Treatment of Hyperactive, Impulsive, and Inattentive Symptoms in the Context of ASD & ID

Many youth with ASD and ID experience symptoms of hyperactivity, impulsivity, and inattention (ADHD) similar to children without ASD and ID. Children and adolescents can benefit from the same evidence-based treatments successful with normal developing children.

In addition to the broad elements of the *Evaluation and Comprehensive Assessment* (always Level 0) on page 4, pay specific attention to:

Level 0 Comprehensive Assessment:

- Developmental history and cognitive assessment (neuropsychological or educational).
- ADHD symptom history.
- Parent and teacher rating scales.
- Teacher behavior reports.
- Parent involvement in community resources.
- Physical examination (if history of staring spells or focal neurological signs: EEG, MRI).

Level 1 Initial Treatment Plan – Stimulant monotherapy:

If child has comorbid ADHD consider methylphenidate as first line medication. Refer to the ADHD guidelines for children and adolescents available at ***medicaidmentalhealth.org*** for information about other stimulants.

Use stimulants with caution since adverse effects may be higher in youth with ASD and ID compared to normally developing youth with ADHD. Stimulants yield benefit in about 50% of children in the ASD and ID population. Close monitoring is recommended.

Level 2 Guanfacine*:

- Obtain resting blood pressure and heart rate at baseline and follow-up visits.
- ECG is not necessary if the child has no evidence of cardiac disease or known family history of sudden death.
- Continue to increase dose until ADHD symptoms are adequately controlled or treatment-limiting side effects emerge (max daily dose of 4mg).
- If partial response, consider combined treatment *(do not combine with clonidine)*.

Please refer to dosing table.

**Despite limited evidence guanfacine ER (Intuniv) may be considered after optimal daily dose of guanfacine is established.*

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Level 3 Atomoxetine:

- ✦ Obtain resting blood pressure and heart rate at baseline and follow-up visits.
- ✦ ECG is not necessary if the child has no evidence of cardiac disease or known family history of sudden death.
- ✦ Consider liver function tests if on other medications or history of hepatic dysfunction.

Please refer to dosing table.

Level 4 Partial Response – Combined Therapy:

Before combination therapy is initiated, when possible, reassess child and consider a specialist referral*.

If there is partial response with either guanfacine or atomoxetine for motor hyperactivity/impulsivity but inattention remains, interfering with functioning, consider addition of short acting methylphenidate (MPH) or amphetamine (AMP) preparation.

Psychosocial intervention is not as effective for core ADHD symptoms.

**Referral to child psychiatrist, pediatric neurologist, or developmental pediatrician.*

Hyperactive, Impulsive, and Inattention Behaviors				
Medication	**Starting Dose**	**Titration***	**Discontinuation**	**Comments**
Guanfacine**	0.5 mg q am	0.5 mg/ week b.i.d.	0.5 mg/ 3 days	Continue to increase until ADHD symptoms are adequately controlled or treatment-limiting side effects emerge (max daily dose of 4 mg).
Atomoxetine	10 mg q am	10 mg/ week	10 mg/ 3 days	Increase until symptoms are adequately controlled or treatment-limiting side effects emerge (max daily dose of 1.4 mg/kg or 100 mg). Can split dose twice daily if better tolerated. Can give qHS, but may be less effective.
MPH or AMP (Short Acting)	2.5 mg q am	2.5 mg/ 3-4 days	No tapering needed	—

**Note. Continue titration until symptoms are adequately controlled, treatment-limiting side effects emerge or max daily dose is reached.*

***Note. Clonidine / Clonidine ER is more sedating, may be considered if partial response to guanfacine. Clonidine dosing is 1/10 guanfacine dosing. Consider starting at qHS to generate tolerance to sedating effects.*

Treatment of Hyperactive, Impulsive, and Inattentive Symptoms in the Context of ASD & ID *(continued)*

References

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