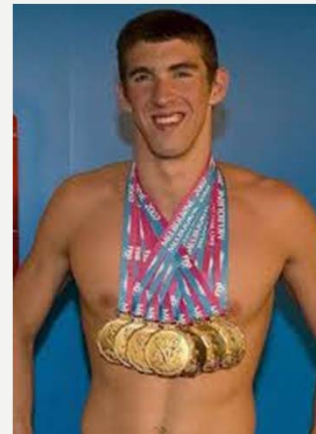
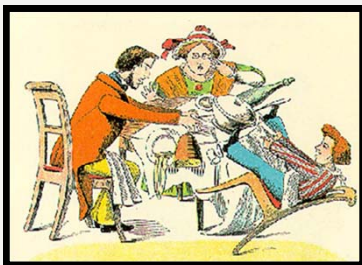


**ADHD
PART I
ADHD DIAGNOSIS
&
TREATMENT IN
PEDIATRIC
PRIMARY CARE**

ABIGAIL SCHLESINGER, MD

THE FACES OF AD/HD



OUTLINE

- ❑ DSM V Diagnosis
- ❑ National Recommendations for ADHD Management
- ❑ Stimulant overview
- ❑ Guidance/Anticipatory Guidance
 - ❑ SLEEP

TAKE HOME POINTS

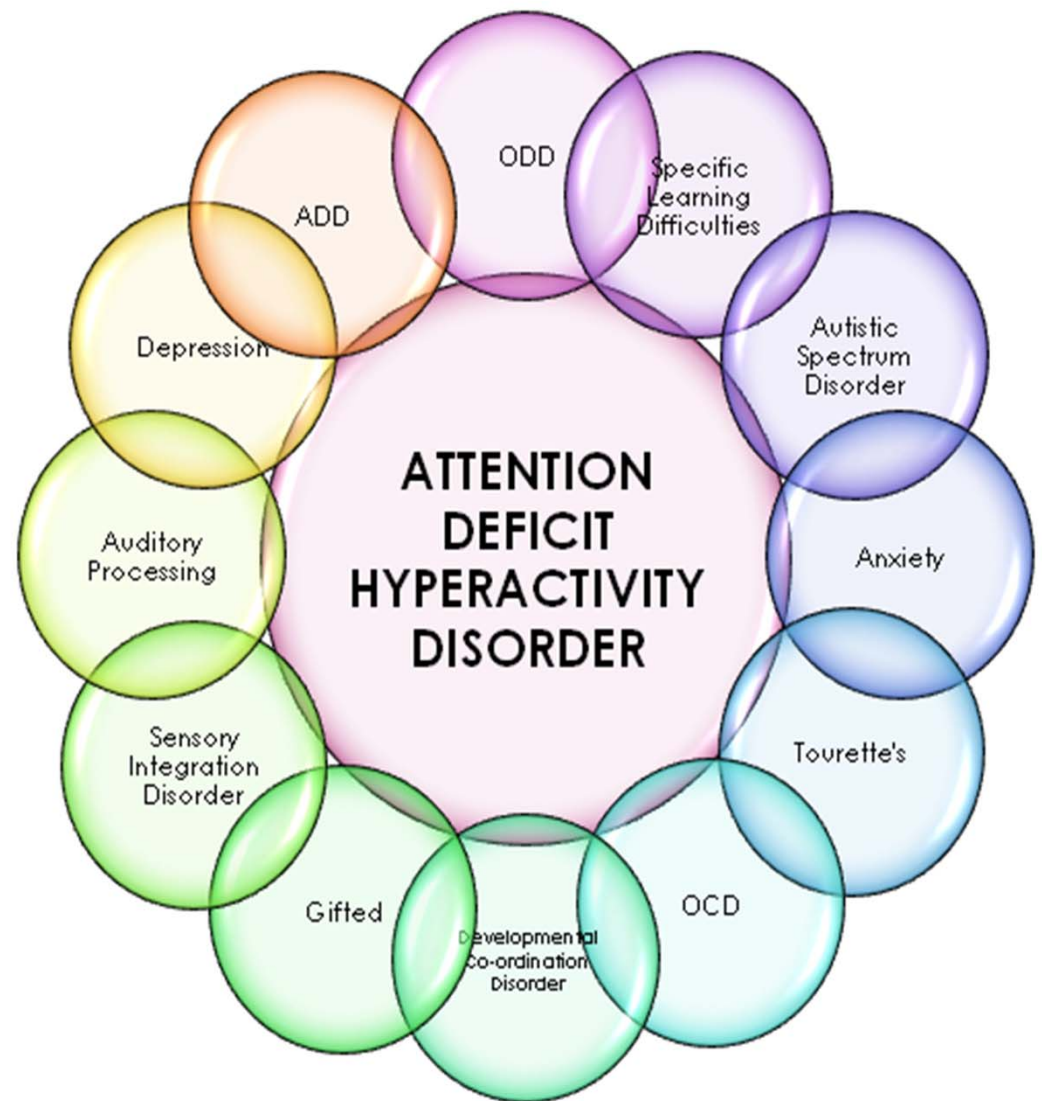
- Inattention $\neq$ Attention Deficit/Hyperactivity Disorder
 - In other words– ADHD is never just one symptom
- Medication helps the core symptoms of ADHD
 - Quality medication management may impact comorbidities
- Non-pharmacologic intervention has a vital role
- Comorbidity is the RULE with ADHD
- ADHD is a lifelong condition – with serious lifelong implications
- A consistent approach(with follow-up) can make the difference

ADHD FOR THE PRIMARY CARE PROVIDER

MAKING THE ADHD DIAGNOSIS

DIFFERENTIAL DIAGNOSIS

- ADHD is characterized by a consistent pattern of symptoms of inattention and/or hyperactivity-impulsivity
 - that are inconsistent with developmental level
 - that negatively impacts social and academic/occupational activities
 - and must be differentiated from ...



DIAGNOSTIC CRITERIA: INATTENTION

1. Careless mistakes (overlooks or misses details)
2. Sustaining attention (difficulty with focus, conversations, long readings)
3. Does not seem to listen (mind seems elsewhere, even without distraction)
4. Does not follow through (starts t& quickly loses focus/fails to follow-thru)
5. Difficulty organizing (poor time management, messy disorganized, difficulty with sequential tasks)
6. Avoids tasks that require sustained mental effort (school work, reports)
7. Loses things (eye glasses, mobile phones etc)
8. Easily distracted (older adolescents by unwanted thoughts)
9. Forgetful (chores, bills)

HYPERACTIVITY/IMPULSIVITY

1. Fidgets
2. Leaves seat
3. Runs about or climbs (in adolescents or adults feeling restless)
4. Unable to play or engage in leisure activities
5. "On the go" "driven by a motor" (may be experienced by others as being restless or unable to keep up with)
6. Talks excessively
7. Blurts out (completes peoples sentences, cannot wait turn in conversation)
8. Difficulty waiting turn (while waiting in line)
9. Interrupts or intrudes (butts into conversations, may take things without asking or receiving permission, may intrude into or take over what others are doing)

“SUBSTANTIAL” CHANGES FROM DSM IV TO 5

1) The onset criterion has been changed

- a) You previously needed impairment prior to age 7
- b) Now you need to have had several symptoms prior to age 12

2) A comorbid diagnosis with Autism is now allowed

3) Adults qualify for diagnosis with 5 symptoms (rather than 6)

AAP RECOMMENDATIONS

- ☐ Consider the Diagnosis
- ☐ Make the Diagnosis
 - Collect Information - get Information from more than one setting
 - Consider comorbidities
- ☐ Approach as a chronic condition
- ☐ Recommend treatment based on age/need
- ☐ Use appropriate “dose” of treatment

THE AAP RECOMMENDATIONS FOR ADHD STATE THAT A PCP SHOULD CONSIDER ADHD IN

- a. Children 5 thru 18
- b. Children 11 thru 18
- c. Children 4 thru 18
- d. With academic or behavioral problems &
- e. Symptoms of inattention, hyperactivity, or impulsivity
- f. a, d and e are true
- g. b, d, and e are true
- h. c, d, and e are true

❖ Quality of Evidence B/Strong Recommendation

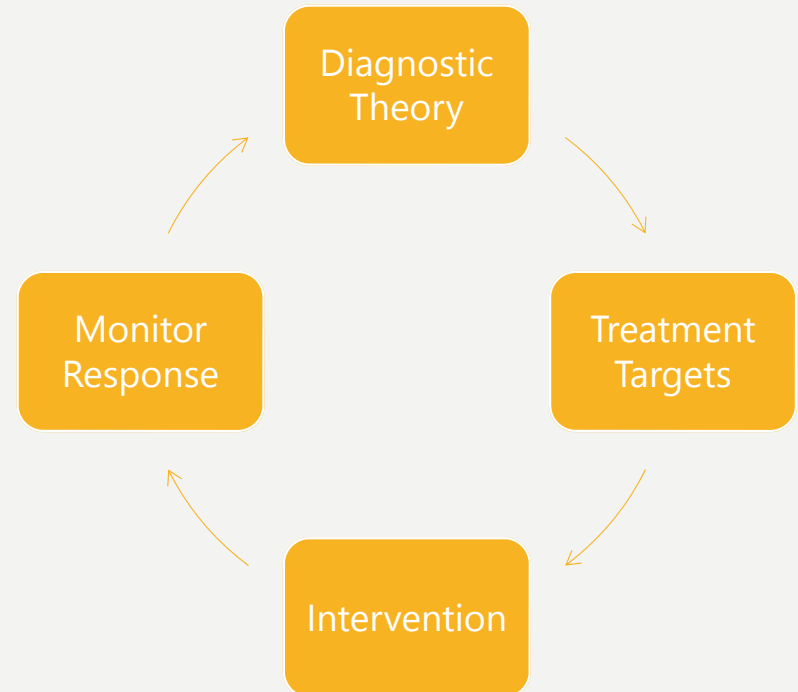
APPROACH TO TREATMENT PLANNING

DIAGNOSTIC THEORY

- Developmental Context, Environment
- Diagnosis



APPROACH TO TREATMENT



MAKE THE DIAGNOSIS : RULE IN ADHD & RULE OUT OTHERS

- ☐ Determine DSM Criteria are met(including impairment in more than 1 major setting);
- ☐ Information should be obtained primarily from reports from parents or guardians, teachers, and other school and mental health clinicians involved in the child's care.
- ☐ Rule out any alternative cause

❖ Quality of Evidence B/Strong Recommendation

2/3 OF CHILDREN WITH ADHD PRESENT WITH ≥ 1 COMORBIDITY

Comorbid Conditions in Children with ADHD

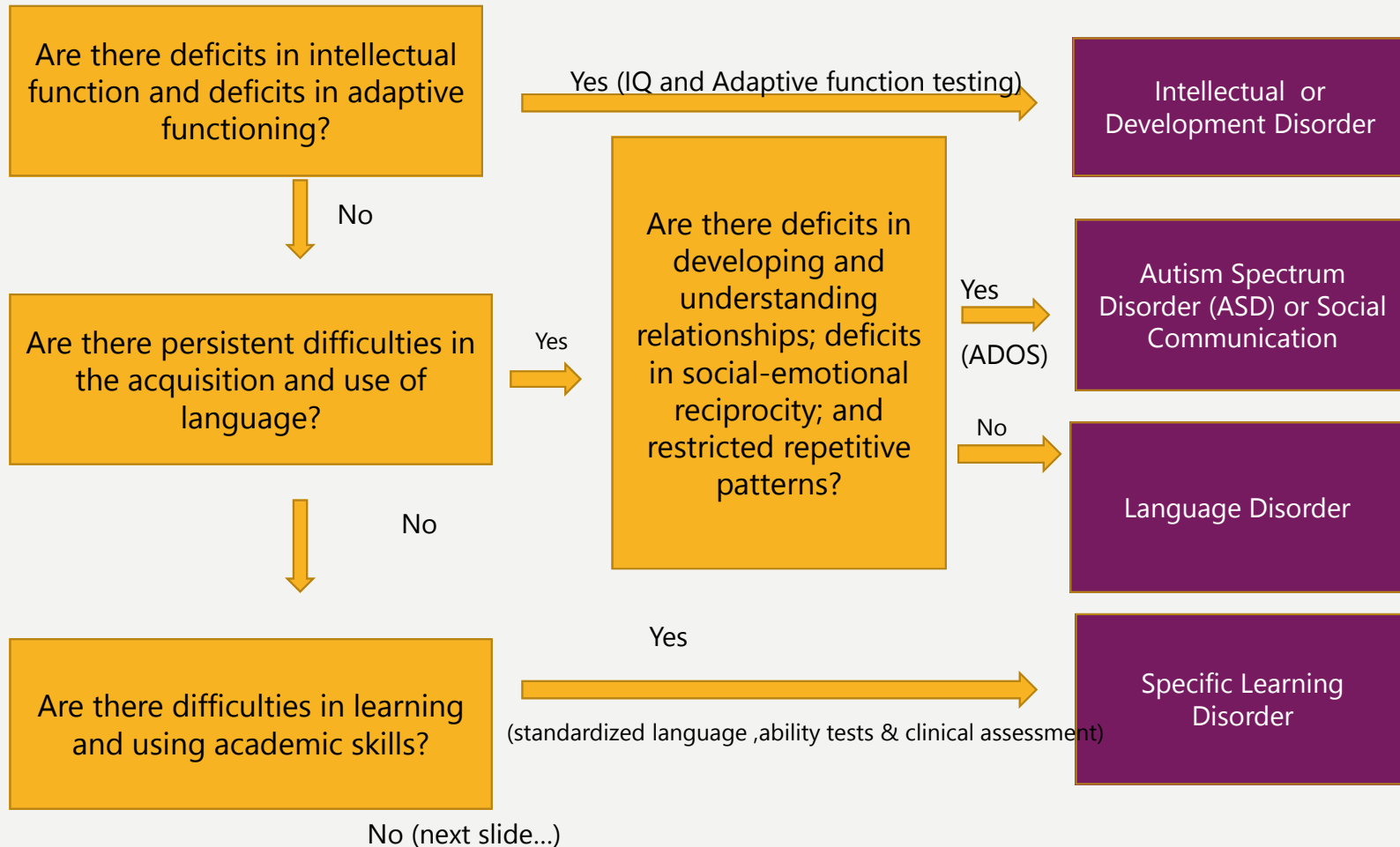
Comorbidities	Range
Anxiety disorder	8% – 30%
Conduct disorder	8% – 25%
Oppositional-defiant disorder	45% – 64%
Affective disorder	15% – 75%
Tic disorder	8% – 34%
Mania/hypomania	0% – 22%
Learning/academic problems	10% – 92%

Spencer TJ, et al. *Pediatr Clin North Am.* 2000;46:915-927.
Biederman J, et al. *Arch Gen Psychiatry.* 1996;53:437-446.

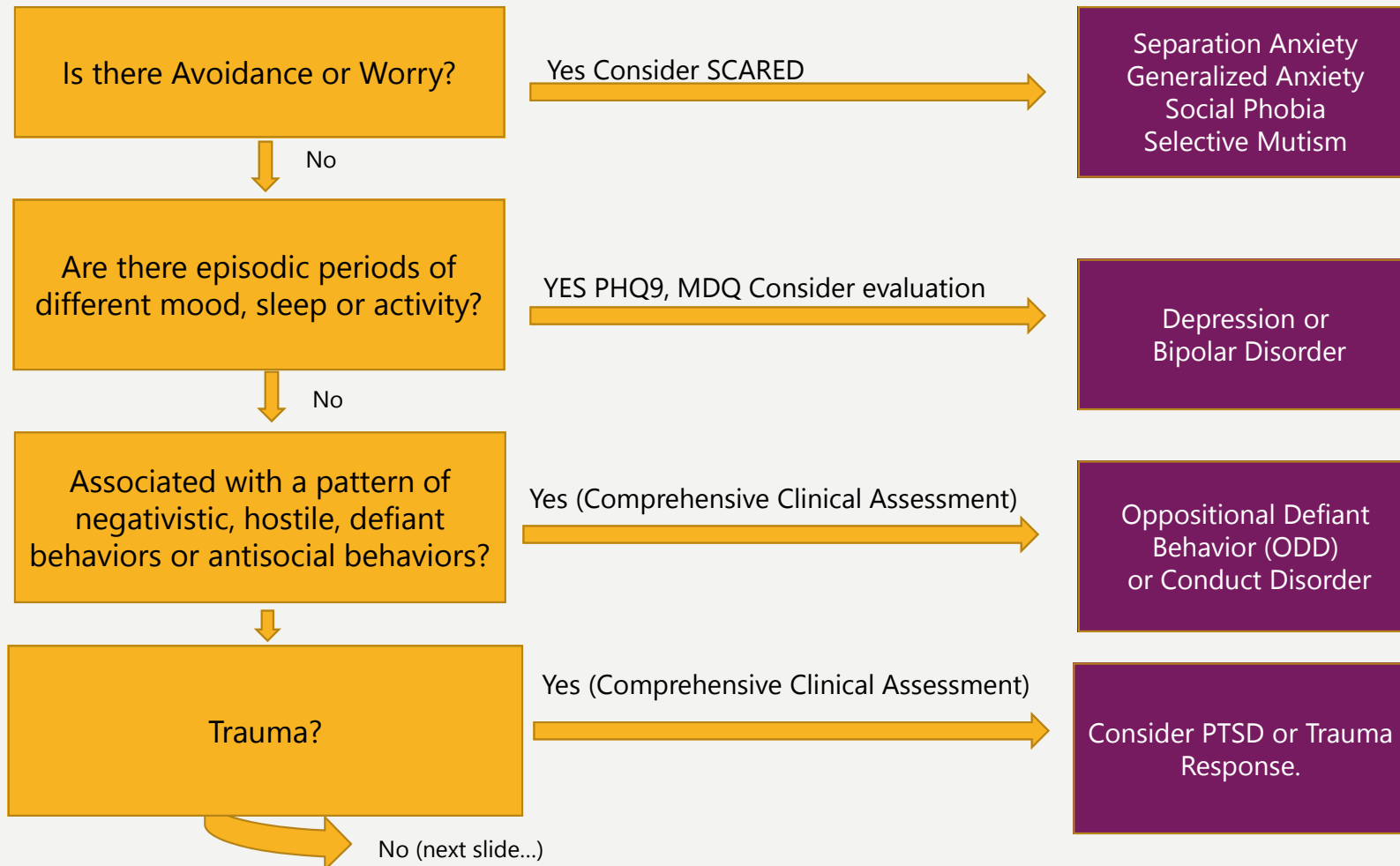
EVALUATION – ASSESS FOR POTENTIAL COEXISTING CONDITIONS

- ☐ Developmental (eg, learning and language disorders or other neurodevelopmental disorders), and
 - ☐ Emotional or behavioral (eg, anxiety, depressive, oppositional defiant/conduct disorders & trauma response),
 - ☐ Physical (eg, tics, sleep apnea, substance use) conditions
- ❖ Quality of Evidence B/Strong Recommendation

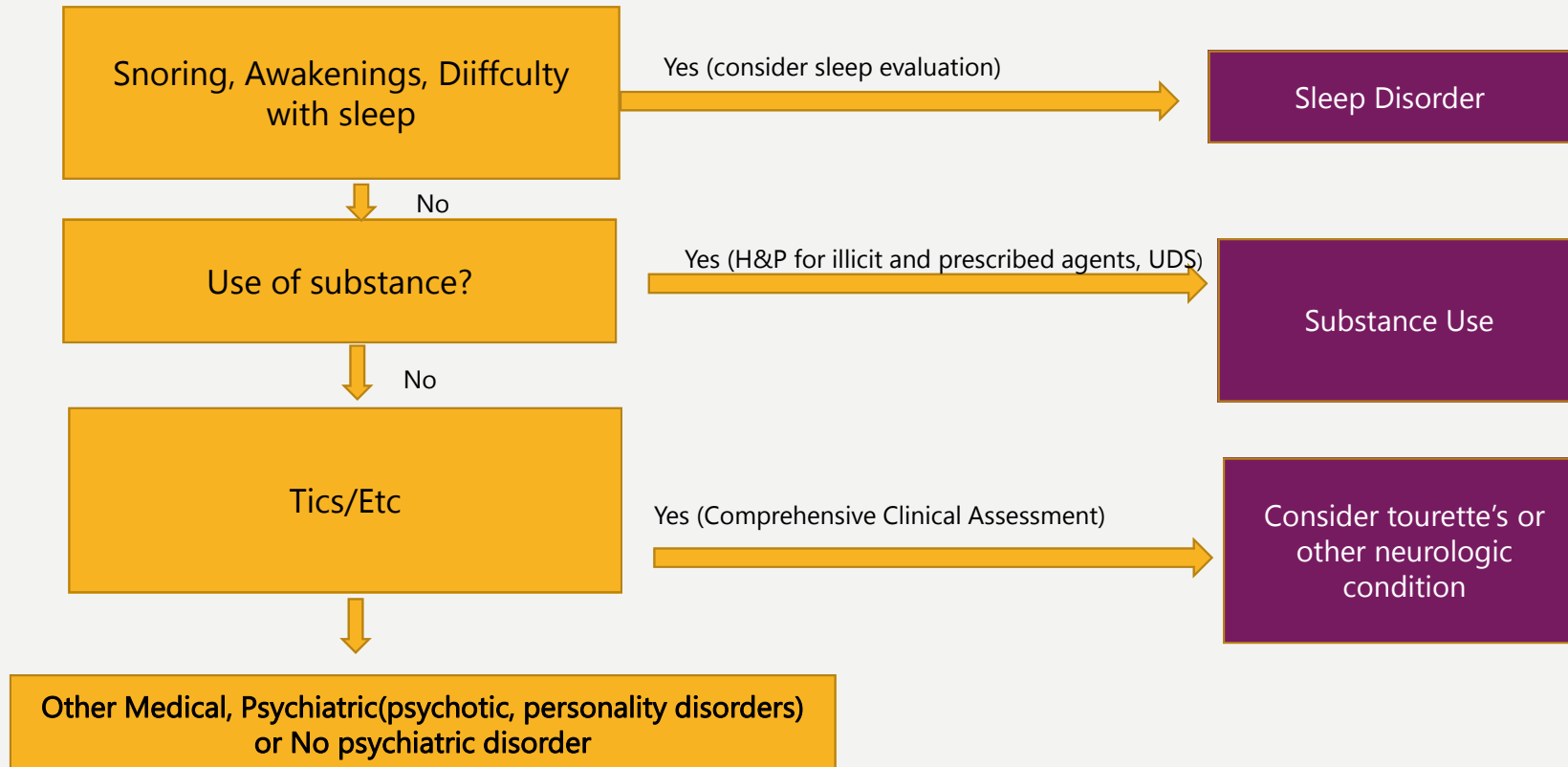
DEVELOPMENTAL/LEARNING



EMOTIONAL/BEHAVIORAL



PHYSICAL/OTHER



OPPOSITIONAL DEFIANT DISORDER OR CONDUCT DISORDER

ODD /
CD

Resistance to work due to refusal to submit to others' demands accompanied by negativity, hostility, and defiance

ADHD

Aversion to work due to difficulty in sustaining attention, forgetting instructions, procrastination, and impulsivity

ANXIETY AND TRAUMA-RELATED DISORDERS

Anxiety/ PTSD

Difficulty concentrating and physical restlessness is related to fear or worry, rumination, intrusive thoughts or images, and other trauma or anxiety symptoms.

ADHD

Inattention and hypermotoric behavior is due to attraction to external stimuli or new activities, or preoccupation with preferred, less cognitively taxing activities.

BIPOLAR (BD) AND DEPRESSIVE DISORDERS(DD)

BD

May show hyperactivity, impulsivity, irritability and distractibility, but these features are episodic and accompanied by other specific features of hypo/mania.

DD

May show inattention, irritability, difficulty completing tasks; however, these symptoms are episodic and accompanied by specific features of depression.

ADHD

May exhibit mood lability throughout the day, however, it is non-episodic and accompanying features of a major mood disorder are not present

BEARS SLEEP SCREENING: PRESCHOOL TOOL PRESCHOOL(2-5 YEARS)

Bedtime Routine	Does your child have any problems going to bed? falling asleep?
Excessive Daytime Sleepiness	Does your child seem overtired or sleepy a lot during the day
Awakenings During the Night	Does your child still take naps? Does she wake up a lot during the night?
Regularity and Duration of Sleep	Does your child have a regular wake up and bedtime everynight? What are they?
Sleep Disordered Breathing	Does your child snore a lot or have difficulty breathing at night?

BEARS SLEEP SCREENING TOOL: SCHOOL AGE CHILD(5-12)

Bedtime Routine	Does your child have any problems at bedtime?(P) Do you have any problems going to bed?(C)
Excessive Daytime Sleepiness	Does your child have difficulty waking in the morning, seem sleepy during the day, or take naps?(P) Do you feel tired a lot?(C)
Awakenings During the Night	Does your child seem to wake up often during the night? Any sleep walking or nightmares?(P) Do you wake up a lot at night? Have trouble getting back to sleep(C)
Regularity and Duration of Sleep	What time does your child go to bed and get up on school days? Weekends? Do you think that your child is getting enough sleep?
Sleep Disordered Breathing	Does your child have loud nightly snoring or any breathing difficulties at night?

BEARS SLEEP TOOL ADOLESCENT(12-18)

Bedtime Routine	Do you have any problems falling asleep at bedtime?(C)
Excessive Daytime Sleepiness	Do you feel sleepy a lot during the day? While driving?(C)
Awakenings During the Night	Do you wake up a lot during the night? Have trouble getting back to sleep?(C)
Regularity and Duration of Sleep	What time do you usually go to bed on school nights? Weekends? How much sleep do you usually get?(C)
Sleep Disordered Breathing	Does your teenager snore loudly or nightly?(C)

GENERAL DIFFERENTIAL

Developmental/ Learning	Emotional/ Behavioral	Physical/Other
Difficulty with Intellectual functioning/adaptive functioning	Avoidance/Worry	Snoring, Awakening, or difficulty with sleep
Difficulty with Acquisition and use of language	Episodic periods of mood	Substance Use
Are there deficits in developing and understanding relationships; deficits in social-emotional reciprocity; and restricted repetitive patterns	Pattern of negativistic, hostile, defiant, or antisocial behaviors	Tics
Difficulty with Learning	Recent(or other) Trauma history	Other psychiatric or medical

Overview of the ADHD Care Process

1

4- to 18- y-old patient identified with signs or symptoms suggesting ADHD.
Symptoms can come from parents' direct concerns or the mental health screen recommended by the TFOMH
See TFOMH Algorithms
See action statement 1



2

Perform Diagnostic Evaluation for ADHD and Evaluate or Screen for Other/Coexisting Conditions:

See action statements 2-3

Family

(parents, guardian, other frequent caregivers):

- Chief concerns
- History of symptoms (eg, age of onset and course over time)
- Family history
- Past medical history
- Psychosocial history
- Review of systems
- Validated ADHD instrument
- Evaluation of coexisting conditions
- Report of function, both strengths and weaknesses

School

(and important community informants):

- Concerns
- Validated ADHD instrument
- Evaluation of coexisting conditions
- Report on how well patients function in academic, work, and social interactions
- Academic records (eg, report cards, standardized testing, psychoeducational evaluations)
- Administrative reports (eg, disciplinary actions)

Child/adolescent

(as appropriate for child's age and developmental status):

- Interview, including concerns regarding behavior, family relationships, peers, school
- For adolescents: validated self-report instrument of ADHD and coexisting conditions
- Report of child's self-identified impression of function, both strengths and weaknesses
- Clinician's observations of child's behavior
- Physical and neurologic examination

SCALES USED FOR DIAGNOSIS ADHD IN CHILDREN

☐ Child Behavior Checklist (CBCL/6-18)

- 120 items – inform about possible syndromes & internalizing/externalizing problems

☐ Conners-Wells' Adolescent Self-Report Scale

- Used for ADHD screening rather than to aid in diagnosis

☐ Conners' Rating Scales

- 4 subscales of oppositional problems, cognitive problems, hyperactivity, and an ADHD index

☐ Vanderbilt ADHD Rating Scales

- Over 40 items rated
- Best coverage of ADHD and ODD symptoms

☐ ADHD Rating Scale

- 18-item scale corresponding to the 18 items in the DSM criteria that is divided into hyperactivity/impulsivity and inattentiveness subscales

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ADHD MEDICATION: CARDIAC ASSESSMENT

see Description

1 Can Assess Child Address Description

1 Can Assess

Item	Yes	No
History		
Shortness of breath with exercise (more than other children of the same age) in the absence of an alternate explanation (e.g. asthma, sedentary lifestyle, obesity)		
Poor exercise tolerance (in comparison with other children) in the absence of an alternate explanation (e.g. asthma, sedentary lifestyle, obesity)		
Fainting or seizures with exercise, startle or fright		
Palpitations brought on by exercise		
Family history of sudden or unexplained death including sudden infant death syndrome, unexplained drowning or unexplained motor vehicle accidents (in first or second degree relatives)		
Personal or family history (in first or second degree relatives) of non-ischemic heart disease such as:		
Long QT syndrome or other familial arrhythmias		
Wolff-Parkinson-White syndrome		
Cardiomyopathy		
Heart Transplant		
Pulmonary Hypertension		
Unexplained motor vehicle collisions or drowning		
Implantable defibrillator		
Physical Examination		
Hypertension		
Organic (not functional) murmur present		
Sternotomy incision		
Other abnormal cardiac findings		

ONGOING TREATMENT – CHRONIC CONDITION

- ☐ Recognize ADHD as a chronic condition
- ☐ Consider children and adolescents with ADHD as children and youth with special health care needs
- ☐ Follow the principles of the chronic care model and the medical home
 - ☐ Have a systematic follow-up plan that includes in person visits,

❖ Quality of Evidence B/Strong Recommendation

TREATMENT RECOMMENDATIONS VARY BY AGE

- ☐ The AAP Recommendations for treatment of children and youth with ADHD vary depending on the patient's age.

FOR PRESCHOOL-AGED CHILDREN (4–5 YEARS OF AGE)

☐ Behavioral Therapy

❖ Quality of Evidence A/Strong Recommendation

☐ If moderate to severe behavioral disturbance and behavioral therapy is not working –

☐ Prescribe methylphenidate

☐ 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

❖ Quality of evidence B/Recommendation

B. FOR ELEMENTARY SCHOOL-AGED CHILDREN (6–11 YEARS OF AGE),

- ☐ FDA Approved Medications and/or behavioral therapy
- ☐ Preferably both medication and therapy
- ☐ The evidence is particularly strong for stimulant medications and sufficient but less strong for atomoxetine, extended-release guanfacine, and extended-release clonidine (in that order)
 - ❖ Quality of Evidence A/Strong Recommendation.
- ☐ The school environment, program, or placement is a part of any treatment plan.

C. FOR ADOLESCENTS (12–18 YEARS OF AGE),

☐ Should prescribe stimulants

❖ Quality of Evidence A/Strong Recommendation &

☐ May prescribe behavior therapy as treatment for ADHD

❖ Quality of Evidence C/Recommendation

☐ preferably both.

TREATMENT – TITRATE TO EFFECTIVE DOSE

- ❑ Achieve maximum benefit while minimizing adverse effects

- ❖ Quality of Evidence B/Strong Recommendation

- ❖ **EVIDENCE SHOWS THAT KIDS IN THE COMMUNITY GET LOWER DOSES THAN THOSE IN RESEARCH STUDIES****

ADHD FOR THE PRIMARY CARE PROVIDER

MEDICATION

TWO (VERY) BROAD CLASSES OF ADHD MEDICATIONS

- Stimulants

- Methylphenidate
- Amphetamine and derivatives

- Non-stimulants

- Alpha-2 agonists
- Atomoxetine (Strattera)
- Bupropion (Wellbutrin)

TWO (VERY) BROAD CLASSES OF STIMULANTS

- Methylphenidate and derivatives
 - FDA approved for age 6 and up
 - AAP recommends starting with methylphenidate at 3-6 due to quality of evidence
- Amphetamine and derivatives
 - FDA approved for as young as 3 (Some forms)
 - DextroStat
 - Adderall

**You Can Not Predict Who Will Respond
Better to One or the Other**

STIMULANTS: MOST EFFECTIVE ADHD TREATMENT

- Side Effects/Concerns
 - Decrease in appetite (with subsequent weight loss)
 - Upset stomach
 - Decline in sleep
 - Cardiac side effects
 - Elevation of pulse and blood pressure
 - AACAP does not recommend routine collection of baseline EKG
 - Potential for abuse/Diversion is High
 - Irritability as “coming off” of medication
- Drug Holidays are fine – but may not be indicated based on impairment and/or symptoms when “coming off” of medication

STIMULANTS :

- Weight based dosing
 - Not generally utilized for therapeutic effect
 - Can be used to estimate how close you are to max dose
 - Methylphenidate @ 1 mg/kg
 - Adderall @ 0.6 mg/kg
- Dose to clinical response
- Consider forced titration

STIMULANT DOSING

- Start low, go up, and follow-up
- Collect data from teachers and parents to assess progress
- Can tell very rapidly if a medication is going to work or not
- Side effects (esp GI) often get better if patients can persevere

FORCED TITRATION – KIDS OVER 5 AND WITHOUT DEV. DELAY

- Concerta 18
 - 1 pill for 1 week then increase to 2 pills
- Vyvanse 20mg
 - 1 pill for 1 week then increase to 2 pills
- Adderall XR 10mg
 - 1 pill for 1 week then increase to 2 pills
- Phone call or visit in 2 weeks
- If no significant side effects but no significant improvement increase dose
- Follow-up in 4 week either way
- Consider follow-up vanderbilts(only the ADHD questions)

******NOTE THESE
ARE NOT
EQUIVALENT
DOSES******

CONCERTA

- In Nov 2014 the FDA said that only 2 generics were equivalent to Concerta – two others may not be releasing in the same way
 - The possible impact is the medication not working as long, or working differently earlier in the day.
- If your prescription does not say concerta on it pharmacies can substitute the generics that have not been approved as equivalent to concerta.
 - Not all long-acting methylphenidate is created equal

OPTIMAL MANAGEMENT

- Assess for comorbidities and treat appropriately
- Encourage Therapy & School supports
- When titrating medications increase aggressively & check-in more frequently(every 4-6 weeks) until behavior optimized.
- Brief Follow-up visits
 - 3-4 times a year when stable
 - Follow-up on ADHD and potential comorbidities at each follow-up
 - Start conversation about what child thinks about medication young
- Have a system in your office for refills
 - Nurse triage looks for last visit and schedules follow-up if not seen in 2-3 months – can also give out forms

RODGER

- Rodger is a 7 year old 1st grade student who takes Metadate CD 40mg. His mom notes that he is very inattentive and hyperactive after school and he just got suspended from the bus for 3 days for bad behavior. Mom called to ask for an increase of medication
- PLAN:
 - Ask mom to get home and school vanderbilts
 - Schedule an appointment

RODGER'S VANDERBILTS

Positive(score > 2)	Mom	Teacher
Inattentive questions(1-9)	8/9	6/9
Hyperactive questions(1-9)	9/9	6/9
ODD questions(19-26)	2/8	2/8
Conduct Disorder(27-40)	0/14	0/14
Anxiety/Depression(41-47)	0/7	0/14

Teacher also comments that she thinks he needs a nap, because he struggles so much more after lunch than in the morning

She states that he is a smart child who has a lot of friends, despite being quite disruptive in afternoon recess.

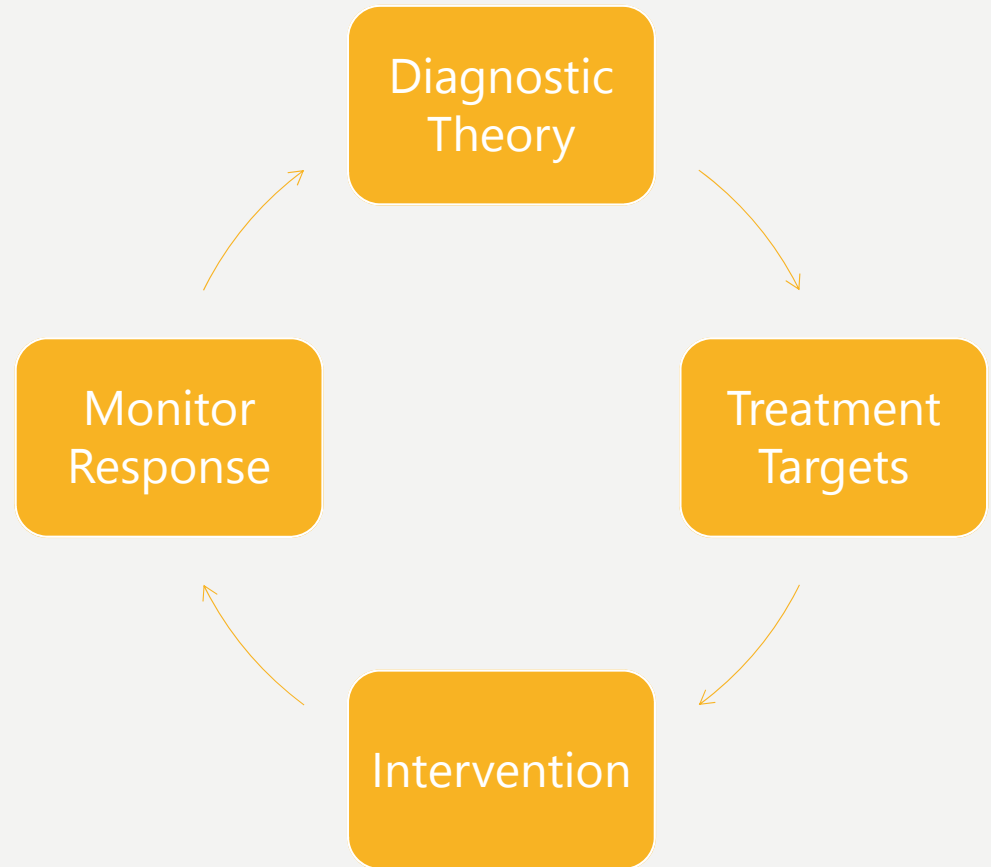
Mom notes that there is a kid, who is only on the afternoon bus, who instigates him

GENERAL DIFFERENTIAL

Developmental/ Learning	Emotional/ Behavioral	Physical/Other
Difficulty with Intellectual functioning/adaptive functioning	Avoidance/Worry	Snoring, Awakening, or difficulty with sleep
Difficulty with Acquisition and use of language	Episodic periods of mood	Substance Use
Are there deficits in developing and understanding relationships; deficits in social-emotional reciprocity; and restricted repetitive patterns	Pattern of negativistic, hostile, defiant, or antisocial behaviors	Tics
Difficulty with Learning	Recent(or other) Trauma history	Other psychiatric or medical

TREATMENT PLANNING

- Diagnosis – definitely ADHD
- Treatment Targets
 - “I want him to be able to stay on the bus”
 - Decreased hyperactivity
 - Improved attention to bus driver
- Intervention
 - Nonmedication
 - Is there a way to separate him from this other boy
 - Medication – Is he actually covered throughout the day?



LENGTH OF ACTION

	Amphetamine	Methylphenidate
Short-acting – 4 hours		Ritalin , Methylin
		*Focalin
Longer short acting- – 4-6 hours	Adderall, Evekeo, Zenzedi, Procentra	
Intermediate Acting --6-8 hours		Metadate CD
		*Focalin XR
Long-Acting --10-12 hours	Adderall XR	Quillivant(liquid), Quillichew, Aptensio XR
*Enantiomer	**Adzenys XR-ODT	Concerta
**Unique equivalency rule	**Vyvanse 70mg	

WHAT HAPPENED WITH RODGER?

- He takes his Metadate CD at 6am.
- He gets on the afternoon bus at 3pm
 - (9 hours after dose)
- Teacher thinks behaviors are getting in the way at 2pm
 - (8 hours after dose)
- PLAN
 - Afternoon dose of methylphenidate –
 - ritalin 10mg
 - Give ½ hour after medication effect is wearing off

WHY DID I CHOOSE 10MG

1. Convert everything back to short acting doses
 - Estimate how much the morning, mid afternoon, and evening dose is(if applicable)
 2. Afternoon dose should be at least $\frac{1}{2}$ AM dose
 3. Afternoon dose should be taken at least $\frac{1}{2}$ hour before symptoms return
-
- Methylphenidate was studied 3 times a day 4 hours apart
 - For example methylphenidate(Ritalin) 20mg three times a day(over a 12 hour period)
 - Metadate CD lasts 8 hours (2 doses of short acting methylphenidate)
 - He takes Metadate CD 40mg –
 - Convert to short-acting – Ritalin 40mg(total daily dose of methylphenidate/ritalin)
 - He is getting medication similar to Ritalin 20mg at 6am and 10-11am
 - So his third dose should be at least $\frac{1}{2}$ AM dose – Ritalin 10mg – 20mg

****More information on converting stimulants in second ADHD webinar****

ADHD FOR THE PRIMARY CARE PROVIDER

GUIDANCE & ANTICIPATORY GUIDANCE

WILL THESE MEDICATIONS IMPACT APPETITE AND GROWTH?

- Appetite – YES Definitely
 - Stimulants and strattera reduce appetite
 - Encourage high calorie meals
 - Discourage skipping meals
 - Consider eating before and after medication kicks in
 - If none of the above work consider periactin 2mg-4mg at bedtime
- GROWTH – A little
 - Controlled studies show that continuous use for long periods of time(2 years or more) are correlated with a slight decrease in height and weight(for age)
 - Naturalistic studies found no effect

TESTING

- What about neuropsychologic testing?
- Neuropsych testing can help clarify strengths and weaknesses. Can augment school findings.
- Insurance will often cover if there is question of a comorbidity
- Does my child need an EEG
- NO
- Even the neurologists do not recommend an EEG as a part of the work-up, although they state that it can “augment” work-up.

ADDICTION

- Will these medication cause addiction?
- No one has been able to show an increase in addictive behavior associated with the use of medication
- Will these medications prevent addiction?
- Although there is no long-term data showing a decrease in addictive behavior as an adult associated with ADHD treatment, there is data showing a decrease conduct behaviors(often associated with addiction) while a person is taking stimulant medication

STIMULANT MEDICATIONS – CARDIOVASCULAR SYSTEM

- Does my child need an EKG?
 - NO
- Do these medications impact the cardiovascular system?
 - YES – Slight increase in blood pressure and heart rate
- My child has tics, can they use a stimulant?
 - YES
 - there is conflicting evidence about whether or not tics increase with stimulants
 - Tics tend to start in school-age children, and they come and go.
 - If tics are clearly worsened by stimulant consider nonstimulant alternative

MY CHILD HAS DIFFICULTY WITH SENSORY PROCESSING – NOT ADHD

- Often times kids with ADHD also have difficulties with sensory processing. (again comorbidity is the rule)
 - They have poor handwriting
 - They are clumsy(have trouble with knowing where their body is in space)
- It is reasonable to send for PT and OT evaluations – kids with ADHD can benefit from that.
- If parent is resistant to the ADHD diagnosis – schedule a follow-up with repeat measures from the rehab providers and school in order to assess further

CAN MY CHILD GET SUPPORT FROM THE SCHOOL?

- In public schools children do qualify for an IEP based on the qualification of "other health impaired."
- Many schools prefer to handle ADHD with a 504 plan
- If you have a 504 plan make sure that the parent is aware what is on it and discusses with the teacher
 - OPEN COMMUNICATION IS KEY
- If a 504 plan is not enough the family must request testing for an IEP IN WRITING.

PRESCHOOL

- Therapy
 - Focused on helping parent develop unique skills needed for child with behavioral problems (although these skills will help with all children)
 - PMT, PCIT, (Or trauma-focused treatment)
- Preschoolers do respond to medication, but have less consistent response, and more side effects.
 - Start low escalate slowly – ritalin 2.5mg in the morning or morning and noon
- How much are the behaviors impacting ability to reach expected development – walking, talking, social, maintaining in school, etc.

SCHOOL AGED CHILD

- My child seems immature. Is that normal?
 - Children with ADHD will typically seem immature compared to their peers.
 - This may be particularly problematic if a child is blurting out and interrupting repeatedly with jokes that are not age appropriate.
- Should we consider an afternoon dose?
- YES
 - Is there after school homework?
 - Are ADHD behaviors worsening the home environment?
 - Do ADHD behaviors make it harder for your child to interact with their peers?