Attention Deficit Hyperactivity Disorder (ADHD) in Children under Age 6

Level 0

Conduct comprehensive assessment, including clearly defined treatment expectations and treatment preference assessment. Rule out medical issues such as hearing loss and consider co-morbid developmental language disorder, Specific Learning Disorder or Autism Spectrum Disorder (ASD).

Facilitate family engagement and psychoeducation about ADHD (evidence-based behavioral interventions, educational interventions, and medication treatments).

Level 1

Provide evidence-based parent management/skills training or other behavioral intervention at home and/or school for a minimum of 12 weeks. In areas where such treatments are unavailable, weigh risks of starting medications against harm of delaying treatment.

If medications are used, response should be monitored using rating scales and appropriate health and safety assessments. Refer to General Principles of Practice Regarding the Use of Psychotropic Medications in Children under Age 6 on page 3. Use preschool dosing guidance and lowest efficacious dose. In particular, closely monitor height, weight and appetite to determine need for weight recovery interventions. Periodically assess continued benefit from medication administration.

Level 2

Initiate monotherapy with immediate-release methylphenidate (MPH) formulation.

Level 3

If MPH is successful, could consider switching to extended release MPH medication.

Level 4

If MPH is unsuccessful, and/or not tolerated, consider immediate-release amphetamine formulations which have FDA indication for ages 3 to 5 years old (limited clinical trial evidence base).

- Consider lisdexamfetamine, which has emerging clinical trial evidence.
- May consider atomoxetine, which does not have FDA indication, but clinical trial efficacy and safety data.
- May also consider alpha-2 agonists, but published data for ADHD are sparse.

Not Recommended:

- Immediate selection of long-acting stimulant preparations for preschoolers, prior to assessing stimulant response.
- Selection of extra-long duration stimulants (e.g., Mydayis® or Adhansia®)
- Antipsychotic medication to treat core symptoms of ADHD.
- Routine concurrent use of two or more alpha-2 agonists; this should be reserved for specific clinical indications, closely monitored for side effects, and maximum dose ranges need to account for additive effects.

Table 3.

ADHD Medication Treatment for Children under Age 6	
Drug Name	**Starting Dose Recommendation**
Methylphenidate and Amphetamine preparations	
Short-acting	
Methylphenidate[1] *Immediate Release:* Ritalin®, Methylin®, Methylin® Chewable Tablets, Methylin® Oral Solution	1.25 mg tid – titrate as needed to doses not exceeding 1 mg/kg/day. *Recommendations extrapolated from the Preschool ADHD Treatment Study (PATS).*
Methylphenidate[2] *Extended Release:* Aptensio XR®	10 mg/day – titrate as needed to doses not exceeding 1.5 mg/kg/day. *Recommendations extrapolated from the Childress et al. 2020 MPH-MLR Study.*
Amphetamine[3] *Immediate Release:* Mixed amphetamine salts (Adderall®), d-amphetamine (Zenzedi®, ProCentra® Oral Solution); d- & l-amphetamine (Evekeo®)	2.5 mg/day – titrate as needed to doses not exceeding 0.5 mg/kg/day. *Amphetamine target dose is generally one-half to two-thirds of methylphenidate dose.*
Amphetamine[4] *Extended Release:* Lisdexamfetamine (Vyvanse®)	5 mg/day – titrate as needed to doses not exceeding 30mg/day. *Recommendations extrapolated from the Childress et al. 2020 LDX study*
Selective norepinephrine inhibitor	
Atomoxetine[5] (Strattera®)	10 mg/day – titrate as needed to doses not to exceed 1.4 mg/kg/day. *Recommendations extrapolated from the Kratochvil et al. 2011 study.*
Alpha-2 Agonists[6]	
Clonidine (Catapres®, KAPVAY®) Guanfacine (Tenex®, Intuniv®)	Starting dose not to exceed: 0.05 mg/day *(clonidine)* 0.5 mg/day *(guanfacine)* Monitor carefully for excessive sedation, increased irritability. *Recommendations based on expert opinion.*

There are limited new data on use of amphetamines and extended-release stimulants in preschoolers, with more in the pipeline for inclusion in future guideline updates.

[1] No FDA indication for children younger than 6 years old; based on Preschool ADHD Treatment Study results (Greenhill et al., 2006).

[2] No FDA indication for children younger than 6 years old; based on MPH-MLR Study results (Childress et al., 2020).

[3] FDA indication for ADHD treatment of children 3-5 years old, but no clinical trial study results available.

[4] FDA indication for ADHD treatment of children 6 years and older, limited clinical trial study results available.

[5] No FDA indication for children younger than 6 years old; based on Kratochvil et al., 2011.

[6] No FDA indication for ADHD except guanfacine extended-release (Intuniv®) and clonidine extended-release (KAPAVY®) in children 6 years and older; limited clinical trial study results available for guanfacine use for ADHD in children below age 6 years old.

Attention Deficit Hyperactivity Disorder (ADHD) in Children and Adolescents Ages 6 to 17 Years Old

Level 0

Comprehensive assessment including a detailed developmental, educational, and symptom history and assess treatment preference.

Recommended rating scales:

- ADHD Rating Scale-IV
- Vanderbilt ADHD Diagnostic Parent and Teacher Rating Scales

Links to rating scales available at ***https://floridabhcenter.org/***.

Facilitate family engagement, psychoeducation about ADHD (evidence-based behavior and medication treatments, and educational interventions).

Ensure that treatment response is monitored using rating scales and appropriate health and safety assessments. In particular, closely monitor height, weight and appetite to determine need for weight recovery interventions, and periodically monitor pulse and blood pressure. Periodically assess continued benefit from medication administration.

Level 1

- Psychostimulant monotherapy (methylphenidate class or amphetamine class, either immediate-release or extended-release). If first choice is ineffective, try monotherapy with another stimulant (Refer to Tables 4 and 5 of ADHD medications on pages 17-20. If supplementation of extended-release with immediate-release psychostimulant required for sufficient coverage, stay within same drug class.

Level 2

- Combination of extended-release alpha-2 agonist with psychostimulant, OR
- Extended-release alpha-2 agonist monotherapy, OR
- Atomoxetine or Viloxazine monotherapy.

Level 3

Immediate-release alpha-2 agonist (as ADHD monotherapy or combination with other ADHD medication classes.

Level 4

Diagnostic reconsideration if none of the above agents result in satisfactory treatment. Consider bupropion or tricyclic antidepressant, or venlafaxine. Despite limited evidence, these medications may be considered if patients cannot tolerate or fail first-line medications.

Desipramine is not recommended due to safety concerns.

Not Recommended:

- Antipsychotic medication to treat core symptoms of ADHD.
- Routine concurrent use of two or more alpha-2 agonists; this should be reserved for specific clinical indications, closely monitored for side effects, and maximum dose ranges need to account for additive effects.
- Concurrent use of two different stimulant classes.

Other Treatment Considerations

- Two newly FDA-approved devices for ADHD treatment are available, the Monarch e-TNS system and the EndeavorRX video game. To date, insufficient long-term efficacy and safety evidence available to include either one in the 2022-2023 treatment guidelines; however, for individual patients and their families, these treatment options may be considered. The Monarch e-TNS does not get combined with ADHD medication treatment, whereas the EndeavorRX video game is designed to be part of comprehensive treatment plan, including medications.
- Omega-3 fatty acid supplementation has shown inconsistent evidence in treating ADHD and is not included in current national guidelines. However, in recent meta-analyses, very small to medium size improvements of ADHD symptoms were reported, and omega-3 supplementation may be considered on individual patient basis (500-1000mg for prepubetal children and 1,000-1,500mg for adolescents).

Table 4.

FDA Approved ADHD Medications in Children and Adolescents Ages 6 to 17 Years Old				
Generic Class/ Brand Name	**Typical Starting Dose**	**FDA Max Dose/Day**	**Off-Label Max Dose/Day**	**Comments**
Methylphenidate and Dexmethylphenidate preparations				
Immediate Release/ Short Duration (~3-4 hours)				Immediate-release stimulants are often used as initial treatment in children (<16 kg), but have disadvantage of b.i.d. – t.i.d. dosing to control symptoms throughout the day. Administer 30-45 minutes before meals with last dose given prior to 6 PM.
Focalin® (dexmethylphenidate hcl tablet)	2.5 mg bid	20 mg	50 mg	
Ritalin® (methylphenidate hcl tablet)	5 mg bid	60 mg	>50 kg: 100 mg	
Methylin® Solution (methylphenidate hcl oral solution)	5 mg bid	60 mg	>50 kg: 100 mg	
Methylphenidate Chewable (methylphenidate hcl chewable tablet)	5 mg bid	60 mg	>50 kg: 100 mg	
Extended Release/ Intermediate Duration (~6-8 hours)				Longer acting stimulants offer greater convenience, confidentiality, and compliance with single daily dosing but may have greater problematic effects on evening appetite and sleep.
Metadate ER® (methylphenidate hcl extended-release tablets)	10 mg qam	60 mg	>50 kg: 100 mg	
Metadate CD® (methylphenidate hcl extended-release capsule)	10 mg qam	60 mg	>50 kg: 100 mg	
Ritalin LA® (methylphenidate hcl extended-release tablet)	20 mg qam	60 mg	>50 kg: 100 mg	
Notes: *Ritalin LA 60 mg (specific brand and dose) and Ritalin SR were discontinued for reasons other than safety and effectiveness. Ritalin LA brand drug is still available in 10 mg, 20 mg, 30 mg, and 40 mg capsules (i.e., doses other than 60 mg). The generic methylphenidate extended-release capsule is available in all doses, including 60 mg.*				

Table 4 *(continued).*

FDA Approved ADHD Medications in Children and Adolescents Ages 6 to 17 Years Old				
Generic Class/ Brand Name	**Typical Starting Dose**	**FDA Max Dose/Day**	**Off-Label Max Dose/Day**	**Comments**
Extended Release/ Long Duration (up to 12 hours)				
Aptensio XR® (methylphenidate hcl extended-release capsule)	10 mg qam then titrate by 10 mg at weekly intervals	60 mg	>50 kg: 100 mg	May be administered without regards to meals. Conversion between most MPH products: discontinue existing product and then titrate new product - do not substitute on mg-per-mg basis. Aptensio XR®, Metadate CD®, Ritalin LA® and Focalin XR® capsules may be opened and sprinkled on soft food for immediate consumption. Beads should not be crushed or chewed. Concerta® should not be crushed, chewed, or broken. Swallow whole with liquids. Non-absorbable tablet shell does not dissolve and may be seen in stool. This is normal. A 27 mg tablet is available if a dosage between 18 to 36 mg is desired. Apply Daytrana® patch 2 hours before effect is needed; may remove 9 hours after application, or sooner if shorter duration of action is desired. Qillivant XR® is an extended-release once-daily suspension. QuilliChew ER® can be broken in half.
AzstarysTM (serdexmethylphenidate/ dexmethylphenidate)	39.2 mg ser-d-MPH/ 7.8 mg d-MPH (equivalent to 20mg d-MPH) once daily in the morning, then titrate up/down in weekly increments	52.3/10.4mg ser-d-MPH/ d-MPH	Not yet known	
Cotempla XR-ODT® (methylphenidate tablet, orally disintegrating)	17.3 mg qam then titrate up by 8.6 mg to 17.3 mg weekly	51.8 mg	Not yet known	
Concerta® (methylphenidate extended-release Tablet)	18 mg qam; may titrate by 18 mg weekly	6-12 years: 54 mg >12 years: 72 mg	>50 kg: 108 mg	
Daytrana® patch (methylphenidate transdermal system)	10 mg patch daily in the morning, then titrate up 5 mg weekly	30 mg	Not yet known	
Focalin XR® (dexmethylphenidate hcl extended-release capsule)	5 mg qam	30 mg	50 mg	
Jornay PM® (methylphenidate HCl extended-release capsule)	20 mg in evening	100 mg	Not yet known	
Quillivant XR® (methylphenidate hcl extended-release oral suspension)	20 mg qam, then titrate up by 10-20 mg at weekly intervals	60 mg	>50 kg: 100 mg	
QuilliChew ER® (methylphenidate hcl extended-release chewable tablet)	20 mg qam then titrate in increments of 10 mg, 15 mg or 20 mg at weekly intervals	60 mg	>50 kg: 100 mg	

Table 4 *(continued).*

FDA Approved ADHD Medications in Children and Adolescents Ages 6 to 17 Years Old				
Generic Class/ Brand Name	**Typical Starting Dose**	**FDA Max Dose/Day**	**Off-Label Max Dose/Day**	**Comments**
Extended Release/ Extra Long Duration (up to 16 hours)				Capsules may be opened and sprinkled on soft food for immediate consumption. Beads should not be crushed or chewed. Doses above 70 mg/day increased adverse events disproportionately.
Adhansia XR® (methylphenidate HCl extended-release capsules)	25 mg qam then titrate by 10 to 15 mg weekly	85 mg in pediatric age group	Not yet known	

Table 5.

FDA Approved ADHD Medications in Children and Adolescents Ages 6 to 17 Years Old				
Generic Class/ Brand Name	**Typical Starting Dose**	**FDA Max Dose/Day**	**Off-Label Max Dose/Day**	**Comments**
Amphetamine preparations				
Immediate Release/ Short Duration/ (~3-6 hours)				Immediate-release stimulants are often used as initial treatment in children (<16 kg) but have disadvantage of b.i.d. – t.i.d. dosing to control symptoms throughout the day. Note that Adderall®, Procentra Oral Solution®, Evekeo®, Evekeo® ODT, and Zenzedi® have the same dosing recommendations.
Adderall® (amphetamine mixed salts tablet)	5 mg daily – bid	40 mg	>50 kg: 60 mg	
Procentra Oral Solution® (d-amphetamine oral solution)	5 mg daily – bid	40 mg	>50 kg: 60 mg	
Evekeo® ODT (d- and l amphetamine oral dissolving tablet)	5 mg daily – bid	40 mg	>50 kg: 60 mg	
Evekeo® (d- and l-amphetamine tablet)	5 mg daily – bid	40 mg	>50 kg: 60 mg	
Zenzedi® (d-amphetamine tablet)	5 mg daily – bid	40 mg	>50 kg: 60 mg	

Table 5 *(continued).*

FDA Approved ADHD Medications in Children and Adolescents Ages 6 to 17 Years Old				
Generic Class/ Brand Name	**Typical Starting Dose**	**FDA Max Dose/Day**	**Off-Label Max Dose/Day**	**Comments**
Extended Release/ Intermediate Duration (5-10 hours)				Longer acting stimulants offer greater convenience, confidentiality, and compliance with single daily dosing but may have greater problematic effects on evening appetite and sleep. Adderall XR® capsule may be opened and sprinkled on soft foods. Vyvanse® capsule can be opened and mixed with yogurt, water or orange juice. Vyvanse® Chewables must be chewed thoroughly before swallowing. Do not divide single doses. For Dyanavel XR® do not substitute for other amphetamine products on mg-per-mg basis. For Adzenys®, do not substitute for other amphetamine products on mg-per-mg basis. For children and adolescents on Adderall XR®, specific starting doses corresponding to Adderall XR® doses are recommended, ranging from 3.1 mg of Adzenys® (for those on 5 mg of Adderall XR®) to 18.8 mg of Adzenys® (for those on 30 mg Adderall XR®). Capsules may be opened and sprinkled on soft food for immediate consumption. Beads should not be crushed or chewed. Doses higher than 25 mg have not been evaluated in clinical trials in pediatric patients
Dexedrine Spansule® (dextroamphetamine sulfate extended-release capsule)	5-10 mg daily to twice per day	40 mg	Not yet known	
Extended Release/ Long Duration (up to 10-12 hours)				
Adderall XR® (amphetamine extended-release mixed salts capsule)	10 mg daily	6-12 years: 30 mg 13-17 years: 20 mg	>50 kg: 60 mg	
Adzenys ER® (d- and l-amphetamine oral suspension, extended-release)	6.3 mg qam unless switched from Adderall XR (Refer to conversion schedule)	6-12 years: 18.8 mg 13-17 years: 12.5 mg	Not yet known	
Adzenys XR-ODT® (amphetamine extended- release orally disintegrating tablet)	6.3 mg qam unless switched from Adderall XR (Refer to conversion schedule)	6-12 years: 18.8 mg 13-17 years: 12.5 mg	Not yet known	
Dyanavel XR® 2.5 mg/mL (amphetamine extended-release oral suspension)	2.5 to 5 mg daily in the morning	20 mg	Not yet known	
Vyvanse® (lisdexamfetamine capsule)	20-30 mg daily	70 mg	Not yet known	
Vyvanse® (lisdexamfetamine chewables)	20-30 mg daily	70 mg	Not yet known	
Extended Release/ Extra Long Duration (up to 16 hours)				
Mydayis® (mixed amphetamine salts)	For 13 years and older only: 12.5 mg	For 13-17 years: 25 mg	Not yet known	

Table 6.

FDA Approved ADHD Medications in Children and Adolescents Ages 6 to 17 Years Old				
Generic Class/ Brand Name	**Typical Starting Dose**	**FDA Max Dose/Day**	**Off-Label Max Dose/Day**	**Comments**
Selective norepinephrine reuptake inhibitors				
Qelbree® (viloxazine)	6-11 years: Begin with 100 mg daily, and then titrate in 100 mg increments 12-17 years: Begin with 200 mg daily and then titrate in 100 or 200 mg increments	6-17 years: 400 mg	Not yet known	Not a Schedule II medication. Monitor closely for suicidal thinking and behavior, clinical worsening, or unusual changes in behavior. Monitor for manic symptoms in patients with bipolar disorder. Capsules can be sprinkled, but should not be cut, crushed or chewed.
Strattera® (atomoxetine)	≤ 70 kg: 0.5 mg/kg/day for 4 days; then 1 mg/kg/day for 4 days; then 1.2 mg/kg/day >70 kg: 40 mg/day; may increase to 80 mg daily after a minimum of 3 days	≤ 70 kg: 1.4 mg/kg or 100 mg, whichever is less >70 kg: 100 mg	Lesser of 1.8 mg/kg or 100 mg daily	Not a Schedule II medication. Consider if active substance abuse or severe side effects of stimulants (mood lability, tics). Give qam or equally divided doses b.i.d. (for effects on late evening behavior). Do not open capsule; must be swallowed whole. Monitor closely for suicidal thinking and behavior, clinical worsening, or unusual changes in behavior.

Table 6 *(continued).*

FDA Approved ADHD Medications in Children and Adolescents Ages 6 to 17 Years Old				
Generic Class/ Brand Name	**Typical Starting Dose**	**FDA Max Dose/Day**	**Off-Label Max Dose/Day**	**Comments**
Alpha- adrenergic agonists				
Intuniv® (guanfacine ER)	1 mg daily then titrate up by 1 mg increments once per week	Lesser of 0.12 mg/kg or 4 mg daily (6-12 years) 7 mg daily (13-17 years)	Lesser of 0.17 mg/kg or 4 mg daily (6-12 years) 7 mg daily (13-17 years)	Not a Schedule II medication. Sedation, somnolence, and fatigue are common and tend to decline over time. Consider baseline electrocardiogram (EKG) before starting. Tablets should not be crushed, chewed, or broken before swallowing because this will increase the rate of release.
KAPVAY® (clonidine ER)	0.1 mg/day at bedtime	0.4 mg/day in divided doses of 0.2 mg bid	0.4 mg/day	Do not administer with high fat meals due to increased exposure. May not see effects for 4-6 weeks. Review personal and family cardiovascular history. Do not abruptly discontinue. Taper the daily dose of Intuniv® by no more than 1 mg, and that of Kapvay® by no more than 0.1 mg every 3 to 7 days to avoid rebound hypertension.

Table 7.

ADHD Medications in Children and Adolescents Ages 6 to 17 Years Old				
Generic Class/ Brand Name	**Typical Starting Dose**	**FDA Max Dose/ Day**	**Off-Label Max Dose/Day**	**Comments**
Alpha- adrenergic agonists				
Catapres® (clonidine)	<45 kg: 0.05 mg nightly; titrate in 0.05 mg increments two times per day, three times per day, or four times per day. >45 kg: 0.1 mg nightly; titrate in 1 mg increments two times per day, three times per day, or four times per day.	27–40.5 kg: 0.2 mg 40.5–45 kg: 0.3 mg >45 kg: 0.4 mg	0.4 mg/day for ages 5 years and older	The following applies to both alpha-2 adrenergic agonists: - May be used as monotherapy or as adjuvant to another medication class for ADHD - Do not routinely combine different alpha-2 adrenergic agents with each other - Effective for inattention, impulsivity and hyperactivity; modulating mood level; tics worsening from stimulants; sleep disturbances. Taper the daily dose of clonidine by no more than 0.1 mg every 3 to 7 days to avoid rebound hypertension.
Tenex® (guanfacine)	< 45 kg: 0.5 mg nightly; titrate in 0.5 mg increments two times per day, three times per day, or four times per day. >45 kg: 1 mg nightly; titrate in 1 mg increments. May dose increments two times per day, three times per day, or four times per day.	27–40.5 kg: 2 mg 40.5–45 kg: 3 mg >45 kg: 4 mg	4 mg/day for ages 7 years and older	May not see effects for 4-6 weeks. Review personal and family cardiovascular history. Consider pre-treatment EKG. Taper the daily dose of guanfacine by no more than 1 mg every 3 to 7 days to avoid rebound hypertension.

Table 7 *(continued).*

ADHD Medications in Children and Adolescents Ages 6 to 17 Years Old			
Generic Class/ Brand Name	**Typical Starting Dose**	**FDA Max Dose/Day**	**Comments**
Antidepressants			
Wellbutrin®† (bupropion)	Lesser of 1.5 - 3 mg/kg/day or 150 mg/day (dosed as 75 mg bid)	Lesser of 6 mg/kg or 300 mg/day. Dose should not exceed 150 mg per dose.	Lowers seizure threshold; contraindicated if current seizure disorder, anorexia nervosa or bulimia nervosa. Usually given in divided doses, b.i.d. or t.i.d. for children and adolescents, for both safety and efficacy.
Wellbutrin SR®† (bupropion SR)	Same as above	150 mg per dose or 400 mg/day	Lowers seizure threshold; contraindicated if current seizure disorder, anorexia nervosa or bulimia nervosa. Usually given in divided doses, b.i.d. for children and adolescents, for both safety and efficacy.
Wellbutrin XL®† (bupropion XL)	Same as above	Lesser of 6 mg/kg/day or 300 mg/day.	Lowers seizure threshold; contraindicated if current seizure disorder, anorexia nervosa or bulimia nervosa. Usually dosed once daily for children and adolescents, for both safety and efficacy.
Tofranil® (imipramine)	1 mg/kg/day in one to three divided doses	Lesser of 4 mg/kg or 200 mg	Obtain baseline EKG before starting imipramine.
Pamelor® Aventil® (nortriptyline)	0.5 mg/kg/day	Lesser of 2 mg/kg or 100 mg	Obtain baseline EKG before starting nortriptyline.
Effexor® (venlafaxine)	12.5 mg/day	Not FDA approved for use under age 18 years; literature-derived suggested maximum of the lower of 150mg/day or 3mg/kg/day (Park et al, 2014)	Venlafaxine has limited evidence, but showed some improvements on ADHD rating scales in small randomized clinical trials.

***Note:** Extended-release formulations of clonidine (Kapvay) and guanfacine (Intuniv) are FDA-approved ADHD medications in children and adolescents 6-17 years old, but immediate-release formulations of clonidine (Catapres) and guanfacine (Tenex) are not FDA-approved for ADHD. Off-label max doses for immediate release clonidine and guanfacine per Clinical Pharmacology database.*

*** For all antidepressant medications, boxed warnings on suicidality apply.*

†Bupropion and bupropion SR have more data on off-label use than bupropion XL.

For a full list of references, visit ***https://floridabhcenter.org/***.

Attention Deficit Hyperactivity Disorder (ADHD) Resources

Selected Resources

- **Books**

For Children:

- Learning To Slow Down and Pay Attention: A Book for Kids About ADHD (Nadeau, Dixon, and Beyl, 2004)
- The Girls' Guide to AD/HD (Walker, 2004)
- My Mouth is a Volcano! (Cook, 2006)
- The Survival Guide for Kids with ADD or ADHD (Taylor, 2006)
- Mrs. Gorski, I Think I Have the Wiggle Fidgets (Esham, 2008)

For Adolescents and Young Adults:

- The Girls' Guide to AD/HD (Walker, 2004)
- Delivered from Distraction: Getting the Most out of Life with Attention Deficit Disorder (Hallowell and Ratey, 2005)

For Parents:

- Driven to Distraction: Recognizing and Coping with Attention Deficit Disorder from Childhood to Adulthood (Hallowell and Ratey, 1994)
- ADHD and Teens: A Parenting Guide to Making It Through the Tough Years (Alexander-Roberts, 1995)
- The ADD and ADHD Answer Book: Professional Answers to 275 of the Top Questions Parents Ask (Ashley, 2005)
- Smart but Scattered: The Revolutionary "Executive Skills" Approach to Helping Kids Reach Their Potential (Dawson and Guare, 2009)
- Taking Charge of ADHD: The Complete, Authoritative Guide for Parents, 3rd Edition (Barkley, 2013)
- Parenting Children with ADHD: 10 Lessons that Medicine Cannot Teach (Monastra, 2014)
- How to Reach and Teach Children and Teens with ADD/ADHD: Practical Techniques, Strategies, and Interventions, 3rd Edition (Rief, 2016)

For Teachers:

- Teaching the Tiger: Handbook for individuals involved in the education of students with ADHD, Tourette's, or OCD (Dornburush and Pruitt, 1995)
- How to Reach and Teach Children and Teens with ADD/ADHD: Practical Techniques, Strategies, and Interventions, (Rief, 2016)

Websites

- American Academy of Child and Adolescent Psychiatry – ADHD Resource Page: https://www.aacap.org/aacap/families_and_youth/resource_centers/adhd_resource_center/Home.aspx
- Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD): https://chadd.org/
- Child Mind Institute – Teacher's Guide to ADHD in the Classroom: https://childmind.org/guide/a-teachers-guide-to-adhd-in-the-classroom/
- Mental Health America: https://www.mhanational.org/
- National Alliance on Mental Illness (NAMI): https://www.nami.org/
- NAMI Florida: http://www.namiflorida.org/
- National Institute of Mental Health: https://www.nimh.nih.gov/
- National Institute of Mental Health—ADHD resource page: https://www.nimh.nih.gov/health/topics/attention-deficit-hyperactivity-disorder-adhd

Note: Above resources and website links were updated at the time of publication.

For a full list of references, visit https://floridabhcenter.org/.