ADHD Child and Adolescent Clinical Guideline

1. ADHD Concern Identified
   - Inattention, Hyperactive, Impulsivity.

2. Evaluation
   - Severity and duration of symptoms.
   - Functional impairment rating scales, medical Hx, family HX, and school performance, presence of comorbid diagnosis.

3. ADHD Diagnosis Only?
   - Yes
     - Develop Treatment Plan:
       - Medication Assess/Mgmt.
       - Family Psycho-Education
       - Behavior Assess/Mgmt.
       - School Based Behavioral Management, IEP
       - Ancillary Treatments: Speech, Occupational Tx, etc.
       - Modify for comorbid
       - Refer to CHADD
   - No
     - Other Dx – ODD, MDD, PTSD, Anxiety, Autism, etc.

4. Comorbid with ADHD?
   - Yes
     - Treatment plan or referral for treatment
   - No

5. Select Medication for ADHD
   - Stimulant
   - Non-Stimulant
   - Alternatives
     - See AAP process-of-care algorithm (Supplemental Table 3)

6. Ongoing care & Reevaluation
   - If symptoms improve follow up at least 2x per year for ADHD issues
   - If no improvement reevaluate to confirm diagnosis and reconsider treatment plan and/or adherence issues.

7. Medication Assess/Management:
   - Physical Exam, Blood Pressure, Ht & Wt, Review interactions with other prescribed medications
   - Return visit for Medication Management within 30 days of initial visit, Titration/Replacement, Augmentation until stable.

**Screening**

Periodically and routinely screen patients for substance use as well as for substance use dependence. Screening requires only two to four minutes.

Use the DAST to screen for drug use. This tool profiles the frequency of substance use behavior. Use the AUDIT-C alone or in combination with the CAGE to screen for alcohol use. AUDIT-C is designed to identify hazardous drinking and focuses on recent drinking behaviors. The CAGE is better at detecting alcohol dependence.

These screening tools and scoring instructions can be found at [http://www.projectcork.org/clinical_tools/index.html](http://www.projectcork.org/clinical_tools/index.html) a site developed and maintained by Dartmouth Medical School. Information about the Audit-C can be found at [http://www.cqaimh.org/pdf/tool_audtitc.pdf](http://www.cqaimh.org/pdf/tool_audtitc.pdf).

**Definitions:**

The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90% of America’s health plans to measure performance on important dimensions of care and service. Initiation and Engagement of Alcohol and Other Drug Dependence (IET) is a HEDIS measure. Members meet the measure by initiating treatment within 14 days of AOD diagnosis and have two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse and dependence on alcohol and illicit drugs.

**References:**


Adopted 12/05.

Revised 6/06, 4/08, 12/09, 04/11, 01/12, 8/14 Reviewed annually
Meets criteria for Bipolar Disorder

Assess for risk factors and level of care

Refer to appropriate level of care based on risk level

Does patient have manic or mixed symptoms?

Yes → Taking mania inducing medication?

Yes → Reduce or stop the medication

No → Taking mania inducing medication?

No → Initiate or adjust treatment with appropriate medication (Refer to med algorithm)

When in outpatient care reassess every 1-2 weeks for 6 weeks

Continued improvement

No → Assess medication adherence, and needed psychosocial interventions

Yes → Maximal level of improvement reached

Yes → Continue current treatment and monitor at least monthly for 3 months

If remains on an atypical antipsychotic please repeat lipid panel and blood glucose or HbA1c

No → Reassess diagnosis, Consider ECT

Obtain consult

Consider add/ change of medication and psychosocial intervention

If in higher level of care symptom reduction allows discharge to outpatient care

Responding to treatment?

No → Consider change or addition of medication

Yes → If started on a atypical antipsychotic please obtain baseline lipid panel and blood glucose or HbA1c

Yes → Continue to Maintenance Guideline

No → Continue current treatment and monitor at least monthly for 3 months

Reassess as needed based on LLOC and severity

Source: The World Federation of Societies of Biological Psychiatry (WFSBP) http://www.wfsbp.org/home

Guidelines for the Biological Treatment of Bipolar Disorders: Update 2012 on the long-term treatment of bipolar disorder

Adapted from the National Guideline Clearing House and the National Institute of Mental Health (NIMH)

Number of prior episodes

First episode-Mania

1st degree family history and/or severe episode

Yes

1st degree family history and/or severe episode

No

Maintenance treatment may not be needed

Second episode-One with Mania

1st degree family history and/or severe episode

Yes

1st degree family history and/or severe episode

No

Consider maintenance treatment

Third or more episode-at least one hypomania

Yes

Consider maintenance treatment

Maintenance treatment indicated

Maintenance initiated

% Reduction of pre maintenance episodes

100

>50%

<50%

<10%

Continue with preventive agent (PA)

Continue with PA and consider combination therapy

Consider new PA and combination therapy

Switch to new PA


Based on medications used follow recommended health screenings and monitoring such as blood glucose with SGA antipsychotics, kidney and thyroid function for Lithium
Major Depression Guideline for Initial Outpatient Treatment of Adults

Perform a diagnostic evaluation to include a full HPI (including “Why Now?”), previous psychiatric tx. Medical history, current and past medications, family history, substance use, etc. Clinical conforms to current DSM criteria for MDD

Assess for most appropriate LOC, accounting for safety/risk issues

Acute Phase:
The goal of tx. is Recovery = absence of symptoms and a return to full function.
- 1st F/U visit within 21 days
- At least 3 F/U visits within 84 days

Screen for SUD. Rule out medical conditions

Yes

Consider ECT, if tolerated

No

Consider other diagnoses, e.g.: dysthymia, bipolar, Substance use, etc.

Communicate findings and treatment plan to referring clinician.

Medication Management:
- Past or family HX of response
- Side Effect Profile
- Generic vs. Brand
- Maximize dose, if tolerated
- Adherence education

Psychotherapy:
Cognitive Behavioral, Interpersonal, supportive, problem solving, social skills, behavioral & psychodynamic therapies

Evaluate response & reassess progress with meds & psychotherapy at least monthly. If moderate improvement is not present within 8 weeks, review med adherence, need for med change, psychotherapy change.

Recovery or significant response?

Consider these actions:
- After 8-12 weeks of limited response, a new medication trial is indicated
- Review diagnosis
- Evaluate for substance use co-morbidity
- Begin augmentation/combination medication strategy*
- Consider ECT
- Referral for 2nd opinion

* If second generation antipsychotic is started obtain baseline lipid and blood glucose levels and retest in 3 months. Test yearly if long term use is indicated.

Maintenance Phase:
Continue Medication at optimal dose.
- 1st episode – 6 months
- 2nd episode – 2 to 3 years
- 3rd episode – indefinitely

Post Maintenance Phase:
Decision is whether to resume full dose, or less.

Taper Med?

Observe carefully for Sx recurrence.
If taper is successful and further visits are not indicated, Educate patient & family re: relapse risk & return of Sx. Consider handouts to reinforce learning

Maintain medication.
Management visits every 2-3 months.
If stability remains, consider referral to PCP for continued medication management and communicate with PCP

Communicate current status to PCP or referring physician

Sources:

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