The webinar will begin shortly, while you wait...

MHPN NETWORKS

Register your interest to join the MHPN & AADPA ADHD Network

MHPN is establishing a new interdisciplinary network for mental health professionals in partnership with the Australian ADHD Professional Association (AADPA). The purpose of this network is to bring practitioners together who have a shared interest in ADHD.

Interested in joining this network? Provide your details by scanning the QR code and we'll be in touch to explain how we can help make it happen.

Register your interest here

MHPN WEBINAR

Monday 7 November 2022

It’s never too late to diagnose ADHD

mhpn
Mental Health Professionals' Network

Tonight's panel

Assoc. Prof. John Kramer
General Practitioner

Dr. Maddi Derrick
Clinical Psychologist

Dr. Roger Paterson
Psychiatrist

Facilitator:
Nicola Palfrey
Clinical Psychologist

The webinar platform

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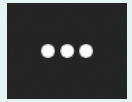

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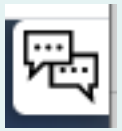

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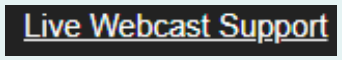

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Learning outcomes

Through an exploration of symptoms experienced by adults affected by ADHD, the benefits of late diagnosis as well as multidisciplinary approach to working with adults living with ADHD, the webinar will provide participants with the opportunity to:

- Discuss the symptoms and signs of ADHD and common co-occurring conditions for adults presenting for a late diagnosis.
- Discuss use of appropriate language to prevent negative narratives, stereotypes and stigma for people living with ADHD.
- Examine the benefits of a delayed diagnosis and treatment for adults living with ADHD.
- Outline the benefits of using a multidisciplinary approach when assessing, treating and supporting adults with a recent diagnosis of ADHD.

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A GP's Perspective

ADHD Crisis Management

Breanna needs help NOW!

What can the GP do to help?

What resources are available?

Assoc. Prof. John Kramer

A GP's Perspective

Breanna is in crisis: What can the GP do?

- Validate her concerns
- Screen for Depression, Threat of Self-Harm, etc
- Identify and mobilise personal and professional resources
- Arrange referrals ASAP
- Regular review (FTF/Telehealth)
- Mental Health Plan (Medicare)
- Bring husband Ashley to next appointment
- Assess needs of other family members
- Medication?? (non-stimulants)

Assoc. Prof. John Kramer

A GP's Perspective

Breanna's crisis needs a team

- GP to coordinate
- Psychologist
- ADHD Coach
- Psychiatrist
- Husband/Extended family
- Relationship counselling
- Online education

Assoc. Prof. John Kramer

A GP's Perspective

Breanna's crisis needs a team

- Monitor mental health, pending other reviews
- Psychiatry Referral updating (school reports, …)
- Questionnaires: Adult ADHD Self-Report Scale (AS/RS), DIVA 2.0
- Education (webinars, websites, medication, …)
- Confirm appointments in place
- Book series of GP visits until other services "kick in"
- Assess son Louis' needs
- Stimulant Prescribing (long term)

Assoc. Prof. John Kramer

A GP's Perspective

Access: The elephant in the room

- Waiting time
- Cost
- Suitably trained clinicians
- Live vs Virtual
- Public Sector Mental Health

Assoc. Prof. John Kramer

A GP's Perspective

GP's "Holding the Fort"

- Whole of family care
- Mobilise support networks
- Support Groups, ADHD Foundation, etc
- ADHD coaching
- Confirm referral appointments
- Assess son Louis' ADHD Management
- Assist husband Ashley to obtain leave from work
- Update Referrals with Questionnaires, Breanna's school reports, etc
- Use Telehealth to monitor condition

Assoc. Prof. John Kramer

A Clinical Psychologist's Perspective

Indicators for considering ADHD

Genetics:

Child diagnosed with ADHD

Parents and brother in a 'high risk group'

Insufficiently explained outcomes:

Decline in academics and social wellbeing in high school

SSRIs not working sufficiently

Many diagnoses, but still searching for a way to make sense of self

Dr. Maddi Derrick

A Clinical Psychologist's Perspective

Co-occurring conditions or signs of ADHD?			
Borderline PD Driven by insecure attachment Idealising and devaluing	**vs**	**ADHD** Impulsivity, novelty-seeking, hyperfocus, emotional dysregulation *plus* Developmental context of adolescence: experimenting with identity, autonomy, risk, relationships	
PND Sleep deprivation Hormone changes Adjustment to change (daily life, relationships etc)	**vs**	**ADHD** Poor environment fit? Burn-out cycles?	
		Self-regulation demands… (attending to 'boring but important tasks, managing time and planning ahead)	**…chronically outstripping capacity** (exacerbated symptoms with sleep deprivation and hormone changes following birth)

Dr. Maddi Derrick

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A Clinical Psychologist's Perspective

Co-occurring conditions or signs of ADHD?		
Social anxiety - Intense fear when interacting with others - Particularly fearful of appearing anxious	**vs**	**ADHD** - Experiences of 'being misinterpreted or negatively judged *leads to* - Hypervigilance to social outcomes, and intrusive thoughts (impulsivity) and rumination (hyperfocus)
OCD - Unwanted thoughts (obsessions) leading to repetitive behaviours (compulsions) - No rational link necessarily	**vs**	**ADHD** - *Looks like 'Obsessions'* - intrusive thoughts (impulsivity), hyperfocus, distrust in own memory or task performance - *Looks like 'Compulsions'* – impulsive actions, checking to enable intrusive thoughts/hyperfocus to end, adaptive rigidity and reliance on systems and structures Leading to impulsive actions
GAD - Persistent worrying out of proportion with likelihood/impact of events	**vs**	**ADHD** -Realistic appraisal of potential outcomes

Dr. Maddi Derrick

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A Clinical Psychologist's Perspective

Benefits of delayed diagnosis and intervention

Pharmacological intervention → Reduced ADHD symptoms → Improved functioning and reduced stress →

Non-pharmacological intervention → Optimised environment fit
- use of compensatory strategies and strengths

Improved self-concept
Improved self-care →

Improved:

- ✓ ***Mental health***
- ✓ ***Physical health***
- ✓ ***Quality of life and wellbeing***

Dr. Maddi Derrick

A Clinical Psychologist's Perspective

Benefits of delayed diagnosis and intervention

Jane, 52 years old:

"In short, my diagnosis has been life changing. Enabling me to be kind to myself. To finally like who I am. To feel love and compassion for me instead of beating myself up about who I am not. To understand how I work and function and what I need to live this ADHD life in a more positive way.

I will not let this neuro typical world I live in dictate how I feel about myself because my brain is different. Difference, I now know, is the very best of things."

Dr. Maddi Derrick

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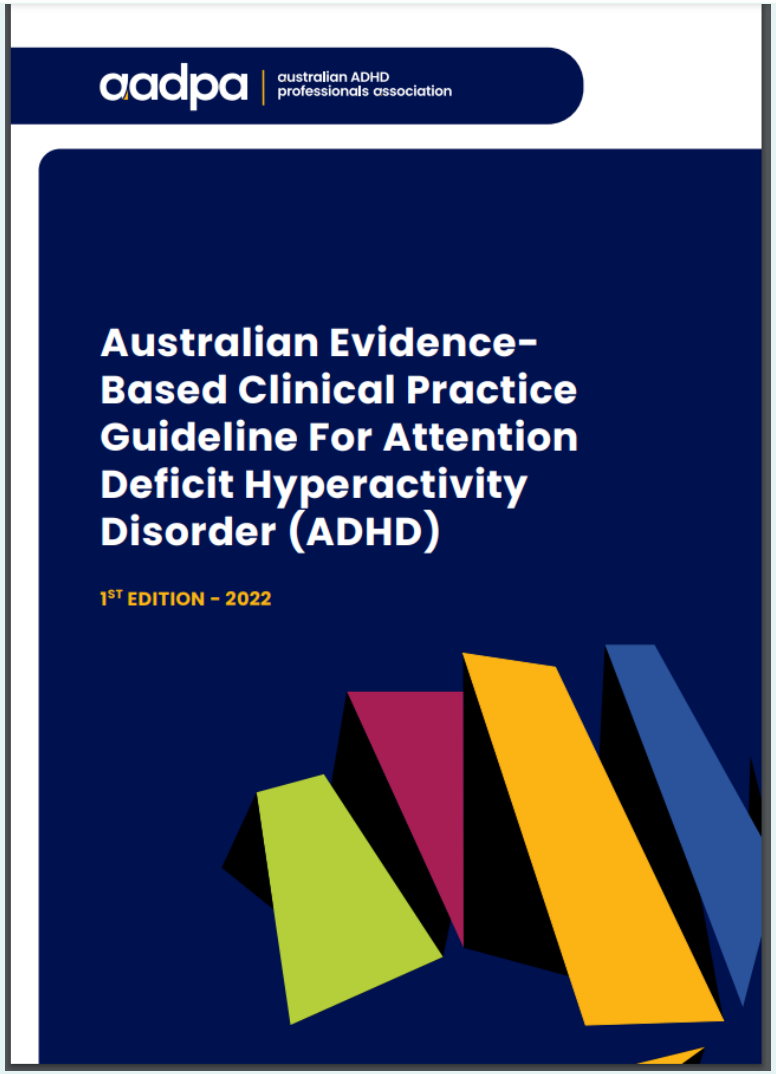
A Clinical Psychologist's Perspective

Redressing stigma, stereotypes and negative narrative

- Name up stigma, misunderstanding and under-recognition
- Discuss if you believe there have been misdiagnoses in the past
- Use an 'environment-fit' framework:
  - Focus on difficulties and strengths equally and in a linked way
  - Focus on adaptive and less adaptive coping in equal and linked ways

Dr. Maddi Derrick

A Psychiatrist's Perspective



Dr. Roger Paterson

A Psychiatrist's Perspective

Words Matter

First-person language is best practice. Try to use positive phrases:

Children with ADHD or living with ADHD

People with lived experiences of ADHD

Avoid language that feeds into stereotypes:

My son is ADHD or she's ADHD

He's got a bit of ADHD

It's good to check how someone likes to talk about themselves and their condition.

AVOID	USE
Suffer Suffering	Live or lives with Struggles
Label	Diagnosis
Behaviour	Symptoms, Traits Characteristics
Naughty Brat	Unable to self-regulate all the time
Manage a child	Care for Support
Deficit	Difference Neurodiverse
Treatable	Thrive with treatment and support

Dr. Roger Paterson

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A Psychiatrist's Perspective

Is concentrating important?

Yes! It is fundamental to effective functioning.

Poor concentration leads to brain "clutter", stress/anxiety, dysthymia/depression, et cetera.
And worse–academic, vocational and social failure, criminal pathway.
Solace? Substance abuse.

Cost to Society?

- Deloitte report 2019: The total annual cost of untreated ADHD in Australia was estimated to be $20 billion
- It affects 800,000 people in Australia (children 5% and adults 2.5%). M/F 2.5:1 children, 1.5:1 adults
- Stimulant medication treatment rates: children 2%, and adults 0.3% (i.e. much less than prevalence rates)
- Costs include loss of productivity, educational and justice system costs, health system costs, well-being cost (reduced quality of life, impaired functioning, premature death).

Dr. Roger Paterson

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A Psychiatrist's Perspective

Attention Deficit Hyperactivity Disorder

- Attention **dysfunction** not deficit: mostly hypo/easily bored focus but(if very interested) can be hyper/locked on focus!
- With or without hyperactivity/impulsivity.
- Common features: Disorganisation, procrastination, poor task completion, emotional difficulties (stress, impatience, temper).
- Comorbidity is the rule (especially trauma, ASD, chronic anxiety/depression, substance abuse).

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A Psychiatrist's Perspective

Attention Deficit Hyperactivity Disorder

ADHD:

- Children: SNAP-IV, Conners
- Youth and adults: Adult Self Report Scale (ASRS), Diagnostic Interview for Adult ADHD (DIVA-5)

Mood:

- Depression anxiety stress scales (DASS)-21
- K-10
- Revised Children's Anxiety and Depression scale (RCADS), used by the Complex Attention and Hyperactivity Disorders Service (CAHDS) at PCH.

SNAP-IV, ADHD Self-Report Scale (ASRS), DASS, K-10 are free.

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A Psychiatrist's Perspective

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Part A

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A Psychiatrist's Perspective

7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					
					Part B

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A Psychiatrist's Perspective

Aetiology of ADHD

ADHD brains are, in part, underactive and immature, there is a developmental lag but ***they get there.*** (Remember, normal maturation is 25 for females and 30, or never, for males!). And stimulant medication may well help rather than hinder this maturation process.

Dr. Roger Paterson

A Psychiatrist's Perspective

Psychoeducation, accommodations and lifestyle modification – the first line treatment for all

Dr. Roger Paterson

A Psychiatrist's Perspective

Psychoeducation

Requires you the clinician to really know what they are talking about and to be able to answer the questions from the patient and their relatives.

- My dad says that ADHD is not real
- What are the causes of ADHD?
- Is it my fault?
- Will I grow out of it?
- What is the best treatment?
- How long will I need to be on medication for?
- Won't medication just turn me into a zombie?
- Will I get addicted?

Dr. Roger Paterson

A Psychiatrist's Perspective

Structured discussion about ADHD

- The positive impacts of receiving a diagnosis, such as:
  - improving their understanding of symptoms
  - identifying and building on individual strengths
  - improving access to services
- The negative impacts of receiving a diagnosis, such as stigma and labelling, and **GRIEF/adjustment**
- The importance of environmental modifications to reduce the impact of ADHD symptoms
- Education and employment issues (for example, impact on career choices and rights to reasonable adjustments at college and in the workplace).
- Social relationship issues
- The increased risk of substance misuse and self-medication
- The possible effects on driving

Dr. Roger Paterson

A Psychiatrist's Perspective

Lifestyle Modification for adults with ADHD

1. Sleep
2. Exercise
3. Emotional regulation techniques
4. Work / Education guidance
5. Communication & relationships
6. Addressing addictions
7. Networks and 'Integration'
8. Dietary changes
9. Outside help: Counselling / Coaching / Therapy
10. Time management, Organisation & Structure

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A Psychiatrist's Perspective

ADHD: Easy to treat

Hard to treat well

Dr. Roger Paterson

A Psychiatrist's Perspective

Stimulant Medications

EFFECTIVE
Stimulant medications are most effective

STIMULATION
They stimulate an underactive part of the brain to become more active and organise the rest of the brain activities

WAKE UP
The 'sleepy conductor' is stimulated to wake up and take charge of the brain 'orchestra'

EXAMPLES
The two best stimulant chemicals for ADHD are: dexamfetamine and methylphenidate

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A Psychiatrist's Perspective

	Effect Size	Number Needed to Treat
Methylphenidate	**0.78**	**4**
Amfetamine	**1.0**	**4**
Atomoxetine	**0.56** (maybe higher when given for longer)	**4**
Guanfacine/Clonidine	**0.67/0.71**	**4**
Cortese et al Lancet 2018 **Comparative efficacy and tolerability of medications for attention-deficit hyperactivity disorder in children, adolescents, and adults: a systematic review and network meta-analysis**		
SSRI for depression in adults	**0.5**	**10**
Antipsychotics for schizophrenia in adults Leucht et al 2012 BJPsych Putting the efficacy of psychiatric and general medicine medication into perspective: review of meta-analyses	**0.25**	**10**

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A Psychiatrist's Perspective

Dosing - milligram per kilogram or start low and build up?

'Dr Fine-tune' and **'Goldilocks'** Method:

- Dosage is determined by **titration**, starting low and building up over days/weeks, aiming for the '**sweet spot'** = maximum help, minimum side effects.
- Frequent appointments for the first 0-6 months and gradually spaced out to 6 monthly reviews
- BP and weight should be monitored, all ages (plus height if still growing).
- Review 3-6 monthly when stable, repeat rating scale.
- Long-term use is justified as long as it is clinically effective ie trials of lower dose or cessation for a few weeks every year is recommended (recommence if ADHD symptoms recur).

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A Psychiatrist's Perspective

Basically, I am a believer in trialling as many different combinations and permutations in the first few months to get an optimal result.

I trial short and long acting dexamfetamine for the first 2 weeks, and then short and long acting methylphenidate for the next 2 weeks if the initial dexamfetamine trial was not very successful.

This could be pushed out to 4 weeks initial dexamfetamine and then 4 weeks initial methylphenidate but I find a lot can go wrong in 4 weeks, and am more comfortable with a 2-week review.

For pre-teen children, I reverse the order, starting with the methylphenidate combination.

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A Psychiatrist's Perspective

Continuation policy for dexamfetamine or methylphenidate

Titration continues over the first few months, and may well involve trials of both dexamfetamine and methylphenidate in short and long acting formulation.

Ideally, patients stabilise on a long acting formulation taken once a day after breakfast. Advantages–increased compliance (less forgetting of lunchtime or afternoon doses). More even medication effect during the day (less peaks and troughs). Less misuse.

The Final medication plan is often a long acting formulation taken in the morning, occasionally boosted by an additional short acting formulation which may be taken either:

1. In the morning to "kick start" the medication benefit if the long acting formulation onset is delayed, and/or

2. In the afternoon to prolong the medication benefit if the morning long acting formulation starts to wear off.

Dr. Roger Paterson

A Psychiatrist's Perspective

Long term use

The good news is that once the dose is stabalised, many people do not change their dose for many years, and reviews with their doctors become infrequent eg; 6 monthly.

Sometimes, some patients find the need to keep increasing their dose to get the same benefit – this is known as tolerance and is not a good thing. To avoid it, occasional breaks from taking medication are useful eg; 1 day a week, a few days a month, a few weeks a year. Similar to "rebooting/resetting" a computer.

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A Psychiatrist’s Perspective

Non-stimulant ADHD medication

ATOMOXETINE/ STRATTERA

A once-daily, antidepressant like ADHD medication which takes a few weeks to work, more subtle, less effective but occasionally useful.

GUANFACINE/ INTUNIV

Once-daily, useful in ADHD especially when stimulants have not been helpful (or only partially and need a boost), or they are contraindicated for some reason.

CLONIDINE (CATAPRES)

Especially useful as a calming agent, mostly taken at night, but occasionally useful during the day or for hyperactive patients.

"STIMULATING ANTIDEPRESSANTS"

These medications take a week or two to work, and probably a month or two to be fully effective. Popular ones are bupropion (Zyban) and fluoxetine (various trade names including Prozac and Lovan).

All are often combined with stimulant medications

Dr. Roger Paterson

A Psychiatrist's Perspective

Are ADHD medications expensive which limits their usefulness?

No, under 19 and **No,** in adults if diagnosed under 19

Ritalin and dexamfetamine:

CHEAP (PBS, or private eg depression)

Ritalin LA, Concerta, lisdexamfetamine, atomoxetine, guanfacine:

CHEAP/PBS if 'diagnosed' 6-18 (17 for guanfacine), and continues in adults.

Newly diagnosed adults?:

- cheap for lisdexamfetamine with a "retrospective" childhood diagnosis.
- more expensive: atomoxetine, Ritalin LA, Concerta and guanfacine on private/month(NB, private health funds may provide rebates):
  - clonidine $20
  - atomoxetine $40
  - Ritalin LA $50
  - Concerta $60
  - guanfacine $100

Dr. Roger Paterson

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A Psychiatrist's Perspective

Handouts are important - patients (especially those with ADHD) remember very little of verbal instructions

- Information on ADHD
- ADHD medication treatments
- Important information about your stimulant medication
- Medication side effects
- ADHD WA community support group (including reading list, helpful websites)
- Dosing schedules

Dr. Roger Paterson

A Psychiatrist's Perspective

	Notification Form Type	GP Co-Prescribing Review	Is UDS Required?	Age Restriction	Stimulants Allowed For Other Dx?	Max Dose Specified?
ACT	As for all S8 forms, approval required beyond 2 months treatment. Checking with Canberra Script is currently voluntary.	Co-manage (only one prescriber at a time). Authority up to 3 years.	No	< 4	Yes	D40mg/MP60mg
NSW	Proceed with prior general approval. Specific stimulant form for each patient. Checking with Safe Script NSW is currently voluntary.	Yes (rarely under 18). Annual review.	No	< 4, > 70, Paed up to 25	Yes	D30mg/MP60mg
NT	Specific stimulant form, wait for approval. NTScript check voluntary currently.	Co-manage (only one prescriber at a time). Bi-annual review.	No	< 4	Unlikely. Check with Med & Poisons Control.	No
QLD	Psychiatrists and pediatricians can proceed without general approval. Check with QScript before prescribing.	GP review at discretion of psychiatrist, no specific interval.	No "Reminder"	< 4	Yes	D40mg/R80mg
SA	As for all S8 forms, specific approval required beyond 2 months treatment. Check with ScriptCheckSA before prescribing.	After specialist initial appt if deemed suitable. Review up to 5 years.	No	Paed up to 25	Yes	No, but second opinion for unusually high doses may be required
TAS	Specific stimulant form, phone or wait for approval.	Co-manage (only one prescriber at a time). 12 - 24 months review.	No "Encouraged"	< 4, > 70, Paed up to 25	Yes	D30mg/MP60mg
VIC	Check with SafeScrip before prescribing.	Co-manage (only one prescriber at a time). Bi-annual review.	No	No. "Clinical Discretion"	Yes	No
WA	Proceed with prior general approval. Specific stimulant form for each patient.	Yes, when stable. Annual review.	Yes "Should" (annual)	Paed up to 25	Yes	D60mg/MP120mg
NZ	Specific stimulant form, proceed with treatment, all specialists have auto approval. May be funding/Pharmac delay.	Co-manage, annual specialist review. In person not mandatory.	No	< 6 only paed or child psych	Yes	No

Dr. Roger Paterson

aadpa

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A Psychiatrist's Perspective

Are alternative therapies often useful in treating ADHD?

- No
- AADPA Guideline: Promote healthy sleep, diet and physical activity
- Therapies which do not work:
  - Elimination or restriction diets.
  - Chiropractic treatment.
  - Behavioural optometry.
  - Neurofeedback (AADPA Guideline: given the lack of agreement, no recommendations regarding the use of neurofeedback were included…)
  - Homoeopathy.
  - Acupuncture.
  - Massage.
  - Sensory integration therapies.
  - Essential fatty acid supplements.
  - Cognitive remediation.

Dr. Roger Paterson

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A Psychiatrist's Perspective

Has mainstreaming been too successful?

Demand for ADHD services now outstrips supply. Long waiting lists for new case assessments

Solutions?

1. Increase supply of specialist paediatricians and psychiatrists?

2. Increase GP co-prescribing?

e.g. Possibly make reviews less frequent, even indefinite. And allow GPs to change doses–possibly require health department training/certification.

National health departments are reviewing this at the moment, encouraged by consumer groups

Dr. Roger Paterson

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A Psychiatrist’s Perspective

All of you are encouraged to join **the Australian ADHD Professionals Association** (Full, Associate, Student).

"The Principle Object of the Association is promoting the evidence-based research, diagnosis, treatment and management of ADHD for the benefit of individuals with ADHD and their families across Australia".

Dr. Roger Paterson

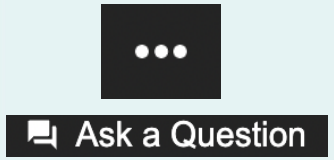
Q&A Session - Please ask us a question!

Assoc. Prof. John Kramer
General Practictioner

Dr. Maddi Derrick
Clinical Psychologist

Dr. Roger Paterson
Psychiatrist

Facilitator:
Nicola Palfrey
Clinical Psychologist



Ask a question: To ask the speakers a question, click on the three dots and then 'Ask a Question' in the lower right corner of your screen.

Thank you for your participation

- A Statement of Attendance for this webinar will be available via your MHPN portal account in four weeks.
- Each participant will be sent a link to the online resources associated with this webinar within two weeks.

Please share your valuable feedback by clicking the banner above

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New episodes released fortnightly on MHPN Presents.

Upcoming webinars:

- **Emerging Minds: Supporting social and emotional wellbeing of children with higher weight, Thurs 17th November**
- **PHN Series: Non-medical supports and programs for older Australians, Tues 6th December**

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MHPN networks

MHPN is working with the Australian ADHD Professionals Association (AADPA) to establish a new practitioner network(s) to bring practitioners together with a shared interest in ADHD.

The webinar's follow up emails will include a link for you to express your interest to get involved.

Please share your valuable feedback by clicking the banner above

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Thank you for your contribution and participation.

Good evening.

Please share your valuable feedback by clicking the banner above

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