FOUNDATION FOR HEALTHY COMMUNITIES

Guidelines for the Recognition and Treatment of Attention Deficit/Hyperactivity Disorder (ADHD) in School-Aged Children

THIS GUIDELINE IS NOT INTENDED TO REPLACE CLINICAL JUDGMENT.

Diagnosis:

For any child with inattention, hyperactivity, impulsivity, academic underachievement or behavioral problems, the clinician should initiate an evaluation for ADHD.

The diagnosis of ADHD requires that a child meet DSM-IV Criteria:

A. Either (1) or (2):

1. Six (or more) of the following symptoms of inattention have persisted for at least six months to a degree that is maladaptive and inconsistent with developmental level:

- **a.** often fails to give close attention to details or makes certain mistakes in schoolwork, work or other activities
- **b.** often has difficulty sustaining attention in tasks or play activities
- **c.** often does not seem to listen when spoken to directly
- **d.** often does not follow through on instructions and fails to finish school work, chores or duties in the workplace (not due to oppositional behavior or failure to understand instructions)
- **e.** often has difficulties organizing tasks and activities
- **f.** often avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
- **g.** often loses things necessary for tasks or activities, e.g. toys, school assignments, pencils, books or tools
- **h.** is often distracted by extraneous stimuli
- **i.** is often forgetful in daily activities

2. Six (or more) of the following symptoms of hyperactivity-impulsivity have persisted for at least six months to a degree that is maladaptive and inconsistent with developmental level:

- **a.** often fidgets with hands or feet or squirms in seat
- **b.** often leaves seat in classroom or in other situations in which remaining seated is expected
- **c.** often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
- **d.** often has difficulty playing or engaging in leisure activities quietly
- **e.** is often "on the go" or often acts as if "driven by a motor"
- **f.** often talks excessively
- **g.** often blurts out answers before questions have been completed
- **h.** often has difficulty awaiting turn
- **i.** often interrupts or intrudes on others, e.g., butts into conversations or games

B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before 7 years of age.

C. Some impairment from the symptoms is present in two or more settings, e.g., at school (or work) and at home.

D. There must be clear evidence of clinically significant impairment in social, academic or occupational functioning.

E. The symptoms do not occur exclusively during the course of a Pervasive Development Disorder, Schizophrenia or other Psychotic Disorder and are not accounted for by another mental disorder, e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder or a Personality Disorder.

Substance/general medical condition exclusion: The disturbance is not due to the direct physiological effects of a substance (e.g., drug of abuse, a medication) or a general medical condition.

Sources of Clinical Evidence

The assessment of ADHD requires evidence obtained from:

- parents or caregivers regarding the core symptoms of ADHD in various settings
- classroom teacher or other school professional

Having parents and teachers complete the Child Attention Profile (CAP), Connors or a similar scale, is recommended. A clinician should review any reports available from a school-based multidisciplinary evaluation.

The diagnosis of ADHD should be confirmed by a valid diagnostic instrument completed by caregivers at home and at school prior to starting medication. Assessment should rule out medical causes of observed behaviors.

Treatment

A management program should be established which recognizes ADHD as a chronic condition, including education of the parents, family, and school personnel about ADHD and about appropriate resources and/or support groups.

Treatment should occur in collaboration with the parents and school personnel.

Medication

Stimulant medication is consistently the most effective modality in treatment studies. Because of marked variability in dose-response relationships for stimulants, clinicians should begin with a low dose of medication and titrate upward. The dosage should continue to increase until no further improvement is seen or side effects become apparent or maximum recommended dose for that medication has been attained.

Behavioral Techniques

Treatment often should include behavioral therapy at home and at school.

POSITIVE REINFORCEMENT: Providing rewards or privileges contingent on the child's performance (Example: child who completes assignment is permitted to use a computer for leisure activities).

TIME-OUT: Removing access to positive reinforcement contingent on performance of unwanted or problem behavior (Example: child hits sibling impulsively and is required to sit in the corner of the room).

RESPONSE COST: Withdrawing rewards or privileges contingent on the performance of unwanted or problem behavior (Example: child loses free time privileges for not completing homework).

TOKEN ECONOMY: Combining positive reinforcement and response cost. The child earns rewards and privileges contingent on performing desired behaviors and loses the reward and privileges based on undesirable behavior (Example: child earns stars for completing assignments and loses stars for getting out of seat. The child cashes in the sum of stars at the end of the week for a prize.)

Follow-Up Visit:

During all clinical visits, information from the child, parents and school should be used in assessing progress, adjusting medication, reinforcing behavioral interventions and educating the parent and child about ADHD. Periodic use by parents and teachers of the Child Attention Profile (CAP), Connors or a similar scale is recommended.

Referral

If a child fails two stimulant medication trials, or a co-morbid psychiatric disorder other than learning disability (Oppositional Defiant Disorder, Conduct Disorder, Anxiety Disorder, Major Depression, Bipolar Disorder, Post-traumatic Stress Disorder) is suspected, referral to a behavioral health provider for further assessment and treatment should be considered.

OBJECTIVE: The prescribing clinician should see the child at least once per month until optimal results are achieved.

OBJECTIVE: Once the patient is stable, follow-up visits should occur once every three months.

ADD/ADHD Follow-Up Visit Checklist

- ☑ Height, weight and blood pressure
- ☑ Interview with child:
  - ✓ What is going well?
  - ✓ How is this grade different from last year?
  - ✓ Do you know why you are taking medication?
  - ✓ Do you think the medication is helping you?
  - ✓ What are you doing for fun at school?
  - ✓ Are you taking medication on weekends?
- ☑ Interview with parent and child together:
  - ✓ To parent: What is going well?
  - ✓ Review parents' two primary concerns
  - ✓ Review child attention profiles if available.
- ☑ Discuss whether a dosage change is needed.
- ☑ Along with the prescription, give the Child Attention Profiles for the parents and teacher to fill out just before the next scheduled visit.

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The information contained in this Guideline is intended for your information regarding issues generally arising with the management of ADHD. This information may not be comprehensive nor is it intended to dictate the appropriate course of treatment in all situations. Treatment decisions are the sole responsibility of the treating physician, and this guideline does not dictate or control physicians' clinical decisions regarding specific patients. Specific clinical decisions must be based on each patient's needs and current medical knowledge. Neither the Foundation for Healthy Communities nor any of the participating health plans is responsible for the accuracy or completeness of the information provided in this guideline and shall not be liable for any injuries, losses, claims, damages, expenses or liabilities arising from or related to the interpretation or application of the information contained in this guideline.

Information comes from the following sources: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Washington, DC, American Psychiatric Association, 1994. American Academy of Child and Adolescent Psychiatry. Practice parameter for the use of stimulant medications in the treatment of children, adolescents, and adults. Journal of the American Academy of Child and Adolescent Psychiatry, Vol. 41 No. 2 (Supplement):26S-49S; 2002. American Academy of Pediatrics. Clinical practice guideline: Diagnosis and evaluation of the child with attention-deficit/hyperactivity disorder. Pediatrics. Vol. 105, No. 5: 1158-1170; 2000. American Academy of Pediatrics. Clinical practice guideline: Treatment of the school-aged child with attention-deficit/hyperactivity disorder. Pediatrics. Vol. 108, No.4: 1033-1044; 2001. Biederman, J. Practical considerations in stimulant drug selection for the attention-deficit/hyperactivity disorder patient – efficacy, potency, and titration. Today's Therapeutic Trends Vol. 20, No. 4:311-328; 2002. Expert Consensus Guideline Series. Treatment of attention-deficit/hyperactivity disorder. Journal of Attention Disorders. Vol. 4, Supplement 1; 2001. MTA Cooperative Group. A 14-month randomized clinical trial of treatment strategies for attention-deficit/hyperactivity disorder. Archives of General Psychiatry. Vol. 56: 1073-1086; 1999