BEHAVORIAL HEALTH DEPARTMENT – PRIMARY CARE CENTER AND FIREWEED TREATMENT GUIDELINES FOR
ADHD

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CBG Approval Date: 6/13/2006
PIC Approval Date: 7/6/2006

Executive Summary

Introduction and statement of Intent

This treatment guideline is intended to assist clinicians in the Behavioral Health department in treatment planning and service delivery for patients with Attention deficit Hyperactivity Disorder (ADHD). It may also assist clinicians treating patients who have some of the signs and symptoms of ADHD but who do not meet the full criteria or symptoms are accounted for by another disorder. The treatment guideline is not intended to cover every aspect of clinical practice, but to focus specifically on the treatment models, modalities, and/or referrals that clinicians in our outpatient treatment setting could provide. These guidelines were developed through a process of literature review and discussion amongst clinicians in the Behavioral Health department and represent a consensus recommendation for service provision for this disorder. The guideline is intended to inform both clinical and administrative practices with the explicit goals of outlining treatment that is: Effective, Efficient, Age Appropriate, Culturally Relevant, and Acceptable to clinicians, program managers, and patients and family

Definition of Disorder

Attention-Deficit Hyperactivity Disorder (ADHD) is defined as an individual having six or more symptoms of either inattention or hyperactivity, for at least six months, to the extent that it is not conducive and conflicting with developmental growth. Some of the symptoms that cause impairment must have been present before the age of seven. Symptoms must be present in two or more settings (home, work or school). There must be clear evidence of clinical significance showing impairment in social, academic, or occupational functioning. Symptoms cannot occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and must not be better accounted for by another mental disorder.

General Goals of treatment

As with treatment of all psychiatric illnesses, the goals of treatment are to reduce or eliminate symptoms and restore function. For ADHD, remission usually means that attention and distractibility are improved to the point that the individual can participate and develop, socially, academically, occupationally, and so on. Goals of treatment may include improvement in attention to the details that are necessary to sustain tasks or play activities through to completion. An organized and focused thought process with improved memory function combined with the ability to control impulses is indicative of ADHD symptom stability.

Summary of 1st, 2nd and 3rd line of treatment

ADHD treatment at this time varies according to different ages and/or severity and involves combinations of Parenting training, Family Therapy, or Individual Therapy, Psychoeductation and Medication Management.

For clients who are diagnosed with ADHD under the age of 12, the first line of treatment would be Family Therapy to address Parenting techniques and build skills such as limit setting, knowledge of appropriate developmental expectations/needs, creating a structured environment, etc. Clients from age 5-12 years would likely benefit from skills groups once parenting skills have been developed, creating a more stable home environment. The Young Families program may be a consideration for the children under the age of 5 and their families. Medication is not a first line treatment for children under the age of 5 as there are no specific guidelines and it is highly controversial. The decision to use medication as a treatment should be determined only after a psychiatric evaluation, on a case by case basis.

Group Therapy is the first line of treatment recommended for clients that range from 12 years of age through adulthood and have ADHD with symptoms in the mild to moderate severity range. These clients diagnosed with ADHD would benefit from groups focusing on development of social skills, increased structure, and affect regulation. Second line of treatment would be medication to help with reduction of symptoms, but preferably in conjunction with treatment to develop social skills, structure and affect

regulation. Individual Therapy would be the third line of treatment for those clients who are not appropriate for group or need some individual sessions to help prepare them for group.

Clients who are age 5 through adult, diagnosed with ADHD, but have symptoms in the moderate to severe range; the first line of treatment is a combination of medication management and individual therapy. The medication would address the severity, stabilizing the symptoms and the individual therapy would work on building the skills to increase daily functioning. Treatment would focus on developing skills for affect regulation, setting up an external system for maintaining structure, and increasing social appropriateness. Once the client is stabilized on medication and has learned some basic skills, he/she would transition into group therapy.

Note that while medication is frequently used in treatment of ADHD, parenting and environmental issues should be thoroughly investigated before using medication. Families that have a chaotic family structure or families at high risk of drug abuse would not be good choices for medication as a first line of treatment. It is also important to note that medication alone is not likely to solve the client's impaired functioning, psychosocial involvement is necessary. Psychoeducation for the patient and/or parent, and family regarding the diagnosis is essential for the most effective treatment.

Approaches for patients who do not respond to initial treatment

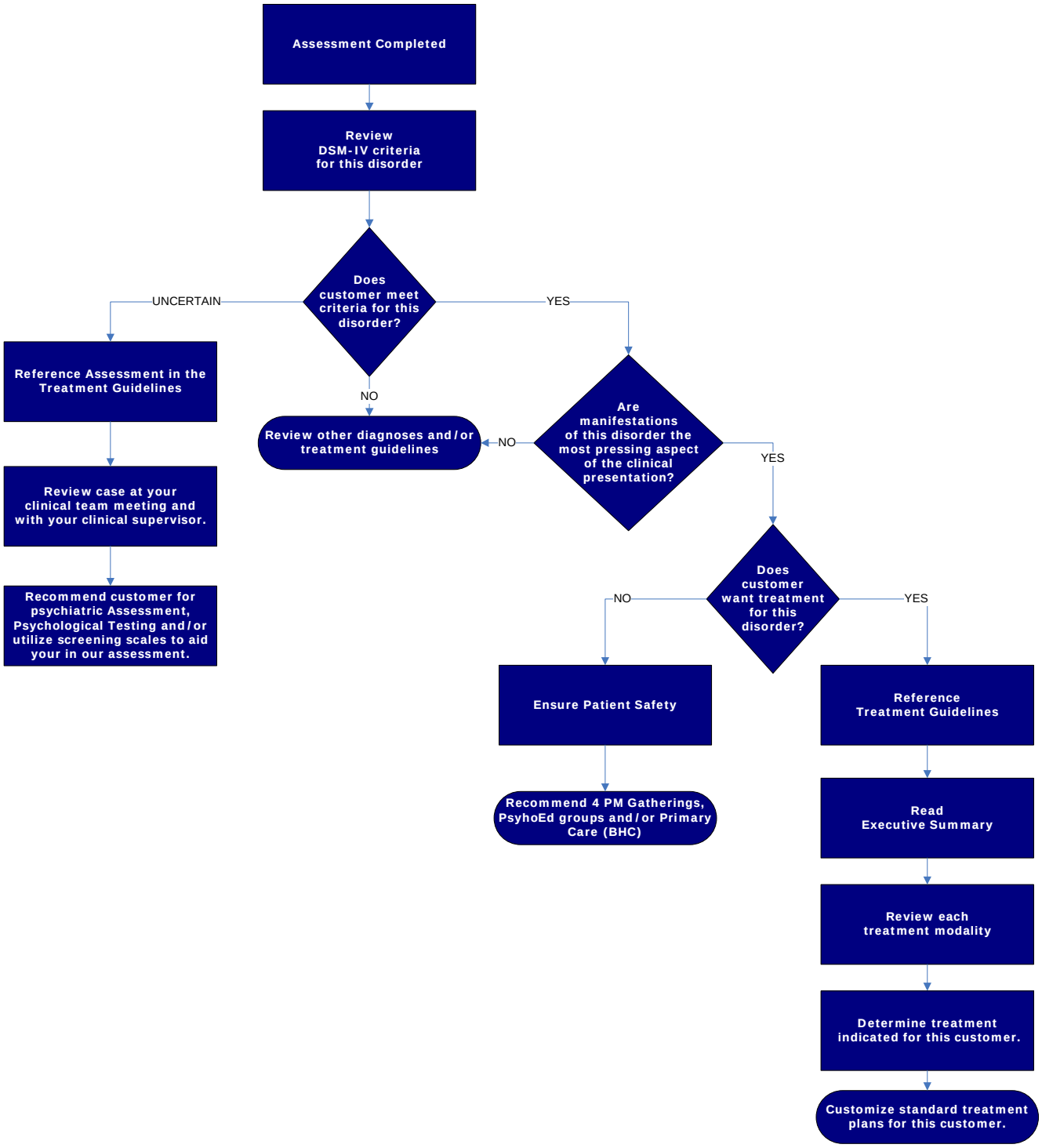
If a patient is not responding well to treatment, the level of compliance with the recommended treatment should be evaluated (i.e., if the client is a child, and the recommended treatment is a combination of parenting techniques and medication; are the parents following recommended parenting techniques? is the child taking his/her medication?). If not, address where the compliance difficulty lies and work on solving those issues. If the client is in compliance with the recommendations and treatment is still not effective, re-evaluation of the diagnosis is recommended. This re-evaluation may include a referral for psychological testing. The client may have a different diagnosis that has similar symptoms or there may be a co-occurring disorder that also needs treatment.

Clinical and demographic issues that influence treatment planning

The prevalence of Attention Deficit/Hyperactivity Disorder (ADHD) is about 3-5 of all school age children and probably 30-50% of all the child mental health referrals. There are approximately twice as many boys diagnosed as girls and about 10-60% of these children will continue to have symptoms in adulthood. The etiology for ADHD is generally considered both neurological and genetic; with approximately 65% of children having ADHD also have a relative with ADHD. It's estimated that about 1/3 of the children diagnosed with ADHD have co-occurring disorders. Common disorders which co-occur are Conduct D/O, Oppositional Defiant D/O, Antisocial Personality, and Substance Abuse D/O.

There are several factors that make diagnosing ADHD difficult. Several disorders have similar symptoms, such as Anxiety, Depression (agitation type), Learning Disorders, and Post Traumatic Stress, as well as Conduct, Oppositional Defiant and Intermittent Explosive. There are also different presentations for boys and girls. Boys tend to be more hyperactive and have more behavioral problems. Girls tend to fall in the category of inattentive, with more social problems or getting lost in their own world.

Flow Diagram



Assessment

The Diagnostic Testing team will be reviewing and commenting on the Psychological Testing column for every disorder.

	Psychiatric Assessment	Psychological Testing	Screening/Scales
Indications	▪ Diagnostic dilemma or clarification of co-morbidity ▪ Unmanageable behavior or other symptoms that have not improved with standard interventions ▪ Patients are already on psychotropic medication and is requesting continuation ▪ Patient or guardian requests a second opinion or wishes to consider pharmacologic intervention ▪ Rule out organic cause and/or contributions to symptoms	▪ Diagnostic clarification following assessment by provider in FMC or PEDS. ▪ Ensure psychiatric eval for adults prior to psychological testing. ▪ Question only answerable by psychological testing ▪ Appropriate physical assessment completed	• Establish baseline and/or monitor treatment effectiveness • Clarify symptoms • Recommend baseline screenings be completed in FMC and PEDS.
Contraindications	▪ Diagnosed severe cognitive disorder or developmental delay and collateral source not available ▪ Consent not available (if patient has guardian) ▪ Patient or guardian has forensic rather than therapeutic goal (i.e. compliance with court or parole requirements, disability determination, etc.)	▪ Extremely dangerous to self and/or others ▪ Untreated psychosis ▪ Initial evaluation / assessment is not done ▪ Referral question not answerable and/or not clear ▪ Any physical causes of the disorder have not been ruled out ▪ School or other source has already conducted psychological testing within the last year (relative contra-indication) ▪ Severely depressed ▪ Limited English proficiency.	▪ Limited English proficiency. (relative contra-indication) ▪ Lack of cooperation
Structure	In patients with cognitive impairment who cannot give adequate history, parent or guardian with knowledge of the patient's history must be available for assessment.	▪ Depends on the referral question	▪ Self-administered for adults and adolescents ▪ Completed by Parent and/or care giver for children or incompetent adults.

Modalities & Treatment Models

Group Therapy

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ Customer is 5 years old or older ▪ Mild to moderate severity ▪ Able to tolerate affect without behavior destructive to group ▪ Sufficient verbal and/or cognitive ability to benefit from treatment ▪ For customers under 18 years old, parental education and involvement is predictive of good outcome and should be integrated whenever possible.	▪ Dangerousness to self or others ▪ Lack of commitment from customer and if customer not competent ▪ Sexually acting out behaviors ▪ Court ordered treatment with no buy in from child and/or guardian ▪ Child abuse investigation incomplete ▪ Untreated Psychosis or mania ▪ History of chronic or extreme disruptive behavior in groups ▪ Untreated substance dependence ▪ Acute intoxication or withdrawal from alcohol or other substances	• Diagnosis social phobia (May need individual therapy for group preparation) • Relatives or significant others in the same group (unless it is a family group and/or couples group) • Meets CMI or SED criteria without receiving rehab services • lack of commitment from parent and/or legal guardian

STRUCTURE

- Groups will be facilitated by a Master's Level Therapist and Case Manager
- For 17 years old and below, some age grouping recommended
- For 18 years old and above consider adult services

Duration	60 to 90 minutes for 10 to 15 weeks
Frequency	Once a week
Size	▪ 3 to 9 years old 4 customers per provider ▪ 10 years old and over 8 to 10 customers per provider
Open vs. Closed	Open or Closed with windows

TREATMENT MODEL

- Group Support
- Social Skills Training

Individual Therapy

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
• Group therapy contraindicated • Customer is 5 years old or older • Moderate to Severe severity • Sufficient verbal and/or cognitive ability to benefit from treatment • Unable to tolerate affect without behavior destructive to group • Recent sexual, physical, abuse and/or neglect • For customers under 18 years old, parental education and involvement is predictive of good outcome and should be integrated whenever possible.	▪ Imminent dangerousness to self or others ▪ Lack of commitment from customer and if customer not competent. ▪ Court ordered treatment with no buy in from child and/or guardian ▪ Child abuse investigation incomplete ▪ Untreated Psychosis or mania ▪ Acute intoxication or withdrawal from alcohol or other substances	▪ Lack of commitment from parent and/or legal guardian (case by case basis)

STRUCTURE

Duration	60 minutes
Frequency	▪ Weekly or Twice a Month ▪ Up to 8 sessions for treatment

TREATMENT MODEL

- Consider Young Families for anyone under 5 years old
- Medication
- Cognitive Behavioral Therapy
- Psychotherapy
- Neurocognitive Therapy
- Cognitive Rehabilitation

Family Therapy / Couples Therapy

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ First line of treatment for 0 to 5 year old ▪ Disorder is impacting the family and/or relationship ▪ Family dynamic exacerbating or triggering symptoms ▪ Sufficient verbal and/or cognitive ability to benefit from treatment ▪ For customers under 18 years old, parental education and involvement is predictive of good outcome and should be integrated whenever possible. ▪ Concurrent with group and/or individual treatment for children or adults with severe mental illness	▪ Imminent dangerousness to self or others ▪ Lack of commitment from customer and if customer not competent, lack of commitment from parent and/or legal guardian ▪ Court ordered treatment with no buy in from child and/or guardian ▪ Active child abuse investigation incomplete (OCS involvement does not preclude family therapy) ▪ Current Domestic violence or abuse of child ▪ Untreated Psychosis ▪ Acute intoxication or withdrawal from alcohol or other substances	▪ Custody dispute

STRUCTURE

Duration	60 minutes
Frequency	▪ Weekly or Twice a Month ▪ Up to 8 sessions for treatment

TREATMENT MODEL

- When Parenting is not sufficient, Family Therapy is highly recommended (with or without child at the discretion of the clinician).
- Medication
- Cognitive Behavioral Therapy
- Systemic Therapy
- Behavioral Therapy
- Social Skills Training
- Parenting Skills Training

Individual Medication Management (5 to 8 years old)

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ Parent and/or legal guardian consent ▪ Current biopsychosocial intake or psychiatric assessment is available.	▪ Refuses Medication Management ▪ Disorder is caused by an untreated physiological disorder. ▪ Stimulants: psychotic symptoms, tics, or any medical condition precluding use of sympathomimetics.	▪ Refuses Medication Management ▪ Disorder is caused by an untreated physiological disorder

STRUCTURE

Obtain ADHD symptoms checklist completed by parent.

Duration	30 minutes
Frequency	Weekly tapering to monthly with symptom stabilization

TREATMENT MODEL

Treatment with medication of children under 5 years old is highly controversial, there are no specific guidelines or protocols; a psychiatric evaluation is essential.

Recommended concurrent Structured Behavioral Modification, individual psychotherapy, psychoedcation, parent counseling, and Psychopharmacology education.

Psychopharmacology recommendations

- First Line – Able to swallow tablets: Methylphenidate (Ritalin), Amphetamine/dextroamphetamine (Adderall).
- If tolerated well, switch to Methylphenidate ER Concerta) or Amphetamine/dextroamphetamine XR (Adderall XR).
- Not able to swallow tablets: Fluoxetine (Prozac)
- Second Line – Bupropion (Wellbutrin) or Fluoxetine (Prozac)
- Third line – Atomoxetine (Strattera), Clonidine (Catapres), or Guanfacine HCL (Tenex), Mentadate

**Tenex and Mentadate are not on the SCF formulary.*
**Adderall, Ritalin,Cylert, and Strattera are FDA approved for treatment of children with ADHD.*
**Wellbutrin, prozac, catapress, and tenex are not FDA approved for treatment of children with ADHD, but are proven effective in symptom control.*

If customer is not responding to treatment, re-evaluate, change diagnosis and/or identify multiple diagnosis requiring several different medications.

Individual Medication Management (8 to 18 years old)

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ Parent and/or legal guardian consent ▪ Current biopsychosocial intake or psychiatric assessment is available	▪ Parent and/or legal guardian consent ▪ Current biopsychosocial intake or psychiatric assessment is not available	▪ Refuses Medication Management ▪ Disorder is caused by an untreated physiological disorder.

STRUCTURE

- Obtain ADHD symptoms checklist completed by parent.
- Obtain ADHD symptoms checklist completed by older children/adolescent.

Duration	30 minutes
Frequency	Weekly tapering to monthly with symptom stabilization

TREATMENT MODEL

Recommended concurrent Structured Behavioral Modification, individual psychotherapy, psychoedcation, parent counseling, and psychopharmacology education.

Psychopharmacology Recommendations

- First Line – Concerta or Adderall
- Second Line – Wellbutrin or Prozac
- Third line – Strattera, Catapres, or Tenex

**Concerta, Adderall, and Strattera are FDA approved for treatment of children/adolescents with ADHD.*
**Wellbutrin, Prozac, catapress, and tenex are not FDA approved for treatment of children/adolescents with ADHD but are proven effective in symptom control.*

If customer is not responding to treatment, re-evaluate, change diagnosis and/or identify multiple diagnosis requiring several different medications.

Individual Medication Management (Over 18 years old)

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ Parent and/or legal guardian consent ▪ Current biopsychosocial intake or psychiatric assessment is available	▪ Refuses Medication Management ▪ Disorder is caused by an untreated physiological disorder. ▪ Stimulants: psychotic symptoms, tics, or any medical condition precluding use of sympathomimetics.	▪ Refuses Medication Management ▪ Disorder is caused by an untreated physiological disorder.

STRUCTURE

- Obtain ADHD symptoms checklist completed by parent.
- Obtain ADHD symptoms checklist completed by older children/adolescent.

Duration	30 minutes
Frequency	Weekly tapering to monthly with symptom stabilization

TREATMENT MODEL

Recommended concurrent Structured Behavioral Modification, individual psychotherapy, psychoedcation, parent counseling, and psychopharmacology education.

Psychopharmacology Recommendations

- First Line with SA in history – Bupropion SR (Wellbutrin SR), Venlafaxine ER (Effexor ER), Atomoxetine (Strattera).
- First Line without SA in history – Methylphenidate SR, (Ritalin SR), Amphetamine/dextroamphetamine XR (Adderall XR), Dextroamphetamine (Dexadrine).
- Second Line – Desipramine (Norpramin), Imipramine (Tofranil), Amitriptyline (Elavil).
- Third line – Clonidine (Catapress).

**The only FDA approved drug for adults with ADHD is Atomoxetine (Strattera).*
**Wellbutrin, effexor, Ritalin, adderall, norpramin, elavil, and catapress are not FDA approved for treatment of adult with ADHD but have prioven effective in symptom control.*

*If customer is not responding to treatment, r*e-evaluate, change diagnosis and/or identify multiple diagnosis requiring several different medications. Antidepressants and antipsychotic medications might be considered in exceptional circumstances.

Group Medication Management

Need for parent and/or guardian presence makes group medication management impractical for customers 0 to 18 years old.

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ If symptoms stable and patient cannot return to primary care for maintenance treatment, group medication management should be considered. ▪ History of non-compliance ▪ Able to tolerate affect without behavior destructive to group ▪ Frequently misses scheduled appointments	▪ Acute dangerousness to self or others ▪ Untreated psychosis ▪ Sexually acting out behaviors ▪ No child care available ▪ Severe untreated hyperactivity	• Diagnosis social phobia (May need individual therapy for group preparation) • Relatives or significant others in the same group (unless it is a family group and/or couples group) • Meets CMI or SED criteria without receiving rehab services

STRUCTURE

Groups will be facilitated by a Master's Level Therapist and Case Manager

Duration	60 minutes
Frequency	Once a week
Size	8 to 10 customers per clinician
Open vs. Closed	Open

TREATMENT MODEL

Behavioral Modification, psychoeducation, and psychopharmacology education.

Psycho Educational Groups

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ Sufficient verbal and/or cognitive ability to benefit from treatment ▪ Able to tolerate affect without behavior destructive to group ▪ Could benefit from skills development	▪ Dangerousness to self or others ▪ Sexually acting out behaviors ▪ Untreated Psychosis or mania ▪ History of chronic or extreme disruptive behavior in groups ▪ Untreated substance dependence ▪ Severe untreated hyperactivity	

STRUCTURE

Groups will be facilitated by 1 to 2 Case Managers.

Duration	60 to 90 minutes for up to 8 weeks
Frequency	Once a week
Open vs. Closed	Open

TREATMENT MODEL

Psycho-educational groups would be behavior modification in nature, with information for developing parenting skills and social skills.

Case Management

All Ages	
Assessment	▪ Collect psychosocial history ▪ Collect collateral history and/or past treatment records ▪ Obtain patient and/or guardian consent ▪ Liaison with outside agencies and/or link to community resources ▪ Administer standardized scales ▪ Lead orientation to services ▪ Review and/or conduct client initial screening and triage
Treatment	▪ Psychosocial education ▪ Maintain supportive contact ▪ Triage current clients in crisis ▪ Crisis management (e.g. triage, risk assessment, skills coaching, referrals when needed) ▪ Community liaison work and coordination of care ▪ Manage charts ▪ Provide aspects of treatment ▪ Assist with group preparation ▪ Draft treatment plans ▪ Follow-up when customer fails to keep appointments. ▪ Encourage medication and treatment compliance
Follow-up	▪ Liaison with outside agencies ▪ Link to community resources ▪ Gather and disseminate information from external referral sources

Referral

INDICATIONS

- Services needed are not available within the Behavioral Health department.
- Diagnostic clarification needed for initial diagnosis of ADHD

CONTRAINDICATIONS

Meets criteria for treatment within the Behavioral Health department system

Primary Care

INDICATIONS

- Initial screening and diagnosis done in FMC and PEDS
- Refuses specialty mental health care
- Uncomplicated Medication Management
- Maintenance Medication Management

CONTRAINDICATIONS

Higher intensity services needed to ensure safety to patient or others

Appendix A: Glossary

Term or Acronym	Term Definition
Acute Intoxication	A reversible substance-specific syndrome due to recent ingestion of (or exposure to) a substance. Clinically significant maladaptive behavior or psychological changes that are due to the effect of the substance on the central nervous system and develop during or shortly after use of the substance. (Adapted from DSM-IV)
Acute Withdrawal	A substance-specific syndrome due to the cessation of (or reduction in) substance use that has been heavy and prolonged. (Adapted from DSM-IV)
CBT	Cognitive Behavioral Therapy
Closed Group	Customers may enter only at initial formation of group.
Closed Group with Windows	Customer enrollment available intermittently
Eclipse	Overshadow, for example, when the symptoms and dysfunction related to one disorder overshadow another making treatment of one more pressing.
Exposure Therapy	Exposure therapy (Haug et al, 2003) with or without response inhibition is most cited as effective for specific phobia, obsessive compulsive disorder and PTSD. Generally, these run 10 -12 sessions with each session targeting a specific skill, exposure level and cognitive reframing. Manuals are available to guide clinical work.
Intervention	Any thoughtful action taken by a clinician or customer with the purpose of addressing a perceived problem or therapeutic goal
IPT	Interpersonal Therapy
NOS	Not Otherwise Specified
Open Group	Participants can enter at any time.
PDD	Pervasive Developmental Disorder
Play Therapy	Play therapy is a form of psychotherapy for children who have been traumatized. It encourages children to explore their emotions and conflicts through play, rather than verbal expression.
Psychiatric Assessment	Formal assessment by a psychiatrist or ANP
Psychoeducation	teaching and training about the disease or problem for which the customer or family member is seeking treatment. Psychoeducation is frequently presumed to be part of all forms of assessment and treatment, yet additional interventions that emphasize education about an illness are often shown to improve outcomes over treatment as usual. Psychoeducation can be incorporated into many treatments, but can be viewed as an intervention in its own right and can be delivered by non-professional staff such as case managers or health educators.
Psychological Testing	Formal psychological assessment which includes clinical interview and appropriate tests conducted by a psychologist and/or psychometrician. This testing is standardized and normed.
Screening/Scales	Brief, easily administered screening and scales which do not require advance training to interpret.
Social Rhythm Therapy	A structured psychotherapy combining elements of behavioral therapy and psychoeducation and shown to reduce rates of relapse and rehospitalization in bipolar disorder

Term or Acronym	Term Definition
Structural Family Therapy (SFT)	Structural Family Therapy is model of treatment in which a family is viewed as a system with interdependent parts. In this treatment model, the family system is understood in terms of the repetitive patterns of interaction between the parts. From such a perspective, the goal of structural family therapy is to identify maladaptive or ineffective patterns of interactions, then alter them to improve functioning of the subparts and the whole.
TBI	Traumatic Brain Injury
Treatment Modality	For purposes of this guideline, we have defined "modality" as the structure in which the customer receives treatment, for example, individual psychotherapy, group psychotherapy, or psychoeducation.
Treatment Model	For purposes of this guideline, we have defined the "model" of care as the underlying theoretical approach to clinical intervention, for example, Cognitive Behavioral Therapy, Insight Oriented Therapy, Interpersonal Therapy.
Untreated Psychosis	For the purposes of this treatment guideline, we define untreated psychosis as psychotic symptoms that are prominent, disruptive in some way, and for which the customer is not accepting or engaging in care that would mitigate such symptoms. The diagnosis of a psychotic disorder or the presence of psychotic symptoms at some point in the course of illness or treatment should not be a barrier to participation in treatment that might be helpful. However, nor should a customer with a significant psychotic disorder be treated with some forms of psychotherapy from which they are not likely to benefit. Clinical judgment will be needed in selecting appropriate treatment for each customer.
Untreated Substance Dependence	Because "dual diagnosis" is the norm, rather than the exception in behavioral health settings, customers with substance abuse problems should not be excluded, a priori, from participation in treatment for other mental health conditions. However, the impact of their substance use on their capacity to participate in treatment must be assessed on an ongoing basis. Customers with current substance dependence may not be appropriate candidates for some forms of treatment.

Appendix B: Literature Summary

Evidence Based Clinical Guidelines
Southcentral Foundation Research Project
Summary Sheet
Attention Deficit/Hyperactivity Disorder

Diagnosis: This summary contains reviewed articles around **Attention Deficit/Hyperactivity Disorder.**

314. **Attention Deficit/Hyperactivity**: This disorder is constructed on two parts: Inattention consisting of problems with listening, following through with instructions, problems organizing and being easily distracted and Hyperactivity consisting of problems with impulsivity, fidgeting, difficulty waiting turns and frequent interruptions. There are three subtypes: Combined Type, Predominantly Inattentive, Predominantly Hyperactive-Impulsive Type.

General Information: This review searched the following data bases: Cochrane Reviews, American Psychological Association, American Psychiatric Association, The Journal of Empirical Mental Health, The National Guideline Clearinghouse, The Texas Algorithm Project, The Harvard Algorithm Project and SAMHSA, NIMH and Mental Health. The keywords for this search were: ADHD, ADD. Attention Deficit, Hyperactivity, group therapy, group psychotherapy, evidence-based, empirically supported treatments/therapies/interventions, reviews, and Boolean combinations of such terms.

This search produced significant hits from which a selected group is included. This does not represent a thorough investigation of the literature. There exist no formal evidence based protocol rather strongly support clinical guidelines, some empirically supported interventions and some best practices. This category of disorder necessitates clear assessment, differential diagnostic skills and anchored measurements of symptoms in order to benefit maximally from interventions. The National Consensus Report on ADHD by NIMH in 1998 noted that while the core symptoms can be addressed, academic improvement is generally flat and that mostly reading scores modestly improve.

Group Therapy and ADHD: The Multimodal Treatment Study for ADHD sponsored by National Institute of Mental Health provides the greatest data on this review and this section. The MAT Comparative group (1999) noted that group family treatment focusing on parent training was instituted. The groups consisted of six families per group. While this component (family/parent training) did not affect changes in the ADHD core symptoms greater than medication or behavioral therapy or combination, it did significantly improve prosocial functioning and decreased oppositionality. No other references rose to the level of empirically or evidence based for the use of group therapy. The MTA study, using Pelham's protocol for summer daily therapy at camp would presuppose group activities, socialization skills development, and environmental feedback sessions. Farmer et al., (2002) cites support for parent training, outpatient therapy using modified CBT and school based treatments. She cites that multifamily therapy has some evidence.
Individual Therapy and ADHD: Root and Resnick (2003) citing a MTA update confirm that behavioral therapy is generally not seen as effective as medication or combination therapy. Individual skills development is facilitated by not necessary according to research therein cited. They also cite critique of the conclusions of medication superiority by other researchers. Nevertheless, the majority of studies reviewed noted the essential application of medication management for acute and moderate to severe cases of ADHD. Owen and Hinshaw et al., (2003) provide an insightful extension to the MTA by asking which of the MTA components (medications, behavioral management interventions, combinations, community support) provides best functional and symptom improvement for which segment of the population under which conditions. Of the numerous pieces, one most salient is that behavioral interventions including parent training and therapy with medications were significantly more effective in social skill acquisition as rated by teachers. Behavioral treatment proved equal to medication in reduction of anxiety based ADHD complications. Therefore, behavioral management, in particular, contingency management behavioral interventions have strong evidence of being effective. Farmer also notes that case management is effective and the combination of child focused and family focused interventions are most effective. Social skill training was supported also.

Brief Therapy Models and ADHD: No brief therapy models were noted. The MTA did titrate the BEH over the 28 days and therefore one could think that some of the component, particularly the parent training fell within the less than 20 sessions.

Professional Status in Brief Therapy: Behavioral management can be supported by trained individuals and educators. Much of the school based protocol and work is organized and conducted by educators instead of credentialed mental health workers. Diagnosis must be made by a credentialed professional and not by school workers or teachers. Case management and parent trainers could be trained with the curricula, information and application of behavioral management principles to be effective.

Structure of most (Brief) Therapy: Individual teachers, parent. Some parent training in groups

Multi-Cultural Considerations: The literature on multi-cultural adaptation of evidence based treatments was less than complimentary. Nagayama Hall, 2001, reviewing the empirically supported literature plainly states: "there is not adequate empirical evidence that any of these empirically support therapies is effective with ethnic minority populations" (p.502). Bernal and Scharron-Del-Rio, (2001) earlier noted the same conclusion and called for a more "pluralistic" methodology in developing evidence based and culturally sensitive treatments. The interpretation of impulsivity, attention and disruption are surely culturally bound. While there is not any specific literature that arose in this brief summary, the definition of ADHD being disruptive in at least two circumstances would cast cultural interpretation and assessment in a stronger light. Arnold, Elliiott and Sachs et al, (2003) note that minority children need more behavioral therapy and respond to combination treatment.

Pharmacological Interventions: Rivas-Vazquez et al, (2003) reviewed the use of Stratter for ADHD. He concludes that it is safe and effective for children, adolescents and adults with ADHD symptoms. He also notes that it lacks the street value of some stimulant medications. Methylphenidate, Concerta and other stimulant medications remain the mainstays for medication management (Brown, 2002; NationaL Guideline 2002). Other drugs used are Wellbutrin, some tricyclics. SSRI have not shown efficacy in targeting the main symptoms.

Manuals: None

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Appendix C: Sample Treatment Plans

Treatment Plan for Attention Deficit / Hyperactivity Disorder (ADHD)

Problem #1:
ADHD

As evidenced by:
- Short attention span; difficulty sustaining attention on a consistent basis
- Susceptibility to distraction by extraneous stimuli
- Impression that the customer is not listening well
- Repeated failure to follow through on instructions, or complete school assignments, chores, or job responsibilities in a timely manner
- Poor organizational skills as demonstrated by forgetfulness, inattention to details, and losing things necessary for tasks
- Hyperactivity as evidenced by high energy level, restlessness, difficulty sitting still, or loud or excessive talking
- Impulsivity as evidenced by difficulty awaiting his/her turn in group situations, blurting our answers to questions before the questions have been completed, and frequent intrusions into others personal business
- Frequent disruptive, aggressive, or negative attention-seeking behaviors
- Tendency to engage in careless or potentially dangerous activities from ___ % participation to ___ % participation
- Difficulty accepting responsibility for actions, projecting blame for problems onto others, and failing to learn from experience
- Low self-esteem and poor social skills

Goals:
1. Sustain attention and concentration for consistently longer periods of time from __ minutes to __ minutes
2. Increase the frequency of n-task behaviors as manifested by regular completion of school assignments, chores, and work responsibilities from ____ # assignments completed to ___ # assignments completed
3. Demonstrated marked improvement in impulse control as evidenced by a significant reduction in aggressive, disruptive, and negative attention seeking behaviors from ___ # altercations per week to ___ # altercations per week
4. Regularly take medication as prescribed to decrease impulsivity, hyperactivity, and distractibility.
5. The parents and/or teachers successfully utilize reward system, contingency contract, or token economy to reinforce positive behaviors and deter negative behaviors.
6. The parents set firm, consistent limits and maintain appropriate parent-child boundaries.
7. Improve self esteem as evidenced by an increase in positive self-statements nd participation in extracurricular activities.
8. Maintain lasting peer friendships
9. Maintain relationships with spouse and family members
10. Demonstrate patience, empathy and appropriate limit setting in roles as parent.

Objectives:
1. Increase participation in extracurricular activities or positive peer group activities.
2. Decrease the motor activity as evidenced by the ability to sit still for longer periods of time.
3. Teachers, spouse and/or supervisors reinforce on-task behaviors, completion of school assignments, and good impulse control.
4. Teachers spouse and/or supervisors schedule breaks between intensive instructional periods and alternate complex activities with less stressful activities to sustain the customer's interest and attention.
5. The parents set firm limits and use natural, logical consequences to deter the customer's impulsive behaviors.
6. Increase the frequency of customer's positive self-statements.
7. Decrease the frequency of arguments and physical fights with his/her siblings, other family members and/or co-workers.
8. Increase verbalization by the customer in which he/she accepts responsibility for misbehavior.

9. Reduce the frequency and severity of temper outbursts, acting-out, and aggressive behaviors.
10. Complete psychological testing to rule out emotional factors or learning disabilities as the basis for maladaptive behavior.
11. Increase positive interactions with peers.
12. Establish a routine schedule to help complete homework, chores, and household responsibilities.
13. The parents identify and utilize a variety of effective reinforces to increase the customer's positive behaviors.
14. Teachers utilize a listening buddy who sits next to the customer in the classroom to quietly answer questions or repeat instructions.
15. The parents maintain communication with the school to increase the customer's compliance with completion of school assignments.
16. The parents and teachers reduce extraneous stimuli as much as possible when giving directions to the customer.
17. Complete psychological testing to confirm the diagnosis of ADHD.
18. Increase on-task behaviors as evidenced by greater completion of school assignments, chores and work responsibilities.
19. Begin to take prescribed medication as directed by the physician.
20. The customer and his/her parents comply with the implementation of a reward system or contingency contract.
21. The parents increase praise and positive verbalizations toward the customer.
22. The parents develop and utilize an organized system to keep track of shool assignments, chores, and work responsibilities.

Therapeutic Interventions:

1. Encourage the customer's parents or spouse to participate in an ADHD support group.
2. Encourage the parents to utilize natural, logical consequences for the customer's disruptive and negative attention-seeking behaviors.
3. Identify and reinforce positive behaviors to assist the customer in establishing and maintaining friendships.
4. Encourage the customer to participate in extracurricular or positive peer group activities to improve his/her social skills.
5. Arrange for the customer to attend group therapy to build social skills.
6. Encourage the customer to use self-monitoring checklists to improve attention, work or academic performance and social skills.
7. Conduct family therapy sessions to assist the parents in establishing clearly identified rules and boundaries.
8. Design a reward system and/or contract to reinforce desired positive behaviors and deter impulsive behaviors.
9. Arrange for appropriate follow-up (i.e. appointment with psychiatrist, pediatrics or family medicine)
10. Design a behavior modification program for the classroom or workspace to improve the customer's academic or work performance, social skills, and impulse control.
11. Assign the customer's parents to read 1-2-3 Magic (Phelan) and process the reading with the therapist.
12. Assist the parents or adult customer, in developing a routine schedule to increase the customer's compliance with school, household or work related responsibilities.
13. Identify a variety of positive reinforcers or rewards to maintain the customer's interest or motivation.
14. Educate the customer's parents and siblings about the symptoms of ADHD.
15. Teach the customer effective problem-solving skills (i.e. identify the problem, brainstorm alternative solutions, select an option, implement a course of action, and evaluate.)
16. Monitor the customer for compliance, side-effects, and overall effectiveness of the medication. Consult with the prescribing physician at regular intervals.
17. Arrange for medication evaluation for the customer.
18. Assist the parents in developing and implementing an organizational system to increase the customer's on-task behaviors and completion of school assignments, chores, or work responsibilities. (i.e. use of calendars, charts, notebooks, and class syllabus.)
19. Instruct the parents on how to give proper directions (i.e. gain the customer's attention, make one request at a time, clear away distractions, repeat instructions, and obtain frequent feedback from the customer.)
20. Teach the customer more effective test-taking strategies (i.e. study over an extended period of time, review material regularly, read directions twice, recheck work.)

21. Consult with his/her teachers to implement strategies to improve the customer's school performance (i.e. sit in front of the class, use a prearranged signal to redirect the customer back to the task, provide frequent feedback, call on the customer often, arrange for listening buddy.)
22. Teach the customer more effective study skills (i.e. clear away distractions, study in quite places, outline or underline important details use a tape recorder, schedule breaks in studying.)
23. Encourage the parents and teachers to maintain regular communication about the customer's academic, behavioral, emotional, and social progress.
24. Teach the customer self-control strategies (i.e. "stop, look, listen, and think") to delay gratification and inhibit impulses.