Clinical Practice Guideline on Attention Deficit Hyperactivity Disorder - Adults

Renewed: November 2016
The IEHP Adult ADHD Clinical Practice Guideline is updated to include the National Institute for Health and Clinical Excellence recommendations, and Diagnostic and Statistical Manual of Mental Disorders V (DSM-V) criteria in accordance to American Psychiatric Association guidance. Diagnosis of adult ADHD is established in accordance to DSM-V criteria, adjusting for presentation in adults compared with children. Hence, an integrated approach to assess adult manifestations of ADHD, including psychiatric interviews, self-reports, and performance-based measures, is recommended. Attached are also additional resources including transition to adult service, treatment of ADHD, pharmacotherapy initiation, titration and monitoring, DSM-V criteria, and a table of structured diagnostic instruments/rating scales for adult ADHD diagnosis.
Attention Deficit Hyperactivity Disorder and Management of ADHD: National Institute for Health and Clinical Excellence

Guideline Objectives:

- To provide recommendations on the diagnosis and treatment of attention deficit hyperactivity disorder (ADHD)
- To assist clinicians, people with ADHD, and their careers by identifying the merits of particular treatment approaches where the evidence from research and clinical experience exists
- Specifically, the guideline aims to:
  - Examine the validity of the diagnostic construct of ADHD
  - Evaluate the role of specific pharmacological agents and non-pharmacological, psychological, and psychosocial interventions in the treatment and management of ADHD
  - Evaluate the role of specific services and systems for providing those services in the treatment and management of ADHD
  - Integrate the above to provide best-practice advice on the care of people with a diagnosis of ADHD through the different phases of illness, including the initiation and maintenance of treatment for the chronic condition, the treatment of acute episodes and the promotion of well-being
  - Consider economic aspects of various interventions for ADHD

Major Recommendations:

Prerequisites of Treatment and Care for All People with Attention Deficit Hyperactivity Disorder (ADHD)

People with ADHD require integrated care that addresses a wide range of personal, social, educational, and occupational needs. Care should be provided by adequately trained healthcare and education professionals.

Identification, Pre-diagnostic Intervention in the Community, and Referral to Secondary Services

Identification and Referral in Adults with ADHD
Adults presenting with symptoms of ADHD in primary care or general adult psychiatric services, who do not have a childhood diagnosis of ADHD, should be referred for assessment by a mental health specialist trained in the diagnosis and treatment of ADHD, where there is evidence of typical manifestations of ADHD (hyperactivity/impulsivity and/or inattention) that:

- Began during childhood and have persisted throughout life
- Are not explained by other psychiatric diagnoses (although there may be other coexisting psychiatric conditions)
- Have resulted in or are associated with moderate or severe psychological, social and/or educational or occupational impairment.

Adults who have previously been treated for ADHD as children or young people and present with symptoms suggestive of continuing ADHD should be referred to general adult psychiatric services for assessment. The symptoms should be associated with at least moderate or severe psychological and/or social or educational or occupational impairment.

**Diagnosis of ADHD**

ADHD is a valid clinical disorder that can be distinguished from coexisting conditions (although it is most commonly comorbid) and the normal spectrum. ADHD differs from the normal spectrum because there are high levels of hyperactivity/impulsivity and/or inattention that result in significant psychological, social, and/or educational or occupational impairment that occurs across multiple domains and settings and persists over time.

A diagnosis of ADHD should only be made by a specialist psychiatrist, pediatrician, or other appropriately qualified healthcare professional with training and expertise in the diagnosis of ADHD, on the basis of:

- A full clinical and psychosocial assessment of the person; this should include discussion about behavior and symptoms in the different domains and settings of the person's everyday life
- A full developmental and psychiatric history
- Observer reports and assessment of the person's mental state

A diagnosis of ADHD should not be made solely on the basis of rating scale or observational data. However, rating scales such as the Conners' rating scales and the Strengths and Difficulties
questionnaire are valuable adjuncts, and observations (for example, at school) are useful when there is doubt about symptoms.

- For a diagnosis of ADHD, symptoms of hyperactivity/impulsivity and/or inattention should:
  - Meet the diagnostic criteria in Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM-V) or International Classification of Diseases 9/10th revision (ICD-9 or 10) (hyperkinetic disorder) (Note: The ICD-10 exclusion on the basis of a pervasive developmental disorder being present, or the time of onset being uncertain, is not recommended), and
  - Be associated with at least moderate psychological, social, and/or educational or occupational impairment based on interview and/or direct observation in multiple settings, and
  - Be pervasive, occurring in two or more important settings including social, familial, educational and/or occupational settings.

As part of the diagnostic process, include an assessment of the person's needs, coexisting conditions, social, familial, and educational or occupational circumstances, and physical health. For children and young people, there should also be an assessment of their parents' or careers' mental health.

- ADHD should be considered in all age groups, with symptom criteria adjusted for age-appropriate changes in behavior.
- In determining the clinical significance of impairment resulting from the symptoms of ADHD in children and young people, their views should be taken into account wherever possible.

**Transition to Adult Services**

Young people with ADHD receiving treatment and care from pediatric services should normally be transferred to adult services if they continue to have significant symptoms of ADHD or other coexisting conditions that require treatment. Transition should be planned in advance by both referring and receiving services. If needs are severe and/or complex, use of the care program approach should be considered.

- A young person with ADHD receiving treatment and care from pediatric services should be reassessed at school-leaving age to establish the need for continuing treatment into adulthood. If treatment is necessary, arrangements should be made for a smooth transition to adult services with details of the anticipated treatment and services that the young person will require. Precise
Timing of arrangements may vary locally but should usually be completed by the time the young person is 18 years.

- During the transition to adult services, a formal meeting involving pediatrics and adult psychiatric services should be considered, and full information provided to the young person about adult services. The young person, and when appropriate the parent or career, should be involved in the planning.

- After transition to adult services, adult healthcare professionals should carry out a comprehensive assessment of the person with ADHD that includes personal, educational, occupational and social functioning, and assessment of any coexisting conditions, especially drug misuse, personality disorders, emotional problems and learning difficulties.

**Treatment of Adults with ADHD**

Drug treatment is the first-line treatment for adults with ADHD with either moderate or severe levels of impairment. Methylphenidate is the first-line drug. Psychological interventions without medication may be effective for some adults with moderate impairment, but there are insufficient data to support this recommendation. If methylphenidate is ineffective or unacceptable, atomoxetine or amphetamine can be tried. If there is residual impairment despite some benefit from drug treatment, or there is no response to drug treatment, CBT may be considered. There is the potential for drug misuse and diversion in adults with ADHD, especially in some settings, such as prison, although there is no strong evidence that this is a significant problem.

- For adults with ADHD, drug treatment should be the first-line treatment unless the person would prefer a psychological approach.

- Drug treatment for adults with ADHD should be started only under the guidance of a psychiatrist, nurse prescriber specializing in ADHD, or other clinical prescriber with training in the diagnosis and management of ADHD.

- Before starting drug treatment for adults with ADHD a full assessment should be completed, which should include:
  - Full mental health and social assessment
  - Full history and physical examination, including:
    - Assessment of history of exercise syncope, undue breathlessness, and other cardiovascular symptoms
Heart rate and blood pressure (plotted on a centile chart)

Weight

Family history of cardiac disease and examination of the cardiovascular system

- An ECG if there is past medical or family history of serious cardiac disease, a history of sudden death in young family members or abnormal findings on cardiac examination
- Risk assessment for substance misuse and drug diversion.

- Drug treatment for adults with ADHD should always form part of a comprehensive treatment program that addresses psychological, behavioral and educational or occupational needs.
- Following a decision to start drug treatment in adults with ADHD, methylphenidate should normally be tried first.
- Atomoxetine or amphetamine should be considered in adults unresponsive or intolerant to an adequate trial of methylphenidate (this should usually be about 6 weeks). Caution should be exercised when prescribing amphetamine to those likely to be at risk of stimulant misuse or diversion.
- When starting drug treatment, adults should be monitored for side effects. In particular, people treated with atomoxetine should be observed for agitation, irritability, suicidal thinking and self-harming behavior, and unusual changes in behavior, particularly during the initial months of treatment, or after a change in dose. They should also be warned of potential liver damage in rare cases (usually presenting as abdominal pain, unexplained nausea, malaise, darkening of the urine, or jaundice). Younger adults aged 30 years or younger should also be warned of the potential of atomoxetine to increase agitation, anxiety, suicidal thinking, and self-harming behavior in some people, especially during the first few weeks of treatment.
- For adults with ADHD stabilized on medication but with persisting functional impairment associated with the disorder, or where there has been no response to drug treatment, a course of either group or individual CBT to address the person's functional impairment should be considered. Group therapy is recommended as the first-line psychological treatment because it is the most cost effective.
- For adults with ADHD, CBT may be considered when:
  - The person has made an informed choice not to have drug treatment
  - Drug treatment has proved to be only partially effective or ineffective or the person is intolerant to it
People have difficulty accepting the diagnosis of ADHD and accepting and adhering to drug treatment.

Symptoms are remitting and psychological treatment is considered sufficient to target residual (mild to moderate) functional impairment.

Where there may be concern about the potential for drug misuse and diversion (for example, in prison services), atomoxetine may be considered as the first-line drug treatment for ADHD in adults.

Drug treatment for adults with ADHD who also misuse substances should only be prescribed by an appropriately qualified healthcare professional with expertise in managing both ADHD and substance misuse. For adults with ADHD and drug or alcohol addiction disorders there should be close liaison between the professional treating the person's ADHD and an addiction specialist.

Antipsychotics are not recommended for the treatment of ADHD in adults.

**How to Use Drugs for the Treatment of ADHD**

Good knowledge of the drugs used in the treatment of ADHD and their different preparations is essential (refer to the FDA and summaries of product characteristics). It is important to start with low doses and titrate upwards, monitoring effects and side effects carefully. Higher doses may need to be prescribed to some adults. The recommendations on improving adherence in children and young people may also be of use in adults.

**General Principles**

- Prescribers should be familiar with the pharmacokinetic profiles of all the modified-release and immediate-release preparations available for ADHD to ensure that treatment is tailored effectively to the individual needs of the child, young person or adult.
- Prescribers should be familiar with the requirements of controlled drug legislation governing the prescription and supply of stimulants.
- During the titration phase, doses should be gradually increased until there is no further clinical improvement in ADHD (that is, symptom reduction, behavior change, improvements in education and/or relationships) and side effects are tolerable.
- Following titration and dose stabilization, prescribing and monitoring should be carried out under locally agreed shared care arrangements with primary care.
• Side effects resulting from drug treatment for ADHD should be routinely monitored and documented in the person's notes.
• If side effects become troublesome in people receiving drug treatment for ADHD, a reduction in dose should be considered.
• Healthcare professionals should be aware that dose titration should be slower if tics or seizures are present in people with ADHD.

**Initiation and Titration of Methylphenidate, Atomoxetine, and Amphetamine in Adults**

• In order to optimize drug treatment, the initial dose should be titrated against symptoms and side effects over 4 to 6 weeks.
• During the titration phase, symptoms and side effects should be recorded at each dose change by the prescriber after discussion with the person with ADHD and, wherever possible, a care provider (for example, a spouse, parent or close friend). Progress should be reviewed (for example, by weekly telephone contact and at each dose change) with a specialist clinician.
• If using methylphenidate in adults with ADHD:
  • Initial treatment should begin with low doses (5 mg three times daily for immediate-release preparations; the equivalent dose for modified-release preparations)
  • The dose should be titrated against symptoms and side effects over 4 to 6 weeks
  • The dose should be increased according to response up to a maximum of 100 mg/day
  • Modified-release preparations should usually be given once daily and no more than twice daily
  • Modified-release preparations may be preferred to increase adherence and in circumstances where there are concerns about substance misuse or diversion
  • Immediate-release preparations should be given up to four times daily.
• If using atomoxetine in adults with ADHD:
  • For people with ADHD weighing up to 70 kg, the initial total daily dose should be approximately 0.5 mg/kg; the dose should be increased after 7 days to approximately 1.2 mg/kg/day
  • For people with ADHD weighing more than 70 kg, the initial total daily dose should be 40 mg; the dose should be increased after 7 days up to a maintenance dose of 100 mg/day
• The usual maintenance dose is either 80 or 100 mg, which may be taken in divided doses.
• A trial of 6 weeks on a maintenance dose should be allowed to evaluate the full effectiveness of atomoxetine.
• If using amphetamine in adults with ADHD:
  • Initial treatment should begin with low doses (5 mg twice daily)
  • The dose should be titrated against symptoms and side effects over 4 to 6 weeks
  • Treatment should be given in divided doses
  • The dose should be increased according to response up to a maximum of 60 mg per day
  • The dose should usually be given between two and four times daily.

**Monitoring Side Effects and the Potential for Misuse in Children, Young People and Adults**

• Healthcare professionals should consider using standard symptom and side effect rating scales throughout the course of treatment as an adjunct to clinical assessment for people with ADHD.
• If there is evidence of weight loss associated with drug treatment in adults with ADHD, healthcare professionals should consider monitoring body mass index and changing the drug if weight loss persists.
• Strategies to reduce weight loss in people with ADHD, or manage decreased weight gain in children, include:
  • Taking medication either with or after food, rather than before meals
  • Taking additional meals or snacks early in the morning or late in the evening when the stimulant effects of the drug have worn off
  • Obtaining dietary advice
  • Consuming high-calorie foods of good nutritional value.
• If growth is significantly affected by drug treatment (that is, the child or young person has not met the height expected for their age), the option of a planned break in treatment over school holidays should be considered to allow 'catch-up' growth to occur.
• In people with ADHD, heart rate and blood pressure should be monitored and recorded on a centile chart before and after each dose change and routinely every 3 months.
• For people taking methylphenidate, amphetamine and atomoxetine, routine blood tests and ECGs are not recommended unless there is a clinical indication.
Liver damage is a rare and idiosyncratic adverse effect of atomoxetine and routine liver function tests are not recommended. For children and young people taking methylphenidate and amphetamine, healthcare professionals and parents or careers should monitor changes in the potential for drug misuse and diversion, which may come with changes in circumstances and age. In these situations, modified-release methylphenidate or atomoxetine may be preferred. In young people and adults, sexual dysfunction (that is, erectile and ejaculatory dysfunction) and dysmenorrheal should be monitored as potential side effects of atomoxetine. For people taking methylphenidate, amphetamine or atomoxetine who have sustained resting tachycardia, arrhythmia or systolic blood pressure greater than the 95th percentile (or a clinically significant increase) measured on two occasions should have their dose reduced and be referred to a pediatrician or adult physician. If psychotic symptoms (for example, delusions and hallucinations) emerge in children, young people and adults after starting methylphenidate or amphetamine, the drug should be withdrawn and a full psychiatric assessment carried out. Atomoxetine should be considered as an alternative. If seizures are exacerbated in a child or young person with epilepsy, or de novo seizures emerge following the introduction of methylphenidate or atomoxetine, the drug should be discontinued immediately. If tics emerge in people taking methylphenidate or amphetamine, healthcare professionals should consider whether:

- The tics are stimulant-related (tics naturally wax and wane)
- Tic-related impairment outweighs the benefits of ADHD treatment.

If tics are stimulant-related, reduce the dose of methylphenidate or amphetamine; consider changing to atomoxetine, or stop drug treatment. Anxiety symptoms, including panic, may be precipitated by stimulants, particularly in adults with a history of coexisting anxiety. Where this is an issue, lower doses of the stimulant and/or combined treatment with an antidepressant used to treat anxiety can be used; switching to atomoxetine may be effective.
Duration, Discontinuation and Continuity of Treatment in Adults

- Following an adequate response, drug treatment for ADHD should be continued for as long as it is clinically effective. This should be reviewed annually. The review should include a comprehensive assessment of clinical need, benefits, and side effects, taking into account the views of the person and those of a spouse, partner, parent, close friends, or careers wherever possible, and how these accounts may differ. The effect of missed doses, planned dose reductions and brief periods of no treatment should be taken into account and the preferred pattern of use should also be reviewed. Coexisting conditions should be reviewed, and the person treated or referred if necessary. The need for psychological, social, and occupational support for the person and their careers should be assessed.

- An individual treatment approach is important for adults, and healthcare professionals should regularly review (at least annually) the need to adapt patterns of use, including the effect of drug treatment on coexisting conditions and mood changes.

Adverse Effects of Medications

- Growth (height and weight) can be affected by drug treatment and needs to be monitored during treatment.

- Patient treated with atomoxetine should be closely observed for agitation, irritability, suicidal thinking and self-harming behavior, and unusual changes in behavior, particularly during the initial months of treatment or after a change in dose. Parents and/or careers should be warned about the potential for suicidal thinking and self-harming behavior with atomoxetine and asked to report these to their healthcare professionals. Parents or careers should also be warned about the potential for liver damage in rare cases with atomoxetine (usually presenting as abdominal pain, unexplained nausea, malaise, darkening of the urine, or jaundice).

- In young people and adults, sexual dysfunction (that is, erectile and ejaculatory dysfunction) and dysmenorrhea should be monitored as potential side effects of atomoxetine.

- People taking methylphenidate, amphetamine, or atomoxetine who have sustained resting tachycardia, arrhythmia, or systolic blood pressure greater than the 95th percentile (or a clinically significant increase) measured on two occasions should have their dose reduced and be referred to a paediatrician or adult physician.
• If psychotic symptoms (for example, delusions and hallucinations) emerge in children, young people, and adults after starting methylphenidate or amphetamine, the drug should be withdrawn and a full psychiatric assessment carried out. Atomoxetine should be considered as an alternative.

• If seizures are exacerbated in a child or young person with epilepsy, or de novo seizures emerge following the introduction of methylphenidate or atomoxetine, the drug should be discontinued immediately.

• Anxiety symptoms, including panic, may be precipitated by stimulants, particularly in adults with a history of coexisting anxiety.

• There is a potential for drug misuse and diversion in children and young people taking methylphenidate and amphetamine.

Refer to the "Monitoring Side Effects and the Potential for Misuse in Children, Young People and Adults" section in the "Major Recommendations" field for additional information on adverse effects of stimulants.
The definition of attention-deficit/hyperactivity disorder (ADHD) has been updated in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) to more accurately characterize the experience of affected adults. This revision is based on nearly two decades of research showing that ADHD, although a disorder that begins in childhood, can continue through adulthood for some people. Previous editions of DSM did not provide appropriate guidance to clinicians in diagnosing adults with the condition. By adapting criteria for adults, DSM-5 aims to ensure that children with ADHD can continue to get care throughout their lives if needed.

**Changes to the Disorder**

ADHD is characterized by a pattern of behavior, present in multiple settings (e.g., school and home), that can result in performance issues in social, educational, or work settings. As in DSM-IV, symptoms will be divided into two categories of inattention and hyperactivity and impulsivity that include behaviors like failure to pay close attention to details, difficulty organizing tasks and activities, excessive talking, fidgeting, or an inability to remain seated in appropriate situations.

Children must have at least six symptoms from either (or both) the inattention group of criteria and the hyperactivity and impulsivity criteria, while older adolescents and adults (over age 17 years) must present with five. While the criteria have not changed from DSM-IV, examples have been included to illustrate the types of behavior children, older adolescents, and adults with ADHD might exhibit. The descriptions will help clinicians better identify typical ADHD symptoms at each stage of patients’ lives. Using DSM-5, several of the individual’s ADHD symptoms must be present prior to age 12 years, compared to 7 years as the age of onset in DSM-IV. This change is supported by substantial research published since 1994 that found no clinical differences between children identified by 7 years versus later in terms of course, severity, outcome, or treatment response.

DSM-5 includes no exclusion criteria for people with autism spectrum disorder, since symptoms of both disorders co-occur. However, ADHD symptoms must not occur exclusively during the course of schizophrenia or another psychotic disorder and must not be better explained by another mental disorder, such as a depressive or bipolar disorder, anxiety disorder, dissociative disorder, personality disorder, or substance intoxication or withdrawal.

**Care Beyond Childhood**

The ADHD diagnosis in previous editions of DSM was written to help clinicians identify the disorder in children. Almost two decades of research conclusively show that a significant number of individuals diagnosed with ADHD as children continue to experience the disorder as adults. Evidence of this came from studies in which individuals were tracked for years or even decades after their initial childhood diagnosis. The results showed that ADHD does not fade at a specific age.

Studies also showed that the DSM-IV criteria worked as well for adults as they did for children but that a lower threshold of symptoms (five instead of six) was sufficient for a reliable diagnosis.
In light of the research findings, DSM-5 makes a special effort to address adults affected by ADHD to ensure that they are able to get care when needed.

DSM is the manual used by clinicians and researchers to diagnose and classify mental disorders. The American Psychiatric Association (APA) will publish DSM-5 in 2013, culminating a 14-year revision process.

APA is a national medical specialty society whose more than 36,000 physician members specialize in the diagnosis, treatment, prevention and research of mental illnesses, including substance use disorders. Visit the APA at www.psychiatry.org. For more information, please contact Eve Herold at 703-907-8540 or press@psych.org

© 2013 American Psychiatric Association
Table 1 Diagnostic Criteria for Attention-Deficit/Hyperactivity Disorder

**DSM-V: Diagnostic Criteria**

A. A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development, as characterized by (1) and/or (2):

1. **Inattention:** Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities:

   - **Note:** The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least five symptoms are required.

   a. Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities (e.g., overlooks or misses details, work is inaccurate).

   b. Often has difficulty sustaining attention in tasks or play activities (e.g., has difficulty remaining focused during lectures, conversations, or lengthy reading).

   c. Often does not seem to listen when spoken to directly (e.g., mind seems elsewhere, even in the absence of any obvious distraction).

   d. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily sidetracked).

   e. Often has difficulty organizing tasks and activities (e.g., difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganized work; has poor time management; fails to meet deadlines).

   f. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework; for older adolescents and adults, preparing reports, completing forms, reviewing lengthy papers).

   g. Often loses things necessary for tasks or activities (e.g., school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).

   h. Is often easily distracted by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts).

   i. Is often forgetful in daily activities (e.g., doing chores, running errands; for older adolescents and adults, returning calls, paying bills, keeping appointments).

2. **Hyperactivity and impulsivity:** Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities:

   - **Note:** The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or a failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least five symptoms are required.

   a. Often fidgets with or taps hands or feet or squirms in seat.

   b. Often leaves seat in situations when remaining seated is expected (e.g., leaves his or her place in the classroom, in the office or other workplace, or in other situations that require remaining in place).

   c. Often runs about or climbs in situations where it is inappropriate. (**Note:** In adolescents or adults, may be limited to feeling restless.)

   d. Often unable to play or engage in leisure activities quietly.

   e. Often fidgets with or taps hands or feet or squirms in seat.

   f. Often leaves seat in situations when remaining seated is expected (e.g., leaves his or her place in the classroom, in the office or other workplace, or in other situations that require remaining in place).
g. Often runs about or climbs in situations where it is inappropriate. (Note: In adolescents or adults, may be limited to feeling restless.)
h. Often unable to play or engage in leisure activities quietly.
i. Is often “on the go,” acting as if “driven by a motor” (e.g., is unable to be or uncomfortable being still for extended time, as in restaurants, meetings; may be experienced by others as being restless or difficult to keep up with).
j. Often talks excessively.
k. Often blurts out an answer before a question has been completed (e.g., completes people’s sentences; cannot wait for turn in conversation).
l. Often has difficulty waiting his or her turn (e.g., while waiting in line).
m. Often interrupts or intrudes on others (e.g., butts into conversations, games, or activities; may start using other people’s things without asking or receiving permission; for adolescents and adults, may intrude into or take over what others are doing).

B. Several inattentive or hyperactive-impulsive symptoms were present prior to age 12 years.
C. Several inattentive or hyperactive-impulsive symptoms are present in two or more settings (e.g., at home, school, or work; with friends or relatives; in other activities).
D. There is clear evidence that the symptoms interfere with, or reduce the quality of, social, academic, or occupational functioning.
E. The symptoms do not occur exclusively during the course of schizophrenia or another psychotic disorder and are not better explained by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, personality disorder, substance intoxication or withdrawal).

Specify whether:
- 314.01 (F90.2) Combined presentation: If both Criterion A1 (inattention) and Criterion A2 (hyperactivity-impulsivity) are met for the past 6 months.
- 314.00 (F90.0) Predominantly inattentive presentation: If Criterion A1 (inattention) is met but Criterion A2 (hyperactivity-impulsivity) is not met for the past 6 months.
- 314.01 (F90.1) Predominantly hyperactive/impulsive presentation: If Criterion A2 (hyperactivity-impulsivity) is met and Criterion A1 (inattention) is not met for the past 6 months.

Specify if:
- In partial remission: When full criteria were previously met, fewer than the full criteria have been met for the past 6 months, and the symptoms still result in impairment in social, academic, or occupational functioning.

Specify current severity:
- Mild: Few, if any, symptoms in excess of those required to make the diagnosis are present, and symptoms result in no more than minor impairments in social or occupational functioning.
- Moderate: Symptoms or functional impairment between “mild” and “severe” are present.
- Severe: Many symptoms in excess of those required to make the diagnosis, or several symptoms that are particularly severe, are present, or the symptoms result in marked impairment in social or occupational functioning.
Table 2. Selected Rating Scales Used in the Diagnosis of ADHD in Adults

<table>
<thead>
<tr>
<th>Rating scale</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Retrospective</strong></td>
<td></td>
</tr>
<tr>
<td>Childhood Symptom Scale by Barkley and Murphy</td>
<td>Retrospective assessment of the 18 DSM-IV criteria Also includes items concerning functional disabilities, oppositional-defiant disorder, and conduct disorder</td>
</tr>
<tr>
<td>Wender Utah Rating Scale (<a href="http://www.venturafamilymed.org/Documents/Wender_Utah%20Rating%20Scale.pdf">link</a>)</td>
<td>Retrospective assessment of childhood ADHD symptoms from ages eight to 10 years Regular version contains 61 questions, short version contains 25</td>
</tr>
<tr>
<td><strong>Current symptom</strong></td>
<td></td>
</tr>
<tr>
<td>Adult ADHD Rating Scale-IV</td>
<td>Long version and quick screen Originaly designed for children and adolescents, but has been used successfully in adults</td>
</tr>
<tr>
<td>Adult ADHD Self-Report Scale Symptom Checklist v1.1 (<a href="http://webdoc.nyumc.org/nyumc/files/psych/attachments/psych_adhd_checklist.pdf">link</a>)</td>
<td>18-item questionnaire intended for use in patients who are at risk of ADHD; a quick six-item screening version also available Available in multiple languages</td>
</tr>
<tr>
<td>Brown Attention-Deficit Disorder Rating Scale and Diagnostic Form</td>
<td>Asks about clinical history, early schooling, family history, physical health, substance use, sleep habits; physician also obtains data from an observer/significant other Contains 40 items Scale is primarily concerned with inattention</td>
</tr>
<tr>
<td>Connors Adult ADHD Rating Scales</td>
<td>Long, short, and screening versions; self-reports and observer reports; eight scales Asks patients about childhood and adult histories Allows for diagnosis of ADHD by DSM-IV criteria, as well as by measuring emotional lability Good interrater reliability between self-report and physician ratings</td>
</tr>
<tr>
<td>Current Symptoms Scale by Barkley and Murphy</td>
<td>Self-report scale of 18 symptoms that correspond to DSM-IV criteria</td>
</tr>
<tr>
<td>Wender-Reimherr Adult Attention-Deficit Disorder Scale</td>
<td>Measures the severity of symptoms in adults with ADHD using the Utah criteria Useful to assess mood lability symptoms</td>
</tr>
</tbody>
</table>

ADHD = attention deficit/hyperactivity disorder; DSM-IV = Diagnostic and Statistical Manual of Mental Disorders, 4th ed Information from references 14 through 16.

Adapted from Post RE et al. Diagnosis and Management of Attention Deficit/Hyperactivity Disorder in Adults, Am Fam Physician 2012.
References:


