## Attention Deficit/Hyperactivity Disorder Assessment & Treatment

### Concerns Suggesting Attention, Impulsivity, or Hyperactivity?
- Need for further evaluation: can't sit still, poor concentration, disorganization, daydreams, doesn’t seem to listen, acts without thinking, risk-taking behavior, memory problems, behavior problems, academic underachievement, expulsion from daycare

### Safety Screen (see Appendix): Administer every visit
- Neglect/Abuse?
- Thoughts of hurting self or others?
  - If yes, does patient have a plan, means, and intent?

### Is child under age 5?
- Yes
- No

#### Positive for Abuse/Neglect:
- Mandated Reporting as indicated
- Threat of harm to self or others:
  - Consider accessing local crisis intervention services. See Appendix for link to contact information.
  - Follow agency/professional protocols to ensure safety

#### Decide whether to:
1)  Initiate evaluation
2)  Refer to mental health specialist for evaluation
3)  Conduct combined evaluation (PCP & MH)

#### 1) Multi-Informant & Multi-Setting Evaluation
- Use information from history and physical to assess rule outs and comorbidity
- Gather information from child, caregiver, and school personnel/daycare provider
- Use ADHD-specific standardized tools for parents and teachers
- Other broadband or specific standardized tools might be helpful in assessing comorbid diagnoses
- Identify age of onset and course of problems
  - Rapid onset is not typical for ADHD.
  - Some level of hyperactivity and impulsivity is expected in children under age 5.

#### 2) Refer for Psychological or Neuropsychological Assessment
- Useful for complex cases, cases with one or more comorbid concerns, aggression at home or school, history of exposure to toxins or brain injury, low cognitive functioning, very high cognitive ability, PDD, or learning disabilities
- Request feedback and coordination

### Diagnosis: Use DSM-5 criteria (See Appendix)
- Consider medical conditions: perinatal complications, seizure disorder, Tourette’s Syndrome, Fragile X Syndrome, hypothyroidism or other endocrine disorder, exposure to toxins (e.g., lead, medications), iron deficiency, sensory impairment, Fetal Alcohol Syndrome
- Consider comorbidity/differential diagnosis: anxiety, Bipolar Disorder, cognitive impairment, depressive disorder, dissociation disorder, Learning Disorder, Oppositional Defiant Disorder, Conduct Disorder, Autism Spectrum Disorder, PTSD, Schizophrenia or other psychosis, speech disorder
- Rule out trauma reaction

### Refer to Early Childhood Mental Health Specialist for Diagnostic Assessment
- If child already has an Early Childhood Mental Health Specialist, referral can begin with this provider
- Request feedback & coordination

### Is child under age 5?
- Yes
- No

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ADHD Treatment Guide

Treatment Decision Questions: (Yes/No)
1) Do parents/caregivers or child prefer to treat non-medically or combine medication with behavioral treatment?
2) Is there a comorbid condition indicating mental health treatment?
3) Does presentation suggest concurrent behavioral treatment might be beneficial?

Is the child under age 5?

Yes

Refer to Early Childhood Mental Health Specialist for Treatment:
- Request information and coordination following referral
- First line of treatment = evidence-based behavior therapy that is administered by parent(s) and/or teacher(s)

Proceed with Medication Treatment:
- Children 6-11 years of age:
  - Begin with FDA-approved stimulant medication for ADHD unless contraindicated
  - Encourage patient/family to pursue evidence-based behavior therapy that is parent- and/or teacher-administered
  - A treatment approach that includes both medication and behavioral therapy is preferable
- Adolescents 12-18 years of age:
  - Begin with FDA-approved stimulant medication for ADHD unless contraindicated
  - May also refer for behavior therapy – see Appendix for indications

No – to all questions

Refer to Mental Health Specialist for Treatment:
- Request information and coordination following referral
- See Appendix for evidence-based treatments and components

If child is being treated medically as well, establish regular bidirectional communication systems to update all providers on treatment responses.

Yes – to any of above

Medication Treatment:
- Consider only if behavioral interventions do not lead to significant improvement and there continues to be significant disturbance in the child’s functioning
  - Begin with FDA-approved stimulant medication for ADHD unless contraindicated

Follow-up and Maintenance:
- Follow-up: Every 2-4 weeks with decreasing frequency as functioning improves
  - Re-administer standardized instruments
  - Monitor treatment progress, side effects, and medication compliance
  - Consider dosage changes before switching medications
  - Consider a different FDA-approved medication or need for reevaluation (i.e., diagnostic clarification) if functioning does not improve
- Maintenance: Every 12-24 weeks
  - Monitor continued need for treatment, progress toward goals, side effects, and height and weight
  - Consider patient/family preferences and drug holidays
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Primary References:
PracticeWise (2015). Evidence-Based Youth Mental Health Services Literature Database.

Appendix

Resources:
AAP Clinical Practice Guideline – ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents ([http://pediatrics.aappublications.org/content/128/5/1007](http://pediatrics.aappublications.org/content/128/5/1007))

Information on Cardiovascular Risk Related to Stimulants:
- FDA Drug Safety Communication: Safety Review Update of Medications Used to Treat Attention-Deficit/Hyperactivity Disorder (ADHD) in Children and Young Adults ([http://www.fda.gov/Drugs/DrugSafety/ucm277770.htm](http://www.fda.gov/Drugs/DrugSafety/ucm277770.htm))

Indicators for Combined Medication Management and Behavioral Therapy:
1) Parent-child conflict
2) Requests for home and school management techniques
3) Severe functioning deficits
4) Comorbid disorder

Safety Screen:
Some questions to assess potential threat of harm to self: Children and adolescents may be asked the following diagnostic questions (Jacobsen et al., 1994).
- “Did you ever feel so upset that you wished you were not alive or wanted to die?”
- “Did you ever do something that you knew was so dangerous that you could get hurt or killed by doing it?”
- “Did you ever hurt yourself or try to hurt yourself?”
- “Did you ever try to kill yourself?”

*If the threat assessment (i.e., Safety Screen) indicates risk of harm to self or others, educate families on the appropriate care options and safety precautions including removal of firearms from the home and securing all medications, both prescription and over-the-counter.*
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Warning Signs of Suicide: (Developed by the U.S. Department of Health and Human Services – Substance Abuse and Mental Health Services Administration (SAMHSA; 2011).

These signs may mean someone is at risk for suicide. The risk is greater if a behavior is new or has increased and if it seems related to a painful event, loss, or change.

- Threatening to hurt or kill oneself or talking about wanting to die or kill oneself
- Looking for ways to kill oneself by seeking access to firearms, available pills, or other means
- Talking or writing about death, dying, or suicide when these actions are out of the ordinary for the person
- Feeling hopeless
- Feeling rage or uncontrolled anger or seeking revenge
- Acting recklessly or engaging in risky activities – seemingly without thinking
- Feeling trapped – like there’s no way out
- Increasing alcohol or drug use
- Withdrawing from friends, family, and society
- Feeling anxious, agitated, or unable to sleep or sleeping all the time
- Experiencing dramatic mood changes
- Seeing no reason for living or having no sense of purpose in life


Current Evidence-Based Traumatic Stress Treatments include: Parent Management Training, Biofeedback, Contingency, Self Verbalization, and Behavior Therapy and Medication

Elements of effective traumatic stress treatment include: praise, psychoeducation, tangible rewards, problem solving, commands, differential reinforcement of other behavior, time out, modeling, therapist praise/rewards, biofeedback/neurofeedback, monitoring, stimulus control or antecedent management, relaxation, communication skills, educational support, goal setting, self-verbalization, attending, natural and logical consequences, relationship/rapport building, response, and self-reward/self-praise

DSM-5 Attention Deficit/Hyperactivity Disorder (ADHD) Criteria:

A. A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development, as characterized by (1) and/or (2):

1. **Inattention:** Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities:

   - Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities (e.g., overlooks or misses details, work is inaccurate).
b. Often has difficulty sustaining attention in tasks or play activities (e.g., has difficulty remaining focused during lectures, conversations, or length reading).
c. Often does not seem to listen when spoken to directly (e.g., mind seems elsewhere, even in the absence of any obvious distraction).
d. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily sidetracked).
e. Often has difficulty organizing task and activities (e.g., difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganized work; has poor time management; fails to meet deadlines).
f. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework; for older adolescents and adults, preparing reports, completing forms, reviewing lengthy papers).
g. Often loses things necessary for task or activities (e.g., school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).
h. Is often easily distracted by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts).
i. Is often forgetful in daily activities (e.g., doing chores, running errands; for older adolescents and adults, returning calls, paying bills, keeping appointments).

2. **Hyperactivity and impulsivity**: Six (or more) of the following symptoms have persisted for at least 3 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities:

   *Note:* The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or a failure to understand tasks or instructions.

For older adolescents and adults (age 17 and older), at least five symptoms are required.

a. Often fidgets with or taps hand or feet or squirms in seat.
b. Often leaves seat in situations when remaining seated in expected (e.g., leaves his or her place in the classroom, in the office or other workplace, or in other situations that require remaining in place).
c. Often runs about or climbs in situations where it is inappropriate. *(Note: In adolescents or adults, may be limited to feeling restless.)*
d. Often unable to play or engage in leisure activities quietly.
e. Is often “on the go,” acting as if “driven by a motor” (e.g., is unable to be or uncomfortable being still for extended time, as in restaurants, meetings; may be experienced by others as being restless or difficult to keep up with).
f. Often talks excessively.
g. Often blurts out an answer before a question has been completed (e.g., completes people’s sentences; cannot wait for turn in conversation).
h. Often has difficulty waiting his or her turn (e.g., while waiting in line).
i. Often interrupts or intrudes on other (e.g., butts into conversations, games, or activities; may start using other people’s things without asking or receiving permission; for adolescents and adults, may intrude into and take over what others are doing).

B. Several inattentive or hyperactive-impulsive symptoms were present prior to age 12 years.

C. Several inattentive or hyperactive-impulsive symptoms are present in two or more setting (e.g., at home, school, or work; with friends or relatives; in other activities).
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D. There is clear evidence that the symptoms interfere with, or reduce the quality of, social, academic, or occupational functioning.

E. The symptoms do not occur exclusively during the course of schizophrenia or another psychotic disorder and are not better explained by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, personality disorder, substance intoxication or withdrawal).

Specify whether:

314.01 (F90.2) Combined presentation: If both Criterion A1 (inattention) and criterion A2 (hyperactivity-impulsivity) are met for the past 6 months.

314.00 (F90.0) Predominantly inattentive presentation: If Criterion A1 (inattention) is met but Criterion A2 (hyperactivity-impulsivity) is not met for the past 6 months.

314.01 (F90.1) Predominantly hyperactive/impulsive presentation: If Criterion A2 (hyperactivity-impulsivity) is met and Criterion A1 (inattention) is not met for the past 6 months.