Managing ADHD with Co-Occurring Anxiety Disorders in Primary Care

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Disclosure

• We have no financial relationships to disclose

• We will not discuss off label use and/or investigational use in our presentation
Learning Objectives

1. Use recently revised AAP practice guidelines to evaluate and manage children with complex ADHD in the primary care setting.
2. Know when, how, and with whom to use evidence-based pharmacological, non-pharmacological, and combined treatment modalities to help children with ADHD+Anxiety.
Case

• Cathy: 10 year old girl
• Well child exam and sports physical
• Screen: PSC-17
• Concerns: homework, lost assignments, restlessness and emotional reactivity
Case (cont.)

- Achievement scores declined
- Past history unremarkable
- Review of systems: 2 weeks of periumbilical pain, 1 week of chest pain and 1 week of headaches
- Physical exam normal
Breakout #1 (10 min.)

• How would you interpret her PSC-17 for her and her family?

• What next steps would you take?
AAP Guideline 2nd ed.

ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents

abstract

Attention deficit/hyperactivity disorder (ADHD) is the most common...
Overview of the ADHD Care Process

4- to 18-year-old patient identified with signs or symptoms suggesting ADHD. Symptoms can come from parents’ direct concerns or the mental health screen recommended by the TFCMH.

See action statement 1

Perform Diagnostic Evaluation for ADHD and Evaluate or Screen for Other Coexisting Conditions:

See action statements 2-3

Family
- Parent questions (questionnaire)
- History of ADHD
- Past medical history
- Psychosocial history
- Review of systems
- Evaluated other coexisting conditions
- Report dysfunction, both strengths and weaknesses

School
- School-based screening information:
- Concerns
- Validated ADHD instrument
- Evaluation of coexisting conditions
- Report how well school functions in academic, work, and social interactions
- Academic records, IEP, report cards, standardized testing, psychosocial evaluations
- Administrative reports (e.g., school records)

Child/adolescent
- Appropriate for child’s age and developmental level
- Impact on overall academic, work, social interactions
- Interactions, including concerns regarding behavior, family relationships, peers, school
- For examples, evaluate self-report instrument of ADHD and coexisting conditions
- Report of child’s self-identified impression of strength, both strengths and weaknesses
- Clinical observations of ADHD behavior
- Physical and neurologic examination

Supplemental Appendix Figure 2
ADHD process of care algorithm. TFCMH indicates Task Force on Mental Health; CYSHON, child/youth with special healthcare needs.
1. The PCP should initiate evaluation for ADHD

- Any child ages 4-18 presenting with academic or behavioral problems and impulsivity, inattention and hyperactivity
- Use an evidence based screening tool
2. Diagnosis should be made using the DSM criteria

• Highlighted Changes in DSM-5:
  – Threshold criteria overall are the same
  – “Presentations,” not subtypes
  – “Onset of symptoms” raised to age 12
  – “Several” symptoms in at least 2 settings
  – “Interference with, or reduced quality of, functioning”
  – Can co-occur with Autism Spectrum
Case (cont.)

- Provisional diagnosis of ADHD-primarily inattentive presentation
- Follow-up planned for 1 month with Vanderbilt forms
- Reassured Cathy that physical symptoms were stress related
Case: 1 month follow-up

• Vanderbilt Assessment Scales were reviewed
• Stomachaches and headaches continued, but no chest pain
Breakout #2 (10 min.)

- Review the Vanderbilt scales
- What concerns do you have?
- What next steps would you take?
Case: 1 month follow-up

- Diagnosis of ADHD was made and Concerta was started
- Follow-up was planned for 2 weeks
3. Evaluation should include assessment for coexisting conditions

- Includes emotional, behavioral, developmental and physical conditions
- Coexisting conditions may affect treatment strategy and response
4. Recognize ADHD as a chronic condition

- Consider them as children and youth with special health care needs
- Management under the chronic care model = medical home
- Communication (schools, therapists)
5. Treatment varies depending on the patient’s age

- For preschool aged children (4-5 years)
  - Parent training FIRST
- For elementary aged children (6-11 years)
  - Medication, therapy, preferably both
- For Adolescents (12-18 years)
  - Medication, therapy, preferably both
6. PCP should titrate medication dosage

- Maximize benefits with minimum adverse effects
- Intensive management is best
- Adequate time and pre-arranged f/u
  - Minimum 2x/yr
  - Studies suggest q3-4 months
Case: 6 months later

- Monthly visits over next 6 months
- Concerta ineffective, as was Straterra
  - increased stomachaches; lost weight with each
- High-dose Adderall XR helped with ADHD and pain → lost weight
  - Adderall XR dose decreased → worse emotional reactivity and physical symptoms
Case: 6 months later

• Screen for Child Anxiety Related Disorders-Child Report (SCARED) completed, more history gathered
Breakout #3 (10 min.)

• How would you interpret what’s going on?
• What next steps would you take?
6 month follow up

- Diagnosed with ADHD with co-occurring Generalized Anxiety Disorder with Somatic Features and School Avoidance
- Referral for psychotherapy
- Follow-up in 1 month
ADHD and Anxiety

• About 1/3 of patients with ADHD have an anxiety disorder
• Anxiety disorders more common in girls with ADHD vs boys
• Also more common in girls with ADHD vs girls without it
### Differentiating ADHD and Anxiety Disorder

<table>
<thead>
<tr>
<th>Sign/Symptom</th>
<th>ADHD</th>
<th>Anxiety</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor Concentration</td>
<td>++</td>
<td>+/-</td>
</tr>
<tr>
<td>Restless</td>
<td>++</td>
<td>+/-</td>
</tr>
<tr>
<td>On edge, hyper-vigilant</td>
<td>+/-</td>
<td>+++</td>
</tr>
<tr>
<td>Hx of developmental differences</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Soft neurologic signs on exam</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Hx of separation anxiety</td>
<td>+/-</td>
<td>++</td>
</tr>
<tr>
<td>Somatic symptoms</td>
<td></td>
<td>++</td>
</tr>
<tr>
<td>Sleep difficulty</td>
<td>+</td>
<td>++</td>
</tr>
<tr>
<td>Feelings of panic, fear, uneasiness</td>
<td></td>
<td>+++</td>
</tr>
</tbody>
</table>
Treatment

• Medication
• Behavioral therapy
• Combined
• Community care versus intensive management in studies
  – initial titration, monthly monitoring, extended release/TID dosing, contact with teacher prior to each visit
Response to Treatment among those with ADHD

• MTA study - ADHD symptom management
  – Medication alone and combined medication with behavioral therapy were best
  – These were better than community care
  – Behavioral therapy alone was less beneficial
Response to Treatment among those with ADHD + ANX

- MTA
  - Behavioral or Combined > Stimulant alone
  - No worse response to medication
- Diamond, et al
  - No difference in response to methylphenidate on behavior measures or side effects
Internalizing Symptoms in MTA Study

• ADHD and internalizing symptoms improved with stimulant medication
  – Even though Behavioral Therapy in MTA study did not specifically target anxiety
  – Some of the anxiety may be related to stress from ADHD impairment
Strategies for Primary Care

• Outside psychiatric or DBP assessment
• Collaborative peer consultation
• Mental health assessment skills training
• Collaborative care interventions
Doctor’s Office Collaborative Care

- Used chronic care model
- Case managers used content modules (6-12 sessions) derived from a CBT approach for behavior problems, ADHD and anxiety
- Incorporated behavioral and medication management recommended by the AAP

Kolko et al, 2014
Outcomes

• Providers
• Patients
• Parents

Kolko et al, 2014
What strategies could you implement in your practice?
References


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• MTA Cooperative Group. Moderators and Mediators of Treatment Response for Children with Attention-Deficit/Hyperactivity Disorder. *Arch Gen Psychiatry.* 1999;56:1088-1096.