What's Next?
ADHD treatment when medication is not "working"…

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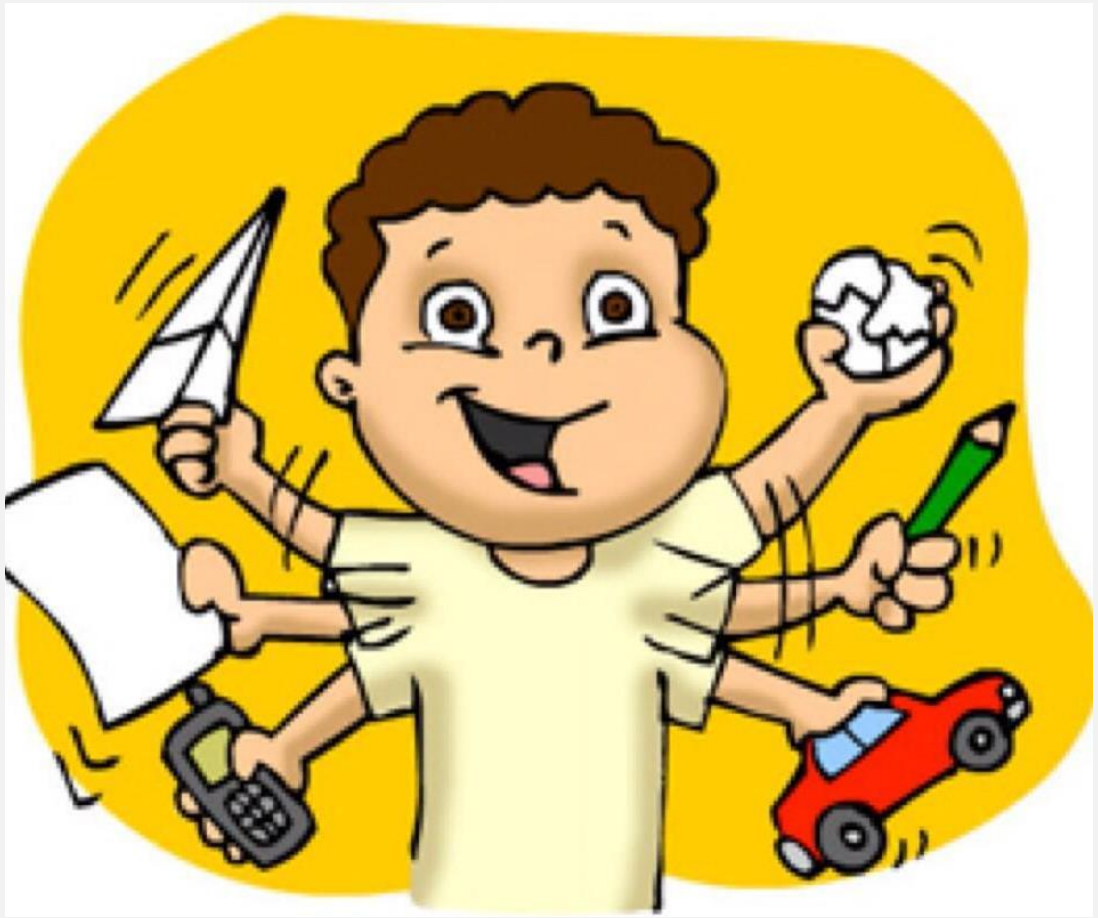
Disclosures

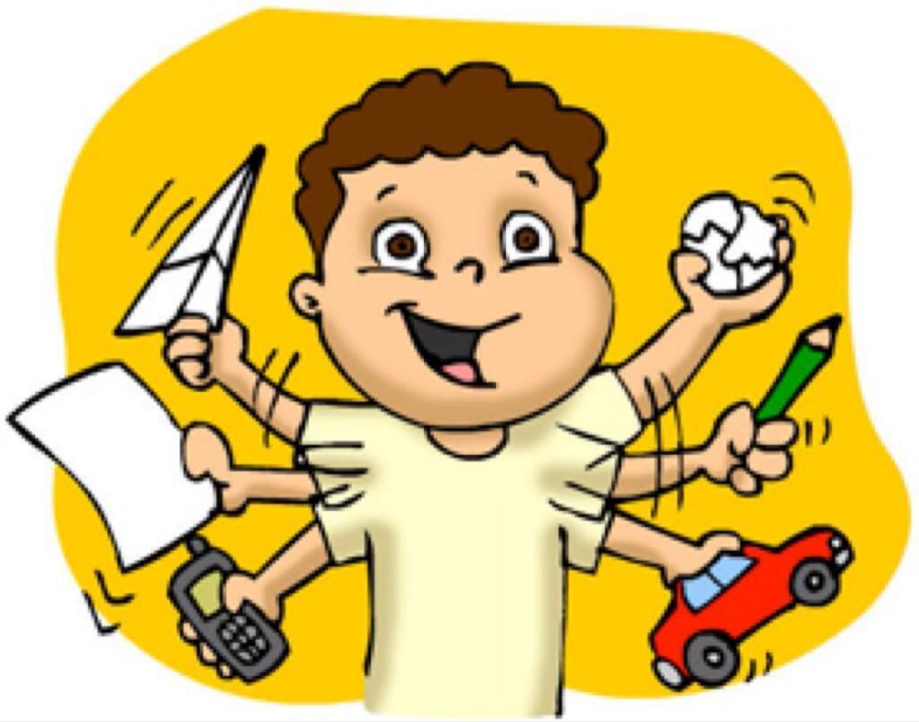
None



Meet Percy,
a 9-year-old with ADHD.

Over the next 20-30 minutes we will work together to help Percy and his family navigate common issues that we encounter especially when we get that call…

“This is not working!”



Percy

- ADHD: Combined Type (c/w P&T VRS)
- Parents sought behavioral intervention; they continue to work with therapist
- Notice of “promotion in jeopardy” in March of 2nd grade prompted motivation for medication
- Started Concerta 18mg, increased to 27mg during last 5 weeks of school a/w improvement, but residual symptoms.
- Held Rx over summer
- Restarted at 27mg a week before school started
- Now 9yo and towards the middle of Oct. in 3rd grade…

The medication is not helpful!

His grades are even worse than they were at this time last year!

School says he's behaving, but you should see him at home!

I think we need to try something else!

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What are most common reasons a medication may “not be working”?

- Adherence
- Insufficient dose
- Observation time
- Diagnostic question
- Comorbidity

What are reasons a medication may not "work"?

- Adherence
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- Is medication being TAKEN?
- Who administers?
- What prompts taking of medication?
- Diversion?

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What are reasons a medication may not "work"?

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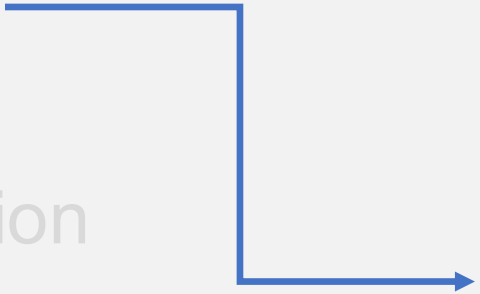

- Has dose been increased?
- Has patient grown?
- Is there an increase in demands on patient?

What are reasons a medication may not "work"?

- Adherence
- Insufficient dose
- Observation time
- Diagnostic question
- Comorbidity

- When is it not working?
- Could medication be wearing off?
- Is onset of action delayed?
- Rebound phenomenon?

What are reasons a medication may not "work"?

- Adherence
- Insufficient dose
- Observation time
- Diagnostic question
- Comorbidity

- Are we sure we are treating the right thing?
- Review differential?
- Additional work-up?

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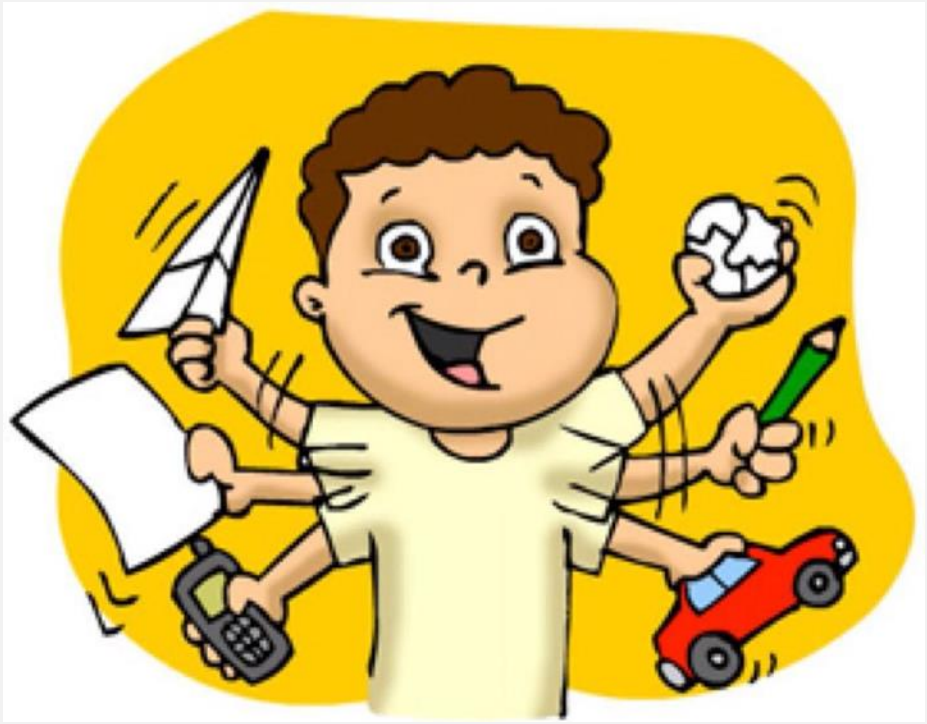
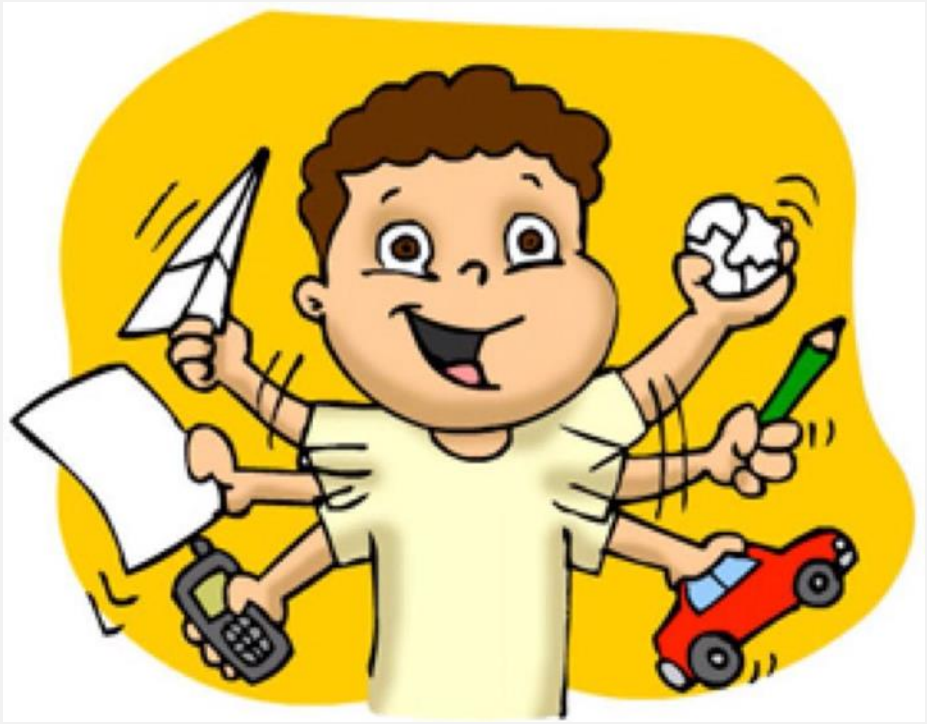
Percy – 9yo



- Mother gives medication (Concerta 27mg) after breakfast every morning
- Behaving fine in school, “at least not getting calls at work”, mornings may be little worse
- “Terrible” when he gets home; “won’t listen”, “all over the place”, “cannot get him to do any homework”, “it’s exhausting”
- He really has hard time settling down to go to bed, but this is not “new”

- **Adherence -> he is taking medication**
- **Observation time**
  - **Worse in morning - > take on empty stomach**
  - **Wears off/rebound -> consider booster**
- **Address sleep disruption**
  - **Sleep hygiene**
  - **Booster may help or Alpha**



Percy – 9yo

- FUVRS (p) – Consistent with ADHD:CT
- FUVRS (t) – Consistent with ADHD:CT, comment notes that “seems to do better around 10am, but has hard time by end of day”
- Both teacher and parent note difficulties in reading
- MGM was diagnosed with cancer and Percy is asking lots of questions about her health in addition to everyone else in the family
- Mother was promoted and is now working later more frequently and not home for most of after school routine

- **Dosage - > Treat to remission!**
- **Comorbidity**
  - **LD?**
  - **New onset anxiety?**
  - **Adjustment D/O?**

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What is our next step?

- Increase dose/Add booster
- SCARED
- CSE Evaluation
- “Mom’s” routine

Titration Considerations:

- Start low and go slow holds…but not too slow!
- Goal to optimize response vs. settling for improvement
- If child is a PARTIAL responder on the max dose of stimulant, switch to another stimulant OR consider augmentation (usually with an alpha 2 agonist)

D5 NICHQ Vanderbilt Assessment Follow-up—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: **Each rating should be considered in the context of what is appropriate for the age of your child. Please think about your child's behaviors since the last assessment scale was filled out when rating his/her behaviors.**

Is this evaluation based on a time when the child ☐ **was on medication** ☐ **was not on medication** ☐ **not sure?**

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3

Treat to remission!

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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
  - Can use web-based calculators as guide:
    - https://www.adhdmedcalc.com/
      - Also helpful in world of stimulant shortages

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

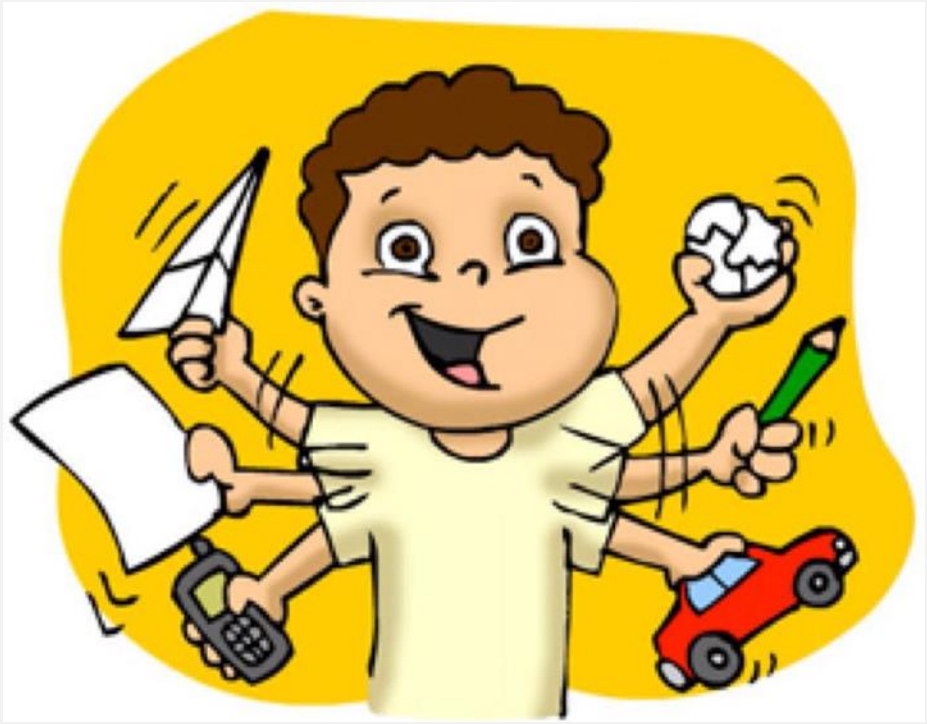
- Can a “booster” of a short acting version of the AM stimulant be added without impact on sleep?
  - Timing of 2nd dose depends on wear off time of the AM medicine
- If hyperactivity/impulsivity is most problematic later in the day an alpha 2 agonist like Guanfacine (Tenex) or Clonidine (Catapres) may be suitable
  - This may also be preferred if stimulant is already significantly impacting food intake/weight

Considerations when adding an Alpha 2 Agonist

- Hyperactivity/Impulsivity > Attention
- Sedation
  - What amount is tolerable? Is it advantageous?
  - Clonidine > Guanfacine
- HR/BP
- Adherence
  - Rebound hypertension

Other Things to Consider If Stimulants Are Not Working: Comorbidity/Diagnostic Issue

- Other Comorbidity?
  - What about co-occurring Anxiety/Depression
    - Is it mild/moderate enough for CBT
    - Remember your screening tools - PHQ-9, SCARED
    - Does this require an SSRI trial?
  - Learning Disorder
    - CSE evaluation for IEP need
    - Neuropsychiatric Testing
  - ODD
    - Parenting-based intervention recommended -> Parent Behavior Management Training



Percy –

9yo…4 weeks later…better, but parents still have concern that something is "not working"…

- Dose increased to 36mg and parents instructed to give before breakfast and @ two weeks 5mg MPH IR added after school
- Associated with improved behavior in school, both in the morning and through the end day, but parents note Percy has asked to stay home 3 times which had never happened before. On days he goes to school he has gone to the nurse feeling sick more frequently
- Unable to implement "Mom's" routine, but afternoons/evenings significantly better
- SCARED (p) – 18
- SCARED (c) – 34 (separation/generalized)
- Sleep hygiene addressed with improved onset of sleep and using melatonin gummy
- CSE evaluation in progress

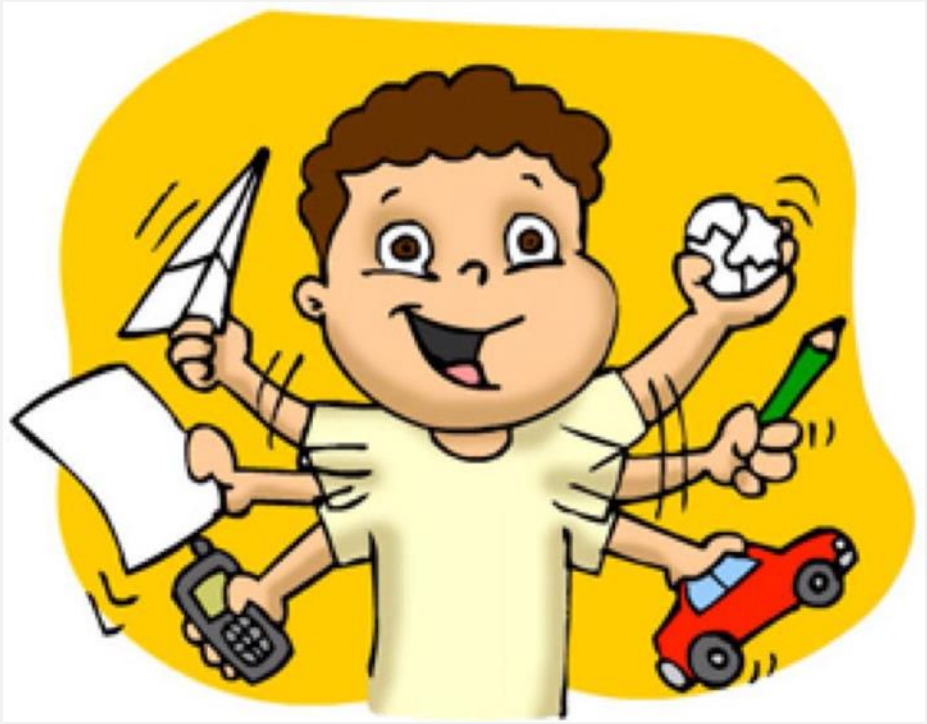
- **Anxiety?**
- **Adverse effect vs Comorbidity**

Treatment is still “not working”, now what?

- Psychoeducation (Anxiety)
- CBT 101
- Percy’s understanding of MGM illness
- Hold medication if concerned for stimulant exacerbation of anxiety

Percy –

9yo… 5 months later…



- Medication held for 1 week 4 months ago and a repeat SCARED completed without significant change.
- As per FUVRS titration was then continued to 54mg, Parent FUVRS (-) and Teacher FUVRS (-); still using 5mg booster
- Just received news that MGM is undergoing treatment and is responding well and remission is expected.

When Might A Stimulant's "Failure" Be More Predictable?

- Existing Tic Disorder –
  - May consider atomoxetine which is less associated w/ tic exacerbation
  - If tic causes impairment, could target both tic and ADHD sxs with Alpha-Agonist

When Might A Stimulant's "Failure" Be More Predictable?

- Significant Anxiety
  - Treat anxiety – CBT, SSRI, etc.
  - Atomoxetine – less likely to exacerbate anxiety vs stimulant…but questionable efficacy

When Might A Stimulant's "Failure" Be More Predictable?

- Children with ASD
  - Generally more sensitive to side effects
  - With ADHD: hyperactive/impulsive type and/or with aggression consider alpha first.

Take homes…
when medication doesn't seem to "work"

- There is not a SINGLE "right way"
- Dosing:
  - Adherence
  - Treat to remission
  - Use FUVRS and other collaterals to guide MDM and titration recommendations
  - If partial response to max dose, consider switching to alternative vs augmenting with alpha
  - Booster (stim or alpha) if wear off is likely
- Comorbidity vs. Misdiagnosis
  - Consider learning disorders – CSE evaluation
  - Use screeners to help rule out (PHQ9, SCARED, GAD7, CRAFFT, CPSS-V)
  - Life circumstances – Adjustment D/O

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Whenever in doubt, always remember, with Project Teach….