



# **Canadian ADHD Practice Guidelines (CAP-Guidelines)**

Third Edition

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**Please Note:**

The CADDRA Canadian ADHD Practice Guidelines (CAP-G) is an active document that will be revised online as new information becomes available. The CADDRA website ([www.caddra.ca](http://www.caddra.ca)) will always have the latest version of the Guidelines available free to download and print. This third edition is in binder format to facilitate the replacement of pages with updated versions. Updated documents will be sent out to CADDRA members at periodic intervals. Extra support documents are also accessible to members online.

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## PREFACE AND ACKNOWLEDGEMENT

**Who is CADDRA?** The Canadian Attention Deficit Hyperactivity Disorder Resource Alliance (CADDRA) is a national, independent, not-for-profit association whose members are drawn from family practice, paediatrics, psychiatry (child, adolescent and adult), psychology and other health professions. We hope to support individuals with Attention Deficit Hyperactivity Disorder (ADHD) and their families and provide ongoing support to those who are delivering care for ADHD in their communities across Canada.

**The evolution of the 3rd Edition.** This third edition of the CADDRA Canadian ADHD Practice Guidelines (CAP-G or Guidelines) evolved from earlier editions of the CAP-G published in 2006<sup>1</sup> and 2008<sup>2</sup>. The Guidelines were developed to help Canadian physicians diagnose and treat ADHD across the lifespan. Many ADHD specialists and general physicians contributed to its writing. The Editorial Committee is made up of the CADDRA Executive Board. All contributing authors are experts selected on the basis of their contributions to treatment, education and research in the area of ADHD and represent several different disciplines from across Canada.

**These Guidelines are unique (even from other Guidelines or Toolkits in the world) in that they:**

- a) have been produced by a multidisciplinary team
- b) have been translated into French and English (including additional online material)
- c) are specific to Canadian practice
- d) include the entire lifespan of this disorder
- e) speak to diagnosis and treatment in real-life conditions of practice where resources are limited
- f) use paper and fonts that make for high resolution photocopies and are formatted so that they can be easily downloaded from the CADDRA website
- g) recognize that ADHD is a disorder which will require treatment using a shared care model between specialists and primary care practitioners
- h) stipulate both what can be handled in primary care and recommend when referral to specialists may be required
- i) express our belief that the best care comes from optimizing care for each individual. We do not prioritize medications on a hierarchy or algorithm that can be considered appropriate for all patients
- j) inform physicians but also empower patients to make informed choices in a collaborative process of care.


### Features of the 3rd Edition

- a) The current CAP-G is an **active document** that will be revised online as new information is obtained, and reprinted as required.
- b) The **binder format** will allow the clinician to add and remove sections as revisions are made and for purposes of photocopying. The binder can also be used to file additional CADDRA information and newsletters.
- c) The final drafts were sent for **independent review** by clinicians across the country and in the US.
- d) The **authors were not paid** in any way for their contribution to the CAP-G. Declarations of conflicts of interests for each author are found on page ii.
- e) The Guidelines receives **no financial grants from industry**. The cost of production is recouped entirely from sales.

- f) The rating scales and tools developed by CADDRA are free and were created with the express purpose of being **user-friendly** in order to allow assessment of ADHD in primary care to become both a rigorous and efficient process. Written permission for use of the additional scales has been obtained.
- g) There is a new section on **psychosocial treatments**.
- h) The **medication sections** have been updated and regrouped.
- i) The Guidelines are part of a **comprehensive educational program** to help clinicians reach the highest standards of clinical care.
- j) These Guidelines are available free of charge on the CADDRA website, **www.caddra.ca**.

The Guidelines should be used by clinicians for interactive instruction on the diagnosis and treatment of ADHD across the lifespan. The website allows clinicians and their patients to download information, diagnostic instruments, forms and scales – all of which have been selected based on their validity, reliability and accessibility. References and an index of terms are included at the end of the document.

***Evidenced-based versus Consensus-based.*** The CAP-Guidelines Committee has reviewed the other ADHD guidelines and consensus statements in current use. There are many, including the American Academy of Child and Adolescent Psychiatry Guidelines<sup>3</sup>, the American Academy of Pediatrics Guidelines<sup>4</sup>, the Texas Children’s Medication Algorithm Project<sup>5</sup>, the American Psychiatric Association Diagnostic and Statistical Manual – Fourth Edition- Text Revision<sup>6</sup>, the European Treatment Guidelines<sup>7</sup>, the National Institute of Health and Clinical Excellence (NICE) Guidelines<sup>8</sup> and the British Association for Psychopharmacology Guidelines<sup>9</sup>. While there is a high degree of consensus among these publications, there are also very significant international differences. The most obvious difference is seen in the recent NICE Guidelines<sup>8</sup>, which recommend medication treatment only in more severe cases, whereas the American practice is almost the opposite: start with medication and then see what else is necessary. In addition, the use of different diagnostic instruments, such as ICD-10 or DSM-IV, has also led to differences in what population is being referenced in a particular Guideline. The Canadian practice is holistic-based care, individualized to the patient, with medications as part of the treatment agenda.

The editors have been careful to identify which facts are consensus-based . This information is noted in the text. Evidence-based (EB) data is cited in the literature detailed in the reference section. CB data was produced, as it suggests, by a consensus of the experts within the CADDRA Board after careful and rigorous consideration of the current facts. CB decisions have been made if there was no current EB data available to deal with a specific clinical issue or where the EB data may have been impractical in the Canadian environment.

It is clear that service delivery for ADHD is only feasible if it is within the scope of primary care practice. There is no country in the world with a sufficient number of specialists to provide diagnosis and treatment for what is one of the most common disorders of childhood and affects 4.4% of adults<sup>10</sup>. There are few if any guidelines available to assist physicians treating adults with a childhood history of ADHD. By providing these Guidelines, in English and in French, it is our hope that this impaired and treatable population will be appropriately serviced in the public healthcare system.

## **CADDRA GUIDING PRINCIPLES**

### **Vision**

To improve the quality of life for patients and their families living with Attention Deficit Hyperactivity Disorder (ADHD) while maximizing their potential across the lifespan.

### **Mandate**

CADDRA is a national Canadian alliance of professionals working in the area of ADHD and dedicated to world class education, training and advocacy.

### **Mission (Objectives)**

- To take a leadership role in disseminating information on ADHD in Canada
- To develop and update the Canadian ADHD Practice Guidelines (CAP-Guidelines)
- To facilitate development and implementation of training standards in the care of ADHD patients
- To share information among all stakeholder groups. To advocate to governments, teaching environments, employment organizations or others who interface with ADHD patients.

## **CADDRA GUIDELINES – CORE PRINCIPLES**

### **Principles for Assessment and Diagnosis**

1. The clinician must be accredited by his or her regional and national associations
2. The clinician has to be adequately trained in order to understand the developmental context of ADHD
3. The diagnosis needs to reflect an understanding of multi-systemic issues that relate to ADHD (e.g. the educational/vocational, psychosocial, psychiatric and the medical interfaces)
4. Every patient deserves to be seen in a place of safety that promotes the therapeutic alliance with the clinician
5. There should be no cost for distributing or scoring any of the materials from the CAP-G so that there is universal access to the best assessment materials
6. Symptoms and functional impairment must be recorded using valid, reliable and sensitive rating scales to evaluate symptom frequency, severity, and outcome
7. The clinician must document all relevant findings in a timely manner both for purposes of outcome but also for review
8. The results of the assessment should be communicated to the patient and their family with clarity and compassion.

### **Principles for Intervention**

#### **The five tiers of holistic-based care**

ADHD is a chronic medical condition and requires long-term planning. It must include regular contact with the patient and the family about progress and performance. The family doctor, along with the pediatrician and child psychiatrist (in the case of children and adolescents) or the psychiatrist (when dealing with adults), are key professionals. Treatment should be multi-modal; there is no one treatment for ADHD (including medication) that has been demonstrated to assure a good long-term outcome in isolation<sup>209</sup>.



### **1. Adequate education of patients and their families**

Psychoeducation must be the first intervention. The more educated the family and the patient are, the better are their choices and the response to treatment. An integrated approach to ADHD education includes information on interventions related to:

- a) support for families and their advocacy of ADHD
- b) psychosocial and medical treatments
- c) patient, parent and school management, and
- d) occupational/educational accommodations.

### **2. Behavioural and/or occupational interventions**

The core strategy is to develop better habits that, ultimately, may lead to coping strategies that minimize the patient's impairments. ADHD patients may take longer to integrate such habits into their lives. The therapeutic alliance between patient and clinician is necessary and an optimistic attitude can facilitate this process.

### **3. Psychological treatment**

ADHD patients are at significant risk of being targets of intentional and unintentional conflict. There is a direct effect on their self-esteem and on the well-being of their families. They require a positive environment, sensitivity and understanding. Interventions may include individual and/or family support, counselling and therapy to help minimize damage to self esteem from such experiences. Cognitive behavioural psychotherapy has been demonstrated to be a useful adjunctive treatment for adolescents and adults, though evidence in children is still controversial.

### **4. Educational accommodations**

ADHD should be classified as a developmental neuropsychiatric disorder and the patient should have access to educational accommodations where necessary. ADHD should be protected by the same type of legislation available in the United States, where every child is entitled to the education that meets his or her needs. By contrast, ADHD alone does not qualify a student for an "exceptional" educational designation in some Canadian provinces. This must change.

### **5. Medical management (as a way to facilitate the other interventions)**

ADHD is a medical condition that requires an understanding of the medical options. Every patient should have access to the best medications available, regardless of their financial situation. Each patient must be treated uniquely. There is no one medication that is suitable for every ADHD patient. The guiding principle of medication management is to start low and go slow for most patients, though weight-based guidelines may be used as a way of estimating dose during the initial prescription.

## **Principles of Informed Consent**

Ensure that the patient and family have had an adequate opportunity to educate themselves and then ask relevant questions regarding the disorder and its treatment. The following 'Principles of Informed Consent' should be reviewed.

### **Patients and their families need to be educated as follows:**

1. They need to understand the proposed treatment plan
2. There must be a discussion of the risks and benefits of the prescribed treatment
3. Information on alternatives to treatment must be provided
4. There needs to be discussion regarding potential risks of no treatment.

A collaborative and long-term relationship between physician and patient is critical. Many doctors and patients associate the basis of their relationship with the prescription. When the medication is discontinued, so is the doctor. Instead, the hope would be that the basis of the relationship is long-term treatment of the disorder that respects the concerns of the child, adult or family in order to maintain the therapeutic alliance.

## **Principles of Advocacy**

Patients and their families must be empowered. Facilitate this process by participating in advocacy campaigns that advance patient care. These will be posted on the **www.caddra.ca** and **www.caddac.ca** websites.

## **ABBREVIATIONS**

<b>ADHD</b>	Attention Deficit Hyperactivity Disorder	<b>GAD</b>	Generalized Anxiety Disorder
<b>ADHD-C</b>	ADHD, Predominantly Combined Subtype	<b>HAM-A</b>	The Hamilton Anxiety Rating Scale
<b>ADHD-HI</b>	ADHD, Predominantly Hyperactive-Impulsive Subtype	<b>HAM-D</b>	The Hamilton Rating Scale for Depression
<b>ADHD-I</b>	ADHD, Predominantly Inattentive Subtype	<b>IH</b>	Idiopathic Hypersomnia
<b>AMP</b>	Amphetamines	<b>IPT</b>	Interpersonal Psychotherapy
<b>ASD</b>	Autism Spectrum Disorder	<b>JDQ</b>	Jerome Driving Questionnaire
<b>ASPD</b>	Antisocial Personality Disorder	<b>LD</b>	Learning Disability
<b>ASRS</b>	Adult Self Report Scale	<b>MD</b>	Major Depression
<b>ATX</b>	Atomoxetine Hydrochloride	<b>MPH</b>	Methylphenidate
<b>BAD</b>	Bipolar Affective Disorder	<b>NICE</b>	National Institute for Health and Clinical Excellence
<b>BD</b>	Bipolar Disorder	<b>OCD</b>	Obsessive Compulsive Disorder
<b>BPD</b>	Borderline Personality Disorder	<b>ODD</b>	Oppositional Defiant Disorder
<b>CAAT</b>	CADDRA ADHD Assessment Toolkit	<b>PD</b>	Personality Disorder
<b>CADDRA</b>	Canadian Attention Deficit Hyperactivity Disorder Resource Alliance	<b>PDD</b>	Pervasive Developmental Disorder
<b>CADDAC</b>	Centre for ADHD/ADD Advocacy, Canada	<b>PLMS</b>	Periodic Limb Movements in Sleep
<b>CAP-G</b>	Canadian ADHD Practice Guidelines	<b>RLS</b>	Restless Legs Syndrome
<b>CB</b>	Consensus Based	<b>S-ADHD</b>	Secondary Attention Deficit Hyperactivity Disorder
<b>CBT</b>	Cognitive Behaviour Therapy	<b>SDB</b>	Sleep Disordered Breathing
<b>CD</b>	Conduct Disorder	<b>SUD</b>	Substance Use Disorder
<b>CV</b>	Cardiovascular	<b>TS</b>	Tourette's Syndrome
<b>DCD</b>	Developmental Coordination Disorder	<b>WISC</b>	Wechsler Intelligence Scale for Children
<b>DEX</b>	Dextro-amphetamine	<b>WFIRS-P</b>	Weiss Functional Impairment Scale – Parent Report
<b>DSM-IV-TR</b>	Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, text revision	<b>WFIRS-S</b>	Weiss Functional Impairment Scale – Self Report
<b>EDS</b>	Excessive Daytime Sleeping	<b>WSR</b>	Weiss Symptom Record
<b>EB</b>	Evidence Based	<b>Y-BOCS</b>	Yale-Brown Obsessive Compulsive Scale