Treating ADHD: Medications and Parent Training & Behavior Management (PTBM)

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Disclosures:

- Dr. Koutras:
  - I have no relevant financial relationships to disclose or conflicts of interest to resolve
  - I will discuss no unapproved or off-label pharmaceuticals
- Dr. Hegg:
  - I have no relevant financial relationships to disclose or conflicts of interest to resolve
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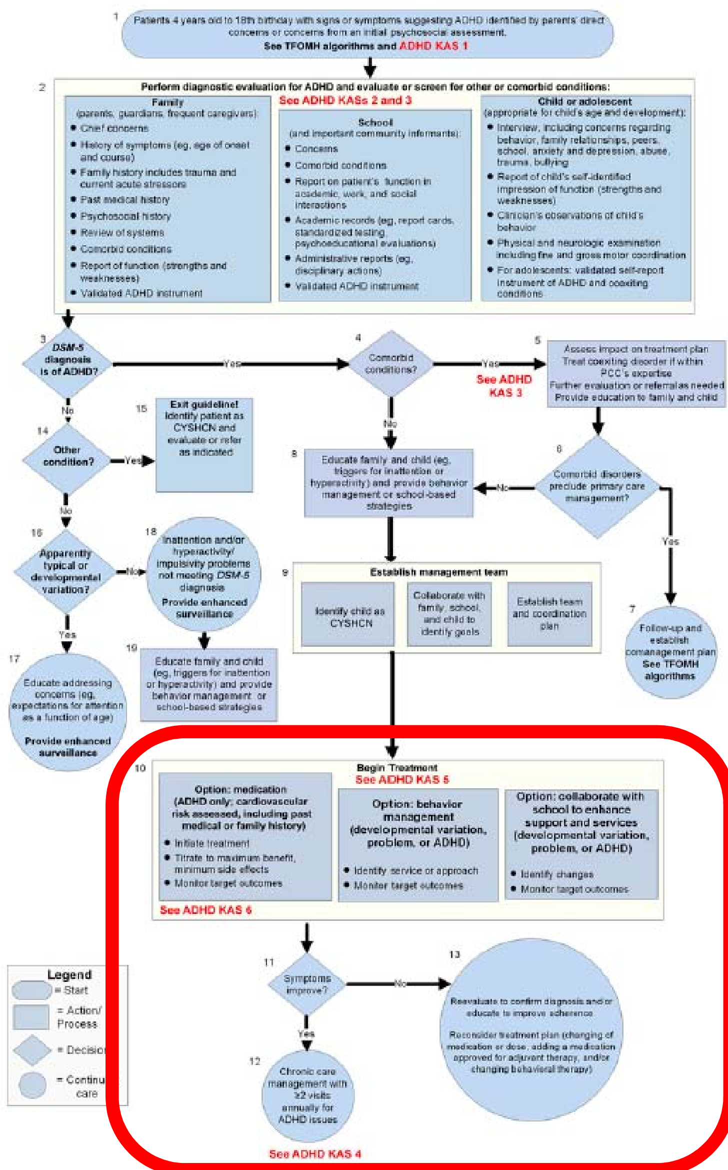

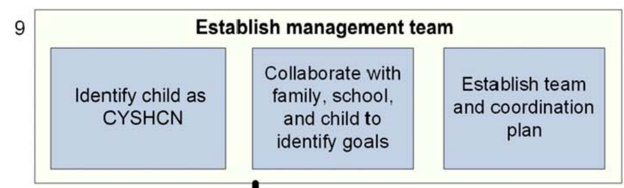

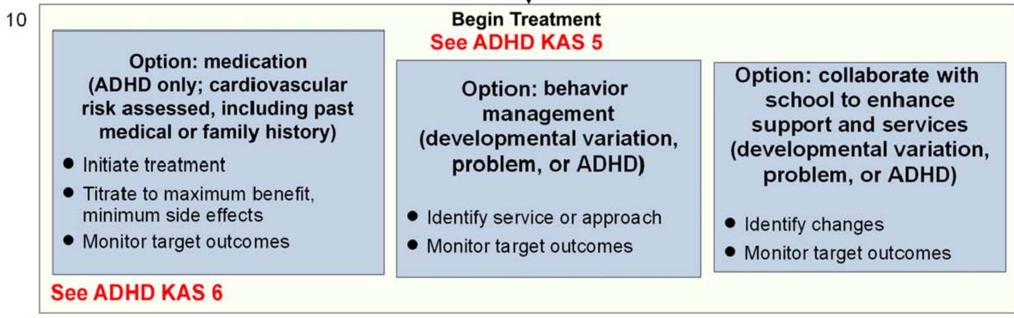

SUPPLEMENTAL FIGURE 7

Treatment. CYSHCN, children and youth with special health care needs.

Wolraich ML, Hagan JF, Allan C, et al. SUBCOMMITTEE ON CHILDREN AND ADOLESCENTS WITH ATTENTION-DEFICIT/HYPERACTIVE DISORDER. Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents. *Pediatrics*. 2019;144:e20192528

Parent Training & Behavior Management (PTBM)

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TABLE 6 KAS 5a: For preschool-aged children (age 4 years to the sixth birthday) with ADHD, the PCC should prescribe evidence-based behavioral PTBM and/or behavioral classroom interventions as the first line of treatment, if available (grade A: strong recommendation). Methylphenidate may be considered if these behavioral interventions do not provide significant improvement and there is moderate-to-severe continued disturbance in the 4- through 5-year-old child's functioning. In areas in which evidence-based behavioral treatments are not available, the clinician needs to weigh the risks of starting medication before the age of 6 years against the harm of delaying treatment (grade B: strong recommendation).	
Aggregate evidence quality	Grade A for PTBM; Grade B for methylphenidate

TABLE 7 KAS 5b: For elementary and middle school–aged children (age 6 years to the 12th birthday) with ADHD, the PCC should prescribe US Food and Drug Administration (FDA)–approved medications for ADHD, along with PTBM and/or behavioral classroom intervention (preferably both PTBM and behavioral classroom interventions). Educational interventions and individualized instructional supports, including school environment, class placement, instructional placement, and behavioral supports, are a necessary part of any treatment plan and often include an Individualized Education Program (IEP) or a rehabilitation plan (504 plan). (Grade A: strong recommendation for medications; grade A: strong recommendation for PTBM training and behavioral treatments for ADHD implemented with the family and school.)	
Aggregate evidence quality	Grade A for Treatment with FDA-Approved Medications; Grade A for Training and Behavioral Treatments for ADHD With the Family and School.

TABLE 8 KAS 5c: For adolescents (age 12 years to the 18th birthday) with ADHD, the PCC should prescribe FDA-approved medications for ADHD with the adolescent's assent (grade A: strong recommendation). The PCC is encouraged to prescribe evidence-based training interventions and/or behavioral interventions as treatment of ADHD, if available. Educational interventions and individualized instructional supports, including school environment, class placement, instructional placement, and behavioral supports, are a necessary part of any treatment plan and often include an IEP or a rehabilitation plan (504 plan). (Grade A: strong recommendation.)	
Aggregate evidence quality	Grade A for Medications; Grade A for Training and Behavioral Therapy

Wolraich ML, Hagan JF, Allan C, et al. SUBCOMMITTEE ON CHILDREN AND ADOLESCENTS WITH ATTENTION-DEFICIT/HYPERACTIVE DISORDER. Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents. *Pediatrics*. 2019;144:e20192528

Key Action Statements (KAS)

KAS	Age Band	First Line	Second Line	Extra Considerations
KAS 5a	4:0 – 5:12	PTBM and/or Behav Class Int	Methylphenidate	
KAS 5b	6:0 – 11:12	FDA-approved med + PTBM and/or Behav Class Int		IEP, 504 Plan
KAS 5c	12:0 – 18:0	FDA-approved med		PTBM & BCI “if available”; IEP, 504 Plan

Wolraich ML, Hagan JF, Allan C, et al. SUBCOMMITTEE ON CHILDREN AND ADOLESCENTS WITH ATTENTION-DEFICIT/HYPERACTIVE DISORDER. Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents. *Pediatrics*. 2019;144:e20192528

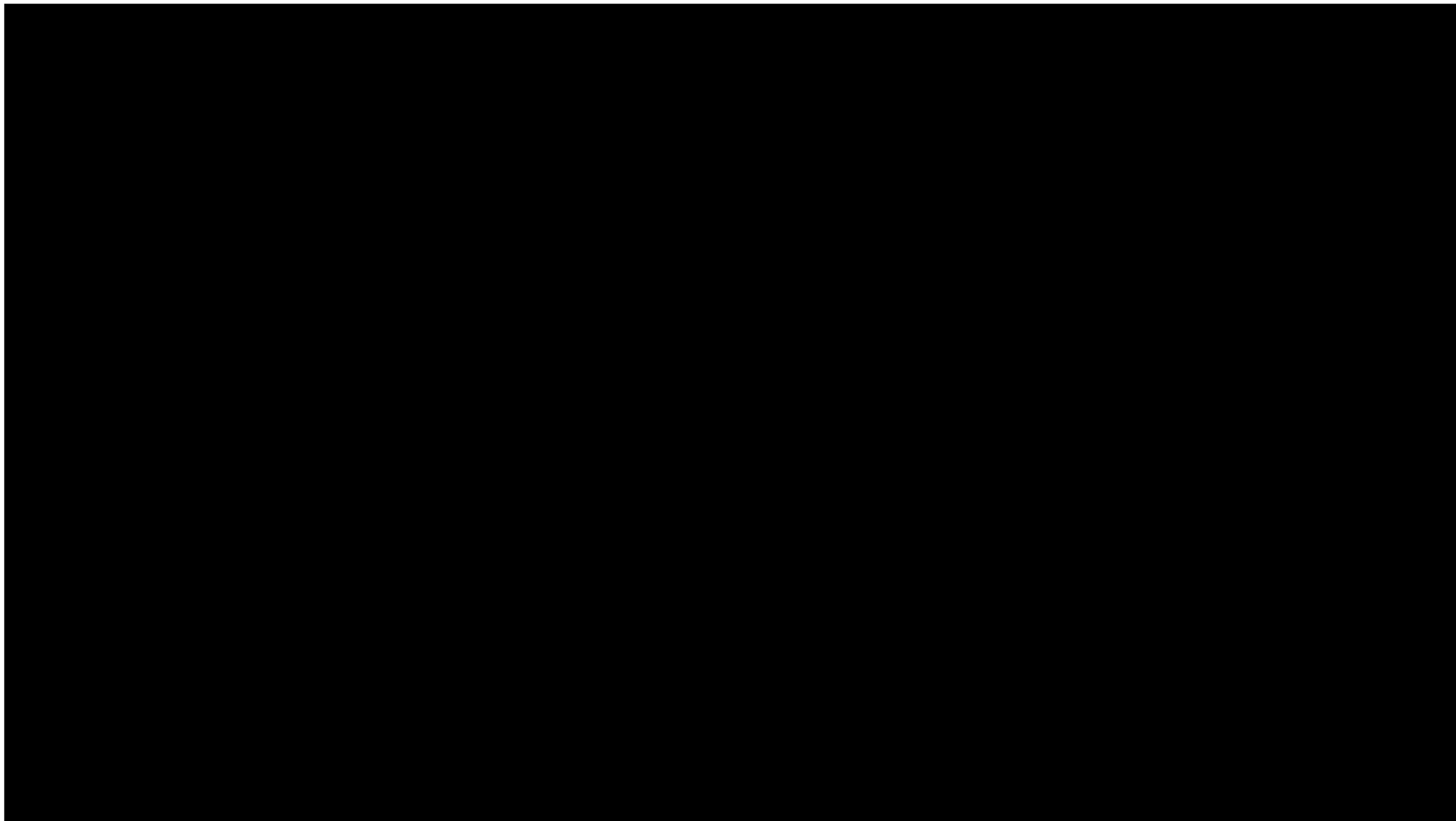
Parent Training & Behavior Management (PTBM)

Level 1: Well-established	Behavioral Parent Training (P, E)	Behavioral Classroom Management (P, E)	Behavioral Peer Intervention (E)	Organization Training (E, A)	Combined Behavior Management Interventions (P, E)
Level 2: Probably Efficacious	Combined Training Interventions (CTI-1)				
Level 3: Possibly Efficacious	Behavioral Parent Training (A)	Neurofeedback Training (E)			
Level 4: Experimental	Cognitive Training (E)	Combined Training Interventions (CTI-2)	Behavioral Parent Training (M)		
Level 5: Questionable Efficacy	Social Skills Training (E)	Physical Activity (E)	Omega 3/6 supplements (A)		

Note: P = preschool; E = elementary; A = adolescents; CTI-1 = combined training interventions that have extensive repetition of skills directly related to daily functioning; M = modified versions of behavioral parent training for specific populations of parents with elementary-school-age children; CTI-1 = combined training treatments with relevant skills and extensive practice and feedback; CTI-2 = combined training treatments that include skills relevant to daily functioning but with limited practice and feedback and includes cognitive behavioral techniques and brief behavioral parent training.

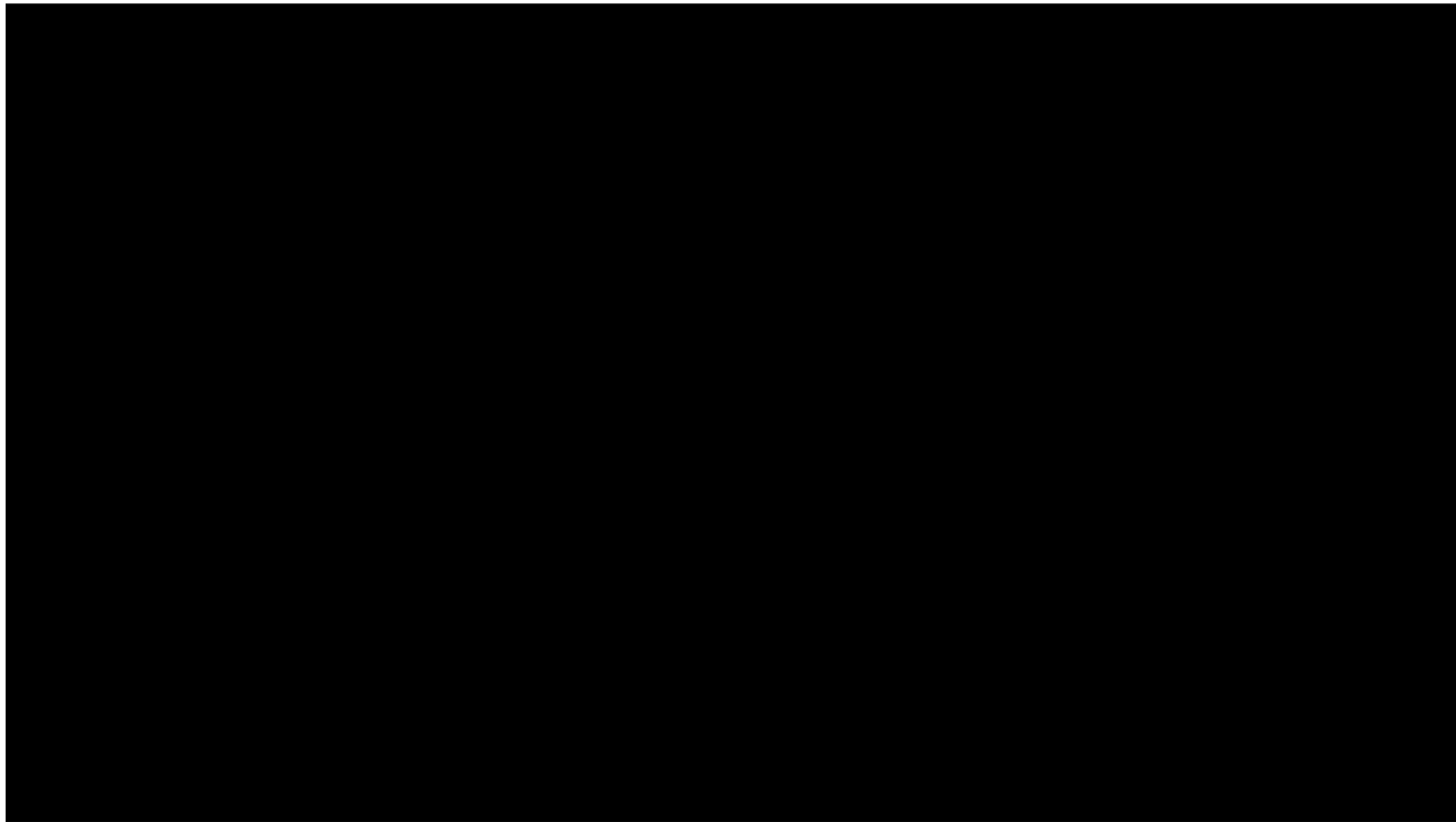
Evans, S. W., et al. (2018). "Evidence-Based Psychosocial Treatments for Children and Adolescents With Attention Deficit/Hyperactivity Disorder." J Clin Child Adolesc Psychol **47**(2): 157-198.

“You Know What I Mean? Giving Directions”



Centers for Disease Control and Prevention (CDC): https://www.cdc.gov/parents/essentials/videos/video_direct_vid.html

“How To Give Good Directions”



Centers for Disease Control and Prevention (CDC): https://www.cdc.gov/parents/essentials/videos/video_direct_vig.html

In-office Resources

- CDC Parenting Videos
  - Demo them in visit
  - Assign them as "homework" for parents/caregivers
- Importance of structure, labelled praise, sleep
  - It's hard to person (for any of us!) if we're not sleeping, don't expect a modicum of positive reinforcement, and have no clue about expectations
- STRONGLY recommend that a Daily Report Card (DRC) be implemented by the school
  - The school psychologist or guidance counselor should have these available, and can tailor them to the specific child
  - Also available through professional outlets (eg: NICHQ/AAP ADHD Resource Toolkits)
- Further Homework: Play with your kiddo, 10min/day, devoting your attention to them fully & narrating their play like a sportscaster
  - Resets your/their expectation about how you communicate with each other
  - Decreases sense of shame/stigma
  - Focuses instead on strengths

You have 7 minutes in a visit – what can you do?

- Use MI approaches to elicit behavior change in parents about how they interact with kids
- First pass intervention is to get parents/caregivers to set aside dedicated, unfettered, 1:1 time with their kiddo
  - Non-evaluative labelled praise
  - No “Righting Reflex”
  - Goal is to change
    - kid’s sensitivity to redirection & expectation for parent-child interaction (from expecting conflict to expecting warmth/praise, which increases likelihood of compliance)
    - Kid’s sense of self-esteem
    - Kid’s motivation
    - Parent’s sense/understanding of their kid
    - (re-)build play in the parent-child dynamic
- CDC Parenting Videos
  - Demo them in visit
  - Assign them as “homework” for parents/caregivers
- STRONGLY recommend that a Daily Report Card (DRC) be implemented by the school
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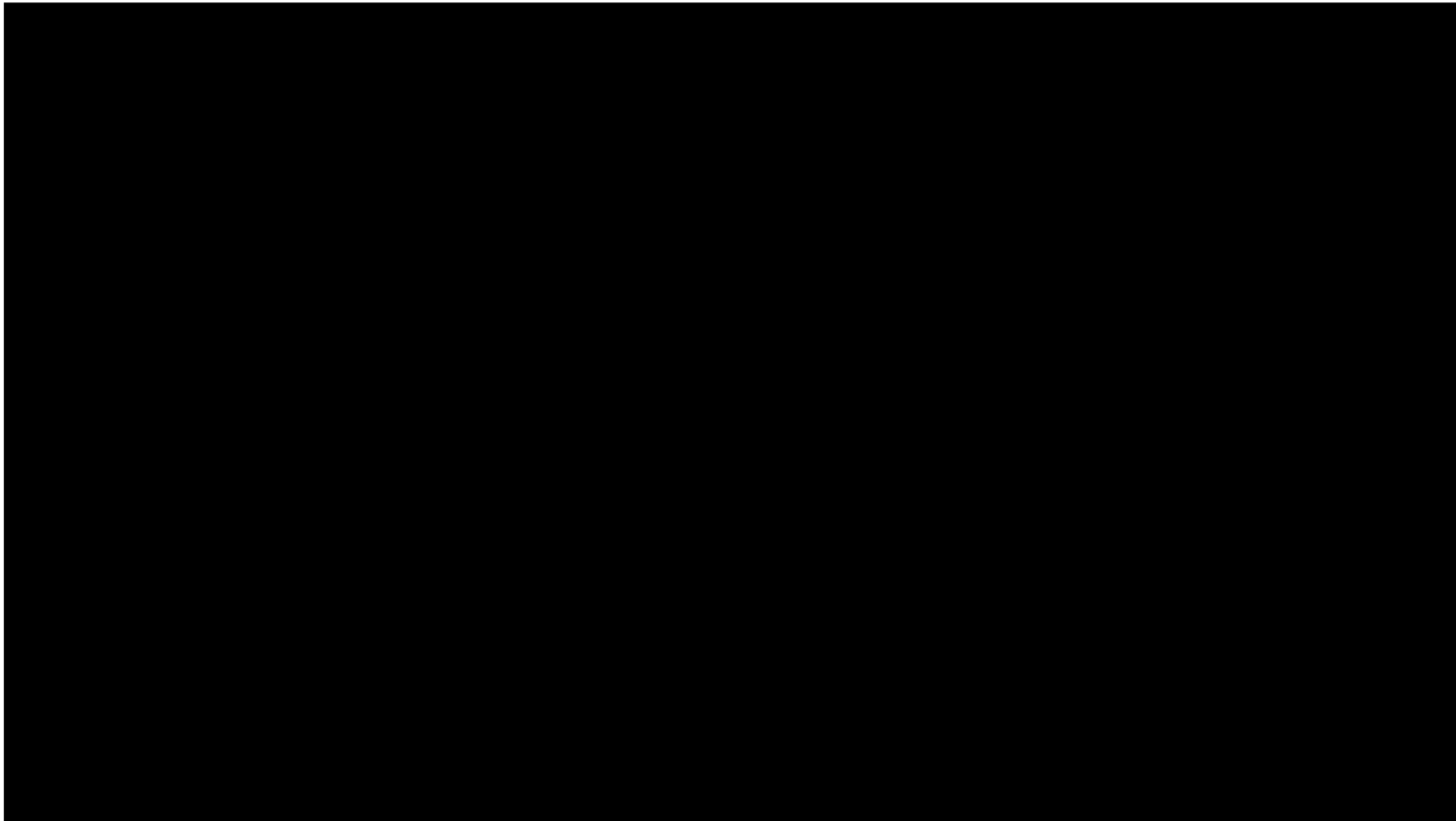
Did you say play?



GoNoodle Get Moving: https://www.youtube.com/watch?v=TGiYrY2bUPc

Daily School Report Card
Circle Y (Yes) or N (No)

Child's Name ________________________ Medication ______________ Today's Date _____________

	Subjects/Times						
1. ____________	Y N	Y N	Y N	Y N	Y N	Y N	Y N
2. ____________	Y N	Y N	Y N	Y N	Y N	Y N	Y N
3. ____________	Y N	Y N	Y N	Y N	Y N	Y N	Y N
4. ____________	Y N	Y N	Y N	Y N	Y N	Y N	Y N
5. ____________	Y N	Y N	Y N	Y N	Y N	Y N	Y N
6. ____________	Y N	Y N	Y N	Y N	Y N	Y N	Y N
7. ____________	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Teacher's Initials							
Total number of Yeses							
Total number of Nos							

Comments:

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How to Establish a School-Home Daily Report Card

Sample Report Card Targets

Academic Productivity

Completes X assignments within the specified time
Completes X assignments with X% accuracy

Starts work with X or fewer reminders

Leaves appropriate spaces between words X% of the time or assignment
Writes legibly/uses 1-line cross outs instead of scribbles/writes on the lines of the paper
Corrects assignments appropriately*
Turns in assignments appropriately*

Appropriately* asks an adult for help when needed
Maintains appropriate* eye contact when talking to an adult with X/fewer than X prompts to maintain eye contact
Respects adults (talks back fewer than X times per period)
Complies with X% of teacher commands/requests/Fewer than X noncompliances per period

Behavior Outside the Classroom

Follows rules at lunch/recess/free time/gym/specials/assemblies/bathroom/in hallway with X or fewer rule violations
Walks in line appropriately*/Follows transition rules with X or fewer violations

How to Establish a School-Home Daily Report Card

Sample Home Rewards

Daily Rewards

Snacks
Dessert after dinner
Staying up X minutes beyond bedtime
Having a bedtime story/Reading with a parent for X minutes
Choosing a radio station in car
Extra bathtub time for X minutes
Educational games on computer for X minutes
Choosing family TV show
Talking on phone to friend (local call)
Video game time for X minutes

Sample School Rewards*

Talk to best friend
Listen to tape player (with headphones)
Read a book
Help clean up classroom
Clean the erasers
Wash the chalkboard
Be teacher's helper
Eat lunch outside on a nice day
Extra time at recess
Write on chalkboard
Use magic markers

Myths

- “Parent training doesn’t help classroom behavior”
- “I’ve already tried everything”
- “CBD cured my ADHD, so it will obviously cure my child’s ADHD”
- “All that time playing Fortnite is causing this”
- “But they’re already seeing a therapist…”
- “Those programs aren’t for people like me or my kid”

Working With Mental Health Providers

- Don’t ask, EXPECT to see a treatment plan
  - Interventions planned
  - Goals
  - Data!!
- “How frequently can I expect to hear from you?”
- Routine depression/anxiety care can involve surveillance of ADHD sxs
  - And it should: mood/anx sxs not uncommon with ADHD – related? Perhaps!

Medications for ADHD Symptoms

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Psychostimulants

- Methylphenidate (MPH)
  - Ritalin, Ritalin-SR, Ritalin-LA
  - Metadate, Metadate-ER, Metadate-CD
  - Concerta
  - Methylin, Methylin-ER
  - Daytrana Trandermal Patch
  - Dexmethylphenidate (Focalin, Focalin-XR)
  - Quivillant
- Mixed Amphetamine Salts (AMP)
  - Adderall, Adderall-XR
- Dextroamphetamine (Dex)
  - Dexedrine, Dextrostat
  - Lisdexamfetamine (Vyvanse)

Psychostimulants

- Beyond use for ADHD, they have acute antidepressant effects (in late-life depression), BUT they can also have some anxiogenic effect
  - Antidepressant effects generally NOT clear for children, and not initiated for this effect in children and adolescents in absence of ADHD
  - Anxiogenic effects can increase irritability and decrease concentration – with comorbid anxiety disorders (such as generalized anxiety disorder), or Post-traumatic Stress Disorder (PTSD)
    - Alpha-2 agonists (clonidine dosed TID, Kapvay BID, guanfacine BID, Intuniv qD)
    - Atmoxetine (Straterra)
- Established for ADHD and narcolepsy; randomized controlled trials in other neurobehavioral disorders are relatively rare.

Psychostimulants

- Psychostimulants treatment gold-standard for uncomplicated ADHD
- With respect to individual stimulants, all appear to be **equally effective in treatment of ADHD**, but they have different time courses
  - Although there is equal efficacy, there is considerable variability in individual response to each stimulant
  - **Methylphenidate may have better efficacy/tolerability profile in children**, and amphetamine better efficacy/tolerability profile in adults (Cortese S, et al., Lancet Psychiatry 2018)

Medication discontinuation

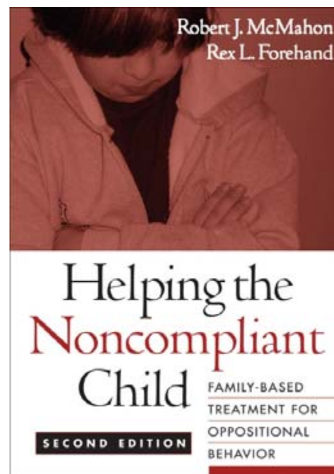
- No clear guidelines of when to do a trial off of medications
- Ask about hyperactivity/impulsivity levels when a dose is missed – safety concerns
- Ask driving history -- ‘near misses or accidents’ and details
- Ask school/work history if misses doses – careless mistakes and ability to complete tasks (efficiency is relative)
- Consider trial off on vacations or school breaks – probably should be attempted every 2-3 years unless safety concerns without medication
- **Weight gain** with discontinuation can be significant – review need for diet (i.e. drinks) and exercise adjustments

Resources

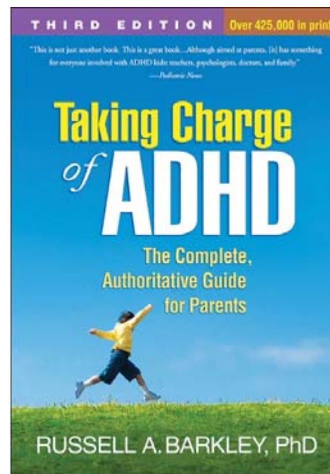
- CDC Positive Parenting Skills
  - https://www.cdc.gov/parents/essentials/videos/index.html
  - Short example and how-to videos for basic parent training in behavior management (PTBM), available in English & Spanish.
- Effective Child Therapy: Evidence-based mental health treatment for children and adolescents
  - https://effectivechildtherapy.org/concerns-symptoms-disorders/disorders/inattention-and-hyperactivity-adhd/#effective-treatments
  - Overview of evidence-based psychosocial treatments for ADHD
- American Academy of Child and Adolescent Psychiatry (AACAP) Facts for Families: ADHD
  - https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Children-Who-Cant-Pay-Attention-Attention-Deficit-Hyperactivity-Disorder-006.aspx
  - Quick overview of ADHD: core symptoms and treatment options

Resources (Cont'd)

Helping the Noncompliant Child



Taking Charge of ADHD



Managing ADHD In School