**Clinical Practice Guidelines: Attention-Deficit and Disruptive Behavior Disorders**

**Attention-Deficit and Disruptive Behavior Disorders: Outpatient Care**

Eligibility Criteria

1. Based on Intake and/or MCO screening admission to Outpatient Level of Care is indicated due to **ALL** of the following:
2. Person served risk or severity of behavioral health disorder is appropriate to proposed level of care and person served has active symptoms that require ongoing treatment as indicated by the following:
   1. Mild [psychiatric, behavioral, or other comorbid conditions for child or adolescent](https://careweb.careguidelines.com/ed24/bhg/15436402.htm)[[C]](https://careweb.careguidelines.com/ed23/index.html)
   2. [Mild dysfunction in daily living for](https://careweb.careguidelines.com/ed24/bhg/15436402.htm) child or adolescent
3. Treatment services available in an outpatient level of care are necessary to meet person served needs, and **1 or more** of the followingis present:
   1. Person Served specific condition related to admission diagnosis is present and judged likely to further improve at the outpatient level of care deteriorate in absence of treatment at proposed level of care.
   2. Person Served specific condition related to admission diagnosis is present and judged likely to deteriorate in absence of treatment at proposed level of care.
   3. Person Served is receiving continuing care (eg, transition of care from more or less intensive level of care).
   4. Recommended treatment is necessary and appropriate, given person served condition or history.
   5. Person Served is willing to participate in treatment voluntarily (or agrees to participate at direction of parent or guardian).
   6. Person Served has sufficient ability to respond as planned to individual and group therapeutic interventions.
   7. [Biopsychosocial stressors](https://careweb.careguidelines.com/ed24/bhg/15436402.htm) have been assessed and are absent or manageable at proposed level of care (eg, any identified deficits can be managed by program directly or through alternative arrangements).

**Evaluation**

1. Exploration of acute precipitants
2. Psychiatric, social, medical, and substance use histories
3. Mental status examination
4. Social Determinants of Health Assessment
5. Symptoms and functioning assessed regularly through assessments such as the PHQ-9, ADHD Rating Scale (ADHD-RS-IV), Vanderbilt ADHD Parent Rating Scale, Vanderbilt ADHD Teacher Rating Scale, the Columbia-Suicide Severity Rating Scale (C-SSRS) and/or other clinically appropriate assessment scale.
6. Symptoms and functioning assessed 1 to 3 times per week during initial stages of treatment and 1 to 6 times per month as treatment progresses and symptom severity is reduced, with no thoughts of suicide or serious harm to self or others for at least 1 week and no need for safety checks in-between visits.
7. Level of care assessed through the Child and Adolescent Functional Assessment Scale (CAFAS), Preschool and Early Childhood Functional Assessment Scale (PECFAS), or (DECA) .

**Medication**

1. Appropriate medication(s) for ADHD and/or possible adjunctive medication for Disruptive Behavior Disorders (DBD).
2. Clinical management and psychoeducation, if medication prescribed (2-4 visits per month).

**Interventions and Therapy**

1. Possible regular safety checks between visits
2. Establish crisis plan with person served and supports
3. Clinical management and psychoeducation, if medication prescribed (2-4 visits per month)
4. Psychotherapy for the child/youth and family, as clinically indicated
5. Case management as needed and appropriate
6. Behavioral parent training for Disruptive Behavioral Disorders (1-3 sessions a week during initial stages of treatment).
7. Behavioral parent training for Attention Deficit Hyperactivity Disorder complicated by marked oppositional behavior or parent-child conflict (1 or 2 sessions per week during initial stages of treatment)
8. Behavioral parent training for ADHD in preschool-age child(1 or 2 sessions per week during initial stages of treatment)
9. Behavioral parent training, if indicated, reduced to 1-6 sessions per month as treatment progresses and reduction in intensity is indicated.

**Discharge Criteria**

1. Adequate person served stabilization or improvement as indicated by **ALL** of the following:

* + - No recent thoughts of suicide or serious harm to self
    - No recent thoughts of homicide or serious harm to another
    - Person served and supports, as appropriate, understand follow-up treatment and crisis plan.

2. Discharge planning for person served and supports transition to maintenance care including:

* Ensuring person served and supports have sufficient knowledge of the person served illness, medication, risk factors for relapse, warning signs of relapse
* Review crisis plan with person served and supports
* Assist with establishing ongoing appointments for maintenance care including, pharmacotherapy and clinical management (eg 4-8 visits per year) for Attention Deficit Hyperactivity Disorder (ADHD) and Disruptive Behavior Disorder (DBD) and behavioral parent training for DBD (6-12 sessions per year)
* Referrals for community supports, such as, self-help groups and/or support groups for parents and caregivers
* Discharge medications and supplies as indicated

3. Symptom relief sufficient as indicated by **ALL** of the following:

* + - Treatment goals met
    - Symptom status acceptable as indicated by **ALL** of the following:
      * Symptoms stabilized
      * No current plan for significant change in treatment or re-evaluation

4. Medical needs absent or manageable at available lower level of care as indicated by **ALL** of the following:

* + - Adverse medication effects absent or manageable
    - Medical comorbidity absent or manageable
    - Medical complications absent or manageable (eg, complications of eating disorder)
    - Substance-related disorder absent or manageable

5. Outpatient care is no longer indicated due to **1 or more** of the following:

* Higher level of care is indicated (person served condition has deteriorated, greater service intensity is necessary to support engagement in treatment or reinforce skills, or more intensive supervision and supports is needed to address clinical needs.
* Person served or guardian declines treatment