Assessment and Management of ADHD in Children and Teens in Primary Care

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Learning Objectives
At the end of the session, the participant will be able to:
1. Provide a comprehensive treatment of children and adolescents with ADHD
2. Describe the use of screening tools as part of the evaluation of ADHD.
3. Incorporate the use of behavioral interventions in practice.
4. Prescribe psychopharmacologic medications safely and competently.

Mental Health/Disability Overview
• 20% of youth ages 13–18 live with a mental health condition
• Suicide is the 3rd leading cause of death in youth ages 10 – 24
• 11% of youth have a mood disorder
• 8% of youth have an anxiety disorder
• In 2015, 3 million adolescents (12.5%) aged 12 to 17 in the United States had at least one major depressive episode in the past year

Attention Deficit Hyperactivity Disorder
• One of the most commonly diagnosed neurodevelopmental conditions in childhood
• More than 1 in 10 (11%) US school-aged children had received an ADHD diagnosis (2011)
• The percentage of US children 4-17 years of age with an ADHD diagnosis continues to increase
• Average annual increase was approximately 7% per year
• 60-85% of children with diagnosis of ADHD meet criteria as adolescents

State of Mental Health Care, 2018
• 10% decline in pool of psychiatrists working public sector/insured from 2003-2013
• Aging of the current workforce, low rates of reimbursement, burnout, documentation requirements, restrictive regulations around sharing clinical information causing decline
• Seventy-seven percent of counties are underserved and 55 percent of states have a “serious shortage” of child and adolescent psychiatry
• Shortage of mental health services, especially in rural areas
• Long wait times for evaluations and treatment
• Stigma associated with psychiatric services
State of Mental Health Care, 2018

- Shortage of emergency mental health services; decreased access to emergency services
- Fragmentation of services and care between behavioral health and medical care
- Children from low income families/underserved have decreased access
- Shortage of school based MH services
- Primary Care Providers (PCPs) identify lack of time, lack of reimbursement, need to use screening tools, lack of expertise, use of psychopharmacology, and lack of mental health resources as barriers

Pediatric Mental Health Specialist Certification

- Pediatric Nursing Certification Board Child and Adolescent Behavioral & Mental Health Specialty Certification Exam
- Post APRN certification specialty in child and adolescent mental & behavioral health
- Purpose: To recognize and validate those APRNs who have added knowledge, skills and expertise in the early identification, intervention and collaboration of care of children and adolescents with mental and behavioral health concerns

Summary DSM V Criteria ADHD

Must have:
Persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development
Several inattentive or hyperactive-impulsive symptoms present before age 12 years
Several symptoms are present in two or more setting, (e.g., at home, school or work, with friends or relatives, in other activities).
There is clear evidence that the symptoms interfere with, or reduce the quality of social, school, or work functioning.

Models for Integration of Mental Health into Primary Care

- Coordination With an External BH Provider
- BH Consultation With the Primary Care Provider
- Onsite Intervention (trained BH provider delivers BH onsite)
- Onsite Collaborative Care (BH works closely with PCP)
- Training the Primary Care Provider in Mental Health Skills

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brief Overview of ADHD

ADHD Practice Guidelines

- The AAP worked with the National Initiative for Children’s Healthcare Quality (NICHQ) to develop the ADHD Toolkit for use by primary care providers. Available for download at: http://www.nichq.org/childrens-health/adhd/resources/adhd-toolkit
Assessment

• Chief Complaint
  • Academic problems
  • Symptoms of ADHD or mental health concerns
  • Behavioral issues
  • Functional impairment
• Medical History
  • Birth history: prematurity, LBW
  • Developmental history
  • Medical conditions
  • ROS: diet, sleep, elimination, exercise, screen time
• Family Medical History
  • History of ADHD, mental health disorders
• Social history
  • Exposure to adverse childhood experiences, community stressors, protective factors
  • Parenting practices
• Behavioral History
  • Open-ended questions re: behavior in all settings (school, home)
• Assess family routine, functioning

Physical Exam
• Complete physical exam
• Comprehensive neurological exam
  • Disorders of tone, posture, persistence of primitive reflexes
  • Abnormal DTR’s, asymmetries, gait abnormalities
  • Tremors, soft neurological signs
  • Performance of neurodevelopmental tasks i.e. sequencing, written and oral expression
• Examine for dysmorphic features
  • Facial: nose, philtrum, ears, lips
  • Hands and feet: incurvature, webbing, palmar crease, clinodactyly, hyperextensibility of joints
  • Growth parameters and body proportion: head growth, trunk and limb size
• If find more than 2 dysmorphic features, consider genetic syndrome

Primary Care - Assessment
NICHQ Vanderbilt Assessment Scales
• Developed for initial evaluation and follow-up of ADHD in preschool and school age children (ages 6-12)
  • Parent Initial and Follow-up Scales
  • Teacher Initial and Follow-up Scales
  • Available at: http://www.nichq.org/childrens-health/adhd/resources/vanderbilt-assessment-scales
• Also screen for coexisting conditions (conduct disorder, oppositional-defiant disorder, anxiety/depression)
• Will help categorize
  • Predominately inattentive
  • Predominately hyperactive/impulsive
  • Combined inattention/hyperactivity

Primary Care - Assessment
NICHQ Vanderbilt Assessment Scales
• Obtain Parent and Teacher Initial Vanderbilt Scales – most helpful if scored before visit
• If clinically significant, may use to help establish diagnosis of ADHD. Useful as screen for anxiety, depression, ODD, conduct disorder
• May want to obtain multiple scales from different teachers.
• May use to track progress – Consider using Initial Assessment Form combined with Side Effect Ratings from Follow-up Assessment forms
• Will allow monitoring of comorbid ODD, conduct disorder, anxiety, and depressive symptoms

Differential Diagnosis
• Consider Medical causes:
  • Diet, elimination, sleep, physical activity, screen time
  • Obstructive sleep apnea: moves a lot in sleep, snores, daytime sleepiness, may or may not have enlarged tonsils
  • Anemia (complaints of fatigue, irritability, diet concerns): can check CBC, Pb
• Consider Co-morbid MH Disorders:
  • Anxiety, Autism, Learning Disorder, Depression
  
Cortese et al, 2016
Treatment of ADHD

Treatment Recommendations for treatment vary, depending on the child's age.

a. Preschool aged children (4-5 yrs): parent or teacher administered behavioral intervention should be the first line of treatment; medication (methylphenidate) may be considered if first line treatments are not available or insufficient

b. Elementary school-aged children (6-11 yrs): the combination of medication and behavioral interventions have the best outcome

c. Adolescents (12-18 yrs): FDA-approved medications for this age group should be prescribed, preferably along with behavior therapy

Behavioral/Psychosocial Interventions in Home

- Schedule/routine
  - Morning routine often difficult - develop a clear written or visual schedule
  - Irritability in the late afternoon, early evening
  - Organize everyday items - one folder for different classes
  - Use homework and notebook organizers
  - Consistent rules (clear, brief) and expectations
  - Homework routine - minimize distractions
  - Use incentives to get work done
  - No more than 2 hours screen time per day, 60 mins physical activity, healthy eating and drinking
  - No proven benefit for interactive metronome training, occupational therapy, vision therapy

Parent Training for ADHD

- Parent training in effective child behavior management is essential
- Recognizes that ADHD affects entire family, behavioral therapy involving all members of the household may restore balance
- Starts with parent understanding of ADHD as a neurophysiologic deficiency
- Evidence Based Programs include: New Forrest Therapy, Triple P, The Incredible Years Series, Parent Child Interactive Therapy (PCIT) https://childmind.org/article/choosing-a-parent-training-program/

Educational Recommendations

- Parent(s) are child's advocate
- If academic issues, may request evaluation by school's multidisciplinary evaluation team
- Parent submits a letter to principal
- Permission must be given (with signature) before process starts
- Comprehensive evaluation done within 60 days
- If child qualifies for special education services, an Individual Education Plan (IEP) can be developed
Individualized Education Plan (IEP)

- If child meets criteria for IEP, may be with LD diagnosis
- May qualify for IEP using ADHD as diagnosis under “Other Health Impaired”
- IEP may incorporate resource teacher support, particularly in MS/HS, where student meets one period a day for organizational assistance, test taking, homework
- IEP can be revised at parental request any time throughout year

Section 504

- If does not meet criteria for special education, same process except an IEP is not written. Section 504 Service Plan may be developed that designates:
  - reasonable accommodations in the educational program
  - related aids and services if deemed necessary (OT, PT, Speech)
- Challenge using 504 is that amount of time services given not designated, nor individual identified to carry out plan
- Communication is key between parent/teachers

Examples of Section 504 Accommodations

- Seating at front of classroom
- Supplement verbal instructions with visual or written instructions
- Trackers/reminders for homework, schedule
- Organized assistance
- Modified test delivery, extended test time
- Assistance with long term projects
- Tailor homework assignments
- Systematic rewards and consequences

Medication Therapy for ADHD

- Medical Therapy
  - Use of medications effective in 70-80% of children
  - Evaluate effectiveness by behavioral changes: motor activity, attention span, concentration, reduced distractibility (school and home)
- Stimulants
  - Immediate Release and Sustained Release
- Non-stimulant – Strattera
- Alpha 2 Adrenergic Agonists

Psychostimulants: 1st line ADHD Treatment

- Methylphenidate approved by U.S. FDA in 1955
- Dextroamphetamine approved by U.S. FDA in 1960

FDA = Food and Drug Administration
Amphetamine
- d,l-AMPH (DEX)
  - Dextroamphetamine
  - Dexedrine
  - Dexedrine SR
  - Vyvanse (lysine-DEX)
- d-(dextro) = Right-handed – therapeutic activity
- l-(levo) = Left-handed – therapeutic activity

Psychostimulants
- Largest effect size (amount of change in ADHD symptoms) of any ADHD med class
- Highest % of responders of any ADHD med class
  - 70-75% of ADHD patients will have a beneficial response to any given stimulant
  - >90% of patients will respond if both MPH and AMPH/DEX are tried

Effects of Stimulant Medications
- Decrease in core ADHD symptoms
  - Inattention
  - Hyperactivity
  - Impulsivity
- Improvements in:
  - Noncompliance
  - Impulsive aggression
  - Social interactions
  - Academic productivity
  - Academic accuracy

Choosing Psychostimulant Medications
- A recent meta-analysis showed that on average, youth with ADHD treated with AMPH and MPH do improve, with a marginally larger improvement in clinician ADHD symptom ratings for AMPH compared to MPH
- Note that up to 25% may respond to only MPH or AMPH but not both
- No current way to predict best stimulant for each individual

Methylphenidate vs. Amphetamines
- All the same side effects are possible
- More common side effects include
  - Decreased appetite (14-22% vs 2-6% placebo)
  - Trouble falling asleep (8-17% vs 2-7% placebo)
  - Stomachaches (11-14% vs 7-10% placebo)
  - Headaches (15% vs 8% placebo)
  - Nervousness (8-17% vs 2-7% placebo)
  - Irritability
  - Social withdrawal or overly focused

Stimulants: Main Mechanism of Action
- In ADHD, low levels of dopamine (DA) and norepinephrine (NE)
- DA and NE transporters "vacuum" DA and NE out of the synapse
- Blocks DA and NE transporters so more DA and NE in the synapse to activate the postsynaptic cell

Swanson JM and Volkow ND. Behav Brain Research. 2002;130:73-78.


Swanson JM and Volkow ND. Behav Brain Research. 2002;130:73-78.
Side Effects Methylphenidates vs. Amphetamines

• A recent meta-analysis indicates that overall side effects (including problems with sleep and emotional side effects) are more prominent with DEX/AMPH compared to MPH
• Response varies by individual
  *— Cortese S et al, Lancet, 2018

FDA Approved Medications for ADHD

<table>
<thead>
<tr>
<th>Medication</th>
<th>Indication</th>
<th>FDA Approval and Age in Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methylphenidate (stimulant)</td>
<td>ADHD</td>
<td>Yes</td>
</tr>
<tr>
<td>Amphetamine (stimulant)</td>
<td>ADHD</td>
<td>Yes</td>
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<tr>
<td>Guanfacine (alpha adrenergic agonist)</td>
<td>Tenex, Intuniv</td>
<td>ADHD</td>
</tr>
<tr>
<td>Clonidine (alpha adrenergic agonist)</td>
<td>Clonidine, Kapvay</td>
<td>ADHD</td>
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<tr>
<td>Atomoxetine (NRI)</td>
<td>Strattera</td>
<td>ADHD</td>
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Starting Psychostimulant Medications

• Start low and titrate upward
• Duration of effect ranges from 4-12 hours
• Try each dose for 3-7 days
• Continue upward titration until
  • Symptoms remit
  • Side effects prevent further titration
  • Maximum dose reached

Considerations in Prescribing Stimulants

• Adverse effects based on severity or frequency; monitor for response and side effects
• Cost: need to check formularies for insurers
• All stimulants are controlled substances- 30 day supply
• Onset of effect 30-45 minutes
• Dosage adjustments made weekly; check in by phone weekly, monitor response with Vanderbilt’s
• Contraindications: known sensitivity, marked anxiety, agitation, glaucoma, tics or Tourette’s, MAO inhibitors, potential for abuse
• Side effects similar-methylphenidate and amphetamine

Cardiovascular Issues

• Recommendation from the American Heart Association followed by the American Academy of Pediatrics for screening include:
  • targeted cardiac history (e.g., patient history of previously detected cardiac disease, palpitations, syncope, or seizures; a family history of sudden death in children or young adults; hypertrophic cardiomyopathy; long QT syndrome)
  • physical examination, including a careful cardiac examination
• Refer for screening ECG or for cardiovascular evaluation if pre-existing conditions or concerns
• Monitor pulse and BP
**Methylphenidate**

- IR preparations have 3-5 hour effect, often prescribed BID or TID
- ER or SR preparations depend on technology in preparation: pulse or bead (7-8 hours), pearls (8-12 hours), or pump (<12 hours)
- Pulse preparations- capsules containing IR beads and delayed release beads. Can be opened and sprinkled on food
- Focalin is dexmethylphenidate preparation: dosing is one-half for Focalin than other methylphenidate preparations.
- Advantage of longer acting preparations is once a day dosing
- Initial dose generally 10 mg/day for methylphenidate

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**Immediate Release Methylphenidate Medications**

- Methylphenidate
  - Ritalin tablets- scored (5, 10 and 20 mg) initial dose 5 mg BID
  - Methylphenidate chewable (2.5, 5 and 10 mg tablets) initial dose 5 mg BID
  - Methylin solution (5 mg/5 ml or 10 mg/mL) initial dose 5 mg BID
  - Focalin (dexmethylphenidate hydrochloride) tablets- (2.5, 5 and 10 mg) initial dose 2.5 mg BID
  - Duration 3-4 hours

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**Extended Release Methylphenidate Medications**

- Methylphenidate ER capsules- 10, 20, 30, 50 mg capsules- duration 8-10 hours
- Concerta (Methylphenidate ER) capsules- noncrushable (18, 27, 36, 54, and 72 mg) initial 9-12 hrs
- Ritalin LA capsules- can be sprinkled (10, 20, 30 and 40, 60 mg) Duration 8 hrs
- Metadate ER tablets (20 and 20 mg) Duration 4-8 hrs
- Metadate CD capsules (10, 20, 30, 40, 50, 60 mg) Duration 4-8 hrs Can be sprinkled
- Focalin XR capsules (5, 10, 15, and 20, 25, 30, 35, 40 mg extended-release) Duration 6-10 hours

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**Quillivant XR, Quillichew ER**

- Methylphenidate hydrochloride for extended release oral suspension (after reconstitution with water): 25 mg per 5 mL (5 mg per mL)
- Quillichew 20, 30, 40 mg chewable tablets
- Recommended for patients 6 years and above, recommended starting dose is 20 mg given orally once daily in the morning
- Daily dosage above 60 mg is not recommended
- Shortage due to hurricane in Puerto Rico

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**Aptensio XR**

- Aptensio XR (Methylphenidate Hydrochloride Extended Release Capsules)
- Immediate-release layer contains approximately 40% dose (peak at ~2 hours)
- Controlled release layer contains approximately 60% dose (peak at ~8 hours)
- 10, 15, 20, 30, 40, 50, 60 mg Extended-Release Capsules
- Lasts 8-12 hours

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**Cotempla XR-ODT**

- Approved 6-17 years
- 8.6, 17.3, 25.9, and 34.6, 51.8 mg disintegrating tablets
- Recommended starting dose for pediatric patients 6 to 17 years of age is 17.3 mg given orally once daily in the morning. Dosage may be increased weekly in increments of 8.6 mg to 17.3 mg per day
- Daily dosage above 51.8 mg is not recommended.
Daytrana Patch

- Methylphenidate ER in a transdermal form
- 10, 15, 20 and 30 mg patches
- Approved for 6-12 year old children
- Apply 2 hours before expected effects.
- Remove after 9 hours. Effects last another 2 hours
- Skin care: vitamin E

Immediate Release Amphetamines

- Adderall tablets- scored (5, 7.5, 10, 12.5, 15, 20, and 30-mg tablets)
- Approved 3-5 year old, starting dose 2.5 mg QD
- Mixed salts of amphetamine (Dextroamphetamine/levoamphetamine)
- Duration- 4-8 hours

Immediate Release Amphetamines

- Zenzedi (d-amphetamine sulfate)
  - 3-5 years 2.5 mg once daily
  - 6-17 years 5-40 mg bid
  - Available in 2.5, 5, 7.5, 10, 15, 20 and 30 mg tablets
  - 4-8 hour effect
- ProCentra (d-amphetamine sulfate)- liquid bubblegum flavor
  - 3.5 years 2.5 mg QD
  - 6-17 years 5-40 mg bid
  - 5 mg/5ml liquid
  - 8 hour effect

Immediate Release Amphetamines

- Evekeo (amphetamine sulfate) Tablets: 5mg, 10mg, scored
  - 50% Levoamphetamine/50% Dextroamphetamine
  - Not recommended for children under 3 years of age
  - In children from 3 to 5 years of age, start with 2.5 mg daily; daily dosage may be raised in increments of 2.5 mg at weekly intervals until optimal response is obtained.
  - In children 6 years of age or older, start with 5 mg once or twice daily
  - Duration 4-8 hours

Extended Release Amphetamines

- Adderall XR capsules-can be sprinkled (5, 10, 15, 20, 25, and 30-mg capsules)
  - Mixed salts of amphetamine (Dextroamphetamine/levoamphetamine)
  - Duration- 8-12 hours
- Dyanavel XR (Amphetamine extended release oral suspension 2.5 mg/ml)
  - Duration- 8-12 hours

Lisdexamfetamine dimesylate Capsules (Vyvanse)

- Prodrug Stimulant
  - Prodrug is a pharmacologic substance that is administered in an inactive or significantly less active form
  - Metabolized in vivo into the active compound (dextroamphetamine). It is designed to improve oral bioavailability. May take longer to become active (making side effects less pronounced)
  - Ineffective if snorted or taken IV
  - Available in 10, 20, 30, 40, 50, 60 mg capsules
  - Also comes in chewable tablets 10, 20, 30, 40, 50, 60 mg/tablet
  - Duration 8-12 hours
Extended Release Amphetamines

- Adzenys XR ODT tablets
  - 3.1, 6.3, 9.4, 12.5, 15.7, 18.8 mg tablets
- Adzenys ER liquid 1.25 mg/ml
- Mydayis
  - Approved 13-17 years
  - 12.5, 25, 37.5, 50 mg capsules
  - Duration up to 16 hours
- Dexedrine spansules (5, 10, 15 mg spansules)

Alpha-2 Adrenergic Agonists

  - Short acting:
    - Guanfacine HCL (Tenex) 1, 2 mg tablets given BID or TID
    - Initial dose 0.5-1.0 mg, slowly progress
    - Duration 4-8 hours
  - Long Acting:
    - Intuniv – approved 6 years and up
    - Comes in 1, 2, 3, 4 mg once daily
    - Duration <24 hours
    - Slowly progress dose (may increase every 5-7 days)

Mechanism of Action for Guanfacine (GUA) and Clonidine (CLON)

- Stimulate pre- & post-synaptic $\alpha_2$ norepinephrine receptors
- Controls NE release and cell firing rate
- GUA selectively binds $\alpha_2A$
- CLON binds $\alpha_2A$, $\alpha_2B$, and $\alpha_2C$

Guanfacine and Clonidine Effects

- Decrease hyperactive sx
- Clinical consensus is that effects on attention not as robust (GUA may be better than CLON)
- Response rate is ≈50%
- Effect size (amount of change in ADHD symptoms) is less than with stimulants
- First line for tics or Tourette’s Disorder

Alpha Adrenergic Agonists

  - (U.S. Food & Drug Administration Approval Date)

Alpha-2 Adrenergic Agonist Side Effects

- In general, less for GUA than CLON
  - Sedation, somnolence – most common
  - Dizziness
  - Irritability
  - Headache
  - Abdominal pain, constipation
  - Rare hallucinations, mania

Arnsten AF. JCAP. 2007; 17:393-406.
Alpha-2 Adrenergic Agonist Side Effects

- Cardiovascular effects
  - Hypotension – less for GUA
  - Need to monitor BP
  - Overdose can be fatal
  - Wean due to risk of rebound HTN
  - Bradycardia

Alpha Adrenergic Agonists

- Can be used in conjunction with stimulants
- Start with low dose usually at bedtime, make weekly adjustments. If discontinuing, should taper.
- Monitor weekly
- May take up to 4 weeks to see effect

Atomoxetine

- U.S. Food & Drug Administration approved in 2002
- Potent NE reuptake inhibitor - binds to Norepinephrine Transporter and increases NE availability in synapse
- Little affinity for serotonin or dopamine transporters

Atomoxetine (ATX) Efficacy

- ATX response rate (36-52%) lower than stimulants (>70%)
- Effect size (amount of change) for ADHD symptoms lower than for stimulants

Atomoxetine Side Effects

- Stomach upset, nausea, vomiting
  - Can be minimized by administration after a meal
  - Diminished appetite
  - Generally be less than with stimulants
  - Somnolence, fatigue
  - Irritability or mood swings

Atomoxetine (ATX) Adverse Events

- In U.S., “black box warning” for suicide risk
  - In controlled trials, suicidal ideation 0.4% for atomoxetine vs none for placebo
  - One suicide attempt/1,357 cases, no suicides
- Adverse effects on liver possible but rare
  - Routine liver enzyme level testing not necessary
- Psychosis and mania also very rare
Atomoxetine hcl (Strattera)

Selective norepinephrine reuptake inhibitor
Must take daily
Takes 1-2 weeks for initial effect and 4-6 weeks for full effect
Doses: 10, 18, 25, 40, 60, 80, 100 mg
Initial dose:
0.5 mg/kg/day in the morning or 2 divided doses up to 70 kg body weight
>70 kg body weight: 40mg/day in morning or 2 divided doses
After minimum of 3 days, increase dose up to 1.2 mg/kg/day, max dose is 1.4 mg/kg/day

Monitor for treatment-emergent side effects

- Delayed sleep: May use low doses of clonidine or Melatonin (1-3 mg, may go higher to 6 mg) for delay of sleep onset
- Tics: Alpha 2 adrenergic agonists such as clonidine and guanfacine may be used for tics, as adjunct or for comorbid aggression.
- Wear off: Need to increase dose to maximum (MPH 3-6 mg/kg/dose BID dextroamphetamine -1-3 mg/kg/dose BID) and then change medication. Can add IR tablet in afternoon, before 4PM

Considerations

- Titration: with children <6 years, may want to start with short acting BID until you get a sense of adequate response, then can change to long acting
- Extended release may not last long enough: May wear off earlier
- Mood changes: if extreme or "changes personality", try new medication
- Children with co-morbidity have unique responses to meds: start low, go slow. Can add SSRIs for anxiety, depression
- Parents require frequent consultation and availability of provider for concerns when starting medication

Evaluation of Response

- If none of the agents routinely use to treat 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
- Some children are rapid or slow metabolizers. May use genetic testing to identify medications that can use as directed, moderate drug-gene interaction, or significant drug-gene interaction (GeneSight, Genecept Assay by Genomind, Harmony, Gene Foresight)
- May want to refer to psychiatry or specialty service

Atomoxetine Prescribing

- Low weight-based starting dose, then increase to weight-based target
- Once daily dosing can be used, but efficacy and side effects may be improved with twice daily dosing (early AM and early evening)
- Effects may be seen as early as 1-2 weeks, maximal effects not achieved for 4-6 wks
  - Maintain full therapeutic dose for about a month to determine effect

Treating Comorbid ADHD + Anxiety/Depression

- Behavioral interventions and counseling are very important

Treating Comorbid ADHD and Anxiety or Depression

• Determine which disorder (ADHD vs. anxiety/depression) is more severe, and begin treatment for that disorder

• Do not begin medications for both at one time → treatment for one may improve symptoms of the other


Resources for Parents and Providers Caring for Children with ADHD

• CHADD (Children and Adults with Attention/Hyperactivity Deficit Disorder) http://www.chadd.org
  ➢ A resource for both parents and providers that include: Home of the National Resource Center for ADHD, ADHD toolkit, information on training opportunities, medications and natural treatment options and includes a magazine: ‘Attention’. Free pay-to-access member for full access to full articles.

• American Academy of Pediatrics (AAP) Healthy Children https://www.healthychildren.org/English/health-issues/conditions/adhd/Pages/Understanding-ADHD.aspx
  ➢ Wide range of information on variety of physical and emotional topics related to ADHD. No cost to access website.

  ➢ Wide range of information on ADHD and other comorbid psychiatric conditions along with treatment options. Free information for both parents and providers. Website not very interactive.

• Child Mind Institute https://childmind.org/about-us/
  ➢ Provides information on symptoms and treatment of mental health disorders. Excellent parenting suggestions and guides. Sections for educators. Includes a symptom checker for parents.

Questions?