Family physicians and specialists unite! A collaborative approach to managing ADHD in the office

It is 15:30 on Thursday. I retrieve the next chart in my door and see the patient is Scott, a 9-year-old boy. The referral note from one of my family physician colleagues asks me to see Scott for attention deficit hyperactivity disorder (ADHD). I turn the page and see a neatly written letter on school letterhead from Scott's teacher addressed to his parents that says, "Scott has ADHD. He needs to see a pediatrician or psychiatrist so he can be started on medication to control his behavior."

An important focus at the yearly Canadian Psychiatric Association conference has been developing the partnership between specialists and family physicians. Recognition of the strength inherent in this collaboration has been the centrepiece of shared care models in psychiatry. Two of the driving forces behind the shared care model have been the dual realities of the increasing incidence of presentation of the most common psychiatric disorders (i.e., depression, anxiety disorders, and ADHD) in the offices of primary care practitioners, and the paucity of mental health professionals, including psychiatrists, to assist in patient management.

One of the recurring modules in these collaborative forums (the Vancouver forum takes place in June) involves discussion of attention deficit hyperactivity disorder. Here are some facts about ADHD:

- ADHD prevalence rates point to 4% to 6% in children, with approximately 70% persistence into adolescence and at least 50% persistence of clinically significant symptoms into adulthood.[1]
- In Canada, it takes more than 18 months for a patient with ADHD to be treated after first contact with a physician.[2]
- Once diagnosed, only half of children and as few as 11% of adults receive treatment.[2]
- Children with ADHD are prone to delinquency, crime, substance abuse, teen pregnancy, and traffic accidents,[2] particularly if untreated.
- Taking into account the direct health, education, and justice-related costs associated with ADHD, the total costs to the government of British Columbia may exceed $500 million each year.[2]
- Untreated ADHD adults are more than twice as likely to have been arrested, are twice as likely to have been divorced, are 78% more likely to be addicted to tobacco and other substances, and have almost a threefold increased risk of committing suicide.[3]

Family practitioners are on the front lines of recognition and early intervention of this frequently debilitating condition, with social and academic issues of childhood often merging and morphing into interference with employment and marital success in adulthood. The heritability coefficients of ADHD are among the highest of any medical condition, meaning a family doctor may see several family members with similar symptoms, creating an ideal confluence of educational and management opportunities. The Multimodal Treatment Study (MTA),[4] now in follow-up of several years' duration, continues to emphasize the importance of effective ADHD management at the primary care level, particularly in the area of medication selection and appropriate dose titration.

Family physicians may feel uncomfortable caring for children, youth, and adults with ADHD. It is important to keep in mind that assessment of symptoms must include "consistent and persistent impairment" in at least two areas of life functioning.[5] A very useful and reliable source of information regarding ADHD assessment and medication issues is Canadian Attention Deficit Hyperactivity Disorder Resource Alliance (www.CADDRA.ca). This site offers a compilation of expert opinions from across Canada, is updated regularly, and includes efficient rating scales and related tools. New research and treatment advances are discussed, and the recommendations bridge the age range from early childhood through adolescence and into adulthood.

Family physicians will require support from pediatricians or psychiatrists where backup or second opinion is necessary. However, valuable time otherwise wasted on wait lists can be put to better use. For example, by the time a specialist appointment becomes available the child or adolescent may be already showing a positive response to the treatment prescribed. The specialist appointment may then be more effectively utilized as a fine-tuning exercise. Specialist time can also be reserved for more complicated cases, for example in cases of comorbidity that cannot be managed comfortably within the confines of typical time constraints in a primary care setting.

Pediatricians and child/youth psychiatrists will continue to play a role in the management of ADHD, but so

much can be accomplished in the early phases of diagnosis and intervention in the family practitioner's office. It is imperative for those in a position of familiarity with the patient and family to increase their facility with clear, straightforward diagnostic tools (e.g., SNAP-IV[6]) and first-line treatment choices.[7] With facility comes confidence, and when this is shared with the family in a positive and optimistic way, the challenges faced along this journey become less onerous.

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References

1. Barkley RA, Fisher M, Smallish L, et al. Young adult outcome of hyperactive children. J Am Acad Child Adolesc Psychiatry 2006;45:192-202.
2. Your Attention, Please: A Call to Improve Access to Care for ADHD Patients. A Policy Paper by BC's Physicians February 2009:2.
3. Weiss G, Hechtman LT. Hyperactive Children Grown Up. 2nd ed. New York: Guildford Press;1993.
4. The MTA Cooperative Group. Multimodal Treatment Study of Children with ADHD. Arch Gen Psychiatry 1999;56:1073-1086.
5. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision (DSM-IV-TR). Arlington, VA: American Psychiatric Publishing, Inc.; 2000.
6. Swanson, JM. The SNAP-IV Teacher and Patient Rating Scale. www.adhdcanada.com/pdfs/SNAP-IVTeacherParetnRatingScale.pdf (accessed 7 January 2010).
7. American Academy of Child Psychiatry. Practice parameter for the assessment and treatment of children and adolescents with ADHD 2007;46:7.

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The first BCMJ.org Health Notes on ketoacidosis accompanies Dr Metzger's article on page 24 of this issue. We would like to thank Dr Metzger for his enthusiasm for this initiative and for writing such an excellent first installment in the series.

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