



Goals of Toolkit:

- Assist primary care physicians in identifying and treating ADHD and co-morbidities in pediatrics
- Encourage use of evidence-based tools throughout healthcare and school systems
- Empower patients and families in the most effective strategies to deal with challenges associated with ADHD

ADHD Overview

ADHD is one of the most common neurodevelopmental disorders of childhood. It is usually first diagnosed in childhood and may last into adulthood.¹ However, with identification, proper treatment and management, individuals with ADHD can lead successful lives and thrive. Professionals who work with people affected by ADHD include physicians (especially psychiatrists, pediatricians, neurologists); psychologists; social workers; nurse practitioners; therapists; teachers; coaches; and other individuals with specialized training to help individuals with ADHD. Each can play a vital role in the comprehensive assessment; treatment and management of ADHD.²

This toolkit is a practical approach to a complex problem. It is based on several key 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 most recent recommendations of the American Academy of Pediatrics (AAP) for the diagnosis and treatment of school-aged children and the practice parameters established by the American Academy of Child and Adolescent Psychiatry (AACAP) for assessing and treating children and adolescents.

Facts About ADHD

- Attention-deficit/hyperactivity disorder (ADHD) occurs in roughly 3–5% of all children and adolescents.
- Children with ADHD often show comorbid psychiatric disorders such as anxiety disorders (~30%), oppositional defiant disorder (~50%), conduct disorders (~30%), and learning disabilities (~50%). Each of these can strongly influence the clinical outcome of the disorder.
- There is evidence that the cause of ADHD can be genetic or environmental. Non-genetic causes of ADHD are neurobiological in nature and consist of factors such as perinatal stress and low birth weight, traumatic brain injury, maternal smoking during pregnancy, and severe early deprivation and maltreatment.³

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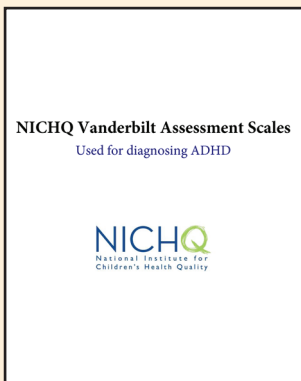
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Evaluation and Diagnosis

Vanderbilt Assessments⁶

The NICHQ Vanderbilt Assessment Scales were developed through the ADHD Learning Collaborative project. This resource is used by healthcare professionals to help diagnose ADHD in children between the ages of 6 and 12. The 1st edition (2002) is available to download for no cost and is only available in English. The 2nd edition (2011) is available only by purchasing the entire 2nd Edition toolkit from the American Academy of Pediatrics (AAP) Bookstore.



Deciding if a patient has ADHD is a several step process. There is no single test to diagnose ADHD, and many other problems, like anxiety, depression, and certain types of learning disabilities, can have similar symptoms.

Diagnosis in children

- The primary care physician should screen for ADHD in any child with symptoms of academic underachievement, difficulty focusing, behavioral issues, hyperactivity, or impulsivity, as well as during any type of mental health assessment. The functional impairment should be present in two or more settings, as outlined in the criteria for ADHD diagnosis in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).
- An ADHD assessment requires evidence directly obtained from parents or caregivers and from the classroom teacher (or other school professional, coach, extracurricular teacher) regarding core symptoms of ADHD in various settings, the age of onset, duration of symptoms, and degree of functional impairment.
- Evaluation should include an assessment for comorbid medical diagnoses and an assessment for psychiatric co-morbidities.
- Before diagnosing ADHD, disorders that can mimic ADHD should be ruled out.⁴
- Girls are often underdiagnosed with ADHD because females often present with the inattentive subtype (rather than hyperactive subtype) of ADHD. It is important for clinicians to recognize this in young female patients because while hyperactivity may improve with age, inattentiveness and impulsivity can often persist into adolescence and adulthood.

Diagnosis in adolescents

Adolescents: Impairment in middle school and high school can have significant consequences and presents additional risks for teenage drivers. 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 UPA and also persists into adulthood in as many as 60% of patients.

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.

In adolescents, symptoms of inattention such as: inability to focus, easy distractibility, and academic decline can be part of depression. Establish a timeline for symptoms of inattention in each patient. If inattention symptoms are present before depression, the symptoms are associated with ADHD. However, if the inattention symptoms started after or concomitant with symptoms of depression, the symptoms are likely associated with depression and therefore depression should be addressed first.

Mental Disorders (DSM-5): 2013 update⁷

People with ADHD show a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development.

Key changes in the DSM-5 for the diagnosis of ADHD:

- Symptoms can now occur by age 12 rather than by age 6;
- Several symptoms now need to be present in more than one setting rather than just some impairment in more than one setting;
- New descriptions were added to show what symptoms might look like at older ages; and
- For adults and adolescents age 17 or older, only 5 symptoms are needed instead of the 6 needed for younger children.

- 1. Inattention:** Six or more symptoms of inattention for children up to age 16, or five or more for adolescents 17 and older and adults; symptoms of inattention have been present for at least 6 months, and they are inappropriate for developmental level:
 - Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or with other activities.
 - Often has trouble holding attention on tasks or play activities.
 - Often does not seem to listen when spoken to directly.
 - Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., loses focus, side-tracked).
 - Often has trouble organizing tasks and activities.
 - Often avoids, dislikes, or is reluctant to do tasks that require mental effort over a long period of time (such as schoolwork or homework).
 - Often loses things necessary for tasks and activities (e.g. school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).
 - Is often easily distracted.
 - Is often forgetful in daily activities.
- 2. Hyperactivity and Impulsivity:** Six or more symptoms of hyperactivity-impulsivity for children up to age 16, or five or more for adolescents 17 and older and adults; symptoms of hyperactivity-impulsivity have been present for at least 6 months to an extent that is disruptive and inappropriate for the person's developmental level:
 - Often fidgets with or taps hands or feet, or squirms in seat.
 - Often leaves seat in situations when remaining seated is expected.
 - Often runs about or climbs in situations where it is not appropriate (adolescents or adults may be limited to feeling restless).
 - Often unable to play or take part in leisure activities quietly.
 - Is often "on the go" acting as if "driven by a motor".
 - Often talks excessively.
 - Often blurts out an answer before a question has been completed.
 - Often has trouble waiting his/her turn.
 - Often interrupts or intrudes on others (e.g., butts into conversations or games.)

(Continued.)

Because symptoms can change over time, the presentation may change over time as well.

In addition, the following conditions must be met:

- Several inattentive or hyperactive-impulsive symptoms were present before age 12 years.
- Several symptoms are present in two or more setting, (such as at home, school or work; with friends or relatives; in other activities).
- There is clear evidence that the symptoms interfere with, or reduce the quality of, social, school, or work functioning.
- The symptoms are not better explained by another mental disorder (such as a mood disorder, anxiety disorder, dissociative disorder, or a personality disorder). The symptoms do not happen only during the course of schizophrenia or another psychotic disorder.

Based on the types of symptoms, three kinds (presentations) of ADHD can occur:

- **Combined Presentation:** if enough symptoms of both criteria inattention and hyperactivity-impulsivity were present for the past 6 months
- **Predominantly Inattentive Presentation:** if enough symptoms of inattention, but not hyperactivity-impulsivity, were present for the past six months
- **Predominantly Hyperactive-Impulsive Presentation:** if enough symptoms of hyperactivity-impulsivity but not inattention were present for the past six months.



Algorithm for Evaluation and Diagnosis

Routine Screening and/or appointment with concern for ADHD

NICHQ Vanderbilt Assessment Scales

NICHQ Vanderbilt Assessment Scales
Used for diagnosing ADHD

1st Visit – Initial Evaluation

1. Perform medical history/physical exam
2. If you suspect ADHD and/or other psychiatric comorbidities, provide the parent validated screening tools (these can be provided in advance of the appointment as well)
3. Explain to family that diagnosing ADHD depends on information from both family to teachers
4. Instruct family to make a follow-up appointment when all forms are complete, preferably within 2-4 weeks

Parent screening tools: PHQ-9

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems (check one that best describes your answer)?

	Not at all	Slightly	Moderately	Very much	Extremely
1. Little interest or pleasure in doing things	0	1	2	3	4
2. Feeling down, depressed, or hopeless	0	1	2	3	4
3. Trouble sleeping or sleeping too much	0	1	2	3	4
4. Feeling tired or having low energy	0	1	2	3	4
5. Poor appetite or overeating	0	1	2	3	4
6. Feeling like you are not the same as you used to be or that you are not living up to your abilities	0	1	2	3	4
7. Trouble concentrating on things such as reading the newspaper or watching television	0	1	2	3	4
8. Moves or speaks so slowly that others notice or that you feel like you are slowed down	0	1	2	3	4
9. Thoughts that you would be better off dead or of hurting yourself	0	1	2	3	4

PHQ-9 scores range from 0 to 27. A score of 10 or greater is suggestive of major depressive disorder.

Patient/Parents

1. Complete screening forms (Vanderbilt, PHQ-9, PSC)
2. Take School forms to child's school psychologist/guidance counselor/teacher
3. Schedule follow up appointment when all forms completed

School

1. Complete screening forms (Vanderbilt)
2. Provide a copy of the completed tools to the parents to take to the physician.
3. Save a copy for the school records.

Parent screening tools: PSC

BRIGHT FUTURES™ TOOLS FOR PROFESSIONALS
INSTRUCTIONS FOR USE
Pediatric Symptom Checklist

The Pediatric Symptom Checklist is a questionnaire screen designed to identify children with emotional, behavioral, and attention problems. It has been validated for use with children ages 6 to 17. The PSC is a 25-item questionnaire that is easy to use and can be completed by parents, teachers, or the child. The PSC is a 25-item questionnaire that is easy to use and can be completed by parents, teachers, or the child. The PSC is a 25-item questionnaire that is easy to use and can be completed by parents, teachers, or the child.

Evaluation/Diagnosis Visit (within 4 weeks of first visit or after receipt of packets)

1. Evaluate and score information in the forms before seeing the patient
2. Perform medical history/physical exam if not done already
3. Review packets and interview patient/parent

Meets diagnostic criteria?

No

Determine need for further evaluation. If appropriate consult with school psychologist or Behavioral Health Professional.

Yes

Suspect comorbid conditions?

Yes

Consider behavioral health professional

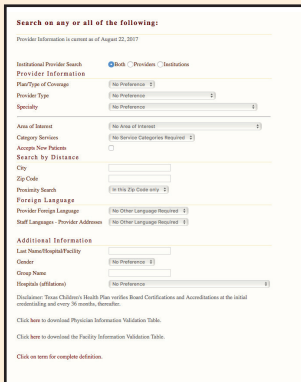
No

Initiate ADHD Treatment Plan



Treatment Plan

To refer to a behavioral health provider, use our **iDirectory** to search for in-network providers.¹¹



The screenshot shows a search form titled "Search on any or all of the following:". Below the title, it says "Provider Information is current as of August 22, 2017". The form includes several sections: "Institutional Provider Search" with radio buttons for "All" (selected), "Provider", and "Institutions"; "Provider Information" with dropdown menus for "Plan/Type of Coverage", "Provider Type", and "Specialty"; "Search by Distance" with a checkbox; "City" and "Zip Code" input fields; "Foreign Language" with a dropdown for "Foreign Language"; "Additional Information" with dropdowns for "Last Name (alphabetical)", "Gender", and "Group Name"; and "Specialty (checkboxes)" with a dropdown for "Specialty (checkboxes)". At the bottom, there are links to download validation tables and a note to click on a link for complete definition.

Treatment in children and adolescents

- 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 in children over the age of 6 and should be used when appropriate to improve target outcomes in children with ADHD. In addition, **behavioral therapy** should be considered, especially in the case of children under the age of 6 and patients with comorbid conditions.
- 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.
- **Special consideration for adolescents:** Frequent monitoring of medication is critical, as stimulants have a higher potential for misuse or diversion in the middle school or high school environment. Sustained release preparations may reduce the risk of chemical dependency.¹⁰

Texas Children's Health Plan HEDIS metrics

HEDIS stands for Healthcare Effectiveness Data and Information Set. It is a widely used set of performance measures by the nation's health plans, and an essential tool in ensuring that our members are getting the best healthcare possible. It is extremely important that our providers understand the HEDIS® specifications and guidelines. TCHP tracks the following HEDIS metrics related to ADHD.

- Patients ages 6 to 12 with a newly prescribed ADHD medication must have a follow-up visit within the first 30 days of ADHD medication first medication prescription fill.
 - Patients ages 6 to 12 with a newly prescribed ADHD medication must have at least two more follow-up visits within the next nine months (after the initial 30 day follow up). (See issue on previous bullet.)
 - In summary, follow-up care for children prescribed a new ADHD Medication should have: at least 1 follow up visit during the first 30 days after the medication was first dispensed and 2 additional follow up visits between 4 weeks and 9 months.
- * Follow-up visit means any outpatient, intensive outpatient or partial hospitalization visit.

Algorithm for Treatment Plan

Patient Diagnosed with ADHD

Initial Treatment Plan

1. For children under the age of 6, the provider should refer for evidence-based behavior therapy as the first line of treatment. Please see page 13.
2. For children 6 and older, begin medication and consider evidence-based behavior therapy as treatment for ADHD. Please see page 10.
3. Work with patient/parents to develop a management plan including medical plan, follow-up plan and suggestions for home and school plans.
4. Educate parents/patients about ADHD; provide educational resources and local support resources.
5. Give parents follow-up Vanderbilt forms to complete before the next visit and provide copies of school Vanderbilt forms.

Patient/Parents

1. Initiate home interventions and target behaviors based on patient's management plan.
2. Complete Follow-up Forms.
3. Take School forms to child's school psychologist/guidance counselor/teacher, establish school goals and interventions and request completion of follow up forms within 3-4 weeks.
3. Schedule follow up appointment within 3-4 weeks and bring completed forms.

School

1. Review the ADHD management plan with the parent and child, and help determine school goals and intervention for behavior management.
2. Make special arrangements as appropriate (Section 504 accommodations, IDEA, etc) Complete follow-up forms and return to parents within 3-4 weeks of diagnosis Save a copy for the school records.

Follow up every 3-4 weeks until symptoms controlled and progress toward goals

1. Review follow up forms from home and school.
2. Monitor height, weight, blood pressure, heart rate, side effects, co-morbidities, and progress toward goals.

Symptoms controlled? Progress toward goals.

No

Reassess diagnosis. Assess adherence to treatment plan or need to modify treatment. Reconsider co-morbidities. Consider referral to behavioral health specialist.

Yes

Ongoing follow up every 3-6 months. Continue treatment plan. Follow up every 3-6 months, have patient/family and school complete forms before next appointments.



Behavior Therapy in Young Children

Behavior therapy is effective treatment for attention-deficit/hyperactivity disorder (ADHD) that can improve a child's behavior, self-control, and self-esteem. It is most effective in young children when it is delivered by parents. Experts recommend that doctors refer parents of children under 6 years old for training in behavior therapy before prescribing ADHD medicine. When parents become trained in behavior therapy, they learn skills and strategies to help their child with ADHD succeed at school, at home, and in relationships.

Behavior therapy, given by parents and with the support of healthcare providers, teaches children to better control their own behavior, leading to improved functioning at school, home and in relationships. Learning and practicing behavior therapy requires time and effort, but it has lasting benefits for the child.

Parent Management Training (PMT) is an effective way for parents to provide behavior therapy for children with ADHD in the home. Parents can learn how to apply PMT in the home through training by a skilled LPC, LCSW, or psychologist in their community. Clinicians can get trained to teach parents PMT techniques through various educational resources. The table below highlights three behavioral therapy programs available to train clinicians. There are many training resources beyond these programs available to clinicians as well.

Some therapists will have training or certification in a program that has been proven to work in young children with ADHD. Such programs include those listed in a 2011 Agency for Healthcare Research and Quality (AHRQ) report:¹²

Name of Behavioral Therapy Program	Available in the Greater Houston area?	Available in the Tyler area?	Available in the Beaumont area?
Triple P (Positive Parenting Program)	Yes, plus resources	No, Online resources only	No, Online resources only
Incredible Years Parenting Program	No, Online resources only	No, Online resources only	No, Online resources only
Parent-Child Interaction Therapy	Yes	No	No

What can parents expect?

Parents typically attend eight or more sessions with a therapist. Sessions may involve groups or individual families. The therapist meets regularly with the family to review their progress, provide support, and adjust strategies as needed to ensure improvement. Parents practice with their child between sessions.

What will parents learn?

Parents learn how to:

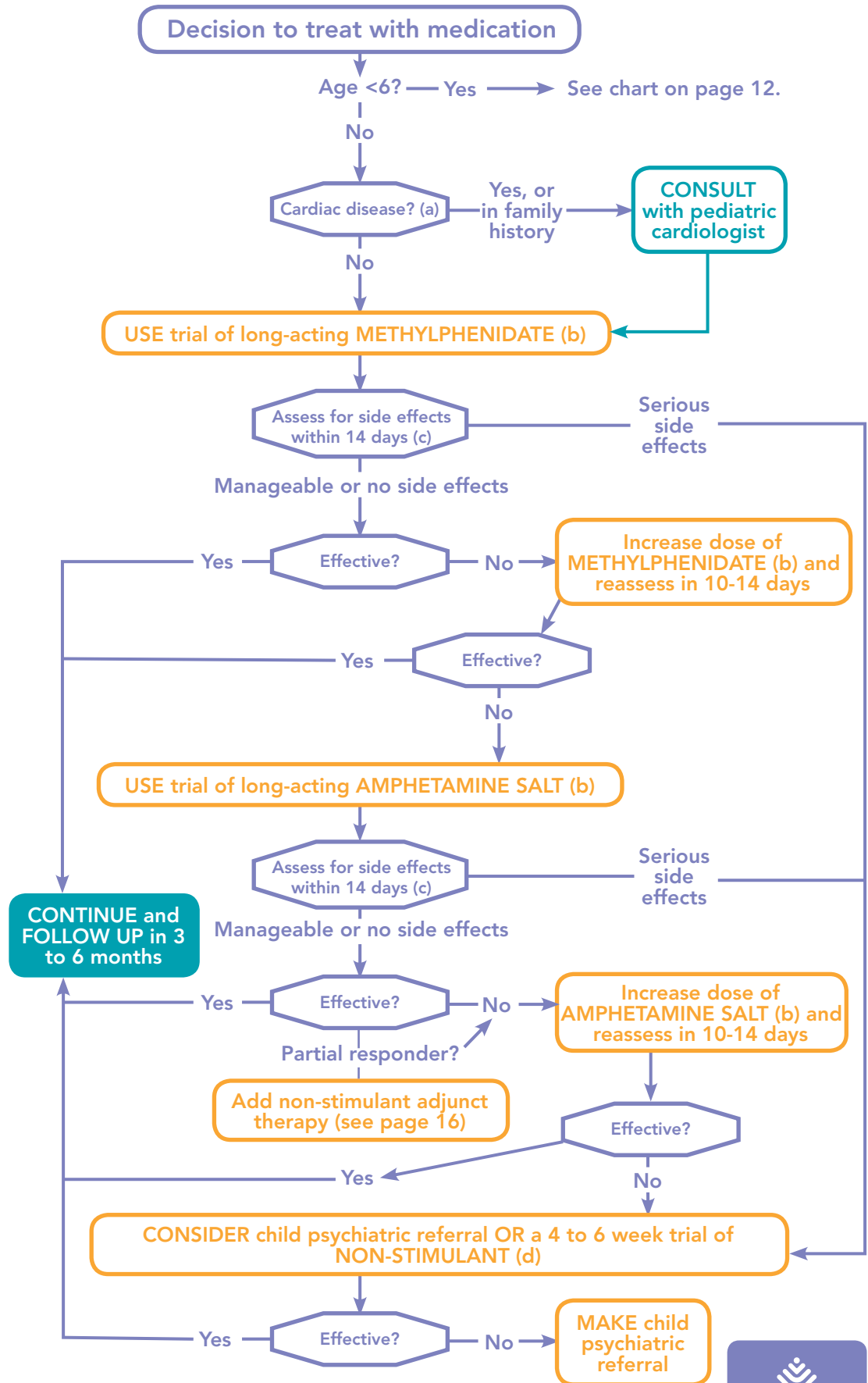
- Strengthen the relationship with their child through positive communication, for example, active listening and describing emotions
- Reinforce good behavior, for example, giving positive attention and effective praise for good behavior
- Create structure and provide consistent discipline, for example, giving effective instructions, withholding attention for unwanted behavior, and effective use of time-out

Children with ADHD often have many challenging behaviors. A therapist will help parents learn these skills and how to use them effectively with their child.

Algorithm for ADHD Medication Management (Age 6-18)

Prescribing Pearls

- Write a 14-day supply prescription when starting new stimulant and schedule a follow up appointment in 1-2 weeks. This enables providers to closely monitor improvement of ADHD symptoms and medication side effects
- Before prescribing any medication, check the formulary to ensure that you are selecting medications that will be covered by TCHP (<https://www.navitus.com/texas-medicaid-star-chip/formulary.aspx>)
- Patient can't swallow pills? Prescribe capsules of long-acting agent and instruct patient to empty capsule contents into applesauce for oral administration. This will not affect duration of action and this is significantly less expensive than Quillivant or Quillichew
- When discontinuing alpha-agonist (clonidine, guanfacine), gradually decrease dose over 1-2 weeks to avoid sudden increase in blood pressure
- Titrate methylphenidate or amphetamine salt to at least 40mg (total daily dose) before switching to new agent or documenting treatment failure



Medication Management Algorithm Notes (Age 6-18)

(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. ^{MCL}

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) Trial of stimulant (METHYLPHENIDATE OR AMPHETAMINE SALT)

- **Stimulant medication is the first-line treatment for ADHD.** Long-acting stimulants are preferred. Complete trial of low cost generic stimulants before trial of brand stimulants See Table I .
- **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 co-morbidities, consider consulting a mental health specialist** before choosing medication. Specific medication choices can be more effective for specific co-morbidities. **See note (d).**

(Continued.)

Medication Management Algorithm Notes (Age 6-18)

(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
 - Obsessive-compulsive symptoms
 - Depression or extreme mood swings
 - Significant anxiety
 - Increase in ADHD symptoms in at least two medication trials
 - Continuous tics

Side Effect	Intervention
Increase aggression, mood lability	Discontinue stimulant and initiate trial of non-stimulant. See Table 1 for list of non-stimulant
Suppressed appetite	Give meal 30-60 minutes prior to dose of stimulant
Insomnia	Initiate melatonin or alpha-agonist at bedtime

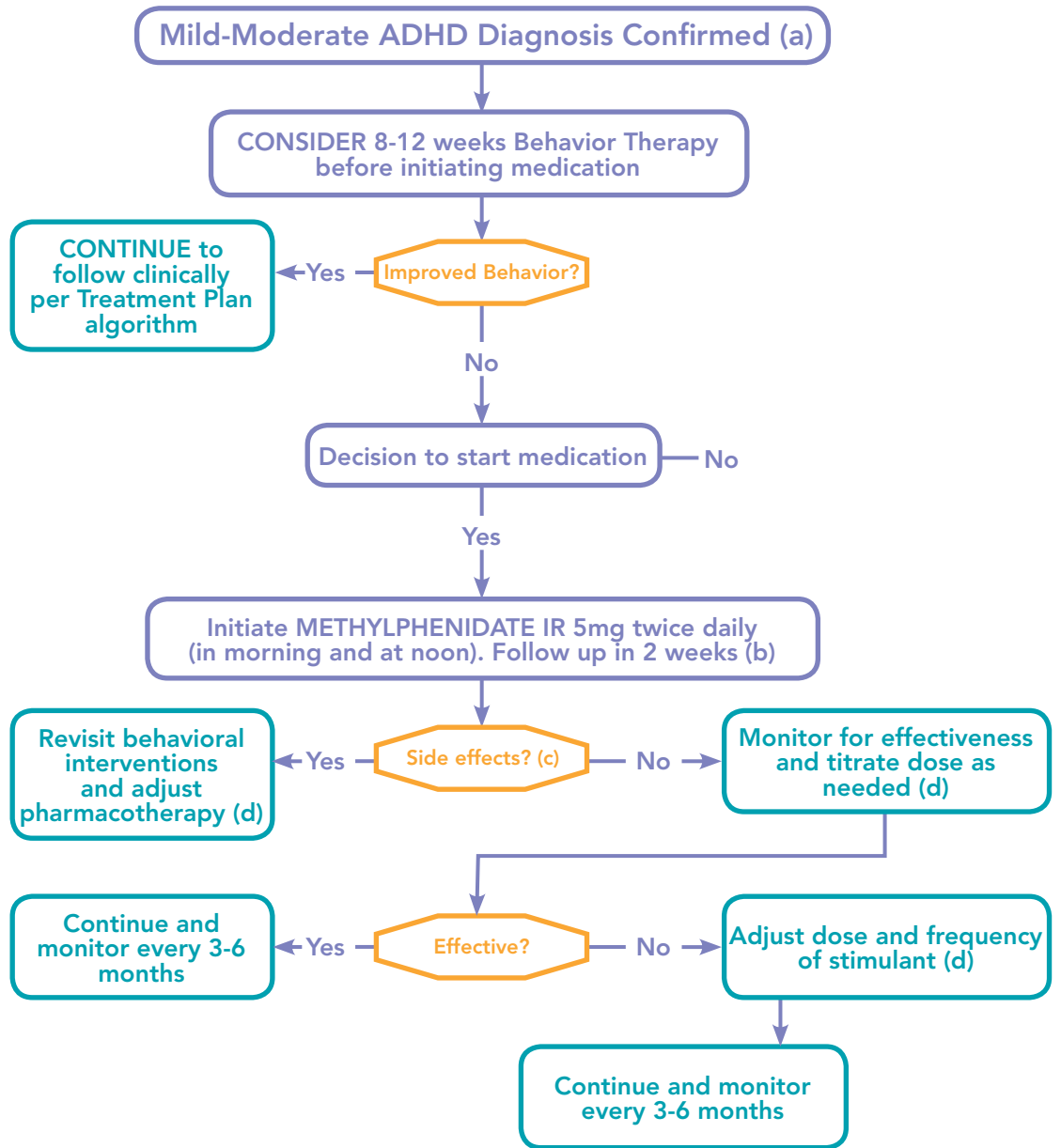
(d) Non-stimulant trial

- 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. ^{THO}

Algorithm for ADHD Medication Management (Age <6)

Severity of ADHD in patients < 6

This algorithm can guide clinicians for mild to moderate ADHD. For patients under 6 who present with severe ADHD, it is appropriate to initiate stimulant medication before behavioral therapy. For these patients, stimulant medication is often required to achieve the appropriate control of ADHD symptoms in order to begin behavioral therapy.



ADHD Medication Management (Age <6) Algorithm Notes

(a)

Criteria for moderate-severe severity: (1) symptoms that have persisted for at least 9 months, (2) dysfunction that is manifested in both the home and other settings such as preschool or child care, and (3) dysfunction that has not responded adequately to behavior therapy (source: <http://pediatrics.aappublications.org/content/pediatrics/early/2011/10/14/peds.2011-2654.full.pdf>).

(b)

The American Academy of Pediatrics recommends use of methylphenidate over dextroamphetamine in children under 6 years of age. Most of the evidence for the safety and efficacy of treating preschool-aged children with stimulant medications has been from methylphenidate. Although there is moderate evidence that methylphenidate is safe and efficacious in preschool-aged children, its use in this age group remains off-label. Although the use of dextroamphetamine is on label, the insufficient evidence for its safety and efficacy in this age group does not make it possible to recommend at this time. Dextroamphetamine is approved by the FDA for use in children younger than 6 years of age. This approval, however, was based on less stringent criteria in force when the medication was approved rather than on empirical evidence of its safety and efficacy in this age group. (<http://pediatrics.aappublications.org/content/pediatrics/early/2011/10/14/peds.2011-2654.full.pdf>)

(c)

Side Effects and Recommended Intervention Table

Side Effect	Intervention
Increase aggression, mood lability	Discontinue stimulant and initiate trial of non-stimulant. See Table 1 for list of non-stimulant
Tics	Combine stimulant with alpha-agonist (clonidine/guanfacine)
Suppressed appetite	Give meal 30-60 minutes prior to dose of stimulant
Insomnia	Initiate melatonin or alpha-agonist at bedtime

(d)

If ADHD symptoms are not controlled, consider these changes:

1. If behavior is not improving, increase dose by 2.5-5 mg and follow up in 14 days (i.e. methylphenidate 5 mg BID → methylphenidate 10 mg BID).
2. If medication is improving behavior but wearing off throughout the day, increase dosing from twice daily to three times daily. When dose is stabilized and tolerated, switch to extended release methylphenidate.



Table I. ADHD Medication (Ages 6-18)

Generic Name	Brand Name	Duration	Dosage Forms	Dosing (Ages 6-18)	
				Initial	Daily Max
Long-Acting Methylphenidate					
Methylphenidate ER	Concerta	10-12 hrs	Tabs: 18, 27, 36, 54 mg	18 mg/d	54 mg
Methylphenidate ER	Metadate ER	6-8 hrs	Tab: 20 mg	20 mg/d	60 mg
Methylphenidate ER (CD)	Metadate CD	8 hrs	Caps: 10, 20, 30, 40, 50, 60 mg	20 mg/d	60 mg
Methylphenidate SR	Ritalin SR (Discontinued)	6-8 hrs	Tab: 20 mg	5 mg BID	60 mg
Methylphenidate ER	Ritalin LA	6-8 hrs	Caps: 10, 20, 30, 40, 60 mg	20 mg/d	60 mg
Dexmethylphenidate ER	Focalin XR	10-12 hrs	Generic Caps: 5, 10, 15, 20, 30, 40 mg	5 mg/d	30 mg
			Brand Caps: 5, 10, 15, 20, 25, 30, 35, 40 mg	5 mg/d	30 mg
No Generic Available	Aptensio XR	5-6 hrs	Caps: 10, 15, 20, 30, 40, 50, 60 mg	10 mg/d	60 mg
No Generic Available	Daytrana	10-12 hrs	Transdermal Patch: 10, 15, 20, 30 mg	10 mg/d	30 mg
No Generic Available	Daytrana	9 hr	Patch: 10, 15, 20, 30 mg	10mg/d	30 mg
No Generic Available	Quillivant XR	12 hr	Suspension: 25 mg/5 mL	20mg/d	60 mg
No Generic Available	Quillichew ER	8 hr	Chewable Tabs: 20, 30, 40 mg	20mg/d	60 mg
Long-Acting Amphetamines					
Mixed amphetamine salts ER	Adderall XR	10-12 hrs	Caps: 5, 10, 15, 20, 25, 30 mg	5-10mg/d	30mg
Dextroamphetamine sulfate ER	Dexedrine Spansules	6-8 hrs	Caps: 5, 10, 15 mg	5mg QD or BID	40 mg
No Generic Available	Adzenys ODT	10-11 hrs	Oral Disintegrating tab: 3.1, 6.3, 9.4, 12.5, 15.7, 18.8 mg	6.3 mg/d	18.8 mg
No Generic Available	Mydayis	10-13 hrs	Caps: 12.5, 25, 37.5, 50 mg	≥13 yrs old: 12.5 mg	25 mg
No Generic Available	Dyanavel XR	13 hrs	Suspension: 2.5mg/mL	2.5-5 mg/d	20 mg
No Generic Available	Vyvanse	10-12 hrs	Caps: 10, 20, 30, 40, 50, 60, 70 mg Chewable Tabs: 10, 20, 30, 40, 50, 60 mg	30 mg/d	70 mg
Short-Acting Methylphenidate					
Methylphenidate IR	Ritalin	3-5 hrs	Tabs: 5, 10, 20 mg	Variable	60mg
Methylphenidate IR	Methylin Chew (Discontin'd)	3-5 hrs	Chewable Tabs: 2.5, 5, 10 mg	Variable	60mg
Methylphenidate solution	Methylin	3-5 hrs	Suspension: 5mg/5mL, 10mg/5mL	Variable	60mg
Dexmethylphenidate	Focalin	3-5 hrs	Tabs: 2.5, 5, 10 mg	Variable	20 mg

(Continued.)



Table I. ADHD Medication (Ages 6-18)

Generic Name	Brand Name	Duration	Dosage Forms	Dosing (Ages 6-18)	
				Initial	Daily Max
Short-Acting Amphetamines					
Mixed amphetamine salts IR	Adderall	4-6 hrs	Tabs: 5, 7.5, 10, 12.5, 15, 20, 30 mg	Variable	40mg
Dextroamphetamine sulfate IR	Procentra	3 hrs	Solution: 5 mg/5mL	Variable	40 mg
Dextroamphetamine sulfate IR	Zenzedi	4-6 hrs	Generic tabs: 5, 10 mg Brand tabs: 2.5, 5, 7.5, 10, 15, 20, 30 mg	Variable	40 mg
Methamphetamine	Desoxyn	3-5 hrs	Tabs: 5 mg	Variable	25 mg
No Generic Available	Evekeo	4 hrs	Tabs: 5, 10 mg	Variable	40 mg
Non-stimulants					
Atomoxetine	Strattera	10-12 hrs	Caps: 10, 18, 25, 40, 60, 90, 100 mg	Weight Based	
Guanfacine ER	Intuniv	12 hrs	Tabs: 1, 2, 3, 4 mg	1 mg/d	4-7 mg
Clonidine ER	Kapvay	12 hrs	Tabs: 0.1mg	0.1 mg/d	0.2 mg BID

Co-morbidities often associated with ADHD

Attention-Deficit/Hyperactivity Disorder (ADHD) often occurs with other disorders. About half of children with ADHD referred to clinics have other disorders as well as ADHD.

The combination of ADHD with other disorders often presents extra challenges for children, parents, educators, and healthcare providers. Therefore, it is important for doctors to screen every child with ADHD for other disorders and problems. This page provides an overview of the more common conditions and concerns that can occur with ADHD. Talk with your doctor if you have concerns about your child's symptoms.¹³

Behavior or Conduct Problems

Children occasionally act angry or defiant around adults or respond aggressively when they are upset. When these behaviors persist over time, or are severe, they can become a behavior disorder. Children with ADHD are more likely to be diagnosed with a behavior disorder such as Oppositional Defiant Disorder or Conduct Disorder. About 1 in 4 children with ADHD have a diagnosed behavior disorder.

► Treatment

Starting treatment early is important. Treatment is most effective if it fits the needs of the child and family. The first step to treatment is to have a comprehensive evaluation by a mental health professional. Some of the signs of behavior problems, such as not following rules, are also signs of ADHD, so it is important to get a careful evaluation to see if a child has both conditions. For younger children, the treatment with the strongest evidence is behavioral parent training, where a therapist helps the parent learn effective ways to strengthen the parent-child relationship and respond to the child's behavior. For school-age children and teens, an often-used effective treatment is combination training and therapy that includes the child, the family, and the school. Sometimes medication is part of the treatment.

Learning Disorder

Many children with ADHD also have a learning disorder (LD). This is in addition to other symptoms of ADHD, such as difficulties paying attention, staying on task, or being organized, which also keep a child from doing well in school. ADHD is characterized by impairment in multiple settings. If impairment is only occurring in school, the patient may have a learning disability without ADHD.

Having a learning disorder means that a child has a clear difficulty in one or more areas of learning, even when their intelligence is not affected. Learning disorders include:

- Dyslexia – difficulty with reading
- Dyscalculia – difficulty with math
- Dysgraphia – difficulty with writing

Data from the 2004-2006 National Health Interview Survey suggests that almost half of children 6-17 years of age diagnosed with ADHD may also have LD. The combination of problems caused by ADHD and LD can make it particularly hard for a child to succeed in school. Properly diagnosing each disorder is crucial, so that the child can get the right kind of help for each.

► Treatment

Children with learning disorders often need extra help and instruction that is specialized for them. Having a learning disorder can qualify a child for special education services in school. Because children with ADHD often have difficulty in school, the first step is a careful evaluation to see if the problems are also caused by a learning disorder. Schools should do their own testing to determine if child needs an intervention. Parents, healthcare providers, and the school can work together to find the right referrals and treatment.

(Continued.)

The American Academy of Pediatrics recommends every child with ADHD should be screened for other disorders and problems.

Anxiety

Many children have fears and worries. However, when a child experiences so many fears and worries that they interfere with school, home, or play activities, it is an anxiety disorder. Children with ADHD are more likely than those without to develop an anxiety disorder. Almost 1 in 5 children with ADHD have a diagnosed anxiety disorder.

Examples of anxiety disorders include:

- Separation anxiety - being very afraid when they are away from family
- Social anxiety - being very afraid of school and other places where they may meet people
- Generalized anxiety – being very worried about the future and about bad things happening to them

Depression

Children with ADHD already have a hard time focusing on things that are not very interesting to them. Depression can make it hard to focus on things that are normally fun. Changes in eating and sleeping habits can also be a sign of depression. For children with ADHD who take medication, changes in eating and sleeping can also be side-effects from the medication rather than signs of depression. Talk with your doctor if you have concerns.

Extreme depression can lead to thoughts of suicide. For youth ages 10-24 years, suicide is a leading cause of death.

Occasionally being sad or feeling hopeless is a part of every child's life. When children feel persistent sadness and hopelessness, it can cause problems. Children with ADHD are more likely than children without ADHD to develop childhood depression. Children may be more likely to feel hopeless and sad when they can't control their ADHD symptoms and the symptoms interfere with doing well at school or getting along with family and friends. About 1 in 7 children with ADHD have a diagnosis of depression.

Examples of behaviors often seen when children are depressed include:

- Feeling sad or hopeless a lot of the time
- Not wanting to do things that are fun
- Having a hard time focusing
- Feeling worthless or useless

► Treatment for anxiety and depression

The first step to treatment is to talk with a healthcare provider to get an evaluation. Some signs of depression, like having a hard time focusing, are also signs of ADHD, so it is important to get a careful evaluation to see if a child has both conditions. A mental health professional can develop a therapy plan that works best for the child and family. Early treatment is important, and can include child therapy, family therapy, or a combination of both. The school can also be included in therapy programs. For very young children, involving parents in treatment is very important. Cognitive behavioral therapy is one form of therapy that is used to treat anxiety or depression, particularly in older children. It helps the child change negative thoughts into more positive, effective ways of thinking. Consultation with a health provider can help determine if medication should also be part of the treatment.

Substance Use Disorder (SUD)

ADHD treatment in childhood may prevent SUD. Studies have shown that treating ADHD in childhood with stimulant medication can help prevent SUD later on. Untreated ADHD is associated with an increased risk of SUD compared to patients treated for ADHD. However, a patient with treated ADHD has a higher risk for SUD than a patient without ADHD. Therefore, all patients with ADHD (treated or untreated) should be regularly assessed for SUD.

Screening for SUD is critical. A significant percentage of adolescents also have SUD. Before treating a teen with stimulants, consider SUD screening.

Address family SUD. Consider SUD screening in patients' family to prevent diversion.¹⁴

Social risks associated with ADHD

Difficult Peer Relationships

ADHD can make peer relationships or friendships very difficult. Having friends is important to children's well-being and may be very important to their long-term development. Although some children with ADHD have no trouble getting along with other children, others have difficulty in their relationships with their peers; for example, they might not have close friends, or might even be rejected by other children. Children who have difficulty making friends might also more likely have anxiety, behavioral and mood disorders, substance abuse, or delinquency as teenagers.

- Parents of children with ADHD report that their child has almost 3 times as many peer problems as a child without ADHD.
- Parents report that children with ADHD are almost 10 times as likely to have difficulties that interfere with friendships.

▶ How does ADHD interfere with peer relationships?

Exactly how ADHD contributes to social problems is not fully understood. Due to inattention, children and adolescents diagnosed with ADHD might not be able to pay attention to social cues. Therefore, their social skills learning can be delayed which and affect their peer relationships. Children who are inattentive sometimes seem shy or withdrawn to their peers. Children with symptoms of impulsivity/hyperactivity may be rejected by their peers because they are intrusive, may not wait their turn, or may act aggressively. In addition, children with ADHD are also more likely than those without ADHD to have other disorders that interfere with getting along with others.

▶ Having ADHD does not mean a child won't have friends

Not everyone with ADHD has difficulty getting along with others. For those children who do have difficulty, many things can be done to help them with relationships. The earlier a child's difficulties with peers are noticed, the more successful intervention may be. Although researchers don't have definitive answers on what works best for children with ADHD, some things parents might consider as they help their child build and strengthen peer relationships are:

- Pay attention to how children get along with peers. These relationships can be just as important as grades to school success.
- Regularly talk with people who play important roles in your child's life (such as teachers, school counselors, after-school activity leaders, healthcare providers, etc.). Keep updated on your child's social development in community and school settings.
- Involve your child in activities with other children. Talk with other parents, sports coaches and other involved adults about any progress or problems that may develop with your child.
- Peer programs can be helpful, particularly for older children and teenagers. Social skills training alone has not shown to be effective, but peer programs where children practice getting along with others can help. Schools and communities often have such programs available. You may want to talk to your healthcare provider and someone at your child's school about programs that might help.

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.¹⁵

Patient and Family Education

My ADHD Stoplight Tool

MY ADHD STOPLIGHT TOOL

GREEN ZONE: I AM CALM AND ABLE TO FOCUS BETTER

YELLOW ZONE: I AM UNABLE TO FOCUS, CHOOSE TO COUNT

RED ZONE: I AM OUT OF CONTROL

CALL 911

Barriers

Best ADHD Apps



TCHP's ADHD Self-Management Tool

Texas Children's Health Plan has developed a self-management tool for ADHD that the healthcare provider can complete with the family. This tool is best utilized in a discussion with the family so they know how and when to use it. TCHP recommends the family be given multiple copies so that at least one at home and one with the school nurse is available. TCHP recommends the tool be reviewed at each follow-up visit for ADHD or as medications change to keep it updated and to address barriers to self-management of ADHD.

The ADHD Self-Management tool has 3 zones: Green, Yellow and Red. Each zone discusses symptoms and behaviors that align with how well a patient's ADHD is being managed. The green zone is where we want the patient to stay. It has a place for up to 3 daily ADHD medications to be entered, discusses common side effects of medications, and goals to help keep the patient in the green zone. The yellow zone is the warning zone with signs and symptoms to identify the patient and self-care skills to help return them to the green zone. The red zone is when a patient is out of control and instructs the caregiver on self-care skills to use and when it would be necessary to call 9-1-1. At the bottom, there is a barriers section where the healthcare provider can select a few barriers that you would like the family to work on.

Apps that assist with ADHD management and scheduling

- **30/30** - create tasks and set the time you need to complete them.
- **Dragon** - uses voice recognition and translates it into text.
- **Dropbox** - keep all your files, photos, videos and documents in one place.
- **Evernote** - note organization app where you can share notes with others as needed.
- **iReward Chart** - similar to a chore chart, but it is in a digital form.
- **Remember the Milk** - keeps track of your to-do lists and choose to get reminders via email or text or even on your calendar.
- **Colornote** - color code your notes, set reminders, and manage your calendar with this app.
- **Remind Me** - lets you make notes and reminders that you can save as wallpaper on your phone.¹⁶

Local ADHD family support and resources

- **Attention Deficit Disorders Association (ADDA): Southern Region** www.adda-sr.org (281) 897-0982.

Supports individuals impacted by attention deficit disorders and related conditions and helps to advocate for the development of community resources and services. For Spanish support and resources: contact (936) 293-9213.

- Support groups
- Advocacy
- Trainings and Conferences

- **ARC of Greater Houston:** Holds trainings on Special Education 101, Monthly Special Education Trainings, offers social and recreational events for those with special health care needs (English and Spanish trainings offered).

<http://www.aogh.org/>

- **Navigate Life Texas website:** search for resources by topic and by county.

<https://www.navigatelifetexas.org/en>



Section 504



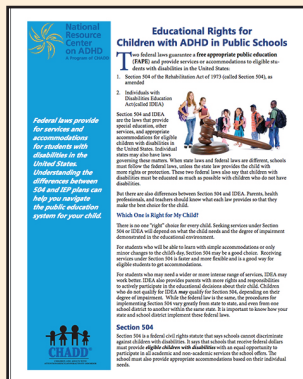
IDEA



Infographic explaining IDEA vs. Section 504 found here:



More information on Educational Rights for Children with ADHD in Public Schools



Working with Schools

Educational accommodations for ADHD are shaped by two laws:²⁰

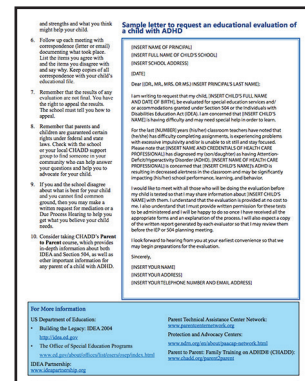
Section 504 (Rehabilitation Act of 1973). This law covers “disability that substantially limits one or more life activities” (and includes learning disabilities). If eligible, the student receives an Accommodation Plan. For students who can benefit from simple accommodations, qualifying under Section 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.

Tips for talking to teachers



Sample letter to teachers



Tips for Talking to Teachers about ADHD

During the academic year, school-age kids spend at least six hours a day at school. Add in extracurricular activities beyond the regular school day, and those six hours can easily become eight or 10. This means that kids spend 25% or more of their time with adults other than their parents—mostly teachers.

As every parent and teacher knows, however, the symptoms of ADHD don’t disappear once your child walks out the front door and gets on the bus. In fact, the classroom setting can present teachers with unique behavior management challenges when trying to teach children with ADHD or related conditions. Communicating effectively with teachers is one of the most important things you as a parent can do to ensure that your child receives the supports and structures needed for success.²¹

Here are five tips to help foster better communication and cooperation with teachers.

1. Understand the teacher’s mindset. Terry Illes, PhD, a school psychologist, explains that there are two main schools of thought regarding ADHD and behavioral disorders in general. The first is the “Behavioral” model; the second is the “Academic” model. Under the Behavioral Model, teachers will ascribe undesirable behavior to motivation, and thus see it as voluntary and willful. This leads to a cycle where the teacher will work to “stamp out” the behavior instead of teaching the child new skills to adapt to the classroom environment. Under the Academic Model, a teacher will recognize the behavior as involuntary and will work to teach new skills over time to help the student maximize potential.

(Continued.)

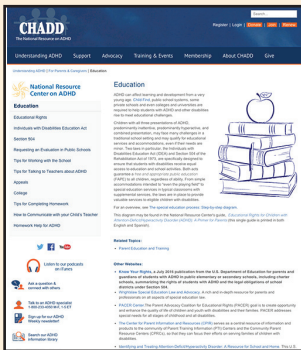


Finding out which mindset a teacher has can go a long way towards figuring out how to approach that teacher and how to work with him or her to better understand your child's needs and provide for them.

- 2. Work with, not against, the teacher.** Approach your child's teacher as an ally rather than as an adversary and acknowledge your responsibility as part of your child's education team. If they are unfamiliar with ADHD, provide the teacher with the basic information, the science behind it and the common treatments. Solicit feedback. Make the teacher part of the solution so that he or she has a stake in the process. Be open about past difficulties and current challenges.
- 3. Start before the school year begins.** Don't wait until the child is already in school and making an impression that can be hard to shake. Be proactive and write a letter or send an email to open communication with the teacher and prepare him or her for your child's behaviors and requirements. Use the message to make the teacher aware of your child's ADHD and of any learning programs, such as a 504 Plan or an Individualized Education Plan. You might also express a desire to meet in person either before the school year or shortly thereafter.
- 4. Establish a system for meeting the child's needs and keeping in contact.** Treat the teacher as a partner in your child's education team. Let your child's teachers know if there are some major changes going on in your family since your child's behavior can be affected. Invite the teachers to contact you with any issues or concerns before they become a problem as well as regular progress reports. Find out what accommodations can be offered or developed to meet your child's needs. Arrange for regular meetings to monitor your child's progress and make adjustments if needed to the accommodations. Having open lines of communication between you and the teacher will help your child.
- 5. Don't go it alone!** Raising a child with ADHD can be, at times, frustrating and demanding. But there are many other parents facing similar situations. Check out local CHADD support groups, message boards, and other resources where you can turn for advice and community.

It is crucial to keep an open line of communication with teachers to allow plans and systems to be adjusted as needed and to ensure that your child is making progress. By taking steps ahead of time to prepare teachers for children with ADHD, parents can save a good deal of stress and heartache up front. Like any good relationship, the key to an effective parent-teacher partnership is open, honest, two-way communication.

For more resources on Education and working with schools see:



Sample letter from PCP to teacher to complete Vanderbilt Teacher Assessments

Dear Teacher:

The parents of one of your students, _____, are seeking to have their child evaluated by our office for a health concern. As part of our evaluation process, we ask that both the child's parents and teacher complete a set of behavioral rating scales. This information is important for the diagnosis and treatment of your student.

Your time and cooperation in this matter is greatly appreciated. Attached to this letter are a set of teacher rating scales and questionnaires, the NCHD Vanderbilt Teacher Assessment Scale.

Generally, the teacher who spends the most time with the child should complete the teacher rating scales. However, if the child has more than one primary teacher, or has a special education teacher, it would be useful for us to obtain a separate set of rating scales from each teacher. If more than one set of rating scales is required, please have the parent contact us directly at our clinic number and we will forward additional rating scales as needed. Please note that the same teacher should complete each entire set of forms.

Please fill out the forms as completely as possible. If you do not know the answer to a question, please write "Don't know," so that we can be sure the item was not simply overlooked. Some of the questions in the rating scales may seem redundant. This is necessary to ensure that we obtain accurate diagnostic information.

We ask that you complete these forms as soon as possible, as we are unable to begin a child's evaluation without the teacher rating scales. The forms should be mailed to us directly in the envelope provided.

Thank you for your assistance and cooperation in the completion of these forms. If you have any questions regarding the enclosed materials, or if you would like additional information regarding services provided, please do not hesitate to contact us.

Sincerely,

Sample letter from parent to school to request educational evaluation of child with ADHD

Dear _____,

I am requesting that my child, _____, be evaluated for special education services and/or accommodations granted under Section 504 of the Individuals with Disabilities Education Act (IDEA). I am concerned that _____ is having difficulty and may need special help in order to learn.

For the last _____ years, classroom teachers have noted that my child has difficulty completing assignments, is experiencing problems with excessive inactivity and/or is unable to sit still and stay focused. Please note that _____ has diagnosed my child as having Attention Deficit/Hyperactivity Disorder (ADHD). _____ is concerned that _____'s ADHD is resulting in decreased attention in the classroom and may be significantly impacting _____ school performance, learning, and behavior.

I would like to meet with all those who will be doing the evaluation before my child is tested so that they share information about _____ with them. I understand that the evaluation is provided at no cost to me. I also understand that I must provide written permission for these tests to be administered and will be happy to do so once I have received all the appropriate forms and an explanation of the process. I will also expect a copy of the written report generated by each evaluator so that I may review them before the IEP or 504 planning meeting.

I look forward to hearing from you at your earliest convenience so that we may begin preparations for the evaluation.

Sincerely,

Toolkit Collaboration Team
 Dr. Andrew Harper, MD
 Dr. Lia Rodriguez, MD
 Jonathan Vecchiet, PharmD
 Jenny Rowlands, MPH CHES



References

- ¹Source: CDC <https://www.cdc.gov/ncbddd/adhd/facts.html>
- ²Source: <http://www.chadd.org/Understanding-ADHD/For-Professionals.aspx>
- ³Source: CDC <https://www.cdc.gov/ncbddd/adhd/facts.html>
- ⁴Source: Intermountain Health and text from TCHP collaboration team
- ⁵Source: Intermountain Health
- ⁶Source: NICHQ <http://www.nichq.org/childrens-health/adhd/resources/vanderbilt-assessment-scales>
- ⁷Source: <https://www.cdc.gov/ncbddd/adhd/diagnosis.html>
American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 5th edition. Arlington, VA., American Psychiatric Association, 2013.
- ⁸Source: Intermountain Health
- ⁹Source: <http://www.ceasar-boston.org/CRAFFT/index.php>
- ¹⁰Source: Intermountain Health
- ¹¹Source: <http://doctorssearch.tchp.us/iDirectory/applicationspecific/search.asp>
- ¹²Source: the CDC <https://www.cdc.gov/ncbddd/adhd/behavior-therapy.html>
- ¹³Source: CDC website: <https://www.cdc.gov/ncbddd/adhd/conditions.html>
- ¹⁴Source: Intermountain Health
- ¹⁵Source: Intermountain Health
- ¹⁶Source: <http://www.healthline.com/health/adhd/top-iphone-android-apps#1>
- ¹⁷Source: National Resource Center on ADHD: a program of CHADD
- ¹⁸Source: From TCH EPIC
- ¹⁹Source: CHADD- <http://www.chadd.org/Understanding-ADHD/For-Parents-Caregivers/Education/Homework-Help-for-ADHD.aspx>
- ²⁰Source: Intermountain Health
- ²¹Source: <http://www.chadd.org/Understanding-ADHD/For-Parents-Caregivers/Education/Tips-for-Talking-to-Teachers-about-ADHD.aspx>

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