

Community First Health Plans Attention-Deficit/Hyperactivity Disorder Clinical Practice Guidelines

Introduction: In our ongoing effort to improve consumer/patient and provider satisfaction, quality of care, and access to the most appropriate level and intensity of treatment, Community First has adopted the following clinical practice guidelines for Attention-Deficit/Hyperactivity Disorder. Community First's guidelines are based upon scientific evidence and knowledge from the following resources: DSM-IV-TM, Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition, American Psychiatric Association, 2000; "Practice Parameters for the Assessment and Treatment of Children, Adolescents and Adults with Attention-Deficit/Hyperactivity Disorder", Journal of the American Academy of Child and Adolescent Psychiatry, Washington DC, October 1997; and InterQual Behavioral Health Psychiatry Level of Care Criteria 2006.

Attention-Deficit/Hyperactivity Disorder, Combined Type

- Criteria for both inattention and hyperactivity/impulsivity are met for the past 6 months.

Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type

- Criteria for only inattention are met for the past 6 months.

Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type

- Criteria for hyperactivity impulsivity are met for the past 6 months.

Attention-Deficit/Hyperactivity Disorder, Not Otherwise Specified

- This category is for disorders with prominent symptoms of inattention or hyperactivity/impulsivity that do not meet criteria for Attention-Deficit/Hyperactivity Disorder.

For individuals, especially adolescents and adults, who currently have symptoms that no longer meet full criteria, "In Partial Remission" should be specified.

Diagnostic Criteria:

I. Either A or B:

- A. Six (or more) of the following symptoms of inattention have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Inattention:

1. often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities
 2. often has difficulty sustaining attention in tasks or play activities
 3. often does not seem to listen when spoken to directly
 4. often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)
 5. often has difficulty organizing tasks and activities
 6. often avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
 7. often loses things necessary for tasks or activities (eg., toys, school assignments, pencils, books, or tools)
 8. is often easily distracted by extraneous stimuli
 9. is often forgetful in daily activities
- B. Six (or more) of the following symptoms of hyperactivity-impulsivity have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Hyperactivity

1. often fidgets with hands or feet or squirms in seat
2. often leaves seat in classroom or in other situations in which remaining seated is expected
3. often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feeling of restlessness)
4. often has difficulty playing or engaging in leisure activities quietly
5. is often “on the go” or often acts as if “driven by a motor”
6. often talks excessively

Impulsivity

1. often blurts out answers before questions have been completed
 2. often has difficulty awaiting turn
 3. often interrupts or intrudes on others (eg., butts into conversations or games)
- II. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years. However, at times inattentiveness specifically may not be noticed prior to age 7.
- III. Some impairment from the symptoms is present in two or more settings (eg., at school or work and at home).
- IV. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.

- V. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (eg., Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

There are no known specific laboratory or other diagnostic tests that establish, confirm or rule out Attention-Deficit/Hyperactivity Disorder.

The most accepted and effective ways of diagnosing ADHD are through:

1. Reports from guardian; parents, grandparents, caretakers, spouses, other significant individuals.
2. Reports from individuals from the school, day care, work place, and other physicians.
3. Clinical interview
4. Legal system; probation officer, court
5. Physical examination to rule out physical causes for the symptoms

The optimal approach/treatment for Attention-Deficit/Hyperactivity Disorder is a multiple-modality approach that combines psychosocial interventions and medical interventions.

1. Psychosocial Interventions
 - Family-Focused Interventions
 - Parent education
 - Parent management training
 - Parent support groups ie. CHADD
 - Family Counseling
 - Child-Focused Intervention
 - Individual counseling
 - Social Skills training
 - School focused interventions (consultation with school personnel)
2. Medications
 - Stimulants: Ritalin (LA), Adderall (XR), Dexedrine, Metadate (CD/ER), Focalin, Concerta,
 - Antidepressants: Imipramine, Wellbutrin, Effexor
 - Alpha 2 Agonist: Tenex, Clonidine
 - Selective norepinephrine reuptake inhibitor: Strattera

When Attention-Deficit/Hyperactivity Disorder is Comorbid with other Disorders:

1. Oppositional Defiant Disorder
2. Conduct Disorder
3. Depressive Disorders
4. Bipolar Disorder

5. Anxiety Disorders
6. Learning Disorders
7. Substance Abuse Disorders

It is optimal to inform guardians that medication for ADHD does not usually impact those behaviors resulting from the above listed disorders. Treatment should include those listed for ADHD but may include more intense interventions.

Psychological Testing is not utilized to diagnose ADHD, however, it may be indicated for ruling out other psychiatric disorders.

Educational Testing is not indicated to diagnose ADHD, however, school resources should be utilized if educational testing is indicated for school placement.

Treatment Intensity:

1. Outpatient
 - a. If the patient is being seen by a non-psychiatrist behavioral health provider and continues to have ADHD symptoms, the patient may have a comorbid condition and should be referred to a psychiatrist for a psychiatric evaluation.
 - b. If the patient is being seen by a non-psychiatrist physician and is on stimulants, tricyclic antidepressants, or other medications used to treat ADHD and not showing a response the patient may have a comorbid condition and should be referred to a psychiatrist for a psychiatric evaluation.

2. Inpatient

In general, patients with an Axis I diagnosis of ADHD do not require hospitalization, however, if a comorbid Axis I diagnosis is identified psychiatric hospitalization may be warranted.

Inpatient intensity of treatment is warranted when a patient meets the Community First Utilization Review Criteria for admission to an acute inpatient facility including:

- Presence of a DSM IV Axis I diagnosis; and
- GAF<30.

As well as one of the following six:

- Dangerous to self or others in the absence of sufficient family or community supports. This includes self-mutilation when it is noted as follows: 1) New onset, 2) Increase in intensity/pattern. Assessment should include the presence of concrete plan of sufficient lethality potential to result in loss of life or serious medical consequences. Behavioral observations and assessment support severity.
- Inability to meet basic needs as a result of psychiatric illness.
- Evaluation or procedure which is only available on an inpatient basis

- Medication combination which is best started on an inpatient basis
- Presence of a psychiatric condition which directly causes a deterioration in a medical condition

Or, if in the judgment of the attending physician, it is thought that the patient requires inpatient hospitalization. This requires specific documentation as to why the physician determined that the admission was the appropriate level of care after consulting with the Community First Associate Medical Director.

The above guidelines are applicable to children 6-12.

With children 3-5 years the above guidelines are also applicable including the following:

- Greater need to evaluate for abuse, neglect, or other environmental factors
- More likely to need evaluation for lead level
- Increased emphasis on parent training
- Need for very structured preschool
- If medication is used, more caution is needed with frequent monitoring.

With adolescents the above guidelines are also applicable including the following:

- Higher possibility of comorbidity with Conduct Disorder, Substance Abuse Disorder, and Suicidality
- Teacher report less useful (adolescents change classes)
- The patient must participate in treatment
- Increased risk of medication abuse by patient
- Greater need for vocational training
- Evaluation of patients driving practices.

With adults the above guidelines are also applicable including the following:

- A complete psychiatric evaluation
- A greater indication for individual cognitive/behavioral counseling
- A greater need for participation in a support group.