

# AlohaCare

Clinical Practice Guideline: **Diagnosis and Treatment Management of Attention Deficit/Hyperactivity Disorder (ADHD) in School-Aged Children**

Section: **Care Management**

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## INTRODUCTION

This clinical practice guideline provides recommendations for the assessment and diagnosis of school-aged children with attention-deficit/hyperactivity disorder (ADHD). This guideline is intended for use by primary care clinicians working in primary care settings.

This clinical practice guideline is not intended as a sole source of guidance in the evaluation of children with ADHD. Rather, it is designed to assist primary care clinicians by providing a framework for diagnostic decision making. It is not intended to replace clinical judgment or to establish a protocol for all children with this condition and may not provide the only appropriate approach to this problem.

## ASSESSMENT/DIAGNOSIS

Recommendation 1: In a child 4-18 years old who presents with inattention, hyperactivity, impulsivity, academic underachievement or behavior problems, primary care clinicians should initiate an evaluation for ADHD.

Recommendation 2: The diagnosis of ADHD requires that a child meet *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* 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 seven years of age.
- C. Some impairment from the symptoms is present in two or more settings, e.g., at school, at work or 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.

Recommendation 3: The assessment of ADHD requires evidence directly obtained from parents or caregivers regarding the core symptoms of ADHD in various settings, the age of onset, duration of symptoms, and degree of functional impairment.

Recommendation 3A: Use of these scales is a clinical option when evaluating children for ADHD. Specific questionnaires and rating scales have been shown to have an odds ratio greater than 3.0 in studies differentiating children with ADHD from normal, age-matched, community controls. Thus, ADHD-specific rating scales accurately distinguish between children with or without the diagnosis of ADHD.

Recommendation 3B: Use of broadband scales is not recommended in the diagnosis of children for ADHD, although they may be useful for other purposes.

Recommendation 4: The assessment of ADHD requires evidence directly obtained from the classroom teacher (or other school professional) regarding the core symptoms of ADHD, the duration of symptoms, the degree of functional impairment and coexisting conditions. A physician should review any reports from a school-based multidisciplinary evaluation where they exist, which will include assessments from the teacher or other school-based professional.

Recommendation 4A: Use of these scales is a clinical option when diagnosing children for ADHD. The ADHD-specific questionnaires and rating scales are also available for teachers. Thus, teacher ADHD-specific rating scales accurately distinguish between children with or without the diagnosis of ADHD.

Recommendation 4B: Use of teacher global questionnaires and rating scales is not recommended in the diagnosing of children for ADHD, although they may be useful for other purposes.

Recommendation 5: Evaluation of the child with ADHD should include assessment for coexisting conditions.

Recommendation 6: Other diagnostic tests are not routinely indicated to establish the diagnosis of ADHD.

## **TREATMENT**

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Recommendation 1: Primary care clinicians should establish a management program that recognizes ADHD as a chronic condition.

Recommendation 2: The treating clinician, parents, and the child, in collaboration with school personnel, should specify appropriate target outcomes to guide management.

Recommendation 3: The clinician should recommend stimulant medication and/or behavior therapy, as appropriate, to improve target outcomes in children with ADHD.

Recommendation 3A: For children on stimulants, if one stimulant does not work at the highest feasible dose, the clinician should recommend another.

**Recommendation 4:** When the selected management for a child with ADHD has not met target outcomes, clinicians should evaluate the original diagnosis, use of all appropriate treatments, adherence to the treatment plan, and presence of coexisting conditions.

**Recommendation 5:** The clinician should periodically provide a systematic follow up for the child with ADHD. Monitoring should be directed to target outcomes and adverse effects by obtaining specific information from parents, teachers, and the child.

**Table 2. Effective Behavioral Techniques for Children with ADHD**

<b>Technique</b>	<b>Description</b>	<b>Example</b>
Positive reinforcement	Providing rewards or privileges contingent on the child’s performance	Child completes an assignment and is permitted to play on the computer.
Time-Out	Removing access to positive reinforcement contingent on performance of unwanted or problem behavior.	Child hits sibling impulsively and is required to sit for 5 minutes in the corner of the room.
Response cost	Withdrawing rewards or privileges contingent on the performance of unwanted or problem behavior.	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 rewards and privileges based on undesirable behavior.	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.

**REFERRAL**

If a child fails two stimulant medication trials, or a co-morbid disorder other than a 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.

**REFERENCES**

American Academy of Pediatrics. Clinical Practice Guideline: Treatment of the School-Aged Child With Attention Deficit/Hyperactivity Disorder. *Pediatrics* Volume 108, Number 4: 1033-1044; October 2001

American Academy of Pediatrics, Clinical Practice Guideline: Diagnosis and Evaluation of the Child with Attention-Deficit/Hyperactivity Disorder. *Pediatrics* Volume 105, Number 5 May 2000.  
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