

Excerpts from:

Practice Parameters for Attention-Deficit/Hyperactivity Disorder Assessment and Treatment

...as developed by the American Academy of Child & Adolescent Psychiatry
[See the Journal of the American Academy of Child & Adolescent Psychiatry, (1997, Oct), 36(10 Suppl):85S-121S]

CHILDREN AGED 6 TO 12 YEARS

- I. Initial evaluation (a complete psychiatric assessment is indicated; see Practice Parameters for the Psychiatric Assessment of Children and Adolescents [American Academy of Child and Adolescent Psychiatry, 1995]).
 - A. Interview with parents.
 1. Child's history.
 - a. Developmental history.
 - b. DSM-IV symptoms of ADHD.
 - i. Presence or absence (may use symptom or criterion checklist).
 - ii. Development and context of symptoms and resulting impairment, including school (learning, academic productivity, and behavior), family, and peers.
 - c. DSM-IV symptoms of possible alternate or comorbid psychiatric diagnoses.
 - d. History of psychiatric, psychological, pediatric, or neurological treatment for ADHD; details of medication trials.
 - e. Areas of relative strength (e.g., talents and abilities).
 - f. Medical history.
 - i. Medical or neurological primary diagnosis (e.g., fetal alcohol syndrome, lead intoxication, thyroid disease, seizure disorder, migraine, head trauma, genetic or metabolic disorder, primary sleep disorder).
 - ii. Medications that could cause symptoms (e.g., phenobarbital, antihistamines, theophylline, sympathomimetics, steroids).
 2. Family history.
 - a. ADHD, tic disorders, substance-use disorders, CD, personality disorders, mood disorders, obsessive-compulsive disorder and other anxiety disorders, schizophrenia.
 - b. Developmental and learning disorders.
 - c. Family coping style, level of organization, and resources.
 - d. Past and present family stressors, crises, changes in family constellation.
 - e. Abuse or neglect.
 - B. Standardized rating scales completed by parents.
 - C. School information from as many current and past teachers as possible.
 1. Standardized rating scales.
 2. Verbal reports of learning, academic productivity, and behavior.
 3. Testing reports (e.g., standardized group achievement tests, individual evaluations).
 4. Grade and attendance records.
 5. Individual Educational Plan (IEP), if applicable.
 6. Observations at school if feasible and if case is complex.
 - D. Child diagnostic interview: history and mental status examination.
 1. Symptoms of ADHD (note: may not be observable during interview and may be denied by

child).

2. Oppositional behavior.
3. Aggressive behavior.
4. Mood and affect.
5. Anxiety.
6. Obsessions or compulsions.
7. Form, content, and logic of thinking and perception.
8. Fine and gross motor coordination.
9. Tics, stereotypies, or mannerisms.
10. Speech and language abilities.
11. Clinical estimate of intelligence.

E. Family diagnostic interview.

1. Patient's behavior with parents and siblings.
2. Parental interventions and results.

F. Physical evaluation.

1. Medical history and examination within past 12 months or more recently if the clinical condition has changed.
2. Documentation of health history, immunizations, screening for lead level, etc.
3. Measurement of lead level (if not already done) only if history suggests pica or environmental exposure.
4. Documentation or evaluation of visual acuity.
5. Documentation or evaluation of hearing acuity.
6. Further medical or neurological evaluation as indicated.
7. In preparation for pharmacotherapy.
 - a. Baseline documentation of height, weight, vital signs, and abnormal movements.
 - b. ECG before TCA or clonidine.
 - c. Consider EEG before TCA or bupropion, if indicated.
 - d. Liver function studies before pemoline.

G. Referral for additional evaluations if indicated.

1. Psychoeducational evaluation (administered individually).
 - a. IQ.
 - b. Academic achievement.
 - c. Learning disorders.
2. Neuropsychological testing.
3. Speech and language evaluation.
4. Occupational therapy evaluation.
5. Recreational therapy evaluation.

II. Psychiatric differential diagnosis.

- A. ODD.
- B. CD.
- C. Mood disorders - depression or mania.
- D. Anxiety disorders.
- E. Tic disorder (including Tourette's disorder).
- F. Pica.
- G. Substance use disorder.
- H. Learning disorder.
- I. Pervasive developmental disorder.
- J. Mental retardation or borderline intellectual functioning.

- III. Treatment planning.
 - A. Establish target symptoms and baseline impairment (rating scales may be useful).
 - B. Consider treatment for comorbid conditions.
 - C. Prioritize modalities to fit target symptoms and available resources.
 - 1. Education about ADHD.
 - 2. Classroom placement and resources.
 - 3. Medication.
 - 4. Other modalities may assist with remaining target symptoms.
 - D. Monitor multiple domains of functioning.
 - 1. Learning in key subjects (achievement tests, classroom tests, homework, classwork).
 - 2. Academic productivity (homework, classwork).
 - 3. Emotional functioning.
 - 4. Family interactions.
 - 5. Peer relationships.
 - 6. If on medication, appropriate monitoring of height, weight, vital signs, and relevant laboratory parameters.
 - E. Reevaluate efficacy and need for additional interventions.
 - F. Maintain long-term supportive contact with patient, family, and school.
 - 1. Ensure compliance with treatment.
 - 2. Address problems at new developmental stages or in response to family or environmental changes.

IV Treatment.

- A. Education of parents, child, and significant adults.
- B. School interventions.
 - 1. Ensure appropriate class placement and availability of needed resources (e.g., tutoring).
 - 2. Consult or collaborate with teachers and other school personnel.
 - a. Information about ADHD.
 - b. Educational techniques.
 - c. Behavior management.
 - 3. Direct behavior modification program when possible and if problems are severe in school setting.
- C. Medication.
 - 1. Stimulants.
 - 2. Bupropion.
 - 3. TCAs.
 - 4. Other antidepressants.
 - 5. Clonidine or guanfacine (primarily as an adjunct to a stimulant).
 - 6. Neuroleptics—risks usually exceed benefits in treatment of ADHD; consider carefully before use.
 - 7. Anticonvulsants—few data support use in the absence of seizure disorder or brain damage.
- D. Psychosocial interventions.
 - 1. Parent behavior modification training.
 - 2. Referral to parent support group, such as CHADD.
 - 3. Family psychotherapy if family dysfunction is present.
 - 4. Social skills group therapy for peer problems.
 - 5. Individual therapy for comorbid problems, not core ADHD.
 - 6. Summer day treatment.
- E. Ancillary treatments.
 - 1. Speech and language therapy.
 - 2. Occupational therapy.
 - 3. Recreational therapy.
- F. Dietary treatment rarely useful.

G. Other treatments are outside the realm of the usual practice of child and adolescent psychiatry and are not recommended.

CHILDREN AGED 3 TO 5 YEARS

Same protocol as above, except for the following:

- I. Evaluation.
 - A. Higher index of suspicion for neglect, abuse, or other environmental factors.
 - B. More likely to require evaluation of lead level.
 - C. More likely to require evaluation of:
 - 1. Speech and language disorders.
 - 2. Cognitive development.
- II. Treatment.
 - A. Increased emphasis on parent training.
 - B. Highly structured preschool.
 - C. Additive-free diet occasionally may be useful.
 - D. If medications are used, exercise more caution, use lower doses, and monitor more frequently.

ADOLESCENTS

Same protocol as for children aged 6 to 12 years, except for the following:

- I. Higher index of suspicion for comorbidity with:
 - A. CD.
 - B. Substance-use disorder.
 - C. Suicidality.
- II. Teacher reports less useful in middle and high school than in grammar school.
- III. Patient must participate actively in treatment.
- IV. Increased risk of medication abuse by patient or peers.
- V. Greater need for vocational evaluation, counseling, or training.
- VI. Evaluate patient's safe driving practices.