Introducing the NEW AAP Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents

Mark L. Wolraich, MD, FAAP
Shaun Walters Professor Emeritus of Pediatrics
University of Oklahoma Health Sciences Center

Joseph F. Hagan, Jr., MD, FAAP
Clinical Professor in Pediatrics
The Robert Larner, MD College of Medicine at the University of Vermont
Disclaimer and Disclosure

- Dr Wolraich reports a Continuing Medical Education trainings relationship with the Resource for Advancing Children’s Health Institute.

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History
Die Geschichte vom Zappel-Philipp

„Ob der Philipp heute still wohl bei Tische sitzen will?“ Also sprach in ernstem Ton der Papa zu seinem Sohn, und die Mutter blickte stumm auf dem ganzen Tisch herum. Doch der Philipp hörte nicht, was zu ihm der Vater spricht. Er gaukelt und schaukelt, er trappelt und zappelt auf dem Stuhle hin und her. „Philipp, das mißfällt mir sehr!“
Die Geschichte vom Hans Guck-in-die-Luft

Einst ging er an Ufers Rond
mit der Mappe in der Hand.
Nach dem blauen Himmel hoch
sah er, wo die Schwalbe flog,
also daß er kerzzengrad
immer mehr zum Flusse trat.
Und die Fischlein in der Rein
sind erstaunt sehr, alle drei.

Wenn der Hans zur Schule ging,
stets sein Blick am Himmel hing.
Nach den Dächern, Walken, Schwalben
schaute er aufwärts allenthalben:
vor die eigenen Füße dicht,
ja, da sah der Bursche nicht,
also daß ein jeder rief:
Seht den Hans Guck-in-die-Luft!

Kam ein Hund daher genannt;
Hänslein blickte unverwandt
in die Luft.
Niemand ruft:
Hans gib acht, der Hund ist nah!
Was geschah?
Bauz! Perauß — da liegen zwei!
Hund und Hänschen nebenbei.

Noch ein Schnitt! und plumps! der Hans
stürzt hinab kopfüber ganz!
Die drei Fischlein, sehr erschreckt,
haben sich sogleich versteckt.
Attention-Deficit/Hyperactivity Disorder (ADHD) Historical Timeline

1846 Heinrich Hoffmann
1900 George still described ADHD symptoms
1937 Benjamin Benzedrine
1955 Hyperactive Child Syndrome
1960 Minimal Brain Dysfunction
1966 Attention Deficit Hyperactivity Disorder (DSM-III-R)
1980 Updated criteria
1987 Attention Deficit Disorder with or without Hyperactivity (DSM-III)
1994 DSM-IV Updated criteria
2013 DSM-5 Updated criteria
Constant Features of ADHD

**Diagnosis:** The name has changed but the symptoms have remained the same:

- **Name:** Minimal Brain Dysfunction ➔ Hyperactive Child Syndrome ➔ Attention Deficit Disorder ➔ Attention-Deficit/Hyperactivity Disorder

- **Symptoms:** Inattention, hyperactivity, impulsivity, and frequently incoordination

**Treatment:** Stimulant medications and behavior modification have had consistent strong scientific evidence for efficacy and safety since the 1970s.
Mortality, ADHD, and Psychosocial Adversity in Adults with Childhood ADHD

1. Increased risk of suicide
2. Criminal behavior
3. Incarcerations
4. Motor vehicle violations and accidents
5. Increased substance rates of comorbid disorders, particularly substance abuse

Evidence

Evidence was assessed in accordance with the AAP policy statement, “Classifying Recommendations for Clinical Practice Guidelines.”

- **Grade A**: Consistent level A studies.
- **Grade B**: Consistent level B or extrapolations from level A studies.
- **Grade C**: Level C studies or extrapolations from level B or level C studies.
- **Grade D**: Level D evidence or troublingly inconsistent or inconclusive studies of any level.
- **Level X**: Not an explicit level of evidence as outlined by the Centre for Evidence-Based Medicine. This level is reserved for interventions that are unethical or impossible to test in a controlled or scientific fashion and for which the preponderance of benefit or harm is overwhelming, precluding rigorous investigation.
Evidence

<table>
<thead>
<tr>
<th>Aggregate Evidence Quality</th>
<th>Benefit or Harm Predominates</th>
<th>Benefit and Harm Enhanced</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level A</strong></td>
<td>Strong recommendation</td>
<td>Weak recommendation (based on balance of benefit and harm)</td>
</tr>
<tr>
<td>Intervention: well-designed and conducted trials, meta-analyses on applicable populations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosis: independent gold standard studies of applicable populations</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Level B</strong></td>
<td>Moderate recommendation</td>
<td>No recommendation may be made.</td>
</tr>
<tr>
<td>Trials or diagnostic studies with minor limitations; consistent findings from multiple observational studies</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Level C</strong></td>
<td>Weak recommendation (based on low-quality evidence)</td>
<td></td>
</tr>
<tr>
<td>Single or few observational studies or multiple studies with inconsistent findings or major limitations.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Level D</strong></td>
<td>No recommendation may be made.</td>
<td></td>
</tr>
<tr>
<td>Expert opinion, case reports, reasoning from first principles</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Level X</strong></td>
<td>Strong recommendation</td>
<td></td>
</tr>
<tr>
<td>Exceptional situations in which validating studies cannot be performed, and there is a clear preponderance of benefit or harm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate recommendation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Revisions in the New Guidelines

1. The guidelines include three papers
   A. Clinical Guidelines
   B. Process of Care Algorithm
   C. Barriers to Implementing the Guidelines
Clinical Guidelines

1. Diagnosis should be based on the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5).

Changes from DSM-IV:

A. For children over 17 years of age, 5 instead of 6 positive behaviors in either dimension are required.

B. Symptoms need to have been present from at least 12 years of age instead of 7 years.
Evaluation Entails

1. Identifying core symptoms
2. Assessing impairment
3. Identifying possible underlying or alternative causes
4. Identifying co-occurring (co-morbid) conditions
DSM-5 Core Symptoms of Inattention

- Manifestations of the following symptoms must occur often*

**Inattention**

- Careless
- Difficulty sustaining attention in activity
- Doesn’t listen
- No follow-through
- Avoids/dislikes tasks requiring sustained mental effort
- Can’t organize
- Loses important items
- Easily distractible
- Forgetful in daily activities

*Must have 6 or more symptoms for at least 6 months to a degree that is maladaptive and inconsistent with developmental level.

DSM-5 Core Symptoms of Hyperactivity-Impulsivity

- Manifestations of the following symptoms must occur often*

**Hyperactivity**
- Squirms and fidgets
- Can’t stay seated
- Runs/climbs excessively
- Can’t play/work quietly
- “On the go”/“driven by a motor”
- Talks excessively

**Impulsivity**
- Blurts out answers
- Can’t wait turn
- Intrudes/interrupts others

*Must have 6 or more symptoms for at least 6 months to a degree that is maladaptive and inconsistent with developmental level.

Assess Function

- Academic Performance
- Peer Relations
- Sibling Relations
- Parent Relations
- Community Activities
DSM-5 ADHD Diagnostic Criteria

- List of core symptoms must be present for past 6 months.
- Several symptoms need to be present before 12 years of age.
- Several inattentive or hyperactive-impulsive symptoms must be present in 2 or more settings (e.g., school and home).
- There needs to be clear evidence that the symptoms interfere with or reduce the quality of social, academic, or occupational functioning.
- Other mental or medical disorders need to be excluded as the cause of the core symptoms.

DSM-5 Subtypes of ADHD

- Predominantly inattentive
- Predominantly hyperactive-impulsive
- Combined
- Not otherwise specified
Preschool Age Diagnostic Issues

- The same criteria are pertinent for preschool age children but more difficult to find qualified observers.
- It may be difficult to get reports in more than one setting.

Adolescent Diagnostic Issues

- Much more difficult to get adequate observers; both parents and teachers have less opportunity to observe them.

- The risk of substance abuse is higher and must be ruled out before a diagnosis can be made.

- The occurrence of co-morbid conditions, particularly anxiety or depression, is more frequent.

Diagnostic Process

The use of ADHD-specific rating scales is clinically helpful in the evaluation of ADHD.
Assessment Should Include Information from Parents, Teachers, and Patients

- ADHD-based rating scales from parents and teachers provide measurable information for diagnosis and treatment.
- Interviews help to clarify observed behavior and detect alternative and/or comorbid diagnoses.
- Observations provide further information about behaviors and parent-child interactions.
## Vanderbilt ADHD Diagnostic Parent Rating Scale

**Child Study Center**

**Department of Pediatrics**

**University of Oklahoma Health Sciences Center**

**Child's Name:**

**Parent's Name:**

**Today's Date:**

**Date of Birth:**

**Age:**

**Directions:** Each rating should be considered in the context of what is appropriate for the age of your child.

When completing this form, please think about your child's behaviors in the past 6 months.

*Is this evaluation based on a time when the child:*

- was on medication
- was not on medication
- not sure

### Behavior:

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Never</th>
<th>Occasionally</th>
<th>Often</th>
<th>Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does not pay attention to details or makes careless mistakes with,</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>for example, homework</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Has difficulty keeping attention to what needs to be done</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Does not seem to listen when spoken to directly</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Does not follow through when given directions and fails to finish</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>activities (not due to refusal or failure to understand)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Has difficulty organizing tasks and activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Avids, dislikes, or does not want to start tasks that require</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>ongoing mental effort</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Loses things necessary for tasks or activities (toys, assignments,</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>pencils, books)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Is easily distracted by noises or other stimuli</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Is forgetful in daily activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10. Fidgets with hands or feet or squirms in seat</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11. Leaves seat when remaining seated is expected</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12. Runs about or climbs too much when remaining seated is expected</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13. Has difficulty paying or beginning quiet play games</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14. Is &quot;on the go&quot; or often acts as if 'driven by a motor&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15. Talks too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16. Blurs out answers before questions have been completed</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17. Has difficulty waiting his or her turn</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>18. Interrupts or intrudes on others' conversations and/or activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>19. Argues with adults</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>20. Loses temper</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>21. Actively defies or refuses to go along with adults' requests or</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>roles</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Deliberately annoys people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>23. Blames others for his or his mistakes or misbehaviors</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>24. Is touchy or easily annoyed by others</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>25. Is angry or resentful</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>26. Is spiteful and wants to get even</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>27. Bullying, threatens, or intimidates others</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>28. Starts physical fights</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>29. Lies to get out of trouble or to avoid obligations (ie, &quot;con&quot; others)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>30. Is truant from school (skips school) without permission</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>31. Is physically cruel to people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>32. Has stolen things that have value</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>33. Deliberately destroys other's property</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

### Academic & Social Performance:

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Above Average</th>
<th>Average</th>
<th>Somewhat of a Problem</th>
<th>Problematic</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

### Tic Behaviors:

- Motor Tics: Rapid, repetitive movements such as eye-blinking, grimacing, nose twitching, head jerks, shoulder shrugs, arm jerks, body jerks, rapid kicks.
- Phonic (Vocal) Tics: Repetitive noises including but not limited to throat clearing, coughing, whistling, sniffing, snoring, screaming, sucking, grunting, repetition of words or short phrases.

### Previous Diagnosis and Treatment:

1. Has the child been diagnosed with ADHD or ADD?
2. Is he/she on medication for ADHD or ADD?
3. Has the child been diagnosed with a Tic Disorder or Tourette's Disorder?
4. Is he/she on medication for a Tic Disorder or Tourette's Disorder?

**Children's Physicians**

**DEVELOPMENTAL-BEHAVIORAL PEDIATRICS**
Vanderbilt ADHD Follow-Up Parent Rating Scale

Child's Name: ____________________________  Parent's Name: ____________________________

Today's Date: ___________  Date of Birth: ___________  Age: ___________

Directions: Each rating should be considered in the context of what is appropriate for the age of your child.

When completing this form, please think about your child's behaviors since you last rated their behavior.

Is this evaluation based on a time when the child: □ was on medication  □ not on medication  □ not sure

Behavior:  Never  Occasionally  Often  Very Often

1. Does not pay attention to details or makes careless mistakes with, for example, homework
   □  □  □  □  □

2. Has difficulty keeping attention to what needs to be done
   □  □  □  □  □

3. Does not seem to listen even when spoken to directly
   □  □  □  □  □

4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)
   □  □  □  □  □

5. Has difficulty organizing tasks and activities
   □  □  □  □  □

6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort
   □  □  □  □  □

7. Loses things necessary for tasks or activities (toys, assignments, pencils, books)
   □  □  □  □  □

8. Is easily distracted by noises or other stimuli
   □  □  □  □  □

9. Is forgetful in daily activities
   □  □  □  □  □

10. Fidgets with hands or feet or squirms in seat
    □  □  □  □  □

11. Leaves seat when remaining seated is expected
    □  □  □  □  □

12. Runs about or is too much when remaining seated is expected
    □  □  □  □  □

13. Has difficulty playing or beginning quiet play games
    □  □  □  □  □

14. Is “on the go” or often acts as if “driver by a motor”
    □  □  □  □  □

15. Talks too much
    □  □  □  □  □

16. Blurs out answers before questions have been completed
    □  □  □  □  □

17. Has difficulty waiting his or her turn
    □  □  □  □  □

18. Interrupts or intrudes in on others' conversations and/or activities
    □  □  □  □  □

19. Argues with adults
    □  □  □  □  □

20. Loses temper
    □  □  □  □  □

21. Activity defies or refuses to go along with adults'/requests or rules
    □  □  □  □  □

22. Deliberately annoys people
    □  □  □  □  □

23. Blames others for his or her mistakes or misbehaviors
    □  □  □  □  □

24. Is touchy or easily annoyed by others
    □  □  □  □  □

25. Is angry or resentful
    □  □  □  □  □

26. Is spiteful and wants to get even
    □  □  □  □  □

Vanderbilt ADHD Follow-Up Parent Rating Scale, Continued

Pittsburgh Side Effects Rating Scale

Child's Name: ____________________________  Parent's Name: ____________________________

Today's Date: ___________  Date of Birth: ___________  Age: ___________

Directions: Listed below are several possible negative effects (side effects) that medication may have on a child with ADHD. Please read each item carefully and use the boxes to rate the severity of your child's side effects since he/she has been on this child's current dose of medication. When requested, or whenever you feel it would be useful for us to know, please describe the side effects that you observed or any other unusual behavior in the “Comments” section below.

Use the following to assess severity:

None: The symptom is not present.

Mild: The symptom is present but is not significant enough to cause concern to your child, to you, or to his/her friends. Presence of the symptom at this level would NOT be a reason to stop taking the medicine.

Moderate: The symptom causes impairment of functioning or social embarrassment to such a degree that the negative impact on social and school performance should be weighed carefully to justify benefit of continuing medication.

Severe: The symptom causes impairment of functioning or social embarrassment to such a degree that the child should not continue to receive this medication or dose of medication as part of current treatment.

Side Effect:

- Headache
- Stomachache
- Change of appetite—explain below
- Trouble of sleeping
- Intermittent in the late morning, late afternoon, or evening—explain below
- Soothing withdrawn—decreased interaction with others
- Extreme sadness or unusual crying
- Dull, tired, listless behavior
- Tremors, feeling shaky
- Repetitive movements, tic, jerking, twitching, eye blinking—explain below
- Poking at skin or fingers, nail picking, lip or cheek chewing—describe below
- Does or hears things that aren’t there

Comments:
The Vanderbilt Scales

- Available at:
  - Sooner Success: [https://soonersuccess.ouhsc.edu](https://soonersuccess.ouhsc.edu)
    - Click “Resources” in top menu bar.
    - Click “Behavior Rating Scales” in drop-down menu.
ADHD Guideline Recommendations

Evaluation of children with ADHD should include assessment for coexisting conditions.
Co-morbidity
(Conditions Commonly Co-occurring with ADHD)

- Disruptive Behavior Disorders
  • Oppositional Defiant Disorder
  • Conduct Disorder
- Depressive Disorders
- Anxiety Disorders
- Cognitive Disorders
  • Learning Disabilities
  • Language Disorders
- Motor Disorders
  • Developmental Coordination Disorder
  • Tic Disorders (Tourette’s)
Rating Scale Screens for Anxiety and Depression

- Anxiety: Screen for Child Anxiety Related Disorders (SCARED)
- Depression: Patient Health Questionnaire Modified for Teens (PHQ-9)
- Child and Adolescent Trauma Screen (CATS)
Treating ADHD as a Chronic Condition

- Need to educate parents and patients about ADHD
- Need to develop a partnership with the family
- Need to develop a management plan with specific targeted goals
- If at all possible, include the teachers
- Requires ongoing monitoring and anticipation of developmental changes
Elementary School–Aged Children (6–11 years)

A. Prescribe US FDA–approved medications for ADHD
   A/strong recommendation

B. and/or evidence-based parent and/or teacher-administered behavior therapy as treatment for ADHD
   B/strong recommendation

C. Preferably both
ADHD Guideline Recommendations

The clinician should titrate doses of medication for ADHD to achieve maximum benefit with minimum adverse effects. **B/strong recommendation**
Medications

- Stimulant Medications: methylphenidate and amphetamines—First Line
- Selective Norepinephrine Reuptake Inhibitor: atomoxetine—Second Line
- Alpha Adrenergic Agents: guanfacine and clonidine—Second Line and also Adjunctive
Why Use Behavioral Treatment for ADHD?

- Has been shown to be effective
- Family may not want to utilize stimulant medications
- Reduces residual symptoms of ADHD
- Makes pharmacologic therapy more effective
- May reduce amount of medication required
- Parent satisfaction is high
Behavioral Interventions

- Reward system
- Time out
- Social reinforcement
- Modeling
- Group problem-solving
- Sports skills
- Social skills training
General Classroom Interventions

- Ensure structure and predictable routines.
- Employ cost-response token economy systems.
- Use daily report cards.
- Teach organizational and work/study skills.
Psychosocial Treatments for ADHD

Some psychosocial treatments for children and adolescents with ADHD have been demonstrated to be effective: Behavioral therapy and training interventions

- Like medication treatment, the long-term positive effects of psychosocial treatments have yet to be determined.
- Ongoing adherence to psychosocial treatment is a key contributor to its beneficial effects.
- A chronic care model is important to ensure sustained adherence.
Psychosocial Treatments for ADHD

Behavioral Therapy

Some psychosocial treatments for children and adolescents with ADHD have been demonstrated to be effective: Behavioral therapy and training interventions.

- **Behavioral therapy** involves training adults
  - to influence the contingencies in an environment
  - to improve the behavior of a child or adolescent in that setting

- In this CPG: Parent Training in Behavior Management (PTBM)
  - Grade A evidence
  - Strong recommendation
Psychosocial Treatments for ADHD

Behavioral Therapy (or PTBM)

- Behavioral parent and classroom training are well-established treatments with preadolescent children.
- PTBM can help parents and school personnel learn how to effectively prevent and respond to adolescent behaviors, such as
  - Interrupting
  - Aggression
  - Not completing tasks
  - Not complying with requests
Psychosocial Treatments for ADHD

Behavioral Therapy (or PTBM)

- Behavioral parent and classroom training are well-established treatments with preadolescent children.
- The positive effects of behavioral therapies tend to persist.
- In contrast, the positive effects of medication cease when medication stops.
Psychosocial Treatments for ADHD

Training Interventions

Some psychosocial treatments for children and adolescents with ADHD have been demonstrated to be effective: Behavioral therapy and \textit{training interventions}

- Training interventions target skill development and involve repeated practice with performance feedback over time.
- Training interventions are well-established treatments to target disorganized behaviors.
- Less research has been conducted on training interventions than on PTBM.
Psychosocial Treatments for ADHD

Insufficient Evidence

Nonmedication treatments for ADHD-related problems with little evidence to recommend or have been found to have little or no benefit:

- Mindfulness
- Cognitive training
- Diet modification
- Electroencephalographic (EEG) biofeedback
- Supportive counseling
- Cannabidiol (CBD) oil
- eTNS
Appropriate Care Requires:

- Communication between families and clinicians other than just in office visits
- Communication between clinicians and school personnel
- Communication between primary care and mental health clinicians
Summary

- ADHD is a real condition with extensive research about its diagnosis and treatment.
- Underdiagnosis and treatment is the more frequent situation than overtreatment, effective, and safe treatments for ADHD.
- For effective treatment, need to consider it as a chronic illness that requires ongoing treatment with appropriate titration and ongoing monitoring to remain effective.
Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder (ADHD) in Children and Adolescents

October 2019

The AAP SUBCOMMITTEE ON CHILDREN AND ADOLESCENTS WITH ATTENTION-DEFICIT/HYPERACTIVE DISORDER

Mark L. Wolraich, MD, FAAP; Joseph F. Hagan, Jr, MD, FAAP; Carla Allan, PhD; Eugenia Chan, MD, MPH, FAAP; Dale Davison, MSpEd, PCC; Marian Earls, MD, MTS, FAAP; Steven W. Evans, PhD; Susan K. Flinn, MA; Tanya Froehlich, MD, MS, FAAP; Jennifer Frost, MD, FAAFP; Joseph R. Holbrook, PhD, MPH; Christoph Ulrich Lehmann, MD, FAAP; Herschel Robert Lessin, MD, FAAP; Kymika Okechukwu, MPA; Karen L. Pierce, MD, DFAACAP; Jonathan D. Winner, MD, FAAP; William Zurhellen, MD, FAAP
You’ve reviewed the guidelines. Now what?
How can we help you do this well?
AAP ADHD Clinical Practice Guideline Supplement: Process of Care Algorithm

Implementing the Key Action Statements of the AAP ADHD Clinical Practice Guideline:

- An Algorithm and Explanation for Process of Care for the Evaluation, Diagnosis, Treatment, and Monitoring of ADHD in Children and Adolescents
AAP ADHD Clinical Practice Guideline Supplement: Systemic Barriers to Care

1. Limited access to care because of inadequate developmental-behavioral and mental health care training during residencies and other clinical training and shortages of consultant specialists and referral resources

2. Inadequate payment for needed services and payer coverage limitations for needed medications

3. Challenges in practice organization and staffing

4. Fragmentation of care and resulting communication barriers
AAP ADHD Clinical Practice Guideline
Supplement: Systemic Barriers to Care

1. Limited access to care because of inadequate developmental-behavioral and mental health care training during residencies and other clinical training and shortages of consultant specialists and referral resources
   - Limited training time in residencies
   - Limited affordable CME activities
   - Financial disincentives to specialty training
   - Not all practices embrace medical home concept and service
AAP ADHD Clinical Practice Guideline Supplement: Systemic Barriers to Care

2. Inadequate payment for needed services and payer coverage limitations for needed medications
   - Res ipsa loquitur
   - So much of this care is not face-to-face
   - New accountable care organizations (ACO) models must account for care coordination!
   - Insurance limitations for ADHD medications
AAP ADHD Clinical Practice Guideline
Supplement: Systemic Barriers to Care

3. Challenges in practice organization and staffing

- These are not sick call slots.
- Diagnostic process of accumulating home and school information is often not supported.
- Ongoing communication with family, school, mental health with little or no support.
AAP ADHD Clinical Practice Guideline Supplement: Systemic Barriers to Care

4. Fragmentation of care and resulting communication barriers
   - You, family, mental health, school
   - HIPAA and FERPA
   - Online communication
   - EHR contained
   - Outside of EHR
You can do this!
Resources

- Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents – [https://pediatrics.aappublications.org/content/144/4/e20192528](https://pediatrics.aappublications.org/content/144/4/e20192528)


- HealthyChildren.org – [https://www.healthychildren.org/English/health-issues/conditions/adhd/Pages/default.aspx](https://www.healthychildren.org/English/health-issues/conditions/adhd/Pages/default.aspx)
Other ADHD Resources From the American Academy of Pediatrics

Understanding ADHD:
Information for Parents About Attention-Deficit/Hyperactivity Disorder

To purchase or to learn more, visit shop.aap.org
Questions?

mwolraich@gmail.com

jhagan@aap.org
Visit *Pediatric Care Online* today for additional information on this and other topics.

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