Transcript for NM-ABC Podcast Ep 05

Amy E Glass: Welcome. This is an episode of the NM-ABC Podcast: Conversations about youth mental health in New Mexico.

----INTERVIEW BEGINS----

Amy E Glass: Welcome to the NMABC podcast, and today we have the pleasure of talking with two wonderful child and adolescent psychiatrists, Dr. Amy Rouse and Dr. Olivia Shadid, and I am so grateful that you are both here!

Olivia S Shadid: Thanks so much for… for having us. Thrilled to be here.

Amy Rouse: Yeah, happy to be here.

Amy E Glass: That's great, and I know you two as part of NMABC's consult team, and in that role, you've been consulting with many primary care providers across New Mexico who work with children and teens who may have mental health needs.

Amy E Glass: And as you both know, pediatricians and other primary care providers spend a lot of their time addressing mental and behavioral health concerns in their practices, and those issues can be really complex.

Amy E Glass: So, I would love for our conversation today to be a handy resource for providers to bookmark and return to.

Amy E Glass: But I do need to give a quick disclaimer that these are just general tips, and every patient is, of course, unique, and this advice does not replace a provider's own clinical judgment.

Amy E Glass: Okay, so now that that's out of the way, in terms of consults, people in New Mexico, providers do have, some resources, and I just wanted to highlight those quickly.

Amy E Glass: NMABC is a great consult resource for pediatric mental health treatment questions, as long as they are not time-sensitive.

Amy E Glass: Okay?

Amy E Glass: And NMABC can be reached either by phone at 505-272-3459, or via email at NMABC at salud.unm.edu.

Amy E Glass: If you have a time-sensitive issue, providers can also contact the UNM PALS line, which can be reached at 505-272-2000.

Amy E Glass: Okay.

Amy E Glass: So I… Thought maybe we could break our conversation today into

Amy E Glass: three content areas that pediatricians and other providers see very often in their practices. So, mood issues, disruptive behaviors, and inattention.

Amy E Glass: concerns. And those are obviously huge topics that we can't possibly cover in a quick conversation, so I'm going to ask you to share just your top tips for these in these areas. Does that sound okay?

Olivia S Shadid: Sounds great.

Amy E Glass: All right. Okay, so let's start with some pearls you might want to share about prescribing SRIs for pediatric patients who are experiencing depression and or anxiety.

Amy E Glass: And, I mean, some tips that are beyond the basics. So, what might be helpful for providers to keep in mind when the first-line treatment options aren't effective, or the side effects are an issue, or maybe there's just a little benefit, but not enough?

Amy E Glass: Dr. Rouse, could we start with you for this one?

Amy Rouse: Sure. So, yes, SSRIs are safe to be prescribed in a primary care, pediatrics, family medicine practice, and a lot of providers that I talk to around the state are already comfortable with one or two SSRIs.

Amy Rouse: We do get this question commonly when, you know, the first line

Amy Rouse: Medicine's not working, what are some other options? And probably the first thing I always check is, what is the dose of the SSRI? I think pediatricians are used to, and family med docs that see the lifespan are used to seeing little kids.

Amy Rouse: Babies used to that weight-based dosing, but in psychopharmacology, we know that we often actually need to get to higher-end dosing, even for kids. So, any kid that is over, you know, 12, 13 years old, typically we're really using adult dosing for… to guide most of our.

Amy Rouse: SSRI prescribing guidelines. So…

Amy Rouse: The other piece of that is, we know that anxiety often does require higher-end FDA dosing, so that's for sertraline or Zoloft, you know, 200 milligrams a day.

Again, even for young teenagers, that's appropriate. For fluoxetine or, Prozac, that would be up to 60 milligrams a day.

Amy Rouse: And for escitalopram or Lexapro, up to 20 milligrams a day. So, oftentimes, the first thing that I see is, you know, sometimes, prescribers just didn't feel comfortable enough going to higher-end dosing. But that is safe and appropriate to do within the primary care setting, as long as, you know, you're talking about, risks and benefits and the expected, time course for

Amy Rouse: Those medications to… to function.

Amy E Glass: Okay, okay, so, so you were, saying that, that.

Amy E Glass: They don't need to be thinking about the weight-based kind of dosing that some other medications may involve, and that anxiety may require higher dosages.

Amy E Glass: Okay. And, that even young adolescents may get up to a full adult dose. Is that an accurate summary of your tips there?

Amy Rouse: Sure is, that's…

Amy E Glass: Awesome, okay. What other thoughts?

Olivia S Shadid: I think, yeah, that's a great summary and super insightful, Dr. Rouse. And, yeah, for those listening at home, Dr. Rouse is also a pediatrician, so has a lot of good insight into, sort of, how things maybe, sort of, are differently guided in the different fields.

Olivia S Shadid: And yeah, we'll echo that when thinking about supporting kids with depression, anxiety, with SSRIs.

Olivia S Shadid: Making sure dose is high enough, you know, like was covered, anxiety, and then particularly OCD, needs, often way higher doses than you might sort of see for, like, starting dose. There's often a lot of room to go up to that FDA max, or even a little higher. There's data to support that for OCD.

Olivia S Shadid: Something that really helps me, too, is looking at which medications are FDA approved for major depression, so in kids, that's down to age 8, is fluoxetine.

Olivia S Shadid: And then down to age 12 is escitalopram. And then for generalized anxiety disorder, it's only escitalopram and duloxetine and SNRI, down to age 7. And there's not as much data for,

Olivia S Shadid: for depression and anxiety with the other SSRIs and SNRIs. There are FDA indications for some of them for OCD. It's a little bit separate. But that's something

that can help guide me, is thinking about, okay, which SSRI or SNRI am I going to choose next for a kiddo with depression and anxiety?

Olivia S Shadid: Talking to the family about if they have experiences or heard things about medication, if there's certain side effects they worry about.

Olivia S Shadid: Like, fluoxetine is great for kiddos that struggle with adherence, because even if they can take it, like, every other day, it could stay at a therapeutic level in their body, because the half-life is so long, which is great for kids or families that struggle with adherence.

Olivia S Shadid: Other side effects I might think about is, like, escitalopram might have a bit of a higher risk, per se, of a headache for kids. Uptodate, if you have access to that, has really nice tables that help compare side effects between these different medications.

Olivia S Shadid: I think other kind of tips with, depression, anxiety is, you know, certainly don't sleep on the benefits of, cognitive behavioral therapy as well. There's data that kind of combining CBT with antidepressants can be, particularly beneficial for kids. So yeah, that's a couple more things that come to mind.

Amy E Glass: Awesome. Those are great tips. All right, so any other thoughts on the depression and anxiety treatment areas before we move on?

Amy Rouse: I think I would just mention another topic that we have been asked about on the consultation line, which is when and how to switch to another SSRI.

Amy Rouse: So it is appropriate to try one or two of the SSRIs before trialing even something like an SNRI.

Amy Rouse: Or referring to psychiatry. You… the biggest risk for most of these is going to be recurrence of symptoms when coming off of

Amy Rouse: medications, but some people do report some discontinuation symptoms, particularly as you get to the lower doses, so if somebody's been on, a high dose of an SSRI for a long time, it's actually harder when they get towards, treat starting doses, that they tend to report more of those discontinuation syndromes, discontinuation symptoms.

Amy Rouse: And those symptoms can be a little bit vague, hard to describe, you know, some people just don't feel well. Some people will talk about headache. For SNRIs, we hear more about brain zaps, but you can occasionally hear people talk about that for SSRIs as well.

Amy Rouse: And so it's… it's, you know, something to… to be aware of. But for gen… for most kids, it's actually pretty mild, and I think sort of anecdotally, I feel like kids are more tolerant of SSRI, tapers than… than adults can be.

Amy Rouse: So, how to start another SSRI? You can discontinue off of one,

Amy Rouse: which it will vary slightly based on the SSRI that you're on. Dr. Shadid mentioned fluoxetine, which has that nice, like, long half-life. You really don't have to taper that very much at all, or if at all, if you're on, you know, anything less than, sort of, the mid-range dosing.

Amy Rouse: Because it just self-tapors because of that nice long half-life.

Amy Rouse: For other medications, like acetalopropam and sertraline, which I use commonly in kids as well, we can do more of a, you know, one week you'll take, say they're on 50 milligrams of sertraline, take, 25 for a week, 12.5 for a week, and then stop.

Amy Rouse: for a younger kid, or a very kid with a lot of side effects, or sort of somatic symptoms in general, you could go more slowly. But there's no hard and fast rules to it. The tapering is really

Amy Rouse: sort of the art of medicine. And so that's one option, just to discontinue one, and then start as you would on the next, you know, normal, starting dose or scheduling plan that you would use for starting any SSRA.

Amy Rouse: But you can, for kids that have really severe symptoms, do a cross-titration, so you're going down on one as you're going up on another. I'm, you know…

Amy Rouse: I'm more of a visual learner, so it really helps me to look at charts, but you can kind of lay over a decrease of one dose of medication, and then an increase of another, and you're just going down one decrease and one increase step.

Amy Rouse: each week or two, until you get to that sort of dose equivalent, back to the dose equivalent that they were on on the other SSRI.

Amy Rouse: So, a little bit of a, you know, some complexity there. This is certainly, you know, not…

Amy Rouse: basics, but, you know, definitely thinking of beyond the basics across titration is something that NMABC could help you with, or, you know, there's… there's lots of resources online where you can find information about that as well.

Amy E Glass: Terrific. Okay. Thank you!

Amy E Glass: Now, I mean, we haven't covered everything there is to say about, SSRIs, SNRIs, obviously, but I think those are some great pearls, right? Some nice takeaways.

Amy E Glass: Okay, so moving on…

Amy E Glass: The other area we were going to talk about for a little bit are some tips related to medications that can be helpful when a child has some disruptive or aggressive or agitated behaviors.

Amy E Glass: that are a concern for the family and the provider. What are some ideas that providers might want to try, and what should they maybe be cautious about? Dr. Shadid, what are your thoughts on this topic?

Olivia S Shadid: That's a great question, and I would say one of the most common things we get called about, it's…

Olivia S Shadid: a set of symptoms that's one of the most common reasons kiddos get connected to behavioral health, mental health systems, because these are the type of behaviors that, you know, show up in school, can disrupt the classroom, distract other kiddos, teacher, can cause family members to feel unsafe or uncomfortable, and there's a lot of interaction with, sort of, other, comorbid conditions or, other systems, like I said, getting more school support.

Olivia S Shadid: or maybe even involvement in the juvenile justice system. So these are really common symptoms that we see. I think something that's really key is getting a sense of what's causing the symptoms, right? Symptoms are symptoms, but figuring out sort of what's driving the kiddo to be acting in those ways is really important. Otherwise, we can't give a whole lot of info on what's the right treatment.

Olivia S Shadid: So, for example, something that's really common is a kiddo may be currently experiencing stress or trauma, or have post-traumatic stress symptoms that can lead to a lot of activation, a lot of hyperreactivity, aggression, impulsivity. That can also be related to, say, ADHD.

Olivia S Shadid: Where a kiddo is seeking a lot of stimulation, in order to feel calm in their body. They might have, sort of, a lot of impulsivity and react when they have any perceived slights. Could be related to depression, anxiety, autism, many, many different things. So,

Olivia S Shadid: And this is a fun part of the job of being a doctor, is really trying to understand a patient, talk to them, and get a sense of what's sort of driving this. And then that will help guide what treatment is indicated. So if it's something like…

Olivia S Shadid: Oppositional defiant disorder, conduct disorder, really first line, and for PTSD as well, all of those, the first line is really psychotherapy, different types. So for

oppositional defiant disorder, ODD, that's a particularly relational, diagnosis, and we sort of leverage a kiddo's susceptibility, they're extra sensitive to

Olivia S Shadid: authority figures to caregivers, so we use that relationship in the therapy. So, types of therapy that have a lot of parent training component seem really helpful for these kids and the families and the systems they're in. For kids with conduct disorder, we think about something called multi-systemic therapy, which, again, really helps the kiddo and all the systems they're involved in.

Olivia S Shadid: Create a more healing, supportive environment for the kid.

Olivia S Shadid: For PTSD, there's trauma-focused cognitive behavioral therapy, seems most helpful. Now, sometimes they're, like, with PTSD, that's, that's something we really commonly hear about, are trauma symptoms or post-traumatic stress symptoms, here in New Mexico.

Olivia S Shadid: That can lead to that sympathetic nervous system being really keyed up, right? And so there's no FDA-approved medication for kids for PTSD. The SSRIs, SNRIs, can be helpful, but aren't… don't seem as helpful as they are in adults with PTSD.

Olivia S Shadid: But we might think about alpha agonists, like guanfacine, clonidine, to help just dampen down that sympathetic nervous system, so the kid isn't so on edge and reactive.

Olivia S Shadid: Those are also helpful in ADHD. So, maybe you're seeing a kid, say, who's been in state custody, it's really hard to get a clear diagnostic picture, they've been in different settings, it's hard to sort of know what's a response to what they're in, and what's something that's more persistent.

Olivia S Shadid: An elephant agonist can be sort of nice while you're collecting further diagnostic information, since it can help with trauma and stress, but also ADHD.

Olivia S Shadid: If there is ADHD, psychostimulants are very well studied, can be very helpful, for symptoms, including that, like, impulsivity, aggression, if the kiddo does have ADHD. Those are a few of the places I start to think about, sort of beyond basics for supporting these kids.

Amy E Glass: Awesome, okay, so the, the tip is, to do some detective work, right, about what may be going on, whether there are some co-occurring conditions.

Amy E Glass: Particularly trauma or, attention, problems. And, to consider maybe alpha agonists.

Amy E Glass: Right? And then also you're emphasizing some of the, treatment approaches that are beyond psychopharmacology, right? So, you know, parent training programs and other kinds of MST and other kinds of interventions.

Amy E Glass: Awesome! Thank you! Okay, and Dr. Rouse, do you want to add anything on this subject?

Amy Rouse: Yes, I mean, Dr. Shaditz said everything beautifully. I mean, I just would echo, even though it is,

Amy Rouse: basic, but I think it's just so essential, even when we're getting beyond the basics, to continually return to what are the underlying causes of these behaviors. So, all behavior has a function. For a lot of kids, you know, the function of that behavior is to get them out of a

Amy Rouse: Potentially traumatic environment. So it's a lot of times a trauma response.

Amy Rouse: Of course, that's not 100% of the time what's going on, so really helpful to think about ADHD, autism, ODD, conduct, all these other diagnoses that can have associated and challenging behaviors.

Amy Rouse: that the… I did bring up autism, which… which Dr. Shadi didn't mention, and one of the, things that we do have is an FDA approval for, second-generation antipsychotics for agitation or… or aggression in autism. I would just, you know.

Amy Rouse: Say, with… use these medications with caution, that even though we do have

Amy Rouse: the FDA approval, there are a lot of side effects with being on, second-generation antipsychotics.

Amy Rouse: And especially being on them for a long time, which may be the case if you're starting the medication on a younger kid.

Amy Rouse: I mean, ideally, it's great if something works for a kid, and at the same time, just the kind of additive long-term effects of the metabolic syndrome associated with SGAs can be just really hard to work around as kiddos get older. So, if it does seem like, they're… especially for a kid on the spectrum who's

Amy Rouse: had a lot of behaviors, maybe tried an alpha agonist already, or some other medications, certainly tried to address, behaviors and co-occurring conditions with therapy and other approaches, interdisciplinary supports at school. Once all of those have really been exhausted.

Amy Rouse: You could certainly consider the second generation antipsychotic, but especially for younger kids, most of the time you're going to be wanting to work with a psychiatrist, because what we know about prescribing to kids on the spectrum is that the medications don't work as well, and they have more side effects. So.

Amy Rouse: just, you know, with caution, even though we have that FDA approval for that diagnosis, and SGAs.

Amy E Glass: Got it. Okay, so, so providers may want to think about consulting with, with a specialist if they are working with patients who have

Amy E Glass: Both a neurodevelopmental condition and a co-occurring mental or behavioral health concern, with medications, and also anytime… is this correct? Anytime that they are,

Amy E Glass: maybe prescribing one of the antipsychotics, that that might be a good time for a consultation? Is… is that correct, or am I hearing you… hearing you, not quite correctly?

Amy Rouse: I think that is correct. I don't think any of these are hard and fast rules, that there might be some times where a referral to a new specialist will be a huge challenge for a kid who has a neurodiverse diagnosis. So, in that case, it might be appropriate to try as hard as you can to keep the kid in the primary care setting where they're familiar with the environment and the prescribed

Amy Rouse: That might be an appropriate time to, if it seemed like the family and the patient and

Amy Rouse: The prescriber all wanted to try a second generation antipsychotic within the primary care setting, that might be appropriate time for consultation to the provider without the child having to go to see a psychiatrist. But at least considering, you know, having that conversation, like, do we need to involve a specialist at this point? I think very reasonable.

Amy E Glass: Okay. And those different levels of consultation, right? Does the patient actually need to see a specialist, or does the provider maybe just want to check in and have a conversation with a specialist? Okay.

Amy E Glass: Thank you. Do either of you have any other thoughts on this particular area of, sort of disruptive or aggressive behaviors before we move on?

Olivia S Shadid: Maybe just one more thing to say is, sort of like we're describing, we really want to, you know, figure out the cause, and often the intervention is something that's more psychosocial, behavioral, rather than a medication.

Olivia S Shadid: Because if a kid's, you know, it's sort of a cry for help, right? And if we just give them a medication to sedate them, and that might,

Olivia S Shadid: make things easier for people around them, or help keep things safe in the moment, but we're not sort of understanding, you know, what suffering they're feeling that's leading to these symptoms happening. So we want to figure that out, and at the same time, sometimes there are cases where a kiddo is, really a danger to themselves or to others. Maybe they're having a hard time, maintaining, say, a placement if they are in state custody, or they're

Olivia S Shadid: Staying out of a hospital or a residential treatment center.

Olivia S Shadid: And often… oftentimes those are kiddos who are probably plugged in with a psychiatrist anyways, but we also know that PCPs can be a huge resource for those kiddos in providing continuity of care as they sort of bounce between places and find

Olivia S Shadid: stability in their mental health. So that said, we sometimes do think about, like, sort of prudent, cautious use of medications to help those aggressive, disruptive symptoms.

Olivia S Shadid: And, you know, you can think about having something scheduled that sort of decreases the, sort of level of irritability or impulsivity overall. And sometimes kids do great with just a PRN, as-needed medication, to sort of, as they're starting to escalate.

Olivia S Shadid: They can pay attention to, this is a sign that I'm starting to escalate, caregivers can pay attention to that, which is great, because then they start to learn, sort of, other behavioral interventions and coping skills to modulate that… that agitation.

Olivia S Shadid: But sometimes a medication can help things from escalating to a really unsafe place, which would be beneficial for the kid in their, environment, too.

Amy E Glass: Thank you, okay. So, a reminder about the role of PRNs in… in this area, thanks.

Amy E Glass: Okay, so our final topic area for today, for our conversation, was just what providers might consider when first-line ADHD meds either are leading to problematic side effects, maybe, like sleep.

Amy E Glass: Difficulty, or appetite suppression, or increased irritability, and how to manage those situations.

Amy E Glass: So, Dr. Rouse, what are your thoughts?

Amy Rouse: Yeah, so,

Amy Rouse: I think this is, I mean, some bread and butter child psych, and also pediatrics, frankly, given how prevalent ADHD is, and the medications, the first-line stimulant medications to treat ADHD.

Amy Rouse: So a topic near and dear to my heart. I think sleep is, like, where it's at here, you know, so, sometimes the sleep problem, is not really a side effect from the medication, but just sort of an escalation of a sleep issue that predated the stimulant medication.

Amy Rouse: Sometimes, you know, it's just a kid's body adjusting to a new, medication, that might have happened even if it wasn't a stimulant, so there's a little bit of, like, if…

Amy Rouse: It seems like sleep got worse right after starting a stimulant. There's a little bit of watch and wait, let the kid adjust to the new medication.

Amy Rouse: But I think a bigger thing is really taking a close look, with the family on, just sleep habits and, understanding, you know, sleep patterns, family, patterns in the evenings.

Amy Rouse: That might be contributing more to disrupting sleep than the medication itself.

Amy Rouse: We also know just that, in general, there's… there are… sleep difficulty as a symptom of ADHD, so, you know, difficulty maintaining those routines and,

Amy Rouse: that consistency that helps with wind down, just by the nature of a kid having ADHD. So adhering to the typical healthy sleep habits that we recommend can be really difficult. So occasionally, you will see sleep actually get better when kids are on stimulants, because they're just better able to, again, organize and follow through with the routine and structure of a bedtime routine.

Amy Rouse: So…

Amy Rouse: The other pieces, you know, not that we… we almost never want to add a medication to treat a side effect, but there is some data that melatonin and ADHD, you know, a lot of kids with ADHD do require some support for sleep.

Amy Rouse: And so melatonin has some really good data for kids with ADHD in particular, you know, and using lower doses of the melatonin can be helpful. So, you know, 1 milligram for even, teenage kids.

Amy Rouse: And then, finally, sometimes we are adding also an alpha agonist to treat a kid's ADHD, but if they're also having just

Amy Rouse: ongoing sleep issues in the evenings, you know, taking advantage of the fact that clonidine makes some kids quite sleepy, so you might get sort of a double bang for your buck, addressing the ADHD symptoms and helping with sleep, which then also helps address the ADHD symptoms. So those two can work really nicely together, the stimulants and alpha agonists.

Amy E Glass: Hit, okay.

Amy E Glass: So really focusing on sleep and sleep hygiene in general, which may be a concern for these patients and their families. And giving it a little extra time, the wait and see, to see if maybe the side effects are going to ease up. And then also thinking about some of the

Amy E Glass: The add-on medications, like alpha agonists.

Amy E Glass: Is that right? Okay. Okay, and Dr. Shadid, what would you like to add?

Olivia S Shadid: Those are great tips, and super high yield. I find myself doing sort of similar, approaches really frequently. I think another sort of tip is, like, okay, kids benefiting from the stimulant, ADHD symptoms are a lot better, but if sleep doesn't.

Olivia S Shadid: get better, can think about switching to shorter-acting, like, immediate release, doses, so that it wears off by bedtime, and kiddo can go to sleep. Sometimes that works well, sometimes it doesn't work as well. It really depends a lot on the kiddo, but a nice thing is that stimulants work quickly, so you can try it, and you'll know pretty quickly, like, within a week, if it's a good fit for a kid. So it's sort of a low risk

Olivia S Shadid: trial. So switching to short-acting can be helpful, immediate release. And then switching over to the other type of stimulant. So, you know, we have the mixed amphetamine salts versus the methylphenidate-type psychostimulants.

Olivia S Shadid: And there's data that about 40% of people respond well to either one for ADHD symptoms, another 40% do better with one versus the other.

Olivia S Shadid: And so it's worth, again, it sort of, doesn't take a whole lot of time to switch and try it, but you can always switch over to the other one and see if that's a better fit for a kiddo.

Olivia S Shadid: Yeah, I think those are sort of some of the other things to consider. Rarely, this is, again, sort of beyond basics, sometimes stimulants are just not

Olivia S Shadid: very tolerable to kids. That gets tricky, because we know stimulants are just so much more effective than sort of other medications we might consider, but if, you know, a family has any concerns about a stimulant, or it's a youth with, like, active

substance use disorder, or poor tolerability of stimulants, then we start to think about things like adamoxetine, less so things like maybe bupropion or SNRIs, but

Olivia S Shadid: If it is a kid that's super sensitive to side effects, we might think about those things that have less data are probably going to be less effective, but maybe enough that in combination with, say, school supports or behavioral interventions, the kid finds more management of their ADHD symptoms.

Amy E Glass: So many wonderful pearls! Thank you! Thank you both for sharing all of this wisdom.

Amy E Glass: As we wrap up, like, what other thoughts? What are some of your parting thoughts that maybe you want to leave providers with, as they work with these patients and families?

Amy Rouse: I think we… this maybe wouldn't be my most important parting thought, but we were…

Amy Rouse: Combining a few of the different side effects, you know, sleep.

Amy Rouse: poor appetite, irritability, some of the, the strategies will be quite similar. Dr. Shadib mentioned switching to the… the… between the two main classes of stimulants is a great approach for any side effect from a stimulant, because, just like she said, any side effect will… could potentially be much improved on the other family of stimulant medications.

Amy Rouse: There's also, you know, playing around with formulation, so the long-acting versus short-acting, but then there's…

Amy Rouse: you know, patches now, liquid medications, there's just a lot of different options, so I think that's something pediatricians and family primary care docs already really excel at, is just figuring out what's gonna be practical for this family at home. So sometimes that's part of the side effect, it's like.

Amy Rouse: well, a kid just doesn't like it. So that's part… something to understand as well. And then I think, you know, the poor appetite is a specific side effect because it's so common that so many primary care doctors just have their own tips and tricks to get around this.

Amy Rouse: And so I don't think I have any magic sauce there. Just trying to make sure kids are getting good, calorie-dense foods before and after the medications in their system, can be a good option, so…

Amy Rouse: Moving beyond my sort of general ADHD side effect thoughts, I think my general words to primary care doctors seeing kids is just, you're doing so much, and you have a huge benefit of knowing your families really well.

Amy Rouse: And that puts you in a position to

Amy Rouse: really be able to address the whole system, and that we know in child psych that it's almost always there's just a system-wide involvement. It's not just what's going on in the kid's brain, but what's going on with the family, and at home, and at school. So primary care, again.

Amy Rouse: those… you're the rock stars of knowing and understanding that, for our kids, so I just always say, you know, don't sell yourself shorts. You're already doing the work, and keep it up. Thank you so much.

Amy E Glass: Ugh, good advice. Okay, Dr. Shadid?

Olivia S Shadid: I mean, I think that's a great note to go out on and echo what Dr. Rouse said. You know, especially with kids and teens.

Olivia S Shadid: We know there's a pretty big placebo effect when it comes to our psychiatric medications, and that's probably because, surprise, kids and teens benefit from having longitudinal relationships where someone is listening to them, giving their beliefs and experience validation, and so that's a part of the therapy, too. Medications can be really game-changing and important, and we want to make sure

Olivia S Shadid: we're prescribing appropriately and safely, but having that… that rapport and that support, is… is huge for… for kids healing and, doing well and living the lives they want to lead. So, yeah, leveraging that relationship that you… you as their PCP have with them is…

Olivia S Shadid: Is huge, and we're so grateful for the work you all are doing there on the front lines.

Amy E Glass: Yes, so true. Okay.

Amy E Glass: Well, thank you! Thank you to all the providers out there doing this important work, and thank you to Dr. Amy Rouse and Dr. Olivia Shadid, who are both,

Amy E Glass: part of the consult team with NMABC. So, if you do have non-urgent questions and wanted to consult about a case or a situation, or just have some general questions, feel free to give NMABC a call, 505-272-3459.

Amy E Glass: Or if you have, more urgent issues that need a faster response, feel free to use the UNM PALS line for consultation.

Amy E Glass: 505-272-2000.

Amy E Glass: Okay, so thank you, and we will also be posting some good resources on the web to go along with this conversation. So, thanks again to both of you for being here and sharing these helpful thoughts.

Amy Rouse: Thank you, Amy.

Olivia S Shadid: Thanks, Amy.

----INTERVIEW ENDS----

Amy E Glass: Thank you for listening to this episode of the NM-ABC Podcast. If you have any questions or comments, please get in touch with us at NM-ABC@salud.unm.edu. We also want to thank BatchBug and Chozic for the music included here.

Amy E Glass: NM-ABC is supported by the Health Resources and Services Administration of the US Department of Health and Human Services. The views expressed in this program are those of the speakers, and do not necessarily represent the official views of, nor an endorsement by HRSA, HHHS or the US Government. Thanks for listening.