponderance of boys over girls in ADHD symptomatology in the region of four (or more) to one (McGee et al, 1992). This is very similar to the gender distribution found in conduct disorder and other so-called externalising behavioural disorders in children. The meaning of this gender distribution is rarely questioned. What sort of biological variable are we attempting to categorise here if this is a biological abnormality? Is it that boys generally have bad genes compared to girls? Is it something to do with the normal biological differences between male and female genes? Is there an interaction between boy's behaviour and changes in social expectations regarding children's behaviour generally? Do social changes in family structure, lifestyles, teaching methods, classroom sizes, rates of violence, rates of substance misuse and so on have an effect on perceptions and beliefs about boy's and girl's behaviour, or even on their behaviour directly? Has life got harder for boys in some way? Has life got harder for parents trying to control normal boy behaviour? Are we still compelled to pay more attention to the externalised behaviour of boys than the internalised behaviour of girls, only now we medicalize this (after all adults in Western societies are usually more tolerant of hyperactivity in girls than in boys (Battle and Lacey, 1972))? Do changes in teaching methods have an effect on how we understand and deal with boys' behaviour? These and other social/cultural questions need to be discussed.	

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			Despite attempts at standardising criteria and assessment tools in cross-cultural studies, major and significant differences between raters from different countries continue to be apparent (Mann et al, 1992). There are also significant differences between raters when raters rate children from different ethnic minority backgrounds (Sonuga-Barke et al, 1993). One replicated finding is an apparently high rate of hyperactivity in China and Hong Kong (Shen et al, 1985; Luk and Leung, 1989). In these studies nearly three times as many Chinese as English children were rated as hyperactive. A more detailed assessment of these results suggested that most of the 'hyperactive' Chinese children would not have been rated as hyperactive by most English raters and were a good deal less hyperactive than English children rated as 'hyperactive' (Taylor, 1994). One suggestion for such a consistently large disparity in hyperactivity ratings between Chinese and English children is that it may be due to the great importance of school success in Chinese culture leading to an intolerance of much lesser degrees of disruptive behaviour (Taylor, 1994). Whatever the reason(s), it demonstrates that hyperactivity and disruptiveness in boys is a highly culturally constructed entity. That ratings of hyperactivity, inattention and disruptiveness are culturally dependent is not surprising as inattention, impulsivity and motor restlessness are found in all children (and adults) to some degree. Diagnosis is based on an	

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			assessment of what is felt to be developmentally inappropriate intensity, frequency and duration of the behaviours, rather than on its mere presence. All the symptoms described in this disorder are of a subjective nature (e.g. 'often does not seem to listen when spoken to') and therefore highly influenced by the raters cultural beliefs and perceptions about such behaviours. After all how do you operationalize, define and understand non-specific words like 'often' and 'excessive', which are invariably found in ADHD rating questionnaires? With regards co-morbidity numerous epidemiological and clinical studies demonstrate the high frequency with which supposedly separate child psychiatric disorders occur in individuals with ADHD (Caron and Rutter, 1991). In children with ADHD co-morbidity with other child psychiatric conditions is common no matter what definition is used (Beiderman et al, 1991). It is estimated that about half the children with ADHD also have a conduct disorder, about half also have an emotional disorder, about one third have an anxiety disorder and another third have depression (Barkley, 1994). Co-morbidity is so prevalent that at least three quarters of ADHD diagnosed children will have at least one other diagnosable child psychiatric condition (Hazell, 1997). The co-occurrence of the symptoms that make up oppositional/defiant and conduct disorders with those that make up hyperactivity and attention deficit disorders is so	

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			strong (Beiderman et al, 1991; Fergusson and Horwood, 1993) that many commentators have questioned the reality of the distinction between them. Psychiatrists have adopted co-morbidity as a way of trying to explain clinical reality when it does not appear to tally with research generated views of mental life. It's a way of maintaining a fantasy that there is a natural, probably biological, boundary where no natural boundaries exist (Tyrer, 1996). This lack of a coherent concept is reflected in the lack of consensus on the question of possible causal mechanisms. Thus the condition was initially viewed as being due to an underlying, excessive motor activity in the child (Schachar, 1991) and later as being due to an underlying central attention deficit (Douglas, 1972; 1983). Others have suggested that the central deficit is one of generalised intellectual impairment (Werry et al, 1987) or of motivation (Draeger et al, 1986). The conviction held by a number of influential researchers about the likely central deficit has had a big influence on the behavioural definitions of the disorder. For example, Douglas's belief (1972) that attention, not hyperactivity, was the essential feature distinguishing these children from other difficult and disruptive children, led to the establishment of the 'Attention Deficit Disorder (ADD)' definition in DSM-III.	

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			Claims have been made that neuroimaging studies confirm that ADHD is a brain disorder. Closer examination of the quoted studies not only reveals a more complex picture, it actually suggests the opposite, as the studies demonstrate that there is no characteristic neurophysiological or neuroanatomical pattern that can be found in children diagnosed as having ADHD. Brain scan studies have not uncovered a consistent deficit or abnormality, with a wide variety of brain structures being implicated, for example; Striatal, Orbital, Prefrontal, Fronto Posterior and Medial Orbital areas, Caudate Nucleus, Corpus Calosum and Parietal lobe (Rapport, 1995). The sample sizes in these studies have all been small and in no study have the brains of the ADHD diagnosed children been considered to be clinically abnormal (Hynd and Hooper, 1995), nor has any specific abnormality been convincingly demonstrated (Baumeister and Hawkins, 2001). Interestingly, after almost twenty five years and over thirty such studies, researchers have yet to do a simple comparison of unmedicated children diagnosed with ADHD with an age matched control group, the one large study that claimed to have done this (Castellanos et al, 2002) for reasons best known to themselves choosing a control group whose age was on average 2 years older (Leo and Cohen, 2003) and thereby all they scientifically managed to prove was that younger children had smaller brains than older ones! Most worryingly, animal studies suggest that any differences observed in	

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			these studies could well be due to the effects of medication that most children in these studies had taken (Breggin, 2001; Moll et al, 2001; Sproson et al., 2001). As in the Castellanos et al. (2002) study, some of the ADHD subjects in the Sowell et al. (2003) study were apparently medication-naïve- 'apparently' because specific descriptions were not provided. The issue becomes considerably more muddled and confusing due to a brief discussion of the potential role of stimulant medication on their findings at the end of Sowell et al.'s (2003) paper. The authors first appropriately acknowledged that, since 55% of their ADHD children were taking stimulants, "the effects of stimulant drugs could have confounded our findings of abnormal brain morphology in children with [ADHD]" (p. 1705). The simplest way to properly evaluate this confounding effect would have been to compare the medicated ADHD children with the unmedicated ADHD children. However, Sowell et al. consciously chose to not make that comparison. The authors further explain that this comparison, between unmedicated and medicated ADHD children, is not needed because the prior study by Castellanos et al. (2002) suggested that medications do not affect brain size! It is difficult to see why Sowell et al. would feel that they should not compare medicated and unmedicated ADHD subjects. Clearly, just as they acknowledged limitations to their main study results, Sowell et al. could obviously have reported the results of the more specific comparison with an	

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			acknowledgement of appropriate limitations. Sowell et al. cite Castellanos et al. to support the methodological choice of not comparing medicated and unmedicated ADHD subjects, but, Castellanos et al. made that very comparison regardless of medication history. Most importantly, Sowell et al.'s data appear directly relevant to either support or refute the conclusions that Castellanos et al. (2002) drew from their comparison. Such a tactic by the researchers raises the suspicion that the comparison of medicated with unmedicated ADHD subjects in Sowell et al.'s study might have produced results that would have diluted the findings that Sowell et al. chose to emphasize instead. What we end up with is speculative 'biobabble'. Even if consistent differences in neuro-imaging studies were found, unidirectional cause and effect cannot be assumed. This is because neurophysiological measures may reflect different children's different reaction to the same situation causing differences in brain chemistry rather than different brain chemistry causing different behaviour (Christie et al, 1995). Thus, differences in brain function have been demonstrated in normal healthy children who have different temperaments (Fox et al, 1995). At the turn of the century doctors used to measure the size and shape of the part of the skull housing the brain. They came up with all sorts of statistical differences and used these to justify a 'scientific' basis for amongst other things, the prevailing racist views of the time.	

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			This now discredited 'science', which lasted for over a hundred years before dying out early last century, was known as phrenology. It was believed that a skilled phrenologist could assess the moral and intellectual qualities of an individual by inspecting the skull and palpating its surface for characteristic bumps and protuberances. If we cannot stop ourselves from impulsively jumping to unwarranted conclusions about the reasons for differences found in brain scanning studies, we will create a modern version of phrenology. Although ADHD-type behaviour may be familial in the sense that it 'runs' or clusters in families, we cannot determine whether this clustering is caused by the greater genetic resemblance of family members, since they also experience similar environmental factors. As Faraone and colleagues (2005, p. 1313) observed, "family studies cannot disentangle genetic from environmental sources . . ." In their opinion, "adoption and twin studies [are needed] to determine whether genes account for the familial transmission of a disorder." All ADHD twin studies have used the 'classical twin method,' more commonly known as 'the twin method.' This research technique compares the concordance rates or correlations of reared-together MZ twins (also known as monozygotic or identical; who share a 100% genetic similarity), versus the same measures of reared-together same-sex DZ twins (also known as dizygotic or fraternal; who share a 50% genetic similarity).	

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			Based on the assumption that both types of twins experience the same kinds of environments, known as the 'equal environment assumption' or 'EEA,' twin researchers attribute a statistically significant greater resemblance of reared-together MZs versus reared-together DZs to genetic factors. There have been no studies of 'reared-apart' ADHD twins. Although the twin method depends on additional assumptions, the equal environment assumption has been the main area of contention between twin researchers and their critics. However, the evidence clearly shows that MZ twins spend more time together, more often have the same friends, are treated more similarly by parents and others, and so forth (Joseph, 2004a). Moreover, MZs share a closer emotional bond than DZs, and more often view themselves as being two halves of the same whole (that is, they experience what some psychologists call identity confusion; see Ainslie, 1985; Jackson, 1960). The twin method—just like a family study—is unable to disentangle the potential influences of genetic and environmental factors. Instead, while belatedly recognizing that MZ twins do indeed experience more similar environments that DZs, some twin researchers attempted to rescue the twin method by redefining the equal environment assumption. Behaviour geneticists and others have renamed the EEA as the 'equal trait-relevant environment assumption' (Carey & DiLalla, 1994). Proponents of the trait-relevant EEA recognize that MZ twins experience more similar environments than DZs, but argue or imply that the	

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			burden of proof for demonstrating that MZ and DZ twins experience dissimilar trait-relevant environments falls not on twin researchers, but on critics of the twin method (examples of twin researchers reversing the burden of proof onto critics include Bouchard, 1993, 1997; Kendler, 1983; Lyons et al., 1991). However, it has been observed that "a basic tenet of science is that the burden of proof always falls squarely on the claimant, not the critic . . . Consequently, it is up to the proponents of these techniques to demonstrate that they work, not up to the critics of these techniques to demonstrate the converse" (Lilienfeld et al., 2003, p. 3). This means that the burden of proof falls on twin researchers to demonstrate that the greater environmental similarity of MZ versus DZ twins does not entirely explain their results. Most twin researchers' recognition that MZ twins experience more similar environments and treatments than DZs invalidates genetic interpretations of MZ-DZ comparisons, for the exact same reason that genetic interpretations of family studies are invalid. There is no reason, therefore, to accept that the twin method measures anything other than the more similar environments of MZ versus DZ twins (plus bias), and all conclusions in favour of genetic influences on psychiatric disorders (including ADHD) derived from the twin method must be disregarded. Nevertheless, Barkley (1998, p. 68) has argued that twin studies furnish "the most conclusive evidence that genetics can	

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			contribute to ADHD." Twin research has found consistently that MZ twins are more concordant for ADHD, or correlate higher for ADHD-type behaviors, than same-sex DZ twins. To date, more than 20 ADHD twin studies have been published (for example, Cronk et al., 2002; Edelbrock et al., 1995; Gilger et al., 1992; Gillis et al., 1992; Hudziak et al., 2003; Saudino et al., 2005; Sherman et al., 1997; Thapar et al., 1995; Willcutt et al., 2000). Although the EEA's validity is an essential aspect of their conclusions in favour of genetics, few authors of the 20+ ADHD twin studies addressed the assumption's merits or provided evidence or citations in support of the traditional or trait-relevant definitions of the EEA. To the extent that they discuss the EEA at all, most ADHD twin researchers adhere to the traditional EEA definition despite the fact that, in the words of twin researchers Scarr and Carter-Saltzman (1979, p. 528), "the evidence of greater environmental similarity for MZ than DZ twins is overwhelming." Although most ADHD twin studies have found greater MZ versus DZ resemblance for ADHD or ADHD-type behaviors, the authors of only 3 of the last 18 published ADHD twin studies addressed the EEA (Joseph, 2006), and only Cronk et al. (2002) defined the EEA in the trait-relevant sense. Moreover, no ADHD twin researchers other than Cronk et al. cited previous research or publications supporting the validity of the EEA. Thus, implicitly or explicitly, all but one group of ADHD twin researchers based their conclusions on the traditional	

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			assumption that the environments of MZ and DZ twins are equal, yet only Gillis and associates (1992) argued that these environments are actually equal! ADHD genetic researchers Hay, and Levy have written that identical twins "may well be treated more similarly than fraternal twins, but this is far more a consequence of their genetic similarity in behaviour (and of ensuing responses by parents and others) than a cause of such similarity" (Hay et al., 2001, p. 12). Like Kendler (1983) before them, Hay and associates failed to understand that the reason MZ twins experience more similar environments than DZs is not relevant in assessing the validity of the twin method. In order to invalidate genetic interpretations of ADHD twin data, critics need only show that MZ and DZ environments are different. Thus, since the evidence overwhelmingly suggests that MZ twins are treated more alike, spend considerably more time together, and experience greater levels of identity confusion and closeness (Joseph, 2004), we would expect MZ twins—on purely environmental grounds—to correlate higher than same-sex DZs on ADHD-related measures. ADHD twin studies, therefore, are based on an unsupported theoretical assumption and, like family studies, are unable to disentangle the potential influences of genes and environment on ADHD-type behavior. ADHD adoption studies have been published by Alberts-Corush et al. (1986), Cantwell (1975), Morrison and Stewart (1973),	

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			Safer (1973), Sprich et al. (2000), and van den Oord et al. (1994). The results of these studies are frequently cited in textbooks, review articles, and scientific papers as supporting genetic theories of ADHD. The authors of the four Adoptive Parents studies (Alberts-Corush et al., 1986; Cantwell, 1975; Morrison & Stewart, 1973; Sprich et al., 2000) compared the ADHD rate among the relatives of different types of families, but had no information on their ADHD adoptees' biological relatives. In fact, no ADHD adoption study has investigated the biological relatives of adopted-away children, meaning that their authors were unable to make direct comparisons between the biological and adoptive families of the same child. In contrast, Kety and colleagues' (1994) schizophrenia adoption studies diagnosed adoptees' adoptive and biological relatives. Unlike the schizophrenia adoption studies, the ADHD Adoptive Parents studies compared diagnoses in a group consisting of adopted-away ADHD children and their adoptive families (AH), versus a group consisting of the families of other ADHD children living with their biological parents. Unfortunately, ADHD genetic researchers typically fail to discuss the severe limitations of the Adoptive Parents design. Too often, they fail to state clearly that researchers were unable to study adoptees' biological relatives, often writing in potentially misleading ways about ADHD adoption research (Joseph, 2006). For example, Faraone and Biederman (2000, p. 57)	

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			wrote that a "testable psychosocial theory" must be able to explain "the elevated rates of ADHD and associated traits among the biological relatives of adopted away ADHD children," falsely implying that researchers obtained data on these biological relatives. And in a subsequent review article in which he discussed ADHD adoption research, Faraone (2004, pp. 305-306) wrote, "By examining both the adoptive and biological relatives of ill probands, one can disentangle genetic and environmental sources of familial transmission." This was logic of Kety's schizophrenia adoption studies. However, no ADHD adoption study has examined the "adoptive and biological relatives" of the same "ill" adoptees. Authoritative ADHD experts such as Barkley (2003, p. 117) then write for a larger audience in technically correct, yet potentially misleading ways: "Cantwell . . . and Morrison and Stewart . . . both reported higher rates of hyperactivity in the biological parents of hyperactive children than in the adoptive parents of such children." Yet another issue in ADHD adoption research is evidence that adoptees as a population are more likely than non-adoptees to receive an ADHD diagnosis (Deutsch, 1989; Deutsch et al., 1982). If true, this casts further doubt on the already extremely shaky conclusions of the ADHD adoption studies. If adoptees and non-adoptees constitute different populations with respect to ADHD, it would be difficult to generalize findings of an ADHD adoption study to the non-adoptee population. Although adoption researchers usually do not address this, many adopted	

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			children are psychologically scarred on the basis of having been abandoned by their primary caregivers. Thus, a more evocative designation for adoption studies would be 'the study of abandoned children'. Jay Joseph has reviewed the individual ADHD adoption studies in detail (Joseph, 2000, 2002, 2006). His conclusions are that these studies are flawed on grounds that include, (1) their failure to study adoptees' biological relatives; (2) researchers' use of non-blinded diagnoses, which they sometimes made on the basis of relatives' recollections; (3) inadequate definitions of ADHD; (4) researchers' inability to control for environmental confounds; (5) researchers' inability to control for the status of adoptive parents as a population screened for psychiatric disorders; (6) potential researcher bias; and (7) the use of late-separated adoptees. The authors of textbooks and review articles usually report that the heritability of ADHD, as demonstrated by twin studies, is about 76% (Faraone et al., 2005), making it one of the "most heritable" disorders in child psychiatry. They arrive at this figure by doubling the MZ-DZ correlation difference. For example, if MZs correlate at .90, and DZs correlate at .50, twin researchers would estimate heritability at .80 (80%). In addition to the fact that these such estimates are based on the validity of the twin method's untenable equal environment assumption, heritability estimates in psychiatry and psychology are inappropriate and	

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			misleading (Joseph, 2004). The heritability statistic was developed in agriculture in order to predict the results of a selective breeding program (Joseph, 2004). However, as Hirsch (1997, 2004) has argued, a numerical heritability estimate (coefficient) is not a "nature/nurture ratio" of the relative contributions of genes and environment, and "highly heritable" single-gene disorders such as phenylketonuria (PKU) can be prevented by a dietary intervention. Thus, even if genes play a role in ADHD, we cannot determine "how much" of the "ADHD phenotype" variation is attributable to genes because, like PKU, a timely (and possibly simple) environmental intervention could prevent a condition with a stated heritability as high as 1.0. Mainstream psychiatry sees ADHD as 'multifactorial complex disorder' meaning that there is 'a complex interacting admixture of multiple genes and multiple environmental risk factors' (Rutter, 2001, p. 227). Thus, molecular genetic researchers must assume that ADHD (1) is a valid entity that can be reliably diagnosed; (2) is caused by, among other factors, genetic variation (polymorphisms) or genetic mutations; and, (3) has corresponding biological defects in the brain. However, although ADHD is frequently referred to as a 'complex genetic disorder,' this is a theory, not a fact. Psychiatric conditions such as ADHD are called 'complex disorders' because of the failure to find genes, while subsequent	

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			failures are explained on the basis of the 'complex' nature of the 'disease' leading to circular reasoning. In fact, the 'lack of success' in finding genes defines 'complex diseases' in psychiatry. Moreover, even if a gene is necessary for ADHD to appear, it still doesn't mean that it is a causative factor. As Ratner (2004, p. 30) pointed out, "The fact that something is a necessary foundation for something does not mean that it causes it." For example, all vehicles traveling over 60 miles per hour on the freeway have two or more tires. However, although tires are necessary for vehicles to move 60 miles per hour, tires do not cause vehicles to move forward; engines do. Ratner challenged claims that a defective gene causes language impairments. "Obviously, language requires a normal genetic substratum," he wrote, "and a defective genome undermines the ability to use language — just as it undermines the ability to play Monopoly." He concluded, however, "this does not mean that a gene causes or predisposes language, any more than it causes or predisposes me to play Monopoly." Yet another problem is that, like twin and adoption studies, molecular genetic research depends on the acceptance of questionable theoretical assumptions. This is manifest not only in the investigators' decision to perform this research, but also because they factor assumptions about genetics into mathematical models of familial transmission. According to McGuffin (2004, p. 179), "Unfortunately, conventional linkage	

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			requires several assumptions. These are that major gene effects (rather than just multiple small gene effects) exist, that there is some way of assuring genetic homogeneity, and that the mode of transmission of the disorder is known." Thus, although ADHD molecular genetic researchers test multiple genetic models in computer analyses of their findings, all models assume that some type of genetic transmission is occurring. But what if no genetic transmission is occurring? The large number of false positive linkage findings in psychiatry in general, and ADHD in particular, may be another example of questionable assumptions leading researchers to the premature conclusion that genetic factors (or actual genes) exist. Their results may be influenced by plugging false assumptions about genetic transmission into their calculations. Like other areas of psychiatry, we have seen many claims of ADHD gene findings. However, subsequent replication attempts fail to support these claims. Researchers currently focus on genes involved with the brain's dopamine receptors, which they view as 'candidate genes' on the basis of an a priori hypothesis derived from neurochemical and neuropharmacological research (Asherson & Curran, 2001; Barr, 2001). The major areas of interest have been the DRD4 dopamine receptor gene, and the DAT1 dopamine transporter gene. Faraone and Biederman (2000, p. 573) claimed that "molecular genetic studies have implicated these two genes . . . in the etiology of ADHD." However, although the original claims have found some	

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			support, several subsequent studies have failed to replicate an association between ADHD and the DRD4 or DAT1 genes (e.g., Bakker et al., 2005; Langley et al., 2005; Mill et al., 2005; Ogdie et al., 2003; van der Meulen et al., 2005). Several complete genome scans have also failed to find consistent evidence in support of regions harboring suspected ADHD genes (Arcos-Burgos et al., 2004; Bakker et al., 2003; Fisher et al., 2002; Hebebrand et al., 2005; Ogdie et al., 2003). According to Faraone and colleagues, "The handful of genome-wide scans that have been conducted thus far show divergent findings and are, therefore, not conclusive" (Faraone et al., 2005, p. 1319). It is generous to state that these genome scan results are "not conclusive." It would be better to conclude that these studies have found no replicated evidence that genes have anything to do with ADHD. ADHD genetic researchers have resorted to citing meta-analyses of studies finding negative and positive results in support of associations between ADHD and chromosomal regions (e.g., Faraone et al., 2001; Langley et al., 2004). As Pittelli (2004, p. 1134) wrote, however, "I find this trend of using meta-analysis to resurrect largely negative genetic linkage studies disturbing. It appears to be nothing more than a manipulation of data to obtain a desired result." It does indeed appear to be such a manipulation, yet readers relatively unsophisticated in genetic research and terminology may well conclude that yet another "ADHD gene" has been identified.	

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			We have seen prominent genetic researchers such as Robert Plomin argue that, although genes for ADHD and other disorders have not been found, we "are on the cusp" of gene discoveries. What Plomin and other genetic researchers rarely consider in print, however, is the possibility that ADHD does not exist. Psychiatric geneticists and their supporters instead write optimistically about the great strides they have made, and how ADHD genes will soon be identified. They write as if they were searching for the cure of a deadly disease, or the virus causing an epidemic. But ADHD is simply a grouping of socially disapproved behaviours falsely passed off as a disease, and finding genes would do little if anything to "cure" these behaviours. Still, in the ADHD genetic literature we find many claims that gene discoveries are imminent, and that finding genes would be an important event. Generally speaking, these investigators substitute language for real gene findings. Thus, when they scan the genome and find no ADHD genes, they can say that genes are "implicated," or that researchers are making "enormous advances," or that genes are "just beginning to be identified," or that studies "suggest" the finding of genes, and so on. Plomin wrote in 2005 (p. 1030) that, although genes in psychiatry and psychology remain to be discovered, this is "an exciting time for child psychology and psychiatry. The field will be transformed as we move from finding genes to using them as genetic risk indicators in our research and eventually in our clinics." And another	

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			researcher wrote in the same year, "Uncovering the genomic underpinnings of ADHD is proving to be one of the most exciting stories in psychiatric genetics" (McGough, 2005, p. 1371). Ultimately, however, optimistic statements cannot eliminate the necessity of finding actual genes. **3. Early identification of ADHD in children in primary care, and identification of factors that should lead to investigation of the possibility of ADHD.** Early intervention strategies are complicated by the potential impact of believing a child to have ADHD. This knowledge could, in itself, be a life-altering event, affecting how parents, classmates, teachers, and others treat a child. And even in the unlikely event that presumed ADHD genes are found in the future, society might still decide to concentrate on eliminating environmental factors contributing to ADHD-type behavior. These interventions would be aimed at all children in the same way that an anti-smoking campaign, which does not target its intended audience by genotype, can help reduce tobacco use. **4. Pathways to treatment.** Pathways have been adversely affected by categorisation of ADHD as a 'neurodevelopment' disorder despite the lack of evidence to support this categorisation. The result has been that the majority of ADHD clinics that have been set up in the NHS are run by paediatricians, who have no training in assessment	

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			or treatment of broader psychosocial factors, resulting in 'care' revolving around drug treatment only, with little or no access for the vast majority of those diagnosed to other treatments. **5. Identification and management of risk.** We need to be aware that the widespread diagnosis and use of stimulants creates many potential public health risks. Doctors may be unwittingly convincing children to control and manage themselves using medication, a pattern that could carry on into adulthood as the preferred or only way to cope with life's stresses. Parents, teachers and others may lose interest in understanding the meaning behind an ADHD labelled child's behaviour beyond that of an illness internal to the child that needs medication, thus contributing to a 'de-skilling' of parents' and teachers' ability to manage and deal with challenging behaviour. The National Association for the Advancement of Coloured People in the United States has offered strong testimony stating their concern that young blacks could end up over represented in the ADHD category and over medicated and has been campaigning for black parents to reject such a diagnosis (British Psychological Society, 1996). The dynamics of Ritalin prescription in North America have changed in recent years however, with the majority of those who get the prescription coming from white middle class	

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			families (Olfson et al, 2002). In this context one dynamic appears to be middle class parent's fears about their children's education. The anxiety is that that if their children don't get into college or university, they are 'sunk'. Thus parents and the middle class teachers of their children are converting this anxiety into requests for the perceived performance enhancing properties of stimulants and with more children in classrooms taking stimulants many parents end up feeling their child is at a disadvantage if they don't (Diller, 1998; 2002). This dynamic is reflected in the trend where stimulants are being prescribed to children without first making a diagnosis. This trend has now become so established that in some areas of the United States, less than half the children prescribed stimulants reach even the broad criteria for making a diagnosis of ADHD (Wasserman et al, 1999; Angold et al, 2000). In the UK anecdotal evidence suggests a different dynamic whereby stimulants are more likely to be used on children from poorer socioeconomic backgrounds thus effectively becoming a drug used for the social control of working class children (or more accurately boys). Ritalin is a drug of abuse as it can be crushed and snorted to produce a high (Heyman, 1994). Surveys have shown that a significant proportion of adolescents in the United States self report using Ritalin for non-medical purposes (Robin and Barkley, 1998). Accounts of abuse of Ritalin and other	

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			stimulants are increasingly being reported in the lay press (Ravenel, 2002). A national survey in the United States found that 2.8% of high school seniors had used Ritalin without a physician's prescription the previous year (Sannerud and Feussner, 2000). The neuro-chemical effects of Ritalin are very similar to that of Cocaine, which is one of the most addictive drugs. Cocaine users report that the effect of injected Ritalin is almost indistinguishable from that of Cocaine (Volkow et al, 1995). Advocates of the use of stimulants have claimed that the likelihood of substance misuse amongst those with a diagnosis of ADHD and treated with a stimulant, concluded that they were less likely to abuse substances when compared to those with ADHD who were not treated with stimulants. However, a larger, community based study (Lambert and Hartsough, 1998) which followed young people into their mid to late twenties (compared to the other studies which have followed young people on stimulants into their late teens) found a significant increase in cocaine and tobacco dependence amongst ADHD subjects taking stimulants when compared to controls, furthermore they discovered a linear relationship between the amount of stimulant treatment and the likelihood of either tobacco or cocaine dependence. **5. Appropriate use of pharmacological treatments.** Stimulants central nervous systems effects are not limited to those children who can be defined by the boundaries of this	

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			disorder. Thus stimulants have the same cognitive and behavioural effects on otherwise normal children, aggressive children regardless of diagnosis and children with co-morbid conduct disorder. This is not surprising. The pharmacological action of Ritalin on the brain is basically that of amphetamines (or its street name - speed) and cocaine which is known to have similar effects in most people who take it (see Timimi, 2005). Research has focused almost exclusively on short-term outcomes. Outcome research in Ritalin treatment has been shown to have serious shortfalls in methodology such as small samples, inadequate description of randomisation or blinding and not accounting for withdrawals or drop outs (Zwi et al, 2000; Joughin and Zwi, 1999). The most recent meta-analysis of randomised controlled trials of methylphenidate found that the trials were of poor quality, there was strong evidence of publication bias, short term effects were inconsistent across different rating scales, side effects were frequent and problematic and long-term effects beyond 4 weeks of treatment were not demonstrated (Schachter et al, 2001). The few long-term studies that have been conducted suggest that stimulants do not result in any long-term improvement in either behavioural or academic achievement (Weis et al, 1975; Rie et al, 1976; Charles and Schain, 1981; Gadow, 1983; Hetchman et al, 1984; Klein and Mannuzza, 1991).	

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			Despite the lack of evidence for any long -term effectiveness, Ritalin is most usually prescribed continuously for seven, eight or more years, with children as young as two being prescribed the drug in increasing numbers despite the manufacturers licence stating that it should not be prescribed to children under six (Zito et al, 2000; Baldwin and Anderson, 2000). The idea that Ritalin is a safe drug with few harmful side effects couldn't be further from the truth. Troublesome and frequently reported side effects include poor appetite, weight loss, growth suppression, insomnia, depression, irritability, confusion, mood swings, obsessive compulsive behaviours, psychosis, explosive violent behaviour, personality change, a flattening of the emotions which, when observed, looks like a zombie-like state, stomach ache, headaches, staring, disinterest, tachycardia, pituitary dysfunction and dizziness. Ritalin is also associated with a lowered self-esteem and suppression of creativity in some children. Ritalin may also have long term adverse effects in as many as one third of those treated, including subtle cognitive effects such as perseveration (obsessive repetition of the same task), preoccupations, sombreness and deterioration in performance on complex cognitive tasks (see Timimi, 2005). Stimulants can also cause cardio-toxicity resulting in sudden death (see for example www.ritalindeath.com which documents that Between 1990 and 2000 there were 186	

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			deaths from methylphenidate reported to the FDA MedWatch program). Recently Adderall XR, was withdrawn from use in Canada after a report found it was responsible for 20 sudden deaths and a dozen strokes. The lack of long-term studies into the effects of stimulants is a concern, as we do not really know what sort of effect giving an amphetamine like substance has on the developing brain. Animal studies have found that taking stimulants can cause a long lasting change in the brain biochemistry of rats (Breggin, 1999; 2002; Moll et al, 2001; Sproson et al., 2001; Robinson and Kolb, 2001).Most recently a team at Harvard medical school, examined the effects of exposing rats to Ritalin during early development on behaviors later in life. They exposed normal rats to twice-daily doses of Ritalin during a period that is equivalent to approximately 4 to 12 years of age in humans. Examining the behavior during adulthood, the researchers found that the animals had a reduced ability to experience pleasure and reward. In addition, they found that the animals exposed to Ritalin during pre-adolescence were more prone to express despair-like behaviors in stressful situations (such as swim tests) as adults. Overall, the animals showed more evidence of dysfunctional brain reward systems and depressive-like behaviors in adulthood (press release available at http://www.mclean.harvard.edu/news/press/current.php?id=65). We often forget that stimulants are powerful amphetamine like drugs with potentially addictive properties. Children can and do	

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			become tolerant to its effect resulting in gradually increasing doses being given to children as years on a stimulant clock up. The potential for tolerance and addiction is further demonstrated by withdrawal states (known as the rebound effect, which manifests in increased excitability, activity, talkativeness, irritability and insomnia) seen when the last dose of the day is wearing off or when the drug is withdrawn suddenly (Zahn et al, 1980). Stories of adults becoming addicted to prescribed stimulants are becoming more prevalent (e.g. Wurtzel, 2002). In November 2004, an article was published with several interviews, which highlighted that questions about the scientific credibility of psychiatric drug research on children and adolescents in the field of child psychiatry (Hearn, 2004). Gene Haislip, the now retired director of the U.S. Drug Enforcement Agency (DEA), set production quotas for controlled substances like the federally restricted stimulant methylphenidate. During that time, he fought hard to raise public awareness about the over-prescribing of stimulants to children, about the drug's high rate of non-prescription use/abuse, and about its long-term health impact on young patients. He notes that "When I was at the DEA, we created awareness about this issue. But the bottom line is we didn't succeed in changing the situation because this – prescribing methylphenidate, for example – is spiraling." Adding "A few individuals in government expressing concern can't equal the marketing power of large companies," (quoted in Hearn, 2004) Haislip suspects the dubious marketing	

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			tactics of big drug money have fueled the spiraled use of stimulants, specifically, a small group of prolific ADHD researchers whose work is funded by corporate producers of ADHD drugs. He also suspects that one or more ADHD patient advocacy groups that receive drug company donations have essentially become fronts to push the prescribing of stimulants to children. William Pelham, a prominent ADHD researcher, and former member of the scientific advisory board for McNeil Pharmaceuticals was also interviewed (Hearn, 2004). Between 1997 and 1999, he was paid by McNeil to conduct one of three studies used to get Food and Drug Administration (FDA) approval for Concerta (a long acting slow release version of methylphenidate) and the company now uses these three studies to claim that 96 percent of children taking Concerta experience no problems in appetite, growth, or sleep. But Pelham says the studies were flawed and this claim is misleading because his study started with children who had already been taking Concerta and who had experienced no significant side effects—children who exhibited side effects weren't included in the study to begin with. Pelham mentions that the company pressured him to delete a paragraph he wrote about the importance of behavioural therapy. Pelham then discusses his experience in collaborating in a follow-up paper, in which the company did the data analysis and coordinated the writing of the paper. In Pelham's words, "I	

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			insisted on seeing the analyses and having major inputs into the manuscript, and it was like pulling teeth to get wording and analyses changed. It was like a whitewash—a praise to Concerta.*"* (quoted in Hearn, 2004). In the world of ADHD advocacy, Children and Adults with Attention Deficit Hyperactivity Disorder (CHADD), a large American-based 'parent support group', engages in lobbying and claims to provide science-based, evidence-based information about ADHD to parents and the public. Critics point out that CHADD's basic function has become that of promoting stimulant medications manufactured by its corporate donors. Pharmaceutical companies donated a total of $674,000 in the fiscal year 2002-2003. Pelham, listed by CHADD as a member of its professional advisory board, came face to face with what he says are the group's glaring conflicts of interest. In 2002, after he received the CHADD Hall of Fame Award, he was subsequently interviewed for *Attention!*, the organization's magazine. In the interview, Pelham said, among other things, that stimulant drugs have serious limitations particularly when employed alone and at high doses. He also pointed out that psychosocial treatments should be the treatment of first choice in ADHD, with adjunctive medication used only when necessary. Eight months later, *Attention!* published Pelham's interview but with large swaths cut out, particularly his comments about the limitations of the stimulants. Commenting on this Pelham says "In recent years, I have come to believe that the individuals who	

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			advocate most strongly in favour of medication – both those from the professional community, including the National Institutes of Mental Health, and those from advocacy groups, including CHADD – have major and undisclosed conflicts of interest with the pharmaceutical companies that deal with ADHD products," (quoted in Hearn, 2004). Shire Pharmaceuticals, makers of the stimulant medication Adderall, buys 65,000 of the 100,000 copies each print run of *Attention!*. Shire sales representatives then place them in doctors' offices (Hearn, 2004). In the UK, the main parent support ADDISS- Attention Deficit Disorder Information and Support Service- is also receiving significant funding from the pharmaceutical industry. For example a recent educational campaign 'launched to support parents of children with ADHD' includes a glossy booklet on ADHD called 'Family Stress Points' produced using an educational grant from Eily Lilly (ADDISS, 2005). In a world run by those with the power to 'buy' media attention, it is not uncommon for single studies to become the basis on which practice develops. One such study was the large multi-centre trial in the United States, testing the efficacy of methylphenidate (MTA, 1999). It is notable that in the years since the publication and popularisation of this study there has been a sharp rise in the rates of stimulant prescription in the UK. The study in question compared four groups of children who were given; medication only, intensive behavioural therapy only,	

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			combined behavioural therapy and medication, and standard community care. The study lasted 14 months and concluded that the medication only and combined behaviour therapy and medication groups had the best outcome, with the combined group having only a marginally better outcome than the medication only group. A closer look inevitably brings up important questions of methodology and the hidden question of conflict of interest (Breggin, 2000; Boyle & Jadad, 1999). The principle investigators were well known advocates of medication with long established financial ties to the pharmaceutical industry. Methodologically this was not a placebo controlled double blind clinical trial, and the parents and teachers who participated in the study were exposed to pro-drug propaganda at the start of the study thus putting them in a mindset of positive expectation for change in those children receiving medication. There are also many question marks with regard the selection and recruiting process, the behavioural interventions used, the lack of attention to the number of children experiencing side effects, and the dismissing of some reported side effects as probably being due to non medication factors (Breggin, 2000). In addition, two thirds of the community treated group were also receiving the same stimulant medication during the period of the study, yet were placed in the poorest outcome category. Some of the participants in the above study were followed up again after a further 10 months- in other words after a total of	

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			24 months in the study- (MTA, 2004). These results are no longer looking so impressive. While the percentages of children with normalized symptom levels (in other words those who in the opinion of the researchers were no longer displaying any ADHD symptoms) were essentially unchanged for the behaviour therapy only and community care groups, they had declined substantially for the combined (from 68% to 47%) and medication only (from 56% to 37%) groups. The medication only group now had a similar percentage to the behaviour therapy only group. Furthermore, there was now no evidence of significant treatment group differences in social skills, reading achievement, and parents' use of negative/ineffective discipline strategies, and those who were receiving medication were now significantly shorter than those who were not. Not surprisingly we have heard little about this potentially damaging (to stimulant sales) follow-up study which suggests that stimulants carry physical risks, may not work the long run and that behavioural modification approaches may serve just as well. According to Pelham, who is on the steering committee for the MTA studies, "No drug company in its literature mentions the fact that 40 years of research says there is no long-term benefit of medications. That is something parents need to know." (quoted in Hearn, 2004). **6. psychological interventions.**	

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			As with non-medical theories of causation, non-drug-based solutions to the problems children with ADHD type behaviours present have been marginalized by the more politically powerful, Drug Company supported medical and consumer bodies. A comprehensive set of therapeutic strategies and approaches needs to be able to tackle a whole set of diverse issues that children with ADHD type behaviours present with. The task should be that of broadening our understanding in a context rich manner rather than narrowing our understanding (and therefore interventions) into context depleted constructs like ADHD. Interventions should be framed to the particular needs of each individual circumstances from the adverse effects of labelling, therapy with the child concerned, right up to working with parents, schools and the local community. This does not mean doing all of these with all children referred but what it does mean is a wholesale shift in attitude away from that of labelling kids with a medical disorder, in the absence of any evidence that they are suffering from a physical defect. In my opinion, the starting point for offering a holistic, integrated, multi-perspective model has to be the rejection of ADHD as label that offers anything meaningful or useful to clinical practice. Paradoxically, although the use of the ADHD diagnosis and stimulant medication may appear to offer a cheap, labour saving way of helping these children and their	

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			families, as with stimulants effectiveness it does the opposite. Although you may get quick results in the short term, in the long term you create a group of children who are dependent (on the drugs and the doctors who prescribe them) and need to carry on seeing their doctor for years (some say the rest of their lives), without ever having dealt with the original difficulties. My experience is that if I see my basic role as that of empowering children, parents and schools to find their own solutions, then dependency on doctors doesn't happen and my clients can be discharged from my clinics in a comparatively short time and with at least as good an outcome (particularly in terms of client's satisfaction) than going down the more labour intensive (in the long term) diagnosis and medication route. In terms of what might be considered 'modernist' (expert derived) interventions useful approaches include family and systemic therapy, such as interventions to improve communication and relationships in the family, address attachment issues, explore family and parental history, and consult with schools and other professionals (e.g. Alexander and Parsons, 1982, Alexander et al, 1988, Henggeller and Borduin, 1990, Oas, 2001); specific behaviour management strategies, such as those to enforce effective discipline (e.g. Stein, 2001, Breggin, 2000, Sells, 2001); addressing lifestyle issues, such as slowing down the pace of life, creating more	

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			family time, regular opportunities for exercise and looking at diet (e.g. De Grandpre, 1999, Armstrong, 1995, Jacobson and Schardt, 1999); and a discussion of the families value system as well as a questioning of my own cultural values and how this may effect my practice (see Timimi, 2005). In terms of post-modern style interventions (privileging families existing knowledge), although little has been written specifically about ADHD, postmodern thinking has informed many useful therapeutic interventions including deconstructing traditional medical and psychological discourses (e.g. Law, 1997, Smith and Nylund, 1997); focusing on strengths and building solutions (e.g. Shazer, 1994); use of metaphor and stories (e.g. Rosen, 1982, Dwivedi, 1997), externalizing the problem (e.g. White and Epston, 1990, Smith and Nylund, 1997) and advocacy work on behalf of the family (Timimi, 2002, 2005). For the sake of convenience I have called the style of working that includes all these differing metaphors that we use in therapy to construct a (hopefully) meaningful and useful intervention a 'multi-perspective' approach (Timimi, 2002; 2005). Using this approach I have, in collaboration with their families, successfully weaned over 30 children off of stimulant medication in the past 2 years, without needing to start such a prescription for a single child, leaving me with no children on my current caseload that take a stimulant. **7. Other physical treatments including dietary**	

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			elimination and supplementation. See above. **8. Treatment approaches for adults with ADHD.** As childhood ADHD does not exist (as stated above the onus is on those who believe in it to provide proof of its existence, not on critics to prove it doesn't) so there is no such thing as adult ADHD. As a culture there are grave public health as well as ethical concerns if we go down the route of medicalising common day-to-day problems for those living in fast paced modern life, such as disorganization and daydreaming. **9. Sensitivity to different beliefs and attitudes of different races and cultures, and issues of social exclusion.** Because of all the above lack of evidence on what component of ADHD is biologically and how to find the biological component, it must be viewed as a cultural construct. Within this construct will lay assumptions about what is 'normal' in terms of childhood behaviour and child rearing practices that is specific to the culture that invented it. Whatever part of conditions such as ADHD are biological (all behaviour ultimately derives from a biological substrate), how we construct meaning out of this is a cultural process. For example, Brewis and Schmidt (2003) carried out a study in a middle class, Mexican school of over 200 pupils. Using standard diagnostic criteria, they found that	

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			about 8% of the children could be diagnosed, as having ADHD, yet there was only one child in that school with the diagnosis. Through interviews with parents and teachers they found that these carers regarded ADHD-type behaviours as within the boundaries of behaviours viewed as normal for these children's ages. Thus all diagnosis of ADHD are based on cultural assumption and any document that sets out guidelines on this diagnosis without acknowledging the cultural nature of the construct ***is*** institutionally racist, for it will project it's own moral and ethical framework (rather than scientific one) using cultural assumptions that will necessarily (though unintentionally) place Western beliefs in a morally superior position to those of other cultures (Timimi, 2005). **10. The role of families and carers in the treatment and support of people with ADHD.** See above **Conclusion** There is an opportunity for NICE to re-consider the basic assumptions behind the construct of ADHD. The only scientific conclusion if the null hypothesis is being observed is that ADHD is not a valid diagnosis (at the very least that it cannot be categorized as a 'neurodevelopmental' disorder). One major concern is that the members of the committee that will examine this will have too many vested interests to make for a scientifically objective examination of the evidence. If there is no	

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			representation from those who criticizes this construct then the guidelines will be flawed scientifically, ethically and this may lead to perpetuating practice that is dangerous to public health. **References:** ADDISS- Attention Deficit Disorder Information and Support Service (2005) available at www.addiss.co.uk accessed on 15 June 2005.Ainslie, R. C. (1985). *The psychology of twinship*. Lincoln: University of Nebraska Press. Alberts-Corush, J., Firestone, P., & Goodman, J. T. (1986) Attention and impulsivity characteristics of the biological and adoptive parents of hyperactive and normal control children. *American Journal of Orthopsychiatry* 56, 413-423. Alexander, J.F. and Parsons, B.V. (1982) *Functional family therapy*. Monterey, C.A.: Brooks-Cole. Alexander, J.F., Waldron, H.B., Newberry, A.M. and Liddle, N. (1988) Family approaches to treating delinquents. In E.W. Nunnally, C.S. Chilman and F.M. Cox, (Eds) *Mental Illness, Delinquency, Addictions and Neglect.* Newbury Park, C.A.: Sage. Angold, A., Erkanli, A., Egger, H.L. and Costello, E.J. (2000) Stimulant treatment for children: A community perspective. *Journal of the American Academy of Child and Adolescent Psychiatry* 39, 975-984.	

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			in children and adolescents? A meta-analysis. *Canadian Medical Association Journal* 165, 1475-1488. Sells, S. (2001) *Parenting your out of control teenager: Seven steps to re-establishing authority and reclaim love.* New York: St Martin's Press. Shazer, S. de (1994) *Words were originally magic.* New York: Norton. Shen, Y.C., Wong, Y.F. and Yang, X.L. (1985) An epidemiological investigation of minimal brain dysfunction in six elementary schools in Beijing. *Journal of Child Psychology and Psychiatry* 26, 777-788. Sherman, D. K., Iacono, W. G., & McGue, M. K. (1997) Attention-deficit hyperactivity disorder dimensions: A twin study of inattention and impulsivity-hyperactivity. *Journal of the American Academy of Child and Adolescent Psychiatry* 36, 745-753. Smith, C. and Nyland, D. (Eds.) (1997) *Narrative therapies with children and adolescents*. New York: The Guildford Press. Sonuga-Barke, E.J.S., Minocha, K., Taylor, E.A. and Sandberg, S. (1993) Inter-ethnic bias in teacher's ratings of childhood hyperactivity. *British Journal of Developmental Psychology* 11, 187-200. Sowell, E.R., Thompson, P.M., Welcome, S.E., Henkenius, A.L.,	

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			Toga, A.W., and Peterson, B.S. (2003). Cortical abnormalities in children and adolescents with attention-deficit hyperactivity disorder. The Lancet, 362, 1699-1707 Sprich, S., Biederman, J., Crawford, M. H., Mundy, E., & Faraone, S. V. (2000) Adoptive and biological families of children and adolescents with ADHD. *Journal of the American Academy of Child and Adolescent Psychiatry* 39, 1432-1437. Sproson, E.J., Chantrey, J., Hollis, C., Marsden, C.A. and Fonel, K.C. (2001) Effect of repeated methylphenidate administration on presynaptic dopamine and behavior in young adult rats. *Journal of Psychopharmacology* 15, 67-75. Stein, D.B. (2001) *Unravelling the ADD/ADHD Fiasco: Successful Parenting Without Drugs.* Kansas City: Andrews McMeel. Taylor, E. (1994) Syndromes of attention deficit and over-activity. In M. Rutter, E. Taylor and L. Hersov (Eds.) *Child and adolescent psychiatry, modern approaches: Third edition*, Oxford: Blackwell Scientific Publications. Taylor, E. and Hemsley, R. (1995) Treating hyperkinetic disorders in childhood. *British Medical Journal* 310, 1617-1618. Thapar, A., Hervas, A., & McGuffin, P. (1995) Childhood hyperactivity scores are highly heritable and show sibling competition effects: Twin study evidence. *Behavior Genetics*	

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			25,. 537-544. Timimi, S. (2002) *Pathological Child Psychiatry and the Medicalization of Childhood.* Hove: Brunner-Routledge. Timimi, S. (2005) *Naughty Boys: Anti-Social Behaviour, ADHD and the Role of Culture*. Basingstoke: Palgrave MacMillan. Tyrer, P. (1996) Co-morbidity or consanguinity. *British Journal of Psychiatry* 168, 669-671. Van den Oord, E. J. C. G., Boomsma, D. I., & Verhulst, F. C. (1994) A study of problem behaviors in 10- to 15-year-old biologically related and unrelated international adoptees. *Behavior Genetics* 24, 193-205. Van der Meulen, E. M., Bakker, S. C., Pauls, D. L., Oteman, N., Kruitwagen, C. L. J. J., Pearson, P. L., Sinke, R. J., & Buitelaar, J. K. (2005). High sibling correlation on methylphenidate response but no association with DAT1-10R homozygosity in Dutch sibpairs with ADHD. *Journal of Child Psychology and Psychiatry* 46, 1074-1080. Volkow, N.D., Ding, Y.S., Fowler, J.S., et al. (1995) Is Methylphenidate like Cocaine. *Archives of General Psychiatry* 52, 456-463. Wasserman, R.C., Kelleher, K.J., Bocian, A., et al. (1999) Identification of attentional and hyperactivity problems in	

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			primary care: A report from pediatric research in office settings and the ambulatory sentinel practice network. *Pediatrics* 103, E38. Werry, J.S., Elkind, G.S. and Reeves, J.C. (1987) Attention deficit, conduct oppositional and anxiety disorders in children. III. Laboratory differences. *Journal of Abnormal Child Psychology* 15, 409-428. Willcutt, E. G., Pennington, B. F., & DeFries, J. C. (2000) Etiology of inattention and hyperactivity/impulsivity in a community sample of twins with learning disabilities. *Journal of Abnormal Child Psychology* 28, 149-159. White, M. and Epston, D. (1990) *Narrative means to therapeutic ends.* New York: Norton. Wurtzel, E. (2002) *More, Now, Again.* London: Virago. Zahn, T.P., Rapoport, J.L. and Thompson, C.L. (1980) Autonomic and behavioural effects of dextroamphetamine and placebo in normal and hyperactive pre-pubertal boys. *Journal of Abnormal Child Psychology* 8, 145-160. Zito, J.M., Safer, D.J., Dosreis, S., Gardner, J.F., Boles, J. and Lynch, F. (2000) Trends in prescribing of psychotropic medication in pre-schoolers. *Journal of the American Medical Association* 283, 1025-30. Zwi, M., Ramchandani, P. and Joughlin, C. (2000) Evidence and	

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
			belief in ADHD. *British Medical Journal* 321, 975-976.	
Department for Education and Skills			This organisation was approached but did not respond.	
Department of Health	1	General	It would be particularly helpful if thought could be given to implementation of the Guideline at an early stage, so that the guidance produced is orientated towards the needs of practitioners.	Thank you for your comments. Implementation issues will be raised at the first Guideline Development Group meeting.
Department of Health	2	3b	This section refers to common comorbidities in children with ADHD, and there is some reference to comorbidities in adults in 3d. Would it be possible to include mention of the common comorbidities in adults with such disorders at this earlier stage?	Thank you. The Scope has been amended to reflect this comment (see 3. b)
Derbyshire Mental Health Services NHS Trust			This organisation was approached but did not respond.	
Dorset ADHD Support Organisation	1	General	Take into account Every Child Matters. The Children's Act 2004: Is providing the legislative spine for developing more effective and accessible services focused around the needs of children, young people and families. Therefore there is scope for a Departmentally Endorsed Policy for Assessing, Diagnosing and Treating ADHD to be incorporated into Every Child Matters.	Thank you for your comments. However, consideration of this is outside the remit of this Scope.
Dorset ADHD	2	General	A full Multi-model service for ADHD throughout the lifespan needs to be implemented. Under the age of 3 years, in many	Thank you for your comments.

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Support Organisation			areas there are already services such as Portage—behaviour management available and SureStart Programmes/Children's Centres. These services may work with children up to aged 5 years, should concerns be raised about the possibility of ADHD then these services may make the referral to appropriate services.	
Dorset ADHD Support Organisation	3	General	Early identification of ADHD. A Pathway plan developed that involves, the parent, health visitors, school nurses, Pre-school/playgroup, teachers, educational psychologists, occupational therapists, social services and GP's in order to make referrals to Paediatricians and CAMHS. ADHD sufferers who have been diagnosed at a fairly early stage and given carefully monitored treatment and therapy are less likely to develop co-morbid conditions and are more likely to do well for themselves in the long run, despite underachieving and remaining completely disorganised and accident prone throughout their lives.	Thank you for your comments.
Dorset ADHD Support Organisation	4	General Pharma cological	Appropriate use of pharmacological treatments should be tailored to meet the individual's needs. Such treatments should be monitored through introduction of a 'Care Plan Record', that each individual with ADHD holds and can be produced during appointments with different agencies involved with their provision of health care.	Thank you for your comments.
Dorset ADHD Support Organisation	5	General Intervent	There needs to be "tighter" in terms of secondary therapies that Healthcare providers are bound to offer. As a result treatments	Thank you for your comments.

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
		ions	like Behavioural Therapy or anger management are seldom offered by Trusts. Pharmacological treatments, provides a window of opportunity for treatment but secondary therapies are needed to address core symptoms longer term.	
Dorset ADHD Support Organisation	6	General	Prior to going down the pharmacological treatments, many parents, carers and service user have already tried dietary elimination and supplementation. Many continue to use this method as part of the treatment plan.	Thank you for your comments.
Dorset ADHD Support Organisation	7	General	All children and young people, from birth to their eighteenth birthday, who have mental health problems and disorders, should have access to timely, integrated, high quality, multi-disciplinary mental health services to ensure effective assessment, treatment and support, for them and their families. A full range of care be made available using the National Service Framework for children and Young People through CAMHS. Mental Health Promotion and Early intervention improve service equity; develop high quality Multi-disciplinary CAMHS Teams	Thank you for your comments.

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Dorset ADHD Support Organisation	8	General Transitions	Adult services for ADHD: There needs to be two distinct groups to be considered (though there will be some overlap) (A) Young people who are making the transition from children's to adult services. (B) Adults who are presenting for the first time in adulthood eg a parent of newly- diagnosed child with ADHD. Transition into adult services should be implemented prior to the child's 19th birthday and that, children's and adult services develop a pathway plan that provides the appropriate service to meet the needs of the service user.	Thank you for your comments. Services specific to young people, adults and the transition from one to the other will be considered as part of this guideline.
Dorset ADHD Support Organisation	9	General Social Inclusion (Please see ODPM Social Exclusion Units Document, Transitions- Young	Figures from the Judicial studies review board highlights the numbers of prisoners who have been socially excluded, these figures are quite alarming. Youth Offending teams, Probation, Young Offenders Institutes and Prisons are highlighting the numbers of individuals with ADHD coming through their services. Now that our prison health care is being provided through local health care providers, it is important that we include this group in accessing the appropriate health care and that early identification and treatment of ADHD is also included within their health care plan.	Thank you for this comment. Section 4.2b now incorporates institutional settings in which the NHS provides health care.

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
		Adults with Complex Needs)		
Dorset ADHD Support Organisation	10	General	The role of the family carer is of major importance as they are the ones providing the care within our community. We also need to consider their own health needs during their caring role. We also need to consider the needs of siblings; the impact of living with a family member with ADHD has on their health and well being. Only too often we hear agencies stating that they are required to listen to the service user and in many cases the voice of the carer is not heard. Parents and carers of those with ADHD are usually the most knowledgeable on the disorder they know what does or does not work for the individual concerned. Parents and carers are usually left in 'limbo' once diagnosis is made as no information leaflets/brochures are produced/provided by the health services making the diagnosis and it is then left to them to seek out the information and find sources of support groups/organisations in their local areas for ADHD.	Thank you for your comments. Service user and carers are full members of the Guideline Development Group and the support needed by family members / carers themselves will be considered.
Dorset Healthcare Trust - Child and Adolescent Mental Health Service			This organisation was approached but did not respond.	

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Eli Lilly and Company Ltd	1	Section 4.3	Clinical outcome measures for the various treatments and/or interventions have not been scoped – self esteem and quality of life of children should be assessed eg factors such as bullying and socialisation and impact on the family.	Thank you for your comments. As with all guidelines outcomes relevant to the individual and their carers will be examined, although the precise outcomes will depend on the evidence-base and can not therefore be specified at an early stage and in advance of the full examination of the evidence-base.
Eli Lilly and Company Ltd	2	4.3.f	When assessing pharmacological therapies the following points should be covered: • The potential for abuse and diversion of the medication • The developmental safety of medication used chronically ie height/weight and other development • Assessment scales completed by children • Compliance	Thank you for this comment.
Eli Lilly and Company Ltd	3	4.3.f	Please correct the spelling of 'atomoxetine' and amend the mechanism of action to '*selective noradrenaline reuptake inhibitor*'	Thank you for your comments, we shall amend (see amended section 4.3g).

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Eli Lilly and Company Ltd	4	4.4.1	The relevant technology appraisal guidance for the guideline is likely to be issued in the near future: Methylphenidate, atomoxetine and dexamfetamine for the treatment of attention deficit hyperactivity disorder in children and adolescents (including a review of guidance no.13)	Thank you for your comments. We are aware of this Technical Appraisal and have included reference to this document (see section 4.4.1)
Eli Lilly and Company Ltd	5	4.2 c)	This section might include the role of health professionals working with schools	Thank you for your comments, this has now been dealt with in section 4.2b.
Eli Lilly and Company Ltd	6	4.3 c)	We support this point and you may want to consider models of care that have evaluated this.	Thank you for your comments.
Eli Lilly and Company Ltd	7	General	The scope should consider the implementation of this guideline especially with regard to workforce capacity and disparity of service provision across the NHS.	Thank you for your comments. Implementation issues will be considered as part of this guideline during the process of guideline production.
Ferring Pharmaceuticals Limited			This organisation was approached but did not respond.	
First Person Plural			This organisation was approached but did not respond.	
GJ International Ltd	1	4.3	If ADHD is suspected, screening as an early assessment tool could save time and money whether ADHD is, or is not, finally diagnosed	Thank you for your comments.

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
GJ International Ltd	2		Monitoring of patients progress over time and titration of medication should be considered for inclusion and reference is taken from the MTA study : 'Correct initial dose titration and regular dose adjustments is essential for successful treatment with medication' (Multimodal Treatment Study of children with Attention Deficit/Hyperactivity disorder, The MTA Study 1999)	Thank you for your comments. Important aspects of pharmacological intervention will be considered as part of the guideline development process (see section 4.3 g). The study you describe will be considered should it pass quality controls adequately.
GJ International Ltd	3		Inclusion of objective assessment of ADHD vs problems using rating scales due to strong reliance upon judgments from others: - Parents: Denying, exaggerating, depression. Rating scales mothers &fathers: r = 0.5-0.7 - Teachers: Differing in competence and expectations. Much vs little help in school. Rating scales: parents &teachers r = 0..3 (Anastopoulos,2001; Mitsis,2000: Sattler,2002)	Thank you for this information.
Gloucestershire Partnership NHS Trust			This organisation was approached but did not respond.	
Great Ormond Street			This organisation was approached but did not respond.	

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Hospital for Children NHS Trust				
Green Machine, The			This organisation was approached but did not respond.	
Hampshire Partnership NHS Trust			This organisation was approached but did not respond.	
Health and Safety Executive			This organisation was approached but did not respond.	
Healthcare Commission			This organisation was approached but did not respond.	
Heart of England NHS Foundation Trust			This organisation was approached but did not respond.	
Hertfordshire Partnership NHS Trust			This organisation was approached but did not respond.	
Human Givens Institute			This organisation was approached but did not respond.	
Hyperactive Children's Support Group (HACSG)	1	2 (c)	HACSG welcomes NICE's taking into account patients' individual needs and preferences.	Thank you for your comments.

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Hyperactive Children's Support Group (HACSG)	2	3 (b)	Co-morbidity is indeed the norm. We wonder if NICE can mention by name the common, co-morbid learning disorders: dyslexia and dyspraxia? We suggest there should also be mention of the co-morbidity of atopic conditions. Although not in the DSM IV list of symptoms, these are present in a significant number of the children of our members. HACSG suggests that co-morbid atopic conditions, such as asthma and eczema, as well as many other commonly-associated physical symptoms frequently reported to us by parents of ADHD children, reinforce the biochemical argument for exploring nutritional involvement in the condition. These include abnormal thirst, frequent ear/chest infections, excessive dribbling, bed-wetting, high pain threshold, digestive/gut problems and sweating, which can all be associated with diet.	Thank you for your comments. We have now amended this section which refers to "common comorbid conditions" (see 4.1.1 b).
Hyperactive Children's Support Group (HACSG)	3	3 (d)	HACSG believes the reference to involvement in crime is important. The figures are unknown for the number of ADHD children excluded from school, those in Pupil Referral Units, those in Young Offenders Institutions, and later, those in adult prisons. The numbers are thought to be significant, but the statistics are at present unavailable. While this slippery slope is not a foregone conclusion, our experience of early dietary modification suggests in many cases it can arrest progression before the first stage.	Thank you for your comments.

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Hyperactive Children's Support Group (HACSG)	4	3 (h)	In addition to these concerns, there are no studies that we are aware of into possible physiological and psychological effects of taking these drugs daily over many years.	Thank you for your comments, this does, unfortunately limit the evidence-base upon which the guideline will be developed.
Hyperactive Children's Support Group (HACSG)	5	4.1	Particular attention needs to be given to the prescribing of medication for 3-6 year olds. It can only be in the best interests of the very young to offer dietary/nutritional Intervention in combination with other non-drug therapies.	Thank you for your comments.
Hyperactive Children's Support Group (HACSG)	6	4.1.2 (b)	We have found that dietary/nutritional interventions can be highly effective for pre-schoolers, including those under 3 who are showing signs of ADHD behaviour (as opposed to normal levels of exuberance and unreasonableness for that age group). The response time is shorter and much of the difficult behaviour and low self-esteem seen in older ADHD children has not materialised or become intractable.	Thank you for your comments.
Hyperactive Children's Support Group (HACSG)	7	4.3 (b)	We welcome examination of existing diagnostic criteria.	Thank you for your comments.
Hyperactive Children's Support Group (HACSG)	8	4.3 (f)	HACSG welcomes examination of the important subject of appropriate use of pharmacological treatments.	Thank you for your comments.

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Hyperactive Children's Support Group (HACSG)	9	4.3 (g)	HACSG welcomes examination of these psychological interventions, which support parents and carers who can be under enormous stress.	Thank you for your comments.
Hyperactive Children's Support Group (HACSG)	10	4.3 (i)	HACSG warmly welcomes the inclusion of dietary elimination and supplementation. We anticipate a full discussion during the Guideline Development Process of dietary/nutritional interventions, as there is a number of children for whom medication is unsuitable: • Those whose symptoms are not severe enough to recommend medication as first choice. • Those children too young to be prescribed medication (although we are aware those under 3 are not covered by the scope at present). • Those whose parents do not wish them, or they themselves do not wish, to take medication. • Those who experience side-effects of medication. • Those who do not respond to medication. Dietary/nutritional interventions also merit consideration by NICE because of their preventative and cost-effective nature.	Thank you for your comments.
Hyperactive Children's Support Group (HACSG)	11	4.3 (l)	As 4.3 (g); family and carers really do need support in bringing up a child with ADHD.	Thank you for your comments.

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Hyperactive Children's Support Group (HACSG)	12	4.3.2 (a)	Regarding exclusion of, 'treatments not normally covered by the NHS', HACSG is a concerned about the interpretation of this exclusion. Our experience is that supplementation is a grey area in the NHS. We hope that, as iron and B12, for example, are commonly prescribed, when tests show deficiencies, the same principle can be applied to other nutrient deficiencies. Parents seeking the advice of HACSG are frequently frustrated by the fact that dietary/nutritional options have not been offered to them. Non-medication options are preferred by many patients. There is now compelling evidence that diet and nutrition must not be overlooked.	Thank you for your comments. Dietary elimination / supplementation will be considered as part of this guideline.
Immogenics Limited			This organisation was approached but did not respond.	
Institute of Psychiatry - Kings College London			This organisation was approached but did not respond.	
Janssen-Cilag Ltd	1		Thank you for the opportunity to review this Scope document. We have no comments to make.	Thank you.
L'Arche UK			This organisation was approached but did not respond.	
Liverpool ADHD Foundation			This organisation was approached but did not respond.	
London Development Centre for Mental Health			This organisation was approached but did not respond.	

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Medicines and Healthcare Products Regulatory Agency (MHRA)			This organisation was approached but did not respond.	
Mental Health Collaborating Centre			This organisation was approached but did not respond.	
Institute of Psychiatry - Kings College London			This organisation was approached but did not respond.	
Janssen-Cilag Ltd			This organisation was approached but did not respond.	
National Institute for Mental Health in England (NIMHE)			This organisation was approached but did not respond.	
National Mental Health Partnership	1	General	Looking at adults as well as children is welcomed, although it is anticipated that this will create operational problems since adult services are few and far between when compared with those for children.	Thank you for your comments.
National Mental Health Partnership	2	General	In the scope there is reference to referral to other therapies, which seems rather limiting and a preconceived view. For example, it could be argued that occupational therapy should be a routine part of the assessment, not a therapy to which some are referred at a later stage.	Thank you for your comments, this has now been amended (see section 4.3h).

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
National Mental Health Partnership	3	General	There needs to be consideration of the tiered model of CAMHS in relation to management. It currently reads as very out-patient clinic based, without consideration of the role of education-based CAMHS teams or CAMHS workers within multi-agency integrated teams.	Thank you for your comments, this has now been amended (see 4.2 b).
National Mental Health Partnership	4	General	Teachers and social workers often receive services, much as parents do, as co-therapists. It is felt that they should be accepted as such and included in the wider user and public engagement process.	Thank you for your comments.
National Mental Health Partnership	5	General	Young people should also be involved in the process. More use could be made of focus groups, or inviting written responses.	Thank you for your comments. The views of young people will be actively sought during the guideline development process and focus groups will be used.
National Nurse Consultants in CAMHS forum			This organisation was approached but did not respond.	
National Patient Safety Agency			This organisation was approached but did not respond.	
National Public Health Service - Wales			This organisation was approached but did not respond.	

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
National Youth Advocacy Service			This organisation was approached but did not respond.	
NCC for Cancer			This organisation was approached but did not respond.	
Neonatal & Paediatric Pharmacists Group (NPPG)	1	4.2	Although Guidance is for the NHS, it is essential for Schools to be fully engaged with this guidance since it is schooling that is integral to the treatment of ADHD. Concise guidance for school nurses may be the road in. This should tackle issues such as storage of medication at school as well as robust guidance on how medicines should be labelled in order that they can be used at school in the most efficient way.	Thank you for your comments. The membership of the Guideline Development Group will address both education and medication management issues. All aspects of pharmacological intervention will be considered during the development of the guideline.
Neonatal & Paediatric Pharmacists Group (NPPG)	2	4.3	It will be important to reflect on the role of non-medical prescribers for this treatment. Specialist nurses for instance play a vital role in the management of ADHD and medication review. It is unlikely however that they will be able to independently prescribe Controlled Drugs and thus their role is hampered by legislation unlike most childhood conditions.	Thank you for your comments.
Neonatal & Paediatric Pharmacists Group (NPPG)	3	4.3	Labelling and the issuing of Patient information Leaflets (PILs) should be addressed. Several of the medication mentioned are being used outside their license and thus inappropriate PIL's must legally be issued. The correct approach to deal with this should be gone through.	Thank you for your comments.
Newcastle PCT			This organisation was approached but did not respond.	

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
NHS Direct			This organisation was approached but did not respond.	
NHS Health and Social Care Information Centre			This organisation was approached but did not respond.	
NHS Quality Improvement Scotland			This organisation was approached but did not respond.	
Northumbria Healthcare NHS Trust			This organisation was approached but did not respond.	
Nottinghamshire Healthcare NHS Trust	1	3 D, E, F, G	Information given without reference. It does say in Section 4 that there are two publications on the NICE Website. It is supposed that the information given can be supported in the above section.	Thank you for your comments. The information given in these sections of any NICE guideline scope are prepared by our technical team in collaboration with leading national and international experts. We do not normally reference the statements of need for any guideline. However, rest assured that when the full guideline is published all statements will be supported by references wherever this is possible.

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Novartis Pharmaceuticals UK Ltd			This organisation was approached but did not respond.	
Nursing & Supportive Care Collaborating Centre			This organisation was approached but did not respond.	
Oxfordshire Mental Health Care NHS Trust			This organisation was approached but did not respond.	
PERIGON (formerly The NHS Modernisation Agency)			This organisation was approached but did not respond.	
PPG group (paediatric/psychiatric pharmacology group)	1	3b	Although the ICD 10 criteria do state exclusion of PDD, we regret that Nice will be following this rigidly as current clinical practice leads most practitioners to look at both disorders as co-existing and treat accordingly. The co-existence of PPD and ADHD has considerable implications for service configuration, management and represents a challenging group. We recommend that PDD is included.	Thank you for your comments. Although we have sympathy with your view, and indeed have amended section 4.1.1b and other similar relevant sections, the guideline must remain focused on the treatment of ADHD. Moreover, expanding the guideline to include PDD would considerably increase the workload and impede progress.

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
PPG group (paediatric/psychiatric pharmacology group)	2	3b	A purist ICD10 approach may also take a certain view on neurological disorder. We are glad that these and learning difficulties of all degrees will be included by NICE. Advice with co-existing epilepsy particularly.	Thank you for this comment.
PPG group (paediatric/psychiatric pharmacology group)	3	4.3f.	Atomoxetine miss-spelt	Thank you for this comment.
PPG group (paediatric/psychiatric pharmacology group)	4		Methyl phenidate, dexamphetamine and atomoxetine are only licensed for treatment of ADHD *in children and adolescents*	Thank you for this information. This has been amended.
PPG group (paediatric/psychiatric pharmacology group)	5		Suggest including combinations of medications rather than monotherapy only	Thank you for your comments.
PPG group (paediatric/psychiatric pharmacology group)	6	General	Suggest a section on service organisation/delivery particularly for (but not only for) treating learning disability, eg minimum services per district population including initial presentation and assessment and follow-up assuming excellent school liason included/types of personnel etc . also minimum training/qualifications for such work	These issues, whilst relevant, are nevertheless issues for implementation rather than guideline development.

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
PPG group (paediatric/psychiatric pharmacology group)	7	General	Any comments on Omega 3 and foods plus recommendations or otherwise for excluding individual food intolerances	Thank you for your comments. Consideration of dietary elimination / supplementation will for part of this guideline.
Primary Care Collaborating Centre			This organisation was approached but did not respond.	
Prison Reform Trust			This organisation was approached but did not respond.	
PromoCon (Disabled Living)			This organisation was approached but did not respond.	
Rethink Severe Mental Illness			This organisation was approached but did not respond.	
Royal College of General Practitioners	1	General	The criteria for diagnosis would be very useful for GPs as early diagnosis might be advanced. Advice whether the diagnosis is appropriately made in General Practice or whether a consultant opinion is necessary or a GP with Special interest would be appropriate. Training in the diagnosis of ADHD is not part of regular GP Training and although some GPs will acquire the skills needed in their registrar year and while experiencing pediatric training many do not.(Speaking as a trainer).I see little subsequent training speaking as an Appraiser	Thank you for your comments.

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Royal College of General Practitioners	2		Access to specialist care is appalling in SW Kent and waits for 18 months are current for CAMS although ADHD is not seen by CAMS and may have a shorter wait. With such overlap in diagnostic categories it seems inappropriate that the diagnosis of ADHD should not be part of the CAMS responsibiltes. Waits of this length make early diagnosis a bit pointless.	Thank you for your comments.
Royal College of General Practitioners	3		Treatment is really a question of GPs acting as scribes at the behest of the specialist although this is essential as the GP is the co-coordinator of the child or young patient's scrip's. I doubt if GPs have much experience of the dangers and side effects of methylphenidate and guidelines are needed. I recently had a young person with anemia on methylphenidate which I think was unrelated. What cardiac monitoring should be carried out in General Practice? The need for hand-written scrip's is I think being addressed and seemed unnecessary	Thank you for your comments.
Royal College of General Practitioners	4	3d	I suggest specifically including alcohol misuse in the final sentence, as this is one of the most common long-term complications.	Thank you for your comments. Alcohol misuse is covered by the current wording ("substance misuse").

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Royal College of General Practitioners	5	4.2b/c	I suggest placing specific emphasis on the interface with school health services, and with educational psychology services.	Thank you for your comments. The membership of the Guideline Development Group will specifically include an education specialist. However, we cannot make recommendations to educational psychologists or others not working in the NHS.
Royal College of General Practitioners	6	4.3c/d	The guideline should ideally include recommended thresholds of severity for initiating referral and treatment.	Thank you for your comments.
Royal College of General Practitioners	7	4.3g/j	Include the role, if any, of psychodynamic psychotherapy in adult ADHD.	Thank you for your comments. We are not aware of any evidence to suggest that psychodynamic psychotherapy has any role (or evidence-base) in the treatment of adults with ADHD.
Royal College of General Practitioners Wales			This organisation was approached but did not respond.	
Royal College of Nursing	1	General		
Royal College of Nursing	2	Title	No comment	

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Royal College of Nursing	3	General	The scope is focussed on children and young people. For adults who seek a diagnosis there may be less evidence available as to current best practice. Guidance for adults may be more difficult to formulate. It maybe helpful to think of ADHD as a spectrum (like autistic spectrum disorder) as there are different levels of severity of symptoms with different impacts on children and families, requiring different interventions.	Thank you for your comments.
Royal College of Nursing	4			
Royal College of Nursing	5	General	Scope leans towards a very biomedical approach. More consideration and support needs to be given to the educational, psychological and social elements of ADHD to the child, young people adult and to the family. In clinical practice, we see a lot of social and emotional difficulties in relation to ADHD and the child.	Thank you for your comments. An education specialist will be a member of the Guideline Development Group. Where applicable, the group will also be assisted by special advisors.
Royal College of Nursing	6	2 c	States that NICE Guidelines support role of healthcare professionals so it is important to specify appropriate nursing input. Need to acknowledge that School nurses could be a crucial link between health services and school setting. Emphasise the whole care pathway for the child.	Thank you for this comment.

Comment [SB1]: is thre text missing here?

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Royal College of Nursing	7	General (2 G)	More emphasis needs to be given to the individual experience of ADHD. Children should be consulted on how does ADHD affects the everyday lived experience and treatment. See http://www.everychildmatters.gov.uk/participation We would strongly suggest that children are consulted possibly through focus groups and managed according to age groups.	Thank you for your comments and this information. Service user testimonials are included in the guideline and focus groups will be used as part of the evidence collection process.
Royal College of Nursing	8	General (2 L)	Consideration needs to be given to diagnosis and would suggest standardising assessment strategies. Consideration needs to be given to standardising the prescribing of medication for ADHD and suggest adherence to the Children NSF Medications for Children and young People. http://www.dh.gov.uk/assetRoot/04/09/05/63/04090563.pdf Attention needs to be given to the monitoring of medication for children with ADHD in settings other than the home, i.e. looked after children and children in special education settings see section 13.3 of http://www.dh.gov.uk/assetRoot/04/09/05/63/04090563.pdf	Thank you for this information.

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Royal College of Nursing	9	General	Co morbidity issues particularly in children who have a recognised learning disability and or physical disability needs to be fully explored. See http://www.dh.gov.uk/assetRoot/04/09/05/56/04090556.pdf Helpful to consider additional diagnosis – not unusual for healthcare professionals at tier 4 to see children with ADHD and Asperger symptoms etc.	Thank you for your comments. The management of comorbities – in so far as they affect the treatment of ADHD – will be considered as part of this guideline (see section 4.1.1b).
Royal College of Nursing	10	3a	The use of DSM-IV and ICD-10 identifies children and young people with different levels of severity of inattention, hyperactivity and impulsivity, thus leading to diagnostic anomalies depending upon the criteria used. Therefore, consensus about which criteria is best used in England and Wales.	Thank you for your comments.
Royal College of Nursing	11	3b	Co-morbidity is well understood in children and young people. consideration should be given to what co-morbidities are present for older adolescents (16-19) who may seek assessment, diagnosis and treatment	Thank you for your comments.
Royal College of Nursing	12	3 d	The term 'self-harm' implies the person's intention – perhaps 'accident-prone' is more accurate?	Thank you for this comment. We have amended the text.
Royal College of Nursing	13	3d	The emotional cost of having ADHD and resulting emotional and behavioural distress needs consideration not just in terms of co-morbidity but in terms of interventions.	Thank you for your comments.

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Royal College of Nursing	14	3e	Prevalence rates are variable see 3a as this will lead to confusion about what reaches criteria for diagnosis.	Thank you for your comments.
Royal College of Nursing	15	3 e	The variation in prevalence in different countries may indicate difference in diagnostic criteria – indicates the need for development of the guideline. Training implications for medical and nursing staff.	Thank you for your comments.
Royal College of Nursing	16	3f	Greater understanding in the guidance about the gender differences in the presentation of ADHD would help clinicians identify females who are currently missed.	Thank you for your comments.
Royal College of Nursing	17	3g and 3h	Medication issues will be addressed in the technology appraisal review. Suggest that there is further research into the long term effects of medication and also psychosocial interventions for ADHD.	Thank you for your comments. The guideline will draw on the Technology Appraisal currently under development (see section 4.4.1)
Royal College of Nursing	18	3 g	The doubling of prescriptions is a concern. The guideline needs to include ways of checking the outcomes of patients having ADHD medication. Documentation across the care pathway is vital. GP practice computer systems are capable of doing this now (some systems more capable than others).	Thank you for your comments.

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Royal College of Nursing	19	4.1.1a	Treatment of ADHD is licensed for children 3 years and over (dexamfetamine) however in developmental terms a diagnosis is rarely given so young and this needs to be clarified. ICD-10 states the behavioural characteristics are present before 6 years, but before school entry hyperactivity is difficult to recognise due to normal variation and only extreme levels should lead to diagnosis in preschool children	Thank you for your comments.
Royal College of Nursing	20	4.2b	The guidance needs to comment on the interface with other agencies such as education and social services as these children fail to access education and appropriate leisure and care activities. For adults consideration about working environments	Thank you for your comments. The guideline will consider all relevant interfaces (see section 4.2b).
Royal College of Nursing	21	4.2	We would strongly recommend that exploration and guidelines should be extended beyond the health care setting and include children in educational and care home settings. It is appreciated that these areas 'may not' be obligated to follow NICE guidelines, however if an exploration of current practices are not explored this could potentially be problematic to children young people and adults in such settings. Again – at tier 4 a lot of our children have required copious work with educational settings etc.	Thank you for your comments. However, this is a clinical guideline and therefore cannot make recommendations outside the healthcare setting (see section 4.2 b).

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Royal College of Nursing	22	4.2 a, b and c	Good to see the different healthcare settings specified – this should ensure that the whole care pathway is considered in the guideline development. GP computer systems need to be capable (some are) of including clinical input from school nurses, health visitors and community psychiatric nurses. This provides an audit trail for quality monitoring.	Thank you for your comments.
Royal College of Nursing	23	4.2c	Shared care arrangements with GP's need to be made explicit and the role of the GP in managing this condition. Consideration about school nursing services to assess, support and monitor children and young people in the school setting. Transition from child to adult services and where these young people are best cared for, as adult mental health may not be the most appropriate	Thank you for your comments.
Royal College of Nursing	24	4.2 j	Transitional services needs to be addressed and focus on outcomes rather than process.	Thank you for your comments. Unfortunately, we do not fully understand the point you have made. The issue here (transition from children services to adult services) will be dealt with by developing guidance on referral and acceptance criteria.

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Royal College of Nursing	25	4.2 k	Recognition within the guidelines on sensitivity to different beliefs and attitudes of different races and cultures and the recognition that children young people and adults with ADHD are not a homogenous group, i.e. that the standardising of treatments and medication need to take account of beliefs re medication and management.	Thank you for your comments. Cross-cultural differences will be considered as part of the guideline development process.
Royal College of Nursing	26	4.2 k	Also need to consider what support network is available across educational and social care for helping children with ADHD and how they can be managed within the home environment – professionals may need to consider/weigh up the needs of more medication if the structure and all systems are not appropriate and cannot be improved upon for example.	Thank you for your comments. This is less a question of the Scope and more a question of the details of guideline content.
Royal College of Nursing	27	4.2 l	We would wholeheartedly agree that the role of the family and of the carers is essential to these guidelines. This fits in with importance of not seeing ADHD as purely a medical problem – symptoms can happen in the context of the family or as a result of trauma etc.	Thank you for your comments.
Royal College of Nursing	28	4.3b	See comments 3a and 3e	

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Royal College of Nursing	29	4.3d	Development of pathways of care that include all agencies health, social services, education, voluntary sector. To emphasise that ADHD is not just a health difficulty that it impacts in other areas of children, young people and adult lives.	Thank you for your comments. The guideline is for the NHS; and this will include consideration of the interfaces with other services. Nevertheless, see revised section 4.2b.
Royal College of Nursing	30	4.3f	Need for robust evidence about the use of unlicensed medication for ADHD. Arrangements for medication review by whom (as this is often a role for nurses), frequency and tools available to assess change, effectiveness and side-effects.	Thank you for your comments.
Royal College of Nursing	31	4.3g	A review of psychosocial interventions used for ADHD would help inform interventions that help, which maybe costly and therefore not felt to have use.	Thank you for your comments. The health economic impact of psychosocial interventions will be considered as part of this guideline.
Royal College of Nursing	32	4.3k	Issues of social exclusion (education in particular) need to be addressed as well as sensitivity to different cultural and spiritual beliefs.	Thank you for your comments.
Royal College of Nursing	33	4.3l	The role of families, carers is essential in the care of children, young people and adults with ADHD.	Thank you for your comments.

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Royal College of Paediatrics and Child Health	1	General	This guideline is to be welcomed and most especially because at long last it will include those outside the usual range covered by research and drug licensing regulations including: 1. children from the age of 3 yrs 2. children with coexisting disorders (conditions that are not only described as 'psychiatric', but also learning disability & neurological conditions).	Thank you for your comments.
Royal College of Paediatrics and Child Health	2	4.1.1	It is essential to recognise that paediatric populations will differ from psychiatric clinic populations. I would hope that clear reference is made to conditions frequently seen in paediatrics but usually omitted from discussions on 'comorbidity' when taken from a psychiatric perspective e.g. Fetal Alcohol, genetic learning disability syndromes (Prader Willi, Angelman's, Williams etc), epilepsy, head injury, and extreme preterm infants grown up.	Thank you for your comments. The GDG will incorporate an expert paediatrician.

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Royal College of Paediatrics and Child Health	3	3b	It should be noted that the ADHD diagnostic criteria do not exclude children with autistic disorders – the scope document is dreadfully phrased. The phrase used in diagnostic criteria is 'not better explained by…'. Individuals on the DSM-IV committee have told me that there was never intention to exclude autism. Some research demonstrates the coexistence of autism and ADHD, for example: Sturm H, Fernell E, Gillberg C. Autism spectrum disorders in children with normal intellectual levels: associated impairments and subgroups. Dev Med Child Neurol 2004; 46: 444-447. There is a tremendous amount of clinical experience here, especially from those of us who regularly receive 2nd opinion requests because a psychiatrist has said this boy with Asperger's syndrome 'can't have ADHD'.	Thank you for your comments. We have amended the scope to address American and European perspectives.
Royal College of Paediatrics and Child Health	4	4.2	Transition to adult services. It is important to recognise that many individuals will have no psychiatric disorder and it will not be appropriate to refer to adult psychiatry. They cannot be well served by these services.	Thank you for your comments.
Royal College of Psychiatrists	1	General	While we welcome the development of guidelines in this controversial and challenging clinical area we hope NICE will be mindful that developing prescriptive guidelines is especially difficult in areas of clinical controversy. It will be most important that best quality evidence is used to support recommendations. When subjects are as controversial as this there is the greatest	Thank you for your comments. We shall base recommendations on the best quality evidence available.

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
			risk that opinion is misconstrued as good evidence.	
Royal College of Psychiatrists	2	3a	We welcome the early recognition that the language used in discussing ADHD often relies heavily on the American usage and DSM IV. It is best that the ICD, which is the classification system used in the NHS, is given primacy in documents to be used by NHS staff.	Thank you for your comments. Amendments have been made throughout the scope to reflect the primacy of ICD-10, and both diagnostic criteria will be addressed.
Royal College of Psychiatrists	3	3d	This paragraph is tendentious and quickly slips into less scientific language in discussing the problem. To say that "children with ADHD can develop emotional and social problems" is to imply the model of ADHD as a primary disorder and the emotional and social problems as secondary. While this may be the case, recognition must be given to the alternative view that emotional and social disadvantage may give rise to mental or behavioural disturbance including that which may be diagnosed as ADHD. Similarly, the sentence " .. affected children are often exposed to years of negative feedback about their behaviour and suffer educational and emotional disadvantage" could be read as implying that the negative feedback about problem behaviour is somehow wrong and that the disadvantage is a direct consequence of a disorder and not the disorder a manifestation of a more complex system of disadvantage: emotional, cognitive, social as well as biological.	Thank you for your comments. The wording has been amended to make the paragraph less tendentious.

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Royal College of Psychiatrists	4	4.1.1.	We hope the guidelines will be written in a way which is applicable to ICD diagnostic systems and not rely on DSM IV	Thank you for your comments. The scope has been amended as the guideline will need to address both diagnostic criteria (see revised section 4.1.1a).
Royal College of Psychiatrists	5	4.1.1. and 4.1.2	The issue of comorbidity is important and we are not clear from the scope how it will be addressed. We would welcome the specific inclusion of consideration of the treatment of comorbid substance use disorders and personality disorders in adults.	Thank you for your comments. We have amended 4.1.1b to include the word "common". The guideline must, nevertheless, maintain its focus upon the treatment of ADHD and limit the treatment of comorbidities to the extent that they affect the treatment of ADHD.
Royal College of Psychiatrists	6	General (suggested clinical questions)	What criteria should be used in primary or secondary care to decide when to continue or stop the prescription of medications initiated in childhood in people no longer under the care of child services?	Thank you for this suggestion.

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Royal College of Psychiatrists	7	General (suggested clinical questions)	What is known about the longer term risks of pharmacological treatment of impulsivity in adults, especially those with comorbid substance use or personality disorder.	Thank you for this suggestion.
Royal College of Speech and Language Therapists	1	General	At present the speech & language needs of these children & young people are at best under-estimated, but often not recognised at all. Few CAMHS teams have access to a specialist Speech & Language Therapist who could play an important role within the multi-disciplinary team.	Thank you for your comments. The Guideline Development Group will be assisted by special advisors where appropriate.
Royal College of Speech and Language Therapists	2	2 c	*'the role of healthcare professionals'* It is important to speech and language therapists to work in a multi-disciplinary way with paediatricians and occupational therapists, sharing information and collaborating on action plans.	Thank you for your comments.
Royal College of Speech and Language Therapists	3	2 c	'*care in partnership with patients'*. Does putting the child at the centre means ascertaining the child's perspective on how (or indeed whether) a problem is defined, and on what needs to change?	Thank you for your comments. The views of young people in particular will be sought through focus groups during the course of the guideline development process.

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Royal College of Speech and Language Therapists	4	3 a	The definition here reflects only the medical model. Therapists may be working from a more functional point of view in terms of *problems* and *helpful strategies* in context, rather than with concepts of *abnormality* or *diagnoses*. Some therapists and some authors have suggested that there is something subversive about translating nonconformity into a *disorder* (Coppock, 2002) Coppock, V. (2002). Medicalising children's behaviour. In B. Franklin (Ed.), *The New Handbook of Children's Rights: Comparative Policy and Practice*. London: Routledge.	Thank you for your comments.

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Royal College of Speech and Language Therapists	5	3 b	There is no mention of speech, language or communication difficulties as a potential co-morbidity despite research that shows a higher prevalence of speech & language disorder than in the general population. Standard assessment tools do often not identify these difficulties and/or there is a high dropout rate from Speech & Language Therapy Services by these families whose concerns are often centred around the child's behaviour. However, speech & language difficulties may in fact be the underlying reason for some of these behaviours. This masks the actual numbers of children & young people requiring speech & language therapy input. Jones & Chesson (2000) suggest a prevalence of 30-50% (compared with 10% in the general population). *Jane Jones & Rosemary Chesson, (2000) Falling through the screen.. RCSLT Bulletin.* **Specific speech & language disorder should be listed within the common co-morbidities.**	Thank you for your comments. The common comorbidities that will be addressed in the guideline will be determined by the guideline development group based upon their collective experience and the evidence-base available (see 4.1.1 b)

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Royal College of Speech and Language Therapists	6	3 b 3 d	Recommendations are needed for assessment. Children with CD often have undiagnosed communication problems and communication problems tend to get a label of 'behaviour problems'. Early and suitably extensive assessment is therefore needed and should be included in the guideline. References: Benasich AA, Curtiss S and Tallal P (1993) Language, learning and behavioural disturbances in childhood: a longitudinal perspective. Journal of the American Academy of Child and Adolescent Psychiatry, 32, 585-595. Cohen N. J., M. Davine, et al. (1993). Unsuspected language impairment in psychiatrically disturbed children: Prevalence and language and behavioral characteristics. Journal of the American Academy of Adolescent Psychiatry 32: 595-603. Whitmire K A (2000) Adolescence as a developmental phase: A tutorial. Topics in Language Disorders, 19, 1-18.	Thank you for your comments.
Royal College of Speech and Language Therapists	7	3 b 4.3 b	For some children, it is difficult to differentiate ADHD from ASD, and the same child can seem to move from one category to another over time, or across different settings. Working with diagnostic categories is unhelpful and confusing if boundaries between them are blurred.	Thank you for your comments.

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Royal College of Speech and Language Therapists	8	4.3 g	Psychological interventions: speech & language therapists have developed expertise in the management of social & emotional difficulties and could play an important role in providing social skills training, parent training and school-based interventions alongside other members of the multi-disciplinary team. Philippa Greathead (on the ADDISS website www.addiss.co.uk) discusses the types of problems that children with ADHD experience including difficulties with syntax, semantics, pragmatics, auditory processing, meta-linguistics and meta-cognition. These impact significantly on a child's or young person's ability to engage in discourse or conversation, generate language, make inferences & predictions and to function socially. **A speech & language therapist has the skills & expertise to enable the child or young person with associated speech & language impairment to access one-to-one and group therapies. There is also a role for the profession in providing advice, consultation & training to parents, carers & other professionals.**	Thank you for your comments.
Royal College of Speech and Language Therapists	9	4.3 j	Within young adults with this diagnosis, verbal skills often mask an underlying comprehension difficulty. Assessment is vital if they are to access and benefit any of the 'talking therapies'.	Thank you for your comments.

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Royal Liverpool Children's NHS Trust	1	General	Please include reference to Looked After Children (LAC) Population who are likely to have higher rate of diagnosis than general child population	Thank you for your comments. The guideline will address common comorbidities as determined by the guideline development group (see 4.1.1b)
Royal Liverpool Children's NHS Trust	2	General	Please include reference to PTSD (chronic) as it may present or be mistaken for ADHD and is under diagnosed in children but over represented in LAC population who will have been exposed to chronic adverse childhood experiences (often traumatic i.e. domestic violence)	Thank you for your comments. The guideline will address common comorbidities as determined by the guideline development group (see 4.1.1b)
Royal Liverpool Children's NHS Trust	3	General	Please consider the issue of peri natal influences such as drug addiction in mother during pregnancy or babies born with drug addictions and later presentation of child for ADHD. Additionally the risks of prescribing stimulant therapy for this client group (history of peri natal drug addiction/exposure). Again for LAC there often is very little early developmental history available.	Thank you for your comments. This is outside the remit for this scope.
Royal Liverpool Children's NHS Trust	4	2(c)	The specific issue of Looked After Children and informed consent needs consideration. Parental responsibility is often jointly held. This may also be true for the non LAC population – so you can have a situation where one parent agrees and another disagrees with a treatment. Stimulant therapy being one of those where there often are serious disagreements.	Thank you for your comments.

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Royal Liverpool Children's NHS Trust	5	3(a)	The core signs (inattention, hyperactivity, & impulsiveness) are also features of PTSD which is under diagnosed in children. Perhaps best not to put "most commonly "– this opens the debate as to why is it most commonly.	Thank you for your comments. We disagree that the core signs of ADHD are the same as PTSD.
Royal Liverpool Children's NHS Trust	6	3(b) & 4.3 (c)	Differential diagnosis – Please ensure screening for traumatic events. For example children who are being abused can be presented as if ADHD by parents who wish to have the "problem" located in the child. Parents may also not associate current hyperactivity to an historical traumatic event.	Thank you for your comments, please see comment above.
Royal Liverpool Children's NHS Trust	7	3(d)	Substance misuse may be a consequence of stimulant treatment i.e. iatrogenic. Caution perhaps in listing this particular sequelae	Thank you for your comments. This will be dealt with by the guideline.
Royal Liverpool Children's NHS Trust	8	3(f)	Figures on ethnicity – some attempt needs to be made to look at this issue as there often is not only gender bias in diagnosis but also racial bias with concomitant treatment bias issues. Figures are also needed for the LAC population – rate of diagnosis compared to general child population and rate of prescription	Thank you for your comments. We shall consider issues pertinent to ethnicity and culture as part of the guideline development process.
Royal Liverpool Children's NHS Trust	9	3(g)	Prescribing may have increased the diagnosing – cautious how this is phrased. Any data on increasing use of Supplementation specifically the Omega3/6 given the media attention	Thank you for your comments. Dietary supplementation will be considered.
Royal Liverpool Children's NHS Trust	10	3 (h)	Some concerns perhaps should be listed – don't use black market perhaps unauthorised selling/illegal trading	Thank you. We have amended the text in the light of your comment.

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Royal Liverpool Children's NHS Trust	11	4.2(b)	For LAC it is not possible to separate out SSD "the corporate parent". Also need consideration about administration of drugs in schools – this may be dealt with in other guidance that could be referred to.	Thank you for your comments. The guideline is, nevertheless, for the NHS. Interface issues will be addressed (see 4.2b) All relevant pharmacological questions will be addressed (see 4.3 g)
Royal Liverpool Children's NHS Trust	12	4.3(f)	Appropriate use of supplementation and/or diet It might be helpful to have a flow chart where less 'aggressive' treatments are given a fair trial (i.e. supplementation/diet/ psychological management) before moving up to more 'aggressive' interventions with known side effects are introduced.	Thank you for this suggestion.
Royal Liverpool Children's NHS Trust	13	General	Critical review of the side effects of pharmacological treatments	Thank you for your comments. The evidence associated with side effects of pharmacological treatments will be considered during the development of this guideline (see 4.3 g)
Royal Liverpool Children's NHS Trust	14	4.2b	There should be some guidelines to the schools regarding storage of category 2 medications in their premises.	Thank you for your comments. Please see our comments above.

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Royal Liverpool Children's NHS Trust	15		Could there be a chapter on 'good practice' from different areas in the country? This could take the form of 'NSF exemplars', ADHD child's journey.	Thank you for this suggestion.
Royal Liverpool Children's NHS Trust	16	4.2c/ 4.3j	Training for the adult services, joint transition clinics would be important areas to cover.	Thank you for your comments.
Royal Pharmaceutical Society of Great Britain	1		Please note that the Royal Pharmaceutical Society of Great Britain will not be commenting on the above.	Thank you.
Salford Primary Care Trust			This organisation was approached but did not respond.	
SANE			This organisation was approached but did not respond.	
Scottish Intercollegiate Guidelines Network (SIGN)			This organisation was approached but did not respond.	
Sheffield Care Trust	1	Title	Does management include treatment? Probably ought to, question may be nit-picking.	Thank you for your comments, management does include treatment.
Sheffield Care Trust	2	Para 3 (b)	Co morbidity is not just common in children: also in adults. Include ASPD, substance misuse, depression.	Thank you for your comments.

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Sheffield Care Trust	3	Para 4.1.2	Agree cannot cover management of co-morbidities. Agree should cover effect of co morbidity on management of adhd.. Suggest might be useful also to comment on influence of adhd on management of co-morbidities.	The areas to which the guideline applies have already been determined by the Department of Health and does not include the management of comorbidites themselves. Thank you, nevertheless, for your comments.
Sheffield Care Trust	4	Para 4.3 (f)	Guidance on drug treatments will be brief if limited to licenced indications for adults, and therefore not very useful. If guidance to be useful for adult psychiatry, may have to extend usual criteria.	Thank you for your comments.
Sheffield Care Trust	5	Para 4.3 (g)	Should there be something about psychological assessment as well as treatment? Suggest there should be.	Thank you for this comment. Please see 4.3 c, which does now address the broader issues regarding assessment.
Sheffield Care Trust	6	General	I'm not sure if there's enough emphasis on diagnostic guidance for adult psychiatrists: more and more referrals come in asking us to make the diagnosis. i.e. not just graduates from CAMHS or paediatrics. (Sometimes parents of kids with adhd, some young adults (18+) with pushy parents, some really awkward personalities who seek an alternative explanation for their difficulties.)	Thank you for your comments. We have amended the Scope in order to reflect the need for diagnostic guidance to cover all age groups (see 4.3b)

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Sheffield Care Trust	7	General	The multidisciplinary care of people with adhd isn't too bad in kids but is really awful for adults. They have often failed in education first time round, so need remedial help; need occupational rehab; have often few friends, so need socialising.	Thank you for your comments.
Sheffield Care Trust	8	General	There is some overlap with other neurodevelopmental disorders, e.g. autistic spectrum disorder, etc. More an issue for CAMHS than adult mental health services at present, but it should be coming our way.	Thank you for your comments.
Sheffield Children's Hospital NHS Trust	1	General	1- This is a highly welcomed guideline. We are delighted that identification will be covered and welcome the holistic approach to management. It is also very positive that the guideline will address those issues in the different age groups, particularly adults.	Thank you for your comments.
Sheffield Children's Hospital NHS Trust	2		2- We hope the Guideline with specifically address not only the Role of screening but also the Role of Tier 2 (particularly Primary Mental Health Workers) in training and in early identification	Thank you for your comments. The guideline will address all relevant personnel within the NHS (see section 4.2).

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Sheffield Children's Hospital NHS Trust	3		3- We would like the guideline to specifically address 'How to assess AD/HD' with a recommendation of minimum set of assessment(s)/ tools / investigations as well as 'desirables' – We would particularly emphasise the role of school observation and of multi-disciplinary assessments which could include psychological evaluation (which would include psychometric assessment), speech and language therapy assessment and occupational therapy assessments	Thank you for your comments.
Sheffield Children's Hospital NHS Trust	4		4- The importance of the routine assessment of co-morbidities (particularly as over 80% of our cases in practice have a comorbidity) needs to be emphasised. We are concerned that assessment of comorbidities is more often than not dictated by the professional background of the practitioner involved in the assessment rather than being a comprehensive screen of known/possible comorbidities (child psychiatrists look more for comorbid mental health disorders and paediatricians look more for comorbid developmental/neurological disorders). Issues of training need to be specifically addressed with regards to comorbidities regardless of the professional background of the assessor. We hope the Guideline will be innovative and proactive enough to address the split that exists between CAMHS and Paediatric services and suggest a joint approach rather than a divisive one	Thank you for your comments. In order to address this issue the Guideline Development Group will include both a child psychiatrist and paediatrician.

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
	5		5- We look forward to the Guideline emphasising the role of psychoeducation and of modifying the environment not only at home but also in school	Thank you for your comments.
Sheffield Children's Hospital NHS Trust	6		6- We appreciate that the Guideline could not possibly cover all aspects of prescribing, we would appreciate comments on the role of Nurse prescribers and of Nurse led clinics	Thank you for your comments.
Sheffield Children's Hospital NHS Trust	7		7- The NICE Guideline will clearly be in line with NSF's age recommendation but we are concerned about the the impact of this on Transition to Adult Psychiatry in services where NSF age recommendation cannot be implemented without extra resources	Thank you for your comments.

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Sheffield Children's Hospital NHS Trust	8		8- We appreciate that the Guideline could make only recommendations regarding practice in the NHS but this Guideline would fail in its remit unless it addresses how the educational needs of the children with ADHD could be met. It also would need to address the issue of Disability Living Allowance as this is highly significant to families and professionals alike	Thank you for your comments. The guideline can only make recommendations to the NHS. However, we recognise the considerable importance of other institutional settings and non-NHS professionals who will be both on the guideline development group and acting as special advisors so that we can address your concerns even though recommendations to those non-NHS professionals/organisations is outside the remit given by the DH (see section 4.2).
Sheffield Children's Hospital NHS Trust	9	Page 2, Section 3 (b)	Although "the diagnostic criteria for ADHD exclude children with pervasive developmental disorders, such as Asperger's syndrome", the guideline would need to comment on the increasing number of children seen in clinical practice who have both Autistic Spectrum Disorder and ADHD symptoms of such severity as to warrant multimodal interventions. Their management often poses a challenge to the clinicians.	Thank you for your comments. It is for these sorts of reasons that it is essential that the guideline should address different diagnostic criteria. However, we cannot address the treatment of other conditions except insofar as they affect the management of ADHD.

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Sheffield Children's Hospital NHS Trust	10	Page 2, Section 3(C)	Although 'there is continuing debate over the causes of ADHD', we would look forward to the guidelines commenting on whether there is the need to differentiate between attachment disorders and ADHD; whether these 2 conditions could co-occur or whether one results in another i.e. severe disruption to early life results in '2ry ADHD'. We see an increasing number of Looked After or Adopted children who have both symptoms of ADHD and ASD as well as Attachment Disorders.	Thank you for your comments. Please see our comments above regarding comorbidity. It is also worth mentioning that the GDG has a very broad base and will consider evidence from a number of quarters; and where evidence is lacking the expertise of the group will be used to reach consensus based recommendations that address contemporary practice and contemporary clinical experience.
Sheffield Children's Hospital NHS Trust	11	Page 5, Section 4.1.1 Page 5, 4.2	We welcome the guideline addressing the specific management of ADHD in individuals with learning disability or defined neurological disorder. We would plead for also addressing those with Substance Use Disorder (adolescent & adults) --- In addition we would plead for individuals with a history of offending (with or without SUD) to be considered. They form a significant proportion of our clinical population.	Thank you for your comments. Please see our comments above. The GDG will incorporate expertise from young offenders institutions.

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Sheffield Children's Hospital NHS Trust	12	Page 6, Section 4.3 (f)	We hope the Guideline will address not only appropriate use of pharmacological treatments but also issues of polypharmacy and advise on a ranking of combination treatments	Thank you for your comments. All aspects of pharmacological intervention will be considered during the development of the guideline (see section 4.3g)
Sheffield South West PCT			This organisation was approached but did not respond.	
Sheffield Teaching Hospitals NHS Trust			This organisation was approached but did not respond.	
Shire Pharmaceuticals Limited			This organisation was approached but did not respond.	
South East Sheffield Primary Care Trust			This organisation was approached but did not respond.	
Southend Primary Care Trust			This organisation was approached but did not respond.	
Staffordshire Moorlans Primary Care Trust			This organisation was approached but did not respond.	

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Sustain: The alliance for better food and farming	1	4.3	Sustain would like to applaud NICE for including dietary elimination and supplementation in the scope. Many parents, teachers, professionals and campaigners have been working over many years to highlight the existence of dietary factors in some children's ADHD. It will be extremely helpful to have this evidence included in the NICE consultation. As such, our only comment at this stage is "well done!".	Thank you.
The Association for Family Therapy	1	4.2 (a)	This section referring to the aspects of healthcare settings covered by the guideline. (a) indicates that the guideline will cover early intervention at primary, community and secondary care levels. This comment relates to the need for the guidance to cover the important role provided by tier three provision (HAS tiered model). The issues are: Primary, community and secondary (if we mean by this primary and tier two levels as described by HAS model) are limited in their ability to resource and provide a multi-modal assessment to ADHD referrals. Increasingly we are aware that primary and secondary level services experience difficulty with atypical presentations and neuro-developmental complex co-morbid features. Frequently when there are over-lapping difficulties and atypical presentations a fine-grained, multi-disciplinary diagnostic assessment is required. The advantage of tier three assessments is that neuro-developmental features, cognitive issues, environmental factors can be addressed as part of a	Thank you for your comments (see section 4.2).

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
			comprehensive multi-disciplinary intervention model. Moreover treatment can be long term and multi-modal. The weakness of tier one/two intervention whilst it may address issues of early identification is that the assessment and treatment outcomes may only partially met the needs of the patient and their family. As a result there may need to be subsequent onward referral to tier three service for 'specialist' neuro-developmental assessment. The result for the patient and the patient's family is an increase in waiting times as they are referred between tiered services and frequently a duplication of assessment. The guideline needs to address the streamlining of service provision and comprehensive service delivery so that comprehensive multi-disciplinary input can be provided at one point of contact for the patient.	
The Association for Family Therapy	2	4.3 (c)	This section refers to the aspects of clinical management that will be covered by the guideline. (C) indicates that the guideline will cover early intervention at primary care. In line with the comment for 4.2 (a) service provision and comprehensive service delivery needs to be addressed at the primary care level. Unless primary care services are able to offer comprehensive, multi-disciplinary assessment and treatment interventions that can be sustained over the long-term (ADHD being a condition that effects individuals across their lifespan) then the likelihood of onward referral increases. Early intervention is crucial but in our view it must be sustained with	Thank you for your comments.

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
			well-resourced provision. The ability to undertake complex assessments with atypical neuro-developmental presentations, which includes the ability to provide psychometric assessment, family assessment, school observation, individual clinical assessment of the child at a single point of contact is as important for these patients as the ability to identify the condition early. A frequent concern of association members is that too often children are diagnosed within primary tier services on the basis of brief, 'parent-only' report/interview, supported by completed questionnaires. In our view this might be described as a 'screen' rather than a comprehensive assessment of ADHD. If children then receive a diagnosis and psycho-pharmacological treatment but difficulties persist or escalate and there is a need for onward referral for a more comprehensive assessment this is potentially detrimental to patient care. The patient may experience a wait before engaging with a new service, there may be duplication of assessment, there are new professionals for the patient to engage with and so on. It is the multi-faceted, long term and complex nature of ADHD presentations that needs to be addressed by the guidance of which early intervention is only one aspect.	

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
The British Psychological Society	1	General	Overall the 'scope' does not provide sufficient detail regarding the exploration of the use of psychological interventions, particularly the work of educational psychologists in working at strategic, systemic and individual child levels in dealing with ADHD. Educational psychologists work on a daily basis with community, school, parents of children experiencing symptoms of ADHD. Educational psychologists work at a multi-agency level (CAMHS etc) and are frequently engaged in multi-professional assessments and interventions. Such work out to be part of the 'scoping' activity.	Thank you for your comments. The guideline is for the NHS and cannot make recommendations to educational psychologists or other professionals working outside the NHS. However, we have incorporated educational expertise within the GDG to ensure that we address interface issues adequately.
The British Psychological Society	2	3	We suggest 'Clinical need for guideline' should include the need to develop consistency in practice (assessment, intervention) across health professionals and in their interface with other agencies. The principle of least intrusive, most effective intervention should be emphasised.	Thank you for your comments. We believe that the emphasis in the revised scope addresses these general issues. We should add that all guidelines should recommend treatments on the basis of a full consideration of both the benefits and the potential harms likely to result from the treatment.
The British Psychological Society	3	3a	A statement about the lack of diagnostic criteria for adults with ADHD needs to be included.	Thank you for your comments. This has been amended (see section 3a).

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
The British Psychological Society	4	3b	About diagnostic criteria for AD/HD excluding children with PDDs: It would be important to emphasize that though dx of AD/HD does exclude those with PDD/ASD dx, the clinical literature and clinical practice strongly suggests that attentional problems are frequently comorbid with PDDs, and at times require treatment in their own right. The guidelines need to reflect this. Some recent papers about this topic: Goldstein & Schwebach (2004); Yoshida & Uchiyama (2004); Gadow, Devincent,Pomeroy, & Azizian (2005); Ogino et al (2005).	Thank you for your comment and information. This is addressed by the scope (in particular see 4.1.1b).
The British Psychological Society	5	3d	There needs to be some acknowledgement of the vast numbers of undiagnosed adults with ADHD – this may be due to the lack of knowledge about ADHD when they were younger, but also due to the ongoing ignorance of adult services about developmental disorders persisting into adulthood.	Thank you for this comment. Please see amended section 3a.
The British Psychological Society	6	3f	The gender imbalance might also be down to the possibility that ADHD presents differently in girls (inattentive, but less disruptive) than in boys.	Thank you for your comments.
The British Psychological Society	7	3g	Currently there are no drugs licensed for adults with ADHD – when this changes, there will be huge cost implications to the NHS.	Thank you for your comments.
The British Psychological Society	8	4.1.1a	With regard to pre-school children, particular consideration should be given to the normality of young children's attention and degree of activity and the need for contextually based assessment (from both home and pre-school settings)	Thank you for your comments.

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
The British Psychological Society	9	4.2b	Regarding the interface between healthcare professionals and other services, good practice would suggest that multiagency shared pathways to assessment and intervention is essential to the provision of effective services and to developing a shared understanding of how children and young people's needs can be best met across the different settings in their lives. The need for guidelines to consider key agreements between healthcare professionals and other services regarding the sharing of advice and assessment and intervention information.	Thank you for your comments. (See revised section 4.2.)
The British Psychological Society	10	4.3:	It may be important to include something about the necessity of referring children for more comprehensive neuropsychological assessment where AD/HD is complicated by a co-morbid psychiatric diagnosis, medical/neurological condition, injury, or suspected learning problems. In the guideline so far, there does not seem to be much information on assessment and how that is carried out.	Thank you for your comments. See amended section 4.3c.
The British Psychological Society	11	4.3b	Contextual assessment information from educational settings should be taken into account alongside diagnostic criteria. Existing diagnostic criteria focuses on children – some of the criteria do not apply to adults (hyperactive symptoms tend to decline over time, attentional difficulties remain).	Thank you for this comment.

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
The British Psychological Society	12	4.3c	Current diagnostic assessment procedures vary considerably between different services/professionals – it would be helpful to have some guidance on the minimum standards of such an assessment (e.g. to include a full developmental history). Identification of ADHD in adults.	Thank you for this comment. The scope does include an examination of diagnostic criteria and the validity of diagnosis. We have also now included a section on assessment (4.3c).
The British Psychological Society	13	4.3f	Medication can be effective in reducing impulsivity, overactivity and inattention. Best practice would be to prescribe medication only after, and alongside continuing social and educational interventions. Atomoxetine is currently licensed for treatment of *children* with ADHD.	Thank you for this comment, we have amended the text (see section 4.3g)
The British Psychological Society	14	4.3i	Other physical treatments could perhaps include physical exercise.	Thank you for this suggestion. We shall consider this.
The College of Mental Health Pharmacists			This organisation was approached but did not respond.	
The David Lewis Centre			This organisation was approached but did not respond.	
The Dyslexia Institute			This organisation was approached but did not respond.	

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
The North West London Hospitals NHS Trust			This organisation was approached but did not respond.	
The Royal Society of Medicine			This organisation was approached but did not respond.	
The Survivors Trust			This organisation was approached but did not respond.	
UCB	1	Section 3	Clinical need for the guideline section outlines treatment and issues of stimulants, but does not mention treatment and issues of the only other licensed treatment, atomoxetine.	Thank you for your comments. The scope does include this and it has also been addressed by the NICE technology appraisal that will also be incorporated into the final guideline (see section 4.4.1).
UCB	2	Section 4.2.c	Suggests inclusion of arrangements for school based diagnoses and referrals (i.e. SENs and nurses) and generates debate around clinical governance arrangements. Specifically, concerning medicines in schools issues (ie: midday dose of a CD medicine).	Thank you for your comments. This is too detailed to outline in the scope. Nevertheless, the GDG includes educational expertise and will therefore, address important issues such as these (arrangement for medication around school time).
UCB	3	Section 4.3	In consideration of the transfer of adolescents from CAMS to adult services with their ADHD; adult services generally do not have the capacity to treat all ADHD sufferers turning 18 years and consequently there may need to be some service expansion.	Thank you for your comments.

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
UCB	4	Section 4.3	Dexamfetamine is licensed for refractory hyperkinetic states and not ADHD per se.	Thank you for your comments.
UCB	5	Section 4.3.f	UCB would recommend that the scope should reflect licensed treatments for ADHD as a principle consideration. The inclusion of drugs such as modafinil, which are unlicensed in ADHD, should be considered only in exceptional circumstances.	Thank you for your comments. Guidelines will only make recommendations about the use of medication within its licensed usage or if a treatment is being/has been used within the NHS above at least minimum frequency.
UK Anaemia			This organisation was approached but did not respond.	
UK Psychiatric Pharmacy Group			This organisation was approached but did not respond.	
University College London Hospitals NHS Trust			This organisation was approached but did not respond.	
University of Wales Swansea		4.3 (i) Other physical treatments	1) There are widespread assumptions in the population that additives cause ADHD. A clear statement, should one prove possible, would help to put this in context. Although summaries in the 1980s concluded that double-blind trials failed to support a role a more recent meta-analysis reported an effect size of 0.2 of a standard deviation. The generality of such a conclusion, should NICE think the data strong enough, should be established. Given the thousands of substances that are added to food it is unreasonable to treat them as a homogeneous	Thank you for this information. The guideline will address dietary supplementation and elimination. However, there are limits to how much we can cover within one guideline and making this more detailed will saddle the guideline development group with an unmanageable task.

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
			category and attempts could be made to identify substances with a high risk of causing problems. 2) The food intolerance approach should be considered as it is clear that additives are in no way uniquely implicated. I have recently used meta-analysis to examine the use of elimination diets and the double-blind evaluation of suspect foods. If it was considered appropriate I could share this work with NICE. A summary is that these well designed studies resulted in an overall effect of 0.8 of a standard deviation. A major question, should that conclusion be accepted, is the extent to which the data reflect a pre-selected group of children. 3) Attempts should be made to establish the frequency of food intolerance and changes with age as it appears that many children to some extent at least grow out of the problem. 4) There are increasing claims that fatty acid supplementation help with ADHD. I have also recently reviewed these data. Again a clear statement would prevent the population being mislead. I was unable to find a single study in which those diagnosed with ADHD responded to supplementation.	
Welsh Assembly Government			This organisation was approached but did not respond.	

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West Glam&West Wales AD/HD Family Support Group(U.K.) Wales			This organisation was approached but did not respond.	
West Midlands Specialised Services Agency			This organisation was approached but did not respond.	
Women's & Children's Collaborating Centre			This organisation was approached but did not respond.	
Young Minds			This organisation was approached but did not respond.	
Young People's Unit			This organisation was approached but did not respond.	
Individual respondent		3a	There seems to be an asymmetry in the references to DSM-IV and ICD-10. For example DSM-IV mentions the presence of symptoms over a time span. This is not mentioned but the ICD-10 time span is.	Thank you for your comments. This has been be amended.

Stakeholder	No.	Section number	Comments Please insert each new comment in a new row.	Developer's response Please respond to each comment
Individual respondent		4.3 c	I was not clear from the wording how widely "early identification" was to be taken. Perhaps it could read "Identification of factors that should lead to the early identification of children in primary care and educational settings for further investigation into the possibility of ADHD"	Thank you for your comments. We have not specified identification in primary care since this suggests some form of screening. We do, however, want to identify groups of children at high risk and amongst whom early identification would be a priority.