NEW JERSEY PEDIATRIC PSYCHIATRY COLLABORATIVE

New Jersey Pediatric Psychiatry Collaborative

ADHD Toolkit and Resources

JUNE 2024

Table of Contents

NEW JERSEY PEDIATRIC PSYCHIATRY COLLABORATIVE

NJPPC ADHD Guidelines for PCPs

Starting Point

PCP Sick Visit:
- Parent/child/teacher express concerns about ADHD
- Do focused screening

PCP Well Visit:
- Screen for mental health problems using PSC 17 or PSC 37
- If concern for ADHD, conduct a more focused assessment

Vanderbilt Parent Assessment Scale

Predominantly Inattentive subtype
- Must score a 2 or 3 on 6 out of 9 items on questions 1-9 **AND**
- Score a 4 on at least 2, or 5 on at least 1, of the performance questions 48-54

Predominantly Hyperactive/Impulsive subtype
- Must score a 2 or 3 on 6 out of 9 items on questions 10-18 **AND**
- Score a 4 on at least 2, or 5 on at least 1, of the performance questions 48-54

ADHD Combined Inattention/Hyperactivity
- Requires the criteria on Inattention **AND** Hyperactive/Impulsive subtypes

Vanderbilt Teacher Assessment Scale

Predominantly Inattentive subtype
- Must score a 2 or 3 on 6 out of 9 items on questions 1-9 **AND**
- Score a 4 on at least 2, or 5 on at least 1, of the performance questions 36-43

Predominantly Hyperactive/Impulsive subtype
- Must score a 2 or 3 on 6 out of 9 items on questions 10-18 **AND**
- Score a 4 on at least 2, or 5 on at least 1, of the performance questions 36-43

ADHD Combined Inattention/Hyperactivity
- Requires the criteria on Inattention **AND** Hyperactive/Impulsive subtypes

Mild Impairment or family prefers no medications:
Psychosocial treatment
- Behavior management training
- Social skills training
- Classroom support/communication
- Give parent resource handout

Moderate Impairment:
See Monotherapy treatment sections below

Severe Impairment:
Refer to specialty care (NJPPC or a CAP in community) for therapy and medication management

Monotherapy with Methylphenidate or Amphetamine preparation.
Refer to Medication Guidelines for starting doses and more information.
Baseline medical assessment: personal/family cardiovascular history; height, weight, pulse, blood pressure, and substance use disorder history.

Obtain **Vanderbilt Parent and Teacher Follow-Up** 2-3 weeks after starting dose and after each dose increase to assess response.

- If scores > cut-points and impairment persists, continue to up-titrate dose stepwise every 2-3 weeks to maximum therapeutic dose as tolerated
- If scores > cut-points at maximum therapeutic dose, consult NJPPC CAP for next steps
- If scores < cut-point with mild to no impairment, remain at current dose for remainder of school year
- Monitor at least every 3-4 months for maintenance of remission, side effects, height/weight changes and vitals; consult with NJPPC CAP as needed

Consider going off medication on non-school days

ADHD Medication Guide*

Revised: February 15, 2024

Methylphenidate Formulations – Long Acting, Oral** (Capsules and tablets in this section are shown at actual size)

Concerta®†	6-12 Yrs: 18-54mg; SD: 18mg 13-17 Yrs: 18-72mg; SD: 18mg ≥18 Yrs: 18-72mg; SD: 18mg or 36mg	G 18mg	G 27mg	G 36mg	G 54mg	Relexxii® (bioequivalent to corresponding Concerta dosing)	G 45mg	G 63mg	G 72mg
Focalin® XR‡ (dexmethylphenidate)	6-17 Yrs: 5–30mg; SD: 5mg 18 Yrs-Adult: 10–40mg; SD: 10mg (biphasic – 50/50)	G 5mg		G 10mg	G 15mg	G 20mg; G 25mg	G 30mg	G 35mg	G 40mg
Cotempla XR-ODT®¶ (grape flavor)	6-17 Yrs: 8.6–51.8mg; SD: 17.3mg	8.6mg		17.3mg	25.9mg	34.6mg	51.8mg		
Aptensio® XR‡	6 Yrs–Adult: 10–60mg; SD: 10mg (biphasic – 40/60)	G 10mg	G 15mg	G 20mg	G 30mg	G 40mg; G 50mg	G 60mg		
Quillivant XR® 25mg/5mL (5mg/mL) (banana flavor)	6 Yrs–Adult: 20–60mg; SD: 20mg	10mg 2mL 1 Bottle: 300mg 60mL		20mg 4mL 1 Bottle: 600mg 120mL	30mg 6mL 1 Bottle: 900mg 180mL	40mg 8mL 2 Bottles: 600mg 120mL 50mg 10mL 2 Bottles: 750mg 150mL	60mg 12mL 2 Bottles: 900mg 180mL		
QuilliChew ER®§ (cherry flavor)	6 Yrs–Adult: 20–60mg; SD: 20mg (biphasic – 30/70)			20mg	30mg	40mg			
Ritalin® LA‡	6-12 Yrs: 10–60mg; SD: 20mg (biphasic – 50/50)	G 10mg		G 20mg	G 30mg	G 40mg	G♦ 60mg		
Metadate® CD‡	6-17 Yrs: 10–60mg; SD: 20mg (biphasic – 30/70)	G♦ 10mg		G♦ 20mg	G♦ 30mg	G♦ 40mg; G♦ 50mg	G♦ 60mg		
Metadate® ER†	6 Yrs-Adult: 20–60mg; SD: 20mg	G♦ 10mg		G♦ 20mg					

Methylphenidate Pro-Drug Formulations - Long Acting, Oral** (Medications in this section are shown at actual size)

Azstarys®? (dexmethylphenidate + serdexmethylphenidate)	6-12 Yrs: 26.1/5.2 – 52.3/10.4; SD: 39.2/7.8 mg; 13 Yrs – Adult: 39.2/7.8 – 52.3/10.4; SD: 39.2/7.8mg	26.1mg SDX / 5.2mg d-MPH	39.2mg SDX/ 7.8mg d-MPH	52.3mg SDX/ 10.4mg d-MPH		

Methylphenidate Formulations – Long Acting/Delayed Onset, Oral** (Medications in this section are shown at actual size)

Jornay PM®‡	6 Yrs–Adults: 20–100mg (dosed in the evening); SD: 20mg	20mg	40mg	60mg	80mg	100mg

Methylphenidate Formulations – Short Acting, Oral** (Medications in this section are shown at actual size)

Focalin® (dexmethylphenidate)	6–17 Yrs: Daily: 5–20mg, divided BID; SD: 2.5mg BID		G 2.5mg	G 5mg	G 10mg	
Ritalin®	6–12 Yrs: Daily: 10–60mg; divided BID or TID; SD: 5mg BID Adults: Daily: 10–60mg, divided BID or TID		G 5mg	G 10mg	G 20mg	
Methylin Chewable§ (grape flavor)	6–12 Yrs: Daily: 10–60mg; divided BID or TID; SD: 5mg BID Adults: Daily: 10–60mg, divided BID or TID	G♦ 2.5mg	G♦ 5mg	G♦ 10mg		
Methylin® Solution (grape flavor)	6–12 Yrs: Daily: 10–60mg; divided BID or TID; SD: 5mg BID Adults: Daily: 10–60mg, divided BID or TID		G 5mg/5mL	G 10mg/5mL		

Methylphenidate Formulations - Long Acting, Transdermal

Daytrana®
6-17 Yrs: 10–30mg; SD: 10mg
(Patches are shown at 100% actual size. The color border around each patch reflects the color of the packaging, not the patch itself.)

- 30mg / 9 hrs ~ 1.5"x 3.9"
- 20mg / 9 hrs ~ 1.5"x 2.6"
- 15mg / 9 hrs ~ 1.5"x 1.9"
- 10mg / 9 hrs ~ 1.4"x 1.4"

Administration Key:

¶ Orally disintegrating tablet
† Must be swallowed whole
§ Chewable
¥ Can be mixed with yogurt, orange juice, or water
‡ Can open capsule and sprinkle medication on apple sauce
? Can open capsule and sprinkle medication into water or onto apple sauce
❣ Can open capsule and mix with apple sauce or yogurt

G Indicates a generic formulation is also available; generic products are not shown
G Indicates a generic (but NOT a branded) formulation is available

- View the latest version of the ADHD Medication Guide at www.ADHDMedicationGuide.com

♦**Discontinued ADHD Medications:** The following FDA-approved proprietary formulations are no longer available (though, in some cases, branded or generic equivalents are still available): Adhansia XR; Adzenys ER (liquid); Cylert (pemoline); Dexedrine Spansules (5mg, 15mg); Dexedrine tablets; DextroStat tablets; LiquADD solution; Metadate CD capsules; Metadate ER tablet (10mg); Methylin Chewable tablets; Ritalin LA capsule (60mg); Ritalin SR tablets (20mg).

***Important Information:** The age-specific dosing information listed for each medication reflects the FDA-approved prescribing information. "SD" refers to the FDA-recommended starting dose, which sometimes varies by age. Practitioners should refer to the full prescribing information for each medication. **Please note:** medications have been arranged on the ADHD Medication Guide for ease of display and visual comparison; dosing comparability cannot be assumed.

- Updated versions of the ADHD Medication Guide can be viewed at: www.ADHDMedicationGuide.com
- Laminated copies of the ADHD Medication Guide can be ordered on-line from the ADD Warehouse
- Contact Dr. Andrew Adesman with any comments or suggestions: ADHDMedGuide@Northwell.edu

This copy of the ADHD Medication Guide is provided by

NEW JERSEY PEDIATRIC PSYCHIATRY COLLABORATIVE

Cohen Children's Medical Center
Northwell Health®

ADHD Medication Guide*

Revised: February 15, 2024

Amphetamine Formulations – Long Acting, Oral** (Medications in this section are shown at actual size)

Dyanavel® XR (d- & l-amphetamine sulfate)	6 Yrs–Adults: 2.5–20mg; SD: 2.5 or 5mg		5mg		10mg		15mg		20mg	
Dyanavel® XR (d- & l-amphetamine sulfate) 2.5mg/mL (bubblegum flavor)	6 Yrs–Adults: 2.5–20mg; SD: 2.5 or 5mg	2.5mg 1mL	5mg 2mL	7.5mg 3mL	10mg 4mL	12.5mg 5mL	15mg 6mL	17.5mg 7mL	20mg 8mL	
Mydayis®‡ (mixed amphetamine salts)	13–17 Yrs: 12.5–25mg; SD: 12.5mg Adults: 12.5-50mg; SD: 12.5mg	G 12.5mg		G 25mg		G 37.5mg		G 50mg		
Adzenys XR-ODT®¶ (d- & l-amphetamine) (orange flavor)	6–12 Yrs: 3.1–18.8mg; SD: 6.3mg 13–17 Yrs: 3.1–12.5mg; SD: 6.3mg Adults: 12.5mg		3.1mg	6.3mg	9.4mg	12.5mg	15.7mg	18.8mg		
Adderall XR®‡ (mixed amphetamine salts)	6–17 Yrs: 5–30mg; SD: 10mg Adults: 5-30mg; SD: 20mg (biphasic – 50/50)		G 5mg	G 10mg	G 15mg	G 20mg	G 25mg	G 30mg		
Dexedrine Spansule® (d-amphetamine sulfate)	6-17 Yrs: 10–60mg; SD: 5mg 1-2x/day		G♦ 5mg	G 10mg	G♦ 15mg					

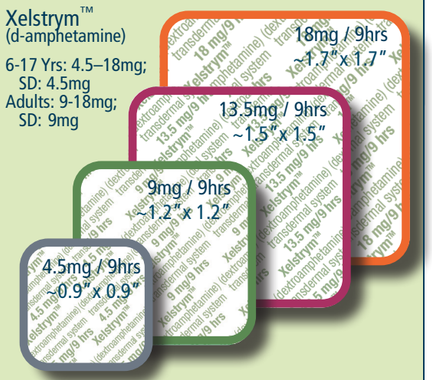
Amphetamine Pro-Drug Formulations – Long Acting, Oral** (Medications in this section are shown at actual size)

Vyvanse®¥ (capsules) (lisdexamfetamine)	6 Yrs–Adults: 10–70mg; SD: 30mg	G 10mg	G 20mg	G 30mg	G 40mg	G 50mg	G 60mg	G 70mg		
Vyvanse®§ (chewables) (lisdexamfetamine) (strawberry flavor)	6 Yrs–Adults: 10–70mg; SD: 30mg	G 10mg	G 20mg	G 30mg	G 40mg	G 50mg	G 60mg			

Amphetamine Formulations- Long Acting, Transdermal

Xelstrym™ (d-amphetamine)

6-17 Yrs: 4.5–18mg; SD: 4.5mg
Adults: 9-18mg; SD: 9mg



(Patches are shown at 100% actual size. The color border around each patch reflects the color of the packaging, not the patch itself.)

Amphetamine Formulations – Short Acting, Oral** (Medications in this section are shown at actual size)

Evekeo® (d- & l- amphetamine sulfate)	3–5 Yrs: SD: 2.5mg 1x/day 6–17 Yrs: 5-40mg divided BID; SD: 5mg 1-2x/day		G 5mg		G 10mg					
Evekeo® ODT (d- & l- amphetamine sulfate)	6–17 Yrs: 5-40mg divided BID; SD: 5mg 1-2x/day	2.5mg	5mg		10mg		15mg	20mg		
Zenzedi® (d-amphetamine sulfate)	3–5 Yrs: SD: 2.5mg 1x/day 6–16 Yrs: 5-40mg divided BID; SD: 5mg 1-2x/day	2.5mg	G 5mg	7.5mg	G 10mg		G 15mg	G 20mg	G 30mg	
Adderall® (mixed amphetamine salts)	3–5 Yrs: SD: 2.5mg 1x/day 6–17 Yrs: 5-40mg divided BID; SD: 5mg 1-2x/day		G 5mg	G 7.5mg	G 10mg	G 12.5mg	G 15mg	G 20mg	G 30mg	
ProCentra® (d-amphetamine sulfate) (bubblegum flavor)	3–5 Yrs: SD: 2.5mg 1x/day 6–17 Yrs: 5-40mg divided BID; SD: 5mg 1-2x/day		G 5mg/5mL							

Non-Stimulants** (Medications in this section are shown at actual size)

Intuniv®† (guanfacine, extended release)	6–12 Yrs: 1-4mg; SD: 1mg 13–17 Yrs: 1-7mg; SD: 1mg Weight-based dosing: SD: 0.05-0.08 mg/kg/day; may increase to 0.12 mg/kg/day	G 1mg	G 2mg	G 3mg	G 4mg					
Kapvay®† (clonidine, extended release)	6–17 Yrs: 0.1-0.2mg BID; SD: 0.1mg qHS	G 0.1mg	(only in dose pack) 0.2mg							
Strattera®† (atomoxetine)	≤70kg: 0.5mg/kg x ≥3days, then 1.2mg/kg (max:1.4mg/kg, not to exceed 100mg) >70 kg: 40mg x ≥3days, then 80mg (max:100mg)	G 10mg	G 18mg	G 25mg	G 40mg	G 60mg	G 80mg	G 100mg		
Qelbree®‡ (viloxaxzine)	6–11 Yrs: 100-400mg; SD: 100mg 12–17 Yrs: 200-400mg; SD: 200mg Adults: 200-600mg; SD: 200mg	100mg	200mg	300mg	+	400mg	+			

This copy of the ADHD Medication Guide is provided by

NEW JERSEY PEDIATRIC PSYCHIATRY COLLABORATIVE

Cohen Children's Medical Center
Northwell Health®

Resources for Providers

Resources Providers May Find Helpful:

- Treatments for ADHD in Children and Adolescents: A Systematic Review
- American Academy of Child and Adolescent Psychiatry

Books Providers May Find Helpful:

- **Cognitive Behavioral Therapy for Adult ADHD: An Integrative Psychosocial and Medical Approach** (2014), by Anthony L. Rostain, MD, FAAP & J. Russel Ramsay, PhD
- **Pediatric Collections: ADHD: Evaluation and Care** (2020), American Academy of Pediatrics
- **Managing Behavioral Issues in Child Care and Schools** (2020), by Mary Margaret Gleason, MD, FAAP, and Allison Boothe Trigg, PhD
- **Quirky Kids: Understanding and Supporting your Child with Developmental Differences** (2021), by Perri Klass, MD, FAAP, and Eileen Costello, MD, FAAP
- **AAP Developmental and Behavioral Pediatrics, 2nd Edition** (2018), by AAP Section on Developmental and Behavioral Pediatrics
- **Pediatrics Mental Health: A Compendium of AAP Clinical Practice Guidelines and Policies** (2020), American Academy of Pediatrics

Resources For Caregivers

Resources Caregivers May Find Helpful:

- What Should I do if my Child's ADHD Medication is Out of Stock during the Shortage?
- ADHD Parent Medication Guide (2020) available through AACAP
- ADHD Parent Resource Center (last updated Oct 2021) available through AACAP
- Managing Inattention, Impulsivity, and Hyperactivity: Tips for Families
- Understanding ADHD: Information for Parents

Books Caregivers May Find Helpful:

- **Taking Charge of ADHD: The Complete Authoritative Guide for Parents (Revised Edition)** (2000), by Russell A. Barkley, PhD
- **Attention Deficit Disorder: The Unfocused Mind in Children and Adults** (2006), by Tom Brown, PhD
- **Teenagers with ADD and ADHD: A Guide for Parents and Professionals** (2006), by Chris Dendy
- **Learning to Slow Down & Pay Attention: A Book for Kids about ADHD** (2004), by Kathleen Nadeau, PhD, Ellen Dixon, PhD, and Charles Beyl
- **Jumpin' Johnny Get Back to Work! A Child's Guide to ADHD/Hyperactivity** (1981), by Michael Gordon, PhD
- **ADHD, What Every Parent Needs to Know** (2019), by Mark L. Wolraich, MD, FAAP, and Joseph F. Hagan, Jr, MD, FAAP

Frequently Asked Questions

The following section contains Frequently Asked Questions, compiled throughout the ADHD Learning Collaborative series. Responses to these questions were provided by the following New Jersey Pediatric Psychiatry Collaborative Champions and subject matter experts:

Meera Wells, MD, FAPA
Medical Director
NJ Pediatric Psychiatry Collaborative

Debra E. Koss, MD, DFAACAP, DFAPA
Clinical Assistant Professor, Department of Psychiatry,
Rutgers-RWJMS

Anthony L. Rostain, MD, MA
Chair, Department of Psychiatry and Behavioral Health
Cooper University Health Care

Sabina Mushtaq, MD
Child and Adolescent Psychiatrist
NJ Pediatric Psychiatry Collaborative

Deborah Steinbaum, MD, MPH, FAAP
Pediatrician
PediatriCare Associates

Frequently Asked Questions

General ADHD Related Questions:

- What are the consequences of untreated ADHD?
- When should a child with ADHD be referred to a psychiatrist/when is ADHD better managed by a neurologist/psychologist vs general pediatrician?
- What is the differential diagnosis/approach to screening for related disorders?
- Between anxiety and ADHD, what do you treat first?
- Any recommendations for parents classes or support groups for children with ADHD?
- Any recommendations for patients who start complaining of an inability to focus in school, who previously had no complaints?

Medication Related Questions:

- What are some new medication options for treating ADHD?
- What is appropriate ADHD medication management in preschool children?
- How to adjust medications and changes to be looking out for?/ How to monitor efficacy of treatment and side effects of medications?
- What are pros and cons of stimulant vs non-stimulant?
- How to choose between the different treatment options and what specific adverse effects to monitor with each choice/Pharmacotherapy of ADHD?
- What to do if a family is unable to get their child's medication due to a shortage?
- What are some non-medication options for management?
- What stimulant would you recommend if concerned about misuse/diversion in college age?

Insurance Related Questions:

- Tips for prescribing/treating Community Health Center population who are uninsured or have public insurance?
- What are recommendations for billing codes since all F codes are denied by insurances for primary care if used independently?

Screening Related Questions:

- Are there alternatives to the Vanderbilt for screening or another tool to use for follow up other than the Vanderbilt that might be shorter?/What are evaluations for high school and college age patients, adult resources, and is it appropriate for pediatricians to be evaluating over 18 years old?
- Vanderbilt for medication follow up- is good control of ADHD symptoms getting 0's and 1's or a decrease in 2's and 3's?
- If there are disparities between Vanderbilt scores from parents and teachers, should we treat?

General ADHD Related Questions:

What are the consequences of untreated ADHD?

Without treatment, a child or teen with ADHD may experience academic and interpersonal challenges. Children with ADHD may fall behind in class, have difficulty completing homework and fail tests. Children with hyperactivity/ impulsivity are also likely to be disruptive in class. As a result, these students may become frustrated or disinterested in school. These challenges may lead to school avoidance, suspension and/or academic failure as well as low self-esteem or dysphoric mood. Interpersonal conflict may include difficulties with peers, siblings and parents. Youth with untreated ADHD may have difficulty making or keeping friends. Parents and children may struggle with communication and experience conflict as they attempt to manage activities of daily living. Adolescents with ADHD are also at greater risk for motor vehicle accidents, substance use and teen pregnancies. Young adults with ADHD are at risk of failed relationships and job loss. Fortunately, there are safe and effective treatment strategies for ADHD that will address the core symptoms and consequences of the disorder

When should a child with ADHD be referred to a psychiatrist/when is ADHD better managed by a neurologist/psychologist vs general pediatrician?

Patients with ADHD who present with symptoms suggestive of co-existing psychiatric conditions should be referred to the NJPPC child and adolescent psychiatrist (CAP) for consultation. Symptoms of co-existing conditions will likely be identified during the process of primary and secondary screening. The NJPPC CAP will gather information from the primary care provider (PCP) and may direct the PCP to continue with the evaluation and offer consultation throughout the process. Alternatively, the NJPPC CAP may conduct a one-time evaluation of the child to directly assess mental status and history. Following consultation, the CAP will recommend the appropriate care provider and the appropriate level of care. The CAP may recommend maintaining the patient under the care of the pediatrician with ongoing consultation from the NJPPC CAP or may recommend referring the patient to a psychiatrist in community. Patients with ADHD and simple anxiety or depression may be managed by the pediatrician in the medical home. Patients with ADHD and more complex psychiatric conditions, such as Bipolar Disorder, may require treatment with a CAP. Patients with ADHD and certain active or unstable symptoms, such as eating disorder , substance use disorder or suicidal ideation, may require higher level of care until stabilized and then may be referred to a CAP in community.

What is the differential diagnosis/approach to screening for related disorders?
Inattention and hyperactivity/impulsivity are core symptoms of ADHD but are not specific to ADHD alone. These symptoms may be present in other psychiatric disorders. Furthermore, co-morbidity is common in ADHD. Patients diagnosed with ADHD are likely to present with co-occurring conditions that impact functioning and require intervention. Therefore, clinicians evaluating a child or adolescent presenting with symptoms of inattention and/or hyperactivity/impulsivity must consider a range of diagnostic possibilities during the process of screening and evaluation. Differential Diagnosis and co-morbidities should include:

- Oppositional Defiant Disorder (ODD)
- Conduct Disorder (CD)
- Depression
- Anxiety
- Tic Disorders
- Substance Use Disorders
- Bipolar Disorder
- Learning Disabilities
- Language Disorders

Screening should always begin with primary instruments, such as the PSC-35, for parents and caregivers of children ages 6 and older, and Y-PSC-37, a self-report screening tool for youth ages 11 and up. These instruments will identify internalizing symptoms (suggestive of anxiety or depression), externalizing symptoms (suggestive of ODD and CD) and attentional issues (suggestive of ADHD). Primary screening should also include the CRAFFT Screening Tool in order pinpoint experience with substance use. Positive results on a primary screening tool should result in administration of the relevant secondary screening instruments:

- Anxiety: Screen for Anxiety Related Disorders (SCARED)
- Attention: Vanderbilt Assessment Scales-Parent and Teacher Versions
- Depression: Patient Health Questionnaire (PHQ-9)
- Suicidal Thinking and Behavior: Columbia-Suicide Severity Rating Scale (C-SSRS)
- or the Ask Suicide Screening Questions (ASQ)

A positive result on a secondary screening instrument should result in a comprehensive evaluation, including a detailed interview with the parent (exploring current symptoms, and developmental, psychiatric, medical history, educational and family history) and assessment of the child (including presence of and awareness of symptoms as well as presenting mood, thought, speech and language patterns). Clinicians are encouraged to contact the NJPPC child and adolescent psychiatrist who will offer guidance and when necessary evaluate the child as part of a one-time consultation.

Between anxiety and ADHD, what do you treat first?
Many experts in this field may say that when dealing with two diagnoses, we have to see which one is the worst. Sometimes there may be subtle signs of ADHD, but then you're seeing anxiety affecting a child's day to day life, so, you would want to treat this first. If symptoms are moderately present, ADHD is an easier diagnosis to treat because you will see a response very quickly. Once you get ADHD off the plate, it may also lead to improvement in anxiety for the child because ADHD feeds into anxiety. Anxiety can sometimes get worse when there is a stimulant on board. As you know, when treating anxiety, it takes longer to see the effect while you're adjusting the medication, oftentimes in clinical practice we might just go with treating the ADHD first and then go to treating the anxiety.

Any recommendations for parents classes or support groups for children with ADHD?
Depends which area you're in. Multiple parent coaches are available in different states, such as Mr. Richard Formica. Many therapists are trained to work with parents of kids with ADHD. Social skills training groups are groups that might be helpful for these kids. They come across as socially immature with a lot of problems interacting with peers from the beginning. Social skills groups are very helpful. (Dr. Mushtaq) Dr.

- https://chadd.org/affiliate-locator/
- ADDitude.
- In Morris County, there is a Facebook group called CHADDMorris County Parent Support Group - They have lots of speakers who are local ADHD professionals including therapists and coaches
- With regard to support groups for parents, it is recommended to check with your child's school/guidance."

Any recommendations for patients who start complaining of an inability to focus in school, who previously had no complaints?
It might be subtle complaints like inattention. If it is just happening in high school, I want to see why they want a stimulant. There may be subtle signs. Collateral is important from parents and schools. I've seen a lot of cases show up at the beginning of middle school and high school. The level of functioning required in those grades is a lot higher than in grade school. Some kids, lack executive functioning, never learned how to organize themselves or take notes - they are a mess. Some of the kids with inattentive symptoms may be just daydreaming in the classroom, never picked out because they are not hyperactive. The higher the grade, the more the expectation from this child. They may have had subtle symptoms that we did not pick up. Pretty common with inattentive type, which tends to be more girls, not the hyperactive ones that come into attention with schools

Medication Related Questions:

What are some new medication options for treating ADHD?
Stimulants: Azstarys, Jornay PM and Xelstrym patch are approved for 6 years and older. Non-stimulant: Qelbree for 6 years and older

What is appropriate ADHD medication management in preschool children?
Behavior Therapy is the preferred treatment for preschoolers. Medications should be considered only if behavior therapy has failed or the symptoms are causing major disruptions in a child's life or putting them in danger. If medications are to be considered use short acting forms of methylphenidate or amphetamine. I typically use methylphenidate low dose first and then switch to amphetamine short acting if it is not working. However one is not better than the other, it is finding what works for the child. The good news is that both come in non pill form that is better for preschoolers. I would recommend always getting a consultation form a specialist when considering medications for children younger than 6 years. Your NJPPC Child psychiatrist will be able to help you with this.

How to adjust medications and changes to be looking out for?/ How to monitor efficacy of treatment and side effects of medications?
As a rule of thumb you want to have a baseline screening tool prior to starting medications, this is what you will use as a comparison to see how the child is doing. The goal is to find the optimal medication dose to treat ADHD. Depending on severity you can increase the dose weekly with keeping an eye on the side effects. Typically the dose is increased every two weeks. Repeat screening tool every two weeks to monitor progress. This along with clinical presentation will give you an idea of efficacy as well. Monitor side effects by educating parents and patient on appetite suppression, poor sleep, upset stomach, headache, dry mouth, irritability and mood changes. In your clinic do vitals and weight check. If poor appetite/weight loss is a concern, educate on having a calorie rich meal prior to stimulant medication, healthy snacks. If sleep is a concern, consider adjusting timing of medicine, and recommend sleep hygiene. Headaches in the beginning usually resolve with time. Irritability and moodiness can happen has a rebound as medication is wearing off, however keep in mind anxiety and other mood issues.

What are pros and cons of stimulant vs non-stimulant?
Stimulants may control 80-90% of core ADHD symptoms. They work on the day they are taken in most cases. However they might be metabolized earlier than intended or advertised (varies amongst individuals). Common side effects include issues with sleep onset and appetite suppression as well as some limitations with growth so in

What are pros and cons of stimulant vs non-stimulant? (cont'd from previous page)
picky eaters or kids with growth issues that are ongoing, this might not be the best starting choice. They have a risk of diversion and misuse so in adolescents that has to be considered and discussed (as well as documented) prior to prescribing them. Some patients with stimulants can have mood changes which may need for these medicines to be discontinued in some cases. Nonstimulants- might be a good choice when stimulant induced sleep issues are intended to be avoided. Additionally these medicines may not affect appetite (in most cases) and growth. They may help in cases where sleep is an ongoing issue. Longer acting preparations may help with next day ADHD morning symptoms hence making morning routines a little bit more manageable vs stimulants. They may also be used in later in the day control of symptoms which might help with bedtime and homework time.

How to choose between the different treatment options and what specific adverse effects to monitor with each choice/Pharmacotherapy of ADHD?

- symptoms profile of the patient
- personal and family history of response to medicine
- preexisting comorbidities ,growth and sleep issues
- age
- FDA approval.
- Availability and cost of the medicine

Very young children may not metabolize medications effectively thus have more risk of side effects. Vital signs will need to be monitored with both groups of medicines. In situations where parent may not be very reliable with dispensing controlled substances non stimulants may be a good starting option.

What to do if a family is unable to get their child's medication due to a shortage?
If you can't find your child's medication at your usual pharmacy, you have two options. First, you can call around to other pharmacies in the area and see if they have availability. As soon as you locate a place, inform your child's prescriber and ask them to transfer the electronic prescription there. Sometimes the pharmacies may have smaller doses available, so it may require changing the strength but keeping the same total daily dose (say 2 x 5 mg instead of 10 mg). The other option is to discuss alternative formulations with your child's prescriber. It may be necessary to switch from slow release to immediate release, or from one type of stimulant to another. An example would be to switch from dexmethylphenidate to methylphenidate, or from methylphenidate to amphetamine. This will require your prescriber to explain the different options before you and they pick one.

What are some non-medication options for management?
There are important non-medication interventions for ADHD including (1) removing food additives and artificial flavorings from your child's diet, (2) supplementing your child's intake of omega-3 free fatty acids, (3) neurofeedback, (4) computer-based (digital) devices, (5) trigeminal nerve stimulation (TNS), (6) yoga/mediation, (7) organizational skills training and (8) time in nature/outdoors. None of these are as powerful as medications, but they can make it easier for kids to focus/pay attention. The other major non-medication interventions are BEHAVIOR THERAPY – including Parent management training, classroom management training and group social skills training. These all require consistent participation over months to years in order to be most effective.

What stimulant would you recommend if concerned about misuse/diversion in college age?
You should not be giving stimulants to young people going off to college if you have a concern about their reliability, ability to not only keep medications kept away, but not to share with their friends. I sometimes switch to non-stimulants, for safety, and because the temptations are too great

Insurance Related Questions:

Tips for prescribing/treating Community Health Center population who are uninsured or have public insurance?
Uninsured patients will need to get assistance with payment for ADHD medications. Many of the pharmaceutical companies have "charitable care" options for needy children and families. Public insurance (Medical Assistance) usually covers most of the medication classes for ADHD.

What are recommendations for billing codes since all F codes are denied by insurances for primary care if used independently?
Here are some billing pointers for ADHD in Primary care: ADHD Coding Fact Sheet for Primary Care Pediatricians

Screening Related Questions:

Are there alternatives to the Vanderbilt for screening or another tool to use for follow up other than the Vanderbilt that might be shorter?/What are evaluations for high school and college age patients, adult resources, and is it appropriate for pediatricians to be evaluating over 18 years old?

For ADHD specifically, there are certainly some other instruments like the Connors instrument, but that is something that is not available in public domain. You need to pay for that resource. The Vanderbilt is something that is available in public domain. It is available to primary care and school personnel, which is why it is our go to as a secondary screening tool. There is an adult self-report ADHD scale that is pretty good- Adult ADHD Self-Report Scale. It is a little tricky for teens. There is no great resource for that. I encourage everybody, if you have a chance, to fill out a Vanderbilt, for yourself as a kid, for a child, or for someone you know. Having experience reading through the questions and thinking about them is useful. Get a better grip on what we're asking parents

Vanderbilt for medication follow up- is good control of ADHD symptoms getting 0's and 1's or a decrease in 2's and 3's?

Shifting toward the left- from 3/2s toward 1/0 is the direction things should be going. The goal is symptom remission if possible. Keep going to try to get towards 1. Don't know if it's possible to get to 0. If some improvement but still causing difficulties, worth it to titrate upwards to see if you can get closer to 1s. Magic line is between 2 and 1. If you get from 2 to a 1, you've made progress.

If there are disparities between Vanderbilt scores from parents and teachers, should we treat?

It's worth a conversation. If the parents aren't seeing it, they may not be observing any problems and may not be taking the situation seriously, which should be explored. If the parents are seeing it, but the teachers are not, it's not that they don't have ADHD. They [the child] may be able to self-regulate enough in the classroom. Talk to the parents about what's going on at home. Toolkit includes psychoeducation, talking to the child, and helping parents monitor treatment. If using medication, there is a broader treatment framework, that is, setting goals that the child can meet. If not attending to all components, and the parents and teachers are at odds, you end up in the middle

NEW JERSEY
PEDIATRIC PSYCHIATRY
COLLABORATIVE

Questions?
Contact us.

www.nj-ppc.org

info@nj-ppc.org