UVM Project ECHO: Adult Complex Mental Health

Course Co-Directors: Mark Pasanen, MD  Sara Pawlowski, MD

ECHO Director: Elizabeth Cote

Series Faculty: Evan Eyler, MD  Jess Oehlke, MD  Kathy Mariani, MD  Jennifer Hall, DO  Jessica O’Neil, DO  Stephanie Fosbenner, MD
RECORDING OF SESSION TO BEGIN
“Introduction” to ZOOM

• Please mute microphone when not speaking
• **Please** use camera as much as possible
• Test both audio & video before joining
• Communicate clearly during session:
  • Can use “raise hand” feature to comment
  • Use chat function for questions, comments or technical issues
Project ECHO

Project ECHO® is a lifelong learning and guided practice model that revolutionizes medical education and exponentially increases workforce capacity to provide best practice specialty care and reduce health disparities through its hub-and-spoke knowledge sharing networks.

People need access to specialty care for complex conditions.

Not enough specialists to treat everyone.

ECHO® trains primary care clinicians to provide specialty care services.

Patients get the right care, in the right place, at the right time.
ECHO model is not ‘traditional telemedicine’.

Treating Physician retains responsibility for managing patient.
Series Objectives

Learning objectives for this ECHO series include the ability to:

• Enhance diagnostic skills in patients with complex mental health issues

• Incorporate new treatment strategies into management of common but challenging mental health disorders

• Improve the care that patients with mental health issues receive in the primary care setting
Session Agenda

• Welcome
• Objectives
• Didactic Presentation (30-35 min)
• Case presentation
  • Clarifying questions
  • Participants – then faculty panel
• Discussion
• Recommendations
• Summary
• Closing Announcements
  • Submission of new cases
  • Completion of evaluations
CMIE Disclosures

University of Vermont (UVM) Office of Continuing Medical and Interprofessional Education (CMIE) is approved as a provider of Continuing Medical Education (CME) by the ACCME. UVM designates this internet live activity for a maximum of 1.5 AMA PRA Category 1 Credits.

UVM CMIE is accredited by the American Nurses Credentialing Center (ANCC) to provide CE for the healthcare team. This program has been reviewed and is acceptable for up to 1.5 Nursing Contact Hours.

As a Jointly Accredited Organization, The Robert Larner College of Medicine at the University of Vermont is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. The University of Vermont maintains responsibility for this course. Social workers completing this course receive 1.5 continuing education credits.

This activity was planned by and for the healthcare team, and learners will receive 1.5 Interprofessional Continuing Education (IPCE) credit for learning and change.

Participants should claim only the credit commensurate with the extent of their participation in the activity.
CMIE Disclosures

**Interest Disclosures:** As an organization accredited by the ACCME to sponsor continuing medical education activities, UVMCMIE is required to disclose any real or apparent conflicts of interest (COI) that any speakers may have related to the content of their presentations.

**Meeting Disclaimer:** Regarding materials and information received during this educational event, the views, statements, and recommendations expressed during this activity represent those of the authors and speakers and do not necessarily represent the views of the University of Vermont.
Sara Pawlowski, MD
Child, Adolescent and Adult Consultant Psychiatrist
Division Chief, Primary Care Mental Health Integration Psychiatry Service
Attending Psychiatrist and Assistant Professor, UVMMC
Objectives

• Increase your confidence in making an ADHD diagnosis (or ruling it out).
  • Truth: I, a psychiatrist, am no better at doing this in adults than any other provider. I just 1) know what to rule out! 2) Hold boundaries when I think stimulants are more risk than benefit.
  • Empower you to say, “Yes, this sounds like ADHD... let’s do this” or “No, this isn’t ADHD ... but you can still do this to improve your attention.”

• Increase your knowledge of treatment (and limitations) including stimulant, non-stimulant and non-medication options.
Part 1: ADHD Diagnosis
ADHD: A Modern Problem?

The great attention deficit: More parents seek ADHD diagnosis and drugs for kids to manage remote learning

"Covid has been a tipping point that has pushed some families to get help," said one expert.

Original Investigation
July 17, 2018

Association of Digital Media Use With Subsequent Symptoms of Attention-Deficit/Hyperactivity Disorder Among Adolescents

Chaelin K. Ra, MPH; Junhan Cho, PhD; Matthew D. Stone, BA; et al

Key Points

Question Is frequent use of modern digital media platforms, such as social media, associated with occurrence of ADHD symptoms during adolescence?
ADHD Diagnostic Criteria
6/9 (5+ adult) core symptoms
Must present before age 12
Average age diagnosis: 6-9
Impairment in school/home/peers (at least two settings)

<table>
<thead>
<tr>
<th>Inattentive Type</th>
<th>Hyperactive / Combined Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Careless</td>
<td>Squirms and fidgets</td>
</tr>
<tr>
<td>Difficulty sustaining attention</td>
<td>Can’t stay seated</td>
</tr>
<tr>
<td>Doesn’t listen</td>
<td>Runs/climbs excessively</td>
</tr>
<tr>
<td>No follow-through</td>
<td>Can’t play or work quietly</td>
</tr>
<tr>
<td>Avoids/dislikes tasks with sustained mental effort</td>
<td>“On the go” / “driven by a motor”</td>
</tr>
<tr>
<td>Can’t organize</td>
<td>Talks excessively</td>
</tr>
<tr>
<td>Loses important items</td>
<td>Blurs out answers</td>
</tr>
<tr>
<td>Easily distractable</td>
<td>Can’t wait turn</td>
</tr>
<tr>
<td>Forgetful in daily activities</td>
<td>Intrudes/ interrupts others</td>
</tr>
</tbody>
</table>
Spectrum-Thinking vs. Disorder/Non-Disorder

<table>
<thead>
<tr>
<th>Trait</th>
<th>Openness</th>
<th>Conscientiousness</th>
<th>Extraversion</th>
<th>Agreeableness</th>
<th>Neuroticism</th>
</tr>
</thead>
<tbody>
<tr>
<td>inventive</td>
<td>consistent</td>
<td>curious</td>
<td>cautious</td>
<td>efficient</td>
<td>easy-going</td>
</tr>
</tbody>
</table>
Epidemiology of ADHD

- Prevalence of ADHD is between 3-5%.
- Prevalence in boys is 3-fold to 6 fold higher than girls.
- Estimated that between 20% to 70% persistence into adulthood.
  - Mainly inattentive symptoms.
  - 50% considered about right by most experts.
Childhood versus Adult Diagnosis

**Child Assessment**

- Full learning evaluation (neuropsychological testing by school psychologist)
  - IQ and cognitive aptitude areas of strength and weakness
  - Learning differences assessed
- Multi-informant report (captures multiple settings) – CBCL, Conner’s forms

**Adult Assessment**

- Skew pan-positive
  - One report
  - Patient has agenda

Diagram:

- Skew pan-positive
  - One report
  - Patient has agenda
A “standard” diagnostic learning evaluation

Types of tests included:

- IQ Test (Weschler)
- Individual subject tests (math, reading, other learning disabilities)
- *Imbedded continuous performance tests (TOVA: Test of Variables of Attention)
- MMPI (Minnesota Multiphasic Personality Inventory)
Co-occurring Psychiatric Disorders

Adult-Onset ADHD Is Usually Something Else

A new study finds that 95 percent of late-onset ADHD cases aren’t ADHD.

Among the many debates and questions that exist about Attention Deficit Hyperactivity Disorder (ADHD) is the question of whether or not its symptoms can begin in adolescence or even adulthood. With a few exceptions, like in cases of traumatic brain injury, the behaviors and thought patterns of ADHD are generally thought to be evident fairly early in childhood. But there are symptoms, many psychiatric issues in ADHD for symptoms

The researchers concluded that the majority of what appears to be late-onset ADHD is better accounted for by substance use, other psychiatric disorders, or non-impairing cognitive fluctuations. They advise very careful assessment of individuals who present with what appears to be late-onset ADHD.

- Oppositional-Defiant Disorder 35%
- Conduct Disorder 14%
- Mood disorder 15-75%
- Anxiety disorders 25-50%
- Substance use 15-35%
- Learning disorders 15-33%
- Tic disorders 2-11%

According to the MTA study, up to 70% of children with ADHD have at least one other diagnosis.
Wender Utah ADHD Rating Scale

Facilitates diagnosis of attention deficit hyperactivity disorder in adults based on childhood symptoms.

### As a child I was (or had):

1. Easily distracted
2. Anxious worrying
3. Nervous fidgety
4. Inattentive daydreaming
5. Hot- or short-tempered

- Not at all or slightly (0)

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Scales: An Attempt at Objectivity
Functioning Impairment and Improvement Goal

- Analogy of “psychic pain” to chronic physical pain scale (0-10 scale).
- Patient expectation of “symptom” eradication (no anxiety, depression, inattentiveness) not realistic.
- Functional improvement? : ”I can’t focus on my TV” versus job, parenting or performance in life improved.
Deprescribing: A Psychodynamically-Informed, Patient-Centered Perspective

David Mintz, Erin Seery and John Cahill

Austen-Riggs Center, Stockbridge, USA; Department of Psychiatry, Yale University School of Medicine, New Haven, CT

Abstract: Medications can have a wide range of symbolically mediated effects on patients and these effects can be positive or negative. When medications serve conflicting counter-therapeutic goals, action, including deprescribing, may be needed to ameliorate them. Drawing on work with...
A Common Case and "Psychiatrized" Formulation

EF is a sophomore at an Ivy League college. He presents with feeling overwhelmed, anxious and despairing, with difficulty focusing sufficiently to maintain the GPA to which he has been accustomed (whilst captaining the lacrosse team and upholding several volunteer commitments). His psychiatrist, who is also providing occasional psychotherapy, diagnoses ADHD and prescribes a stimulant, resulting in successful completion of the semester and resolution of his symptoms. Several weeks into the new semester, despite continuation of the stimulant, his symptoms recur. His prescriber considers a dose increase.

Harm from medications can emerge when they are used counter-therapeutically to deny personal limitations. EF’s high achieving family holds that success requires being the top student in any situation. He may experience his overwhelm and disorganization as a problem of living (i.e., he is exceeding his healthy capacities); however, his high expectations make it more likely that he will experience himself as pathologically limited. Interpreting his dilemma as a problem of illness (i.e., ADHD) makes it more likely he will use medications, in part, to deny his limitations. This may work in the short term; however, EF is likely to struggle with depression and anxiety for as long as he is beholden to unreasonable expectations, and his prescriber unintentionally participates by seeing his limitations as pathologic rather than ordinarily human.
Prior to each session, if you have specific questions for our faculty expert(s), please let us know and we will pass along ahead of time.
CONCLUSIONS

• Slides are posted at www.vtahec.org
• Volunteers to present cases (this is key to the Project ECHO model)
  • Please submit cases to Mark.Pasanen@uvm.edu
• Please complete evaluation survey after each session
• Once your completed evaluation is submitted, CE information will be emailed.
• Please contact us with any questions, concerns, or suggestions:
  • Mark. Pasanen@uvm.edu
  • Elizabeth.Cote@uvm.edu