Clinical Update: ADHD

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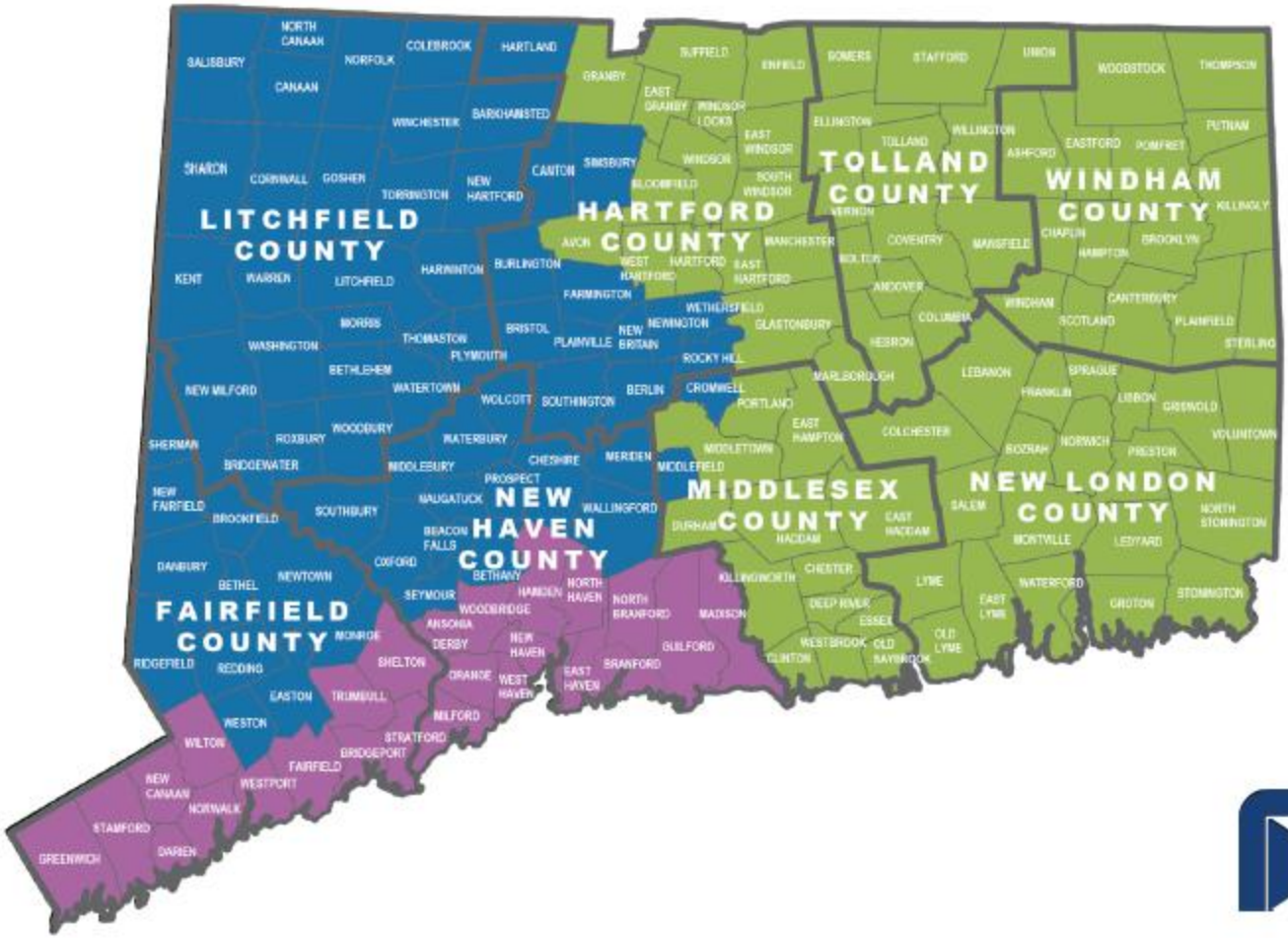
ACCESS-Mental Health CT - Institute of Living

Connecticut Academy of Family Physicians

October 30th, 2025

ACCESS-Mental Health CT

- Hartford Hospital 855.561.7135
- Wheeler Clinic, Inc. 855.631.9835
- Yale Child Study Center 844.751.8955



ACCESS Mental Health CT

How To Start?

- Develop flow for academic problems
- Hearing & vision
- Genetic abnormalities?
- In psychiatric care?
- School screen
  - Birth to 3
  - Preschool
  - 504 or IEP
  - Grade level
- Mental Health History Form

Cardiac Health and Family History Form

(To be completed by Patient, parent or guardian prior to examination)

- Patient History
- Has your child ever had any of the following conditions or symptoms:
- 1. History of any kind of heart problem? Yes No
- 2. Palpitations, fast heart rate or extra skipped beats? Yes No
- 3. Syncope(fainting) or dizziness with exercise? Yes No
- 4. Seizures Yes No
- 5. Is your child taking any supplements(non-prescription drugs)? Yes No
- 6. Congenital deafness Yes No
- (a person born without the ability to hear and never improved)?
- 7. Is your child taking any medications (prescription and over the counter) Yes No
- If yes, please list them:
- _____
- _____

Family History

- 1. Has anyone in your family had a heart attack before the age of 40? Yes No
- 2.Has anyone in your family died from sudden death? Yes No
- 3.Does anyone in your family have a cardiac arrthymia? Yes No
- (This is when the heart has an irregular heart beat, skipped or extra beats?
- 4.Congenital Deafness Yes No
- (a person born without the ability to hear and never improved)?
- 5. Does anyone in your family have these cardiac conditions:
- * Hypertrophic cardiomyopathy (HCM)? Yes No
- *Prolonged QT Syndrome? Yes No
- *Wolf Parkinson White or other specific condition Yes No

(To be completed by Patient, Parent or Guardian prior to examination)

Patient History

Has **your child** ever had any of the following conditions or symptoms:

1. History of any kind of heart problem? ☐ Yes ☐ No
2. Palpitations, fast heart rate or extra or skipped beats? ☐ Yes ☐ No
3. Syncope (fainting) or dizziness with exercise? ☐ Yes ☐ No
4. Seizures ☐ Yes ☐ No
5. Is your child taking any supplements (non prescription drugs)? ☐ Yes ☐ No
6. Congenital Deafness ☐ Yes ☐ No
   (a person born without the ability to hear and never improved)?
7. Is your child taking any medications (prescription and over the counter) ☐ Yes ☐ No
   If yes, please list them:

_____
_____
_____

Family History

1. Has anyone in your family had a heart attack before the age of 40? ☐Yes ☐ No
2. Has anyone in your family died from sudden death? ☐ Yes ☐ No
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4. Congenital Deafness ☐ Yes ☐ No
   (a person born without the ability to hear and never improved)?
5. Does anyone in your family have these cardiac conditions:

   * Hypertrophic cardiomyopathy (HCM)? ☐ Yes ☐ No
   * Prolonged QT Syndrome ? ☐ Yes ☐ No
   * Wolf Parkinson White or Other specific condition ☐ Yes ☐ No

CHILD AND FAMILY MENTAL HEALTH HISTORY

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

Part of routine screening for your health includes considering mood and emotional concerns.
Instructions: For each question put an "X" in the box beneath the answer that best describes you (the patient), your parents, and siblings (brothers and sisters).

	YES	NO	UNSURE
1. Have you, your parents or siblings ever suffered from a psychiatric, behavioral, or emotional disorder?	☐	☐	☐
If YES, which disorder(s):			
a. Attention Deficient Hyperactivity Disorder (ADHD)	☐	☐	☐
b. Anxiety	☐	☐	☐
c. Bi-polar disorder	☐	☐	☐
d. Depression	☐	☐	☐
e. Psychotic Depression	☐	☐	☐
f. Alcohol and/or substance abuse	☐	☐	☐
g. History of suicide	☐	☐	☐
h. History of sexual/physical/emotional abuse	☐	☐	☐
i. Other (describe):_____	☐	☐	☐
2. Have you, your parents, or siblings ever been hospitalized for a psychiatric, behavioral, or emotional reason? If YES, please describe:_____	☐	☐	☐
3. Are you, your parents or siblings taking any medication for psychiatric, behavioral, or emotional reasons? If YES, what type of medication:_____	☐	☐	☐
4. Has your family experienced any major stresses, changes, or losses within the past year? If YES, which stresses or changes:	☐	☐	☐
a. Death of a close family member, relative, friend or pet	☐	☐	☐
b. Divorce or separation	☐	☐	☐
c. Marriage	☐	☐	☐
d. Abuse or trauma	☐	☐	☐
e. Conflict or bullying	☐	☐	☐

Initial Packet For Family:

- Letter For School
- 3-5: request Early Childhood Assessment Team
- 5+ request psycho-educational testing
- Vanderbilt screens for home and school with your fax
- Signed consent to speak to school staff

Letter For School

- DATE:
- RE:
- DOB:
- I have met with the above-named child and family to evaluate the patient for school problems.
- The child's physical exam, including a neurological assessment, is normal. We request that the school system conduct the following, or forward the results if already conducted.
-
- Comprehensive Psycho-Educational Testing
- Teacher Vanderbilt and Teacher Assessment Forms
- Planning and Placement Team (PPT) Notes
-
  Please fax or mail a copy of these results to our primary care office via contact information listed below.
-
- Thank you for your assistance in this matter. Please feel free to contact me with any questions or concerns.
-
- Sincerely,
- _____ _____
- Health Care Provider Parent or Guardian

NICHQ Vanderbilt Assessment Scale—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. When completing this form, please think about your child's behaviors in the past 6 months.**

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
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3

D4 **NICHQ Vanderbilt Assessment Scale—TEACHER Informant**

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Directions: **Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the beginning of the school year. Please indicate the number of weeks or months you have been able to evaluate the 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. Fails to give attention to details or makes careless mistakes in schoolwork	0	1	2	3
2. Has difficulty sustaining attention to tasks or activities	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by extraneous 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 in classroom or in other situations in which remaining seated is expected	0	1	2	3
12. Runs about or climbs excessively in situations in which remaining seated is expected	0	1	2	3
13. Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks excessively	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting in line	0	1	2	3
18. Interrupts or intrudes on others (eg, butts into conversations/games)	0	1	2	3
19. Loses temper	0	1	2	3
20. Actively defies or refuses to comply with adult's requests or rules	0	1	2	3
21. Is angry or resentful	0	1	2	3
22. Is spiteful and vindictive	0	1	2	3
23. Bullies, threatens, or intimidates others	0	1	2	3
24. Initiates physical fights	0	1	2	3
25. Lies to obtain goods for favors or to avoid obligations (eg, "cons" others)	0	1	2	3
26. Is physically cruel to people	0	1	2	3

AACAP Resources: ADHD

- Facts For Families Handouts
- Parents Medication Guide ADHD (Spanish, ASD)
- Practice Parameters
- ADHD Resource Center
- AAP resources

Practice Parameters AACAP

Practice Parameter for the Assessment and Treatment of Children and Adolescents With Attention-Deficit/ Hyperactivity Disorder

ABSTRACT

This practice parameter describes the assessment and treatment of children and adolescents with attention-deficit/ hyperactivity disorder (ADHD) based on the current scientific evidence and clinical consensus of experts in the field. This parameter discusses the clinical evaluation for ADHD, comorbid conditions associated with ADHD, research on the etiology of the disorder, and psychopharmacological and psychosocial interventions for ADHD. *J. Am. Acad. Child Adolesc. Psychiatry*, 2007;46(7):894–921. **Key Words:** attention-deficit/hyperactivity disorder, evaluation, treatment, practice parameter.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents

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CAFP Update on ADHD ~
October 30th, 2025

DSM 5 Updates:

DSM IV	DSM V
Symptoms present before age 7	Symptoms present before age 12
Subtypes:	**Presentations:** Inattentive, Hyperactive-Impulsive, Combined
No specification	Must specify: mild, moderate, severe
Impairment in more than one setting	Several symptoms should be present in more than one setting
	If you are 17 or older, only 5 symptoms are needed instead of 6

Follow Up in 2 weeks

- Review screens & testing
- Decide whether to start medication
- Parent information on how ADHD is managed
  - How parents request refills
  - Frequency of follow up

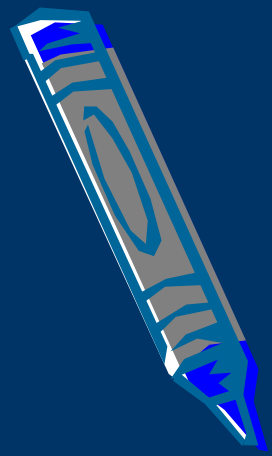
Starting Medication

- Stimulants first
- Target: 1 mg/kg methylphenidate
- ½ mg/kg focalin, adderall, & Dexedrine
- Starting dose = half
- Vyvanse 30=Adderall XR 10 Vyvanse 50=Adderall XR 20 Vyvanse 70=Adderall XR 30
- Guanfacine, clonidine, & atomoxetine

Medications Approved by the FDA for ADHD (Alphabetical by Class)

Generic Class/ Brand Name	Dose Form	Typical Starting Dose	FDA Max/Day	Off-Label Max/Day	Comments
Amphetamine preparations					
Short-acting					Short-acting stimulants often used as initial treatment in small children (<16 kg), but have disadvantage of b.i.d.-t.i.d. dosing to control symptoms throughout day
Adderall[a]	5, 7.5, 10, 12.5, 15, 20, 30 mg tab	3–5 y: 2.5 mg q.d.; ≥6 y: 5 mg q.d.–b.i.d.	40 mg	>50 kg: 60 mg	
Dexedrine[a]	5 mg cap	3–5 y: 2.5 mg q.d.			
DextroStat[a]	5, 10 mg cap	≥6 y: 5 mg q.d.–b.i.d.			
Long-acting					Longer acting stimulants offer greater convenience, confidentiality, and compliance with single daily dosing but may have greater problematic effects on evening appetite and sleep Adderall XR cap may be opened and sprinkled on soft foods
Dexedrine Spansule	5, 10, 15 mg cap	≥6 y: 5–10 mg q.d.–b.i.d.	40 mg	>50 kg: 60 mg	
Adderall XR	5, 10, 15, 20, 25, 30 mg cap	≥6 y: 10 mg q.d.	30 mg	>50 kg: 60 mg	
Lisdexamfetamine	30, 50, 70 mg cap	30 mg q.d.	70 mg	Not yet known	
Methylphenidate preparations					
Short-acting					Short-acting stimulants often used as initial treatment in small children (<16 kg) but have disadvantage of b.i.d.-t.i.d. dosing to control symptoms throughout day
Focalin	2.5, 5, 10 mg cap	2.5 mg b.i.d.	20 mg	50 mg	
Methylin[a]	5, 10, 20 mg tab	5 mg b.i.d.	60 mg	>50 kg: 100 mg	
Ritalin[a]	5, 10, 20 mg	5 mg b.i.d.	60 mg	>50 kg: 100 mg	
Intermediate-acting					Longer acting stimulants offer greater convenience, confidentiality, and compliance with single daily dosing but may have greater problematic effects on evening appetite and sleep
Metadate ER	10, 20 mg cap	10 mg q.a.m.	60 mg	>50 kg: 100 mg	
Methylin ER	10, 20 mg cap	10 mg q.a.m.	60 mg	>50 kg: 100 mg	
Ritalin SR[a]	20 mg	10 mg q.a.m.	60 mg	>50 kg: 100 mg	
Metadate CD	10, 20, 30, 40, 50, 60 mg	20 mg q.a.m.	60 mg	>50 kg: 100 mg	
Ritalin LA	10, 20, 30, 40 mg	20 mg q.a.m.	60 mg	>50 kg: 100 mg	Metadate CD and Ritalin LA caps may be opened and sprinkled on soft food
Long-acting					
Concerta	18, 27, 36, 54 mg cap	18 mg q.a.m.	72 mg	108 mg	Swallow whole with liquids Nonabsorbable tablet shell may be seen in stool.
Daytrana patch	10, 15, 20, 30 mg patches	Begin with 10 mg patch q.d., then titrate up by patch strength	30 mg	Not yet known	
Focalin XR	5, 10, 15, 20 mg cap	5 mg q.a.m.	30 mg	50 mg	
Selective norepinephrine reuptake inhibitor					
Atomoxetine					Not a schedule II medication
Strattera	10, 18, 25, 40, 60, 80, 100 mg cap	Children and adolescents <70 kg: 0.5 mg/kg/day for 4 days; then 1 mg/kg/day for 4 days; then 1.2 mg/kg/day	Lesser of 1.4 mg/kg or 100 mg	Lesser of 1.8 mg/kg or 100 mg	Consider if active substance abuse or severe side effects of stimulants (mood lability, tics); give q.a.m. or divided doses b.i.d. (effects on late evening behavior); do not open capsule; monitor closely for

Sample letter clarifying Office ADHD policy



Dear Parents:

We would like to take this opportunity to share the office policy regarding follow up/medication refills for ADD/ADHD.

The treatment plan for your child requires close follow up. You can expect that your child will have regularly scheduled follow up appointments with the doctor. We may not be able to refill a prescription if your child has not had a follow up appointment.

Medication refills will only be written by the prescribing doctor. To allow time for the prescribing doctor to write your prescription, requests should be called to our office 5-7 days before you expect to run out of medication. Each prescription may only be written for a 30 day supply.

To assist with planning our doctors are available in the office on the following days:

Dr. Smith :Monday through Friday

Dr. Jones: Wednesday, Thursday, Friday

Dr. Percy: Monday Tuesday

Thank you!

Your Health Care Team

Follow Up Visits:

- Effect
- Side effects
- Blood Pressure, Pulse, & BMI
- Follow-up Teacher Vanderbilt

Kaylee

- 9 y.o. female seen in your practice a couple of times
- Family calls to make an appointment for “school concerns”
- As you are reviewing the chart, you realize Kaylee has not had a routine physical exam in 2-3 years
- You turn visit into a physical
- Family receives routine screens PSC-17 is within normal limits

Kaylee, continued

- Height/weight/BMI=50th percentile
- Hemoglobin =WNL
- Blood pressure=100/60 Heart rate=65
- Hearing Test=pass
- Vision Test= 20/200 bilaterally

Does Kaylee have ADHD?

Alan

- 11 y.o. male followed in your practice since birth.
- Mom calls for an appointment to discuss Eric's school progress.
- School complains that Eric is fidgety, does not pay attention or follow directions. He is socially successful and is respectful to teachers.
- His physical is up to date, no concerns about hearing or vision
- You send letter and Vanderbilt to school as well to parents.
- You make an appointment with Alan and his mother in 2 weeks to review information
- Teacher's score on Vanderbilt= 39
- Parent's score on Vanderbilt=11
- You observe Alan coloring quietly, completes word find, follows directions, able to sit still and attend

SAMPLE **NICHQ Vanderbilt Assessment Scale—PARENT Informant**

Today's Date: **4-7-02** Child's Name: **John Doe** Date of Birth: **10-18-94**

Parent's Name: **Jane and Louis Doe** Parent's Phone Number: **555-1212**

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When comple this form, please think about your child's behaviors in the past 6 months.

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

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

46. Is sad, unhappy, or depressed	0	(1)	2		
47. Is self-conscious or easily embarrassed	0	(1)	2		

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Prob
48. Overall school performance	1	2	3	(4)	
49. Reading	1	2	3	4	
50. Writing	1	2	3	(4)	
51. Mathematics	1	2	(3)	4	
52. Relationship with parents	1	2	3	(4)	
53. Relationship with siblings	1	2	3	(4)	
54. Relationship with peers	1	2	3	(4)	
55. Participation in organized activities (eg, teams)	1	2	(3)	4	

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: **9**

Total number of questions scored 2 or 3 in questions 10–18: **7**

Total Symptom Score for questions 1–18: **39**

Total number of questions scored 2 or 3 in questions 19–26: **0**

Total number of questions scored 2 or 3 in questions 27–40: **0**

Total number of questions scored 2 or 3 in questions 41–47: **0**

Total number of questions scored 4 or 5 in questions 48–55: **6**

Average Performance Score: **3.9**

Physician Note: John Doe met DSM
ADHD Combined Inattention/Hyper

Does Alan have ADHD?

- Should you initiate a stimulant trial?
- What else might be going on here?

- If Vanderbilt screens and/or your clinical observation does not agree, reconsider diagnosis
- Could Alan's behavior be explained by an undiagnosed learning disability?
- Why might his symptoms be different at school?

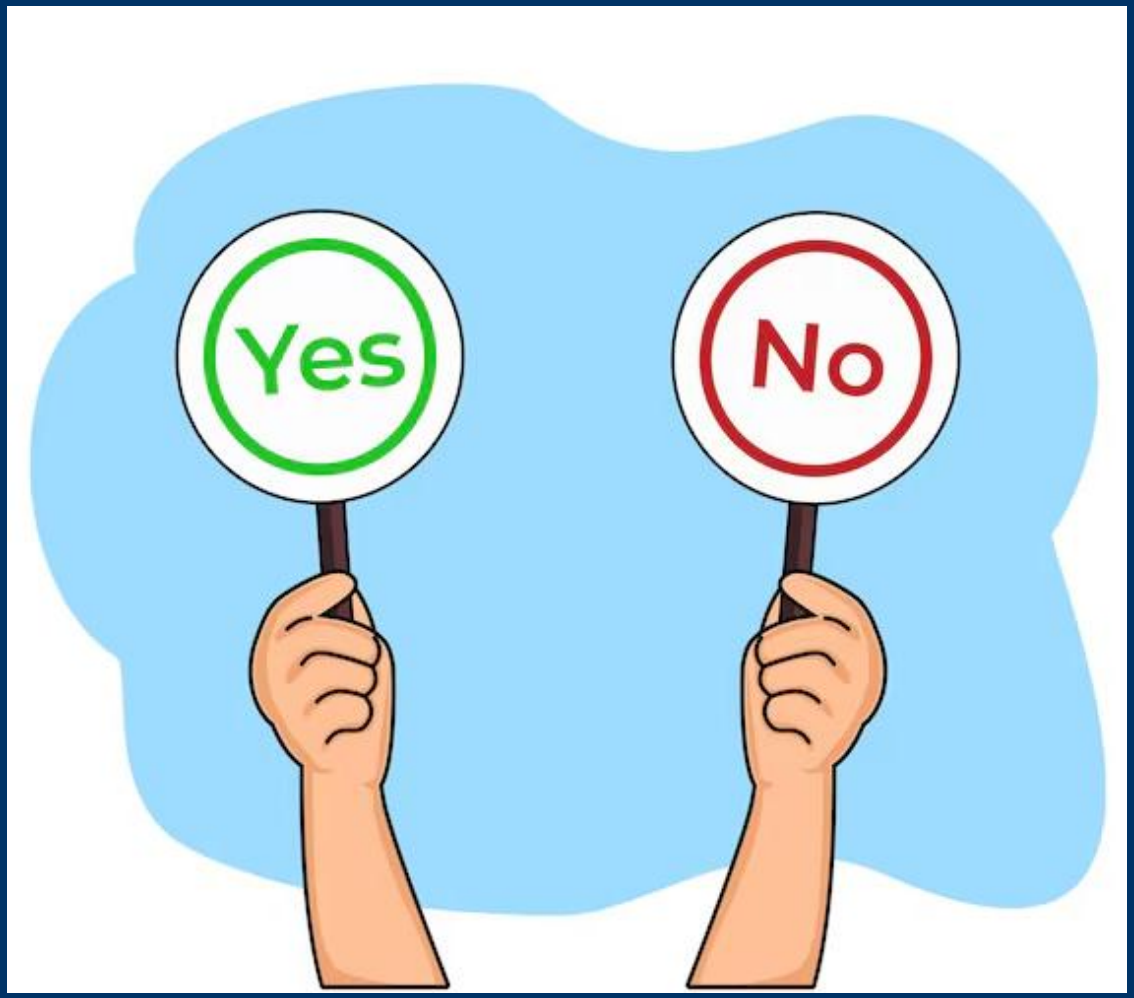
Billy

- Billy, an 8 year old, comes in for a well child visit.
- Mom notes a drop in academic performance for 3rd grade and wonders about a learning problem.
- Teachers states “he just needs to show more effort”. He is too easily distracted by his peers.
- What do you do?

Billy, Continued

- PE is up to date- no medical concerns
- Send Vanderbilt screens to home and school
- Arrange follow up in 2 weeks
- Teacher's Vanderbilt =39
- Parent's Vanderbilt=38
- Psych testing shows no LD, reports consistent with ADHD
- Should you initiate a stimulant?

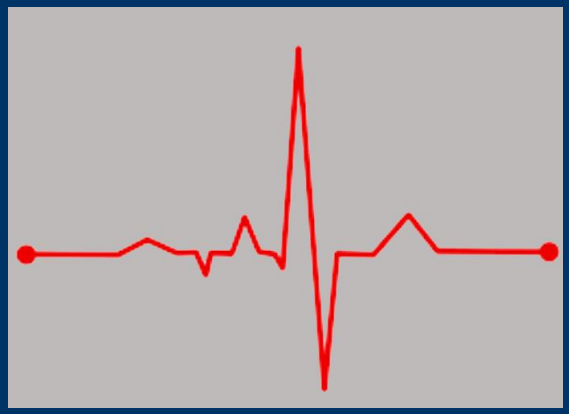
Start Stimulant?



What did we forget?

- Billy's brother had a radio frequency ablation last year for WPW
- Billy's father had one too
- What is the most prudent course of action?

- EKG



- Pediatric Cardiology?

If family history screen was very strongly + for Bipolar Disorder, would this change your plans?

Family History Positive for Bipolar Disorder

- For an atypical presentation, consider referral to child psychiatry
- Or proceed with caution and have a low threshold for discontinuing stimulant & referring

Carlos

- 8 yo boy you first saw in the newborn nursery
- You follow his 2 siblings for years
- Mom calls you and leaves a message that Johnny is struggling in 3rd grade

Carlos – cont.

- Vanderbilt screening
- Obtain release for school
- F/U in 2 weeks
- The office manager obtains copies of psycho-educational testing which showed: IQ=102 without split
- Achievement Tests = Normal

You are ready now

- Schedule the patient in a 30-minute slot at the end of the day
- You review your most recent physical exam - WNL
- You meet with the parents and Johnny
- Johnny “School is too hard this year! I like Xbox better.”
- Parents: “It is like he is driven by a motor. When we sit down to supervise his homework it takes 3 hours because he needs constant re-direction and he is so distracted by everything!”

Carlos Family History

- Father, Uncle Ted and 1 sibling were diagnosed and treated for childhood-onset ADHD
- Cardiac History WNL

Now it is time

- You start methylphenidate ER 18 mg daily
- You make another appointment for 2 weeks
- After 1 month, you send the teacher either the Vanderbilt follow up. They fax it directly
- You enjoy the teacher's comments that Johnny is like "a new boy"

Summary:
Obtain clinical information

- From family
- From school
- Consider alternative etiologies: sleep apnea, hypothyroidism, anemia

In Summary continued: consider comorbidities

- Anxiety
- Mood disorders
- Trauma-based disorders (PTSD)
- Rarely: Psychosis
- Tourette's

In Summary Final: Recognize as a chronic condition

- Maintain ongoing follow up
- PCP office should become a medical home
- Use a chronic care model for treatment
- This can involve a “Chronic Disease Registry” in your office which could look like:
- -a cardex
- -an excel spread sheet
- Some offices will designate one person (medical assistant or nurse)to be in charge of all matters involving ADHD diagnosis and follow up
- This person can ensure parents complete all relevant paperwork & that you have the results of Vanderbilt screening. They can also obtain copies of any formal psycho educational testing done by school

ADHD DSM-V

People with ADHD show a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development:
Inattention: Six or more symptoms of inattention for children up to age 16, or five or more for adolescents 17 and older and adults; symptoms of inattention have been present for at least 6 months, and they are inappropriate for developmental level:

Inattention

Six or more of the following symptoms of inattention have been present for at least 6 months to a point that is inappropriate for developmental level

- Often does not give close attention to details or makes careless mistakes in schoolwork, work, or other activities.
- Often has trouble keeping attention on tasks or play activities.
- Often does not seem to listen when spoken to directly.
- Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (loses focus, gets sidetracked).
- Often has trouble organizing activities.
- Often avoids, dislikes, or doesn't want to do things that take a lot of mental effort for a long period of time (such as schoolwork or homework).
- Often loses things needed for tasks and activities (e.g. toys, school assignments, pencils, books, or tools).
- Is often easily distracted.
- Is often forgetful in daily activities.

Hyperactive-impulsive Presentation

Six or more of the following symptoms of hyperactivity-impulsivity have been present for at least 6 months to an extent that is disruptive and inappropriate for developmental level

- Often fidgets with hands or feet or squirms in seat when sitting still is expected.
- Often gets up from seat when remaining in seat is expected.
- Often excessively runs about or climbs when and where it is not appropriate (adolescents or adults may feel very restless).
- Often has trouble playing or doing leisure activities quietly.
- Is often "on the go" or often acts as if "driven by a motor".
- Often talks excessively.
- Often blurts out answers before questions have been finished.
- Often has trouble waiting one's turn.
- Often interrupts or intrudes on others (e.g., butts into conversations or games).

Female Vs. Male ADHD

- Females tend to be more inattentive, less disruptive but social impact often significant
- Girls show less impulsivity (MTA, 2001)
- More associated with academic impairment, not behavioral impairment
- Impulsivity associated with more “social butterfly chatter” rather than aggression or disruption
- Girls w ADHD have higher levels of anxiety, somatization; less ODD/CD

Nonpharmacologic Interventions

- Family education
- Behavior therapy
- Social skills training?
- Regular follow-up
- Anticipatory guidance re: accidents, substance use, & conduct disorder

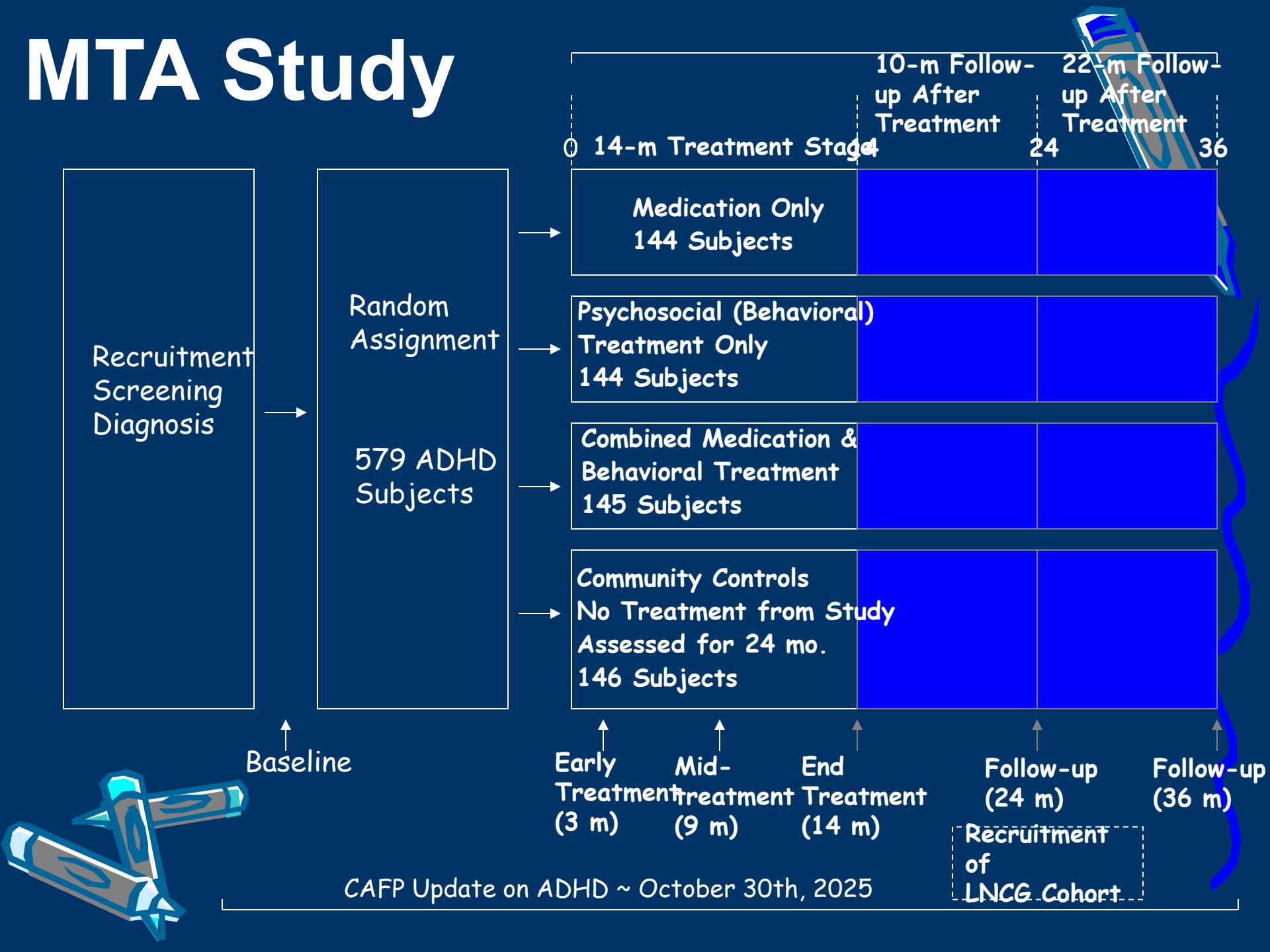
ADHD & School

- Impact on learning varies depending on symptom impact
- Full psycho-educational evaluation if learning below grade level
- Neuropsychological evaluation
- 504 plan vs IEP designation

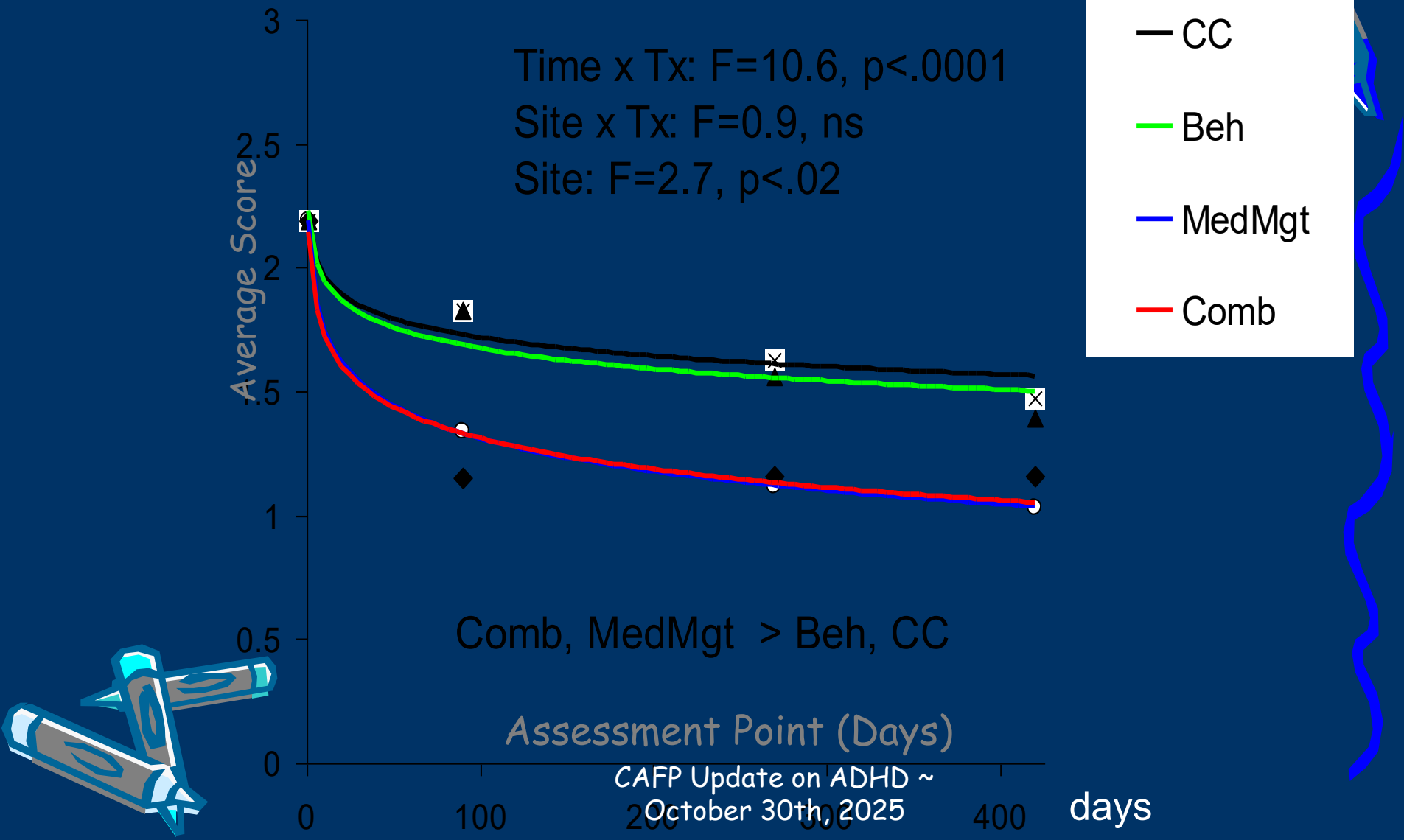
PATS Study (2006): Preschool ADHD Treatment Study

- Methylphenidate efficacy in preschool children
- Effect size in MTA .9-1.2 75-80%
- Effect size in PATS (0.4-0.8)
- More side effects & intolerance (11% discontinued) and impact on growth rates
- A higher threshold for pharmacotherapy is warranted

MTA Study


10-m Follow-up After Treatment
22-m Follow-up After Treatment
0
14-m Treatment Stage
14
24
36
Recruitment
Screening
Diagnosis
Random Assignment
579 ADHD Subjects
Medication Only
144 Subjects
Psychosocial (Behavioral) Treatment Only
144 Subjects
Combined Medication & Behavioral Treatment
145 Subjects
Community Controls
No Treatment from Study
Assessed for 24 mo.
146 Subjects
Baseline
Early Treatment (3 m)
Mid-treatment (9 m)
End Treatment (14 m)
Follow-up (24 m)
Follow-up (36 m)
Recruitment of LNCG Cohort

14-Month Outcomes
Teacher SNAP-Inattention



Teacher-Rated Inattention (CC Children Separated By Med Use)

Key Differences,

MedMgt vs. CC:

Initial Titration

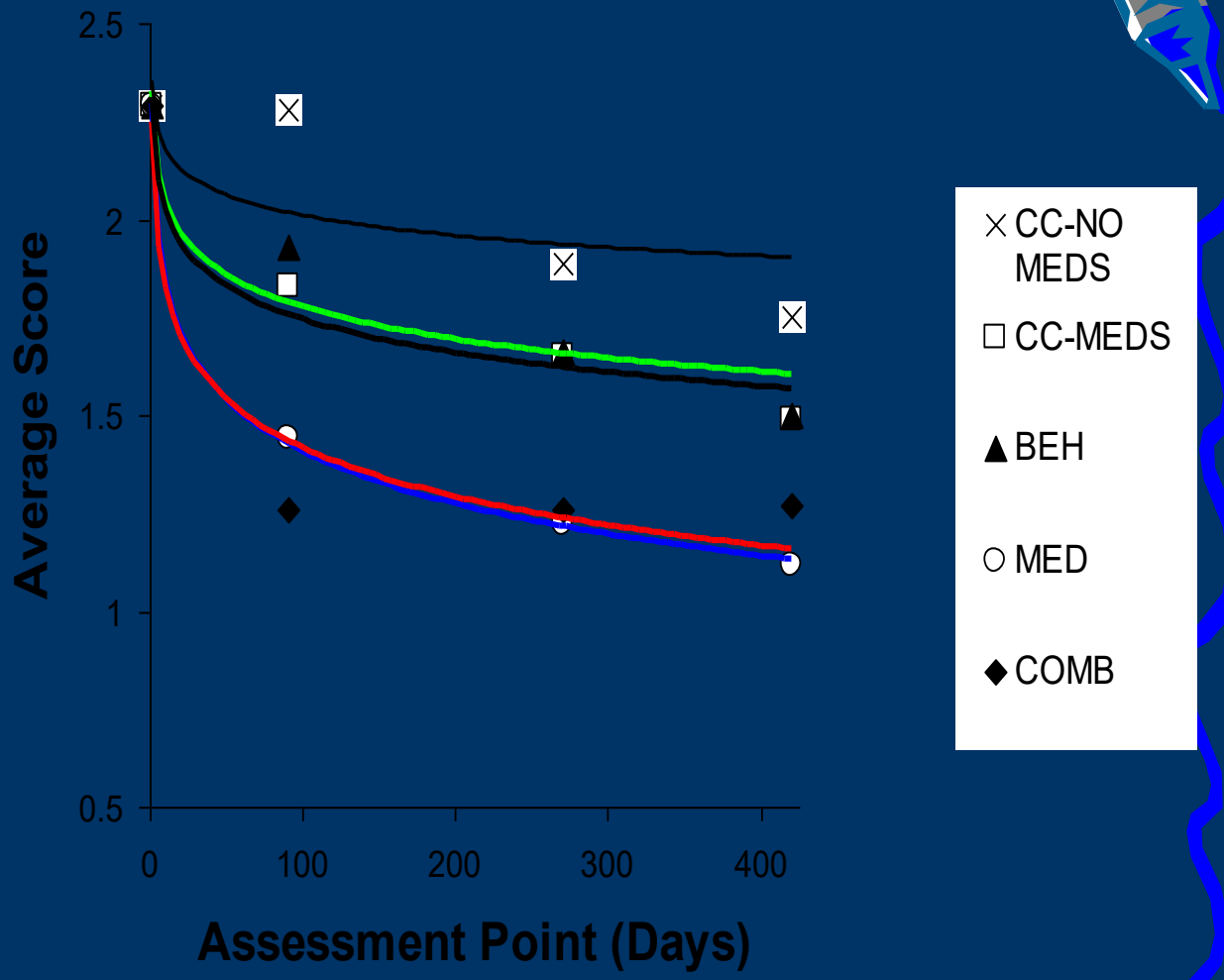
Dose

Dose Frequency

#Visits/year

Length of Visits

Contact w/schools



Medication Trials

- Stimulant
- Stimulant from alternate family vs alpha agonist or strattera
- Alternative from last step
- Alternative from last step
- Bupropion, modafinil
- Omega-3

STAGE 1: METHYLPHENIDATE AGENTS

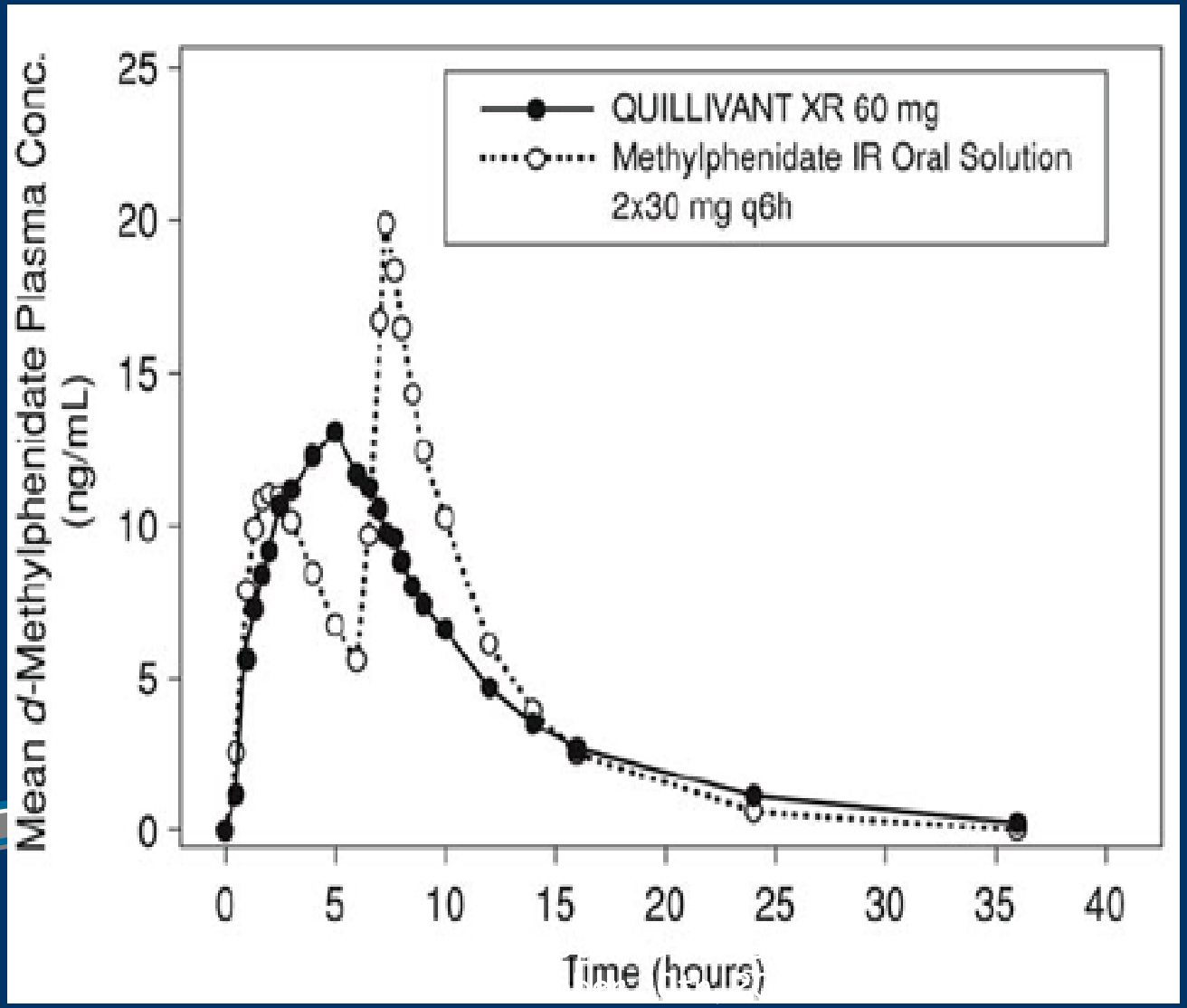
Daytrana

- Transdermal absorption
- Lasts 9 hours
- Needs to be placed and removed every day alternating sites
- Less ups & downs?
- Skin irritation

Quillivant XR 25mg/5cc

- Liquid long-acting
- 20% immediate-release, 80% extended release
- FDA-approved for age 6 and older

- Quillivant XR pharmacokinetics



Stage 2: Amphetamine class

- Similar
- Greater SE?
- Choice of which long-acting has to do with dispensing system

Amphetamines

- Dexedrine
- Adderall
- Dexedrine spansule
- Adderall XR
- Vyvanse
- Dextroamphetamine Transdermal

Adderall XR

- First developed as a diet medication but FDA felt that the addictive qualities did not outweigh the benefits.
- Made up of mirrored amphetamine salts

Vyvanse

- Active agent is dextroamphetamine
- Not biologically active until cleaved during absorption by the small bowel
- Absorption is rate limited which creates a continuous duration of action
- Longest acting
- Swallowed whole or sprinkled in water
- Less rebound?

Long-Acting Stimulants: The Bad News

- Weight loss
- Sleep disturbance
- Tolerance of short-acting stimulants does not assure tolerance of long-acting preparations

Can’t Swallow Pills?

Stage 3: Nonstimulants

- Atomoxetine
- Guanfacine
- Clonidine
- Bupropion?

Atomoxetine: NRI

- A norepinephrine reuptake inhibiter
- Not controlled
- First nonstimulant approved by FDA for age 6 and over
- Must be taken daily

Strattera Dosing

- Choose starting dose and maintain for minimum of 3 days
- Proceed to target dose thereafter

Patient Weight Range	Starting Dose (Minimum of 3 days)	Target Dose
40-62 lbs	18 mg	25 mg
63-93 lbs	25 mg	40 mg
94-126 lbs	40 mg	60 mg
127+ lbs	40 mg	80 mg*

Atomoxetine Side Effects

- Appetite suppression
- Insomnia
- Tremor
- Dizziness

Alpha 2 Agonists

- Guanfacine & Clonidine
- Decrease release of norepinephrine by presynaptic noradrenergic receptor
- Blunt sympathetic fight or flight response
- Approved for HTN in adults
- Effective in children for tics, ADHD, & aggression

Guanfacine ER (Intuniv)

- Daily
- Sedation
- FDA approved for ADHD in children over 6
- Start with 1mg and titrate as tolerated to target 2-4 mg

Clonidine (Kapvay)

- FDA approved as an adjunct to stimulant for ADHD
- BID or QPM for rebound
- More sedation than guanfacine
- Start 0.1mg & titrate to target 0.2-0.4 mg/day
- Onyda XR – once daily formulation

Combinations that make sense

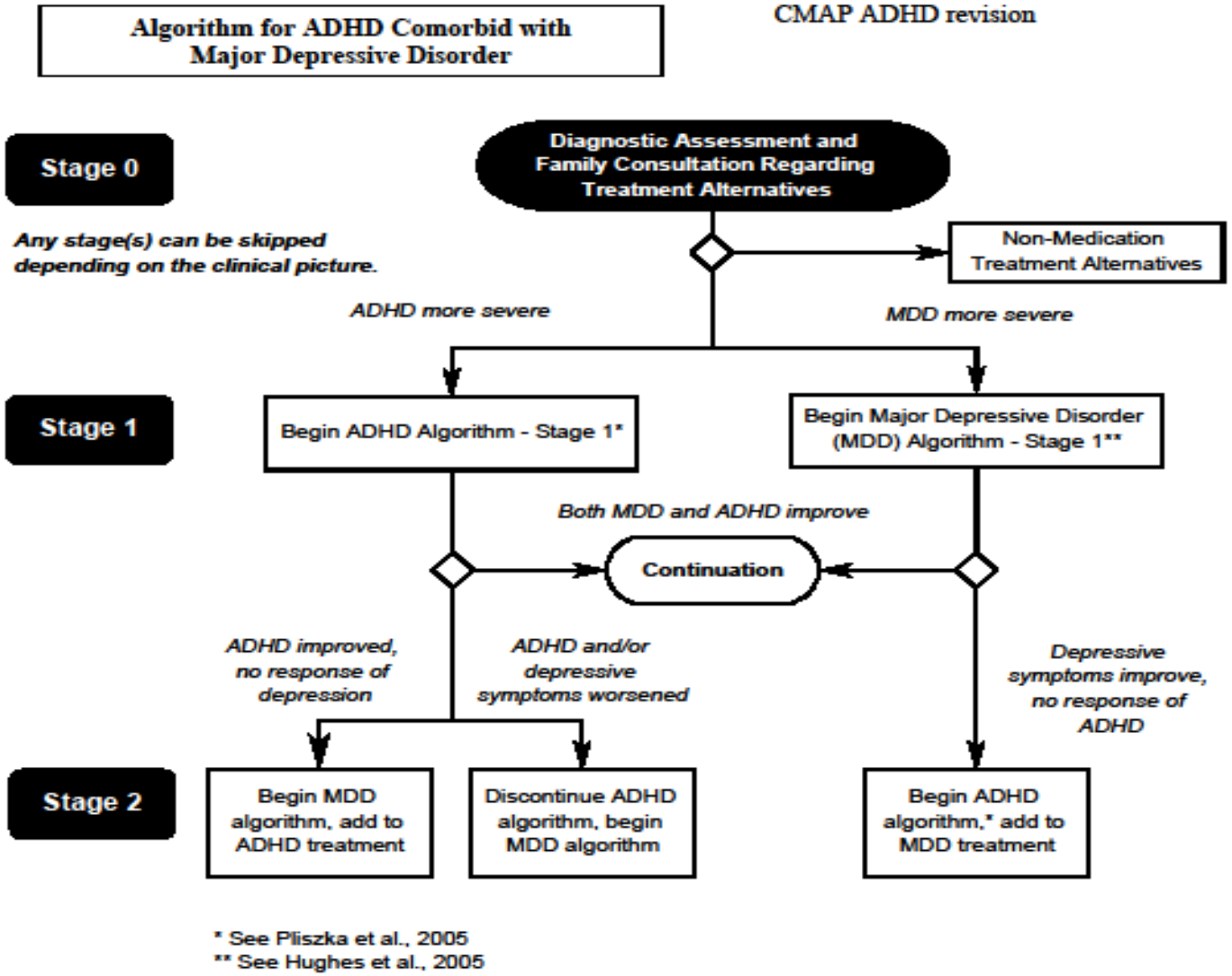
- Stimulant plus guanfacine
- Stimulant plus kapvay
- Stimulant plus strattera
- Long-acting stimulant with afternoon short-acting stimulant

Combinations that do not make sense

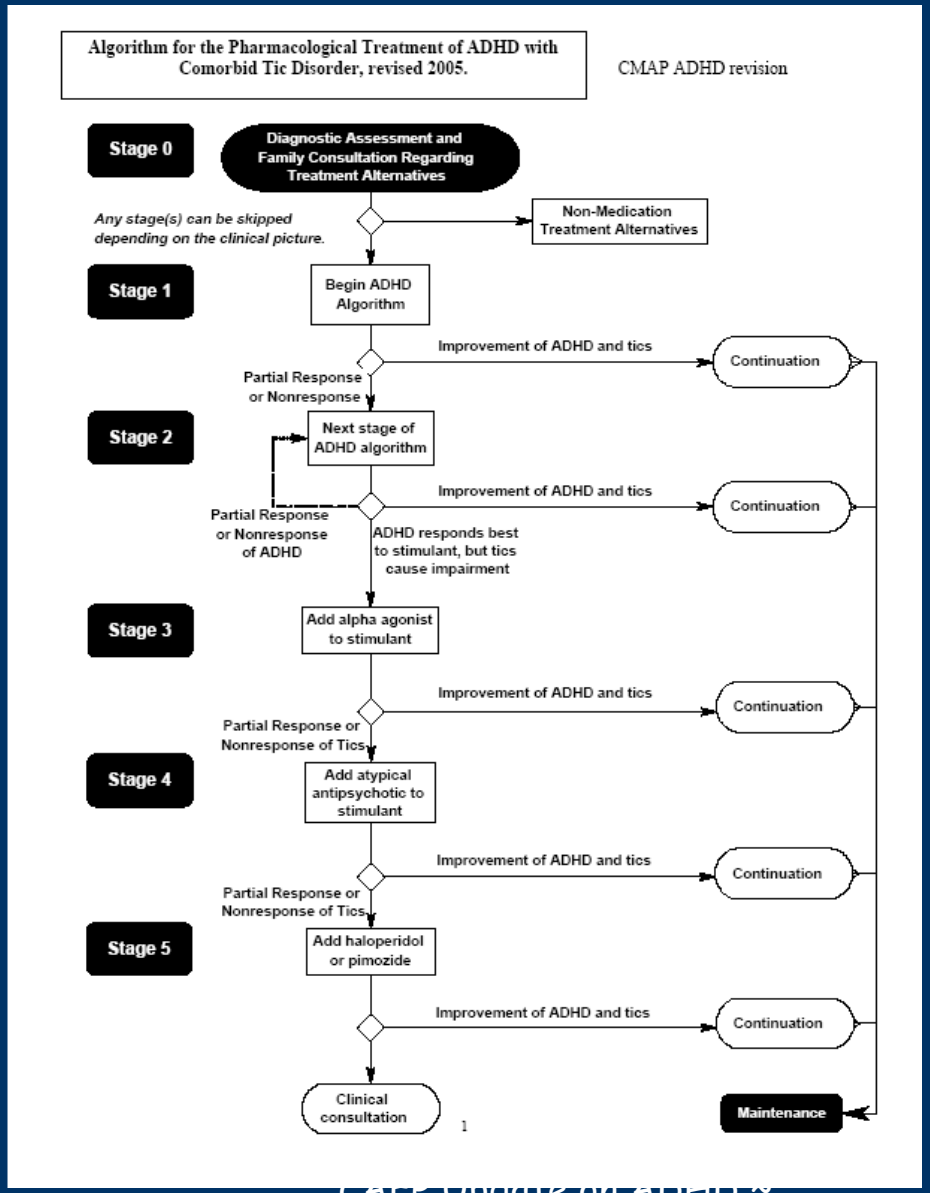
- Amphetamine with methylphenidate
- Guanfacine with clonidine

Comorbidities

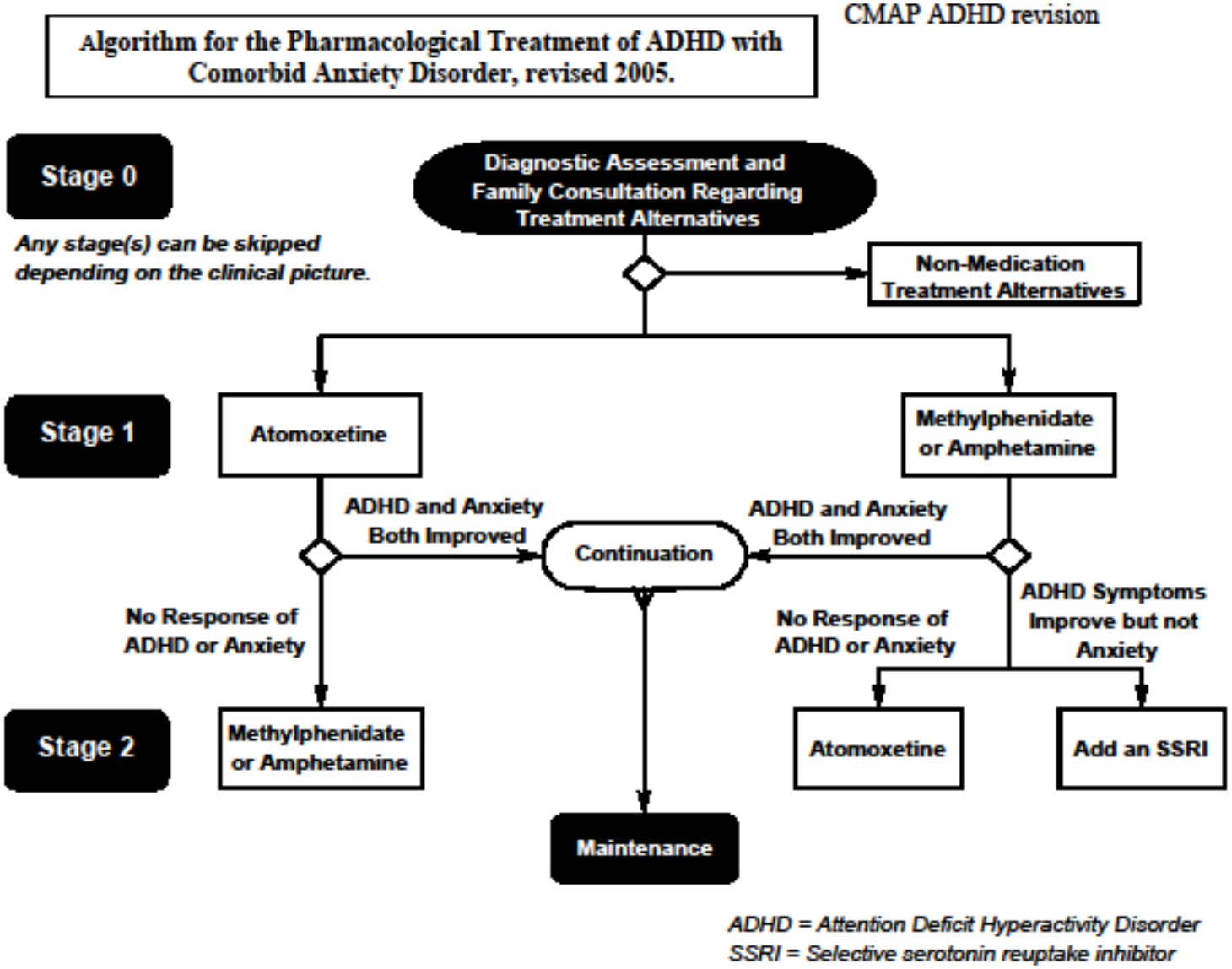
- The norm rather than the exception
- Look for ODD, tics, anxiety & mood d/o
- If so consider combined treatment


Algorithm for ADHD Comorbid with Major Depressive Disorder
CMAP ADHD revision
Stage 0
Diagnostic Assessment and Family Consultation Regarding Treatment Alternatives
Any stage(s) can be skipped depending on the clinical picture.
Non-Medication Treatment Alternatives
ADHD more severe
MDD more severe
Stage 1
Begin ADHD Algorithm - Stage 1*
Begin Major Depressive Disorder (MDD) Algorithm - Stage 1**
Both MDD and ADHD improve
Continuation
ADHD improved, no response of depression
ADHD and/or depressive symptoms worsened
Depressive symptoms improve, no response of ADHD
Stage 2
Begin MDD algorithm, add to ADHD treatment
Discontinue ADHD algorithm, begin MDD algorithm
Begin ADHD algorithm,* add to MDD treatment
* See Pliszka et al., 2005
** See Hughes et al., 2005

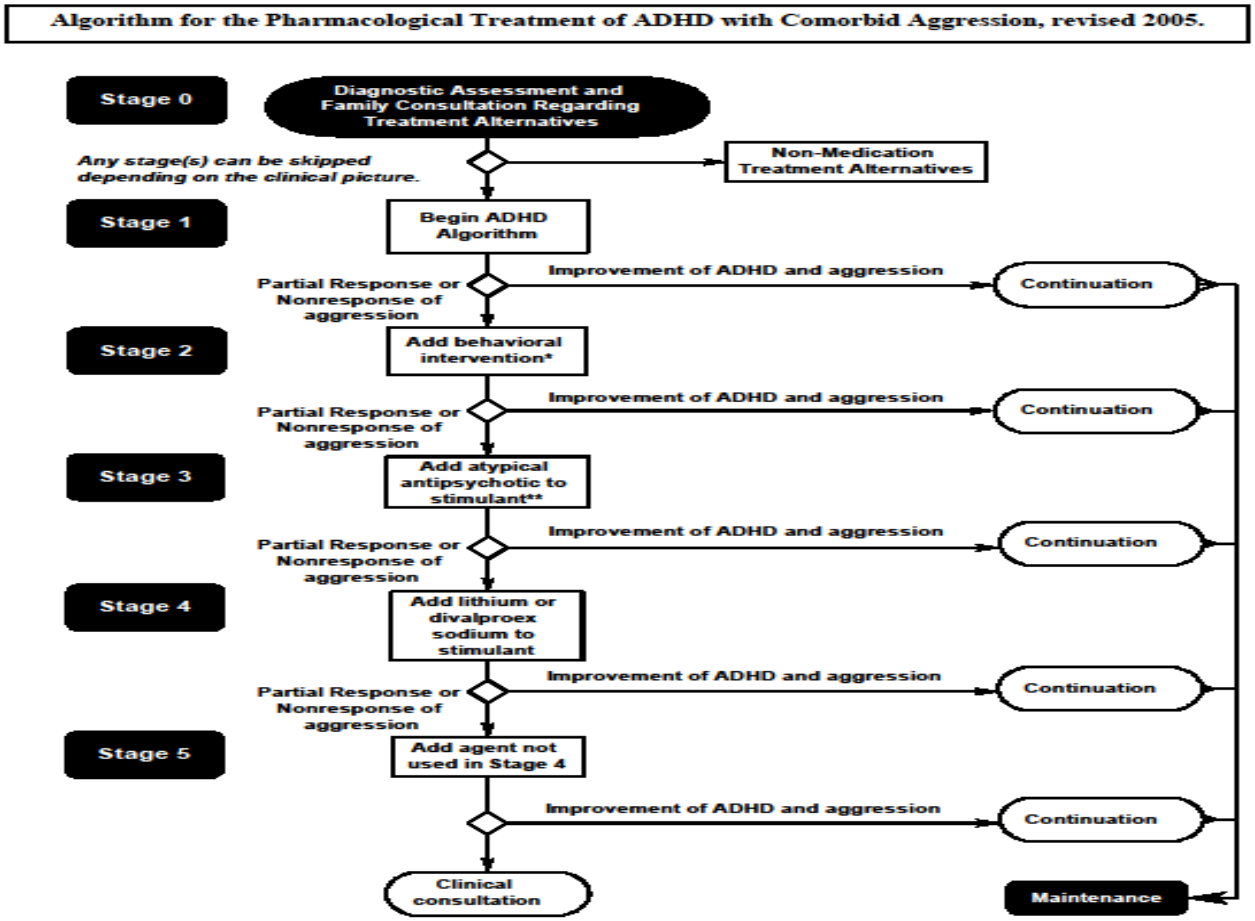
ADHD with tics



CMAP ADHD revision



ADHD with Aggression



CAFP Update on ADHD ~
October 30th, 2025

Risperidone in ADHD

- ONLY if with sever aggression and or tics which do not respond to alpha-agonist
- Potential side effects: weight gain, dyskinesias, prolactinemia
- FDA support from research on autism
- Can safely be used in primary care but only at low-dose and w careful monitoring

Genomic Testing

- Consider after failed trial(s)
- Efficacy unproven
- Collection
- Payment

Video Game Treatment

- ADHD inattentive symptoms age 8-12
- 25 minutes/day 5 day/week X 4 weeks
- Test of Variables of Attention *(Kollins '20)*

Understanding Video Games: a Child Psychiatrist's

Summary of Treatment Planning:

- Family psycho-education
- Consider behavioral therapy
- Consider 504 plan
- Consider medications
- Choose either methylphenidate or dexedrine to start
- Short acting stimulant, then based on tolerance and efficacy choose Long-acting equivalent
- Maintain follow up

Take Home points :

- "untreated" course of ADHD increases risk for comorbidities: substance use disorders, Anxiety, Depression, ODD/Conduct Disorder or a sense of "failure"

Take Home Points continued:

- Adults can often find a role that works for their individual strengths/weaknesses (NY times, “A natural cure for ADHD” November, 2014)
- The first 18-21 years of life can be a real challenge
- The push for identification and treatment of ADHD is NOT meant to simply pathologize normal variants of behavior but rather to promote an “at-risk” child’s developmental trajectory

And finally-
Take home points continued

- Medication management alone is never enough (see MTA, community sample, and follow up studies)
- Regular follow up and check-ins with school
- Individualize therapies based on nature of difficulties
- (PMT, CBT, social skills training, educational/ remediation or therapy)

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- 9-5 M-F
- Consolation
- Referrals
- Face to Face Eval
- Trainings

Phone Consultations

- Screening
- Diagnosis
- Parental guidance
- Labwork
- Medication
- Referrals

Community Access / Referrals

- Psychiatry
- Individual & family therapy
- Home-based services
- PHP/IOP
- Access calls family to arrange
- Optimal location/insurance/reputation
- Inform PCP of date & time

Face to Face Evaluations

- For patients who may be managed by PCP
- Virtual or in-person
- Within 2 weeks of referral
- <1 hour drive
- No additional charge
- Call & send report within 2 days

Integrated Care Partners Top
10 Questions re Psychotropics~
April 25th, 2024

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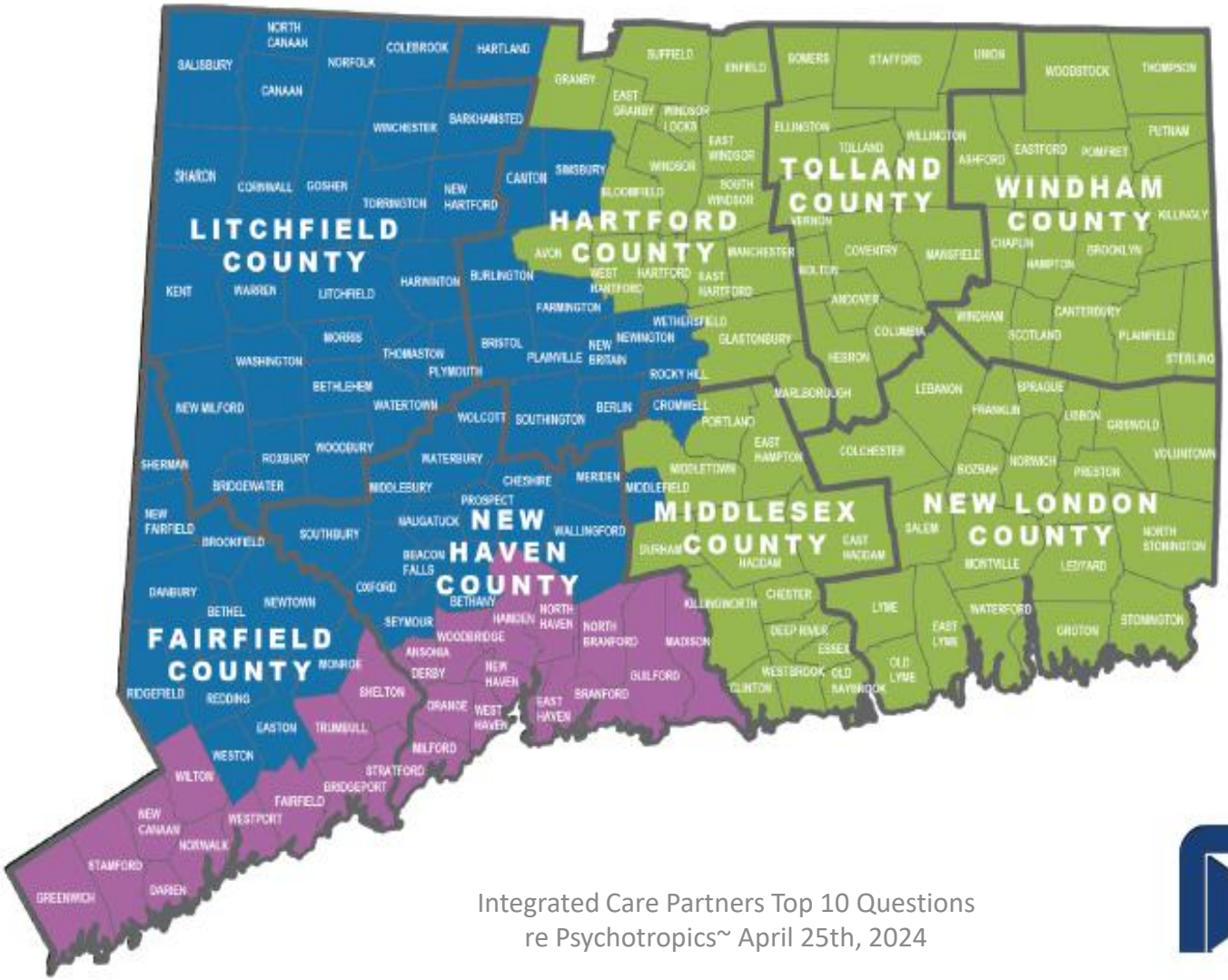
- Hartford Hospital 855.561.7135
- Wheeler Clinic, Inc. 855.631.9835
- Yale Child Study Center 844.751.8955



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Discuss!