

LITERATURE REVIEWS

Australian Evidence-Based Clinical Practice Guideline for Attention Deficit Hyperactivity Disorder: The Role of Psychologists

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The Australian evidence-based clinical practice guideline for attention deficit hyperactivity disorder (ADHD) was approved by the National Health and Medical Research Council in July 2022. The guideline provides multidisciplinary recommendations for the screening, diagnosis, treatment and support of children, adolescents and adults with ADHD and can be found online (<https://adhdguideline.aadpa.com.au/>). This article discussed the psychologist's role in supporting people with ADHD. The guideline can be used to improve training of psychologists and ensure evidence-based and standardised support for people with ADHD in clinical practice. The guideline also identified future research needs, including for Australian Aboriginal and Torres Strait Islander peoples. There are a lack of validated tools for ADHD screening and diagnosis and a lack of evidence based support for this group, with various barriers resulting in reduced access to healthcare. We discussed how these issues may similarly impact Māori in New Zealand.

Introduction

Attention deficit hyperactivity disorder (ADHD) is the most common neurodevelopmental/mental health condition in childhood, and affects 6%–10% of Australian children and adolescents and 2%–6% of adults (Graetz et al., 2001; Sawyer et al., 2018). Without evidence-based treatment, ADHD can have significant lifelong impacts on interpersonal relationships and academic and occupational functioning, as well as wide ranging psychological impacts, including high levels of substance use and suicidal behaviours and poor long-term outcomes (Di Lorenzo et al., 2021; Erskine et al., 2016). The social and economic burden of ADHD in Australia has been estimated at US\$12.76 billion per year (Sciberras et al., 2022). In July 2022, the Australian National Health and Medical Research Council (NHMRC) endorsed the Australian evidence-based clinical practice guideline for ADHD (AADPA, 2022). This guideline was the culmination of several years of work by the Australian ADHD Professionals Association (AADPA) and focused on

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Australian populations. It aimed to provide best-practice evidenced-based recommendations for the multidisciplinary clinical care of over 800,000 Australians with ADHD. The guideline is intended for clinicians, including medical and allied health professionals such as psychologists and others involved in the support of people with ADHD.

Although our primary example focuses on Australian populations, many of these points could be relevant for other populations. Despite their geographical separation, Australia and New Zealand share significant historical and contemporary parallels, particularly in their relationships with Indigenous populations; Aboriginal and Torres Strait Islanders and Māori, respectively. Both countries have a legacy of settler-colonisation that continues to impact Indigenous communities, making it essential for health professionals to develop culturally sensitive and inclusive practices to better address mental health needs such as ADHD. However, it should be noted that the cultural implications for Māori have not been explored in these guidelines. The intention of this paper is to provide insights into the specificities of ADHD among Aboriginal and Torres Strait Islander peoples and respond to calls for a broader dialogue about the mental health needs of Indigenous peoples (Lacey et al., 2022). We hope this exploration will shed light on potential cultural gaps in current practice and stimulate further investigations and inclusive strategies for mental health care across diverse Indigenous populations.

Given their unique skill sets, psychologists play a key role in the identification, assessment and support of people with ADHD. This encompasses skills in understanding and applying diagnostic systems, including differential and comorbid diagnosis, understanding and interpreting standardised interviews, tests and questionnaires, and expertise in the provision of psychotherapy. Psychologists who do not work directly with people with ADHD may work with groups at high risk for developing ADHD, and should therefore also be aware of the recommendations in the guideline. This paper explored the main guideline recommendations relevant to psychologists, along with considerations relevant to ADHD among Aboriginal and Torres Strait Islander peoples, which may be of relevance to care for New Zealand Māori.

Method

The guideline was developed using a rigorous and transparent approach that followed the Australian NHMRC standards and procedures (National Health and Medical Research Council, 2007, 2016), including use of the Grading of Recommendations, Assessment, Development and Evaluation (GRADE) approach (The GRADE Working Group, 2009). After a review of existing international guidelines, the UK National Institute for Health and Care Excellence (NICE) 2018 guideline for the diagnosis and management of ADHD (NICE guideline NG87) was selected for adaptation given its evidence-based approach and comprehensive coverage (NICE, 2018). A

multidisciplinary Guideline Development Group (GDG) was assembled that comprised 23 people, including those with a lived experience of ADHD and clinicians and academics with expertise in ADHD. Two independent clinical co-chairs oversaw the guideline development. All GDG members were required to declare any conflicts of interest, which were rigorously evaluated by the two clinical GDG co-chairs plus an independent bioethicist. Disciplines represented included psychology, psychiatry, paediatrics, speech pathology, occupational therapy, nursing, education and clinical pharmacology.

Rigorous methods were used to develop the guideline. An experienced project methodologist was employed to conduct new and updated systematic reviews and meta-analyses using GRADE to rate the quality and certainty of recommendations (The GRADE Working Group, 2009). AGREE II methodology was used to develop and subsequently assess the methodological quality of the guideline. Where systematic reviews were not able to be conducted (e.g. because of a lack of randomised controlled trials in a particular area), narrative reviews were written by GDG members. Full details of the guideline development methods can be found at <https://adhdguideline.aadpa.com.au/about/methods/>.

The drafted recommendations were evidence-based recommendations, clinical consensus recommendations or clinical practice points. These recommendations underwent several rounds of review, including a public consultation process and independent expert clinical and methodological reviews. This resulted in 113 clinical recommendations, which can be found at: <https://adhdguideline.aadpa.com.au/>. Below, we describe the guideline recommendations relevant to psychologists, which are summarised in [Table 1](#). The guideline also noted the importance of the neurodiversity movement and providing affirming support (Dwyer, 2022). Guidance regarding this point is provided in [Box 1](#).

Box 1. Providing Neuroaffirming Psychological Care for People with ADHD

The neurodiversity movement generally views neurodevelopmental conditions such as autism and ADHD as naturally occurring differences and not ‘disorders’ or ‘pathologies’ (Dwyer, 2022). A social disability model is often employed. In this model a person is only ‘disabled’ if society and the person’s environment is not accommodating of their differences. The focus is therefore on educating society and helping the person make changes to their environment so they can live to their full potential.

Neuroaffirming psychologists align with clients to help them understand their unique differences in an accepting and strengths-based manner. The focus is not on changing their neurodiversity, but on making environmental changes so they can live and function optimally.

Table 1.

Main Roles and Actions of Psychologists in ADHD Identification, Assessment and Support Based on the Australian ADHD Guideline

Area	Role
Identification and Screening	• Awareness of groups at high risk for having ADHD (1.1) • Consideration of screening clients with awareness of strengths and limitations of tools (1.2)
Diagnosis	• Conducting ADHD diagnostic assessments (2.1, 2.2) including: ◦ Clinical interview with developmental, psychiatric and ADHD criteria assessments ◦ Use of standardised measures with awareness of their strengths and limitations ◦ Assessment of functional impacts of symptoms ◦ Multidisciplinary approach to enable liaison with medical practitioners (psychiatrist, paediatrician, general practitioner) completing the medical assessment component of a diagnostic assessment • Psychoeducation about ADHD following a diagnosis, with a strengths-based affirming approach (2.3) • Communication about ADHD to others involved in the client's care, including education and workplace adjustments, impact of ADHD on clinical care for other conditions (2.3.8) • Provision of education about evidenced-based multimodal treatments, support groups and government support/benefits (3.1)
Support	• Optional role as the client's care coordinator when multiple clinicians are involved (3.1.3) • Assistance with transitions between services, including optional role as the client's transition lead (3.2) • Provision of guidance on lifestyle factors (diet, physical activity levels, sleep) (4.1) • Provision of evidence-based cognitive behavioural interventions (4.2) for young children, children, adolescents and adults including: ◦ Education and information on the causes of ADHD and impacts on functioning ◦ Environmental modifications to promote a positive, predictable and structured environment ◦ Behavioural modification approaches to help minimise the functional impacts of ADHD ◦ Psychological adjustment and cognitive restructuring • Provision of coaching based interventions (4.6) • Support to improve adherence to treatments (4.8)

Identification and Screening

Identification

The guideline reviewed the evidence for groups that were at high risk for developing ADHD. This included various mental health conditions, developmental disorders, medication conditions, prenatal factors and particular groups of people. Mental health conditions that confer risk for ADHD include anxiety disorders (D'Agati et al., 2019), mood disorders such as bipolar and depressive disorders (Sandstrom et al., 2021), substance use and addictive disorders (Lange et al., 2018), oppositional defiant and conduct disorders, trauma disorders (Szymanski et al., 2011) and personality disorders such as borderline personality disorder (Philipsen, 2006). Developmental disorders where people are at high risk for also having ADHD include autism spectrum disorder (Stevens et al., 2016), tic disorder and specific learning disorders (Boada et al., 2012; Morsanyi et al., 2018). Particular medical conditions, such as epilepsy or acquired brain injury (Ilie et al., 2015), can also place people at higher risk for ADHD. Sleep disorders are also common (Cortese et al., 2009; Sedky et al., 2014). Particular pregnancy and birth factors, such as extremely low birth weight and extreme preterm birth are also common risk factors for ADHD (Momany et al., 2018), as well as alcohol use during pregnancy resulting in foetal alcohol spectrum disorder (Lange et al., 2018). Groups at particular risk for having ADHD include those with a family history

Box 2.

Example ADHD Screening Rating Scales (Used with Permission from AADPA)

Young children (<5 years)	Children and adolescents (5–17 years)	Adults (≥18 years)
- Achenbach System of Empirically Based Assessment - Attention Problems scale - Child Behaviour Checklist DSM Oriented ADHD subscale	- Achenbach System of Empirically Based Assessment - Attention Problems scale - Child Behaviour Checklist - DSM Oriented ADHD subscale - Strengths and Difficulties Questionnaire (Hyperactivity subscale) - Conners' 3 short form - Swanson, Nolan and Pelham (SNAP) scale - ADHD Rating Scale 5 - Vanderbilt ADHD Diagnostic Rating Scale	- WHO Adult ADHD Self Report Scale (ASRS) (Part A) - Conners' Adult ADHD Rating Scale - Short - Wender Utah Rating Scale (WURS) - Short

of ADHD, children in out-of-home care and incarcerated people (Baggio et al., 2018). People with suicidal ideation and behaviour are also at higher risk for having ADHD (Balazs & Keresztesy, 2017). Psychologists who work with these individuals need to be aware of their risk for ADHD.

ADHD is the most common mental health condition of childhood. As such, psychologists who work with children should have some experience and expertise in this area. More broadly, having any mental health condition is a risk factor for ADHD, and all psychologists working with clients should understand ADHD symptoms and risk factors and have the ability to screen clients for ADHD. Adults with ADHD who have remained undiagnosed often have secondary anxiety, depression and substance use, and have been resistant to treatment for these conditions (Sibley, 2021). Psychologists should consider ADHD in people with these presentations. The legacy of gender disparity in medical science has also resulted in women and girls being more likely to have a missed diagnosis, which psychologists should reflect on when considering ADHD among girls and women who present with mental health conditions (Hinshaw et al., 2021; Quinn & Madhoo, 2014).

Screening

The guideline considered whether there should be population based screening for ADHD through exploring the sensitivity and specificity of screening tools. Lack of identification of people with ADHD and a subsequent lack of treatment results in high costs to the individual with ADHD, their family and society (Asherson et al., 2012; Deloitte Access Economics, 2019; Ginsberg et al., 2014; Sciberras et al., 2020). This includes the cost of increased accidents and injuries, lost work productivity, increased incarceration and early mortality (Dalsgaard et al., 2015; Küpper et al., 2012). Early identification of people with ADHD can allow early intervention, which reduces later impacts on functioning and maximises positive outcomes. Several different screening tools are used to detect ADHD in children, adolescents and adults. [Box 2](#), taken from the guideline, highlights some of the most commonly used screening measures.

Sensitivity and specificity need to be considered when using screening tools. Sensitivity, or the true positive rate, is the proportion of people with ADHD who are correctly identified. Specificity, or the true negative rate, is the proportion of people without ADHD who are correctly identified as such. Most studies aim for 80% specificity and sensitivity. However, the particular context and related costs and benefits need to be explored for each service when considering screening tools.

A recent systematic review and meta-analysis (Mulraney et al., 2021) explored screening tools for ADHD in children and adolescents, none of which had 80% sensitivity and specificity. Often, tools have high sensitivity and specificity when groups of people with ADHD are compared with non-clinical controls; however, specificity is often poor when there are clinical control groups. This is because the symptoms of ADHD may overlap with other mental health and developmental disorders (Reale et al., 2017; Stevens et al., 2016). The guideline concluded that current screening tools did not have sufficiently high sensitivity and specificity to warrant recommendations for universal or population-level screening. However, organisations that provide services, including diagnostic assessment, to people from groups at high-risk for an ADHD diagnosis could consider systematic screening for ADHD. Clinicians should be aware of the sensitivity and specificity of the tools they use and make informed decisions about whether the benefits of screening outweigh any potential harms and costs.

The guideline also noted particular indicators that should alert clinicians to possible ADHD when supporting people from high-risk groups, specifically when they are not responding to treatment or having difficulties adhering to treatment. These difficulties could include having problems attending appointments on time or forgetting appointments, or showing signs of ADHD symptoms (e.g. restlessness, difficulties maintaining routines, lacking time awareness, poor working memory, disorganisation, forgetfulness and distraction) that are not explained by other psychiatric diagnoses. Importantly, once a person screens positive for ADHD they should be referred for ADHD assessment.

Diagnosis

Psychologists, along with psychiatrists and paediatricians, are among the few professional groups that meet the guideline recommendations for conducting ADHD assessments. Psychologists in Australia must be registered with the Australian Health Practitioner Regulation Agency. Psychologists are usually adequately trained in diagnostic assessment using the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD). Through their training, they should gain experience conducting clinical interviews, administering and interpreting standardised tests and rating scales, and conducting assessments of functional impairment. While not all

psychology training programmes provide sufficient training in ADHD, psychologists can gain specific experience in ADHD diagnostic assessment as required by the guideline through additional ADHD education and supervision with ADHD-experienced supervisors.

The guideline details the best practice diagnostic steps. These include the clinical interview, which involves conducting developmental assessments, obtaining a psychiatric history, assessment of ADHD diagnostic criteria, using and interpreting standardised rating scales, assessing functioning (academic and occupational) and assessing any co-occurring or differential diagnoses. As medical assessment is also required as part of the diagnostic assessment for ADHD; psychologists require a multidisciplinary team approach with psychiatrists, paediatricians and general practitioners who can explore medical conditions which may mimic ADHD symptoms. Psychologists should be aware that although cognitive and neuropsychological assessments may be extremely helpful for a client's self-understanding and differential/comorbid diagnoses, they are not required to make a diagnosis of ADHD.

Differential and Co-occurring Diagnosis

Internationally, around two-thirds of children and adolescents with ADHD have a co-occurring condition (Reale et al., 2017). In adults with ADHD, up to 80% will have at least one other co-occurring condition or disorder (Katzman et al., 2017; Kessler et al., 2006). As ADHD symptoms may overlap with symptoms of other conditions, careful consideration of the onset and course of symptoms is required to make decisions about differential diagnoses. For example, difficulties with concentration and focusing attention associated with a major depressive episode are usually limited in duration, whereas attention problems due to ADHD are typically lifelong. It is also possible (and common) that people may have both ADHD and experience a major depressive episode at some time in their life. There are no conditions that can exclude a diagnosis of ADHD; therefore, ADHD and other present conditions should be diagnosed as per DSM or ICD criteria. Best-practice guidance for the diagnosis of differential or co-occurring conditions should be consulted.

Providing Information After a Diagnosis

Psychologists can play a key role in providing psychoeducation about ADHD following a diagnosis. This should be strengths-based, noting both the positives and negatives of a diagnosis. The provision of information should be aimed at helping the client understand their ADHD symptoms and how these may impact on their functioning. Clients also need to understand the secondary consequences of ADHD, such as emotion regulation difficulties, how symptoms may be more severe in particular contexts and situations, impacts of co-occurring conditions and workplace/academic accommodations.

Education about the different pharmacological and non-pharmacological interventions should be provided to help clients' choose appropriate support. They should also be informed about any ADHD support groups or relevant government benefits. Psychologists should also offer to communicate with other health professionals and people involved in their clients' care regarding the ADHD diagnosis and any adjustments required.

Support

There are a range of different support roles that psychologists can take in providing care for clients with ADHD. Psychologists should be aware of evidence-based treatment for ADHD and communicate this to clients. Pharmacological and non-pharmacological support are recommended in the guideline, including frontline stimulant medication treatment, which can be accessed through a paediatrician or psychiatrist. Non-pharmacological treatments include lifestyle adjustments, parent/family training for children and cognitive-behavioural approaches for adolescents and adults. Multimodal (e.g. pharmacological and non-pharmacological) treatment should be offered and the client supported to choose which support to access. Psychologists should inform clients of what symptoms and areas of functioning different treatments will target. For example, pharmacological treatment can reduce core ADHD symptoms, whereas non-pharmacological treatment can help improve a client's functioning and well-being.

Care Coordination

When multiple clinicians and practitioners are involved in a client's care, it may be beneficial to discuss the use of a care coordinator with the client and their family. In some cases, a psychologist may take on this role and ensure good communication and coordination within the client's care team.

Transitions

Transition periods are a time when people are at risk for breaks in care, such as when an adolescent transitions to adult care. The psychologist can assist at these times by helping with transition activities such as finding a new treatment team.

Lifestyle Changes

Clients may need to be supported to implement lifestyle changes. This may be through providing psychoeducation and cognitive and behavioural strategies that target changes to a person's environment. Targets can include improving sleep, diet and physical activity levels.

Cognitive Behavioural Approaches

Cognitive behavioural approaches, including parent/family training and cognitive behaviour therapy are recommended in the guideline. Cognitive behavioural approaches for people with ADHD and their families should include some of the following components.

1. Education and information on the causes of ADHD and its impacts on functioning.
2. Environmental modifications to promote a positive, predictable and structured environment.
3. Behavioural modification approaches to help minimise the functional impact of ADHD.
4. Psychological adjustment and cognitive restructuring.

Parent/family training is recommended for preschool children and children with ADHD. These interventions help parents to optimise parenting skills to meet the additional parenting needs of children with ADHD. Components may include general parenting guidance as well as ADHD-specific guidance that considers the impact of ADHD symptoms on the child and family. Psychologists need to inform families that parent/family training does not imply that parenting skills are inadequate, but rather that specific skill development relating to supporting children with ADHD is often required.

Numerous parent/family training programmes were reviewed. The guideline does not suggest any specific programme, but instead recommends that some of the following components should be covered.

- Education and information on the causes of ADHD and impacts on functioning.
- Environmental modifications to promote a positive, predictable and structured environment, and reduce impacts of ADHD symptoms.
- Behaviour modifications to help minimise the impact of symptoms and impairments associated with ADHD.
- Information on positive parenting approaches.

It was also recommended that more intensive parent/family training programmes should be offered to parents/families of children with ADHD who have co-occurring oppositional defiant disorder or conduct disorder. The guideline recommended that cognitive behavioural interventions could be offered to children with ADHD and should be offered to adolescents and adults. Psychologists should consider the developmental capabilities of the

child/adolescent, including their capacity to self-reflect and their awareness of and ability to influence their thinking processes. Younger children may benefit from a foundational focus on emotional literacy, proactive help-seeking, problem-solving and self-esteem growth, whereas children approaching adolescence may benefit from simple behavioural techniques. Through adolescence, increasingly sophisticated behavioural and cognitive restructuring techniques may be of benefit. For adults, the types of programmes reviewed included mindfulness-based cognitive therapy, dialectical behaviour therapy, cognitive behaviour therapy and mindfulness/meditation training. Cognitive behavioural approaches for adults should include components of the four areas noted above.

ADHD Coaching

ADHD coaching could also be offered to adults, and should similarly involve educational information, environmental changes and behaviour modification. ADHD coaching is often provided by allied health professionals, including psychologists. It could also be provided by an ADHD coach who is appropriately credentialled, such as via membership with the International Coaching Federation.

ADHD and Indigenous Peoples

ADHD is universal phenomenon that is present in most regions of the world (Polanczyk et al., 2007). The guideline noted the need for a cultural lens when identifying and supporting people with ADHD. However, despite the DSM-5 revisions claiming incorporation of cultural sensitivity, the cultural relativity of ADHD (like other diagnoses) has not received appropriate scientific attention. For Aboriginal and Torres Strait Islander peoples (and other cultures), ADHD symptoms and mental health conceptualisation more broadly can be interpreted differently from existing diagnostic criteria (Bredström, 2019). For example, there could be a misidentification of ADHD symptoms that could be considered culturally appropriate behaviours. The lack of culturally-specific knowledge regarding the identification, assessment and treatment of ADHD in Indigenous peoples may therefore result in harm or further health inequity.

To understand how cultural relativity influences mental health, it is valuable for psychologists to consider how other cultures view mental health. Aboriginal and Torres Strait Islander people consider health as a holistic concept that interconnects with numerous domains, including connections to spirituality, country, community, culture, the body, the mind and kinship systems (Dudgeon et al., 2014; Loh et al., 2017). There is only a small amount of research that contributes to understanding, identifying, diagnosing and treating ADHD in Aboriginal and Torres Strait Islander peoples (Loh et al., 2016). This lack of research may result in over-diagnosis or under-

identification of ADHD, ongoing stigma, inappropriate treatment or ultimately a lack of access to and acceptance of effective treatment. There are various initiatives for psychologists in Australia to provide culturally competent care. This deficit of research is reflected in the Australian Psychological Society (APS) ethical guidelines for the provision of psychological therapy and research for Aboriginal and Torres Strait Islanders (APS, 2015) and the APS reconciliation action plan (APS, 2011).

Psychologists need to provide culturally appropriate and responsive care to all. The guideline makes several recommendations that acknowledge the lack of validated tools and the need for culturally responsive care. Ideally, psychologists should be able to conduct culturally relevant screening assessments for ADHD in Aboriginal and Torres Strait Islander peoples. This would include understanding differences in mental health in cultural contexts. Psychologists should therefore incorporate mechanisms of self-reflection and cultural humility, as well as cultural and social assessments of the meaning and significance of symptoms. Existing ADHD symptom questionnaires and other tools used for screening and assessing ADHD may not be valid in Aboriginal and Torres Strait Islander peoples and should therefore be used with caution (Chau et al., 2023). As is appropriate when working with clients from other cultures, psychologists should use a strengths-based approach and seek the assistance of a cultural interpreter or Aboriginal and Torres Strait Islander health worker to assist in navigating cultural differences.

Differential and co-occurring disorder diagnoses may also be challenging given that Aboriginal and Torres Strait Islander adolescents and adults may have high levels of co-occurring difficulties, such as substance use disorders, trauma disorders and high levels of suicidal behaviour (Azzopardi et al., 2018). These difficulties are linked with intergenerational trauma and the widespread violent and ongoing influence of settler-colonisation. Therefore, differentiating between the cause of these impacts and underlying neurodevelopmental conditions can be complex.

There are many barriers to accessing assessment and support that further complicate treatment of ADHD in Aboriginal and Torres Strait Islander populations. For example, there is a well-established link between mistrust of healthcare providers and the history of medical maltreatment and the forcible removal of Indigenous children from their families (known as the Stolen Generations) (Loh et al., 2017). Other barriers include a lack of services in rural and remote areas and the high cost of ADHD treatment, particularly for adults where there are few publicly funded services.

There are further deficiencies in evidence regarding psychosocial interventions for ADHD in Aboriginal and Torres Strait Islander populations. Early research on parent-training programmes that had been culturally adapted for

Aboriginal and Torres Strait Islander communities (such as a variation of the Group Triple P) indicated that they can be culturally acceptable and have positive effects on children's symptoms (Andersson et al., 2019).

Reflecting the inter-connected conceptualisations of health, psychologists who provide interventions should include input from parents, families, community and elders. This will assist in maximising treatment effectiveness given the strong family values in Aboriginal and Torres Strait Islander cultures. Non-pharmacological interventions need to be culturally sensitive and appropriately tailored for Aboriginal and Torres Strait Islander peoples with consideration of the local cultural context. Psychologists should consider linking with Aboriginal Health Services, Aboriginal workforces or organisations to navigate these complexities. This should include seeking supervision and collaborating with Aboriginal and Torres Strait Islander mental health clinicians. Furthermore, research shows that Aboriginal and Torres Strait Islander people point to the most effective social and emotional well-being programmes and services as being those that provide a wide and holistic spectrum of support, including creative practices, advocacy and practical socioeconomic support (Murrup-Stewart et al., 2019).

It is noted that many of the gaps and challenges in delivering evidenced-based ADHD care to Aboriginal and Torres Strait Islander people are similar to those for Māori in Aotearoa/New Zealand. There were some early attempts at rectifying these gaps in research on the presentation of ADHD, validity of screening and assessment tools and the efficacy of ADHD non-pharmacological treatment among Māori. For example, Kersten et al. (2017) found low sensitivity and specificity using the Strengths and Difficulties Questionnaire in 4- and 5-year-old Māori children, and noted that lower thresholds were needed than the published cutoffs. Cargo et al. (2022) found that preschool Māori children screening positive for ADHD concerns were less likely to be receiving pharmacological treatment when living outside of major urban areas than non-Māori children.

Bredström argued that 'research in this field poses a real challenge to psychiatric diagnosing as it shows that not only do symptoms vary across cultures, but that culture also affects how disorders are understood, explained and coped with' (2019, pp. 351–352). It is therefore important that research should be framed using guidelines for research in Aboriginal and Torres Strait Islander peoples from the NHMRC (NHMRC, 2018), Te Ara Tika Guidelines for Māori Research (Hudson et al., 2010) and the Treaty of Waitangi principles. The shared challenges in culturally responsive ADHD diagnosis and treatment may offer opportunities for future research collaboration between Australian and New Zealand-based psychologists and researchers.

Conclusions

The role of the psychologist in ADHD identification, diagnosis and support is extensive. The Australian ADHD guideline provides evidence-based recommendations to help support clinicians, including psychologists, in providing best practice care to their clients. Although there are many areas where further research into clinical diagnosis and support is needed, the guideline provides an excellent starting point for psychologists working with people with ADHD to support their clients in a positive and strengths-based way. It will be updated in 5 years and it is hoped that many of the current gaps will be filled through the focus on ADHD that has been provided through the release of the Australian guidelines. Despite being focused on Australia, much of the guideline should be relevant for New Zealand psychologists.

Implications for Practice

- The Australian ADHD guideline provides recommendations and tools that can help psychologists provide evidence-based screening, diagnosis, treatment and support.
- Psychologists are key in identifying people with ADHD given their work with high-risk groups and expertise in the use of standardised tools used for screening, including awareness of their limitations.
- Psychologists are trained in DSM and ICD diagnoses and can work with medical practitioners (psychiatrists, paediatricians, general practitioners) to diagnose ADHD through the use of clinical interviews (developmental and psychiatric assessments as well as assessment of ADHD criteria), use of standardised instruments, assessment of the functional impacts of symptoms and assessment of differential and co-occurring conditions.
- There are a lack of validated tools and interventions for ADHD in Aboriginal and Torres Strait Islander peoples and psychologists should be aware of the limitations in validity of screening and assessment tools and conduct a culturally responsive assessment, including a cultural and social assessment of the meaning and significance of symptoms, within a strengths-based approach.

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