Multidisciplinary mental health care for adults with a recent ADHD diagnosis

Prof Mark Creamer (00:00:06):

Hello and welcome to this webinar on multidisciplinary mental health care for adults with a recent ADHD diagnosis. We're talking about attention deficit hyperactivity disorder tonight, and a warm welcome to all of you who are watching us live. Also, to those of you who are watching us later on a recording. Before we start, I would like to acknowledge the traditional custodians of the lands across Australia, upon which our panellists and our participants are located, and I'd like to pay our respects to their elders past, present, and emerging. My name's Mark, Mark Creamer. I'm a clinical psychologist and have a long background in working in both public and private sector mental health as well as in academic and policy settings. But my specialty is actually mental health effects of trauma and I have to be very honest and say that I don't know a great deal about ADHD. And so I'm looking forward enormously to being able to pick the brains of our expert panel tonight. I have to say, and I'm sure my panel would agree that we are not pretending that we have all the answers to what is really a very complex and challenging area, but we will certainly do our best. And a reminder that there are a number of resources, tech support, other things on the website if you need it.

(00:01:31):

But without further ado, let me introduce our panel and a reminder that the panel biographies are all available on the website, so I'm going to keep it very, very brief. Dr. Naomi Rutten is a general practitioner and psychotherapist. She's president of the Australian Society for Psychological Medicine and she's joining us tonight from South Australia. Welcome, Naomi.

Dr Naomi Rutten (00:01:56):

Thank you. Mark,

Prof Mark Creamer (00:01:58):

I wonder if you could just give us a couple of sentences on your interest in PTSD, not PTSD. Sorry, that's my area. Sorry. ADHD.

Dr Naomi Rutten (00:02:07):

That's fine. It is my area. So GP, as you said, GP psychotherapist, and I specialise in developmental and complex trauma, but it really sort of started overflowing into complex behaviour disorders, which included lots of autism and ADHD, so became very interested in that. And then I do a lot of the pre-assessment and ongoing care and treatment, both medically and psychologically. I was diagnosed with ADHD three years ago, and I'm a mother of two children with ADHD, so two out of three of my kids have ADHD.

Prof Mark Creamer (00:02:43):

Thank you very much. It's very interesting. Now, just let me throw this one at you. Without warning, do you think that having a diagnosis of ADHD helps or hinders in your therapist?

Dr Naomi Rutten (00:02:55):

So as a therapist and as a doctor, I think it helps because it allows you to have an understanding and an empathy that people who don't have ADHD can't have. They can have compassion, but they can't have that shared experience, that shared understanding. So my patients find it useful. I find it useful in regards to functioning. It is challenging.

Prof Mark Creamer (00:03:18):

Sure, sure. I'm sure. And we'll learn more about that as we go through the night. Thanks very much, Naomi. Now for our participants, for the purposes of the hypothetical, I'm going to be asking our panellists to take a particular role and I need to emphasise that this may not be the role that they do in their normal jobs. It is however, a hypothetical and we'll jump in and out of it and I'll ask people to take the hat off and put it back on again and so on. And indeed perhaps put on different hats depending on how it evolves. So we will certainly draw on Naomi's enormous knowledge of ADHD during tonight. But for the purpose of our hypothetical, Naomi is going to be acting as a generalist general practitioner in the community. Second panellist tonight is Amanda Butt. Amanda is a mental health nurse practitioner joining us from New South Wales tonight where she has established her own online mental health service. And as an aside, I have to congratulate Amanda on being recognised as the 2025 Australian Mental Health Nurse of the Year. Congratulations and welcome, Amanda.

Amanda Butt (00:04:26):

Thank you so much, Mark. Lovely to be here.

Prof Mark Creamer (00:04:29):

And could I ask you also just to say a few words about your interest in ADHD?

Amanda Butt (00:04:34):

Yeah, definitely stems from saying how often it's missed. I see it in high functioning women in our prison population leading to use of misdiagnosis, ineffective treatment and preventable disease.

Prof Mark Creamer (00:04:46):

Right. Okay, good. Thank you for that. And we will draw on that as we go through. For the purposes of our hypothetical tonight, Amanda is going to take the role of a mental health nurse practitioner with expertise in ADHD who acts as a consultant to an inpatient psychiatric ward. Our next guest is Dr. Karuppiah Jagadheesan. He's a consultant psychiatrist in both public and private sector mental health facilities here in Melbourne. And he's joining us tonight actually live from India. He's kindly said that we can call him Jag, which is great. Much easier for me. So welcome Jag. Thanks for joining us. You're on mute at the moment, I think?

Dr Karuppiah Jagadheesan (00:05:32):

Yes, thank you. Mark, can you hear me?

Prof Mark Creamer (00:05:35):

Yes, I can hear you. I can hear you perfectly. Thanks for joining us. And could you also just give us a sentence or two about your interest in ADHD?

Dr Karuppiah Jagadheesan (00:05:43):

So I have been working in both public and private for a while, and in private there has been increasing need for assessment and support of individuals with the ADHD and also realised there is a big gap in the public. So that's an area of interest of mine, how to allow people to get assessed at the public system. So I do sit as a chair for the ADHD network within the Royal College of Psychiatry. And so it helps to have a broader perspective on things and at the same time we help with the certain processes. Thank you.

Prof Mark Creamer (00:06:18):

Excellent. Thanks Jag. And for the purposes of our hypothetical tonight, JAG will be taking a role pretty close to his own as a psychiatrist in a community community-based private practise. So we're a private practitioner. Our final panellist for this evening is Emma Ketley. Emma is a mental health occupational therapist. She's got experience in a variety of mental health settings both in the UK and in Australia. And she's joining us tonight from wa. Welcome, Emma.

Emma Ketley (00:06:50):

Hello from Whadjuk Country. I'm delighted to be here.

Prof Mark Creamer (00:06:53):

Good. Well, it's lovely to have you. And as with the others, can I ask you about your interest in ADHD? Very briefly?

Emma Ketley (00:07:01):

Yeah. I'm actually an ADHD coach and a mental health occupational therapist that works as a psychotherapist. And my background is working with borderline personality diagnosis in clients with emotional dysregulation. And around 2020 I realised just how many diagnoses of the mental health type were actually overshadowing the needs of people that had co-occurrence of ADHD. So around 2020 and 2021, I commenced ADHD coach training at aca, which is a flagship academy based over in America, but it was an online course.

Prof Mark Creamer (00:07:40):

Fascinating. Okay, well thank you very much Emma. Thanks for joining us tonight. And for the purposes of tonight's hypothetical, Emma also we'll be taking a role very similar to the one she does. She will be working as a community-based occupational therapist and ADHD coach in a private practise setting in the community. As you can see, we've got an outstanding bunch of experts in the area of ADHD today. It's a very, very warm welcome to all of you. Tonight we're going to work our way through a little case study, a hypothetical vignette. So in a minute I'll introduce the vignette of Tanya, who's going to be our case for the webinar, and I'll ask each of our panel members in their allotted role to talk in turn about how they might assist Tanya as she negotiates her way through the system. We'll then open it up for a broader discussion about some of the issues raised by this case.

(00:08:38):

And I do want to place a particular emphasis on the idea of multidisciplinary care. I actually hope that we will be able not only to talk about multidisciplinary care, but also to demonstrate a multidisciplinary approach in the way we manage. By the way we interact with each other and we challenge each other and we support each other. So hopefully we'll be able to model it as well. But do remember it is a hypothetical. People will come in and out of role as required. I'd also note that there are some different regulations and services in different states of Australia and so we will try and draw attention to that where it's relevant. But now let me introduce our vignette and if you

wanted to just jot down some notes, please feel free to do so because we're going to be coming back to Tanya a fair bit.

(00:09:31):

Tanya is a 45-year-old woman. She's very high functioning. She's got a successful corporate career in high level project management. She's been married for 15 years to Greg. Greg is the primary carer at home. He also works part-time as a bookkeeper and they have two children, Damien who's 13 and Jacinta who's 11. Tanya has a history of some kind of unspecified anxiety, probably generalised anxiety disorder or something similar, but she's never had a formal diagnosis. And the only treatment she's had is some medication. She's been given a low dose SSRI sertraline, which she continues to take.

(00:10:15):

So Naomi, let me bring you in. Tanya has been a long-term patient at your practise, but she's a very irregular attender. You don't know her very well, but she turns up in your consulting room telling you that she's been struggling for some months now and it turns out that the precipitant seems to have been an incident where her 13-year-old son nearly got expelled from school. That seems to have settled down, but she says that since then she really has not been coping very well. And again, our participants may wish to jot down some of these notes. Indeed, our panellists might as well. Actually, she tells you, Naomi, that she is very much more restless and distracted than usual. She can't concentrate even on simple tasks. She finds herself making many mistakes, she's losing things, she's forgetting things, forgetting appointments and so on. And all of this is extremely distressing for her because she did feel in control before. Her relationship with Greg, her husband is very strained. He complains that she doesn't listen to him, that she looks zoned out half the time, her anxiety is worsened, her self-esteem has plummeted and basically she feels overwhelmed and doesn't think she can face going back to work.

(00:11:40):

So Naomi, as a busy generalist GP, you're seeing Naomi in your practise, what are your first steps?

Dr Naomi Rutten (00:11:49):

And I think a lot of GPs that are watching it will feel, the first thing is always to really gather that history about what the concerning symptoms are for her, how long they've been going on for, and

then in what way they're affecting her function. So I've spent a bit of time with her assuming the first appointment that she's come to is a 15 minute appointment, getting a bit of an idea of how's your sleep, how's things within, you mentioned the relationships, that sort of stuff, but sort of appetite exercise, going through those lifestyle measures, how are they affecting her? Because we'd only have 15 minutes, I'd probably start by thinking things like perimenopause having in the back of your head, it's much rare for that age group, but always thinking memory problems or conditions that are related to memory problems. So I'd probably organise a blood test for her to check her iron levels, vitamin D levels, base bloods of haematology and electrolytes, doing a broad scope to really get a picture of what's going on, make sure that we're not missing anything to toward, again, examination wise, how is she appearing?

(00:13:10):

Is she looking pale? Is there evidence of a physiological condition that might be contributing to her symptoms and looking at those as we then. And then what I would then be doing while she gets the blood is booking probably two, at least two more 30 minute appointments where you can really sit down and go through things, get a further history of what's going on, how long it's been happening, and make sure you're pulling apart what the underlying causes might be. One of which could be ADHD, which of course the symptoms worsen with perimenopause. So really looking at perimenopausal symptoms that might be overlapping at the time as well.

Prof Mark Creamer (00:13:51):

Good. Okay. Well you do make another appointment with her for the following week, but at this stage are you thinking at all about involving anybody else

Dr Naomi Rutten (00:14:01):

At this stage? Depending on her function. So if she was saying that she can't get to work, she's so stressed, she can't function, she can't work, we might be sitting there, I might be thinking, well, do we need to bring in psychological supports, counselling supports or things like that. A lot of GPs are trained in focused psychological services, so may feel comfortable to do bits and pieces of that themselves, but if they aren't, they may refer outward in that regard as well.

Prof Mark Creamer (00:14:33):

Are you going to be able to find someone to refer her to

Dr Naomi Rutten (00:14:37):

Where I am? The wait list would be nine to 12 months,

Prof Mark Creamer (00:14:41):

So

Dr Naomi Rutten (00:14:41):

I might find a counsellor, but personally I would be waiting to see what the underlying cause is and really nutting out what the cause is before I refer. Because even different counsellors, different psychologists, therapists will have different areas of expertise. So I really want to make sure I know what area to target before I go into that, so

Prof Mark Creamer (00:15:05):

Fair enough too. Okay. Just briefly, can I ask you to take your hypothetical hat off for a minute and say what do you think the other things that you think a generalist GP who doesn't know much about ADHD, what might they miss in a scenario like this?

Dr Naomi Rutten (00:15:23):

One of the things that could be easily missed is an assumption 45 high stress job and an assumption that it's perimenopause and her anxiety, it might be chronic high level work and therefore burnout and sort of bundling it up into those things and actually missing that cognitive impairment that she's got. Like yes, we need to make sure, is the cognitive impairment from the anxiety and depression or is the anxiety and depression secondary to the fact that there's a neurodevelopmental condition that is causing it to be much more difficult to function?

Prof Mark Creamer (00:16:02):

Yeah. Good. Okay. And anyway, look, who knows, it may well settle. She's had a chance to talk to you, she's feeling supported, so it might well settle. You've got an appointment with her for the following week, alas, the following day you get a call from her husband Greg to say that Tanya has admitted herself to a private psychiatric facility. They have very high level private health insurance, this family, so she's admitted herself voluntarily to this private psych hospital. She's saying that she can't cope.

So the ward nurse who admits her, Amanda is aware of your expertise, not quite sure what to do. She gives you a ring. What are your first steps in this situation?

Amanda Butt (00:16:50):

So she's coming to see me. Sorry, you're saying Naomi's called me or the patient's with me now?

Prof Mark Creamer (00:16:55):

No, the nurse on the ward of the inpatient unit and she says, look, I dunno quite what to do with this, but we do have this expert mental health nurse practitioner, I'll give you a ring and say what should I do with this patient? Have you got any ideas you could advise this ward nurse, the staff on the psychiatric unit?

Amanda Butt (00:17:14):

Yeah, absolutely. So the first thing I teach my students and my mentees is, and there's a foundation of my own practises, the therapeutic relationship. So that comes before anything. So you'd want them to develop that rapport, create emotional safety and provide a trauma informed space. So just making sure she's safe, you're doing a risk assessment containing that, ensuring that she's not suicidal, that she's okay for the time being, and then we start to involve family and explore her immediate supports to see what the is about.

Prof Mark Creamer (00:17:50):

And would you talk to Naomi?

Amanda Butt (00:17:53):

I would love to, yes. I would waltz right in there and do the assessment myself if I could. But yes, firstly, if she's building that rapport, we want her to be able to build that rapport with whoever she's going to spend that the most time with.

Prof Mark Creamer (00:18:07):

Given what I was going to say, we know about Tanya but we don't, but we might suspect strongly. Do you think that she would need special assistance in transitioning to a new environment?

Amanda Butt (00:18:19):

Yeah, absolutely. So change would be something quite difficult for someone like Tanya because she's got everything usually under control and then things started to unravel. So a new environment would be quite scary for her and this is why we would engage family and any immediate supports to ease her in and ensure that she's got the right environment and supports and also asking them questions. She may not be in the right frame of mind to be answering questions about risk and safety and her type of presentation and why she's presented herself.

Prof Mark Creamer (00:18:52):

Good. I'd like to come back to risk in a minute, but given that it's not a specialist, A-A-D-H-D clinical or anything like that, what do you think might be reasonable goals for a brief admission to a private psychiatric ward in this case? What might they hope to achieve with someone like Tanya?

Amanda Butt (00:19:14):

So stabilising her functioning, ensuring that she's able to do her everyday tasks, activities of daily living. Is she able to shower, is she able to get her meals ready? So ensuring that she's got some level of functioning to be able to be discharged. The other thing is risk and safety. Is she safe enough to be discharged? Is she going to hurt herself or is she at this point where you said she was distressed, what level of distress is that and to what extent has she thought about that distress? So ensuring she's got that scaffolding around her to ensure that she doesn't fall back down again, creating a crisis management plan, distraction techniques, all that sort of thing. But to ensure that level anxiety isn't too high, we need to look at that SSRI and it might just be a temporary thing before we then find out she does have ADHD and explore that diagnosis in more detail. She may need that dose of SSRI looked at a little bit just as a temporary measure to help her through the anxiety and get her through that admission.

Prof Mark Creamer (00:20:18):

Super. Okay, well we've got the ideal person to consider that medication. So after about five days she does stabilise and she does feel a lot better. You've done your risk assessment and you don't feel that she's a risk to herself or to the family or to others. So she stabilised and she's now ready to be discharged into the care of a psychiatrist in the community. Given your contact with her, Amanda, will you just be available to stay in contact if she wants it?

Amanda Butt (00:20:49):

Absolutely. You can create a proper discharge plan having all those supports there, people she's able to contact. It's a private facility so you'd definitely be available for someone like that. And yeah, again ensuring that you have all the supports available.

Prof Mark Creamer (00:21:04):

Okay, thank you. So Jag, you've received a referral from Naomi and also a discharge summary from Amanda and the ward. Given what you know so far, what would be your first steps when Amanda comes to, sorry, not Amanda, Tanya comes to see you.

Dr Karuppiah Jagadheesan (00:21:21):

Thank you, mark. I think it seems like a lot of good work has been already done. So the first psychiatric assessment is very broad and general approach in general. So what I would be interested in knowing is that the high functioning individual is suddenly losing the plot A for an apparent reason of has son is struggling in a way. So it's very important to understand what some of the factors are leading up to this level of say dysfunction or suddenly losing control. So I will be working through the symptom clusters to see what will be playing a role and also to explore some of the dynamic factors. As you have alluded that there's a history of anxiety disorder, so it may be asking more questions to characterise that and whether it's a generalised anxiety which often can coexist with people with the neurodevelopmental disorders or is it an anxiety part of SA personality structure like cluster C or perfectionism, which often exists again in neurodevelopmental scenarios and I'm looking into any trauma history, most traumatic stress disorder or anything like an obsessive compulsive disorder.

(00:22:37):

So having a broader approach to the anxiety to characterise. The second thing is whether the anxiety is leading to what we call it like a secondary depression, which is emerging like emerging depression, which is flaring the risk side as well as functional impact that will help us to plan management obviously. And even though she's feeling better, she's out of the hospital system at least good to know whether she had any similar preexisting flareup of depression, whether it's a part of a reoccurring depression or is it a low grade persistent dys, which has just a flare up because of the stressful situation. And the third is to explore, as I mentioned, a bit more about her nature. So a project manager who generally tends to have a lot of structure and routine and to clarify any personality aspects that may be playing a role other than just perfectionism, is there any element of

say cluster B or cluster C and characterise it and what some of the strategies Tanya would be playing to cope so far, whether it's mainly routines like physical exercise or any sort of activities or any sort of say alcohol use which is hidden and which is playing underlying or any sort of misuse of benzodiazepine or things like that over the counter products which may be used to elevate anxiety, which often happens in high functioning individual, they don't use many other substances, they usually use substances that can be easily available, not seen very bad to other people.

(00:24:11):

Then to clarify how long this anxiety disorders and to explore developmental history and to look into, generally it takes a session up until depending upon the cues of what we get from the clinical history, if there is a general struggle, as you say with the concentration listlessness zoned out, these are very typical terms. We often hear these days in ADHD scenario and often I have seen that women present very late in the life and they can mask it very much as well. So exploring neurodevelopmental history, both the ADHD as well as autism and also look for any family history which may be indicative of genetic factors playing as well as Ian mentioned. So it seems like our medical history has been rolled out, but I would be still keen to look into any sort of underlying thyroid disorders which may be playing a role or which has come a little bit more prominent now, making the anxiety worse. And lastly about psychosocial factors, sun is having a big problem and why Tanya is giving up now. So to look for sun's behaviours might give a clue about both neurodevelopmental as well as trauma. We know there are times there is a transgenerational trauma happens when there are neurodevelopmental disorders like ADHD running the family not in a full syndrome level at a trait level and members can communicate very intensively that can create a microtrauma. So exploring that and the lastly relationship with her aspect,

(00:25:54):

Whether he was compensating or whether it's falling apart somewhere or she had end up with some sort of a problem. So having a very holistic approach and trying to figure out what really broke the back of the camel now why. So that's what I will be more interested in the fast assessment and if Tanya has settled enough, I wouldn't be making a huge change with the dose of the SSRA, but I would like to make sure it's sufficient. If it is a low dose, if she's only on say 50, it didn't stop having an episode. So certainly I will have to dose to the next level, which will be close, maybe a hundred. We know it can go much higher and certainly I will emphasise the need for psychological interventions and make sure that she's able to apply some of the strategies to deal with problems. So that's why I accommodate the first one. Yeah,

Prof Mark Creamer (00:26:49):

Yeah, excellent. Okay, so I mean you've raised a load of points there that I will come back to because I think they're really important, but I just highlight the fact, the sort of a comment that both Naomi and you made that of course there are a number of potential diagnoses here and we really need to do a very thorough assessment before we jump into any definitive diagnosis. But having done your thorough assessment, you do think that there's a pretty good chance that she does have ADHD adult onset, ADHD, and we'll come back to that in a minute, but you decide that she needs a bit more support than you can offer Actually, just quickly, how often would you hope to see Tanya given your private practise, how busy you are, how often might you see her?

Dr Karuppiah Jagadheesan (00:27:39):

I think that varies depending upon how the situation is. So it could be weekly initially for first next appointment in a week, then fortnightly to monthly. And so basically depending on what are the supports Tanya is having time is already linked up with some support to the community through the counsellor and they can offer some space to reflect then my session be slightly after the care

Prof Mark Creamer (00:28:09):

Point taken. But you would try and see her fairly often, at least initially. Okay. So you decide that she needs more than you are able to offer, you think that she would benefit. You talked about psychosocial support and so on. So you contact Emma. Now for our purposes, Emma, as we said, you're working as an ot, mental health OT and ADHD coach in private practise. You've been provided with a referral letter from jag. You've also got background stuff from Naomi and from Amanda. Let me start with your role as an ot. Just very briefly, what do you think you might be able to offer Tanya in your role as an occupational therapist?

Emma Ketley (00:28:49):

Okay, so occupational therapists work with people through a functional lens enabling people to participate in meaningful activities that they want and they need to do. So there are so many Tanyas around at the moment where they have been doing so well for so long and then all of a sudden there's an impact on functioning. So the first thing that I would do as an occupational therapist is as Amanda mentioned, there was probably some assessments on the ward. So I would reach out to see if there was any OT assessments. I would probably then also want to really flesh out and explore the

team are around what's actually sitting in line with an ADHD assessment. So as we know, the criteria for ADHD assessment is that it's showing up in more than one or more settings. So look at occupational performance across productivity. So what's her performance like at work, her self-care, and also her leisure activities and whether there's any occupational imbalance there. And how I would probably frame that is using a tool that I personally like, which is a model of human occupation tool, which is no cares, which is a performance self-assessment for Tanya to complete.

(00:30:08):

We would look at, there's obviously a number of situational stresses, her son with the school situation. As we know ADHD has got around a 70% heritability. So it's possible that we haven't got a diagnosis for Tanya yet, but that's also running in her family and it's intergenerational. So I might ask her about her mother. Some other other members of the panel have said, and obviously she's on a medication for anxiety sertraline and there's some issues with her husband. So sertraline would have an impact on intimacy. There's a lot of sexual dysfunction side effects that can come alongside that medication. So I would probably ask her as an activity of daily living, those questions around what is her roles and responsibilities, is she comfortable and is there any kind of barriers to her participating? And that would be my start point.

Prof Mark Creamer (00:31:05):

Yeah, and on the basis of that functional assessment largely that will dictate a whole range of potential interventions. Can you, just because time is going on, but I am fascinated in this idea of an ADHD coach, can you just give us a quick summary of what it is or what you might offer Tanya if she decides to take that up?

Emma Ketley (00:31:24):

Okay, so in this situation, just be quite clear if there was any ongoing stress, if there was any risk or mental health distress. I work both as an ADHD coach and as an occupational therapist I would probably point her towards occupational therapy support or psychotherapy support. So we can look at the mental health distress. If however that is stabilised and she feels that she just wants to really understand this new diagnosis, which might be ADHD, then an ADHD coach partners with someone. So we partner with very much client driven. There doesn't need to be a referral. The goals are set by the client and it's very much more a reflective future focused role looking at helping Tanya understand her new self, discovering her strengths and building on her future roles and aspirations.

Prof Mark Creamer (00:32:20):

I'm sure that you could say how long's a piece of string, but what might be a rough idea of how much time you might spend with your client if you were the coach daily contact for example.

Emma Ketley (00:32:33):

Yeah, I think with coaching, because it's very much client driven rather than symptom reduction or stabilising or capacity building, which is more occupational therapy. With coaching, I might get to a point where Tanya feels that everything has settled down and I could work with her up to a year, but that might be, there's a maintenance check-in monthly if I was ADHD coaching.

Prof Mark Creamer (00:33:04):

Okay. Okay, lovely. Alright, there's a whole lot more I'd like to ask about that, but I've got a massive clock sitting here and it's telling me I've got time moving on, mark. Get moving. Okay, there's

Emma Ketley (00:33:14):

So much more I could say.

Prof Mark Creamer (00:33:16):

Sure there is. Well I'm sure there's a lot more that all of you could say and I'm absolutely confident about that. So I guess what we could say is that we now have our multidisciplinary team around Tanya. So we have support as needed from her GP, Naomi, and from Amanda, mental health nurse practitioner. We've got a psychiatrist who's seeing her every couple of weeks or whatever as required. And we've got Emma providing some OT and some possibly ADHD coach support. So she's in a good place and we are now ideally a team that are going to work together. And that I think is the challenge. And I'm going to come back in a minute and talk more about how we might do that as a multidisciplinary team, but I do just want to, because I think it is an important question. We've kind of alluded to diagnosis all the way through, but let's put it on the table and talk about diagnosis of ADHD. I mean, we can look up the DSM criteria and I think we should, I think you all know it, but those of us who don't know it, we should have a look at it. What do you think are the DSM criteria good? Do they capture the essence of this condition? And I am happy for anyone to jump in, although oh, nobody wants to. Yeah, go on there Emma.

Emma Ketley (00:34:41):

So her criteria, the diagnosis could be covered under a lot of the inattentive DSM symptoms for ADHD, but in looking at whether DSM really reflects client experience, they don't mention emotional dysregulation. Emotional dysregulation is not reflected in the DSM criteria for ADHD. And anecdotally as a lived experience person with ADHD, it is very much a marker of ADHD,

Prof Mark Creamer (00:35:10):

But we do have, I don't know the criteria, so forgive me, but we do have the inattentive, but we also have impulsive, I guess are those subtypes valuable? I might bring you in Jag, what do you think? Are they useful subtypes or useful? I'll come back to you Emma, because you want to say something more, but let's just have give Jag a second. Yeah,

Dr Karuppiah Jagadheesan (00:35:28):

Yeah. So thank you Max. So what I must say is this fluid at DSM, I think it has evolved over a period of time, but still has issues and limitations and it focuses typically on say young boys, that's a prototypical picture. It's trying to portray. That's where the problem here, it doesn't capture the experience of particularly women in general and that's where the emotional dysregulation aspect is left out. And also there is a limitation that it doesn't capture more of the cognitive disorganisation, which is an underlying core thing. It looks for more markers of those disorganisation than actually pinpointing on disorganisation is the main thing. So there are limitations to DSM, but even though it's widely accepted as a diagnostic tool and the ICD is not too far from DSM in that sense.

Prof Mark Creamer (00:36:24):

Okay. Yeah, I mean I'm interested in your comment there about how perhaps it doesn't reflect very well the person that we are talking about. So an adult female kind of thing. You are nodding. Naomi, do you want to add to that? I mean, I guess the question is how likely is it that Tanya would've actually been diagnosed with ADHD? Given what Jack's saying and I young boys not fat,

Dr Naomi Rutten (00:36:48):

It's really, really variable depending on what history has taken, what investigations, but also what focus but also, so one of the things that I think all of us would've done is what is it that she wants to work on? She may be like, no, I don't believe in a DH adhd. I don't believe in those things. There

might be cultural or religious. There's all sorts of things that might mean that for her you wouldn't even broach the idea of it. So depending on which doctor, which therapist, which support people she had, it could be missed, especially in females and especially as J and Emma were saying, and I think Amanda would agree, the DSM five does miss those elements and also the masking especially of women that they have to do. So I do have a good friend and she and I sort of wrote our own assessment criteria sort of like have you gone, how long is the smell test of a load of washing? How often are you putting a load of washing on and forgetting and then sniffing it? Is it okay because forgot functional things that we all do for those of us that have ADHD. Am

Prof Mark Creamer (00:38:03):

I right in saying I've got this vague memory from when I did know a little bit. Does it have to be childhood onset? Do we have to say this person has had these problems all their lives?

Dr Naomi Rutten (00:38:13):

My understanding is it can show up in adulthood. Personally, I think it's probably always been there, but they've masked and coped and had coping skills throughout that have managed things. I think during adolescence because of that change in function during adolescence, there'll often be a significant worsening of symptoms, but it doesn't mean they can't mask or I often find, especially those that don't have so much of the hyperactivity and more of the inattentive through school because they're dissociating and they're quiet, they don't get seen, especially girls, they're just no, there's nothing wrong with them. They've been quiet, they're not a hassle. ADHD are busy, noisy people, not everybody. One of my sons has a DD over doesn't necessarily have the hyperactivity. So I think it can very, very easily be missed and masked and they have their coping strategies and therefore it shows up in adulthood. But personally I think it's probably always been there.

Prof Mark Creamer (00:39:15):

Yeah, sure, sure.

Amanda Butt (00:39:16):

Mark, I see this a lot in my practise as well because I do diagnose ADHD, but I see that in childhood it was there, but they were masking it in a way that they had a lot of structure. Their parents were quite strict, so they had to abide by certain things, otherwise there'd be consequences. So they

weren't able to forget anything or they weren't able to lose any of their belongings so they'd get in big trouble. And then also the competitive sports, if they were doing any competitive sports throughout their schooling years or if they were doing scouts. So again, regime routine they could mask throughout their entire childhood and adolescence years. And then when they stopped doing all of that, that's when it starts to rear its ugly head.

Prof Mark Creamer (00:39:58):

Quite just we should just touch on it. And since you were talking in, we've heard a bit of stuff on the news about New South Wales recently expanding the, I think to GPS saying that GPS can diagnose whatever that means, and I still don't quite know what that means because you say you would make a diagnosis, I expect Emma would and Naomi, whatever, but that's correct, is it, and do you think that's a good thing that we've expanded? It probably means, sorry, just does it mean you can make a diagnosis in order to prescribe a stimulant? Is that what it's about?

Amanda Butt (00:40:31):

Yeah, I think Naomi could answer more about if they're able to prescribe under this new legislation.

Dr Naomi Rutten (00:40:37):

Yeah, so I think, and I'd have to look carefully in South Australia, but it was for GPs who have done extra training and it's going to be limited to certain number of GPs. They can do a diagnosis and I agree with Amanda and Emma and Jack, we can all diagnose it. We know we have the tools and the skills and the knowledge to diagnose it. It doesn't mean it's accepted by other places or professionals, and it also doesn't mean that we can initiate prescribing of stimulant medications.

Prof Mark Creamer (00:41:11):

Sure.

Dr Naomi Rutten (00:41:13):

According what they're doing in New South Wales is that a certain number of GPs who have done extra training will then be allowed to assess, diagnose, and initiate medication, sort of bridging that gap?

Prof Mark Creamer (00:41:25):

Yeah, sure. According to my research, GPS with specialist training can do it in WA, Queensland and now New South Wales. So it's still many states where we are relying on probably a fairly long wait to see a psychiatrist in many cases. However, I'd like to just get you now to put a different hypothetical hat on, although it won't affect you too much, Naomi, but Tanya had plenty of money. She had a very high level private health insurance and so on. How would things be different? How would her path through the system be different if she came from low SES groups? She didn't have any health insurance, she had to go through the public sector and let's quickly just take it through your area. So in terms of the GP, would that make much difference?

Dr Naomi Rutten (00:42:11):

Yeah, where I am, there are a few in the public system, there are psychiatrists that will do a private clinic attached to it. The waiting list for those is over 12 months and it can be a little bit hit and miss of who they're seeing and when and things like that. The other, if I refer privately, it's usually anywhere from $1,400 to $1,800. And the reality is I've got numerous patients who just simply can't afford a diagnosis so that they can get the treatment that we know so that they don't die younger.

Prof Mark Creamer (00:42:53):

It's an RNA isn't it? It's absolute. Amanda, I know you're not, you don't see yourself as an expert in inpatient care, but nevertheless, can we just chat briefly about she, if she needed an admission and she was admitted to a public psychiatric facility, now I'll get Jag to comment on this as well in a minute. Would she have had different care? Would she have been able to get in?

Amanda Butt (00:43:14):

It's unlikely that she would get in at this stage. There was no overarching suicidal ideation or suicidal plan. There was no psychotic symptoms. It was just that she's not able to function and so that wouldn't be on a high priority list to be admitted in a public health system at this stage.

Prof Mark Creamer (00:43:32):

Would you go along with that Jag be hard to get her into a public sector?

Dr Karuppiah Jagadheesan (00:43:37):

Yes, absolutely true. That's a reality of better. And the maximum would be that Tanya gets attended by say, crisis team and the crisis team functions differently and the threshold for allowing somebody to access inpatient care is different. It's mainly risk driven and very rarely we see admissions for diagnostic purposes. That used to be much before but not anymore. So there is a real barrier, but I just want, this is one of the areas. The Senate inquiry also highlighted that there's a huge gap in the public system supporting this access for ADHD care. So hopefully we see some changes eventually, but at the moment there is a big barrier

Dr Naomi Rutten (00:44:23):

Mark. I just want to add in there too, even if she turned up to the public system and that sort of stuff, even if they referred her to a community mental health team, it's unlikely given her symptoms that the community mental health team are going to see her as well. So the reality is that her first point of call would be either someone like Amanda or the regular GP managing things and utilising people like Emma, psychologists, councils, other therapists and stuff as well.

Prof Mark Creamer (00:44:53):

Well, can you see her, Emma, if you're not going to get paid well, if you're not going through the private system, can you see her through the public system?

Emma Ketley (00:45:03):

How I work right now in my own private practise, I don't in reach so much. No, not, I suppose there is that obviously the private practise model that I follow, but just coming on board with what you've said earlier, sadly this is what I believe was happening to a lot of my clients that were diagnosed with borderline personality disorder because if you follow Tanya's trajectory, if she continues to decompensate, her relationship suffers. Situations will remain unresolved. This is where she will be going into decompensation and crisis and this is where she's highly likely. The other diagnosis, borderline personality, anxiety, depression, suicidality, that is what's going to get her noticed and entered into the public mental health

Prof Mark Creamer (00:45:52):

System. It is a bit tragic that it has to get to that point. It's when it could be stopped before, but that's the world that we work in. Let's talk a little bit, if we could, about multidisciplinary care and whether

we keep her in the private sector or the public sector or a mix of the two. We've got the four of you as part of her multidisciplinary team, what in an ideal world, what would it look like? What would multidisciplinary care for Tanya look like? Does anyone want to have a stab at painting a picture? For me,

Amanda Butt (00:46:26):

In my role now as a mental health nurse practitioner in private practise, I do bulk bill unlimited sessions for mental health care. So I would be seeing Tanya in this case as many times. If she wanted, it'd be all bulk billed, but I'd then in reach to JAG as a psychiatrist to set up the medication regime. I'd then tap into Naomi's services and hope that she could continue prescribing a stimulant if it is. Or I could prescribe the non-stimulant and we'd all work together. In that sense, I'd probably be able to see her more frequently of being bulk billed and then maybe Jag would see her every few months and Naomi would continue to look after physical health and bloods, et cetera.

Prof Mark Creamer (00:47:12):

Good bearing in mind, we are still talking about the ideal world, so that sounds good in the ideal world, Emma. Yeah.

Emma Ketley (00:47:19):

Yeah. I mean some other points of funding are the better access to mental health scheme. So that's what Amanda was talking about when she was talking about the bulk billing. The Medicare rebates are available for up to 10 sessions for psychotherapy with Medicare endorsed professionals, and if everything was stabilised, there's also funding available to offset the cost of ADHD coaching. As Tanya is working, she actually can have access to job access funding, which will give her about 1,600 a year to be able to use that to help manage ADHD in the symptoms to maintain. Well, that's

Prof Mark Creamer (00:48:04):

Good. It's not a huge amount of money for a whole year, but still something. But let's come back onto the idea of how's the team working together? So Amanda presented quite a nice picture there, I think. How realistic is that, do you think, how often and what would you need? You'd need a regular case conference, you need to be chatting to the whole team every three or four months and just say how are you going and what you're doing.

Dr Naomi Rutten (00:48:29):

It really depends on, yeah, I mean that kind of depends on how the patient's going. So I think all of us really, even though we may not be in the same building, we all work in multidisciplinary ways. So I just how a letter from a paediatrician asking me to take on care of a patient that I've never seen before and then I might see them manage the medication, refer back to the PD if need be, and then intersperse letters in between times utilise whether it's an OT for this person or a counsellor or a psychologist or somebody else. And so you don't necessarily have to have formal case conferences because you're sending letters to each other and updating each other in between, especially if they're stable. So we already work in multidisciplinary teams. It just doesn't look like a let's meet once every we and sit down and discuss all the common clients of working in one central place.

Prof Mark Creamer (00:49:29):

Do you think jag, is it easier to do the kind of things that we're talking about? And I take Naomi's point, it doesn't have to be actually talking that often, but do you think it's easier to do that in the public system than it is in the private or vice versa? Even

Dr Karuppiah Jagadheesan (00:49:46):

Public system is easier because there is a system of case manager and there are case managers with certain disciplines and we have peer support, like lived experience workforce, and we have junior staff. So there are systems which can be easily replicated. How we manage with the chronic illness, a similar model, but awareness and skills to manage ADHD is very low. So the gap is at the moment private. I agree with what Naomi is saying and Amanda is highlighting as well. In an ideal world, if you take it as an ideal world, first of all, there is no model has been tested out properly to see how to care. But in an ideal world, certainly it would be good to have, practically speaking, we do send letters and try to communicate because that's all probably time we have. But there is a change in Medicare as well that they are probably already implemented an item for a case conference, which allows other practitioners to come along and have a chat. It may not be for Tanya, maybe other complex patients, it'll be a good space to use because sometimes you hear from clients saying that there is a gap in communication between different practitioners. So having a complex ADHD comes along with a number of other conditions. So when somebody is more complex, having a conversation through a case conference, even once a year or once in six months, be lot more easier to have a shared understanding in goals.

Prof Mark Creamer (00:51:21):

Absolutely.

Dr Karuppiah Jagadheesan (00:51:21):

That's an ideal. Yeah.

Prof Mark Creamer (00:51:23):

And what do you think gets in the way? I mean, my experience in mental health was that that didn't happen very often to be quite honest. People did tend to work away on their own and there might be the occasional letter, as you say, Naomi, but there wasn't a great deal of communication and I'm just wondering what gets in the way. I suppose the obvious thing is time and so on.

Dr Karuppiah Jagadheesan (00:51:44):

A lot of the time, private, we all work in different hours after hours, so that's the one problem. And also lack of incentives from funding aspect as well to do this type of a case conference and when people are very busy, there is no incentive. That's not helpful as well. So I think both time resource availability as well as incentives all need to be aligned. And it's a habit. I think it's a new, sorry, it's also a new thing for the system. If we all do it, say next 12 months, there is a constant push to develop this of a case conference model once in six months for certain patients. Probably it'll become easier for us to do eventually.

Prof Mark Creamer (00:52:30):

Yeah, yeah, absolutely. Naomi?

Dr Naomi Rutten (00:52:32):

Yeah, sorry Jack. It's one of those things. So for case consultations, GPs, there's very strict funding rules for it. And so often if it's something where there has to be a certain number of doctors or professionals that are attending or things like that to be eligible for the rebate, so often it's a financial thing as well as a time thing. And I think all of us, we are just so overwhelmed with the amount of patients that we're trying to see. So it's that real mix of where we're chasing our tails and we end up

writing letters, but it's often in our spare time and therefore we don't earn any money whilst we're doing it. And it's time that we're away from our own families and our own lives.

Dr Karuppiah Jagadheesan (00:53:21):

Certainly agree, Naomi.

Prof Mark Creamer (00:53:24):

Okay. Well at least we agreed on what the ideal looks like and if we can get closer to that, the better. Has anybody got any hints for our participants out there in the real world how they might be able to do this a bit better? Is there, let me ask you Jag, because well actually, and you, Naomi, I think there are some clinicians who are a bit frightened of ringing up the GP or the psychiatrist. We know they're really busy and the secretary won't let you through and all that kind of stuff. Do you think they should persevere?

Dr Naomi Rutten (00:53:59):

It depends,

Dr Karuppiah Jagadheesan (00:53:59):

Yes.

Dr Naomi Rutten (00:54:03):

From the GP side of things, you can continue to, but again, trying to grab hold of the psychiatrist who are super busy and then when they call, we're super busy and it can be difficult. There is a sort of online psychiatry number that GPS can call to ask questions and advice around that, trying to keep on top of what services are around you and available to you so that you know who to call and who's sort of going to be able to be part of the team for your patient. And I suppose for a lot of areas and people who can access telehealth, that can often be a bit wider and there's more opportunities for things that way.

Prof Mark Creamer (00:54:54):

Okay. Again, time's going on, we could easily spend the whole webinar talking about treatment, but I would just like to explore what the various components of treatment might be, and perhaps if I could talk to you first, Jagger and perhaps Naomi about medication, what we think of first, we tend to think of stimulus like a stimulus, Ritalin or whatever. Is that reasonable? Is that likely to be the first line of treatment or a different medication?

Dr Naomi Rutten (00:55:25):

So I tend even before I've done or referred for the assessment, I'll ask the patient, do they want a diagnosis or do they want a to consider stimulants? If they don't want to consider stimulants, i'll diagnose and we'll manage all the other ways and lots of education around the purpose of the stimulants. It's there to help make things the function easier, but it's not going to fix the ADHD. So stimulants are often the first line, but the reality is not everybody's going to respond well to them. It's complex accessing them. Some GPs don't want to do the prescribing. Again, it's more of a process. So each state's slightly different. For me, I have to then lodge an application online through script check SA to get approval for ongoing prescribing. That takes time. Then it can take anywhere from two to three months to get approval to then prescribe. So in amongst all that, you're then considering, well, let's look at the lifestyle factors, let's look at the behavioural things that we can change as well.

Prof Mark Creamer (00:56:37):

Yeah, absolutely. Jack, can I just begin to pick up on Naomi's point, if we decide against stimulants, are there other medications that would routinely be used? I've heard of clonidine being used for example, but any other medications that would often be used in ADHD apart from the stimulants?

Dr Karuppiah Jagadheesan (00:56:57):

So non stimulants, they're not aware. Obviously they're not bad compared to stimulants. Stimulants have, they have a very high margin of success. So their effect size is close to I think 80%. It's all of the highest what we see in medicine in general. Oh really? Very nice. Very. So it does work, but what happens, they are very short-acting medication. Even if you have a long-acting version still, they don't persist for 24 7. So that's a limitation of stimulant therapy. It may help the person to work through the daytime. What happens afterwards, it's a problem and there's a tolerance issue. So now stim, I find it particularly if they can be waiting, even though they're second line, there are criteria

why we go for non-stimulant. But if they could have coexisting anxiety disorders, depression, they can wait. Then non-stimulants like AutoID oxygen, which is an antidepressant, it's not a bad option.

(00:57:57):

Once it works, it works throughout the day and night. So it's much more stabilising. So what we also need to realise is that not everybody, I've seen what Naomi says, there are times people just want the diagnosis to have a closure of maybe to have an understanding of their life story. I've seen people didn't want to take any medication, they're happy with how they are, and they just want to work on few psychological tools and they don't want to see me anymore. So we have to realise that individual goals are very important, unless they're really struggling day-to-day functioning wise, we don't necessarily need to go for a full medication option. But if they have tried everything, then certainly there's a medication option to consider.

Prof Mark Creamer (00:58:43):

Okay. Can I ask Emma and Amanda to come in then? And Naomi's already alluded to a lot of things, and you have earlier in your talks as well. What would you see just very briefly as being the primary components of intervention for, let's assume that we have made a diagnosis of ADHD with Tanya. What would you see as being the most valuable, the kind of really high impact interventions apart from the medication? Either or you,

Emma Ketley (00:59:11):

Amanda do. You can go first. So we're talking about a late diagnosis case of someone that has spent their life in an role. And so a late diagnosis at this point is really impactful in the framework of all of sudden questioning your self identity. There's actually a lot of grieving that can happen in late diagnosis. So there's probably a space here for self-compassionate understanding around what the diagnosis means for them and what it will mean in the future. It's also been alluded to by members of the team already that the medication will just help improve her focus. For Tanya, it's actually the skills, the pills won't teach any skills. So if anything, it'll give her the ability to focus more and that sometimes amplifies the anxiety and depression already in this context of ambiguous loss and grief. So the work for OT here would be around really what transferable skill sets has she got, what strengths has she got to really perform functionally those tasks that are so important for her.

Prof Mark Creamer (01:00:32):

There might be

Emma Ketley (01:00:32):

Some executive functioning scaffolding and for the coaching it might actually be questioning around with this new version of yourself, what do you want to do?

Prof Mark Creamer (01:00:43):

I think it's a very important point and of course that's your specialty. I do think that certainly in my training we barely mentioned functional outcomes our job is to get symptoms down and yet this functional stuff, I think so important. Amanda, is there anything you would like to add? Very briefly. I want to move on to something else.

Amanda Butt (01:01:01):

Yes, just the same as what Emma would do in terms of trying to find out what the person wants to do in terms of functioning. So we do a lot of things like setting reminders and alarms and whiteboards and lots of things that they can structure their lives around. And so they're not forgetting appointments and so they're not forgetting things and these are the little things that they may already have in their life. And just also looking around sleep, because you mentioned kine and in Australia we don't have the long acting version, which can be used for a DH, adhd. We only got the immediate version and we use that sometimes for sleep. So when you've got your stimulant throughout the day or your non-stimulant, you can use that clonidine at night for sleep. So I use that a lot in my practise.

Prof Mark Creamer (01:01:42):

Yeah, fascinating. Okay. I'm sorry we've had to rush that section because it's very important. But anyway, I think we've alluded to it all the way through the various components and very valuable as we come towards the end. I'd like to talk a bit about outcomes, I guess outcomes and next steps. But let's say we've now been seeing Tanya for a little while. She's got this top class multidisciplinary team working with her, which she's very fortunate to have. I'm not suggesting that everybody would have that, but she's got it. What do you think would be a good outcome in this case? What could we reasonably expect as being the best possible outcome for someone like Tanya? And I'm happy for

you to just kind of free associate, but I've got some questions and perhaps we start No, no, you free associate. What do you think would be a good outcome for her?

Dr Naomi Rutten (01:02:34):

Imagine that me stepping in and talking first for me, it'd be like is she reaching her function goals? So is she sleeping well? Is she feeling better within herself? Her confidence being able to do the work that she wants to do, working on the relationship with her husband, her children, her parenting skills as well. So it's really from my perspective, all about her function and how well she's feeling she's functioning and how balanced her symptoms feel for her. So that's what I'd be looking for and working towards.

Prof Mark Creamer (01:03:10):

Yeah. And quite rightly, I know you'll say in answer to my question, well it depends what she wants, but how important is it for her to get back to her work? Her work is pretty important to her. Are we going to put a high priority on that? Do you think?

Dr Naomi Rutten (01:03:22):

It's funny, I've got my psychotherapist hat on it, it's like, but is it important to her or was it important to her? So is it important to her now and was that something she was doing because she had to prove herself because she never felt good enough because she had ADHD and had to work so hard, but now she knows she's got ADHD, she can go, this is okay and this is enough. So maybe her values of worth and success might've altered a little bit.

Prof Mark Creamer (01:03:51):

Okay. Would others like to jump in on what you would see as a good outcome? When would you say to yourself, I did a good job with her Jag,

Dr Karuppiah Jagadheesan (01:04:00):

I just reinforce what Naomi is saying. So two things. One is it's individually driven. And so when I say individually driven carrier is important, if Tanya believes that getting back to work gives that sense of identity and that sense of being in control, we certainly need to work towards that. And lack of control is one of the reasons why she has presented in the way what we are talking about. And so

second thing is that she needs to have that subjective satisfaction because there are issues happening at home that needs to be addressed enough as well. So we need to focus on that and so that he can fulfil him role as a parent. Otherwise there is a likelihood self-esteem can go down and it leads to more frictions at home. In a medical sense, there is a symptom remission. Some people prefer symptom remission and rather than just a partial improvement, some people don't like symptom remission.

(01:05:00):

I've seen not some people, very few, they want to be left alone to be themselves. They don't like to have a streamlined single thought approach. They want to have a free flowing creative mindset. So it varies. And what I have seen is that sometimes once they have an experience of a medication, if it clicks further, when they say how their mind is different, then they decide often whether they like to pursue it. Like I have seen, for example, similar case if a project manager 50, 55-year-old male comes along wants to be assessed because he has been dealing with anxiety, but very highly functioning project manager with the thorough assessment confirmed that this A DSG, he wanted to try the medication we went on with one of the stimulants within a couple of weeks. He says, I don't need to organise myself to that detail anymore. I have so much of a free space in my head, so it can be relieving in medicine. So it depends on what individuals want to focus on.

Prof Mark Creamer (01:06:01):

Yeah, yeah. Quite Emma or Amanda, what would you be your good outcomes? What would you say we can achieve with Tanya

Amanda Butt (01:06:09):

To you Amanda? I think family functioning, having that cohesive family. So at some point we would've involved maybe a family therapist in one of our multidisciplinary team meetings and had a look at if Greg is the primary carer at home, why did that occur? And so maybe Tanya wants to do that now and I think, I guess that success would be around what she really wants and whether she's met that, but definitely involving that family in her goals and in her functioning.

Prof Mark Creamer (01:06:41):

And the point that you just made, and indeed many of you have made implicitly, is that, and we see it that we in mental health all the time, that if the identified patient manages to change and get

better or change or whatever, that changes the whole dynamic at home and suddenly, whoa, everything's very different. And so I think you're right. We really need to be aware of those possibly changed dynamics. Emma, do you want to say anything? Do you want to add anything in terms of outcomes?

Emma Ketley (01:07:07):

Yeah, just I'm obviously loving what the MDT has already said around really exploring her choices of the work that she was doing. Was that overcompensation? Was that her struggling with this, the sense of being different of having this different neuro type of being ADHD? And is that something that she wants to return to? And I think my goals would be reflective of her goals, obviously, but I would be looking perhaps for a sense of greater self-advocacy that she can speak up, she can actually ask for accommodations if that's what she needs for at work. She can actually ask for medications to be adjusted if she feels that that's impacted on her relationship at all, and a sense of self-determination. So rather than masking through overcompensation and overachievement, what actually does she really want to do? Is she happy to?

Prof Mark Creamer (01:08:03):

And of course this is an impossible question, but that doesn't stop me asking it. One of the dilemmas we often have I think, is when is enough? When have we given her as much as we can reasonably do? And if you look at the graph of how people improve in treatment, generally speaking, we get this big steep improvement and it gradually flattens off and flattens off. And it comes a point where continuing to see the client is actually not terribly sensible. I'm not expecting any magic answers, but does anyone want to just say anything about that? When do we stop?

Dr Naomi Rutten (01:08:33):

Well, I actually was writing this in a report today, mental health and these sorts of issues, it's not a broken leg, it's not a, oh, excellent, they're fixed. It's quite likely that they will need ongoing monthly or bi-monthly or three monthly, however long that it stretches out. And it's almost, I look at it like almost a supervision or a reflection time where they can go, okay, it's just a checkpoint. How are we going? How are our symptoms? Let's see where things are going. Do we need to do anything? And so it is actually a preventative thing ongoing to prevent any deterioration of symptoms to make sure that they maintain as healthier balance as possible. So it doesn't mean they'd need to see all of everybody in the multidisciplinary team, but I think that it's really important that people have,

whether it's the GP or the nurse practitioner or the ot, the ADHD coach, whoever it is, that they have that check-in point ongoing

Prof Mark Creamer (01:09:41):

And that if they need to, then if the wheels are starting to come off, you can get in quickly and you can bring our magnificent team back together to help her through. Okay, we could easily go on for another hour. And I have got through most of the questions on my list. Not all, but anyway, have to be realistic, but we could go on for ages. I found it a fascinating discussion. I must say that I've learned a huge amount and I'm sure our participants have as well, but we do have to move towards winding up. Just before we wind up, I would like to give our panellists the opportunity to say a few final words, any reflections on this process, anything that we missed that we should have talked about, any take home messages for our participants, and perhaps we'll go through it in the same order we've been going through. So Naomi, if it's okay with you, any final closing comments from you? So

Dr Naomi Rutten (01:10:35):

First thing is just to bring up the point, she's 45 think perimenopause as well because it actually exacerbates ADHD symptoms. So if she can, and if it's side effects and allow and that sort of stuff, consider some menopausal hormone therapy as well in regards to anybody who's got ADHD or thinks they've got ADHD. But then for those who don't have ADHD, just to have a bit of self-compassion and also just understanding and it's really about, one of the biggest things for myself was I was able to just stop asking myself to do something that physiologically I can't do. So just have that self-compassion, that self understanding it's not, not trying hard enough or you're not smart enough. You can't physiologically do it. Okay,

Prof Mark Creamer (01:11:28):

Thanks Naomi. Some very brief. I'm going to make you talk less than Naomi. Some very brief comments. Amanda,

Amanda Butt (01:11:35):

I completely agree with Naomi. The one thing that I would've also looked at is cognitive disengagement syndrome or sluggish cognitive tempo, which can be misdiagnosed as inattentive

ADHD without the hyperactivity. So that's a very common one that I see in my current practise. That's my last comment.

Prof Mark Creamer (01:11:54):

Excellent. Okay, thank you very much. Jag, any closing comments you'd like to leave our participants with?

Dr Karuppiah Jagadheesan (01:12:02):

I think it's already Naomi and Amanda has mentioned, so I think it's important to have a very holistic approach because there are a lot of the clinics are being flooded with the need for assessment. I also hear that there is a reluctance blowing up on the other side not to engage with any clients asking for assessment. So I think we need to be compassionate at the same time be holistic so that we provide a thorough assessment. If it leads to ADHD, then we talk about ADHD. And what also we need to realise there is the power with the psychoeducation, it's underutilised tool. Often that's enough for people to just carry on with the line once they understand what it is. So it doesn't need to be medication specific interventions for a lot of people. So that's what I mean.

Prof Mark Creamer (01:12:53):

Very good point. And we shouldn't dismiss those apparently simple kind of things that we can do that can be very valuable. Emma, a closing comment?

Emma Ketley (01:13:01):

Yeah, I think this just draws the line again under how important it's to understand the difference between something that might be depression or might be more of a neuro difference burnout. And obviously there's very different approaches with burnout. It is actually to ease off with that sense of self-compassion. And Tanya is so common to the health professionals and executives that I actually see in coaching where people push themselves to the limit and then they just can't do it. So if you've met one person with ADHD, you've only met one person. The value of context is so important. And I think one of the key message of whether I'm working as a therapist or in my ADHD coaching role is just to explain through psychoeducation that this isn't a moral failing of this client. They've not done anything wrong. In fact, if anything they've overachieved is usually a situation where you're dealing with so much more but seen to be doing less somehow that I think the biggest thing we can do as

compassionate conveying professionals is just to express that this is not a moral failing. This is just brain wiring.

Prof Mark Creamer (01:14:12):

An important message to end on. Emma, important, thank you so much to all of you. That's been absolutely wonderful. And to our participants, if you'd like to know any more about Naomi, Amanda, Jag, or Emma, go to the landing page for this episode on the MHPN website. You'll also find a feedback survey there and it's very short. And we really would encourage if you could, to fill in the feedback survey, tell us what you thought about tonight and the format and so on. But also tell us a bit about what you think MHPN can do for you to meet your needs. You're going to receive a certificate of attendance in the coming days, but for now it's goodbye. Thank you very much again to our panellists, Naomi, Amanda, Jag, and Emma, and thank you all to our participants for being with us tonight. I hope you enjoyed it as much as we have. And please keep an eye out for future webinars from MHPN. I saw there's one coming up on infant mental health, which is a fascinating topic, and I think I'll come along for that one and another one working on addiction. So there's lots of stuff happening. Keep an eye on the MHPN website. But in the meantime, thank you very much again to our panellists and to you our participants. Thanks again and bye for now. Bye.