DIAGNOSTIC CODES

309.00	Adjustment Disorder with Depressed Mood
309.24	Adjustment Disorder wit Anxiety
309.28	Adjustment Disorder with Mixed Anxiety and Depressed Mood
309.30	Adjustment Disorder with Disturbance of Conduct
309.40	Adjustment Disorder with Mixed Disturbance of Emotions and Conduct
309.90	Adjustment Disorder, Unspecified

Cross Reference ICD.9.CM

NOTES AND INSTRUCTIONS FOR REVIEWERS

Reviewers to Consider:

- Current mental health evaluation, i.e., Mental Health Evaluation Form.
- Telephone interview with applicant.
- Telephone interview with applicant's mental health provider or treating physician.

COMMENTS

Background: There has been a great deal of debate over the validity and reliability of Adjustment Disorder. Adjustment Disorder is considered to be a "subthreshold" psychiatric disorder that does not meet the criteria for an Axis I disorder. Many therapists, wishing not to "label" their patients with an Axis I or Axis II disorder, provide their patients with a diagnosis of Adjustment Disorder. This is less stigmatizing, but severe enough that the clinician will receive third-party reimbursement for the therapy. Consequently, an applicant with the diagnosis of Adjustment Disorder should be evaluated carefully for possible Axis I disorders or other psychiatric comorbidity. This disorder tends to significantly affect a person's social and occupational functioning, and up to 29% of individuals with Adjustment Disorder have suicidal thoughts.

Key Symptoms: The patient develops emotional or behavioral symptoms in response to identifiable stressor(s) occurring within 3 months of the onset of the stressor(s). There is marked distress that is in excess of what would be expected from exposure to the stressor, and there is significant impairment in social or occupational functioning. The disturbance does not meet the criteria for another Axis I disorder and is not due to bereavement. If the disturbance is less than 6 months the patient is diagnosed with Acute Adjustment Disorder. If the disturbance lasts for 6 months or longer the diagnosis is Chronic Adjustment Disorder. The prognosis for adults with Adjustment Disorder is good with 71% being completely well at a 5-year follow-up. Twenty-one percent of this population developed a major depressive disorder or alcoholism. If Adjustment Disorder begins in adolescence the prognosis is more guarded, with only 44% being well after 5 years and 43% developing a major psychiatric disorder. A poorer prognosis is associated with greater chronicity and longer periods of treatment.

Medications/Therapy: The primary treatment for Adjustment Disorder is psychotherapy. Psychotherapy is aimed at measures that

INFORMATION REQUIRED *Any history*

All Applicants:

- Mental Health Treatment Summary Form
- Review of functional status as documented in the Mental Health Treatment Summary

If Applicable

- Discharge summary for *all* psychiatric hospitalizations.
- Additional review of functional status, e.g., contact Volunteer Recruitment and Selection.

If Currently Undergoing Treatment with Psychotropic Medication

- Statement from prescribing physician to include the following:
  - Diagnosis
  - Medication history, i.e., dates, doses, response, adverse effects.

CLEARANCE CRITERIA

CLEARANCE CRITERIA	REVIEWER	GUIDANCE
1. No history of moderate or severe anxiety symptoms for at least the past 2 years. 2. Functioning well socially and occupationally during the past 1 year (corresponds to a GAF of 75 or above). 3. Active phase of psychotherapy or counseling complete. Continuing counseling for normative issues only. 4. No history of suicide attempt, gesture, or ideation with plan. 5. No history of coexisting psychiatric disorders (Axis I and Axis II) 6. No history of psychosis.		
Meets clearance criteria 1 - 6, AND • Symptom free, or effective management of mild anxiety symptoms for *at least* the past 2 years; AND • *No use* of psychotropic medications for *at least* the past 1 year.	RN	CLEAR **PCMO FOLLOW-UP** Mefloquine contraindicated.
Meets clearance criteria 1 - 6, AND • Symptom free, or effective management of mild anxiety symptoms for *at least* the past 1 year; AND • *No use* of psychotropic medications for *at least* the past 1 year.	RN	CLEAR WITH RESTRICTION 8B Accommodation **PCMO FOLLOW-UP** Mefloquine contraindicated.
Meets clearance criteria 1 - 6, AND • Symptom free, or effective management of mild anxiety symptoms for *at least* the past 1 year; AND • *Continuous or intermittent use* of psychotropic medications *within* the past 1 year; OR • If on continuous psychotropic medication, stable for *at least* the past 3 months.	RN	CLEAR WITH RESTRICTION 8B Accommodation **PCMO FOLLOW-UP** Medication monitoring every 3 months. Mefloquine contraindicated.
Does not meet clearance criteria due to one or more of the following: • History of moderate or severe anxiety symptoms *within* the past 2 years. • Ineffective management of *mild* anxiety symptoms *within* the past 1 year. • Some impairment of functioning, socially or occupationally, during the past 1 year (corresponds to a GAF below 75) • Active phase of psychotherapy or counseling not complete. • Not stable for at least the past 3 months on psychotropic medication.	MHA	DEFER Deferral period consistent with clearance criteria.

(continued on next page)

OBSESSIVE-COMPULSIVE DISORDER

Includes Obsessive-Compulsive Personality Disorder

INFORMATION REQUIRED

All Applicants:

- Mental Health Treatment Summary Form
- Review of functional status as documented in the Mental Health Treatment Summary.

If Applicable:

- Discharge summary for all psychiatric hospitalizations.
- Additional review of functional status, e.g., contact Volunteer Recruitment & Selection.

If Currently Undergoing Treatment with Psychotropic Medications:

- Statement from prescribing physician addressing:
  - Diagnosis
  - Medication history, i.e., dates, doses, response, adverse effects.
  - Required monitoring over the next 3 years.

CLEARANCE CRITERIA	REVIEWER	GUIDANCE
1. Effective management of mild obsessions and compulsions for *at least* the past 1 year. 2. No relapses of severe obsessions or compulsions for *at least* the past 1 year. 3. Functioning well socially and occupationally during the past 1 year (corresponds to a GAF of 75 or above). 4. Active phase of psychotherapy or counseling complete. Continuing counseling sessions for normative issues only. 5. No history of suicide attempt, gesture, or ideation with plan. 6. No history of coexisting psychiatric disorders (Axis I and Axis II). 7. No history of psychosis.		
Meets clearance criteria 1 - 7, AND • No use of psychotropic medications for *at least* the past 1 year.	**RN**	**CLEAR**
Meets clearance criteria 1 - 7, AND • If on psychotropic medication, stable for *at least* the past 6 months.	**RN**	**CLEAR WITH RESTRICTION** 8B Accommodation
	PCMO FOLLOW-UP Medication monitoring every 3 months. Avoid Mefloquine.	
Does not meet clearance criteria due to one or more of the following: • Ineffective management of mild obsessions and compulsions during the past 1 year. • Episodes of severe obsessions or compulsions during the past 1 year. • Some impairment of functioning socially or occupationally during the past year (corresponds to a GAF below 75) • Active phase of psychotherapy or counseling not complete. • Not stable on psychotropic medications for *at least* the past 6 months.	**MHA**	**DEFER** Deferral period consistent with clearance criteria.
Does not meet clearance criteria due to one or more of the following: • History of suicide attempt, gesture, or ideation with plan. • History of coexisting psychiatric disorders (Axis 1 and Axis II).	**MHA**	Risk varies - assess based on detailed history.
Does not meet clearance criteria due to one or more of the following: • History of repeated, severe, episodes of obsessions or compulsions. • History of psychosis.	**MHA** **MED ADVISOR**	**DEFER/MNQ**

DIAGNOSTIC CODES

300.3	Obsessive-Compulsive Disorder
301.4	Obsessive-Compulsive Personality Disorder
	Cross Reference ICD.9.CM

NOTES AND INSTRUCTIONS FOR REVIEWERS

Reviewers to Consider:

- Current mental health evaluation, i.e., Mental Health Evaluation Form.
- Telephone interview with applicant.
- Telephone interview with applicant's mental health provider or treating physician.
- Degree of emotional impairment associated with obsessive-compulsive behavior.

COMMENTS

Background: The severity of Obsessive-Compulsive Disorder ranges from mild to severely disabling. In the milder forms the patient's obsessions and compulsions are undetectable by others. In the more severe forms the patient is unable to function socially or occupationally. Even with treatment a patient rarely is symptom free. Successful medication typically results in a 30% to 60% reduction in obsessions and compulsions. This disorder is most often lifelong and tends to wax and wane throughout the patient's life.

Key Symptoms: The individual experiences either obsessions or compulsions. Obsessions are defined by recurrent and persistent thoughts, impulses or images in excess of worries about real-life problems. The person attempts to ignore or suppress these thoughts impulses or images, or to neutralize them with some other thought or action. She/He recognizes that the obsessional thoughts, impulses and images are a product of his or her own mind, but cannot control or suppress them. Compulsions are defined by repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating works silently) that the person is driven to perform in response to an obsession. These behaviors or mental acts are done to prevent or reduce distress or to prevent some dreaded event or situation. It is important to note that the person recognizes that the obsessions or compulsions are excessive or unreasonable.

A 40-Year Follow-up of Patients With Obsessive-Compulsive Disorder: Improvement was observed in 83%, including recovery in 48% (complete recovery, 20%; recovery with subclinical symptoms, 28%). Among those who recovered, 38% had done so already in the 1950s. Forty-eight percent had obsessive-compulsive disorder for more than 30 years. Early age of onset, having both obsessive and compulsive symptoms, low social functioning at baseline, and a chronic course at the examination between 1954 and 1956 were correlated with a worse outcome. Magical obsessions and compulsive rituals were correlated with a worse course. Qualitative symptom changes within the obsessive-compulsive disorder occurred in 58% of the patients. Conclusions: After several decades, most individuals with obsessive-compulsive disorder improve, although most patients continue to have clinical or subclinical symptoms. [*Skoog, Gunnar; Skoog,Ingmar. Arch Gen Psychiatry. 1999;56:121-127*]

Mefloquine: According to the FDA, Mefloquine is contraindicated "in patients with active depression, a recent history of depression, generalized anxiety disorder, psychosis, schizophrenia or other major psychiatric disorders, or with a history of convulsions." Roche also states that "mefloquine should be used with caution in patients with a history of depression."

Literature review available.

Does not meet clearance criteria due to one or more of the following: • History of suicide attempt, gesture, or ideation with plan. • History of coexisting psychiatric disorders (Axis I and Axis II)	MHA	——— Risk varies - assess based on detailed history.
Does not meet clearance criteria due to one or more of the following: • History of psychosis. • History of repeated, severe, episodes of anxiety.	MHA MED ADVISOR	DEFER/MNQ

DIAGNOSTIC CODES

300.2 Generalized Anxiety Disorder

Cross Reference DSM - IV

NOTES AND INSTRUCTIONS FOR REVIEWERS

Reviewers to Consider:

- Current mental health evaluation, i.e., Mental Health Evaluation Form.
- Telephone interview with applicant.
- Telephone interview with applicant's mental health provider or treating physician.

COMMENTS

Background: Central to the diagnosis of Generalized Anxiety Disorder (GAD) is chronic worry about minor day-to-day problems. The worrying is severe enough to impede the patient's [illegible] and occupational functioning.

Key Symptoms: Individuals with Generalized Anxiety Disorder show symptoms of excessive anxiety and worry, occurring more days than not, for at least 6 months. The anxiety and worry are associated with 3 or more of the following symptoms: restlessness or feeling "keyed up" or "on edge"; being easily fatigued; difficulty concentrating or "their mind going blank"; irritability; increased muscle tension; or sleep disturbance. Many individuals with GAD report that they have felt anxious and nervous all their lives. Worrying about minor day-to-day problems is central to the diagnosis of GAD. Anxiety also causes distortions in reality which may be exacerbated by the environment in Peace Corps.

Mefloquine: According to the FDA, Mefloquine is contraindicated "in patients with active depression, a recent history of depression, generalized anxiety disorder, psychosis, schizophrenia or other major psychiatric disorders, or with a history of convulsions." Roche also states that "mefloquine should be used with caution in patients with a history of depression."

Literature review and abstract available.

POSTTRAUMATIC STRESS DISORDER (PTSD)

MH 2.5

Includes Acute, Chronic, and Delayed Onset PTSD

For Acute Stress *Disorder*, See "Short Term Academic, Family, and Support Group Counseling".

INFORMATION REQUIRED

All Applicants:

- Mental Health Treatment Summary Form
- Review of functional status as documented in the Mental Health Treatment Summary.

If Applicable:

- Discharge summary for *all* psychiatric hospitalizations.
- Additional review of functional status, e.g., contact Volunteer Recruitment & Selection.

If Currently Undergoing Treatment with Psychotropic Medications:

- Statement from prescribing physician addressing:
  - Diagnosis
  - Medication history, i.e., dates, doses, response, adverse effects.
  - Required monitoring over the next 3 years.

CLEARANCE CRITERIA	REVIEWER	GUIDANCE
1. If history of *acute* PTSD, effective management of stress symptoms for *at least* the past 3 months. 2. If history of *chronic* PTSD, effective management of stress symptoms for *at least* the past 1 year. 3. Functioning well socially and occupationally during the past 1 year (corresponds to a GAF of 75 or above). 4. Active phase of psychotherapy or counseling complete. Continuing counseling sessions for normative issues only. 5. No history of suicide attempt, gesture, or ideation with plan. 6. No history of coexisting psychiatric disorders (Axis I and Axis II). 7. No history of psychosis.		
Meets clearance criteria 1 - 7, AND • No use of psychotropic medications for *at least* the past 3 months.	**RN**	**CLEAR**
Meets clearance criteria 1 - 7, AND • If on psychotropic medications, stable for *at least* the past 3 months.	**RN**	**CLEAR WITH RESTRICTION** 8B Accommodation
	PCMO FOLLOW-UP Medication monitoring every 3-4 months. Avoid mefloquine.	
Does not meet clearance criteria due to one or more of the following: • If history of *acute* PTSD, ineffective management of stress symptoms during the past 3 months. • If history of *chronic* PTSD, ineffective management of stress symptoms during the past 1 year. • Some impairment of functioning socially or occupationally during the past 1 year (corresponds to a GAF below 75). • Active phase of psychotherapy or counseling not complete. • Not stable on psychotropic medications for *at least* the past 3 months.	**MHA**	**DEFER** Deferral period consistent with clearance criteria.
Does not meet clearance criteria due to one or more of the following: • History of suicide attempt, gesture, or ideation with plan. • History of coexisting psychiatric disorders (Axis I and Axis II). • History of psychosis.	**MHA**	—— Risk varies - assess based on detailed history.

DIAGNOSTIC CODES

309.81 Posttraumatic Stress Disorder
Specifies: Acute, Chronic, and With Delayed Onset

Cross Reference DSM - IV

NOTES AND INSTRUCTIONS FOR REVIEWERS

Reviewers to Consider:

- Current mental health evaluation, i.e., Mental Health Evaluation Form.
- Telephone interview with applicant.
- Telephone interview with applicant's mental health provider or treating physician.

COMMENTS

Background: Posttraumatic Stress Disorder (PTSD) may result when an individual is exposed to a traumatic event that involves actual or threatened death or serious injury, or a threat to the physical integrity of the self or others. There must be a significant precipitating trauma to be diagnosed with PTSD, but the stressor alone is not sufficient. This disorder may occur at any age. Symptoms typically begin within the first 3 months after exposure to the trauma, although there may be a delay of months or years. In rare cases, usually involving torture or sexual abuse, symptoms may appear 30-40 years after the trauma. Approximately 30% of individuals recover completely and 40% continue to experience mild symptoms. Twenty percent of patients continue to experience moderate symptoms and 10% remain unchanged or worsen over time. Complete recovery occurs within 3 months in approximately 50% of the cases. Psychiatric comorbidity is common with PTSD. Common comorbid conditions for PTSD include: Panic Disorder, Agoraphobia, Obsessive-Compulsive Disorder, Social Phobia, Specific Phobia, Major Depressive Disorder, Somatization Disorder, and Substance-Related Disorders.

Post Traumatic Stress Disorder Specifiers:

- Acute: Duration of symptoms is less than 3 months.
- Chronic: Symptoms last 3 months or longer.
- With Delayed Onset: At least 6 months have passed between the traumatic event and the onset of symptoms.

Acute Stress Disorder: Following a traumatic event a high percentage of persons experience Acute Stress Disorder (ASD). Symptoms of ASD are similar to PTSD. The symptoms are experienced during or immediately after the trauma, last for at least 2 days, and resolve within 4 weeks after the conclusion of the traumatic event. When symptoms persist beyond 1 month, a diagnosis of PTSD may be appropriate if the full criteria for PTSD are met. After one month 70% to 90% may show the full symptoms picture for PSTD.

Key Symptoms: The person's response to a traumatic event is one of intense fear, helplessness, or horror. The event is persistently re-experienced in one or more of the following ways: intrusive distressing recollections of the event, distressing dreams of the event, acting or feeling as if the event were recurring, intense distress at exposure to cues that symbolize or resemble an aspect of the traumatic event, or physiological reactivity to internal or external cues that resemble

Mefloquine: According to the FDA, Mefloquine is contraindicated "in patients with active depression, a recent history of depression, generalized anxiety disorder, psychosis, schizophrenia or other major psychiatric disorders, or with a history of convulsions." Roche also states that "mefloquine should be used with caution in patients with a history of depression."

Literature review available.

INFORMATION REQUIRED

All Applicants:

- Mental Health Treatment Summary Form
- Review of functional status as documented in the Mental Health Treatment Summary.

If Applicable:

- Discharge summary for *all* psychiatric hospitalizations.
- Additional review of functional status, e.g., contact Volunteer Recruitment & Selection.

If Currently Undergoing Treatment with Psychotropic Medications:

- Statement from prescribing physician addressing:
  - Diagnosis
  - Medication history, i.e., dates, doses, response, adverse effects.
  - Required monitoring over the next 3 years.

CLEARANCE CRITERIA	REVIEWER	GUIDANCE
Applicant presents with a history of one or more of the following disorders:		
1. Anxiety Disorder Not Otherwise Specified. 2. Substance-Induced Anxiety Disorder.	**MHA**	—— Risk varies - assess based on detailed history.
	PCMO FOLLOW-UP Mefloquine contraindicated.	
3. Anxiety Disorder Due to a General Medical Condition.	**MHA** **MED ADVISOR**	—— Risk varies - assess based on detailed history.

DIAGNOSTIC CODES

NOTES AND INSTRUCTIONS FOR REVIEWERS

Reviewers to Consider:

- Current mental health evaluation, i.e., Mental Health Evaluation Form.
- Telephone interview with applicant.
- Telephone interview with applicant's mental health provider or treating physician.

COMMENTS

Anxiety Disorder Not Otherwise Specified: The patient presents with symptoms of prominent anxiety or phobic avoidance that do not meet criteria for any specific Anxiety Disorder, Adjustment Disorder with Anxiety, or Adjustment Disorder with Mixed Anxiety and Depressed Mood. Examples include: (1) a mixed anxiety-depressive disorder where the patient has both anxiety symptoms and depression, but the criteria are not met for either a Mood Disorder or and Anxiety Disorder; (2) the patient has significant social phobic symptoms that are related to the social impact of having a general medical condition or mental disorder, e.g., stuttering, Body Dysmorphic Disorder; (3) situations in which the clinician has concluded that an Anxiety Disorder is present, but is not certain whether it is a primary disorder, due to a medical condition, or is substance induced.

Substance-Induced Anxiety Disorders: The patient demonstrates prominent anxiety, Panic Attacks, or obsessions and compulsions related to the use of a specific substance. There is evidence from the history, physical examination, and laboratory findings that the symptoms developed during, or within 1 month of, Substance Intoxication or Withdrawal, or that medication use is etiologically related to the disturbance. The sympathomimetics, e.g., cocaine, amphetamines, and caffeine, have been most associated with anxiety symptoms. There are many prescription medications that are also associated with the production of anxiety disorder symptoms. There is no evidence of an Anxiety Disorder prior to the use of the medication, alcohol, or other substances. Once the substance/medication has been removed the Anxiety Disorder should gradually dissipate.

Anxiety Disorder Due to a General Medical Condition: The patient demonstrates prominent anxiety, Panic Attacks, or obsessions and compulsions that can be traced to the direct physiological consequence of a general medical condition. There must be a direct temporal association between the Anxiety Disorder and the general medical condition. Once the medical condition has resolved the Anxiety Disorder should gradually dissipate. In situations where the Anxiety Disorder persists, there is a possibility that the medical condition "unmasked" an underlying Anxiety Disorder.

Mefloquine: According to the FDA, Mefloquine is contraindicated "in patients with active depression, a recent history of depression, generalized anxiety disorder, psychosis, schizophrenia or other major psychiatric disorders, or with a history of convulsions." Roche also states that "mefloquine should be used with caution in patients with a history of depression."

Literature review available.

INFORMATION REQUIRED

All Applicants:

- Mental Health Treatment Summary Form
- Review of functional status as documented in the Mental Health Treatment Summary.

If Applicable:

- Discharge summary for all psychiatric hospitalizations.
- Additional review of functional status, e.g., contact Volunteer Recruitment & Selection.

If Currently Undergoing Treatment with Psychotropic Medications:

- Statement from prescribing physician addressing:
  - Diagnosis
  - Medication history, i.e., dates, doses, response, adverse effects.
  - Required monitoring over the next 3 years.

CLEARANCE CRITERIA

1. Effective management of ADHD symptoms for *at least* the past 1 year.
2. If symptom management requires the use of medication, i.e., prn or continuous; stable on medication for *at least* the past 6 months.
3. Functioning well socially and occupationally during the past 1 year (corresponds to a GAF of 75 or above).
4. Active phase of psychotherapy or counseling complete. Continuing counseling sessions for normative issues only.
5. No history of suicide attempt, gesture, or ideation with plan.
6. No history of coexisting psychiatric disorders (Axis I or Axis II).
7. No history of psychosis.

CLEARANCE CRITERIA	REVIEWER	GUIDANCE
Meets clearance criteria 1 - 7, AND • Effective management of symptoms *does not* require current use, and has not required past use, of psychotropic medications, amphetamines, or stimulants.	RN	CLEAR
Meets clearance criteria 1 - 7, AND • Effective management of symptoms requires *current use*, or use *within* the past 3 years, of one or more of the following medications: - *Selective Serotonin Reuptake Inhibitors* (SSRIs), *e.g., paroxetine (Paxil)* - *Selective Norepinephrine Reuptake Inhibitors* (SNRIs), e.g., Strattera. - *Norepinepherine Dopamine Selective Inihibitors* (NDRIs), e.g., bupropion (Wellbutrin, Zyban, Buspar). - *Central Alpha-Agonists*, e.g., clonidine.	RN	CLEAR WITH RESTRICTION 8B Accommodation PCMO FOLLOW-UP Avoid mefloquine
Meets clearance criteria 1 - 7, AND • Effective management of symptoms requires *current use* or use *within* the past 3 years, of *amphetamines*, e.g., (Adderall), dextroamphetamine (Dexadrine).	RN	CLEAR WITH RESTRICTION Adderall Accommodation 8B Accommodation
Meets clearance criteria 1 - 7, AND • Effective management of symptoms requires *current use*, or use *within* the past 3 years, of *stimulants*, e.g., methylphenidate (Ritalin).	RN	CLEAR WITH RESTRICTION Ritalin Accommodation 8B Accommodation

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Meets clearance criteria 1 - 7, AND Effective management of symptoms requires *current use*, or use *within* the past 3 years, of *tricyclic antidepressants, e.g.*, imipramine, desipramine.	**MHA** **MED ADVISOR**	——— Risk varies - assess based on detailed history.
Does not meet clearance criteria due to one or more of the following: • Ineffective management of ADHD symptoms during the past 1 year. • If symptom management requires the use of medication, i.e., prn or continuous, not stable on medication for *at least* the past 6 months. • Some impairment of functioning socially or occupationally during the past 1 year (corresponds to a GAF below 75). • Active phase of psychotherapy or counseling not complete.	**MHA**	**DEFER** Deferral period consistent with clearance criteria.
Does not meet clearance criteria due to one or more of the following: • History of suicide attempt, gesture, or ideation with plan. • History of coexisting psychiatric disorders (Axis I or Axis II). • History of psychosis.	**MHA**	——— Risk varies - assess based on detailed history.

DIAGNOSTIC CODES

314.01	Attention-Deficit/Hyperactivity Disorder, Combined Type
314.00	Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type
314.01	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulse
	Cross Reference ICD.9.CM

NOTES AND INSTRUCTIONS FOR REVIEWERS

Reviewers to Consider:

- Current mental health evaluation, i.e., Mental Health Evaluation Form.
- Telephone interview with applicant.
- Telephone interview with applicant's mental health provider or treating physician.

COMMENTS

Background: The diagnosis of ADHD in adults remains controversial. The disorder is a neurobiologic condition that is most likely genetic based. It is caused by an alteration in neurotransmitter function originating in the lower brain and limbic structures that results in frontal lobe disinhibition. Attention Deficit Hyperactivity Disorder is a behavior pattern characterized by difficulty sustaining focused attention to tasks, poor impulse control, and cognitive or physical restlessness, or both. Frequently individuals have co-existing psychiatric disorders, particularly depressive disorders, anxiety disorders, and substance-related disorders. ADHD is often confused with mild Bipolar Disorders.

Key Symptoms: In adults, ADHD presents with symptoms of disorganization, poor concentration, inability to finish projects, procrastination, anticipatory anxiety, impulsive outbursts, careless mistakes at work, restlessness, and significant impairment in occupational functioning. The symptoms must have been present in childhood (prior to the age of 7 years) and must be present for at least 6 months. ADHD can persist into adulthood, but it does not have new onset in adulthood.

Progression: "The exact proportion of persons with ADHD who outgrow the disorder is unclear. Follow-up studies estimate that 40-80 percent of children still meet the criteria for full disorder in adolescence, and 8 to 66 percent in late adolescence and young adulthood. Adults who were never identified as having ADHD in childhood may present with many of the symptoms of the disorder. Such persons can be evaluated and successfully treated." [*Sametiken, A. and Ernst, M., "NEJM", January 7, 1999*]

Therapy/Medications: Cognitive-behavioral therapy is the form of psychotherapy that has demonstrated the greatest efficacy in treating the psychosocial deficits in ADHD. Medications are helpful with attention and hyperactivity but they do not correct the social difficulties in individuals with ADHD. Medications commonly used to treat ADHD include stimulants methylphenidate (Ritalin), dextroamphetamine (Dexadrine), antidepressants (imipramine, desipramine, bupropion), and clonidine. Pemoline (Cylert) is no longer recommended for initial therapy of ADHD due to the risk of hepatotoxicity. Imipramine and desipramine require baseline EKGs.

Literature review available.