Intermountain Healthcare continues to work toward developing and refining processes and tools to improve management of ADHD. This care process model (CPM) and accompanying tools (forms, data, patient education) were developed in cooperation with several other organizations, including the Intermountain Pediatric Society, the American Academy of Pediatrics Utah Chapter, and Children and Adults with Attention Deficit Hyperactivity Disorder (CHADD) of Utah.

Why Focus ON ADHD?

- **High prevalence.** ADHD is one of the most common chronic childhood disorders, and often persists into adulthood. Current CDC estimates indicate that the prevalence of ADHD has increased from 2003 to 2007, with approximately 9.5% of all children and teenagers diagnosed with the disorder and rates as high as 13.8% for teenagers age 15 to 17. The prevalence of adult ADHD is estimated at 4%, according to a national comorbidity survey.

- **Need to screen for and treat comorbidities.** Complicating the assessment and treatment of ADHD is the fact that at least ½ of children have one or more coexisting conditions that may affect treatment decisions. A Mental Health Integration (MHI) care team can support and guide choices that are effective in treating specific comorbidities.

- **Long-term consequences for patients.** Children with ADHD who don’t receive appropriate treatment may be at increased risk for substance abuse, teenage pregnancy, complex learning difficulties, school problems, and even criminal behavior as they move into adolescence and beyond.

- **Challenge of managing parental and public expectations.** Physicians must cope with intense pressure from parents presenting their child’s case as a crisis situation — pushing physicians to act with immediacy, rather than deliberation. Also, public scrutiny of treatment with psychotropic medications can contribute to uncertainty for families about the best course of medical treatment.

- **Need for communication and collaboration between physicians, family members, and school staff.** Lack of ongoing continuity and consistency can severely impact outcomes for the child or adolescent patient. This CPM provides tools to help physicians communicate and collaborate with patients, parents, and schools to plan treatment, set goals, and follow up on progress.

What’s new IN THIS UPDATE?

(2016 update indicated in bold type below)

- Intermountain measures (at right)
- DSM-5 updates (page 2)
- New Substance Use Disorder screening tool (page 5)
- 2016 medication updates (pages 10–13)
- A new tool to help parents, clinics, and schools collaborate to address children’s mental health problems using the MHI process (page 14 — sidebar)
OVERVIEW

The recommendations in this CPM — and the tools that support them — constitute a pragmatic approach to a complex problem. They are based on several core principles:

- **The treatment of ADHD is a collaborative process**, which must actively involve the patient’s family as well as school staff and medical personnel.
- **ADHD must be viewed from a holistic perspective**, considering comorbid conditions that may contribute to dysfunction.
- **The goal of treatment is to improve day-to-day functioning** in previously identified areas of impairment, not merely to suppress ADHD symptoms.

This care process model aligns with the recommendations of the American Academy of Pediatrics (AAP) for the diagnosis and treatment of school-aged children\(^1\,\text{AAP1, AAP2}\) and the 2007 practice parameter established by the American Academy of Child and Adolescent Psychiatry (AACAP) for assessing and treating children and adolescents.\(^\text{PLI1}\)

### Diagnosis in children

See pages 4 through 5 for details on diagnosis; key points appear below.

- The primary care physician should initiate the **ADHD evaluation** for all children who present with inattention, hyperactivity, impulsivity, academic underachievement, or behavior problems. **ADHD screening** should also be included when a patient undergoes other types of mental health assessment.
- Diagnosis of ADHD requires meeting **criteria** set forth in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*.\(^\text{DSM}\)
- The assessment requires **evidence directly obtained from parents or caregivers and from the classroom teacher** (or other school professional) regarding core symptoms of ADHD in various settings, the age of onset, duration of symptoms, and degree of functional impairment.
- Evaluation should include **assessment for psychiatric comorbidities**.
- Before diagnosing ADHD, **disorders that can mimic ADHD should be excluded**.
- ADHD is established using the methods above; **other diagnostic tests** (such as SPECT scan or EEG) are **not routinely indicated**.

### Treatment in children

See pages 6 through 9 for details on treatment; key points appear below.

- Treatment programs should recognize ADHD as a **chronic condition**.
- The treating clinician, parents, and child — in collaboration with school personnel — should specify **appropriate goals to guide management**.
- **Stimulant medication** has been shown to be the most effective treatment for patients with ADHD and should be used when appropriate to improve target outcomes in children with ADHD. Where comorbid conditions exist, **behavioral therapy** (if appropriate) should be recommended.
- When the selected management for a child with ADHD has not met target outcomes, clinicians should **re-evaluate** the original diagnosis, use of all appropriate treatments, adherence to the treatment plan, and presence of coexisting conditions.
- The clinician should periodically provide **systematic follow up**. Monitoring should be directed to the child’s individual goals and any adverse effects of treatment, with information gathered from parents, teachers, and the child.

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**ADHD DIAGNOSTIC CRITERIA: DSM-5 UPDATES**

The definition of ADHD has been updated in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* to more accurately characterize the experience of affected adults.\(^\text{DSM}\) Refer to the DSM-5 for details. In 2015, Intermountain-employed physicians will be able to access an online version of the DSM-5 through the eResources page on IntermountainPhysician.org.
Diagnosis and treatment in adolescents and adults

- **Adolescents:** Impairment in middle school and high school can have significant consequences and presents additional risks for teenage drivers (see sidebar). The following are a few considerations to keep in mind for evaluating and treating adolescent patients:
  - **Adolescent patients diagnosed in childhood:** The initial symptoms that prompted treatment (restlessness, interrupting, difficulty waiting in line) can fade in adolescence. However, be cautious about discontinuing treatment. ADHD persists into adolescence in as many as 85% of patients, and also persists into adulthood in as many as 60% of patients (see below for advice on diagnosis and treatment of adults).
  - **Patients evaluated in adolescence:** Adolescents being evaluated for depression or anxiety should be assessed for ADHD as well. You may also see patients who have been able to cope with elementary school despite ADHD symptoms, but request help when faced with increased demands for focus and organization in middle school or high school. At this age, the proportion of girls with ADHD can increase.
  - **Diagnosis and treatment:** As with pediatric patients, use the diagnosis, treatment, and medication management algorithms on pages 4 through 9. Frequent monitoring of medication is critical, as stimulants have a higher potential for misuse or diversion in the middle school or high school environment.

- **Adults:** Up to 60% of childhood ADHD cases persist into adulthood. Often, the hyperactive symptoms of childhood resolve, leaving symptoms related to executive function that can impair daily functioning and work performance (see sidebar).

  - **Diagnosis:** Adults often realize that they may have ADHD when their child is diagnosed. However, the American Academy of Pediatrics (AAP) diagnosis guidelines and many diagnostic tools are focused on children. If you or your adult patients suspect ADHD, use the ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist provided in the MHI Adult Baseline Packet (see sidebar). Confirm the diagnosis through consultation with a mental health professional. Diagnosis of adult ADHD does not require formal diagnosis during childhood; research indicates symptom onset before age 7 is not a key factor in diagnosing adult ADHD, and the DSM-5 revises age-of-onset criterion to age 12 (was age 7 in DSM-IV) (see sidebar on previous page).

  - **Treatment:** Stimulants and, to a lesser degree, antidepressant medications with norepinephrine and/or dopamine stimulation actions are the standard of treatment. Dosages are comparable to dosages for children on an mg/kg basis. Sustained release preparations may reduce the risk of chemical dependency.

Psychiatric comorbidities

Since psych comorbidities are relatively common with ADHD, screening for these conditions is vital. Identifying comorbidities can help physicians determine risk, assess the need for therapy, and choose the most effective medication.

- **The MHI Baseline Packet (Adult or Child & Adolescent) can help you identify comorbidities.** These packets include validated tools to screen for symptoms of several comorbidity.

- **An MHI team can help you provide comprehensive evaluation and treatment.** For example, some medications may be more effective with certain ADHD/comorbidity combinations. A Mental Health Specialist can provide insight on medication and other treatment options. Community resources can also be very helpful.

Substance use disorder (SUD)

- **ADHD treatment in childhood can prevent SUD.** Studies have shown that treating ADHD in childhood with stimulant medication can help prevent SUD later on.

- **For adolescent and adult patients, family screening for SUD is critical.** A significant percentage of adolescents and adults with ADHD also have SUD. Before treating a teen or adult with stimulants, consider screening both patient and family for SUD.

TEENAGE DRIVING RISKS

ADHD can cause additional risks for teenage drivers. Teenagers and young adults with ADHD are more likely to drive a car without a license, have their licenses suspended or revoked, have crashes, and be at fault for these crashes. A study with a large sample of ADHD patients followed into adolescence and adulthood — and demographically similar controls without ADHD — suggests an increased risk of potentially dangerous driving outcomes for the ADHD patients.

SCREENING AND DIAGNOSIS OF ADULT ADHD

Adult ADHD often presents itself differently than childhood ADHD:

- **Adult ADHD frequently has one or more of these core features:** inattention, distractibility, impulsiveness, poor concentration, inability to persist at tasks, difficulties with working memory, and difficulties with organization and planning.

- **Adults may not recall early symptoms; diagnosis of adult ADHD does not require formal diagnosis in childhood.** The male-female ratio for adult patients with ADHD is different than that for children; the male-female ratio drops to 3:2, and women are often more impaired than men.

To screen for ADHD, use the ADHD Self-Report Scale (ASRS-v1.1). Symptom Checklist, developed and validated by the World Health Organization for adult ADHD screening. © 2013 World Health Organizations. Used with permission.

To confirm a diagnosis of ADHD in adults, consult with a mental health professional.

RESOURCES FOR ADULTS

Organizations:

- CHADD (Children and Adults with ADHD): chadd.org (see also the National Resource Center on ADHD: help4adhd.org)

- Attention Deficit Disorder Association (ADDA): add.org

Books:

- Driven to Distraction: Recognizing and Coping with Attention Deficit Disorder, Edward Hallowell and John Ratey. Touchstone 2011.


THE KEY TO DIAGNOSIS
The key to diagnosis is evaluating impairment. Determine whether the child’s behavioral symptoms impair social, academic, or occupational functioning. Treatment is recommended based on this impairment and its severity.

RESOURCES FOR DIAGNOSIS
Several resources — available at intermountainphysician.org/clinicalprograms under the “Mental Health Integration (MHI)” topic — can help you evaluate and diagnose patients.

- MHI Baseline Packets:
  - Child & Adolescent Baseline Evaluation Packet includes a validated parent screening tool and home impairment scale
  - School Baseline Evaluation Packet includes a validated teacher screening tool and school impairment scale
For access to the Vanderbilt ADHD screening tool, visit nichq.org/childrens-health/adhd/resources/vanderbilt-assessment-scales

- Scoring and Evaluating MHI Forms (Adult and Child & Adolescent): Explains how to score the baseline packet and evaluate risk, illustrated with case study examples.

- Stratification and Care Plan (Adult and Child & Adolescent): Is used for initial diagnosis and treatment planning.

ALGORITHM 1: EVALUATION AND DIAGNOSIS

Routine Screening and / or Patient Family Requests Appointment

1. Can patient be seen within 1-2 weeks? (c)
   - no
   - yes

1ST OFFICE VISIT — Initial Evaluation

1. Perform medical history / physical exam (d).
2. If you suspect ADHD and / or other psych comorbidities, give the parent a Child & Adolescent Baseline Evaluation Packet to complete before next visit and a School Baseline Evaluation Packet to take to the school psychologist or teacher(s) to complete by next visit (see sidebar for tool description).
3. Explain to parent(s) that diagnosing ADHD depends on information from both parents and teachers.
4. Instruct parent(s) to make a follow-up appointment when both packets are complete, preferably within the next 3 to 4 weeks.

Patient / Parent

1. Complete the Baseline Evaluation Packet.
2. Take School Evaluation Packet to child’s school psychologist / guidance counselor, and arrange for a time to pick up forms.
3. Once both packets are complete, make a follow-up appointment with the primary care provider.

School

2. Administer any other tools the school feels would help in diagnosis or in planning interventions.
3. Give a copy of the completed intervention tools to the parent to take to the physician. Save a copy for the school records.

EVALUATION / DIAGNOSIS VISIT
(within 3 to 4 weeks of first office visit or receipt of packet)

1. Use MHI program resources to evaluate and “score” information in the packets before seeing the patient (can be done by primary care provider or office staff).
2. Perform medical history / physical exam if not already done in an initial evaluation (d).
3. Review packets, and interview patient / parent.

Meet diagnostic criteria? (e)
- no
- yes

Suspect comorbid conditions? (f, g)
- no
- yes

Discontinue ADHD algorithm; determine need for further evaluation. If appropriate, consult with school psychologist.

Based on level of risk (h), activate MHI team or consider mental health specialist referral.

Initiate ADHD Treatment Plan (see page 6)
(a) A focus on children and adolescents

This algorithm is primarily structured for diagnosis of ADHD in children and adolescents. To diagnose adults, use the ADHD Self-Report Scale Symptom Checklist (World Health Organization), provided in the MHI Adult Baseline Packet, and consult with a mental health professional. See resource information on pages 15–16.

(b) Screening and/or appointment request

Some parents will request an appointment based on a child’s ADHD symptoms, but other parents will not. Screening for ADHD during routine health appointments can help in identifying and treating this common disorder. Asking about concerns at school, work, or home can reveal problems that indicate the need for further evaluation.

(c) Timing of initial evaluation and completion of packets

This algorithm presents one common flow of events that works for many offices. Some offices may choose to send the Baseline Evaluation Packet and the Baseline School Packet to the parent (or patient) before the initial visit, especially if it will be several weeks before the initial appointment.

(d) History and physical exam

History and physical exam should include assessment of the child’s developmental history, hearing and vision, any learning difficulties or psychiatric illness, and family history of ADHD. The MHI Child & Adolescent Baseline Packet includes an Initial History and Consultation form to help with this task.

For adult patients, consider checking the DOPL database. Go to csd.utah.gov.

(e) Diagnostic criteria

Refer to the DSM-5 for details on updated diagnostic criteria for ADHD. In 2015, Intermountain-employed physicians will be able to access an online version of the DSM-5 through the eResources page on IntermountainPhysician.org.

(f) Comorbid conditions

Studies show a significant percentage of children with ADHD have one or more other associated conditions. The most common comorbid conditions being ADHD with one of the following:

- Oppositional defiant disorder (35%)
- Conduct disorder (26%)
- Anxiety disorder (26%)
- Depressive disorder (18%)

Also, a significant percentage of patients with autism spectrum disorder meet ADHD DSM-5 criteria. While bipolar disorder is often estimated to occur in fewer than 1% of children and adolescents, these prevalence rates — and the criteria used to establish bipolar disorder in children — are controversial. The research generally agrees that children who do have bipolar disorder also have high rates of ADHD.

(g) Substance use disorder (SUD)

In adolescents and adults, SUD is common, particularly for patients who also have conduct disorder. To screen for SUD, interview the patient (if an adolescent, preferably with parents not present) using:

- The CRAFFT tool for adolescents
- The Intermountain-Modified National Instituted on Drug Abuse Quick Screen™ questions below for adults

(See the Substance Use Disorder CPM for more information about using these tools and next steps if patient screens positive.)

For adult patients, also consider checking the DOPL database. Go to csd.utah.gov.

(h) Risk assessment and level of complexity (mild, moderate, or severe)

Risk assessment and level of complexity (mild, moderate, or severe) is based on evaluating coexisting conditions, family coping style, level of impairment, history of mental/behavioral disorders, and other factors. See Scoring and Evaluating Child & Adolescent MHI Forms for more information on assessing risk. For patients with a moderate risk level, consider collaborative care involving members of the MHI team. For patients with a severe risk level, consult with, or consider referral to, a Mental Health Specialist.
THE KEY TO TREATMENT

The key to treatment is communication between primary care providers, parents, and schools — including ongoing follow-up assessment and treatment adjustment. Treatment targets should not be based on symptoms, but rather on identified areas of impairment in home, school, or social functioning.

RESOURCES TO HELP

The following resources — available at intermountainphysician.org/clinicalprograms under the “Mental Health Integration (MHI)” topic — can be helpful for planning, goal setting, following-up, and communicating.

- **ADHD Management: Team Plan** can be used to communicate the treatment plan with parents and school staff, set goals for home and school, and track progress. See note (b) on the following page for more information on this tool.

- **MHI Child & Adolescent Follow-up Evaluation Packet** and **School Follow-up Evaluation Packet** include the same validated and impairment scales as the baseline packets (see sidebar on page 4).

ALGORITHM 2: TREATMENT PLAN OVERVIEW

**Patient Diagnosed with ADHD**

**INITIAL TREATMENT PLAN**

1. Begin medication and consider other treatments as indicated (a).
2. Work with patient/parents to develop a management plan, including medical plan, follow-up plan, and suggestions for home and school plans (b).
3. Educate parents/patient about ADHD; encourage parents to contact CHADD of Utah and enroll in ADHD parent education classes (see page 15).
4. Give **Child & Adolescent Follow-up Evaluation Packet** to complete before next visit and **School Follow-up Evaluation Packet** to take to school psychologist/guidance counselor (see left sidebar).
5. Instruct parent to make follow-up visit within 3 to 4 weeks, and to bring follow-up packets.

**Patient / Parent**

1. Contact CHADD of Utah and enroll in ADHD parent education classes.
2. Initiate home interventions and target behaviors based on the patient’s management plan (b).
3. Take **School Follow-up Evaluation Packet** and a copy of the **ADHD Management: Team Plan** to the school psychologist/guidance counselor, establish school goals and interventions, and request completion of follow-up forms within 3 to 4 weeks.
4. Complete all forms in the **Child & Adolescent Follow-up Evaluation Packet**.
5. Make a follow-up appointment within 3 to 4 weeks and bring completed follow-up forms.

**School**

1. Review the **ADHD Management: Team Plan** with the parent and child, and help determine school goals and interventions for behavior management.
2. Make special arrangements as appropriate (Section 504 accommodations, IDEA, etc) (c).
3. As requested by parent and within 3 to 4 weeks of initial diagnosis, complete **School Follow-up Evaluation Packet** and give a copy to the parent(s) to take to primary care provider.

**FOLLOW-UP EVERY 3–4 WEEKS until symptoms controlled and progress toward goals**

- Review follow-up MHI packets from home and school (if available).
- Monitor height, weight, blood pressure, heart rate, side effects, comorbidities, and progress toward goals.
- Activate Mental Health Integration team as appropriate.

**Symptoms controlled? Progress toward goals?**

- **no**
  - Reassess diagnosis.
  - Assess adherence to treatment plan or need to modify treatment.
  - Reconsider comorbidities (a).
  - Consider referral to mental health specialist.

- **yes**
  - Continue treatment plan.
  - Follow up every 3 to 6 months; have PATIENT/PARENT and SCHOOL complete follow-up packets before next appointment.

**ONGOING FOLLOW-UP (every 3–6 months)**

Indicates an Intermountain measure
# TREATMENT PLAN ALGORITHM NOTES

## (a) Treatment options

Ongoing research continues to show that medication and behavioral coaching by the primary care provider are effective in treating uncomplicated ADHD. Adding behavioral therapy is most appropriate for patients with ADHD and comorbid mental health conditions.

## (b) A helpful shared decision-making tool to plan treatment

The **ADHD Management: Team Plan** is helpful in planning treatment, communicating with parents and teachers, setting goals, and tracking progress.

A **Medical Plan** section includes medication instructions, follow-up specialist and care management appointments, and a checklist for monitoring medication side effects.

A **Home Plan** section includes a to-do list for parents/families, information on resources, and an area to record at-home goals for behavior, relationships, emotions, and responsibilities.

A **School Plan** section includes a to-do list for the school psychologist/guidance counselor, information on resources, and an area to record school goals for behavior, relationships, emotions, and responsibilities.

## (c) Education accommodations

Educational accommodations for ADHD are shaped by two laws:

- **Section 504 (Rehabilitation Act of 1973).** This law covers "disability that substantially limits one or more life activities" (and includes learning disabilities). If eligible, the student receives an **Accommodation Plan.** For students who can benefit from simple accommodations, qualifying under Section 504 can be easier than IDEA. For example, simple accommodations provided under Section 504 for a child with ADHD might include reducing the number of homework problems (without reducing the level or content of what is taught), providing the student with a quiet place to work without distractions, providing extra time for tests, creating a notebook so teachers and parents can keep each other informed about the child’s progress, or having a school nurse oversee a student’s medication.

- **IDEA (Individuals with Disabilities Education Act).** This act covers "disability that adversely affects educational performance." The act lists 14 disability categories for eligibility; ADHD is included under "Other Health Impairment." If eligible, a student receives an **Individual Education Plan (IEP)** that may include specially designed instruction and related services. Students who have an IEP are also entitled to alternate procedures that must be followed if they are suspended or expelled. Qualifying under the IDEA may be a better choice for students who need more extensive services or accommodations.

See page 16 for more information as well as tips for working with schools and teachers.
KEYS TO EFFECTIVE MEDICATION MANAGEMENT

The key to medication management is frequent, effective communication between primary care providers and parents during medication trials. To determine the best medication and dosage for the patient, carefully monitor side effects and progress based on goals. Parents may not always take the initiative to contact the primary care provider during a medication trial, so consider contacting the parent regularly.

ALGORITHM 3: MEDICATION MANAGEMENT

Decision to Treat with Medications

- Cardiac disease? (a)
  - yes, or in family history → CONSULT with pediatric cardiologist
  - no → USE trial of long-acting STIMULANT (b)

- Side effects? (c)
  - Serious side effects → Manageable or no side effects
  - Effective? (b)
    - yes → USE trial of 2nd long-acting STIMULANT (b)
    - no → Make child psychiatric referral OR a 4- to 6-week trial of NON-STIMULANT (d)

- Manageable or no side effects
  - Effective? (b)
    - yes → CONTINUE, and FOLLOW UP in 3 to 6 months
    - no → CONSIDER child psychiatric referral OR a 4- to 6-week trial of NON-STIMULANT (d)

- Effective?
  - yes → CONTINUE, and FOLLOW UP in 3 to 6 months
  - no → MAKE child psychiatric referral
### MEDICATION MANAGEMENT ALGORITHM NOTES

#### (a) Screening for cardiac disease
Stimulant medication is the first-line treatment for ADHD, and there is no evidence of increased sudden cardiac death (SCD) in otherwise healthy pediatric patients taking stimulants. However, before prescribing a stimulant, patients should be screened for pre-existing heart disease.

**Cardiac screening should include:**
- Patient history of previously detected cardiac disease, severe palpitations, arrhythmias, syncope, chest pain, hypertension, or exercise intolerance not accounted for by obesity (specific signs of hypertrophic cardiomyopathy, associated with sudden unexpected deaths in children and adolescents, include chest pain, arrhythmias, hypertension, and syncope)
- Family history focused on sudden death in children or young adults, hypertrophic cardiomyopathy, or long QT syndrome

If screening reveals pre-existing heart disease or symptoms that suggest significant cardiovascular disease: Refer the patient for consultation with a cardiologist before a stimulant trial.

#### (b) STIMULANT trial (s)
- Stimulant medication is the first-line treatment for ADHD. Long-acting stimulants are preferred.
- A legitimate trial of a stimulant is 3 to 4 weeks, titrating the dose if needed over that period. (See table 1 on pages 10-11 for more information on the starting dose and maximum level of recommended medications.) During the medication trial, increase the dose to optimal level without side effects—see note (c) below. Also, use each trial to assess the accuracy of ADHD and/or comorbidity diagnosis.
- Careful, frequent monitoring of the patient during each medication trial is important. Encourage patients/parents to inform you about medication side effects, and see table 3 on page 12 for a summary of suggested monitoring steps for each medication. The ADHD Management: Team Plan contains a checklist to help patients monitor side effects; if the Team Plan is not used, consider giving parents a copy of the medication follow-up page from the MHI Child & Adolescent Follow-up Evaluation Packet. Parents may not always take the initiative to contact the primary care provider, so consider contacting the parent regularly.
- Use stimulants with caution in patients with a history of drug or alcohol dependence or with possibilities of misuse, including distribution to others.
- For patients with comorbidities, consider consulting a mental health specialist before choosing medication. Specific medication choices can be more effective for specific comorbidities. See note (d).

#### (c) STIMULANT side effects
- Possible side effects of stimulants are listed in table 3 on page 13. Many side effects of stimulants are mild, of short duration, and reversible with adjustments to dose or dosing interval.
- For mild side effects, use your judgment about continuing with dosage adjustments to the current stimulant, switching to another stimulant, or switching to a non-stimulant.
- If any of the following serious side effects occur, switch to a trial of a NON-STIMULANT, AND/OR consider a psychiatric consult/referral.
  - Hallucinations or other psychotic symptoms
  - Depression or extreme mood swings
  - Significant anxiety

#### (d) NON-STIMULANT trial
- After two or more failed stimulant trials or based on unpleasant or serious side effects from stimulants, consider switching to a non-stimulant medication or, if appropriate, adding a non-stimulant medication. (Consider a psychiatric consult before initiating combination therapy.)
- Three of the non-stimulant drugs listed in table 2 on page 12 are approved by the FDA for treatment of ADHD: atomoxetine/Strattera, guanfacine ER/Intuniv, and clonidine ER/Kapvay. The other non-stimulant medications are off-label; consider the off-label medications with caution.
- Within the non-FDA approved options in table 2, consider an antidepressant if mood lability or depression is prominent or an alpha-adrenergic agonist if hyperactive/impulsive symptoms or aggression are most prominent.
<table>
<thead>
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<th>Drug (Brand Name)</th>
<th>Duration</th>
<th>Forms and administration</th>
<th>Pediatric dose</th>
<th>Adult dose</th>
<th>Tier, cost&lt;sup&gt;2&lt;/sup&gt;</th>
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<td></td>
<td></td>
<td>Initial</td>
<td>Daily Max</td>
<td>Brand (generic)</td>
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<td>amphetamine</td>
<td>13 hours</td>
<td>2.5 mg/mL extended-release oral suspension</td>
<td>Age ≥ 6: 2.5–5 mg / day</td>
<td>20 mg</td>
<td>20 mg Not covered, $$$ (No generic)</td>
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<td>(Dyanavel XR)</td>
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<td></td>
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<td>20 mg</td>
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<td>amphetamine</td>
<td>10 to 12 hours</td>
<td>5, 10, 15, 20, 25, 30 mg extended-release capsules</td>
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<td>20 mg / day</td>
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<tr>
<td>mixed salts</td>
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<td>Swallow whole, sprinkle on applesauce</td>
<td>Ages 13–17: 10 mg / day</td>
<td>8 hours</td>
<td>10 mg / day</td>
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<td>20 mg</td>
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<td>lisdexamfetamine</td>
<td>10 to 12 hours</td>
<td>10, 20, 30, 40, 50, 60, 70 mg extended-release capsules</td>
<td>Age ≥ 6: 30 mg / day</td>
<td>70 mg</td>
<td>30 mg / day</td>
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<td>(Vyvanse)</td>
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<td>Swallow whole, or mix in water, yogurt, or orange juice</td>
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<td>20 mg</td>
<td>20 mg</td>
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<tr>
<td>dextromethadrine</td>
<td>10 to 12 hours</td>
<td>5, 10, 15, 20, 25, 30, 35, 40 mg extended-release capsules</td>
<td>Age ≥ 6: 5 mg / day</td>
<td>30 mg</td>
<td>10 mg / day</td>
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<td>(Focalin XR)</td>
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<td>Swallow whole, sprinkle on applesauce</td>
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<td>methylphenidate</td>
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<td>18, 27, 36, 54 mg extended-release tablets</td>
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<td>54 mg</td>
<td>10 mg / day</td>
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<td>Ages 6–12 ONLY: 18–36 mg / day</td>
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<td>20, 30, 40 mg extended-release, chewable tablets</td>
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<td>5, 10, 15 mg timed-release capsules</td>
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<td>40 mg</td>
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<td>sulfate&lt;sup&gt;TM&lt;/sup&gt;</td>
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<td>Swallow whole, sprinkle on applesauce</td>
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<td>10 mg</td>
<td>20 mg</td>
</tr>
<tr>
<td>(Dexedrine, Spansule)</td>
<td></td>
<td></td>
<td></td>
<td>20 mg</td>
<td>20 mg</td>
</tr>
<tr>
<td>methylphenidate</td>
<td>6 to 8 hours</td>
<td>20 mg extended-release tablets</td>
<td>Age ≥ 6: 20 mg / day</td>
<td>20 mg</td>
<td>20 mg / day</td>
</tr>
<tr>
<td>ER (Metadate ER)</td>
<td></td>
<td>Swallow whole</td>
<td></td>
<td>20 mg</td>
<td>20 mg</td>
</tr>
<tr>
<td>(Aptensio XR)</td>
<td></td>
<td></td>
<td></td>
<td>20 mg</td>
<td>20 mg</td>
</tr>
<tr>
<td>methylphenidate</td>
<td>6 to 8 hours</td>
<td>20 mg extended-release tablets</td>
<td>Age ≥ 6: 5 mg twice daily</td>
<td>60 mg</td>
<td>20 mg / day</td>
</tr>
<tr>
<td>SR (Ritalin SR)</td>
<td></td>
<td>Swallow whole</td>
<td>(Generic ONLY: Tier 1, $$)</td>
<td>6 hours</td>
<td>20 mg / day</td>
</tr>
<tr>
<td>methylphenidate</td>
<td>8 hours</td>
<td>10, 20, 30, 40, 60 mg extended-release capsules</td>
<td>Age ≥ 6: 20 mg / day</td>
<td>60 mg</td>
<td>20 mg / day</td>
</tr>
<tr>
<td>ER, CD (Metadate CD)</td>
<td></td>
<td>Swallow whole or sprinkle on applesauce</td>
<td>(Generic: Tier 1, $$$-$$$$; available in 5, 10, 15, 20, 30, and 40 mg)</td>
<td>8 hours</td>
<td>20 mg / day</td>
</tr>
<tr>
<td>methylphenidate</td>
<td>6 to 8 hours</td>
<td>10, 20, 30, 40, 60 mg extended-release capsules</td>
<td>Age ≥ 6: 20 mg / day</td>
<td>60 mg</td>
<td>20 mg / day</td>
</tr>
<tr>
<td>ER, LA (Ritalin LA)</td>
<td></td>
<td>Swallow whole or sprinkle on applesauce</td>
<td>(Generic: Tier 1, $$$, 10 mg not available)</td>
<td>6 hours</td>
<td>20 mg / day</td>
</tr>
</tbody>
</table>

**NOTE:** Table continues on page 11 with footnotes from above at end of table.
### TABLE 1. STIMULANTS, CONTINUED

<table>
<thead>
<tr>
<th>Drug (Brand Name)</th>
<th>Duration</th>
<th>Forms and administration</th>
<th>Pediatric dose</th>
<th>Adult dose*</th>
<th>Tier, cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Initial</td>
<td>Daily Max</td>
<td>Initial</td>
</tr>
<tr>
<td><strong>SHORT ACTING (SECONDARY)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>amphetamine mixed salts (Adderal)</td>
<td>4 to 6 hours</td>
<td>• 5, 7.5, 10, 12.5, 15, 20, 30mg tablets • Swallow whole</td>
<td>Age ≥ 6: 5mg, once or twice daily</td>
<td>40mg</td>
<td>10mg/day</td>
</tr>
<tr>
<td>amphetamine sulfate (Evekeo)</td>
<td>4 hours</td>
<td>• 5, 10mg tablets • Swallow whole</td>
<td>Age ≥ 6: 5mg, once or twice daily</td>
<td>40mg</td>
<td>5 – 10mg/day</td>
</tr>
<tr>
<td>dexamphetamine (Focalin)</td>
<td>3 to 5 hours</td>
<td>• 2.5, 5, 10mg tablets • Swallow whole</td>
<td>Age ≥ 6: 2.5mg twice daily</td>
<td>20mg</td>
<td>2.5mg twice daily</td>
</tr>
<tr>
<td>dextroamphetamine sulfate IR (Zenzedi)</td>
<td>4 to 6 hours</td>
<td>• 2.5, 5, 7.5, 10, 15, 20mg tablets • Swallow whole</td>
<td>Age ≥ 6: 5mg, once or twice daily</td>
<td>40mg</td>
<td>5mg once or twice daily</td>
</tr>
<tr>
<td>(Dexedrine) (Procentra)</td>
<td>4 to 6 hours</td>
<td>• 5, 10mg tablets • Swallow whole</td>
<td>Age 3 – 5: 2.5mg/day</td>
<td>40mg</td>
<td>Not FDA approved</td>
</tr>
<tr>
<td>(Dexedrine) (Procentra)</td>
<td>3 hours</td>
<td>• 5mg/5mL oral solution</td>
<td>Age 3 – 5: 2.5mg/day</td>
<td>Not FDA approved</td>
<td></td>
</tr>
<tr>
<td>methamphetamine (Desoxyn)</td>
<td>3 to 5 hours</td>
<td>• 5mg tablets • Swallow whole</td>
<td>Age ≥ 6: 5mg, once or twice daily</td>
<td>25mg</td>
<td>5mg once or twice daily</td>
</tr>
<tr>
<td>methamphetamine (Desoxyn)</td>
<td>3 to 5 hours</td>
<td>• 5mg tablets • Swallow whole</td>
<td>Age ≥ 6: 5mg, once or twice daily</td>
<td>60mg</td>
<td>5mg/day twice daily</td>
</tr>
</tbody>
</table>

---

31. Some doses shown are not FDA approved for treatment of adults with ADHD (as indicated in the note within each medication’s dosage column).

32. **Tier and cost:** Tier 1 = $10 copay; Tier 2 = $30 copay; Tier 3 = $70 copay for 30-day prescription (based on RxSelect 2015 benefit design; benefit designs may differ). Cost is based on 30-day actual cost (not copay) and generic unless otherwise noted: $ = $1 to $25; $$ = $26 to $75; $$$ = $76 to $150; $$$$ = over $150. For the most recent SelectHealth formulary information, visit [http://www.selecthealth.org](http://www.selecthealth.org) or call 801-442-4912 (option 1) or 800-442-3129 (option 1).

33. Actavis is currently the only methylphenidate ER generic that carries an A-B equivalence rating to brand Concerta from the FDA. All other manufacturers’ methylphenidate ER generics are not considered bioequivalent but are still FDA approved to be manufactured and dispensed; however, these other generics cannot be interchanged for Concerta brand at point of sale.
### TABLE 2. NON-STIMULANTS USED IN ADHD TREATMENT

(See page 13 for side effect profiles and monitoring recommendations.)

<table>
<thead>
<tr>
<th>Drug (Brand)</th>
<th>Duration</th>
<th>Forms and administration</th>
<th>Pediatric dose</th>
<th>Adult dose</th>
<th>Tier, cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Initial</td>
<td>Daily Max</td>
<td>Initial</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>FDA-APPROVED</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>atomoxetine (Strattera)</td>
<td>10 to 12 hours</td>
<td>10, 18, 25, 40, 60, 80, 100 mg capsules; Swallow whole</td>
<td>Ages ≥ 6, &lt; 70 kg: 0.5 mg/kg/day; ≥ 70 kg: 40 mg/day</td>
<td>1.4 mg/kg or 100 mg, whichever is less</td>
<td>40 mg/day; once daily or 2, evenly divided doses</td>
</tr>
<tr>
<td>guanfacine ER (Intuniv)</td>
<td>12 hours</td>
<td>1, 2, 3, 4 mg extended-release tablets; Swallow whole</td>
<td>Ages 6 – 17: 1 mg once daily</td>
<td>Ages 6 – 12: 4 mg once daily</td>
<td>1 mg/day</td>
</tr>
<tr>
<td>clonidine ER (Kapvay)</td>
<td>12 hours</td>
<td>0.1 mg extended-release tablets; Swallow whole</td>
<td>Age ≥ 6: 0.1 mg/day</td>
<td>0.2 mg twice daily (0.4 mg/day)</td>
<td>0.1 mg/day</td>
</tr>
<tr>
<td><strong>Not FDA approved for treatment of ADHD (off label)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>clonidine (Catapres)</td>
<td>6 to 10 hours (tablets)</td>
<td>0.1, 0.2, 0.3 mg tablets or transdermal system; Swallow tablets whole; when titrated to optimal, stable oral dose, may switch to equivalent transdermal dose</td>
<td>≤ 45 kg: 0.05 mg/day at bedtime</td>
<td>≤ 45 kg: 0.2 mg/day, in divided doses</td>
<td>0.1 mg/day</td>
</tr>
<tr>
<td>guanfacine (Tenex)</td>
<td>17 hours</td>
<td>1, 2 mg tablets; Swallow whole; if switching from immediate release (IR), discontinue IR and titrate dose of extended release (ER) starting with 1 mg daily</td>
<td>≤ 45 kg: 0.5 mg/day at bedtime</td>
<td>≤ 45 kg: 1 mg/day at bedtime</td>
<td>27 – 40.4 kg: 2 mg/day in divided doses</td>
</tr>
<tr>
<td><strong>Not FDA approved for treatment of ADHD (off label)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>bupropion (Wellbutrin)</td>
<td>14 to 30 hours</td>
<td>75, 100 mg film-coated tablets; Swallow whole</td>
<td>3 mg/kg/day or 150 mg/day, whichever is least</td>
<td>300 mg/day (in 2 or 3 divided doses)</td>
<td>100 mg twice daily</td>
</tr>
<tr>
<td>(Wellbutrin SR)</td>
<td></td>
<td>100, 150, 200 mg extended-release tablets; Swallow whole</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Wellbutrin XL)</td>
<td></td>
<td>150, 300 mg extended-release tablets; Swallow whole</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 Some doses shown are not FDA approved for treatment of adults with ADHD (as indicated in the note within each medication’s dosage column).

2 Tier and cost: Tier 1 = $10 copay; Tier 2 = $30 copay; Tier 3 = $70 copay for 30-day prescription (based on RxSelect 2015 benefit design; benefit designs may differ). Cost is based on 30-day actual cost (not copay) and generic unless otherwise noted: $ = $1 to $25; $$ = $26 to $75; $$$ = $76 to $150; $$$$ = over $150. For the most recent SelectHealth formulary information, visit [http://www.selecthealth.org](http://www.selecthealth.org) or call 801-442-4912 (option 1) or 800-442-3129 (option 1).

3 Half life of medication; duration has not been established.
<table>
<thead>
<tr>
<th>Medication</th>
<th>Side effects</th>
<th>Monitoring</th>
<th>Other comments</th>
</tr>
</thead>
</table>
| **stimulants**      | • Appetite disturbance or anorexia, sleep disturbance, weight loss, transient headache, stomachache  
                      • Less commonly include increased heart rate and blood pressure, social withdrawal, headache, irritability, nervousness, abdominal pain, motor tics (usually transient) | • If history and physical exam reveals heart disease (see page 9) consult with cardiologist for initial evaluation and monitoring  
                      • Routinely monitor blood pressure, heart rate, and growth  
                      • Monitor for mania, hallucinations, emergent psychotic or manic symptoms, obsessive-compulsive symptoms, significant anxiety (consider non-stimulant or a psychiatric consult for these symptoms) | • Many side effects of stimulants are mild, of short duration, and reversible with adjustments to dose or dosing interval  
                      • Use caution with patients who have a history of drug or alcohol dependence or with possibilities of misuse, including distribution to others  
                      • Consult with cardiology before use in patients with structural cardiac abnormalities  
                      • In patients with comorbid tic disorders, methylphenidate is preferred as it does not appear to worsen tic symptoms\(^{10}\) |
| atomoxetine (Strattera) | Weight loss, abdominal pain, appetite disturbance, vomiting, nausea, dyspepsia, sleep disturbance, motor tics | • Monitor for liver injury, suicidal thinking and behavior, unusual behavior, worsening symptoms, psychotic or manic symptoms, hallucinations or delusions  
                      • Routinely monitor BP and heart rate | • Advise families and caregivers of need for close monitoring  
                      • Consult with cardiology before use in patients with structural cardiac abnormalities  
                      • May be beneficial for ADHD patients with comorbid tic disorders\(^{10}\) |
| guanfacine/ clonidine | Headache, fatigue, abdominal pain, sedation, syncope, depression, bradycardia, hypotension, xerostomia | • If history and physical exam reveals heart disease (see page 9) consult with cardiologist for initial evaluation and monitoring  
                      • Routinely monitor BP and heart rate | • Taper to avoid rebound hypertension  
                      • If switching from immediate release (IR), discontinue IR and titrate dose of extended release (ER); start with 1 tablet/day  
                      • May be beneficial for ADHD patients with comorbid tic disorders\(^{10}\)  
                      • May be used alone or adjuvant to another medication for ADHD |
| bupropion           | Dizziness, nausea, agitation, xerostomia, constipation, motor tics, lower seizure threshold, cardiac dysrhythmia | Monitor for suicidal thinking or behavior (particularly in first few months of therapy or following changes of dosage) | Contraindicated in patients with a current seizure disorder, as it lowers seizure threshold |
RESOURCES FOCUSED ON PATIENTS AND FAMILIES

To help you coach parents on these topics, Intermountain Healthcare offers several education handouts for patients and families. Classes, support groups, and websites are also available through CHADD and other organizations.

- **Education materials.** These materials are available on intermountain.net and can be ordered at minimal cost (see page 16).
  - **Attention Deficit Hyperactivity Disorder:** An 8-page handout that describes ADHD, diagnosis, treatment options, tips for management at home and school, and resources.
  - **ADHD: Talking with Your Child:** A 4-page fact sheet that explains a recommended approach (with an example conversation) and covers how to help a child adjust to medication, how a child can explain ADHD to friends and classmates, and how to help the family adjust.
  - **ADHD in Adults:** A 4-page fact sheet that explains the symptoms of ADHD in adults, the diagnosis process, treatments, and effective ways to manage the condition.

- **Classes:** CHADD of Utah offers **Parent to Parent: Family Training on ADHD**, a program endorsed by the American Academy of Pediatrics. Find the schedule and registration information at CHADDofUtah.com. (Classes and printed materials from CHADD are also available in Spanish.)

- **Other organizations and websites** that provide education about ADHD are listed on page 16.

### PATIENT AND FAMILY EDUCATION

The keys to effective patient and family education are:

- Helping parents understand ADHD and common comorbidities
- Connecting patients and parents to resources
- Helping parents set goals with their child and understand their child’s ADHD management plan
- Helping parents understand medication options, risks, and benefits
- Helping parents work with their child’s teachers

### Why education is important

Patients and their families need education about ADHD and how to deal with the impairments it may cause. Parents may experience stress, self-blame, social isolation, and depression while trying to raise a child with ADHD. They may feel completely overwhelmed. If left untreated, ADHD can have devastating effects that can escalate as a child grows older, as shown below.

#### Possible effects of untreated ADHD as a child ages:

<table>
<thead>
<tr>
<th>Age 6</th>
<th>Age 10</th>
<th>Age 14 to 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low self-esteem</td>
<td>Disruptive behavior</td>
<td>Criminal behavior</td>
</tr>
<tr>
<td>Poor social skills</td>
<td>Learning delay</td>
<td>School exclusion</td>
</tr>
<tr>
<td>Challenging behavior</td>
<td>Oppositional defiant disorder</td>
<td>Substance abuse</td>
</tr>
<tr>
<td>Conduct disorder</td>
<td>Lack of motivation</td>
<td>Teenage pregnancy</td>
</tr>
</tbody>
</table>

| Conduct disorder | Complex learning difficulties |

### What parents need to know

To care for their child with ADHD, parents need to learn:

- What ADHD is, other conditions that are likely to exist with it, and what types of behavior problems they can expect
- What treatment options are available, and when or if behavioral therapy is appropriate
- The medication options that are available, the risks and benefits of medication, and the long-term benefits of staying on medication long-term
- What behavior modification plans are age-appropriate for their child
- What educational laws are in place to service children with ADHD and which educational strategies will help their child best
- How to advocate for a child with ADHD in various settings — with extended family, in the neighborhood, with medical professionals, at school, and in sports programs
For providers:
To find all the ADHD tools described in this CPM, clinicians can go to intermountainphysician.org/clinicalprograms, choose “Clinical Topics A–Z,” and then choose “Attention Deficit Hyperactivity Disorder” from the A to Z menu. A Clinical Topic Page (see the example at right) provides access to CPMs and supporting tools. Resources include:

For patients and teachers:
• Clinicians can access Intermountain ADHD patient education materials using the clinical topic pages described above, and order copies via iprintstore.org. Call 801-442-3186 for more information.
• Appropriate materials will also appear in iCetra based on diagnosis code, or they can be found through the Education Module.
• Patients and teachers can be referred to Intermountain’s public website at intermountainhealthcare.org for information, tools, and links to other web resources.

At school, a child with ADHD may have trouble paying attention, sitting still, or regulating patterns of behavior:

ADHD is a biological disorder caused by underactivity in certain portions of the brain. This often emerge at school. It’s important to take appropriate action when they do:

The classroom requires self-control and attention, so symptoms that might indicate ADHD doesn’t follow through.

If a student is diagnosed with ADHD, work with parents school-based evaluation.

What if I notice a student has ADHD-like behaviors?
• I appreciate your collaboration in providing the best care for this student. Thank you.

The family is the textbook role. Elliot’s a great kid — can do for him within my role. Elliot’s a great kid — can do for him within my role. Elliot’s a great kid — can do for him within my role. Elliot’s a great kid — can do for him within my role.

There are two options for psychiatric evaluation. Follow that up with a school-based evaluation.

With the parent’s permission complete these forms through the parent. Management of ADHD requires ongoing communication between the primary care pediatrician, nurses, nurse practitioners, mental health care providers, specialists, and others.

Addressing Children’s Mental Health: A Process for Parent-Clinic-School Collaboration

Care Process Model References
For a full list of references used in this CPM, see: Attention Deficit Hyperactivity Disorder CPM Reference List.

For patients:
• Children and Adults with Attention Deficit/Hyperactivity Disorder:
  • chadd.org
  • Utah Children and Adults with Attention Deficit/Hyperactivity Disorder:
    • chaddofutah.com
  • National Resource Center on ADHD (for adults and children):
    • help4adhd.org, which includes helpful “What We Know” sheets on over 20 topics, available in English and Spanish:
      • help4adhd.org/en/about/wwk
  • ADHD Medication Guide produced by the American Academy of Child and Adolescent Psychiatry and the American Psychiatric Association:
    • parentsmedguide.org

OTHER WEB RESOURCES
For providers:
• ADHD topic sponsored by the American Academy of Pediatrics, National Initiative for Children’s Healthcare Quality (NICHQ): nichq.org/areas_of_focus/adhd_topic.html
• American Academy of Pediatrics: aap.org (Search for ADHD)
• National Institute of Mental Health ADHD portal: nimh.nih.gov/topics/topic-page-adhd.shtml

For providers:

• ADHD Medication Guide
  • Help4Adhd.org: help4adhd.org
  • MedGuide: medguide.org
  • PatientsMedGuide.org: patientsmedguide.org
  • CareProcessModel.org: careprocessmodel.org
  • intermountainphysician.org/clinicalprograms
  • ADHD Patient Management Plan

Fact sheets:
• ADHD: Talking with Your Child or Teen
• ADHD: Tips for Teachers
• ADHD: Talking to Your Child or Teen’s Teachers
• ADHD in Adults

SUMMARY OF INTERMOUNTAIN RESOURCES

For providers:

For patients and teachers:

Intermountain Patient Handouts Search Results

Attention Deficit Hyperactivity Disorder
  • (4-page handout)

ADHD: Tips for Teachers
  • ADHD Care Process Model
  • ADHD Patient Management Plan
  • Scoring instructions and tools

Addressing Children’s Mental Health: A Process for Parent-Clinic-School Collaboration

Care Process Model References
For a full list of references used in this CPM, see: Attention Deficit Hyperactivity Disorder CPM Reference List.
RESOURCES FOCUSED ON SCHOOLS
The following resources are available for parents and teachers to access and print from the public website at intermountainhealthcare.org/adhd.

• ADHD: Tips for Teachers: A 4-page handout available for teachers that covers talking with parents about symptoms while remaining in compliance with Utah legislation; it also includes suggestions for ADHD management.

• ADHD: Talking to Your Child’s or Teen’s Teachers: A 4-page fact sheet for parents that includes suggestions for working with a child’s teachers on ADHD interventions.

• Addressing Children’s Mental Health: A Process for Parent-Clinic-School Collaboration: This flow chart provides further detail on how the schools implement their part of this CPM, along with three tiers of school interventions/support.

For more information on laws governing teacher involvement and/or education accommodations, see:


• Explanation of the differences between Section 504 and IDEA, focused on accommodations for students with ADHD: chadd.org/Understanding-ADHD/For-Parents-Caregivers/Education/Section-504.aspx

Other Internet resources include:

• The Utah Quest for What’s Best website provides information for schools, clinicians, and parents, including communication tools, Utah resources, and a care process flow chart: questforwhatsbest.info

• Teaching Children with Attention Deficit Hyperactivity Disorder, a free handbook provided by the U.S. Department of Education, includes effective instructional strategies for students with ADHD: https://www2.ed.gov/rschstat/research/pubs/adhd/addh-teaching-2008.pdf

Access all ADHD resources on the Behavioral Health Clinical Program page of intermountainhealthcare.net.

WORKING WITH SCHOOLS
Teachers play a vital role in the diagnosis and treatment of a child’s ADHD, including:

• Providing key information used in accurately diagnosing ADHD
• Helping implement the child’s management plan, which may include education accommodations
• Providing ongoing feedback about symptoms and behavior

It’s important that physicians and parents understand the challenges teachers face in playing these roles, including applicable state laws and guidelines.

Utah guidelines for teacher involvement
Recent (2007) Utah legislation on medical recommendations for children limits how school staff can participate in behavioral health evaluation and/or treatment. If parents or teachers receive inaccurate or incomplete information about this legislation, they may think they are prohibited from providing information about symptoms. Knowing the facts can help you assist parents as they communicate with school staff. Key highlights pertaining to ADHD evaluation and communication include:

• Teachers MAY:
  – Provide information and observations to parents about a student’s progress, behavior, and interactions.
  – Refer a student to a school counselor or other mental health professional within the school system.
  – If requested by a student’s parent, complete a behavioral health evaluation form.

• Mental health professionals working in the school system ALSO MAY: 
  – Recommend (but not require) psychiatric/behavioral evaluation or treatment for a child.
  – With parental written consent, conduct a psychiatric/behavioral health evaluation or screening of a child.
  – On request, provide parents with a list of three or more healthcare providers.

• Teachers MAY NOT recommend that a parent seek or use psychiatric or psychological treatment.

• School system staff (both teachers and health professionals) MAY NOT require that a student take psychotropic medication. For more information, see the ADHD: Talking to Your Child’s or Teen’s Teachers fact sheet, described at left.

Laws governing education accommodations for ADHD
Educational accommodations are shaped by two laws (see page 7 for details):

• Section 504 (Rehabilitation Act of 1973). Covers “disability that substantially limits one or more life activities” (including learning disabilities). If eligible, the student receives an Accommodation Plan. For students who can benefit from simple accommodations, qualifying under Section 504 can be easier than IDEA.

• IDEA (Individuals with Disabilities Education Act). Covers “disability that adversely affects educational performance.” Lists 14 categories for eligibility; ADHD is included under “Other Health Impairment.” If eligible, a student receives an Individual Education Plan (IEP) that may include specially designed instruction and related services. IDEA may be a better choice for students who need more extensive services or accommodations.