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Updated ADHD guideline addresses evaluation, diagnosis, treatment from ages 4-18

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The release of revised AAP guidelines for the care of children and adolescents with attention-deficit/hyperactivity disorder (ADHD) offers clinicians updates and opportunities as they strive to provide excellent care.

Clinical Practice Guideline for the Diagnosis, Evaluation and Treatment of Attention-Deficit/Hyperactivity Disorder (ADHD) in Children and Adolescents -as well as a process of care algorithm and a paper on barriers to care -are available at https://doi.org/10.1542/peds.2019-2528 and will be published in the October issue of *Pediatrics*.

The complex care of patients with ADHD occurs best in the patient-centered medical home. Updated from 2011, the guidelines are relevant for primary care pediatricians, pediatric nurse practitioners and physician assistants, and those in family medicine.

Diagnosis

The guidelines on establishing the diagnosis are based on the *Diagnostic and Statistical Manual of Mental Disorders*, *Fifth Edition* (*DSM-5*). The *DSM-5* criteria are similar to the 2011 guidelines with two exceptions. Fewer problem behaviors are required for those 17 years or older, and there must be evidence that symptoms began before age 12 years instead of before age 7.

The guidelines also emphasize ruling out other causes of ADHD-like symptoms and identifying comorbid conditions.

Therapies, tools for treatment

Recommended treatments also remain essentially unchanged. The stimulant medications methylphenidate and amphetamines in their various forms generally are the initial treatments. The number of extended-release forms of stimulant medications has increased since the last guideline was published.

Atomoxetine and the extended-release alpha-2 agonists guanfacine and clonidine remain the secondary alternative medications. The extended-release alpha-2 agonists also are approved by the Food and Drug Administration as adjuvant treatments.

Behavior therapy is recommended as the first-line treatment for preschoolers. However, the guideline authors determined that descriptions of behavior therapy for children were not specific enough. Studies that were reviewed predominantly included recommendations for parents and other caregivers. Therefore, the guidelines describe behavior management for preschoolers with ADHD as parent training in behavior management. Of note, a few studies described some value to similar parent and teacher training in behavior management for high school students with ADHD.

Supplemental information

An updated process of care algorithm includes additional assessment tools with rating scales for anxiety, depression, substance abuse and trauma.

The guidelines and algorithm continue to emphasize the importance of considering ADHD as a chronic illness for which there are effective symptomatic treatments but no cure. Some individuals, however, attain the ability to

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compensate adequately as they mature. As ADHD is a chronic illness, ongoing care based on the principles employed in providing medical home services are useful for care.

A companion paper discusses the challenges clinicians experience in seeking to implement the guidelines, including inadequate payment for services, less-than-adequate pediatric training in mental health, limited consultative services, and barriers to communication with schools and consultative services. The paper also provides suggestions for how clinicians, families and organizations can help address these barriers.

A historical commentary on the diagnosis and treatment of ADHD provides perspective to better understand the basis for the clinical guidelines and their subsequent revisions.

It is available at https://doi.org/10.1542/peds.2019-1682 and also will be published in the October issue of *Pediatrics.*

Evolution of the guidelines

Pediatricians have been involved in clinical services and research for children with ADHD going back at least 50 years. To improve the quality of clinical services for patients with ADHD, the AAP published clinical guidelines for diagnosis in 2000 and for treatment in 2001. These guidelines established the use of the *DSM* criteria for diagnosis, recommended behavioral rating scales to help establish the diagnosis, and outlined standards for follow-up and monitoring.

The clinical guidelines were revised in 2011 with essentially the same recommendations. However, the applicable age for diagnosis and treatment, which had been from 6-12 years of age, was broadened to include preschoolers (4- to 6-year-olds) and adolescents up to age 18 years. An algorithm on how to implement the revised guidelines also was published.

The changes led to more quality improvement and Maintenance of Certification (MOC) projects, including a revised ADHD toolkit, Education in Quality Improvement for Pediatric Practice module and American Board of Pediatrics MOC modules on diagnosis and treatment.

The AAP has been a leader in improving the care of children with ADHD. It has played a leading role in defining appropriate diagnostic and treatment standards and developing tools clinicians can use meet the standards. The guidelines have set a standard of care and a format for helping clinicians meet that standard.

Drs. Wolraich and Hagan are lead authors of the guideline. Dr. Wolraich is chair and Dr. Hagan vice chair of the Subcommittee on Children and Adolescents with Attention-Deficit/Hyperactivity Disorder.

Resources

- Caring for Children with ADHD: A Practical Resource Toolkit for Clinicians, Third Edition (available early October)
- Session at the 2019 National Conference: "How Will the New ADHD Guidelines Impact Your Practice?" from 7:30-8:15 a.m. on Oct. 28 (F4012) and 7:30-8:15 a.m. on Oct. 29 (F5009)
- "ADHD: What Every Parent Needs to Know, Third Edition"