Case Presentations:
Anxiety and Complex ADHD

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University of Nebraska Medical Center

DISCLOSURES

This presentation was prepared for the MHTTC Network under a cooperative agreement from the Substance Abuse and Mental Health Services Administration (SAMHSA).

At the time of this publication, Miriam Delphin-Rittmon served as Assistant Secretary for Mental Health and Substance Use and Administrator of SAMHSA. The opinions expressed herein are the views of the speakers and do not reflect the official position of the Department of Health and Human Services (DHHS), or SAMHSA. No official support or endorsement of DHHS, SAMHSA, for the opinions described in this presentation is intended or should be inferred.

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The MHTTC Network uses affirming, respectful and recovery-oriented language in all activities. That language is:
STRENGTHS-BASED AND HOPEFUL
INCLUSIVE AND ACCEPTING OF DIVERSE CULTURES, GENDERS, PERSPECTIVES, AND EXPERIENCES
HEALING-CENTERED/ TRAUMA-RESPONSIVE
INVITING TO INDIVIDUALS PARTICIPATING IN THEIR OWN JOURNEYS
PERSON-FIRST AND FREE OF LABELS
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CONSISTENT WITH OUR ACTIONS, POLICIES, AND PRODUCTS
Adapted from: https://mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf

Mid-America Mental Health Technology Transfer Center (MHTTC)

- Funded by the federal Substance Abuse and Mental Health Services Administration (Grant number: H79SM081769).
- Awarded to UNMC's Behavioral Health Education Center of Nebraska (BHECN).
- Serves to align mental health services across Missouri, Iowa, Nebraska, and Kansas with evidence-based practice.

Announcements

- This webinar is recorded.

https://mhttcnetwork.org/centers/mid-america-mhttc/tele-behavioral-health-consultation-tbhc-primary-care-webinar-series

Nebraska Mental Health Access Grant

- 5-year, $2.2 million HRSA grant through maternal and child health bureau
- Designed to improve timely access to behavioral healthcare for children in rural Nebraska
- The main goal is to provide primary care providers access to behavioral health supports

Goals

- Enhance **early screening** of behavioral health disorders
- Conduct a clinical demonstration project in a network of providers to **expand and diversify integrated behavioral health provision in PC** pediatric and family medicine practices, with a focus upon **rural** communities
- Evaluate the overall **effectiveness of increasing access to PCP's to behavioral health consultation**

https://www.unmc.edu/mmi/services/psychology/teleproviderconsult.html?msclkid=77c12956b5f311ec8c21922c759e3b30

Tele-Behavioral Health Consultation (TBHC)

- Behavioral health providers or case managers on-site at primary care clinics
- Behavioral health/care managers determine need for consultation with psychiatry
- Consultant consults with PCP (audio or audio-visual) on the same day
  - Child Psychiatry
  - Developmental Medicine
  - Psychiatric Nurse Practitioner

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Behavioral Health Consultation for Primary Care Providers

The UNMC Tele-Behavioral Health Consultation Team (TBHC) provides psychiatry support to primary care providers in Nebraska who are managing pediatric patients with behavioral health problems. Providers are available to offer guidance on diagnosis, medications, and psychotherapy interventions to assist primary care providers in better managing patients in their practices. Support is available through phone and synchronous audio/video teleconference consultations to referring primary care providers.

How Does it Work?

1. The participating provider or representative initiates a request to Dani Porter at (402) 559-3838 or through the website at unmc.edu/mmi/departments/psychology/psych-patientcare/teleproviderconsult.html
2. A member of the TBHC team will contact the provider within the same business day to offer guidance.
3. The TBHC is not an emergency service. Emergencies will be routed to local emergency services.
4. The UNMC TBHC team does not prescribe medication. They provide support for prescribers.

Team Members

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Psychiatric Nurse Practitioner

Ryan Edwards, M.D.
Psychiatrist

Cindy Ellis, M.D.
Developmental-Behavioral Pediatrician

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A Good State of Mind
www.dhhs.ne.gov/NEPMAP

This (UNMC Tele-Behavioral Health Consultation Team) is supported by an award from Nebraska Department of Health and Human Services (NEDHHS). The award is made possible by the Health Resources and Services Administration's (HRSA) Pediatric Mental Health Care Access Program, Grant No. U40MC36320, with NEDHHS as lead state agency. The contents of the project are the responsibility of UNMC MMI and do not necessarily represent official views of, or endorsement by, HRSA or NEDHHS.

Primary Care Providers (PCPs)

- PCPs can request a consultation three ways:

  1) Visit our website:
  https://www.unmc.edu/mmi/services/psychology/teleproviderconsult.html

  2) QR Code

  3) Call 402-559-3838

Objectives

- Identify symptoms of selective mutism with comorbid generalized anxiety disorder.
- Describe evidenced-based treatment interventions for selective mutism and anxiety in an integrated primary care practice.
- Review the factors that contribute to Complex ADHD.
- Discuss practice guidelines for interdisciplinary behavioral and medication treatments for complex ADHD in a primary care practice.

Selective Mutism & Complicated Anxiety & Depression

Chief Complaint

JJ is a 6-year-old male with parental history of refusing to speak in school to his teacher and other staff. He does not respond to questions when asked. He has one friend that he speaks to only during recess time but not during class time. His mother reports that he has no difficulty with talking with family members at home. His teachers have reported they are concerned about this behavior and are wondering if he could be autistic because he doesn't talk even though they haven't seen any other atypical behaviors such as repetitive behaviors, rigidity with rules and routines, sensory sensitivities or special interests. JJ does not speak to you but rather puts his head down when you ask him questions.

Pertinent History

Past Psychiatric History

- No previous history of disruptive or atypical behaviors. JJ attended preschool and had several friends. Engaged in verbal communication. No hx of symptoms of anxiety or depression.
- No psychiatric medications.

Social History

- Lives with biological married parents and 2 older siblings, ages 9 and 11 sisters. Mother works as a computer programmer and father is an industrial engineer. Family lives in urban community. JJ participates in soccer. Gets along well with siblings. Caucasian family. They have always lived in the U.S, and only speaks English language.

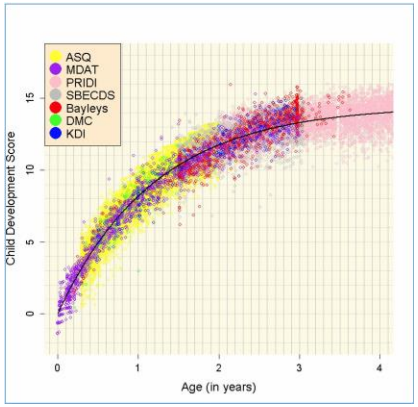
Family Psych History

- Father – Depression/Anxiety
- Mother – Anxiety
- PGF – Substance Use
- Sister – ADHD –Inattentive Presentation

Pertinent Medical History

Past Medical History –

- **Prenatal and Birth.** No maternal complications. Delivered vaginally at 38 weeks gestation**.** Discharged from hospital with mother at 2 days. Breast fed x 9 months.
- No operations or hospitalizations.
- No current medications
- NKA
- Immunizations - UTD



Family medical History -

- PGF – Heart disease, Substance Use disorder
- Mother – Hypothyroid
- MGM – Breast cancer

Developmental - Met all developmental milestones on time. Spoke 2 words at 14 months of age. 15 words at 18 months and using phrase speech at 2 years of age. Speech 80% understandable at 4 years of age and 100 understandable at 5 years of age.

Educational - Currently in 1st grade in Gen Ed classroom. Meets all course work with Satisfactory grades in all subjects.

Clinical Pearls - Diagnostic

Differential Diagnosis –

- Communication Disorders, Neurodevelopmental Disorders/Schizophrenia or Psychotic Disorders, Social Anxiety, & Selective Mutism
    - Communication Disorders & Neurodevelopmental or Psychotic Disorders – speech and language not different in two settings
    - Selective Mutism – Normal language skills and will speak in presence of immediate family members but not often with friends , cousins, grandparents
        - Onset is usually before 5 years age but may not come to clinical attention until entry into school
        - Can occur in both males and females
    - Social Anxiety is often diagnosed comorbid with selective mutism

•Diagnosis: Selective Mutism

Initial Treatment

- Referral to Behavioral Psychologist/Therapist in Integrated Primary Care Setting

Follow up visit - 3 months later

- Patient has been seen by the behavioral psychologist for 3 months.
    - Interdisciplinary approach at behavioral psychologist providing consultation to school with school counselor and speech and language therapists.
    - Behavioral therapy is focusing on graduated exposure and fading familiar individual out of school setting (Parent is involved in therapy)
    - Rewards are given for approximations of vocalizations or whispers
    - Continued exposure with more difficult tasks and reinforcement with preferred activity/toys
    - Video taping of child speaking with parent and /or progress in independent communication with parent and counselor

•Some progress is noted with speaking with the parent and counselor in the private session but still unable to speak while in classroom.

Visit 3 – 6 months later

- JJ is out of school for summer and continues to have fluent speech in the home environment.
- He has been involved in soccer and communicates with a couple peers but not with his coach or friend's parents.
- Parents have noted some irritability, and more oppositional behaviors than previously.
- They also report clinginess and reports of fears when they leave him at home with older siblings. He has been in therapy all summer, but parents are wondering how he is going to manage going back to school.

Differential Dx- Separation Anxiety, Generalized Anxiety Disorder, Oppositional Defiant disorder. Further testing on the SCARED shows elevations in separation, generalized and social anxiety subdomains.

Diagnosis: Generalized Anxiety Disorder

Treatment – Sertraline 12.5 mg daily; titrate up to 25 mg in one week and continue to titrate based upon progress and tolerance.

Visit 4 – 2 months later

- JJ is now in 2nd grade and tolerating the Sertraline 25 mg well and has shown significant improvement in his speech production in the school setting.
- He is now talking with more peers and a select group of teachers.
- At home, he continues to have fluent speech and talking with cousins and grandparents. He is less clingy with his parents and shows less irritability
- JJ continues to play soccer and talks to one coach and 3-4 peers.

Fast forward 7 years

- JJ has done well for the past 7 years in academic performance at school and was able to show full engagement in social activities. He became a very good soccer player and was playing on “select teams”.
- Over the past 7 years, Sertraline was titrated up to 100 mg as minor setbacks occurred, with positive response to each dose increase
- JJ sustained a serious tibia/fibula fracture and is no longer able to play on soccer team.
  Within 3-4 months, JJ has become increasing depressed and reported anhedonia, loss of appetite and is sleeping poorly. He reports worthlessness, and loss of energy.
  He expressed suicidal ideations to his peers who then relayed this information to his mother. He also has begun to stop talking with teacher’s and is showing withdrawal from family and peers.

PHQ-9 = 20

- **Dx - MDD single episode, moderate.**
- Treatment – Initially Sertaline was increased to 150 mg with no improvement. Then Fluoxetine was prescribed with no improvement and then Escitalopram was prescribed but with no improvement. He was then admitted to partial hospitalization and Duloxetine ER 40 mg was prescribed.

Current Status

- JJ is now doing well – PHQ -9 = 5
- He is helping coach soccer.
- He has begun speaking to teachers and peers again.
- Academically, he is doing well – all As and Bs
- He continues to attend biweekly therapy appointments.
- Medication follow up occurs every 2 months.

Complex ADHD: Case study

Preschool ADHD

Preschool ADHD

Chief Complaint

Leo F. is a 3 yr 4 mo old male who presents with behavioral concerns in preschool and home.

- First concerns at age 2 yrs
  - frequent and severe tantrums difficult to manage in daycare. Asked to leave 2 different daycares.
  - seen by psychology who felt he had normal dev for 2-year-old and was “not a good fit for his daycare”. Some parent training regarding behavior management was provided.

Chief Complaint (continued)

- Entered preschool at age 3 yr. Youngest in class of 20. Teacher concerns included:
  - hyperactive and constantly moving from station to station, didn't sit for circle time
  - noncompliance and power struggles with teachers (his noncompliance is sometimes due to distractibility, but it is intentional when he is asked to do something he does not want to do)
  - aggression that has increased. Some aggression appears to be impulsive in nature and some is seemingly unprovoked.

Chief Complaint (continued)

- At home, increasing defiance, tantrums, and aggression over past 6 months. He plays with some peers his same age and usually does well but prefers to be with adults. He is very busy but has many toys he plays with appropriately. Prefers to run around outside. He needs close supervision to stay safe.
- mood is usually happy and positive.

Social History

- Lives with parents and 6-year-old-sister. Both parents professionals working out of the home full time. Extended family lives out of state, but parents have extensive ties to community.

Family History – Psychiatric/Medical

- Father – arthritis; Mother – anxiety; sister – no dev or behavior concerns
- 2 mat uncles w/ ADHD, 2 first cousins – ADHD, combined subtype
- Numerous paternal relatives with anxiety/depression

Past Medical History

- Recurrent ear infections; myringotomy with tubes at ages 12 and 19 months with reduction in ear infections. Hearing normal.
- No complications with pregnancy or labor/delivery. No prenatal exposures. Delivery repeat C-section at 39 weeks EGA. BW 7 lb 11 oz. APGARS 8 and 9. Parents both age 30 at birth.

Developmental History

- No concerns on routine developmental screening with Ages and Stages and MCHAT.
- His teachers have reported that he is proficient in his pre-academic skills. His strengths are gross motor and verbal skills. In terms of social skills, Leo is interested in other kids and plays with them (when he wants to). He has good communication and play skills.

Review of Systems

- Good general health – no recent ear infections.
- sleep – difficult to settle at bedtime, sleeps 8-9 hours/night with 1-2 awakenings, no naps since age 15 mo
- appetite – good, eats a variety
- otherwise neg

Differential Diagnosis

- Difficult temperament with high levels of activity/impulsivity
- Delayed social/emotional development
- Oppositional Defiant Disorder
- Inappropriate expectations for behavior for age
- Sleep disorders causing sleep deprivation that present with behavioral patterns similar to ADHD
- Anxiety/mood disorders
- Exposures – prenatal (alcohol), childhood (lead toxicity)
- Absence seizures
- Complex ADHD

Complex ADHD

Complex ADHD is when children and adolescents with ADHD have one or more coexisting conditions(s) or other factor(s) that complicates the evaluation and treatment of their ADHD:

- Presenting at an unusually early (< 4 years) or late (> 12 years) age
- Having a coexisting condition (medical, psychiatric, or developmental/learning), including:
  - ASD
  - Tic Disorder
  - Substance Use Disorder
  - Anxiety
  - Depression
  - Disruptive Behavior Disorder
- Moderate to severe impact of symptoms on daily functioning
- Primary Care Physician being uncertain about diagnosis of ADHD
- Inadequate response to treatment

Complex ADHD

Hallmarks of Complex ADHD guidelines:

- Interprofessional Care
- Psychological Testing and Mental Health Diagnostic Assessment
- Multimodal Treatment
- Evidence-based Psychosocial Interventions
- Treatment for Coexisting Conditions
- Life Course Perspective

Initial treatment plan:

- Discuss differential diagnosis with parents
- Refer for outpatient behavioral psychology consultation in integrated primary care setting
- Schedule follow-up appointment in 3 months

3 month follow-up visit (age 3 yr 7 mo)

- Leo attends a home daycare with 1 other child. He continues to require constant supervision and be "difficult to manage", but the new provider has not given up yet.
- At home, he continues to have frequent tantrums, is noncompliant but with less aggression, and hyperactive. Parents still unable to take him on outings or to stores. No naps and still wakes during the night requiring adult attention to get back to sleep.

3 month follow-up visit (age 3 yr 7 mo)

- In outpatient therapy with behavioral psychologist x 2 months
  - Treatment has focused on PCIT, home behavior management and sleep hygiene, including some recommendations for daycare providers
  - Initial psychology evaluation consistent with diagnosis of ADHD (including Conners Parent Rating Scale-R for ages 3-17), but psychologist hesitant to diagnose ADHD under 4 years of age using DSM-5 criteria
- Treatment:
  - continued outpatient therapy, including parent training (and daycare provider training)
  - schedule follow up in 3 months

6 month follow-up visit (age 3 yr 10 mo)

- Parents report ongoing problematic behaviors at home and daycare. Compliance slightly improved with very frequent and consistent reinforcement. Still difficult to take on family outings.
- Daycare provider feels Leo needs to be in more structured preschool setting but doubts he will be successful there due to his need for constant supervision and redirection.
- Parents want to enroll him in an all-day pre-K program that starts in 4 months.

6 month follow-up visit (age 3 yr 10 mo)

- Leo has been in outpatient therapy with behavioral psychologist for 5 months
  - Psychologist reports good parent participation and treatment fidelity but limited progress after 6 months. She also recommends that Leo needs a more structured program.
  - Psychologist is still reluctant to formally diagnose ADHD < age 4 years but recommends consideration of additional medical treatment due to limited progress.

6 month follow-up visit (age 3 yr 10 mo)

- Preliminary medical diagnosis of ADHD
  - ADHD Rating Scale IV – Preschool Version (Parent) for ages 3-5 years

Subscale	Score	(Cutoff) Significance
Inattention	11	(14) Not Significant
Hyperactive/Impulsive	25	(17) Significant
TOTAL	36	(32) Significant

- Treatment
  - continued outpatient therapy
  - trial of methylphenidate – 2.5 mg in am, titrate to 5 mg as directed (child can't swallow pills)
  - Schedule follow up in 1 month w/ phone management as needed

7 month follow-up visit (age 3 yr 11 mo)

- Improvement noted at home and daycare with am dose of MPH titrated to 5 mg in am – Leo reverts to previous problem behaviors in the afternoons
- Continues in outpatient therapy
  - Psychologist has made provisional ADHD diagnosis and will do formal ADHD evaluation when Leo enters preschool in a few months.

- Treatment
  - continued outpatient therapy
  - Increase methylphenidate to 5 mg in am and at noon
  - Schedule follow up in 1 month w/ phone management as needed

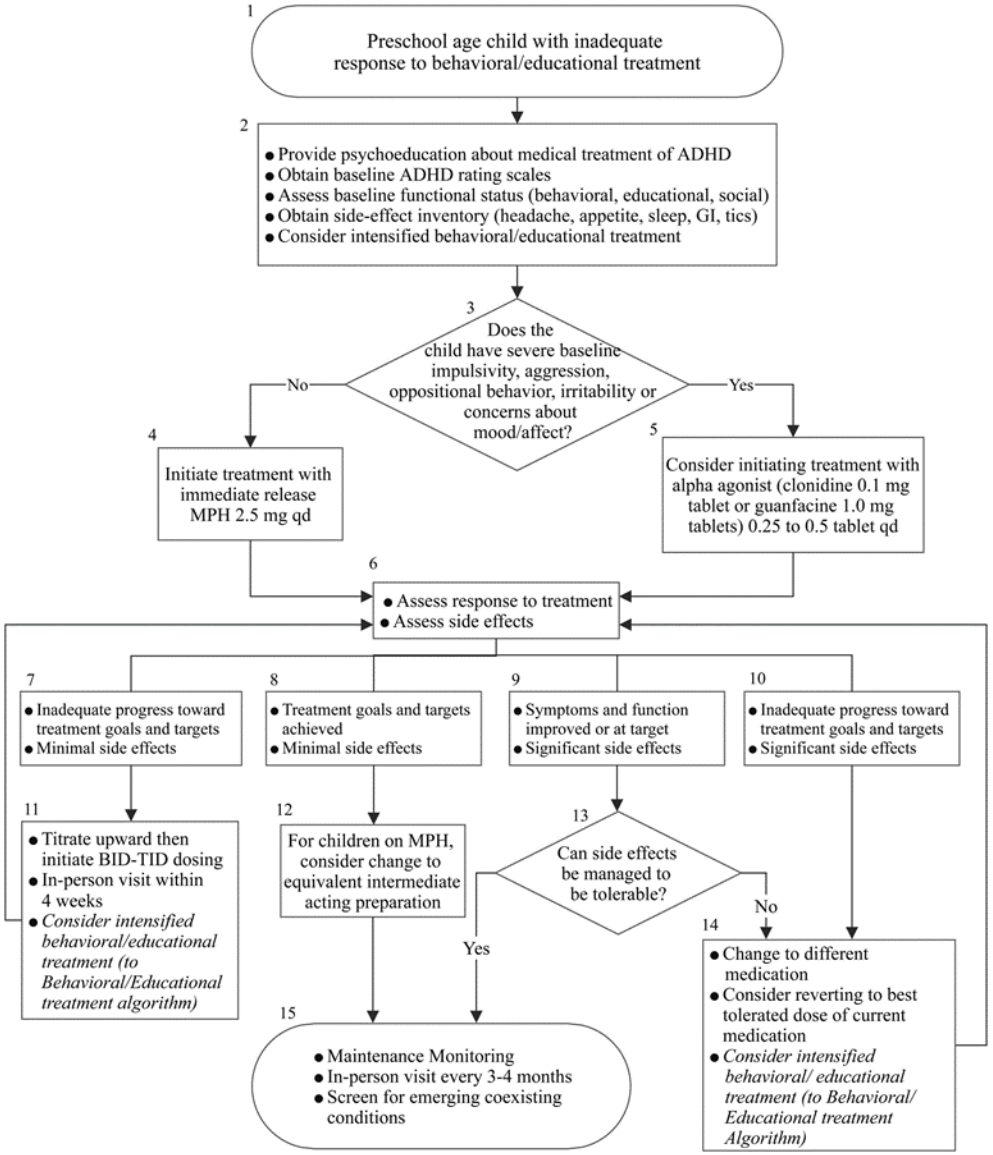
8 month follow-up visit (age 4 yrs)

- Continued improvement noted at home and daycare in the mornings, but afternoons are difficult. There are concerns about starting preschool in about 6 weeks
- Leo and his parents continue to work with behavioral psychologist – has initiated formal ADHD evaluation with provisional ADHD diagnosis
- He continues on methylphenidate liquid 5 mg in am
  - Noon dose provided extended benefit, but appetite decreased and sleep worse.
  - After 12 days, noon dose decreased to 2.5 mg with minimal efficacy in the afternoon – after one more week, the afternoon dose stopped

8 month follow-up visit (age 4 yrs)

- Treatment considerations:
  - Try alternate stimulant – may not be covered by insurance until > 5 years old (generics are usually the only formulations approved)
  - Try clonidine (.025 to .05 mg/day) or guanfacine (.25 to .5 mg/day) – start with a low dose and gradually titrate
  - Consider intensified behavioral/educational treatment

Preschool Age Complex ADHD General Medication Treatment Algorithm (ages ≥ 3 years to < 6 years)



SDBP 2020

Questions?

Case studies:

Selective Mutism & Complicated Anxiety & Depression

Preschool ADHD

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