HPH Guidelines for Evaluation and Initial Management of ADHD

Effective February 27, 2017

Purpose of This Clinical Tool:

Attention-deficit/hyperactivity disorder (ADHD) is the most common neurobehavioral disorder of childhood and can profoundly affect the academic achievement, well-being, and social interactions of children. The American Academy of Pediatrics first published clinical recommendations for the diagnosis and evaluation of ADHD in 2000.

Summary of AAP Clinical Recommendations:

1) The PCP should evaluate for ADHD in any child 4-18 years old who presents with academic or behavioral problems and symptoms of inattention, hyperactivity, or impulsivity.

2) To make a diagnosis:
   a. Determine that DSM-IV criteria have been met, including impairment in more than one major setting.
   b. Information should be obtained from reports from parents/guardians, teachers, and other school and mental health clinicians involved in child's care.
   c. Other alternative causes of symptoms have been ruled out.

3) Include assessment for other conditions that might co-exist with ADHD:
   a. Emotional or behavioral disorders: anxiety, ODD, depression, conduct disorder.
   b. Developmental disorders: learning and language disorders, neurodevelopmental disorders.
   c. Physical conditions: tics, sleep apnea.

4) Recognize ADHD as a chronic condition and therefore consider children and adolescents with ADHD as children and youth with special health care needs. Thus, management should follow the principles of the chronic care model and the medical home.

5) Recommendations for treatment vary depending on the patient's age:
   a. *Preschool aged children (4-5 years of age):* prescribe evidence based behavioral therapy as the first line of treatment and may prescribe Methylphenidate if the behavior interventions do not provide significant improvement and there is moderate-to-severe continuing disturbance in the child's function. In areas where evidence-based behavioral treatments are not available, the clinician needs to weigh the risks of starting medication at an early age against the harm of delaying diagnosis and treatment.
   b. *Elementary school-aged children (6-11 years of age):* prescribe US FDA approved medication and/or evidence-based parent and/or teacher-administered behavior therapy as treatment. The evidence is particularly strong for stimulant medications and sufficient but less strong for atomoxetine, extended release guanfacine, and extended release clonidine. The school environment, program, or placement is part of any treatment plan.
   c. *Adolescents (12-18 years of age):* prescribe US FDA approved medication with the assent of the adolescent and may prescribe behavior therapy as treatment.

6) The PCP should titrate doses to medication to achieve maximum benefit with minimum adverse effects.

Initial Medication Management:

Goals: Negotiate goals with parents and patient:

- Ex: Increased work completion, decreased need for correction of behavior at school, decreased negative interactions with other children.
- Start with lowest dose of short acting medication Methylphenidate 5 mg (Ritalin equivalent) or mixed salts of amphetamine 5 mg (Adderall equivalent) BID (morning and lunchtime) and adjust as needed for symptom control.
- Evaluate with Vanderbilt questionnaire once before starting and at 1 month after medication.
- Recheck patient in office in 1 month after starting medication and assess:
    - School function – getting work done, behavioral problems, last report card satisfactory
    - Adherence to medications – missed doses, taking meds as prescribed
    - Side effects – sleep, appetite, headaches, stomach pain, tics, weight loss
    - Monitor for appropriate weight gain and normal blood pressure
- Continue to recheck patient every month until symptoms controlled and there is evidence of weight gain or stabilizations (if initial weight loss noted).
- Consider changing medication if:
    - Significant side effects
    - No symptom relief despite maximum dose of medication
    - Weight loss x 2 months on meds or 4 months without weight gain
- When weight is stable and if no sleep problems consider switch to long-acting medication:
    - Methylphenidate CR (Concerta semi equivalents, Concerta and the Mcneill generic are more expensive and no longer on most insurance formularies) tend to last about 10-12 hours.
    - Methylphenidate LA or ER (tend to last about 8-10 hours).
    - Mixed salts of amphetamine XR (Adderall XR equivalents) tend to last about 10 -12 hours.
- Once patient is stable on medications – evaluate every 2-3 months.
- Do not recommend medication holidays = continue meds 7 days a week to maximize symptom control and minimize side effects associated with medication breaks.

First line medication: Ritalin SA (short-acting) 5mg or 10mg

- Start with Ritalin SA Q4H x 2 doses (breakfast and lunch dosing).
- Good medication to start with due to short duration – will see results quickly and will wear off in 4-6 hours if there are side effects to medications.

Adderall

- Consider switching to this medication if symptoms not controlled on Ritalin.
- Dosing to start at ½ of last Ritalin dose used.

Strattera

- Consider use of these long acting medications if there are still side effects on Adderall.

Consider Referral to:

1) Psychiatry or Developmental Pediatrician if there are any of the following:
    - Concerns about new development of anxiety or pre-existing anxiety worsens with treatment
    - There is failed monotherapy or a need for polypharmacy
    - Patient has maxed out on current medications (54 mg of Concerta, 30mg of Adderall XR)
    - There are other co-morbidities complicating diagnosis or treatment = ex. Autism, Eating Disorders

2) Cognitive Behavioral Therapist if there is significant Oppositional or Conduct Disorder behaviors.