



## Attention Deficit/Hyperactivity Disorder\* (ADHD) Clinical Guidelines

In collaboration with FBH Partners' Providers, MHCBBC, and JCMH

DSM-IV-TR Diagnostic Code: 314.01; 314.00; 314.9

### Screening/Diagnosis Guidelines:

1. A diagnosis of ADHD should consist of an assessment of **core symptoms**, which are inattention, impulsivity and/or hyperactivity. These symptoms should occur in more than one setting, and, in addition to behavioral symptoms, there must be some evidence of functional impairment in daily living. The use of standardized rating scales from multiple informants is highly desirable.
2. For **children** the diagnosis of ADHD should come from a synthesis of information gathered from parents/primary caretakers, school reports, and an interview of the child. In addition, research indicates that as many as one third of children with ADHD have a coexisting condition, in particular oppositional defiant disorder, conduct disorder, anxiety and mood disorders, and learning disabilities. These secondary disorders should be assessed as they can complicate treatment.
3. For **adults** the assessment should include a history of ADHD symptom development, school and work performance and social development. ADHD should be diagnosable in childhood, as adult-onset ADHD is contrary to the natural history of this disorder. Reports from parents or significant others is helpful in determining core symptoms.
4. Individuals with ADHD may experience symptoms of **other mental disorders**, e.g. anxiety disorders, oppositional/defiant disorder or conduct disorder, sequelae of abuse or neglect, and/or mood disorders. Early onset mania or a bipolar mixed state may be hard to distinguish from ADHD, although ADHD is likely to have an earlier onset, sustained clinical course, and a family history of attention disorders. Learning, speech and language disorders, as well as developmental disorders, should be considered.
5. A thorough physical exam should be requested and reviewed to rule out **medical issues**, such as impaired vision or hearing, malnutrition, primary sleep disorder, seizures or head trauma, genetic disorders and toxic brain syndromes, e.g. *in utero* alcohol exposure.
6. The **age of onset**, for both children and adults, of core symptoms of ADHD (inattention, impulsivity, and/or hyperactivity) must be evident before age seven; a careful history should be gathered to determine this.

## Treatment Guidelines:

1. Drug and alcohol use should be **assessed regularly** as adolescents and adults with an ADHD diagnosis have a much higher incidence of substance abuse than the general population. In addition, mood (irritability/depression), and both appetite and sleep changes should be monitored.
2. For youth, **ongoing collaboration**, with parents and teachers, is an essential component of treatment. It is important to provide support and education to the primary adults in the child's life as well as help to establish a management program that ensures consistency between home and school environments. The therapist can help establish communication methods between home and school, such as through a daily report card. Realistic and measurable goals with clear plans for follow-up should be established.
3. For most children and adults with ADHD, **pharmacologic treatment**, such as stimulant medication, is highly effective in managing core symptoms. Children and young adolescents should not be responsible for administering their own medications due to impulsivity and disorganization; however, this can be encouraged in older adolescents.
4. The attached **medication algorithm** is recommended in prescribing for youth and adults with ADHD; rationale for deviations from this algorithm should be documented in the clinical record.
5. Parents and, where appropriate, teachers can be trained in specific **behavior modification** techniques for improving behavior including increased structure, use of positive reinforcements and consequences, and reduction of distractions.
6. **Education and support** should be provided to parents and when possible, teachers, about the chronic nature of ADHD, its effects on learning, self-esteem, behavior, social skills and family functioning. Parent or support groups (e.g. CHADD) can be an effective mode for this education, providing the added benefit of normalizing family experiences. Provide developmentally appropriate education for the child about ADHD.
7. Symptoms of ADHD often persist into **adulthood**, as well as secondary difficulties including problems with academic/vocational issues, relationships, poor self-esteem, anxiety, and depression. Along with appropriate medication (see attached medication algorithm), structured psychotherapy, with clear attainable goals, and education regarding the nature of ADHD can be helpful.

\*Adapted from American Academy of Child and Adolescent Psychiatry (1997). Practice parameters for the assessment and treatment of children, adolescents, and adults with ADHD. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36 (10, Suppl.), 85S-121S American Academy of Pediatrics (2000). Clinical practice guidelines: Diagnosis and evaluation of the school-aged child with ADHD. *Pediatrics*, 105 (5), 1158-1170.