Complete Summary

GUIDELINE TITLE

Practice parameter for the assessment and treatment of children and adolescents with attention-deficit/hyperactivity disorder.

BIBLIOGRAPHIC SOURCE(S)

Pliszka S, AACAP Work Group on Quality Issues. Practice parameter for the assessment and treatment of children and adolescents with attention-deficit/hyperactivity disorder. J Am Acad Child Adolesc Psychiatry 2007 Jul;46(7):894-921. [190 references] PubMed

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Practice parameters for the assessment and treatment of children, adolescents, and adults with attention-deficit/hyperactivity disorder. J Am Acad Child Adolesc Psychiatry 1997 Oct;36(10 Suppl):85S-121S.

** REGULATORY ALERT **

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- May 2, 2007, Antidepressant drugs: Update to the existing black box warning on the prescribing information on all antidepressant medications to include warnings about the increased risks of suicidal thinking and behavior in young adults ages 18 to 24 years old during the first one to two months of treatment.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Attention-deficit/hyperactivity disorder (ADHD)

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management
Screening
Treatment

CLINICAL SPECIALTY

Family Practice
Neurology
Pediatrics
Psychiatry
Psychology

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

To lay out evidence-based guidelines for the effective diagnosis and treatment of attention-deficit/hyperactivity disorder (ADHD)

TARGET POPULATION

Children (ages 3 to 12 years) and adolescents (ages 13 to 17 years) with attention-deficit/hyperactivity disorder

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnosis/Evaluation/Screening

1. Screening patients for attention-deficit/hyperactivity disorder (ADHD) as part of mental health assessment
2. Patient evaluation including interviews with parent and patient, obtaining information about patient's school or day care functioning, review of the patient's medical, social, and family histories
3. Psychological and neuropsychological tests if the patient's history suggests low cognitive ability or low academic achievements
4. Evaluation for comorbid psychiatric disorders

Management/Treatment

1. Development of comprehensive treatment plan
2. Parent and child psychoeducation about ADHD and its various treatment options
3. Psychopharmacological intervention including stimulants, atomoxetine, bupropion, tricyclic antidepressants, and alpha-agonists
4. Monitoring for treatment side effects
5. Psychosocial intervention (including behavior therapy) if indicated, in conjunction with medication treatment
6. Follow-up including assessment of the continued need for treatment and monitoring patient's height and weight

MAJOR OUTCOMES CONSIDERED

- Incidence of comorbid disorders
- Effectiveness of treatment
- Adverse effects of medication

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The list of references for this parameter was developed by searching PsycINFO, Medline, and Psychological Abstracts; by reviewing the bibliographies of book chapters and review articles; by asking colleagues for suggested source materials; and from the previous version of this parameter. The searches were conducted from September 2004 through April 2006 for articles in English using the key word "attention-deficit/hyperactivity disorder." The search covered the period 1996 to 2006 and yielded approximately 5,000 references. Recent authoritative reviews of literature, as well as recent treatment studies that were in press or presented at scientific meetings in the past 2 to 3 years, were given priority for inclusion. The titles and abstracts of the remaining references were reviewed for particular relevance and selected for inclusion when the reference appeared to inform

the field on the diagnosis and/or treatment of attention-deficit/hyperactivity disorder (ADHD).

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

The strength of the empirical evidence is rated in descending order as follows:

[rct] - *Randomized, controlled trial* is applied to studies in which subjects are randomly assigned to two or more treatment conditions.

[ct] - *Controlled trial* is applied to studies in which subjects are nonrandomly assigned to two or more treatment conditions.

[ut] - *Uncontrolled trial* is applied to studies in which subjects are assigned to one treatment condition.

[cs] - *Case series/report* is applied to a case series or a case report.

METHODS USED TO ANALYZE THE EVIDENCE

Review
Review of Published Meta-Analyses

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The American Academy of Child and Adolescent Psychiatry (AACAP) develops both patient-oriented and clinician-oriented practice parameters. Patient-oriented parameters provide recommendations to guide clinicians toward the best treatment practices. Treatment recommendations are based both on empirical evidence and clinical consensus, and are graded according to the strength of the empirical and clinical support (see the "Rating Scheme for the Strength of the Recommendation" field). Clinician-oriented parameters

provide clinicians with the information (stated as principles) needed to develop practice-based skills. Although empirical evidence may be available to support certain principles, principles are primarily based on expert opinion and clinical experience.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Recommendations for best treatment practices are stated in accordance with the strength of the underlying empirical and/or clinical support, as follows:

[MS] *Minimal standards* are recommendations that are based on rigorous empirical evidence (e.g., randomized, controlled trials) and/or overwhelming clinical consensus. Minimal standards are expected to apply >95% of the time (i.e., in almost all cases).

[CG] *Clinical guidelines* are recommendations that are based on empirical evidence and/or strong clinical consensus. Clinical guidelines apply approximately 75% of the time (i.e., in most cases). These practices should almost always be considered by the clinician, but there are significant exceptions to their universal application.

[OP] *Options* are practices that are acceptable, but not required. There may be insufficient empirical evidence and/or clinical consensus to support recommending these practices as minimal standards or clinical guidelines.

[NE] *Not endorsed* refers to practices that are known to be ineffective or contraindicated.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

This parameter was reviewed at the Member Forum at the Annual Meeting of the American Academy of Child and Adolescent Psychiatry (AACAP) in October 2005. From July 2006 to September 2006, this parameter was reviewed by a Consensus Group convened by the Work Group on Quality Issues.

This practice parameter was approved by the AACAP Council on October 18, 2006.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Definitions of the strength of the empirical evidence ratings (**rct**, **ct**, **ut**, **cs**) and the strength of the empirical and/or clinical support ratings (**MS, CG, OP, NE**) are provided at the end of the "Major Recommendations" field.

Screening

Recommendation 1. Screening for Attention-Deficit/Hyperactivity Disorder (ADHD) Should Be Part of Every Patient's Mental Health Assessment **[MS]**.

In any mental health assessment, the clinician should screen for ADHD by specifically asking questions regarding the major symptom domains of ADHD (inattention, impulsivity, and hyperactivity) and asking whether such symptoms cause impairment. These screening questions should be asked regardless of the nature of the chief complaint. Rating scales or specific questionnaires containing the Diagnostic and Statistical Manual (DSM) symptoms of ADHD can also be included in clinic/office registration materials to be completed by parents before visits or in the waiting room before the evaluation. If a parent reports that the patient suffers from any symptoms of ADHD that induce impairment or if the patient scores in the clinical range for ADHD symptoms on a rating scale, then a full evaluation for ADHD as set out in the next recommendation is indicated.

Evaluation

Recommendation 2. Evaluation of the Preschooler, Child, or Adolescent for ADHD Should Consist of Clinical Interviews with the Parent and Patient, Obtaining Information about the Patient's School or Day Care Functioning, Evaluation for Comorbid Psychiatric Disorders, and Review of the Patient's Medical, Social, and Family Histories **[MS]**.

The clinician should perform a detailed interview with the parent about each of the 18 ADHD symptoms listed in Diagnostic and Statistical Manual, Forth Edition (DSM-IV). For each symptom, the clinician should determine whether it is present as well as its duration, severity, and frequency. Age at onset of the symptoms should be assessed. The patient must have the required number of symptoms (at least six of nine of the inattention cluster and/or at least six of nine of the hyperactive/impulsive criteria, each occurring more days than not), a chronic course (symptoms do not remit for weeks or months at a time), and onset of symptoms during childhood. After all of the symptoms are assessed, the clinician should determine in which settings impairment occurs. Because most patients with ADHD have academic impairment, it is important to ask specific questions about this area. This is also an opportunity for the clinician to review the patient's academic/intellectual progress and look for symptoms of learning disorders (see Recommendation 4 bellow). DSM-IV requires impairment in at least two settings (home, school, or job) to meet criteria for the disorder, but clinical consensus agrees that severe impairment in one setting warrants treatment.

After reviewing the ADHD symptoms, the clinician should interview the parent regarding other common psychiatric disorders of childhood.

The parent should complete one of the many standardized behavior rating scales that have well-established normative values for children of a wide range of ages and genders. Scales in common use are listed in Table 1 of the original guideline document.

Family history and family functioning should be assessed. Because ADHD is highly heritable, a high prevalence of ADHD is likely to be found among the patient's parents and siblings.

Refer to the original guideline document for more information.

Recommendation 3. If the Patient's Medical History Is Unremarkable, Laboratory or Neurological Testing Is Not Indicated **[NE]**.

There are few medical conditions that "masquerade" as ADHD, and the vast majority of patients with ADHD will have an unremarkable medical history. The measurement of thyroid levels and thyroid-stimulating hormone should be considered only if symptoms of hyperthyroidism other than increased activity level are present.

Exposure to lead, either prenatally or during development, is associated with a number of neurocognitive impairments, including ADHD. If a patient has been raised in an older, inner-city environment where exposure to lead paint or plumbing is probable, then serum lead levels should be considered. Serum lead level should not be part of routine screening.

Unless there is strong evidence of such factors in the medical history, neurological studies (electroencephalography [EEG], magnetic resonance imaging, single-photon emission computed tomography [SPECT], or positron emission tomography [PET]) are not indicated for the evaluation of ADHD.

Recommendation 4. Psychological and Neuropsychological Tests Are Not Mandatory for the Diagnosis for ADHD, but Should Be Performed if the Patient's History Suggests Low General Cognitive Ability or Low Achievement in Language or Mathematics Relative to the Patient's Intellectual Ability **[OP]**.

The clinician must determine whether the academic impairment is secondary to the ADHD, if the patient has ADHD and a learning disorder, or if the patient has only a learning disorder and the patient's inattentiveness is secondary to the learning disorder.

Neuropsychological testing, speech-language assessments, and computerized testing of attention or inhibitory control are not required as part of a routine assessment for ADHD, but may be indicated by the findings of the standard psychological assessment.

Recommendation 5. The Clinician Must Evaluate the Patient with ADHD for the Presence of Comorbid Psychiatric Disorders **[MS]**.

The clinician must integrate the data obtained with regard to comorbid symptoms to determine whether the patient meets criteria for a separate

comorbid disorder in addition to ADHD, the comorbid disorder is the primary disorder and the patient's inattention or hyperactivity/impulsivity is directly caused by it, or the comorbid symptoms do not meet criteria for a separate disorder but represent secondary symptoms stemming from the ADHD.

When patients with ADHD meet full DSM-IV criteria for a second disorder, the clinician should generally assume the patient has two or more disorders and develop a treatment plan to address each comorbid disorder in addition to the ADHD.

Older adolescents with ADHD should be screened for substance abuse disorders, as they are at greater risk than teenagers without ADHD for smoking and alcohol and other illegal substance abuse disorders.

Treatment

Recommendation 6. A Well-Thought-Out and Comprehensive Treatment Plan Should Be Developed for the Patient with ADHD **[MS]**.

The patient's treatment plan should take account of ADHD as a chronic disorder and may consist of psychopharmacological and/or behavior therapy. This plan should take into account the most recent evidence concerning effective therapies as well as family preferences and concerns. This plan should include parental and child psychoeducation about ADHD and its various treatment options (medication and behavior therapy), linkage with community supports, and additional school resources as appropriate. The treatment plan should be reviewed regularly and modified if the patient's symptoms do not respond.

Recommendation 7. The Initial Psychopharmacological Treatment of ADHD Should Be a Trial with an Agent Approved by the Food and Drug Administration (FDA) for the Treatment of ADHD **[MS]**.

The following medications are approved by the FDA for the treatment of ADHD: dextroamphetamine (DEX), D- and D,L-methylphenidate (MPH), mixed salts amphetamine, and atomoxetine.

Refer to the original guideline document including Table 2 for detailed information on FDA-approved medications for ADHD treatment.

Recommendation 8. If None of the Above Agents Result in Satisfactory Treatment of the Patient with ADHD, the Clinician Should Undertake a Careful Review of the Diagnosis and Then Consider Behavior Therapy and/or the Use of Medications Not Approved by the FDA for the Treatment of ADHD **[CG]**.

If a patient fails to respond to trials of all of the agents listed in Recommendation 7 after an adequate length of time at appropriate doses for the agent as noted in Table 2 of the original guideline document, then the clinician should undertake a review of the patient's diagnosis of ADHD. This does not require the patient to be completely reevaluated, but the clinician should be certain of the accuracy of the history that led to the diagnosis of

ADHD and examine whether any undetected comorbid conditions are present, such as affective disorders, anxiety disorders, or subtle developmental disorders. The clinician should ascertain that these factors are not the primary problems impairing the patient's attention and impulse control. Primary care physicians should consider referral to a child and adolescent psychiatrist at this point.

Bupropion, tricyclic antidepressants (TCAs), and alpha-agonists are often used in the treatment of ADHD even though they are not approved by the FDA for this purpose.

Refer to the original guideline document including Table 3 for detailed information on agents used for ADHD not approved by FDA.

Recommendation 9. During a Psychopharmacological Intervention for ADHD, the Patient Should Be Monitored for Treatment-Emergent Side Effects **[MS]**.

Refer to the "Potential Harms" field for information regarding side effects of treatment.

Treating physicians should be familiar with the precautions and reported adverse events contained in product labeling. Strategies for dealing with side effects include monitoring, dose adjustment of the stimulant, switching to another stimulant, and adjunctive pharmacotherapy to treat the side effects. If one of these side effects emerges, then the physician should first assess the severity of the symptom and the burden it imposes on the patient. It is prudent to monitor side effects that do not compromise the patient's health or cause discomfort that interferes with functioning because many side effects of stimulants are transient in nature and may resolve without treatment. This approach is particularly valuable if the patient has had a robust behavioral response to the particular stimulant medication. If the side effect persists, then reduction of dose should be considered, although the physician may find that the dose that does not produce the side effect is not effective in the treatment of the ADHD. In this case the physician should initiate a trial of a different stimulant or a nonstimulant medication.

Recommendation 10. If a Patient With ADHD Has a Robust Response to Psychopharmacological Treatment and Subsequently Shows Normative Functioning in Academic, Family, and Social Functioning, Then Psychopharmacological Treatment of the ADHD Alone Is Satisfactory **[OP]**.

The data suggest that for ADHD patients without comorbidity who have a positive response to medication, adjunctive psychosocial intervention may not provide added benefit. Therefore, if a patient with ADHD shows full remission of symptoms and normative functioning, it is not mandatory that behavior therapy be added to the regimen, although parental preferences in this matter should be taken into account.

Recommendation 11. If a Patient with ADHD Has a Less Than Optimal Response to Medication, Has a Comorbid Disorder, or Experiences Stressors

in Family Life, Then Psychosocial Treatment in Conjunction with Medication Treatment Is Often Beneficial **[CG]**.

In contrast to the lack of an additive effect of behavioral and pharmacological treatment in children with ADHD alone, one study provided strong evidence that patients with ADHD and comorbid disorders and/or psychosocial stressors benefit from an adjunctive psychosocial intervention. The clinician should individualize the psychosocial intervention for each ADHD patient, applying it in those patients who can most benefit because of comorbidity or the presence of psychosocial stress.

Recommendation 12. Patients Should Be Assessed Periodically to Determine Whether There Is Continued Need for Treatment or If Symptoms Have Remitted. Treatment of ADHD Should Continue as Long as Symptoms Remain Present and Cause Impairment **[MS]**.

The patient with ADHD should have regular follow-up for medication adjustments to ensure that the medication is still effective, the dose is optimal, and side effects are clinically insignificant. For pharmacological interventions, follow-up should occur at least several times per year. The number and frequency of psychosocial interventions should be individualized as well. The procedures performed at each office visit will vary according to clinical need, but during the course of annual treatment, the clinician should review the child's behavioral and academic functioning; periodically assess height, weight, blood pressure, and pulse; and assess for the emergence of comorbid disorders and medical conditions. Psychoeducation should be provided on an ongoing basis. The need to initiate formal behavior therapy should be assessed and the effectiveness of any current behavior therapy should be reviewed.

If a patient with ADHD has been symptom free for at least 1 year, then inquiries should be made about whether the patient and family still think the medication provides a benefit. Signs that the ADHD has remitted include lack of any need to adjust dose despite robust growth, lack of deterioration when a dose of stimulant medication is missed, or new-found abilities to concentrate during drug holidays. Low-stress times such as vacations are a good time to attempt a withdrawal from medication, but parents should assign some cognitively demanding tasks (reading a book, practicing mathematics problems) to be sure that remission has occurred. The start of a new school year is not a good time to attempt a drug holiday, but once a patient's school routine is established, the medication can be withdrawn and teacher input solicited. Medication should be reinstituted if the patient, parents, or teachers report deterioration in functioning.

Recommendation 13. Patients Treated With Medication for ADHD Should Have Their Height and Weight Monitored Throughout Treatment **[MS]**.

In assessing for clinically significant growth reduction, it is recommended that serial plotting of height and weight on growth charts labeled with lines showing the major percentiles (5th, 10th, 25th, 50th, 75th, 90th, and 95th) be used. This should occur one to two times per year, and more frequently if practical. If the patient has a change in height or weight that crosses two

percentile lines, then this suggests an aberrant growth trajectory. In these cases a drug holiday should be considered if return of symptoms during weekends or summers does not lead to marked impairment of functioning. The clinician should also consider switching the patient to another ADHD medication. It is important for the clinician to carefully balance the benefits of medication treatment with the risks of small reductions in height gain, which as of yet have not been shown to be related to reductions in adult height.

Summary

The key to effective long-term management of the patient with ADHD is continuity of care with a clinician experienced in the treatment of ADHD. The frequency and duration of follow-up sessions should be individualized for each family and patient, depending on the severity of ADHD symptoms; the degree of comorbidity of other psychiatric illness; the response to treatment; and the degree of impairment in home, school, work, or peer-related activities. The clinician should establish an effective mechanism for receiving feedback from the family and other important informants in the patient's environment to be sure symptoms are well controlled and side effects are minimal. Although this parameter does not seek to set a formula for the method of follow-up, significant contact with the clinician should typically occur two to four times per year in cases of uncomplicated ADHD and up to weekly sessions at times of severe dysfunction or complications of treatment. Nothing in this parameter should be construed as justification for limiting clinician contact by third-party payers or for regarding more limited contact by the clinician as substandard when clinical evidence documents that the patient is functioning well.

Definitions:

Strength of the Empirical Evidence Ratings

[rct] - *Randomized, controlled trial* is applied to studies in which subjects are randomly assigned to two or more treatment conditions.

[ct] - *Controlled trial* is applied to studies in which subjects are nonrandomly assigned to two or more treatment conditions.

[ut] - *Uncontrolled trial* is applied to studies in which subjects are assigned to one treatment condition.

[cs] - *Case series/report* is applied to a case series or a case report.

Strength of the Empirical and/or Clinical Support Ratings

[MS] *Minimal standards* are recommendations that are based on rigorous empirical evidence (e.g., randomized, controlled trials) and/or overwhelming clinical consensus. Minimal standards are expected to apply >95% of the time (i.e., in almost all cases).

[CG] *Clinical guidelines* are recommendations that are based on empirical evidence and/or strong clinical consensus. Clinical guidelines apply approximately 75% of the time (i.e., in most cases). These practices should almost always be considered by the clinician, but there are significant exceptions to their universal application.

[OP] *Options* are practices that are acceptable, but not required. There may be insufficient empirical evidence and/or clinical consensus to support recommending these practices as minimal standards or clinical guidelines.

[NE] *Not endorsed* refers to practices that are known to be ineffective or contraindicated.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate assessment and treatment of children and adolescents with attention-deficit/hyperactivity disorder

POTENTIAL HARMS

Side Effects of Pharmacotherapy

- *Stimulants*: The most common side effects include appetite decrease, weight loss, insomnia, or headache. Less common side effects include tics and emotional lability/irritability. Stimulant treatment may also be associated with a reduction in expected height gain, at least in the first 1 to 3 years of treatment.
- *Atomoxetine*: Side effects of atomoxetine that occurred more often than those with placebo include gastrointestinal distress, sedation, and decreased appetite.
- The U.S. Food and Drug Administration (FDA) and its Pediatric Advisory Committee have reviewed data regarding psychiatric adverse events to medications for the treatment of attention deficit/hyperactivity disorder (ADHD). For each agent examined (all stimulants, atomoxetine, and modafinil), there were reports of rare events of toxic psychotic symptoms, specifically involving visual and

tactile hallucinations of insects. Symptoms of aggression, suicidality (but no completed suicides), and cardiovascular issues were also reported.

- *Bupropion* may cause mild insomnia or loss of appetite. Extremely high single doses (>400 mg) of bupropion may induce seizures even in patients without epilepsy.
- *Tricyclic Antidepressants (TCAs)* frequently cause anticholinergic side effects such as dry mouth, sedation, constipation, changes in vision, or tachycardia. Among the TCAs, desipramine should be used with extreme caution in children and adolescents because there have been reports of sudden death. For TCAs electrocardiography must be performed at baseline and after each dose increase. Once the patient is on a stable dose of the TCA, a plasma level should be obtained to ensure the level is not in the toxic range.
- *Alpha- agonists*: Side effects of alpha-agonists include sedation, dizziness, and possible hypotension. Abrupt discontinuations of alpha-agonist are to be avoided.
- *Combinations of Medications*: There have been four deaths reported to the FDA of children taking a combination of methylphenidate and clonidine, but there were many atypical aspects of these cases.

CONTRAINDICATIONS

CONTRAINDICATIONS

- Bupropion is contraindicated in patients with a current seizure disorder.
- The package insert for stimulants states that these medications should generally not be used in children and adolescents with preexisting heart disease or symptoms suggesting significant cardiovascular disease.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

American Academy of Child and Adolescent Psychiatry (AACAP) practice parameters are developed to assist clinicians in psychiatric decision making. These parameters are not intended to define the standard of care, nor should they be deemed inclusive of all proper methods of care or exclusive of other methods of care directed at obtaining the desired results. The ultimate judgment regarding the care of a particular patient must be made by the clinician in light of all of the circumstances presented by the patient and his or her family, the diagnostic and treatment options available, and available resources.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Pliszka S, AACAP Work Group on Quality Issues. Practice parameter for the assessment and treatment of children and adolescents with attention-deficit/hyperactivity disorder. J Am Acad Child Adolesc Psychiatry 2007 Jul;46(7):894-921. [190 references] PubMed

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1997 (revised 2007 Jul)

GUIDELINE DEVELOPER(S)

American Academy of Child and Adolescent Psychiatry - Medical Specialty Society

SOURCE(S) OF FUNDING

American Academy of Child and Adolescent Psychiatry

GUIDELINE COMMITTEE

Work Group on Quality Issues

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

This parameter was developed by Steven Pliszka, MD, principal author.

Work Group on Quality Issues Members: William Bernet, MD (Co-Chair); Oscar Bukstein, MD (Co-Chair); and Heather J. Walter, MD (Co-Chair); Valerie Arnold, MD; Joseph Beitchman, MD; R. Scott Benson, MD; Allan Chrisman, MD; Tiffany Farchione, MD; John Hamilton, MD; Helene Keable, MD; Joan Kinlan, MD; Jon McClellan, MD; David Rue, MD; Ulrich Schoettle, MD; Jon A. Shaw, MD; Saundra Stock, MD

AACAP Staff: Kristin Kroeger Ptakowski; Jennifer Medicus

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Dr. Pliszka receives or has received research support from, acted as a consultant to, and/or served on the speakers' bureaus of Shire, McNeil Pediatrics, and Eli Lilly.

Dr. Bukstein receives or has received research support from, acted as a consultant to, and/or served on the speakers' bureaus of Cephalon, Forest Pharmaceuticals, McNeil Pediatrics, Shire, Eli Lilly, and Novartis.

Drs. Bernet and Walter have no financial relationships to disclose.

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Practice parameters for the assessment and treatment of children, adolescents, and adults with attention-deficit/hyperactivity disorder. J Am Acad Child Adolesc Psychiatry 1997 Oct;36(10 Suppl):85S-121S.

GUIDELINE AVAILABILITY

Electronic copies: Available from the American Academy of Adolescent and Child Psychiatry (AACAP) Web site.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on June 30, 1998. The information was verified by the guideline developer on December 1, 1998. This NGC summary was updated by ECRI Institute on October 16, 2007.

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