Foothills Behavioral Health Clinical Guideline
In collaboration with MHCBBC, JCMH, and the IPN
Attention Deficit/Hyperactivity Disorder*
DSM-IV-TR Diagnostic Code: 314.01; 314.00; 314.9

Screening/Diagnosis Guidelines:

1. **Assessment:** For both children and adults, the diagnosis of ADHD is based on DSM-IV criteria, which specify core symptoms of 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.
   - **a) 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.
   - **b) Adults:** The assessment should include history and context of the development of ADHD symptoms, as well as history of 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 can be helpful in determining core symptoms.

2. **Differential Diagnosis:** Should include 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.

3. **Medical History:** Results of 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.

4. **Age of Onset:** For both children and adults, core symptoms of ADHD (inattention, impulsivity, and/or hyperactivity) must be evident before age seven; a careful history should be gathered to determine this.

5. **Concomitant Mental Disorder:** Research indicates that as many as one third of children with ADHD have a coexisting condition, in particular oppositional defiant disorder, conduct disorder, as well as anxiety and mood disorders. Also learning disabilities commonly co-occur with ADHD. It is important to assess for these as they can complicate treatment.

6. **Substance Abuse/Dependence:** Research indicates that adolescents and adults with an ADHD diagnosis have a much higher incidence of drug and alcohol abuse than the general population, so this should be assessed regularly. The presence of substance abuse can worsen the course of ADHD and complicate treatment, and may require specific intervention.

Treatment Guidelines:

1. **Collaboration:** Ongoing collaboration with parents and teachers is an essential component of treatment for children and adolescents with ADHD. It is important to provide support and education about ADHD to the primary adults in the child's life as well as help to establish a management program that recognizes ADHD as a chronic condition, and provides consistency between home and school environments.

2. **Pharmacologic Treatment:** For most children and adults with ADHD, 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.

3. **Medication Algorithm:** 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.

4. **Behavior Modification:** Parents and teachers of children with ADHD can be trained and supported in specific techniques for improving behavior, including increased structure, use of positive reinforcements and consequences, and limitations of distractions. The therapist can help establish communication methods between home and school, such as a daily report card. Realistic and measurable goals with clear plans for follow-up should be established.

5. **Education/Support:** Information should be provided to parents and teachers about the chronic nature of ADHD, its effects on learning, self-esteem, behavior, social skills and family functioning. Parent groups 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, with updates as s/he matures. Educate families about support groups to families, such as Children and Adults with Attention/Deficit Hyperactivity Disorder (CHADD).

6. **Treatment of Adults:** Symptoms of ADHD often persist into adulthood, as well as secondary difficulties such as 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 can be helpful. In addition, education, regarding the nature of ADHD, should be part of treatment.

*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 and American Academy of Pediatrics (2000). Clinical practice guidelines: Diagnosis and evaluation of the school-aged child with ADHD. *Pediatrics, 105* (5), 1158-1170.