Irish Journal of Psychological Medicine (2018), **35**, 247–249. doi:10.1017/ipm.2017.82 PERSPECTIVE PIECE

Attention deficit hyperactivity disorder (ADHD): perspective of the general adult psychiatrist

D. Murray[1,*] and P. Devitt[2]

[1] *Glebeview Clinic, Swords Co, Dublin, Ireland*
[2] *Dublin, Ireland*

Attention deficit hyperactivity disorder (ADHD) is a neurodevelopmental disorder with onset in childhood. In Ireland adult ADHD treatment is drifting in an *ad hoc* manner into general adult psychiatric services. We propose this process should be halted in favour of a delivering a carefully planned adult ADHD service.

Received 30 October 2017; Revised 26 November 2017; Accepted 01 December 2017; First published online 9 January 2018

Key words: ADHD, general adult psychiatrist, services.

Introduction

Attention deficit hyperactivity disorder (ADHD) is a neurodevelopmental disorder affecting both children and adults. It is described as a persistent pattern of inattention and/or hyperactivity-impulsivity that gets in the way of daily life or typical development. Individuals with ADHD may also have difficulties with maintaining attention, executive function and working memory. There has been polarised debate in relation to ADHD in the past, with one side arguing that ADHD is a valid diagnosis (Asherson *et al*. 2010) and the other arguing that it is not (Moncrieff and Timimi, 2010).

With increasing demands for an ADHD service for adults, some managers in the Health Service Executive (HSE) are asking general adult psychiatrists (GAPs) to treat ADHD. Some clinical directors have agreed to accept patients for a limited or 'prescriptions only' service. Many GAPs, however, have been reluctant to take on assessment and treatment of ADHD.

Why GAP have been reluctant to take on ADHD

First, ADHD *per se* is not a condition which was previously treated by GAP services. It is seen as a new stream of referrals with uncertainty about how much work it could ultimately generate. A survival instinct perhaps may have lead to many GAPs to avoid facilitating such a stream which could quickly become a flood. Second, it is likely that a significant number of GAPs have doubts about the validity of the ADHD diagnosis. This is largely based on their clinical experience of never coming across a prototypical case in spite of extensive dealings with adult patients over many years.

* Address for correspondence: D. Murray, Glebeview Clinic, Swords Co, Dublin, Ireland.
(Email: declanmurray@hotmail.com)

Third, many of the patients referred from Child and Adolescent Mental Health Services (CAMHS) are stable on long-term medication. GAPs refer long-term stable patients back to primary care, and the same should apply to ADHD patients. Moreover, in these referrals GAPs were being asked to monitor drugs they had not prescribed themselves for a condition which they had never seen in its active phase. Fourth, the threshold for a patient to be seen in adult psychiatric services is generally deemed to be much higher than for CAMHS and most cases of ADHD would not qualify as a severe mental illness needing secondary services. For these reasons it is understandable that ADHD referral letters were often returned to CAMHS with the suggestion to direct these patients to their General Practitioner or other expert for medication management. GAP services would only see patients with ADHD if they had a co-morbid psychiatric illness of a nature and severity which falls within the remit of GAPs.

Remit of GAP

Although there is no single definition for the role of GAPs, it is mainly in the area of the severe and enduring mental disorders such as schizophrenia, bipolar disorder, melancholic depression, disabling anxiety/obsessive compulsive disorder and severe personality disorders. This very challenging range of conditions needs a highly motivated, multi-disciplinary team with involvement of families, carers and a variety of other community resources. The diagnosis, treatment, rehabilitation, recovery and maintenance of remission of these disorders more than occupies, indeed stretches to the very limit, current teams' time and resources. Allowing an open-ended accretion of new disorders outside the current area of expertise will inevitably erode the quality of service for the severe and enduring mental disorders which would be a major disservice to

our patients. A key skill for consultant psychiatrists is an ability to prioritise clinical need and to resist without compromise an excessive workload. Doctors are very keen to help as many as possible as soon as possible. But yielding to this instinct without adequate planning and resources in the short term will be harmful in the long run. If you try to please everyone you may end up pleasing no-one. GAPs should be wary of the 'foot in the door' strategy of a prescription only service. Such a service is bound to grow. The increased workload could lead to staff being constantly rushed and stressed, with issues such as burnout, high staff turnover and a negative service user experience coming to the fore. For GAPs, a balanced compassionate robust prioritising of clinical need leaves ADHD outside their scope of practice. For any new service there needs to be careful description of the nature and extent of the problem, of what interventions are required, as well as the provision of the appropriate resources including training of all relevant staff. HSE policy on service changes includes active engagement and participation of service users, staff and their representatives in the change process (HSE, 2008). This policy should be followed.

Those planning the adult ADHD service should take note of the UK National Institute for Health and Clinical Excellence (2008) guidelines which recommend multi-disciplinary specialist ADHD teams and/or clinics for children and young people and separate teams and/or clinics for adults. These teams and clinics should have expertise in the diagnosis and management of ADHD. This recommendation for a specialized service may be relevant in our jurisdiction as well.

Specialised service

There are good reasons ADHD requires a different style of service. ADHD is one of the neurodevelopmental disorders which usually manifest in childhood with impairments in personal, social, academic or occupational functioning. The neurodevelopmental disorders frequently co-occur; for example, many children with ADHD also have a specific learning disorder. By contrast, disorders typically seen by GAPs are mostly of adult onset, can have acute presentations and may require urgent intensive interventions and even hospital admission. Such intensive interventions are usually followed by maintenance management, monitoring for relapse/recurrence and focus on rehabilitation and recovery.

Trying to manage ADHD patients without a dedicated service increases the potential for drug misuse problems. The symptoms of ADHD can be feigned to obtain and abuse medication. ADHD can also co-occur with antisocial behaviour as well as substance abuse. Therefore, ADHD patients need an expert ADHD service with detailed controls and prescribing. Lack of such expertise, as well as leading to poor treatment outcomes, could give rise to an epidemic of stimulant over-use and abuse such as has occurred with benzodiazepines and analgesics.

Conclusion

ADHD still has a degree of controversy surrounding it. Leaving this aside and accepting that an ADHD service for adults is necessary, it is worth pondering the late Dr Dermot Walsh's words on the state of services for the elderly and the intellectually disabled in Ireland in 1991, quoted recently in his obituary (Kelly, 2017):

> For neither is there a comprehensive nationwide, rationally-controlled and operated coherent system of care-delivery despite recent policy documents in both cases. What does exist is a ramshackle *ad hoc* jumble of poorly-oriented inputs without an overall policy objective or planned programme approach. Unfortunately, all this rebounds on the psychiatric service so that, as a general catchall for fringe medical and social problems, psychiatry has taken up the slack.

There are clear signs that we are heading down the ramshackle *ad hoc* route with ADHD and that 26 years later GAP is still being used as a catchall. Even regarding ADHD as a legitimate disorder, it remains of insufficient severity to be managed in GAP. What is required is 'a comprehensive nationwide, rationally controlled and operated coherent system of care delivery' (in current policy parlance, a Clinical Programme), but operated in a Primary Care setting. Serious comorbid conditions could be referred in the usual manner to GAP. If GAPs accept ADHD patients in a 'prescriptions only' arrangement, the pressure to develop a decent service will be dissipated, and an opportunity to do the right thing will be lost.

Financial support
This article received no specific grant from any funding agency, commercial or not-for-profit sectors.

Conflicts of Interest

D.M. has received payment form Lundbeck for lectures. P.D. has no conflicts of interest to disclose.

Ethical Standards

The author asserts that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committee on human experimentation with the Helsinki Declaration of 1975, as revised in 2008.

https://doi.org/10.1017/ipm.2017.82 Published online by Cambridge University Press

References

Asherson P, Adamou M, Bolea B, Muller U, Morua SD, Pitts M, Thome J, Young S (2010). Is ADHD a valid diagnosis in adults? Yes. *British Medical Journal* **340**, 549.

Health Service Executive (2008). Improving our services: a users' guide to managing change in the Health Service Executive. http://www.hse.ie/eng/staff/Resources/hrstrategiesreports/Improving_our_Services,_A_Guide_to_Managing_Change_in_the_the_HSE_-_Oct_2008.pdf. Accessed 28 December 2017.

Kelly BD (2017). Dr Dermot Walsh 1931-2017. *Irish Journal of Psychological Medicine* **34**, 217–220.

Moncrieff J, Timimi S (2010). Is ADHD a valid diagnosis in adults? No. *British Medical Journal* **340**, 547.

National Institute for Health and Clinical Excellence (2008). Attention deficit hyperactivity disorder: diagnosis and management. https://www.nice.org.uk/guidance/CG72/chapter/Recommendations. Accessed 21 October 2017.

https://doi.org/10.1017/ipm.2017.82 Published online by Cambridge University Press