

## Guideline Highlights

### Attention Deficit Hyperactivity Disorder

**Target Population:** Children who present with inattention, hyperactivity, impulsivity, academic underachievement, or behavior problems 5 to 18 years of age.

**Exclude:** Child with autism spectrum disorder or PDD, Child with mental retardation, Child who is better accounted for by another mental disorder or a CNS dysfunction.

### Assessment and Diagnosis Recommendations

1. Evaluate children who present with ADHD symptoms. A history and physical will begin the process to determine appropriateness of further evaluation.
2. Full ADHD assessment also includes:
  - behavioral assessment using a narrow-band scale (such as the Vanderbilt Rating Scale\*)
    - gathering rating scale information from both parents and teachers
    - utilizing the *DSM-IV*
    - evaluating impairment in more than one setting
    - screening for comorbidities (included in the Vanderbilt Rating Scale\*)
  - obtaining family histories of ADHD and psychiatric disorders.
3. Begin education upon diagnosis.  
Introduce a chronic care model.  
Make family aware of support and information resources.
4. Have family select 3-6 desired outcomes to guide management.

### Treatment and Follow-up Recommendations

5. Discuss treatment options with the family, including:
  - combined medication and behavior therapy (**most effective**),
  - medication alone, and
  - behavior therapy alone.
6. Medication treatment begins with a short- or long-acting stimulant, titrated systematically (as frequently as weekly). If one stimulant does not achieve desired outcomes, first consider another stimulant.
7. Second-tier medications include alpha<sub>2</sub>-adrenoreceptor agonists, atomoxetine, bupropion and tricyclic antidepressants.
8. Behavior therapy includes group parent training of 6-12 weeks' duration, and environmental modification at home and school in the form of daily routines.
9. Success of initial therapy is measured by follow-up parent and teacher rating scales (such as the Vanderbilt\*), achievement of family-selected outcomes and tolerance of side effects.
10. If treatment is not successful, reevaluate for:
  - poor compliance
  - unrealistic expectations
  - overriding influence of coexisting condition
  - incorrect diagnosis
11. If treatment is successful:
  - determine frequency of follow-up visits in order to monitor target outcomes and adverse effects
  - provide on-going education as appropriate to the changing needs of the family
  - communicate actively and directly with school personnel
12. Consults and referrals:
  - appropriate specialists for clinical consults or referrals are professionals who have expertise in child/adolescent psychology, child/adolescent psychiatry or developmental pediatrics.
  - utilize community support resources for behavior therapy, help with school issues, and family education.

\* <http://www.nichq.org/resources/toolkit/>