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Therapeutic directions and strategies for ADHD (Attention Deficit and Hyperactivity Disorder) children and adolescents

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FINAL DOCUMENT

1. ADHD (Attention Deficit and Hyperactivity Disorder) is a neurophsychiatric pathology confined mainly to paediatric patients, its main features are lack of attention, impulsivity and hyperactivity. Although in Italy it hasn't been conducted so far any epidemiological study that would allow an accurate estimation of this disorder evidence at a National rate, there are other Countries (such as USA) where the incidence of ADHD is estimated between 3 and 5 % of scholar-age population; while the incidence of particularly severe forms (Hyperactivity Disorder of ICD-10 class by OMS) is estimated to be 1% of scholar-age population. However the gap of existing data given by the scientific literature seems to be quite wide, due to the different criteria used in diagnosis and of observed settings.

2. ADHD might reveal with different clinical symptoms, from pre-scholar age to adulthood, it involves and can compromise many stages of the child's development and social integration, leading him/her to other and more severe phsychiatric pathologies and/or social discomfort in the following stages of his/hers life. According to neurophysiological genetic and neuroradiological evidences today it can be highly accepted the pshychopathological definition of ADHD as a neurobiological disorder showing as alteration of the environmental spur reaction elaboration. The symptomatological expression is often related to the quality of scholar and family integration.

3. For a correct evaluation of the child the ADHD diagnosis should be based upon DSM-IV classification, it should be conducted by physicians specialized in children's mental health problems that have been previously skilled in diagnosis and therapy of ADHD as well as other disorders showing similar symptoms (differential diagnosis) or that might be

associated to it (co morbidity) . This evaluation should always involve not only the child but also his/her parents and teachers: information on his/her behaviour should be gathered from different sources, nevertheless the child's functional commitment should always taken into account according to his/hers cultural and environmental background. Therefore it's particularly recommended the use of questionnaires (i.e. Conners' scale and ADHD-RS, SCOD) and diagnosis interviews (i.e. Kiddie-SADS and PICS-IV) properly standardized and assessed on national specimen. Family Paediatrician 's involvement and communication are very important since the beginning of the diagnosis path.

4. About two third (2/3) of ADHD children show symptoms of other disorder related to social and environmental difficult situations, it's therefore suggested a multidisciplinary approach that, as for other complex pathologies, would strictly refer to a common shared diagnosis and therapeutic protocol (i.e. the algorithm of attached 1). ADHD should be considered a chronic infirmity (disorder) showing its highest peak during scholar age. The main goal of therapeutic interventions approached by children's care operators should be that of improving the whole child's welfare. Particularly the relations with parents, brothers and sisters, teachers and pals; to decrease inadequate and undesirable behaviour; to improve the scholastic learning skills; to increase the self-esteem and self-government; to work on the social tolerance of the disorder in order to improve the whole life quality of the child.

5. Although it's suggested the widest range of possible interventions, the lack of an appropriate availability of psycho-educational approach justifies the pharmacological therapy when necessary. Parents must be widely and properly informed on the nature of the disorder and be taught on the specific educational modalities. The whole range of multi-modal therapeutic approach , and on the family Centres or/and Associations where they can find help and support.

6. Every single intervention should be applied according to individual features such as: the age, the seriousness of symptoms, the secondary disorders (co morbidity), the cognitive resources and finally the social and family situation. The psychological interventions should include the total involvement of parents, teachers and patient.
    - Parents' involvement (Parent Training) aims to enable their acceptance of their child's behaviour, it should give them the right strategies to manage and help their child, it should improve the quality of interactions among family members and social environment.
    - Teachers' involvement (Teacher Training) aims to supply a suitable scholastic integration of the child, to re-organize the whole classroom perception towards the child and finally to provide the proper educational strategies.
    - Child's involvement includes interventions of cognitive modulation in order to enable him/her to reconsider his/her thinking processes and therefore provide him/her with a right strategy to manage their inability. Though it's often suggested a psychotherapy, particularly with those patients having depressive and/or anxious problems, this psychotherapy approach should help the social processes between ADHD subjects and other children, besides a rehabilitation intervention more specifically concerned about the scholar abilities. This non-pharmacological approach it's mainly indicated for pre-scholar age ADHD children, for less severe forms or those with predominant inattention , for those types without a severe

impulsivity, aggressiveness or behavioural disorder or whenever the family or the patient is not willing to accept a pharmacological treatment. They are particularly indicated for those types with learning problems and anxious disorders.

7. The pharmacological intervention should always be discussed with the parents and properly explained to the child, introducing it as an extra help for the efforts he makes to solve his/her problems and not as an "automatic" solution to them, being aware of all the psychological consequences that a medicament could bring. The medicament prescription should always be issued after an informed agreement of parents or legal tutors of the child.

8. The stimulants (particularly the methylphenidate) are medication of first choice as part of a multi-modal scheme in treatments of children with severe and invalidating ADHD forms (compromising the whole functioning, measuring for example less or equal to 40 on a C-GAS rating scale). Methylphenidate results to be effective on about two third (2/3) of treated patients. There are also other medications currently in use (i.e. tricyclic antidepressant, with a norepinephrine action, alpha-adrenergic agonists) although according to the available evidences they should be considered of second choice.

9. Methylphenidate must be prescribed with care to those ADHD children having symptoms and/or any familiar background of bi-polar disorder, tics or Gilles de la Tourette, hyperthyroidism or tireotossicosi, cardiopathy or glaucoma. It must be prescribed with care also to those children having epilepsy or any other kind of internist pathology reported by the Family Paediatrician. Family Paediatrician co-operation is very important also to monitor the side-effects and the undesirable reactions (attached 2).

10. Methylphenidate therapy must be initiated by the children NeuroPsychiatrist only after having considered all the available information and having heard all the health operators that take care of the child and his family (psychologist, paediatrician, welfare assistant etc.). It's suggested that the first prescription should be issued by the Referring Centres appointed by the District Dept.(at least one every Region/District) operating within NHI accredited Institutes of Children Neurophychiatry. The whole diagnostic and therapeutic path should refer throughout by the above Centres, which should therefore provide, according the National Health Scheme, the necessary professional Physicians such as Paediatricians, Psychologist, welfare assistant and Pedagogue.

11. Children taking methylphenidate must be regularly monitored and checked. It's recommended that every child should follow a personalized therapeutical scheme that includes a regular checking by the referring Neurophsychiatrist after the first or second month of therapy, in order to allow the efficiency and tolerability of the medication. In case it's decided to continue the pharmacological treatment, the ADHD child or adolescent should follow regular monitoring check-outs every four months at the beginning and every six months afterwards. The therapeutic scheme should report the treatment term (maximum six months, renewable). Evaluation of intermediate periods could be made by the Children Neurophychiatric of the Territorial Dept. together with the family paediatrician, psychologist and welfare assistant. It is suggested that during these intermediate stages the territorial NPI or paediatrician would be allowed to issue the prescription, strictly referring to the National Health Reference Centres' directions (guidelines), a copy of which should

always be attached to the prescription. It would be recommended to suspend the medical treatment at least once a year (usually during holidays) in order to verify its efficacy and benefits.

12. Every ADHD child should be monitored with periodical check-ups for at least two years, no matter which kind of treatment he/she's receiving. The monitoring should regard the seriousness of symptoms, the whole functions, the co morbidity (if any) and/or complications appearance, the efficaciousness and tolerability of therapeutic interventions.

13. It's suggested that the whole diagnostic, therapeutic and follow-up path would be part of a detailed and specific National Scheme, with District (Regions) divisions, aiming to a common and appropriate assistance to ADHD child and to his/her family. According to the above said, for a suitable schedule of future interventions, the following undertakings should be started up:
    a) **A census of the existing Reference Centres** and of the already followed patients, this job should be taken care of by the SINPIA (Italian Society of Child and Adolescent Neuropsychiatry) and by the Parents' Associations.
    b) **A formal epidemiologist study** that definitively evaluates the National rate of ADHD cases and of those disorders associated to it, as well as the other diagnostic and therapeutic approaches already in use.
    c) **A National Register of ADHD cases** related to methylphenidate prescriptions when it will be reintroduced in Italy.

14. Directions of present document can be reassumed as follows:

- ADHD and other disorders showing similar symptoms diagnosis must be made by Children and Adolescents' Mental Health Physicians and should involve since the beginning the child, the parents, the teachers and the family paediatrician.

- Treatment scheme must provide proper suggestions and support to parents and teachers, as well as specific psychological interventions. Pharmacological treatment should be followed only when suggested by a NPI , according to the International Community Directions and taking into account the child and the family's psychological aspects. The NPI should also coordinate and monitor the child's welfare path together with social operators and family.

- It's necessary to layout a National Scheme (with District/Region connections) especially designed for this particular pathology (disorder) for a diagnosis that would allow an accurate evaluation, in order to provide the best assistance to ADHD child and his family.