ATTENTION DEFICIT/HYPERACTIVITY DISORDER (ADHD)  
CLINICAL PRACTICE GUIDELINE

The American Academy of Pediatrics (AAP) published its third clinical guideline for the treatment of attention-deficit/hyperactivity disorder (ADHD) in November, 2011. To update and replace the previous two guidelines the AAP developed a working subcommittee which included primary care pediatricians, developmental-behavioral pediatricians, and representatives from the American Academy of Child and Adolescent Psychiatry, the Child Neurology Society, the Society for Pediatric Psychology, the National Association of School Psychologists, the Society for Developmental and Behavioral Pediatrics, the American Academy of Family Physicians, and Children and Adults With Attention-Deficit/ Hyperactivity Disorder (CHADD), as well as an epidemiologist from the Centers for Disease Control and Prevention (CDC).

The AAP ADHD clinical guideline is evidence based, intended for use by primary care clinicians and includes six action statements for the evaluation, diagnosis, and treatment of ADHD in children and adolescents between 4 and 18 years of age. Independent Health presents the AAP summary of the action statements below. To view the entire texts and explanations please see the published guideline: Pediatrics Volume 128, Number 5, November 2011 or log on to the following website: http://pediatrics.aappublications.org/content/early/2011/10/14/peds.2011-2654. AAP notes that this guideline is intended to be integrated with broader algorithms developed as part of the mission of the AAP Task Force on Mental Health.

In addition to the AAP recommendations, Independent Health strongly recommends the use of an evidence based clinical scale to measure response and track progress. The use of clinical scales has shown to improve outcomes and provide a foundation for process improvement. Examples of appropriate scales for ADHD are the Vanderbilt and the Connors Rating Scales.

American Academy of Pediatrics  
CLINICAL PRACTICE GUIDELINE FOR THE DIAGNOSIS, EVALUATION, AND TREATMENT OF ATTENTION-DEFICIT/HYPERACTIVITY DISORDER IN CHILDREN AND ADOLESCENTS

SUMMARY OF KEY ACTION STATEMENTS

1. The primary care clinician should initiate an evaluation for ADHD for any child 4 through 18 years of age who presents with academic or behavioral problems and symptoms of inattention, hyperactivity, or impulsivity (quality of evidence B/strong recommendation).

2. To make a diagnosis of ADHD, the primary care clinician should determine that Diagnostic and Statistical Manual of Mental disorders, fourth Edition criteria have been met (including documentation of impairment in more than 1 major setting); information should be obtained primarily from reports from parents or guardians, teachers, and other school and mental health clinicians involved in the child’s care. The primary care clinician should also rule out any alternative cause (quality of evidence B/strong recommendation).
3. In the evaluation of a child for ADHD, the primary care clinician should include assessment for other conditions that might coexist with ADHD, including emotional or behavioral (eg, anxiety, depressive, oppositional defiant, and conduct disorders), developmental (eg, learning and language disorders or other neurodevelopmental disorders), and physical (eg, tics, sleep apnea) conditions (quality of evidence B/strong recommendation).

4. The primary care clinician should recognize ADHD as a chronic condition and, therefore, consider children and adolescents with ADHD as children and youth with special health care needs. Management of children and youth with special health care needs should follow the principles of the chronic care model and the medical home (quality of evidence B/strong recommendation).

5. Recommendations for treatment of children and youth with ADHD vary depending on the patient’s age:
   a. For preschool-aged children (4-5 years of age), the primary care clinician should prescribe evidence-based parent- and/or teacher-administered behavior therapy as the first line of treatment (quality of evidence A/strong recommendation) and may prescribe methylphenidate if the behavior interventions do not provide significant improvement and there is moderate-to-severe continuing disturbance in the child’s function. In areas where evidence-based behavioral treatments are not available, the clinician needs to weigh the risks of starting medication at an early age against the harm of delaying diagnosis and treatment (quality of evidence B/recommendation).
   b. For elementary school-aged children (6-11 years of age), the primary care clinician should prescribe US Food and Drug Administration-approved medications for ADHD (quality of evidence A/strong recommendation) and/or evidence-based parent- and/or teacher-administered behavior therapy as treatment for ADHD, preferably both (quality of evidence B/strong recommendation). The evidence is particularly strong for stimulant medications and sufficient but less strong for atomoxetine, extended-release guanfacine, and extended-release clonidine (in that order) (quality of evidence A/strong recommendation). The school environment, program, or placement is a part of any treatment plan.
   c. For adolescents (12-18 years of age), the primary care clinician should prescribe Food and Drug Administration-approved medications for ADHD with the assent of the adolescent (quality of evidence A/strong recommendation) and may prescribe behavior therapy as treatment for ADHD (quality of evidence C/recommendation), preferably both.

6. The primary care clinician should titrate doses of medication for ADHD to achieve maximum benefit with minimum adverse effects (quality of evidence B/strong recommendation).

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Independent Health offers Behavioral Health Case Management to help our members take the right steps toward good health and wellness. Member contacts are confidential and may include letters, telephone calls, education, referrals and assistance with coordination of care among providers, as needed. Skilled behavioral health staff can offer tips on how to get the most out of available resources for mental health and substance abuse issues. To refer a patient, or for assistance with questions or concerns about behavioral health resources, providers may call 716-631-3001 x5333 and ask for a Behavioral Health Case Manager.