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Letter

Rationing ADHD services? A potentially risky strategy

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Attention-deficit hyperactivity disorder (ADHD) is a highly impairing condition associated with multiple adverse effects that include suicide and premature mortality.[1,2] The global prevalence of ADHD is 5%[3] for children and 3%[4] for adults. In recent years, the rate of referrals for ADHD assessment has risen exponentially in the UK and across Europe, such that services can no longer meet demand. Around 700 000 people are waiting for ADHD assessments in England alone. Although there is ample evidence that ADHD is underdiagnosed and undertreated in the UK,[5] we are aware that there is enormous pressure to reduce waiting times and manage demand for ADHD assessment. One suggestion that has been raised by some is that perhaps 'milder' forms of ADHD do not need assessment and treatment.[6] ADHD lies on a continuum, and the threshold for diagnosis may have changed over time. However, it is unclear how 'milder' forms of ADHD could be meaningfully defined; one approach might be to look at total symptom score. Although treatment trials include all who meet standardised DSM or ICD-11 diagnostic criteria,[7] an assumption here is that adverse outcomes for 'mild' ADHD will be such that risk management or treatment would not be indicated.

To begin examining this issue, we reanalysed the association between childhood ADHD symptoms and mortality by age 58 years using data from the 1958 birth cohort, an age group that would have been unlikely to have received ADHD treatment or diagnosis. Our original published findings[8] focused on the association of childhood ADHD with premature mortality in this cohort, in which our definition of ADHD applied to 3% of the population.[8,9] We now present a secondary analysis to further examine whether associated risk extends beyond the extreme end of the distribution of ADHD severity. We derived a simple symptom score at age 7 that summed parent-reported Rutter A Scale and teacher ratings. Parent ratings were based on frequency of symptoms and teacher ratings on certainty of symptom presence. Scores were 0 if the symptom was considered to be absent by both raters; 1 if the symptom was sometimes present (according to the parent) and/or may be present (according to the teacher), and 2 if the symptom was rated as being frequently present (parent) and/or certainly present (teacher). ADHD scores obtained using this method ranged from 1 (only one ADHD symptom endorsed as possibly present by one rater) to 8 (both symptoms rated as certainly or frequently present). We examined the relationship between each individual score and premature mortality. All individual scores, apart from an ADHD score of 1, were associated with premature mortality. Odds ratios ranged from 1.4 (95% CI 1.1–1.6) for those scoring 2 ($n = 2523$; 18.0% of total sample) to 2.6 (95% CI 1.3–5.3) for those scoring 8 ($n = 66$; 0.5% of total sample).

This reanalysis suggests that in terms of premature mortality risk, it is not justifiable to suggest that those with 'milder' ADHD are not at elevated risk of adverse outcomes and thus do not require assessment or risk management. This is unsurprising, given that ADHD, like blood pressure and lipid levels, lies on a continuum of risk.

In summary, we conclude that much more investigation is needed to examine risks and benefits of changes to diagnosis, risk management and treatment approaches including outcomes such as premature mortality, suicide and functioning across multiple domains. This is necessary before ICD-11 and DSM-5 ADHD are redefined or ADHD support and services are deprioritised for 'mild' ADHD for reasons of political expediency and funding constraints.

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Author contributions

A.T. and A.K.T. conceptualised the question and cowrote the initial draft; all authors contributed further to refinement of the question, the analysis plan and editing of the paper.

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Declaration of interest

A.T. was Chair of the independent ADHD Taskforce commissioned by NHS England. She also has served on the Welsh Government Adult ADHD Task and Finish Group and previously was co-chair of the Welsh Government Neurodivergence Ministerial Advisory Group and the Welsh Government clinical advisory group for ADHD assessment and support. All roles were unfunded.

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