Feedback Form: Draft Australian Evidence-Based Clinical Practice Guideline For ADHD

We would like to hear any feedback you have on the recommendations presented in the draft guideline as well as any comments you may have on the evidence presented in the associated technical report. **Please read the checklist for submitting comments on the last page of this document as we are unable to accept forms that are partially or incorrectly completed.**

Feedback on the draft Australian evidence-based clinical practice guideline for ADHD must be received by **11:59pm on Tuesday 5th April 2022** to be considered. To submit this feedback document please go to https://aadpa.com.au/guideline-feedback/ and follow the upload instructions.

Please provide the following information

Your full name	Zena Burgess
Your email address	z.burgess@psychology.org.au
State in which you are based	Victoria
City in which you are based	Melbourne
Do you represent an organisation	☒ Yes ☐ No
Name of organisation which you represent. *Leave blank if you do not represent an organisation*	Australian Psychological Society
Your profession	CEO
Conflicts of interest or perceived conflicts of interest. *Please disclose any real or perceived past, current, direct or indirect, conflicts of interest. For example, whether you or a family member benefits financially from providing an intervention that is part of this guideline; or if you or a family member has received financial support from companies involved in providing ADHD treatments. Conflict of interests can extend beyond financial reimbursement. If you or a family member may benefit in any way by your feedback, please declare it.*	
All submissions will be published. Please indicate if you wish for your submission to be identified or deidentified.	☒ Identified ☐ Deidentified

1. General Feedback

Please use the area below to provide any feedback that does not relate directly to the draft recommendations. This may include feedback about feasibility or implementation.
(Maximum 250 words)

The Australian Psychological Society (APS) appreciates the opportunity to provide feedback on the Draft Australian Evidence-Based Clinical Practice Guideline For ADHD (draft guideline) and commends the work of the Development Group in creating this important document. The APS is represented on the Development Group and recognises the care and consideration provided by the highly experienced and qualified members of this group in the development process. Our feedback includes comments and suggestions from APS members to ensure the broadest possible approach to our review of the draft guideline. We acknowledge that the Development Group may have already considered many of these issues and have been somewhat constrained by methodology requirements.

Notwithstanding this, the APS believes the draft guideline:

- Appears to minimise the role of psychology in the assessment, diagnosis and treatment of ADHD.
- Fails to sufficiently define the broad range of psychological interventions available for people with ADHD.
- Focusses on specific outcome measures (e.g., reduction of ADHD symptoms) which fail to account for improved wellbeing across various contexts (e.g., psychological, social, educational and vocational).
- Simplifies assessment as a means to diagnose without recognising its importance for treatment planning, which is particularly relevant for the provision of psychological interventions.

The APS is concerned the draft guideline may have negative implications for psychologists working with people with ADHD (including impacting our professional practice and issues related to indemnity), and lead to poorer psychosocial outcomes for consumers due to decreased psychological support resulting from insufficient information about appropriate treatment options.

2. Feedback On Recommendations

Use the table below to provide specific feedback on draft recommendations. All feedback must consider the rigorous and transparent guideline development processes, which includes integration of evidence, multidisciplinary expertise and consumer perspectives. Feedback involving any alterations of recommendations should refer to guideline methods, relevant sections in the draft guideline and the technical report.

Document (Guideline Or Technical Document)	**Section Of Document**	**Page Number**	**Recommendation Number**	**Comment** **(Maximum 150 Words)**
Guideline document	Chapter 2 Diagnosis and assessment	77 - 87	2.1 – 2.3 (inclusive)	The draft guideline omits to describe the clear benefits of a comprehensive neurodevelopmental assessment, despite pointing to high risk group categories and the need to exclude neurodevelopmental or mental health conditions, along with the requirement to assess a person's functional impairment and quality of life. Neurodevelopmental assessment, while not required for diagnosis of ADHD, is warranted in order to: 1. Identify and account for common comorbidities. 2. Identify a subgroup that is especially at risk of poor outcomes. 3. Provide recommendations and strategies to optimise functioning via appropriate treatment. 4. Provide a differential diagnosis. 5. Ensure appropriate assessment of impairment and functioning. A clinical practice point would help to ensure the above is clearly elucidated within the draft guideline.
Guideline document	Chapter 2 Diagnosis and assessment	78	2.1 – 2.3 (inclusive)	The draft guideline references CADDRA as a basis for its limited support for neuropsychological testing. However, the CADDRA guidelines seem to have a more nuanced perspective on neuropsychological testing than is represented in the draft guideline, i.e., neurodevelopmental evaluations are noted as being "most useful in situations of diagnostic uncertainty" (p5). The APS questions the view that neurodevelopmental tests do not measure real-world cognitive or academic impairments that characterise ADHD; particularly, as the CADDRA guidelines cite studies with supporting evidence for the validity of such tests in assessing ADHD impairments. The CADDRA guidelines also state that "Detailed history-taking (longitudinal cognitive difficulties since childhood) and neuropsychological testing may help the clinician to make a diagnosis of ADHD. In summary, diagnosis in older adults requires identification of past and current symptoms/impairments, and differential diagnosis should include other neuropsychiatric conditions." (p36) This information appears not to have been considered within the draft guideline.

Guideline document	Chapter 2 Diagnosis and assessment	78	2.1 – 2.3 (inclusive) and 4.3	Inclusion of a clinical practice point in the draft guidelines would clarify that the results of neuropsychological assessments are intended to be interpreted in parallel with other forms of assessment, i.e., clinical interview, rating scales, direct observation, and information such as school reports. Indeed, research has found neuropsychological testing increased specificity by 10% (see below). Neuropsychological assessment is also valuable to clinicians in identifying established coping mechanisms. There is evidence that this is beneficial to subsequent outcomes for young people with ADHD; having implications for treatment. • Pettersson, R., Söderström, S., & Nilsson, K. W. (2018). Diagnosing ADHD in adults: an examination of the discriminative validity of neuropsychological tests and diagnostic assessment instruments. *Journal of attention disorders*, *22*(11), 1019-1031. • Pritchard, A. E., Koriakin, T., Jacobson, L. A., & Mahone, E. M. (2014). Incremental validity of neuropsychological assessment in the identification and treatment of youth with ADHD. *The Clinical Neuropsychologist*, *28*(1), 26-48.
Guideline document	Chapter 3 Treatment and support	87	3.1	The APS commends the draft guideline for recommending a multimodal treatment and support approach to assist people with ADHD.
Guideline document	Chapter 4 Non-pharmacological interventions	100-106	4.3 & 4.4	The draft guideline has a limited consideration of psychological interventions relevant to the treatment of ADHD, i.e., "Cognitive behaviour therapy" (CBT) is used to describe a range of treatment options that psychologists would not ordinarily consider as appropriately defined under this one heading. Indeed, the MBS refers to Psychological Strategies (evidence based psychological interventions that integrate research evidence regarding clinical efficacy with clinical expertise) and delineates different treatment options, i.e.: Psycho-education, Cognitive behavioural therapy, Relaxation strategies, Skills training, Interpersonal therapy among others. Terminology used to describe treatment modalities within the draft guideline should be consistent with established understandings and include CBT as *one* option for intervention, rather than as a broad brush descriptor of psychological interventions for people with ADHD. Recommendations 4.3/4.4 need to be changed, or include a clinical practice point, to reflect these different treatment methods and to properly describe the diverse options available to people with ADHD.

Guideline document	Chapter 4 Non-pharmacological interventions	100-108	4.2.1-4.2.3 4.3.1-4.3.4, 4.3.9 & 4.4.4	The APS ADHD practice guide (for psychologists providing services to people with ADHD) includes evidence for interventions such as behavioural therapy (behavioural parent training and behavioural classroom management), social skills training, neurofeedback, and Cogmed. Importantly: 1. Parent and family training, are understood as a form of behavioural therapy typically delivered by psychologists. 2. Social skills training needs to be understood in broader terms, i.e. focussing less on *what* to do in social situations and more on *how* . The APS ADHD practice guide states; "children with ADHD know what they should be doing (thus have the skills), but struggle to implement them." 3. Neuropsychological interventions are not the same as neurofeedback or cognitive training. A clinical practice point with respect to the above considerations would provide clarity regarding these forms of intervention, and could emphasise the most efficacious use of these therapies for people with ADHD.
Guideline document	Chapter 4 Non-pharmacological interventions	106, 109 - 110	4.3.1 & 4.4.5	Despite the fact that "high quality evidence is lacking and among studies" (p. 109) the draft guidelines state that ADHD coaches "could be considered as part of a treatment plan". While it is acknowledged that "ADHD coaching shares common elements with CBT and other psychosocial treatments." (p. 110), it seems to be emphasised as a treatment option, despite the following statement; "evidence supporting coaching as an intervention for ADHD is currently relatively weak". (p. 110). The APS suggests that psychological interventions, accessible and affordable via Medicare, should be recommended as a first-line non-pharmacological treatment option – for the benefit of consumers - at least until further evidence is forthcoming about the efficacy of coaching as an intervention for people with ADHD.
Guideline document	Chapter 4 Non-pharmacological interventions	106	4	The following comment is made on page 106 of the draft guideline: "…in recommending CBT as a routine treatment, health inequity may result." This implies causality. The APS disagrees with this statement. In fact, the APS recommends the use of CBT (and other treatments described under this banner in the draft guideline) for people with ADHD. Psychologists provide a cost-effective option, particularly as psychological treatment for people with ADHD is supported by Medicare, and is time limited as per best practice for CBT. In addition, psychologists can provide concession rates or bulk bill when indicated by a person's financial circumstances.

Guideline document	Chapter 4 Non-pharmacological interventions	100-108	4	The draft guideline minimises the role of psychologists in assisting people with ADHD. A focus on symptom reduction as an outcome measure seems to have influenced this decision, without due regard to the psychosocial benefits, and improved experience, resulting from psychological interventions. A biopsychosocial approach to ADHD (that is neuro-divergent affirmative), aimed at improving case conceptualisation and providing holistic treatment (that adequately accounts for people from psychosocially vulnerable groups) is required. The addition of a clinical practice point to clarify that the intent of psychological treatment for people with ADHD is to improve social, cognitive, relational, educational and vocational issues (and address co-morbidities) rather than to necessarily reduce core symptoms, would rectify this.

3. Feedback On Additional Evidence

If you believe additional evidence should be considered that was not included in the guideline development process please provide comments below including a reference to the evidence and justification. Any new evidence needs to consider that evidence was included only if it met rigorous pre-specified selection criteria as outlined in the technical document. Whilst additional evidence cannot be included in the systematic reviews, additional evidence can be included in the narrative review sections where it: 1) will influence a recommendation or practice point, and 2) meets the rigorous pre-specified selection criteria described in the associated technical report.

Section Of Document	**Recommendation Number**	**Evidence Details (example)**	**Comment** ***(Maximum 150 Words)***
Chapter 2 - Diagnosis and assessment & Chapter 5 Pharmacological interventions	Recommendations: 2.1 – 2.3 (inclusive)	Kazda, L., Bell, K., Thomas, R., McGeechan, K., Sims, R., & Barratt, A. (2021). Overdiagnosis of attention-deficit/hyperactivity disorder in children and adolescents: a systematic scoping review. *JAMA network open*, *4*(4), e215335-e215335.	This review found evidence of ADHD over diagnosis and overtreatment in pharmacological treatment for children and adolescents. Evidence gaps remain and future research is needed, in particular research on the long-term benefits and harms of diagnosing and treating ADHD with pharmacological treatment in youths with milder symptoms. Practitioners should be mindful of these knowledge gaps to ensure safe and equitable practice and policy.

Checklist For Submitting Comments

- Use this comment form and submit it as a **Word document (do not save as a PDF)**.
- Combine all comments from your organisation into 1 response. **We cannot accept more than 1 response from each organisation**.
- Do not paste other tables into this table – type directly into the table.
- Ensure each comment stands alone; do not cross-refer within one comment to another comment.
- **Clearly mark any confidential information or other material that you do not wish to be made public.**
- **Do not name or identify any person or include medical information about yourself or another person** from which you or the person could be identified as all such data will be deleted or redacted.
- Spell out any abbreviations you use
- For copyright reasons, **do not include attachments** such as research articles, letters or leaflets. We return comments forms that have attachments without reading them. The stakeholder may resubmit the form without attachments, but it must be received by the deadline.
- **We do not accept comments submitted after the deadline stated for close of consultation.**

Types of Feedback Accepted

Three (3) types of feedback will be considered: **general feedback, feedback on recommendations and feedback on additional evidence**. Please provide feedback in the relevant feedback tables in the document below. Any comments greater than the maximum word count per cell will not be considered.

Note: We reserve the right to summarise and edit comments received during consultations, or not to publish them at all, if we consider the comments are too long, or publication would be unlawful or otherwise inappropriate.

Comments received during our consultations are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the comments we received, and are not endorsed by AADPA, its officers or advisory Committees.

Data Protection

The information you submit on this form will be retained and used by AADPA and its advisers for the purpose of developing its guidance and may be passed to other approved third parties. Please do not name or identify any individual patient or refer to their medical condition in your comments as all such data will be deleted or redacted. The information may appear on the AADPA website in due course in which case all personal data will be removed in accordance with AADPA policies. Click here to read AADPA's privacy policy. ***By submitting your data via this form you are confirming that you have read and understood this statement.***