Mental Health Care Guide

For Primary Care Clinicians

Attention Deficit Hyperactivity Disorder (ADHD/ADD)

OPAL-K

Oregon Psychiatric Access Line about Kids

DOERNBECHER CHILDREN'S HOSPITAL
OHSU
Oregon Health & Science University

C. OPAL-K Attention Deficit Hyperactivity Disorder (ADHD/ADD) Care Guide

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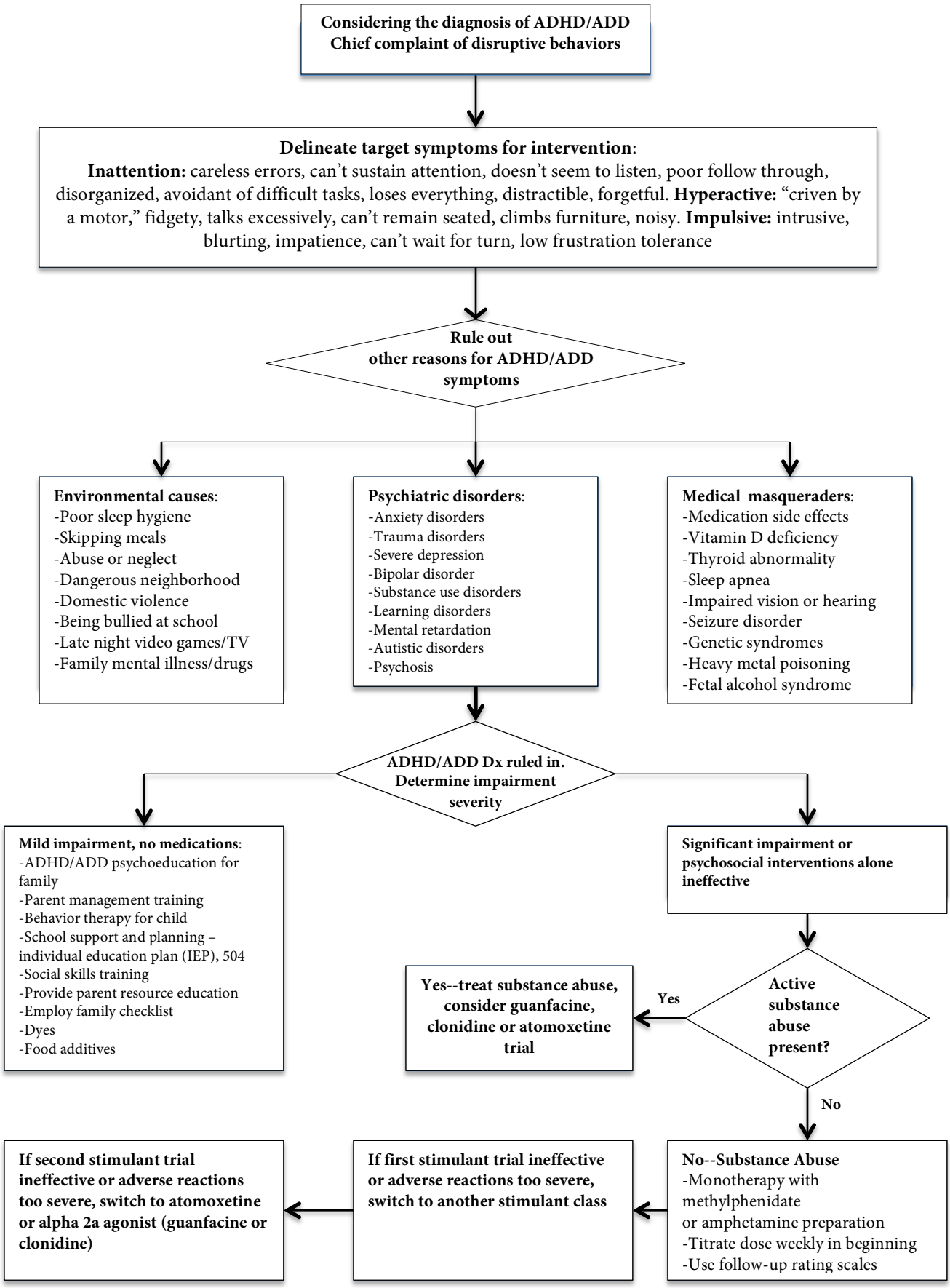
C1: Opal-K Assessment & Treatment Flow Chart For Attention Deficit Hyperactivity Disorder (ADHD/ADD)



C2: ADHD/ADD OPAL-K Assessment Guidelines for Primary Care Clinicians

Interview/History

- Look for environmental causes of inattention/hyperactivity: poor sleep hygiene (playing video games all night), poor eating habits (no breakfast or lunch), trauma (being bullied at school or abused at home)
- Obtain information to rule in or rule out co-morbid diagnoses, particularly anxiety disorders, low IQ, learning disability, PTSD and depression
- Timeline for onset of symptoms will help rule in other causes of symptoms (although inattentive ADHD is frequently missed in early school years)
- Obtain school records whenever possible for diagnostic clarification and later comparison
- Some children and parents will have no idea about the presence of symptoms they assume the behavior is normal, e.g., "That's just the way boys are"
- Check for parenting styles to assist in parental guidance and counseling later

Mental Status Exams (MSE)

- Lack of hyperactivity or ability to focus during office visit does not rule out ADHD diagnosis
- Have child perform simple tasks to rule out learning problems like reading out loud, writing, calculations and other age-appropriate cognitive and concentration activities
- Use puzzles and books (*Where's Waldo*, *I Spy*) that test concentration and focus and frustration tolerance

Rating Scales

- Rating scales alone should not be used to make the diagnosis of ADHD/ADD
- Rating scale for teachers and parents are crucial for ruling out parental/teacher bias
- Baseline scales can be used for later comparison to monitor efficacy and dose titration
- Free ADHD scales, such as the Vanderbilt Assessment Scale, are available online (See page C3 – C9)

Tests and Labs

- Lead levels usually not positive unless child has pica or lives in contaminated home
- Consider sleep study, EEG, ferritin and thyroid levels when indicated from history
- ADHD/ADD is still a clinical diagnosis. There is no specific single psychological test or brain scan that rules in the diagnosis of ADHD/ADD
- Psychological testing can be useful to rule in diagnosis (in subtle cases particularly in ADHD inattentive type) and rule out other issues such as learning disability or borderline intellectual functioning

Vanderbilt ADHD Diagnostic Parent Rating Scale

Patient Name: _____ **Today's Date:** _____

Date of Birth: _____ **Age:** _____

Grade: _____

Each rating should be considered in the context of what is appropriate for the age of your child.

Frequency Code: 0 = Never; 1 = Occasionally; 2 = Often; 3 = Very Often

1. Does not pay attention to details or makes careless mistakes, such as in homework	0	1	2	3
2. Has difficulty sustaining attention to tasks or activities	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through on instruction and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by extraneous stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs excessively in situations when remaining seated is expected	0	1	2	3
13. Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes on others (butts into conversations or games)	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to comply with adults' requests or rules	0	1	2	3

Vanderbilt ADHD Diagnostic Parent Rating Scale

Each rating should be considered in the context of what is appropriate for the age of your child.

Frequency Code: 0 = Never; 1 = Occasionally; 2 = Often; 3 = Very Often

22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and vindictive	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Initiates physical fights	0	1	2	3
29. Lies to obtain goods for favors or to avoid obligations ("cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen items of nontrivial value	0	1	2	3
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3

Vanderbilt ADHD Diagnostic Parent Rating Scale

Each rating should be considered in the context of what is appropriate for the age of your child.

Frequency Code: 0 = Never; 1 = Occasionally; 2 = Often; 3 = Very Often

45. Feels lonely, unwanted, or unloved; complains that "no one loves" him or her	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance

	Problematic		Average		Above Average
Academic Performance					
1. Reading	1	2	3	4	5
2. Mathematics	1	2	3	4	5
3. Written expression	1	2	3	4	5
Classroom Behavior					
1. Relationships with peers	1	2	3	4	5
2. Following directions/rules	1	2	3	4	5
3. Disrupting class	1	2	3	4	5
4. Assignment completion	1	2	3	4	5
5. Organizational skills	1	2	3	4	5

VANDERBILT ADHD DIAGNOSTIC PARENT RATING SCALE (VADPRS)

Scoring Instructions for the VADPRS:

Behaviors are counted if they are scored 2 (often) or 3 (very often).

Predominantly inattentive subtype	Requires 6 or more counted behaviors on items 1 through 9 and a performance problem (score of 1 or 2) in any of the items on the **performance section**.
Predominantly hyperactive/ impulsive subtype	Requires 6 or more counted behaviors on items 10 through 18 and a performance problem (score of 1 or 2) in any of the items on the **performance section**.
Combined subtype	Requires 6 or more counted behaviors each on both the inattention and hyperactivity/impulsivity dimensions.
Oppositional-defiant disorder	Requires 4 or more counted behaviors on items 19 through 26.
Conduct disorder	Requires 3 or more counted behaviors on items 27 through 40.
Anxiety or depression	Requires 3 or more counted behaviors on items 41 through 47

The **performance section** is scored as indicating some impairment if a child scores 1 or 2 on at least 1 item.

Vanderbilt ADHD Diagnostic Teacher Rating Scale

Patient Name: _____ **Today's Date:** _____

Date of Birth: _____ **Age:** _____

Grade: _____

Each rating should be considered in the context of what is appropriate for the age of the children you are rating.

Frequency Code: 0 = Never; 1 = Occasionally; 2 = Often; 3 = Very Often

1. Fails to give attention to details or makes careless mistakes in schoolwork	0	1	2	3
2. Has difficulty sustaining attention to tasks or activities	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through on instruction and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustaining mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by extraneous stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
12. Runs about or climbs excessively in situations in which remaining seated is expected	0	1	2	3
13. Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks excessively	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting in line	0	1	2	3
18. Interrupts or intrudes on others (eg, butts into conversations or games)	0	1	2	3
19. Loses temper	0	1	2	3
20. Actively defies or refuses to comply with adults' requests or rules	0	1	2	3
21. Is angry or resentful	0	1	2	3

Vanderbilt ADHD Diagnostic Teacher Rating Scale

Each rating should be considered in the context of what is appropriate for the age of the children you are rating.

Frequency Code: 0 = Never; 1 = Occasionally; 2 = Often; 3 = Very Often

22. Is spiteful and vindictive	0	1	2	3
23. Bullies, threatens, or intimidates others	0	1	2	3
24. Initiates physical fights	0	1	2	3
25. Lies to obtain goods for favors or to avoid obligations (ie, "cons" others)	0	1	2	3
26. Is physically cruel to people	0	1	2	3
27. Has stolen items of nontrivial value	0	1	2	3
28. Deliberately destroys others' property	0	1	2	3
29. Is fearful, anxious, or worried	0	1	2	3
30. Is self-conscious or easily embarrassed	0	1	2	3
31. Is afraid to try new things for fear of making mistakes	0	1	2	3
32. Feels worthless or inferior	0	1	2	3
33. Blames self for problems, feels guilty	0	1	2	3
34. Feels lonely, unwanted, or unloved; complains that "no one loves" him or her	0	1	2	3
35. Is sad, unhappy, or depressed	0	1	2	3

Performance

	Problematic		Average	Above Average	
Academic Performance					
1. Reading	1	2	3	4	5
2. Mathematics	1	2	3	4	5
3. Written expression	1	2	3	4	5
Classroom Behavioral Performance					
1. Relationships with peers	1	2	3	4	5
2. Following directions/rules	1	2	3	4	5
3. Disrupting class	1	2	3	4	5
4. Assignment completion	1	2	3	4	5
5. Organizational skills	1	2	3	4	5

VANDERBILT ADHD DIAGNOSTIC TEACHER RATING SCALE (VADTRS)

Scoring Instructions for the VADTRS:

Behaviors are counted if they are scored 2 (often) or 3 (very often).

Inattention	Requires 6 or more counted behaviors from questions 1 through 9 for indication of the predominantly inattentive subtype.
Hyperactivity/ impulsivity	Requires 6 or more counted behaviors from questions 10 through 18 for indication of the predominantly hyperactive/impulsive subtype.
Combined subtype	Requires 6 or more counted behaviors each on both the inattention and hyperactivity/impulsivity dimensions.
Oppositional defiant and conduct disorders	Requires 3 or more counted behaviors from questions 19 through 28.
Anxiety or depression symptoms	Requires 3 or more counted behaviors from questions 29 through 35.

The **performance section** is scored as indicating some impairment if a child scores 1 or 2 on at least 1 item.

C10: OPAL-K Attention Deficit Hyperactivity Disorder (ADHD/ADD) Treatment Guidelines for Primary Care

Parental Guidance and Counseling

- The most important part of treating ADHD/ADD is parent education
- Parents are usually relieved to find that there is a biological base for hyperactivity and inattention
- Stress to parents that changes do not occur overnight. Improvement takes time
- Do not underestimate the power of praise by clinicians and parents
- Parental teamwork is crucial to success

Evidence-Based Psychotherapies

- Present research shows that "parenting skills training" is the most effective
- Cognitive behavioral therapies (CBTs) in general are not well supported in literature, particularly in younger children

Medication Considerations

- Stimulants are still considered the best initial pharmacotherapy for ADHD/ADD by most
- Stimulants to be given with food -- better absorbed and less chance for GI upset
- Stimulant Rx in general are not a risk for abuse when used as prescribed
- Consider using non stimulant when concerned about abuse in older youth. Use alpha 2a agonists for children with anxiety and trauma symptoms
- Remember to monitor for height, weight, pulse and blood pressure every visit
- Obtain baseline EKG if indicated (significant cardiac history, family cardiac history)

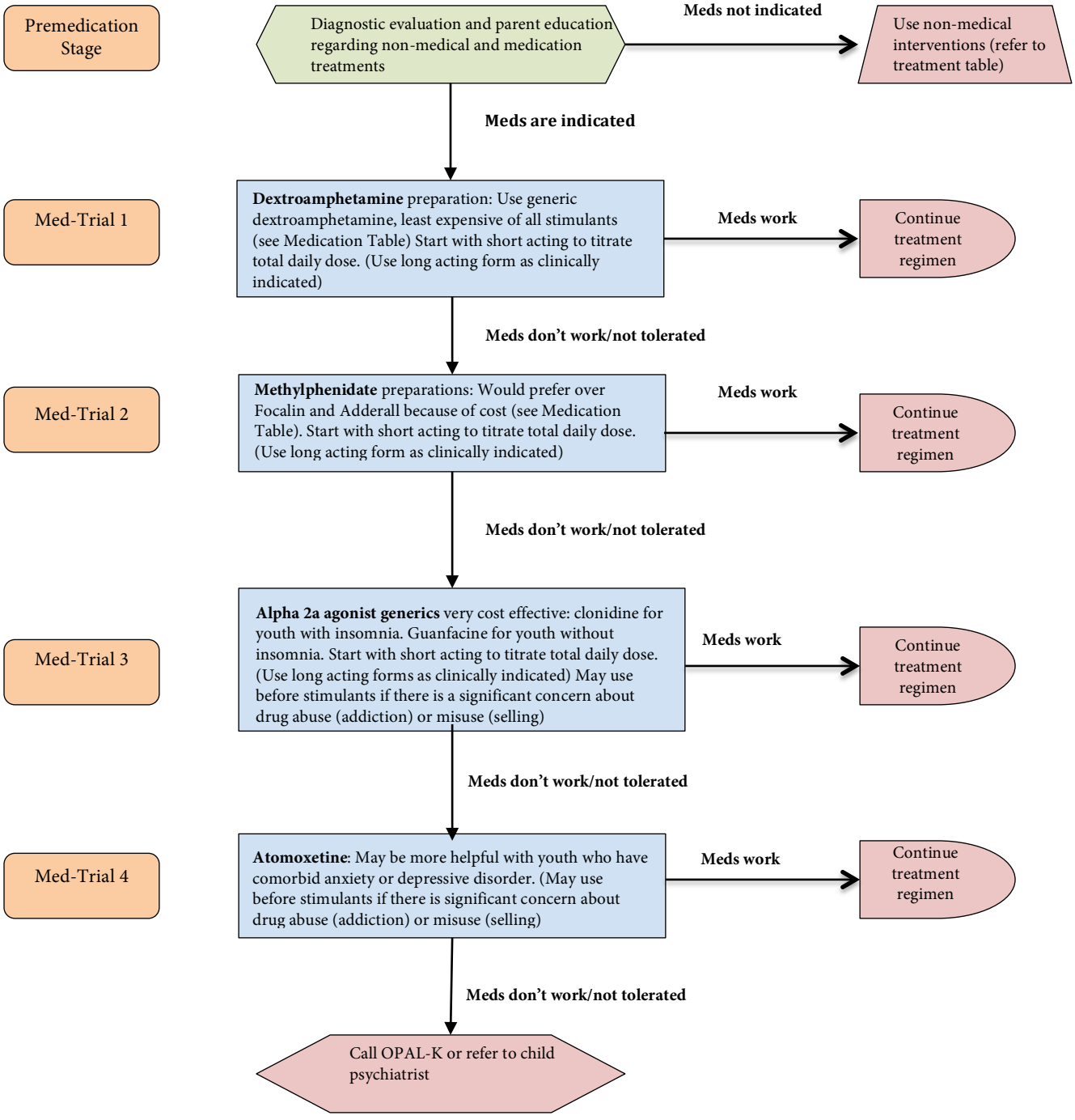
Other interventions

- Collaboration with school can be very useful, providing psychoeducation to teachers, supporting/suggesting Individualized Education Programs (IEPs) and 504 accommodation plans
- ADHD/ADD diagnosis will qualify youth for IEP
- Children frequently appreciate books on ADHD/ADD, being able to identify with an inattentive/impulsive story character decreases stigma
- Recently, more evidence supports dietary interventions for ADHD/ADD (for example, recent research warrants a second look at Feingold Diet)
- Biofeedback and sensory integration treatments **not** considered community standard

Resources

- Parent support groups
- Online information

C11: Opal-K Medication Treatment Algorithm For ADHD/ADD



C12 – C15: Stimulant Medications and Other Medications For ADHD/ADD

Medication information from www.epocrates.com

Drug/Action	Tablet Size/Cost per month from EPOCRATES Accessed 01/02/2012	Dosing	FDA Recommended Maximum Dose/Age Ranges	Duration of Effects	Common Side Effects
Methylphenidate Increased synaptic dopamine via decreased dopamine reuptake.					
Ritalin **Methylin** **Metadate** Generic	**Generic** 5 mg - $$ (20) 10 mg - $$ (20) 20 mg - $$ (20)	Initiate 5 mg BID to TID Increase by 5-10 mg increments up to 60 mg max. Estimated dose range .3-.6 mg/kg/dose	60 mgs 3 years+	About 3-4 hours	Insomnia, decreased appetite, weight loss, growth retardation, headache, irritability, stomachache and rebound agitation
Focalin (Isolated dextroisomer of methylphenidate)	5 mg - $$ (20) 10 mg - $$ (20)	Half the dose as noted for methylphendate	20 mgs 6 years+	About 3-4 hours	Same as above *May* be less prone to causing sleep or appetite disturbance
Focalin XR 50% short acting and 50% long acting	5 mg - $$$$(20) 10 mg - $$$$ (20) 15 mg - $$$$ 30 mg - $$$$	Double the dose of regular release Focalin once a day	20 mgs 6 years+	About 8 hours	Same as above
Ritalin SR **Methylin ER** **Metadate ER**	**Ritalin SR** 20 mg - $$$ (20) **Methylin ER** 10 mg - $$ (20) 20 mg - $$ (20) **Metadate ER** 20 mg - $$ (20)	Start with 20 mg daily. May combine with short acting for quicker onset	60 mgs 3 years+	Onset delayed for 60-90 minutes. Duration supposed to be 6-8 hours, but can be quite individual and unreliable	Same as above
Ritalin LA 50% immediate release beads and 50% delayed release beads **Metadate CD** 30% immediate release and 70% delayed release beads	**Ritalin LA** 10 mg - $$$$ (20) 20 mg - $$$$ (20) 30 mg - $$$$ (20) 40 mg - $$$$ (20) **Metadate CD** 10 mg - $$$ (20) 20 mg - $$$ (20) 30 mg - $$$ (20) 60 mg - $$$$ (20)	Initiate at 10-20 mg once daily. Adjust weekly in 10 mg increments to maximum of 60 mg taken once daily	60 mg 3 years+	Onset in 30-60 minutes. Duration about 8 hours	Same as above
Concerta 22% immediate release and 78% gradual release	18 mg - $$$$ (20) 27 mg - $$$$ (20) 36 mg - $$$$ (20) 54 mg - $$$$ (20)	Starting dose is 18 mg once daily, up to a max of 72 mg daily	72 mg 6 years+	Onset in 60-90 minutes. Duration about 10-14 hours	Same as above, but less rebound risk

Quillivant XR extended release oral suspension 20% immediate release 80% extended release **Product must be reconstituted by pharmacist only**	**Quillivant XR** All doses: $$$$	Initially, 20mg once daily in the morning. May increase by 10–20 mg per week if needed; max 60 mg daily	60 mg/day 6 years + Duration 8-12 hours		Same as above
Dextroamphetamine Increased synaptic dopamine via increase dopamine synthesis and release as well as decreased reuptake					
Dextrostat **Dexedrine**	**Dexedrine** 5 mg - $$$ (20) **Dextroamphetamine** 5 mg - $$ (20) 10 mg - $$ (20)	For ages 3 -5 years: initiate at 2.5 mg. Increase by 2.5 mg at weekly intervals, 6 years and older: initiate at 5 mg once or twice daily. 40 mg/day max	40 mgs 3 years+	Onset in 30-60 minutes. Duration about 4-5 hours	Insomnia, decreased appetite, weight loss, headache, irritability, stomachache Rebound agitation May also elicit psychotic symptoms and mania at higher rate than methylphenidate
Dexedrine Spansule dextroamphetamine sulfate ER	5 mg - $$$ (20) 10 mg - $$$$ (20) 15 mg - $$$$ (20)	Single daily dosing up to a maximum of 40 mg/day.	40 mgs 3 years+	Onset in 30-60 minutes Duration about 5-10 hours	Same as above
Mixed Amphetamine Salts Increased synaptic dopamine via increased dopamine synthesis and release as well as decreased reuptake	5 mg - $$ (20) 7.5 mg - $$ (20) 10 mg - $$ (20) 12.5 mg - $$ (20) 15 mg - $$ (20) 30 mg - $$ (20)				
Adderall	5 mg - $$$ (20) 10 mg - $$$ (20) 15 mg - $$$ (20) 20 mg - $$$ (20) 30 mg - $$$ (20)	Initiate at 5 or 10 mg each morning (age 6 and older). Max 30 mg per dose	40 mgs 6 years+	Onset in 30-60 minutes Duration about 4-5 hours	Same as above
Adderall XR 50% immediate release beads and 50% delayed release beads	5 mg - $$$$ (20) 10 mg - $$$$ (20) 15 mg - $$$$ (20) 20 mg - $$$$ (20) 25 mg - $$$$ (20) 30 mg - $$$$ (2)	Starting dose is 5 or 10 mg each morning (age 6 and older). May be adjusted in 5-10 mg increments up to 40 mg per day	30 mgs 6 years+	Onset in 60-90 minutes (possibly sooner) Duration 10-12 hours	Same as above
Vyvanse lidexamfetamime	20 mg - $$$$ (20) 30 mg - $$$$ (20) 40 mg - $$$$ (20) 50 mg - $$$$ (20) 60 mg - $$$$ (20) 70 mg - $$$$ (20)	Start at 20mg/day and increase by 10mg/week based on symptoms response	70 mg 6 years +	Prodrug is converted to active form Dextro-amphetamine in one hour Half-life is about 12 hours	Same as above

OTHER ADHD/ADD MEDICATIONS

Drug/Action	Tablet Size/Cost per month from EPOCRATES Accessed 01/02/2012	Dosing	FDA Recommen-dations for Maximum Dose & Age Range	Duration of Effects	Common Side Effects
ATOMOXETINE Selective norepinephrine reuptake inhibitor					
Strattera	10 mg - $$$$ (30) 18 mg - $$$$ (30) 25 mg - $$$$ (30) 40 mg - $$$$ (30) 60 mg - $$$$ (30) 80 mg - $$$$ (30) 100 mg- $$$$ (30)	Initiate at 0.5 mg/kg. The targeted clinical dose is 1.2 mg/kg, but titrate slowly at weekly intervals. Medication must be used each day	100 mgs 6 years+	Starts working within a few days to one week, but full effect may not be evident for a month or more. Duration of effect 24 hours	Decreased appetite, GI upset can be reduced if medication taken with food. Sedation can be reduced by dosing in evening. Lightheadedness. Risk of suicidal ideation and mania.
ALPHA-2 AGONISTS Increases norepinephrine via alpha-2 stimulation					
(Catapres)	**Catapres** 0.1mg - $$$ (60) 0.2 mg - $$$$ (60) 0.3 mg - $$$$ (60) **Generic** 0.1 mg - $$ (100) 0.2 mg - $$ (100) 0.3 mg - $$ (100)	Starting dose is .025 -.05 mg/day in evening. Increase by similar dose every 5-7 days, adding to morning, mid-day, possibly afternoon, and again evening doses in sequence. Total dose of 0.1-0.3mg/day divided into 3-4 doses		Onset in 30-60 minutes. Duration about 3-6 hours	Sleepiness, hypotension, headache, dizziness, stomachache, nausea, dry mouth, depression, nightmares. **Possible severe rebound hypertension if abruptly discontinued**
Kapvay **S**low release clonidine	**MedSaver card price** 0.1mg - $$$$ (75)	Long-acting form start 0.1 mg po once daily increase by 0.1mg/d every week as indicated			Same as short-acting clonidine
Catapres – TTS Transdermal Therapeutic System Patch	0.1 mg/d - $$$$ (4ea) 0.2 mg/d - $$$$ (4ea) 0.3 mg/d - $$$$ (4ea)	Corresponds to daily doses of 0.1 mg, 0.2 mg and 0.3 respectively. Cannot cut patch		Duration 4-5 days so avoids the vacillations in drug effect seen in tablets	Same as Catapres tablet, but 50% of children will have contact dermatitis
Guanfacine (Tenex) Guanfacine XR (Intuniv) (guanfacine)	**Generic** 1mg - $$ (30) 2mg - $$ (30) **Intuniv** 1 mg - $$$$ (30) 2 mg - $$$$ (30) 3 mg - $$$$ (30) 4 mg - $$$$ (30)	Starting dose is 0.5 mg/day in evening and increase by similar dose every 7 days as indicated in divided doses 2-3 times per day. Daily dose range 0.5 - 4mg/day. DO NOT skip days Intuniv is dosed once daily		Duration about 6-12 hours	Compared to clonidine, lower chances/severity of side effects, especially fatigue and depression. Also less headache, nausea, stomachache, dry mouth **Possible rebound hypertension if doses are missed**

C16: OPAL-K ADD/ADHD Checklist for Families with an ADHD/ADD Child

Living with a child who has ADHD/ADD can be very frustrating and at times overwhelming. The following checklist can help families become more effective in managing the behavior issues associated with ADHD/ADD children.

Checklist for parents:

- ☐ Children with ADHD/ADD need more attention: supervision, support and encouragement
- ☐ Constantly praise your child for positive behaviors every day, even every hour
- ☐ Eliminate any negative statements or scolding (try to stay positive)
- ☐ Help your child set up a written schedule for home and activities in the community
- ☐ Make sure schedule includes exercise, sleep and eating activities
- ☐ Be consistent with your expectations and rules, keep track of compliance and give rewards
- ☐ Prompt your child to make good choices, however if they are unable, tell them ahead of time that you will make choices for them when they are out of control
- ☐ Listen and empathize with anger and frustration, then coach child to make good decisions

Checklist for siblings:

- ☐ Make sure you understand what ADHD/ADD is and what to expect from your ADHD/ADD sibling
- ☐ Don't feel responsible for your sibling's behavior
- ☐ Don't be responsible for discipline, let your parents take care of consequences
- ☐ Don't hesitate to use your parents to assist in conflicts
- ☐ Don't hesitate to ask your parents for attention for yourself
- ☐ Do be patient if they are unable to meet your needs immediately
- ☐ Have a plan of how to handle negative attention-seeking behavior from your ADHD/ADD sibling

Checklist for schools:

- ☐ Provide regular feedback to parents about their child's progress
- ☐ Provide academic and behavioral tracking for parents
- ☐ Devise a reward program that can be used at home
- ☐ Praise the ADHD/ADD student whenever possible
- ☐ Assist in evaluation for individualized education program (IEP) or 504 accommodations when indicated

Checklist for child:

- ☐ Find one place to do your homework and one place to put school bag/backpack
- ☐ Prepare your school bag with packed assignments the night before school
- ☐ Make a schedule with your parents for homework, playtime, chores, sleeping and eating
- ☐ Make sure to tell your doctor if your medicine is bothering you.
- ☐ Make sure your teacher knows when you are having trouble with schoolwork
- ☐ Have a plan with your teacher about what to do when you are feeling hyper, frustrated or angry
- ☐ Let adults remind you when you are bothering peers so they continue to be your friends

C17 – C18: ADHD/ADD Resources For Patients, Families and Teachers

Books for Parents

"Taking Charge of ADHD: The Complete Authoritative Guide for Parents, 3rd Edition" (2005) by Russell A. Barkley, Ph.D.

"Raising Resilient Children: Fostering Strength, Hope and Optimism in Your Child" (2002) by Robert Brooks, Ph.D. and Sam Goldstein, Ph.D.

"Attention Deficit Disorder: The Unfocused Mind in Children and Adults" (2006) by Tom Brown, Ph.D.

"Delivered from Distraction: Getting the Most Out of Life with ADHD" (2005) by Edward M. Halowell, M.D. and John J. Ratey, M.D.

"Teenagers with ADD: A Parent's Guide" (1995) by Chris Zeigler Dendy, M.S.

"You Mean I'm Not Lazy, Stupid, or Crazy?" (2006) by Kate Kelly and Peggy Ramundo

Books for Youth

"Learning to Slow Down & Pay Attention: A Book for Kids about ADHD" (2004) by Kathleen Nadeau, Ph.D., Ellen Dixon, Ph.D., and Charles Beyl

"Jumpin' Johnny Get Back to Work: A Child's Guide to ADHD/Hyperactivity" (1981) by Michael Gordon, Ph.D.

"Smart but Scattered Teens: The Executive Skills Program for Helping Teens Reach Their Potential" (2013) by Richard Guare, PhD and Peg Dawson, Ed.D.

"The Survival Guide for Kids with ADD or ADHD" (2013) by John F. Taylor, Ph.D.

"Understanding my Attention Deficit Hyperactivity Disorder" (2008) by Kara Tamanini

"Putting on the Brakes: Understanding and Taking Control of Your ADHD" (2008) by Patricia Quinn, Ph.D. and Judith Stern, M.A.

C18: ADHD/ADD Resources For Patients, Families and Teachers (continued)

Websites/Online Resources

Children and Adults with ADHD (Support groups, information resource)
www.chadd.org

Oregon Family Support Network (OFSN)
www.ofsn.org

Teach ADHD (Teaching advice for ADHD kids)
www.teachadhd.ca

Parents Med Guide (Developed by AACAP and APA: quality information about medications for ADHD and more)
www.parentsmedguide.org

"What is Attention Deficit Hyperactivity (ADHD/ADD) Disorder?"
http://www.nimh.nih.gov/health/topics/attention-deficit-hyperactivity-disorder-adhd/index.shtml

National Resource Center on ADHD (information website developed by CHADD)
http://www.help4adhd.org/

Children Who Can't Pay Attention (Part of AACAP Facts for Families)
http://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/Facts_for_Families_Pages/Children_Who_Cant_Pay_Attention_ADHD_06.aspx

C19: OPAL-K ADHD/ADD Resources for Clinicians

Books for Clinicians

"Caring for Children with ADHD: A Resource Toolkit for Clinicians" (CD-ROM) by Mark Woolraich, M.D. (American Academy of Pediatrics)

"What Causes ADHD: Understanding What Goes Wrong and Why" (2009)
by Joel Nigg, Ph.D.

"ADHD: A Complete and Authoritative Guide" (American Academy of Pediatrics Press: 2004)
Authors: American Academy of Pediatrics, Sherill Tippins (Editor) , Michael I. Reiff, M.D. (Editor)

"ADHD in the Schools, Second Edition: Assessment and Intervention Strategies" (2005) by George J. DuPaul, Gary Stoner

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