ADHD Medication, Demystified

What Parents Need to Know Now

A practical parent-centered conversation

How to think about choices, benefits, side effects, monitoring, and what to do when the first plan is not working.

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Tonight’s 4 questions

1. What’s new in ADHD medications — and what actually matters?
2. What are the benefits and risks of medication?
3. What is the REAL question to ask when deciding about medication?
4. How do I know if it is working — and what should we do if it is not?

Opening framework from the event invitation/pamphlet.

First: medication is one part of ADHD care

For school-age children and adolescents, evidence-based care can include FDA-approved medication plus behavioral interventions and school supports.

Medication targets core ADHD symptoms; it does not teach every organizational, emotional, social, or academic skill.

Parent training, classroom/behavioral supports, organizational skills, sleep, exercise, and treatment of co-occurring conditions can all matter.

The goal is not “a pill that makes a child different.” The goal is improved functioning with acceptable trade-offs.

The medication landscape — simplified

STIMULANTS: methylphenidate- and amphetamine-based medicines remain the most established medication class.

NONSTIMULANTS: include atomoxetine, guanfacine/clonidine products, and viloxazine.

FORMULATION MATTERS: immediate-release vs extended-release; duration and delivery can change the day-to-day experience.

NEWER DOES NOT AUTOMATICALLY MEAN BETTER. A newer medication may create another useful option for a particular clinical problem.

CDC; FDA; AAP parent medication toolkit.

Why there are so many ADHD medications

Different children can have very different responses to medications that look similar on paper.

Common trade-offs include duration, appetite, sleep, mood/irritability, cardiovascular effects, rebound symptoms, and adherence.

Comorbid anxiety, tics, mood disorders, substance-use risk, sleep problems, and other medical factors can change the conversation.

Sometimes the right answer is a different formulation — not necessarily a completely different class.

The REAL question to ask

Not: “Which ADHD medication is the best?”

Instead: “What specific problem are we trying to improve, what benefit would count as meaningful, and what trade-offs are we willing to accept?”

Define the target before starting: attention? impulsivity? emotional regulation? homework completion? classroom functioning? driving safety? morning/evening coverage?

Then decide how you will measure the answer.

Benefits: what should success look like?

Better ability to start, sustain, and complete age-appropriate tasks.

Less impulsive responding and fewer avoidable conflicts.

Improved classroom participation and work completion.

Better ability to use skills the child already has.

Improved functioning — not simply “looks quieter.”

Parent, child, teacher, and clinician observations can all contribute.

How do we know if medication is working?

Pick 2–4 observable targets before treatment.

Ask: “What can my child do now that was consistently difficult before?”

Look across settings: home, school, activities, and social situations.

Track benefit against the medication’s expected duration.

Track side effects at the same time — benefit and burden must be evaluated together.

A simple 0–10 parent scorecard

Attention / task completion: ____ / 10

Impulsivity / self-control: ____ / 10

Emotional regulation: ____ / 10

School functioning: ____ / 10

Evening/home functioning: ____ / 10

Side-effect burden: ____ / 10

Repeat after a defined observation period and bring the pattern to the clinician.

If it’s NOT working, don’t just keep pushing

First ask: Was the target clearly defined?

Was there enough opportunity to observe benefit?

Is the duration appropriate for the child’s schedule?

Are side effects limiting the apparent benefit?

Could sleep, anxiety, learning differences, mood, family stress, or another condition be driving the problem?

Then the clinician may consider a formulation change, a different medication, or a broader treatment adjustment.

AAP/CDC principle: observe, adjust, and monitor benefit versus adverse effects.

Common parent concerns

“Will medication change my child’s personality?”

“Will my child become dependent?”

“Does taking a stimulant cause substance-use problems?”

“Will medication stunt growth?”

“Does my child have to take medication forever?”

“If the first medication fails, does that mean medication doesn’t work?”

Use these questions to normalize discussion rather than making assumptions.

What parents should know about stimulants

Stimulants are among the most studied and commonly used ADHD medications.

They can be highly effective, but response and tolerability vary from child to child.

Common concerns include appetite, sleep, headaches, stomach symptoms, irritability, heart rate/blood pressure, and misuse/diversion risk.

FDA labeling emphasizes safe storage, not sharing medication, and monitoring for misuse and addiction risk.

Growth, blood pressure, heart rate, sleep, appetite, and functioning should be monitored as clinically appropriate.

FDA stimulant safety communication; CDC ADHD treatment guidance.

What parents should know about nonstimulants

Nonstimulants include several medications with different mechanisms and time courses.

They may be considered when stimulants are poorly tolerated, insufficient, or when particular clinical factors make them attractive.

They generally do not produce the same rapid onset as stimulants, so expectations about timing matter.

Some can be useful when ADHD symptoms overlap with other behavioral or physiologic concerns — the choice is individualized.

FDA; CDC; AAP parent medication toolkit.

NEW in 2026: SIMTRIYO® (centanafadine)

FDA approved in July 2026 for ADHD in adults and pediatric patients age 6+ who weigh at least 20 kg (44 lb).

It is a CNS stimulant and a norepinephrine-dopamine-serotonin reuptake inhibitor (NDSRI).

That makes its pharmacology different from traditional stimulant approaches that primarily target dopamine/norepinephrine signaling.

It is an extended-release, once-daily formulation.

Because it is newly approved, families and clinicians should distinguish FDA approval from the amount of long-term, real-world experience accumulated over decades with older medicines.

FDA Simtriyo Prescribing Information, revised July 2026.

Why SIMTRIYO is interesting

It is the first FDA-approved ADHD medication built around simultaneous norepinephrine, dopamine, and serotonin reuptake inhibition.

The scientific idea: ADHD symptoms may be influenced by more than one neurotransmitter system.

The clinical question is not whether the mechanism sounds novel — it is whether a particular patient gets meaningful functional benefit with acceptable tolerability.

Clinical trials demonstrated symptom improvement versus placebo in pediatric and adult studies; longer-term real-world experience will continue to accumulate.

SIMTRIYO: what parents should know about safety

FDA labeling carries boxed warnings for suicidal ideation/behavior in pediatric patients and for abuse, misuse, and addiction.

Children 6+ should be monitored for new/worsening mood or behavioral changes, especially early in treatment.

Other labeled concerns include increased blood pressure/heart rate, psychiatric adverse reactions, growth effects, tics/Tourette's, peripheral vasculopathy, and serotonin syndrome.

Common adverse reactions differed by age and included decreased appetite, nausea, headache, rash, abdominal pain and/or insomnia.

These warnings do not mean a medication is inappropriate for every patient; they mean the risks must be actively considered and monitored.

SIMTRIYO: the key counseling point

Think of it as a NEW OPTION — not a “miracle medication.”

Ask what clinical problem makes this option worth considering for this particular child.

Review the child’s medical history, cardiovascular history, psychiatric history, other medications, and misuse/diversion risk with the treating clinician.

Have a monitoring plan before starting: target symptoms + functioning + appetite/sleep + vital signs + growth + mood/behavior.

Parents should report concerning new symptoms promptly to the prescribing clinician.

Medication myths — and better questions

MYTH: “If medication works, we don’t need skills.” → BETTER: “How can medication help my child use skills more effectively?”

MYTH: “More focus automatically means better functioning.” → BETTER: “Is functioning actually improving?”

MYTH: “One failed medication means none will work.” → BETTER: “What did we learn from the first trial?”

MYTH: “Newer means safer or better.” → BETTER: “What evidence do we have, and what is still unknown?”

The medication decision: 6 factors

1. TARGET: What problem are we treating?
2. BENEFIT: What improvement would be meaningful?
3. BURDEN: What side effects are unacceptable?
4. FIT: Does the medication/formulation fit the child's day?
5. CONTEXT: What comorbidities or family factors matter?
6. MONITORING: How will we know whether to continue, adjust, or change course?

A parent–clinician conversation script

“Here are the two or three things we most want to improve.”

“Here is what we are most worried about.”

“How long should we expect before we can judge benefit?”

“What side effects should we watch for?”

“What will we measure at home and at school?”

“What is our plan if this is only partly helpful or not helpful?”

What about the child’s voice?

For adolescents, medication decisions should include the young person’s perspective and approval.

Ask what the child notices — benefits, unwanted effects, stigma, school-day coverage, appetite, sleep, and emotional experience.

Shared decision-making improves the chance that a treatment plan is understood and followed.

The goal is partnership, not a battle between “medication” and “no medication.”

Medication is not the whole treatment plan

Behavioral parent training can be valuable.

School accommodations and behavioral classroom supports can be essential.

Organizational skills training can address executive-function demands.

Sleep, physical activity, nutrition, and screen/media routines can influence day-to-day functioning.

Treat co-occurring anxiety, depression, learning disorders, sleep disorders, or other conditions when present.

Medication should make the overall plan more effective — not replace it.

Take-home messages

ADHD medication is not a one-size-fits-all decision.

The REAL question is: “What specific benefit are we trying to achieve, and at what cost?”

Measure function, not just symptoms.

If the first medication is not right, that is information — not failure.

New options such as SIMTRIYO expand the menu, but novelty is not the same as superiority.

Good treatment is an ongoing process of shared decision-making, monitoring, and adjustment.

Questions parents can take home

What are our child’s highest-priority ADHD problems?

What would meaningful improvement look like in 4–8 weeks?

What side effects matter most for this child?

How will we monitor school and home functioning?

When should we call the clinician?

What is Plan B if the first approach is not helpful?

From the event pamphlet + expanded parent discussion.

Selected references

FDA. SIMTRIYO (centanafadine) Prescribing Information. Revised July 2026.

FDA. Novel Drug Approvals for 2026 — SIMTRIYO listed as a novel drug approved July 24, 2026.

CDC. Clinical Care of ADHD in Children. Updated July 30, 2026.

CDC. Treatment of ADHD — medication and behavioral treatment guidance.

FDA. Updating Warnings to Improve Safe Use of Prescription Stimulants. 2022.

American Academy of Pediatrics. ADHD Basic Facts: What Every Parent Should Know Before Starting a Child on Medication. 3rd ed.

One sentence to leave parents with

“The goal is not to find the perfect medication — it is to find a treatment plan that helps your child function better while respecting who they are and what matters to your family.”