# Attention Deficit/Hyperactivity Disorder (ADHD) Clinical Guidelines

**Developed in collaboration with the mental health centers associated with NBHP and FBHP**
**DSM-IV-TR Diagnostic Code: 314.01; 314.00; 314.9**
**Unless otherwise noted, guidelines apply to both adults and children with ADHD**

## Diagnostic Considerations:

**1. Review diagnostic criteria** in DSM. Core symptoms of ADHD include: inattention, impulsivity, and/or hyperactivity. The DSM defines 3 subtypes: predominantly inattentive type, predominantly hyperactive or combined type. Females with ADHD more often present as inattentive, whereas males tend to exhibit more symptoms of hyperactivity.

**2. Assessment and diagnosis** should come from a synthesis of information gathered from a variety of sources. Reports from parents and/or significant others are important for accurate diagnosis. ADHD is highly heritable, and family history of ADHD should be assessed, along with family history of other mental health disorders.

- **For children:** be aware that when interviewed alone, children with ADHD often benefit from the individual adult attention and structure and may not display as many ADHD symptoms as in other situations. In assessing symptoms at school, ask the parent about the teacher's style. Teachers who provide more structure will pick up on symptoms more quickly than those who are more lax. Similarly, parenting styles will affect how easily parents notice the symptoms.
- **For adults:** symptoms should be diagnosable in childhood, as adult-onset ADHD is contrary to the natural history of this disorder. School, work, and social development should be considered.

**3. Commonly used rating scales for ADHD**

- **For children:** use reports from parents/primary caretakers, school, and an interview of the child. Standardized rating scales, such as Conners Behavior Rating Scale (CBRS) from multiple informants is highly desirable. Additional behavior scales, such as Child Behavioral Checklist (CBCL) or Behavior Assessment System for Children (BASC) can be helpful for differential diagnosis or diagnosis of co-occurring conditions.
- **For adults:** Brown ADD Scale for Adults, Conners Adult ADHD Rating Scales, and Adult ADHD Self-Report Scale by WHO.

**4. Assess for strengths, resources, and environmental stressors** of the client and their support systems. Consistency of support by family and school caregivers can facilitate positive change. Focus on the client's current coping strategies and areas of effectiveness can foster hope and motivation in the client and family.

**5. Co-occurring disorders** are common with ADHD.

- **For children:** research indicates that as many as one third of children with ADHD have a co-occurring condition, in particular oppositional defiant disorder, conduct disorder, anxiety and mood disorders. Learning, speech and language disorders, as well as developmental disorders, should be considered.
- **For adolescents and adults:** if untreated for ADHD, there is a higher incidence of substance abuse than the general population. Secondary disorders should be assessed as they can complicate treatment.

**6. Differential diagnosis** should include mania or a bipolar mixed state, which may be difficult to distinguish from ADHD. ADHD is likely to have an earlier onset, sustained clinical course, and a family history of attention disorders.

- **For children:** chronic family discord, academic placement and other environmental factors can cause symptoms that appear similar to ADHD. Additional factors that can mimic symptoms of ADHD include academic misplacement, either under or over stimulating, stress responses to family conflict or disorganized home life, or age appropriate behaviors in active children.

**7. A thorough review of health status** and physical exam should be requested and reviewed to rule out medical issues, such as impaired vision or hearing, allergies or environmental sensitivities, hyperthyroidism, malnutrition, seizures or head injury, genetic disorders and toxic brain syndromes, e.g. *in utero* alcohol or lead exposure.

**8. Consider cultural factors** that influence diagnosis and treatment. In cultures that emphasize orderliness and adherence to strict behavioral expectations, ratings of hyperactivity may be higher [i.e., seen as more deviant] than when the same behaviors are rated by individuals from cultures that have less rigid behavioral standards for children. It is important to recognize that perceptions of hyperactive, inattentive, and disruptive behaviors may be influenced by the observer's culture. When considering this diagnosis, the clinician should inquire about cultural expectations or beliefs and should obtain observational data from multiple perspectives, whenever possible.

**Treatment Guidelines:**

1. **Focus treatment planning** on specific areas of functioning. Identify target behaviors based on the client's presentation (incomplete tasks, forgetfulness, behavioral disturbance, etc.), and develop a plan that focuses on those specific behaviors. Be sure to emphasize the strengths of the client and support systems.

**2. Secondary difficulties** including problems with academic/vocational issues, relationships, poor self-esteem, anxiety, and depression should also be considered in treatment planning. Set specific goals around secondary difficulties as well, for example increase independence in self-care or work completion.

**3. For children, ongoing collaboration,** with parents and teachers, is an essential component of treatment. Research on evidence based practices that include family involvement and parent training have been found to be most effective. This includes providing support and education to the primary adults in the child's life and establishing a behavioral management program that ensures consistency between home and school environments. The clinician can help establish communication methods between home and school, such as through a daily report card (see http://www.addresources.org/?q=node/611 for more information). Realistic and measurable goals with clear plans for follow-up should be established.

**4. Medication can be one treatment foundation**, particularly when behavioral therapy alone is not working. Pharmacologic treatment, such as stimulant medication, is highly effective in managing core symptoms. Communicate with the prescriber about any side effects your client reports, such as weight loss due to decreased appetite. See attached medication algorithm.

- **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.

**5. Behavior therapy** is recommended as the primary psychosocial intervention. See resource list for more information on behavioral interventions.

- **For children:** parents and, where appropriate, teachers can be trained in specific behavior modification techniques for improving behavior including increased structure and environmental changes (such as classroom seating or study area), use of positive reinforcements and consequences, and reduction of distractions.
- **For adolescents and adults:** encourage structuring their environments and schedules.

**6. Psychoeducation and support** about the nature of ADHD, its effects on learning, self-esteem, behavior, social skills and family functioning should be provided. Improvements are sustainable with ongoing interventions and supports. Intensity of ongoing intervention varies by client.

- **For children:** educate parents and when possible, teachers, about the effects of ADHD. Parent or support groups (e.g. CHADD, http://www.chadd.org/ ) can be an effective mode for education, providing the added benefit of normalizing family experiences. Provide developmentally appropriate education for the child.

**7. Continue assessment of drug and alcohol use** throughout treatment. Be aware of possible misuse of stimulant medications, either overusing or giving/selling to others.

**8. Assess responsiveness to treatment plan** periodically, and adjust as needed. If treatment does not obtain positive results, it may be necessary to reevaluate the original diagnosis, co-existing symptoms and treatment goals.

Adapted from American Academy of Child and Adolescent Psychiatry (2007). 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.

## Resources for Professionals

Barkley, R. (1997). *Defiant Children: A Clinician's Manual for Parent Training* (Second Edition). New York: Guilford Press.

Barkley, R (2005). *Attention Deficit Hyperactivity Disorder: A Handbook for Diagnosis and Treatment* (Third Edition). New York: Guilford Press.

DuPaul, G. & Stoner, G. (1994). *ADHD in Schools: Assessment and Intervention Strategies*. New York: Guilford Press.