



ADHD Management

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Disclosures

or

“Neither I nor my spouse/partner has a relevant financial relationship with a commercial interest to disclose.”





ADHD





ADHD

- What to do if and when a first stimulant trial does not seem to be working any more?





- Is the child **TAKING** the medicine as prescribed?
- How does the parent know?
- Conversation about the “nitty gritty” of medication adherence – where is the medicine kept?
- How much is the child responsible for versus the parent and is it appropriate for developmental level?





- Is an alarm useful?
- What about location of meds?
- Who reminds whom?
- Who is paying attention to supply running low?





Let's assume there is no adherence concern

- Is the medicine ineffective all day long, or is there a significant AM/PM discrepancy?
- Is there a recognizable wear off time?





- Consider getting a new/current Vanderbilt Rating Scale from home and school to verify nature and extent of ADHD symptoms as well as provide additional information on duration of action (some will look good during the school day while meds are active, but be quite symptomatic after school into the evening hours)
- Is there an unpleasant **REBOUND** – meaning what looks like worse ADHD at the time medicine wears off?



- Does day time dose need an increase?
- Do you need a longer duration of action version?
- Do you need later day supplementation?





If there is a good “daytime” stimulant response and later day coverage is the issue?

- Is there time for a 2nd dose of AM medicine?
- Is there time for a short acting version of the AM stimulant?
- If hyper activity/impulsivity is most problematic later in the day an alpha 2 agonist like Guanfacine (Tenex) or Clonidine (Catapres) may be suitable
- This may also be preferred if stimulant is already significantly impacting food intake/weight
- Timing of 2nd dose depends on wear off time of the AM medicine





If daytime symptom control is the issue then a dose **increase** is called for

- Your task is to determine the place of OPTIMUM response, not just improvement.
- If child is a **PARTIAL** responder on the optimum dose of stimulant then a switch to another stimulant versus Augmentation (usually with an alpha 2 agonist) may require consideration



For Adding an Alpha 2 Agonist

Things to consider:

- 1) What degree of coverage are you looking for?- short acting versus long-acting (Intuniv is long acting Guanfacine, Kapvay is long acting clonidine and may require twice a day dosing)
- Formulary requirements may dictate choice. Clonidine is stronger than Guanfacine. That may mean more sedation - is that what you want or not?



If With Your Initial Trial of a Stimulant You Have Optimized the Dose and Unacceptable Side Effects Supervene

- Switch to the alternative stimulant type e.g. from a methylphenidate derivative to an amphetamine derivative or vice versa
- There is no absolute equivalency
- You will have to see anew how your patient tolerates and responds to the new compound





Are There Circumstances Where You Might Begin With Other Than A Stimulant?

- 1) Significant tics – consider Strattera which does not make tics worse
- 2) If tics need treatment anyway – could start with an alpha 2 agonist for BOTH ADHD and TIC suppression





- For some children with Autism Spectrum Disorder, the very young and very hyperactive – rather than mostly inattentive- many will prefer to start with an alpha 2 agonist
- Stimulant response is less predictable the lower the IQ
- Guidelines for medication use in preschoolers emphasizes psychosocial interventions first if possible





- Where does Wellbutrin (Bupropion) fit in?
- It is classified as an antidepressant – an NDRI (Norepinephrine Dopamine Reuptake Inhibitor)
- It might be a first choice for a depressed older child who also has ADD/ADHD- Remember efficacy is less than for stimulants





- Can you combine stimulants, alpha 2 agonists, and Strattera – Yes for selected cases and with Project Teach guidance





Other Things to Consider If Stimulants Are Not Working

- 1) Is there something new that is stressful or dysregulating – divorce, illness, trauma, etc. – that would call for psychotherapeutic intervention?
- Is there a co-occurring condition?
- ODD is the most common complication – likely to require Parent Behavior Management training
- What about co-occurring Anxiety/Depression
- Is it mild/moderate enough for CBT
- Does this require an SSRI trial?
- Remember your screening tools, PHQ-9, SCARED





How is School Going?

- Does the child need a new educational assessment or re-assessment?
- Is there a Learning Disability or does this need to be explored with specific testing (medicines **DO NOT** take away a learning disability)
- Do any other neurodevelopmental conditions need consideration?
- In the age of **COVID** advocacy for in-person learning may be appropriate



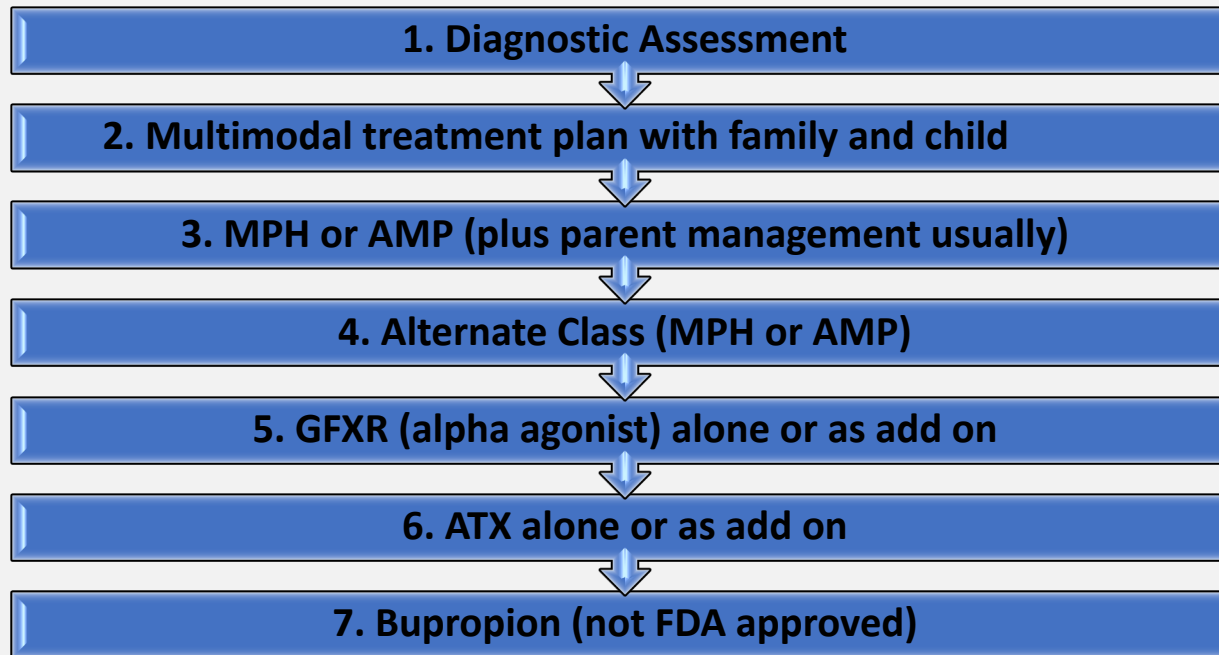


Autism Spectrum Disorder

- Gold standard for diagnosis is ADOS, ADI, SDQ and appropriate level of the Vineland Scale
- Speech/Language/Communication Disorders – will require assessment and treatment recommendations from the discipline of speech pathology



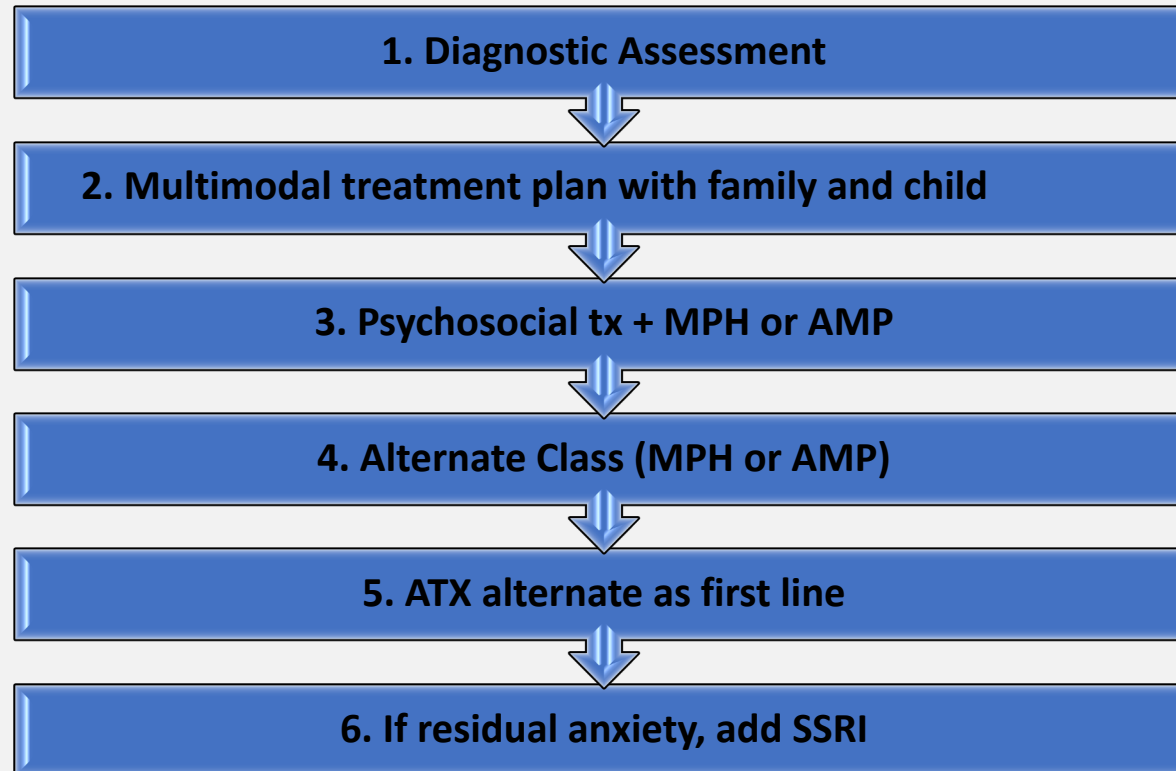
Garden Variety ADHD





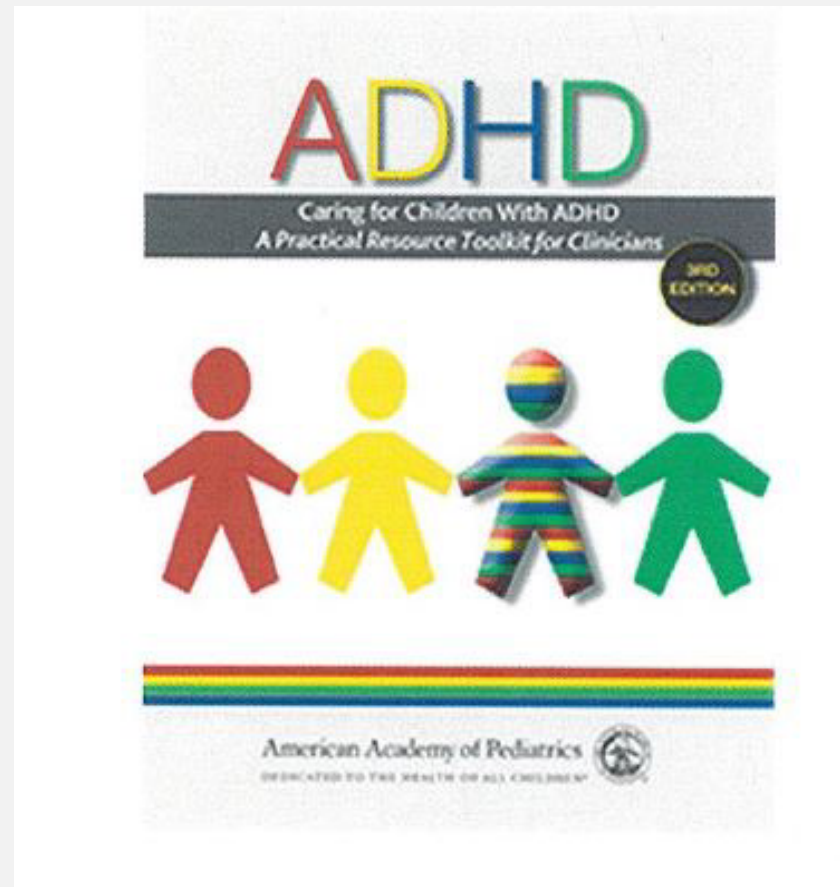
ADHD + Anxiety/Depression

Comorbidities and ADHD



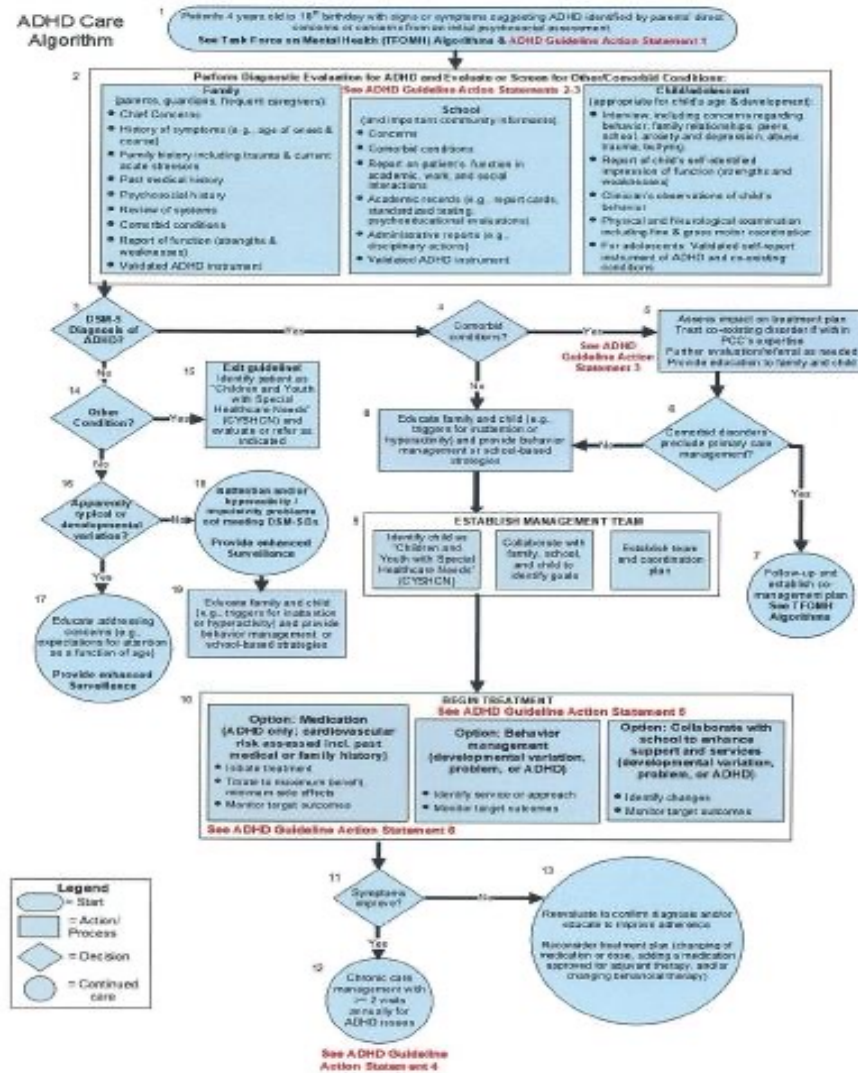


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ADHD Care Algorithm





Any Other Problems Call Project Teach

