# Curbside Consult with a CAP: Identifying and Treating ADHD in Pediatric Primary Care


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JSUMC CHILD AND ADOLESCENT PSYCHIATRY OUTPATIENT SERVICES

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# Financial Disclosures

There are no financial disclosures.

# Learning Objectives

- Identify, recognize and diagnose symptoms of ADHD in pediatric patients.
- Identify and recognize common comorbid disorders seen with ADHD.
- Understand the short and long-term risks of untreated ADHD in the pediatric population.
- Describe the pharmacologic and non-pharmacologic interventions for patients with ADHD.
- Understand how to objectively monitor symptoms of ADHD in reported cases of clinical worsening.
- Decide when to refer to psychiatry for further evaluation and/or management.

# In Response to the Current Situation…

- Understand behavioral issues that are likely to occur with long-standing in-home restrictions, and how to address them.

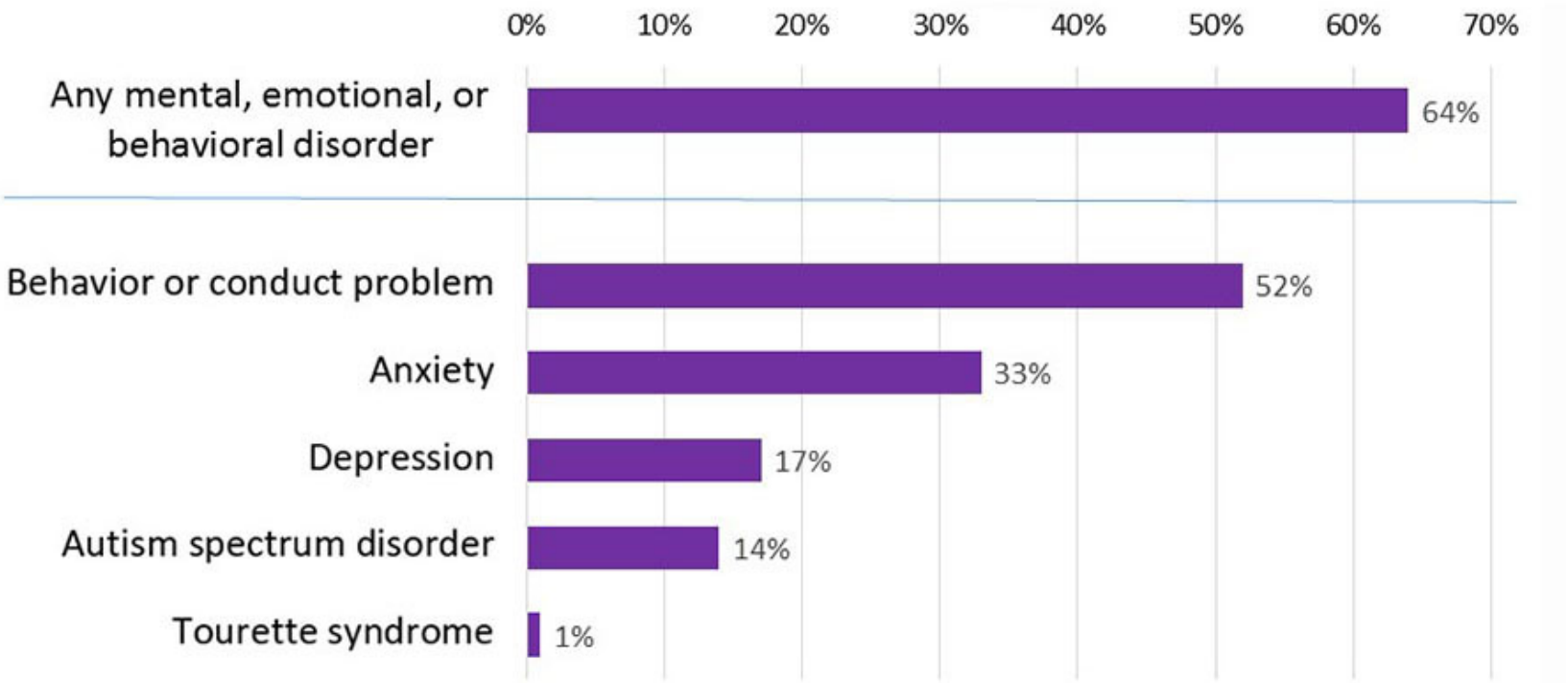
# By the Numbers - Prevalence

- ADHD is a highly prevalent mental health disorder found in the pediatric population.
- According to CDC survey data (2016)[1]
  - 9.4% of all children have received a diagnosis of ADHD in their lifetime.
    - 388,000 → 2–5 y.o.
    - 4 million → 6–11 y.o.
    - 3 million → 12–17 y.o.
  - Boys more likely to be diagnosed than girls (12.9% vs 5.6%).

# By the Numbers - Comorbidities

- Comorbidities are common.
- Emotional, behavioral, speech and learning disorders.
- May impact the presentation and impacts of ADHD on a case by case basis.

# By the Numbers - Comorbidities



# Risk Factors – Predisposing[2]

- Family History → 88% heritability[3]
- Cigarette smoking, alcohol or illicit drug use during pregnancy
- Prenatal exposure to environmental toxins
- Early-age to environmental toxins
- Low birth weight
- Neurological/brain injuries

# Risk Factors - Untreated

- Symptomatic ADHD has both short and long-term impacts on the well-being of children.
- <u>Short term</u>
  - Difficult peer-peer interactions
  - Poor peer-parent relations
  - Poor academic performance
  - Poor self-image (“Mommy, nobody in my class likes me.”)
- <u>Long term</u>
  - Substance use
  - Criminal/antisocial behavior
  - Development of mental health comorbidities

# ADHD in Primary Care

- It is <u>important</u> to identify and treat ADHD in the clinical setting
- ***Complicated*** cases may be best handled by specialists.
  - multiple comorbidities
  - global deterioration of social, academic, and behavioral/emotional functioning
  - Moderate-severe developmental delay
- **Uncomplicated** cases may be effectively managed by PCPs
  - No comorbidities
  - Isolated functional deficits

# Identification of ADHD

- Begins with screening
- Commonly used screening tool is the PSC-Y
- 5 of 37 items on the PSC-Y address ADHD
  - 4 → Fidgety, unable to sit still
  - 7 → Acting as if driven by a motor
  - 8 → Daydreaming
  - 9 → Distracts easily
  - 14 → Have trouble concentrating
- Screening only. **Not** diagnostic

# Diagnosis

- Diagnosis of ADHD is made through historical information, collateral data and clinical evaluation.
- 3 subtypes
  - ADHD – Predominantly Hyperactive Type
  - ADHD – Predominantly Inattentive Type
  - ADHD – Combined Type
- Specific criteria laid out in the DSM-5

# Diagnosis – ADHD-Hyperactive Type

Must display **at least 6 symptoms** for **at least 6 months**.

- Often fidgets/taps hands or feet, or squirms in seat.
- Often leaves seat in situations when remaining seated is expected.
- Often displays inappropriate running or climbing behavior.
- Often unable to play or engage in leisure activities quietly.
- Often "on the go," acting as if "driven by a motor."
- Often talks excessively.
- Often blurts out answers before a question has been completed.
- Often has difficulty waiting turns (e.g. waiting in line)
- Often interrupting or intruding on others (e.g. butting into conversations, games or activities; using other people's things without permission

# Diagnosis – ADHD-Inattentive Type

Must display **at least 6 symptoms** for **at least 6 months**.

- Often fails to give close attention to details or makes careless mistakes in schoolwork.
- Often has difficulty sustaining attention in tasks or play activities.
- Often does not seem to listen when spoken to directly (e.g. "Daydreaming")
- Often does not follow through on instructions and fails to finish schoolwork, chores or duties
- Often has difficulty organizing tasks and activities. (e.g. messy desk/binder, messy schoolwork, poor morning time management)
- Often avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort.
- Often loses things necessary for tasks or activities.
- Often easily distracted by extraneous stimuli.
- Often forgetful in daily activities.

# Diagnosis – ADHD-Combined Type

- Must display **at least 6 symptoms** in **both domains** for **at least** 6 months.

# Additional Qualifiers

Symptoms must be **clinically significant**.

- Inconsistent with expected developmental level
- Having a direct negative impact on **academic**, **social** and **occupational** activities

At least several of these symptoms must have been apparent **prior to age 12**.

Symptoms must occur in **at least 2 settings**.

Home

Outside of Home (school, sports, clubs)

# Diagnostic Instruments

- Vanderbilt Assessment[4]
  - 55 items scored 0-3
  - 18 items for ADHD (9 each for inattentive and hyperactive subtypes)
  - ADHD – 6/9 symptoms must score 2 or 3
  - ODD, Conduct Disorder, anxiety, depression
- SNAP-IV
  - 26 items scored 0-3
  - 18 items for ADHD
  - Also tests for ODD
- Can be used to aid in diagnosis as well for monitoring of response to treatment.

## NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

**Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.**

**Is this evaluation based on a time when the child** ☐ **was on medication** ☐ **was not on medication** ☐ **not sure?**

| Symptoms | Never | Occasionally | Often | Very Often |
|---|---|---|---|---|
| 1. Does not pay attention to details or makes careless mistakes with, for example, homework | 0 | 1 | 2 | 3 |
| 2. Has difficulty keeping attention to what needs to be done | 0 | 1 | 2 | 3 |
| 3. Does not seem to listen when spoken to directly | 0 | 1 | 2 | 3 |
| 4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand) | 0 | 1 | 2 | 3 |
| 5. Has difficulty organizing tasks and activities | 0 | 1 | 2 | 3 |
| 6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort | 0 | 1 | 2 | 3 |
| 7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books) | 0 | 1 | 2 | 3 |
| 8. Is easily distracted by noises or other 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 too much when remaining seated is expected | 0 | 1 | 2 | 3 |
| 13. Has difficulty playing or beginning quiet play activities | 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 in on others' conversations and/or activities | 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 go along with adults' requests or rules | 0 | 1 | 2 | 3 |
| 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 wants to get even | 0 | 1 | 2 | 3 |
| 27. Bullies, threatens, or intimidates others | 0 | 1 | 2 | 3 |
| 28. Starts physical fights | 0 | 1 | 2 | 3 |
| 29. Lies to get out of trouble or to avoid obligations (ie, "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 things that have value | 0 | 1 | 2 | 3 |

The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

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Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

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## NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

| Symptoms (continued) | Never | Occasionally | Often | Very Often |
|---|---|---|---|---|
| 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 |
| 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 | Excellent | Above Average | Average | Somewhat of a Problem | Problematic |
|---|---|---|---|---|---|
| 48. Overall school performance | 1 | 2 | 3 | 4 | 5 |
| 49. Reading | 1 | 2 | 3 | 4 | 5 |
| 50. Writing | 1 | 2 | 3 | 4 | 5 |
| 51. Mathematics | 1 | 2 | 3 | 4 | 5 |
| 52. Relationship with parents | 1 | 2 | 3 | 4 | 5 |
| 53. Relationship with siblings | 1 | 2 | 3 | 4 | 5 |
| 54. Relationship with peers | 1 | 2 | 3 | 4 | 5 |
| 55. Participation in organized activities (eg, teams) | 1 | 2 | 3 | 4 | 5 |

**Comments:**

**For Office Use Only**

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–26: _____

Total number of questions scored 2 or 3 in questions 27–40: _____

Total number of questions scored 2 or 3 in questions 41–47: _____

Total number of questions scored 4 or 5 in questions 48–55: _____

Average Performance Score: _____

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## D4 NICHQ Vanderbilt Assessment Scale—TEACHER Informant

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

**Directions:** **Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the beginning of the school year. Please indicate the number of weeks or months you have been able to evaluate the behaviors: _____.**

**Is this evaluation based on a time when the child** ☐ **was on medication** ☐ **was not on medication** ☐ **not sure/**

| Symptoms | Never | Occasionally | Often | 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 instructions 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 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/games) | 0 | 1 | 2 | 3 |
| 19. Loses temper | 0 | 1 | 2 | 3 |
| 20. Actively defies or refuses to comply with adult's requests or rules | 0 | 1 | 2 | 3 |
| 21. Is angry or resentful | 0 | 1 | 2 | 3 |
| 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 (eg, "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 |

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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## D4 NICHQ Vanderbilt Assessment Scale—TEACHER Informant, continued

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

| Symptoms (continued) | Never | Occasionally | Often | Very Often |
|---|---|---|---|---|
| 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<br>*Academic Performance* | Excellent | Above Average | Average | Somewhat of a Problem | Problematic |
|---|---|---|---|---|---|
| 36. Reading | 1 | 2 | 3 | 4 | 5 |
| 37. Mathematics | 1 | 2 | 3 | 4 | 5 |
| 38. Written expression | 1 | 2 | 3 | 4 | 5 |

| *Classroom Behavioral Performance* | Excellent | Above Average | Average | Somewhat of a Problem | Problematic |
|---|---|---|---|---|---|
| 39. Relationship with peers | 1 | 2 | 3 | 4 | 5 |
| 40. Following directions | 1 | 2 | 3 | 4 | 5 |
| 41. Disrupting class | 1 | 2 | 3 | 4 | 5 |
| 42. Assignment completion | 1 | 2 | 3 | 4 | 5 |
| 43. Organizational skills | 1 | 2 | 3 | 4 | 5 |

**Comments:**

Please return this form to: _____

Mailing address: _____

_____

Fax number: _____

**For Office Use Only**

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–28: _____

Total number of questions scored 2 or 3 in questions 29–35: _____

Total number of questions scored 4 or 5 in questions 36–43: _____

Average Performance Score: _____

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# Treatment of ADHD

- Medication management and/or behavioral therapy.
- MTA study (1999)[5]
  - Children with ADHD randomized to 4 groups and followed over 14 months

1) Algorithmic med management
2) Behavioral Therapy
3) Combination MM + BT
4) Community Treatment

# Results of MTA Study

- 2 groups with medication management showed superior improvement in symptoms over therapy alone.
- Behavioral therapy alone was not superior to community treatment alone.
- However → combining behavioral therapy with med management was useful learning strategies to modify problematic behaviors.

# MTA Study: 8-year follow-up[6]

- Type or intensity of 14 months of treatment for ADHD in childhood (7.0–9.9 years old) did not predict functioning 6-8 years later.
- Rather, children with behavioral and sociodemographic advantages, had the best long-term prognosis.
- Innovative treatment approaches targeting specific areas of adolescent impairment are needed.

# FDA-Approved ADHD Medication

| Stimulants | | |
|---|---|---|
| **Class** | Trade Name | Generic Name |
| **Amphetamines** | Adderall | mixed amphetamine salts |
| | Adderall XR | extended release mixed amphetamine salts |
| | Dexedrine | dextroamphetamine |
| | Dexedrine Spansule | dextroamphetamine |
| | Vyvanse | Lisdexamfetamine (extended release) |
| **Methylphenidate** | Concerta | methylphenidate |
| | Daytrana | methylphenidate (patch) |
| | Focalin | dexmethylphenidate |
| | Focalin XR | extended release dexmethylphenidate |
| | Metadate ER | extended release methylphenidate |
| | Metadate CD | extended release methylphenidate |
| | Methylin | methylphenidate hydrochloride (liquid & chewable tablets) |
| | Quillivant XR | extended release methylphenidate (liquid) |
| | Ritalin | methylphenidate |
| | Ritalin LA | extended release methylphenidate |
| | Ritalin SR | extended release methylphenidate |
| **Non-stimulants** | | |
| **Class** | Trade Name | Generic Name |
| **Norepinephrine Uptake Inhibitor** | Strattera | Atomoxetine |
| **Alpha Adrenergic Agents** | Intuniv | extended release guanfacine |
| | Kapvay | extended release clonidine |

# Non-Pharmacologic Interventions

Traditional behavioral therapy

- Play therapy for preschool and school-age.
- Individual or group therapy
- Teaches and reinforces appropriate social skills and behaviors
- Can be given in school, by guidance counselor. Or outside of school.

- In-home therapy
  - Parental guidance on in-home structure and reinforcement (e.g. token economy)
  - Helps identify maladaptive in-home patterns
- 504 Plans
  - In-class modifications tailored specifically to the needs of children with ADHD
    - Increased test time
    - Preferential seating → during tests or during class to minimize distractions
    - Time before or after school for additional help
- Individualized Education Plans (IEP)
  - The result of a school-initiated Child Study Team Evaluation
  - Usually reserved for children with more global academic, social and behavioral impairments.

COVID-19
CORONAVIRUS DISEASE 2019

# COVID-19 Emerging Issues

- School Cancellations
- Concerns about kids with ADHD staying at home
  - Parents asked to assist with homeschooling
  - Children having difficulty adjusting to home-school environment
  - Behavioral/Emotional comorbidities surfacing in the home
  - Questions about medication continuation and/or adjustment
  - Concerns vary on a case-by-case basis

# ADHD and COVID19 - Issues to Anticipate

- Worsening of ADHD symptoms and comorbidities.
  - Boredom
  - Increased oppositional behavior
  - Increased irritability and/or explosive outbursts
  - Difficulty sustaining attention to school work
  - Increased hyperactive behavior
- Some of this is to be expected and normal, especially in the short-term as kids adjust to a new day-to-day routine.

# ADHD and COVID19 – General Guidelines

- Parents should do their best to maintain a routine and structure across multiple domains
  - Wake up time and bedtime
  - Daily hygiene
  - Daily schoolwork expectations
    - Though children with ADHD may not be able to dedicate the full length of a day to school work without teaching staff, daily schoolwork should still be an expectation.
    - Work should be done in a dedicated workspace. Preferably <u>not</u> in the bedroom or on the bed.
  - Avoid micromanagement. Think big picture.
- Avoid micromanagement. Think big picture.

# ADHD and COVID19 – General Guidelines

- Young children with ADHD are active, and thus, physical activity should still be promoted.
- Encourage parents to get creative.
- Think of ways to keep young kids physically active in the home.
  - Dancing
  - Exercise
  - Doing something – anything – is better than nothing.
- Young children should also be mentally stimulated.
  - Drawing/coloring
  - Group activities/games with family

# Parental Self-Care

- Take breaks from watching, reading, or listening to news stories, including social media
- Take care of your body
  - Deep breaths, stretching, meditation
  - Try to eat health, well-balanced meals, exercise regularly, get plenty of sleep
  - Limit alcohol consumptions
- Make time to unwind. Try to do some other activites you enjoy
- **Connect with others**. Share thoughts and ideas.

# AACAP Guidelines – Parent-Child Communication[7]

There are no "right" or "wrong" ways to talk with children about such public health emergencies. However, here are some suggestions you may find helpful:

- Create an open and supportive environment where children know they can ask questions. At the same time, it's best not to force children to talk about things unless and until they're ready.

- Answer questions honestly. Children will usually know, or eventually find out, if you're "making things up". It may affect their ability to trust you or your reassurances in the future.

- Use words and concepts children can understand. Speak at an age-appropriate level.

# AACAP Guidelines – Parent-Child Communication[7]

- Children <u>learn from watching</u> their parents and teachers.
  - Be a role model. Take breaks, get plenty of sleep, exercise, and eat well. Connect with your friends and family members

- <u>Limit children's exposure to frightening media</u>

# AACAP Guidelines – Parent-Child Communication[7]

- Be reassuring, let children know that there are lots of people helping the people affected by the coronavirus outbreak

- Acknowledge and validate the child's thoughts, feelings, and reactions. Let them know that you think their questions and concerns are important and appropriate.

# Medication Management

- Both parents and pediatricians have questions about the approach to take with medications while children are at home.
- No cut and dry answers.
- Medication decisions should be handled on a case-by-case between parents and PCP.

# Medication Management (con't)

- Treatment decisions should be guided by
  - Severity of ADHD impairment
  - Indications for medication use (e.g. isolated focus at school vs anger, irritability and severe impulsivity at home as well as school)
  - Baseline level of functioning without medication
  - Risks and benefits of continued medication use

# Medication Management- Case #1

HPI: 13 yr M with history of ADHD and ODD presents via telephonic follow-up. He has been on Concerta 36mg for the last 3 years, taking on school days as well as weekends. Mom states that he “is a mess” when he is not on it, and struggles to control his temper and emotions. When he does not take his Concerta, he tends to be very argumentative and sometimes gets into physical altercations with his sister.

Due to COVID-19, school has recently been suspended. His mother wants to know if he should continue taking his Concerta during this time.

***What are some questions we as practitioners should be asking ourselves and the parents?***

# Medication Management – Case # 1

Clinical Questions:

Functioning at baseline – relatively poor

Extent of impairment – Multidimensional impairment (social, academic, behavioral)

Side Effects to medication – Minimal

Risks of ongoing management – Minimal (based on minimal side effect profile)

Benefits of ongoing management – Moderate – High

Clinical Decision: In this case, the decision was made to continue with treatment for the time being.

Patient normally followed-up every 3 months, but due to recent changes, offered to follow every 4-6 weeks.

Education: Mother informed that any short-term symptom worsening may be a result of adjustment reaction, but that symptoms would continue to be monitored, and short-term adjustments made if indicated.

# Medication Management – Case # 2

HPI: 17 yr M with history of ADHD-CT presents via telephonic follow-up. He has been well controlled on Ritalin 20mg BID for the last 5 years. His behavior has been so well-managed that at his last appointment 3 months ago, both he and his mother wished to reduce his dose to just 20mg once a day at lunch, to help him focus more in the 2nd half of the day and at basketball practice. He has been doing well since this reduction.

Due to COVID-19, school activities have been suspended. He is running out of medications, but his mother would like to decide whether or not he should continue his medication, or if now would be a good time to trial off.

***What are some questions we as practitioners should be asking ourselves and the parents?***

# Medication Management – Case #2

Clinical Questions:

Functioning at baseline – Good. No behavior issues since Elementary School.

Extent of impairment – isolated academic impairment

Side Effects to medication – Minimal

Risks of ongoing management – Minimal (based on minimal side effect profile)

Benefits of ongoing management – Minimal – moderate. Academic workload is not rigorous in his senior year of high school, and all sports are suspended for the time being.

Clinical Decision: In this case, mother and patient had already expressed a desire to taper down on medication. Continuing with medication would not necessarily be risky, but also may not be particularly beneficial. Medication was discontinued for now with follow-up in 1 month.

Education: Mom and patient encouraged to monitor for signs of clinical worsening, and to contact if so.

# Medication Management – Case # 3

HPI: 13 yr F presents via telephonic follow-up. She was seen 2 weeks ago for an initial evaluation for ADHD med management. History was highly suggestive of ADHD combined type along with Learning Disorder. She had been started on a brief trial of Focalin 2 years ago, which seemed to help, but she was discontinued because parents were "not comfortable having her on medications forever." Vanderbilt assessments given to both mom and teachers scored 9/9 positive for both inattention and hyperactivity.

Due to COVID-19, school has been suspended, but Mom states she remains extremely hyperactive and impulsive. She notes that she has been "off the chain," running around the house non-stop, arguing with her sister, and just recently singed her eyebrows with a lit match. She is also attempting to leave the house and hang out with friends despite social restrictions.

***What are some questions we as practitioners should be asking ourselves and the parents?***

# Medication Management – Case # 3

Clinical Questions:

Functioning at baseline – Poor. Impulsive and reckless.

Extent of impairment – Multidimensional (academic, social, behavioral)

Side Effects to medication – None reported when took 2 years ago.

Risks of initiating management – Appetite suppression, headache, stomach ache in the short term. Non-zero possibility of symptoms worsening or lack of improvement.

Potential benefits of initiating management – High. Treat impulsivity, dangerous/reckless behavior, improve in-home relations, improve academic focus while home schooled.

Clinical Decision: After discussion, the decision was made to start an initial trial of Focalin XR 10mg. Vanderbilt assessments were emailed to the mother to monitor treatment response, and next appointment was scheduled for 2 weeks.

# Pediatric Psychiatry Collaborative

## *Regional Hubs*

- **Atlantic Health Hub @ Newton Medical Center**
- **Atlantic Health Hub @ Goryeb Children's Hospital**
- **Hackensack Meridian Hub @ Hackensack University Medical Center**
- **Hackensack Meridian Hub @ Palisades Center**
- **Hackensack Meridian Hub @ Saint Peter's Family Health Center**
- **Hackensack Meridian Hub @ Jersey Shore University Medical Center**
- **Cooper Hub @ Cooper University Medical Center**
- **Cooper Hub @ Pennsville**
- **Essex County served by Rutgers University Behavioral Health Care.**

***More information on the Essex Hub can be found here:*** https://ubhc.rutgers.edu/clinical/community/collaborative-behavioral-health-care-project-essex-hub/collaborative-behavioral-health-care-project-essex-hub/collaborative-behavioral-health-care-project-essex-hub.xml

Hackensack Meridian *Health*

Cooper University Health Care

The Children's Hospital AT SAINT PETER'S UNIVERSITY HOSPITAL
A MEMBER OF SAINT PETER'S HEALTHCARE SYSTEM
*Treating you better...for life.*

Atlantic Health System
Goryeb Children's Hospital

St. Joseph's Health
ST. JOSEPH'S CHILDREN'S HOSPITAL

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™
New Jersey Chapter

# PPC Hub Benefits

- A child and adolescent psychiatrist available for consultative support through the Child Psych. consult line
- A psychologist/social worker available to:
  - Assist the pediatrician with diagnostic clarification and medication consultation,
  - Speak with a referred child's family regarding the child's mental health concerns and to assist in providing diagnostic clarification.
- One-time evaluation by a child and adolescent psychiatrist (CAP) at no charge to the patient when appropriate.
  - Based on the recommendation of the CAP, the PPC Hub staff will work with the family to develop the treatment and care coordination plan.
- Continuous education opportunities in care management and treatment in the primary care office for the common child mental health issues: ADHD, depression, anxiety, etc.

# Useful Resources

American Academy of Child and Adolescent Psychiatry

https://www.aacap.org/

NJ Children's System of Care (PerformCare)

https://www.performcarenj.org/

1-877-652-7624 (24/7 access)

Children and Adults with Attention-Deficit/Hyperactivity Disorder

https://chadd.org/

1-866-200-8098 (Monday-Friday 1-5pm)

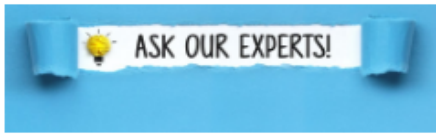
Substance Abuse and Mental Health Services Adminstration

https://www.samhsa.gov/

# Additional Resources

- AAP News – Coronavirus Disease Outbreak
- NEW – HIPPA Requirements for Telehealth
- CDC updates guidance on PPE for health care personnel; COVID-19 declared a pandemic
- AAP Postpones Leadership Conference, Shares COVID-19 Guidance
- Emergency Preparedness and Response
- Coverage and Benefits Related to COVID-19 Medicaid and CHIP
- CDC Webinars and Calls
- CDC Guidance to Healthcare Providers
- CDC Situation Updates
- NJDOH COVID-19
- DCF – Coronavirus (COVID-19)

## www.njaap.org




Over the next few weeks, we will offer several webinars and Q&A sessions to address specific challenges to help you in your healthcare settings. If you have specific clinical questions regarding COVID-19, please send them to us at covid@njaap.org. We will do our best to address them during upcoming Q&A sessions. We will be offering these calls on a weekly basis...can't make it, we will also post the recorded session.

**Session #1 – March 23, 1 pm**
Click Here

**Session #2 – March 26, 7:30 am**
Click Here

**UPCOMING WEBINARS:**

**FREE TO MEMBERS**

A Practical Approach to Implementing Telemedicine for Pediatrics (COVID-19)

Wednesday, March 25
12:00 – 1:00 PM EST

Update: Covid-19 What You Need To Know

Friday, March 27
12:00 – 1:00 PM EST

# Additional Resources:

- NAMI: https://www.nami.org/getattachment/About-NAMI/NAMI-News/2020/NAMI-Updates-on-the-Coronavirus/COVID-19-Updated-Guide-1.pdf
- The National Child Traumatic Stress Network: https://www.nctsn.org/sites/default/files/resources/fact-sheet/outbreak_factsheet_1.pdf
- CDC: https://www.cdc.gov/coronavirus/2019-ncov/prepare/managing-stress-anxiety.html
- SAMHSA: https://www.samhsa.gov/coronavirus
- NY Times: https://www.nytimes.com/2020/03/18/parenting/coronavirus-kids-events-cancelled.html?smid=em-share
- Verizon Low-Income Internet Program: http://www.njshares.org/otherprograms/communications-lifeline.asp

# References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4. National Institute for Children's Health Quality https://www.nichq.org/resource/nichq-vanderbilt-assessment-scales
5. The MTA Cooperative Group. A 14-Month Randomized Clinical Trial of Treatment Strategies for Attention-Deficit/Hyperactivity Disorder. *Arch Gen Psychiatry.* 1999;56(12):1073–1086. doi:10.1001/archpsyc.56.12.1073
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7. American Academy of Child and Adolescent Psychiatry https://www.aacap.org/coronavirus

# Questions?

## Please contact:


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