Webinar Transcript

Contemporary Care for ADHD in Adulthood: Medication, Psychosocial Supports and Beyond

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Dr Maddi Derrick (00:00:01):

Good evening all and welcome to Contemporary Care for ADHD in adulthood, medication, psychosocial supports and beyond. Next slide, thanks. The Mental Health Professionals Network would like to acknowledge the traditional custodians of the land, seas, and waterways across Australia, upon which our webinar presenters and participants are located. We wish to pay our respects to elders past and present and acknowledge the memories, traditions, cultures, and hopes of Aboriginal and Torres Strait Islander people. My name is Dr. Maddi Derrick. I am a clinical psychologist and I'll be moderating tonight's session. I run a practise in Hobart that is focused on psychological services assessment and intervention for people of all ages and their families with ADHD and any co-occurring conditions. I also have a very neurospicy family tree both above me and below me and all around me and I have ADHD myself.

(00:01:05):

I have both personal and professional interests in what we'll be discussing tonight and I'm really looking forward to hearing from our esteemed panel. We have psychiatrists, Dr. Kyle Hoath, clinical psychologist, Rebecca Alexander, and GP, Dr. Corin Miller. Next slide. Thank you. So tonight, we're going to be exploring the value of collaborative care in supporting adults with an ADHD diagnosis and how multidisciplinary best practise can be achieved and maintained in this ever-changing context that we have at the moment where we have a lot of evolving policies and workforce issues and access issues. To help anchor our conversations, we're going to use our little case vignettes here, our two fictional people with ADHD. We have Raj, who's 32 on the surface at least looks capable, is holding down a good job and he's seeking greater understanding of how ADHD may relate to the experiences he has and he's trying to balance career demands while navigating all the online information and support pathways.

(00:02:18):

We also have Tina at 48, a woman who's very resilient, again, perhaps on the surface and is reflecting on these longstanding experiences that she has through this new lens of ADHD. She's balancing caregiving responsibilities, life stage changes, of course, at 48 years old, and she's really exploring the support options that might fit her support needs. Next slide, thank you.

(00:02:49):

Okay, so we're going to start with the context of clients or patients first contact with health or allied health, where they're seeking help entering into the system. We've got policy reform that's changing around them and how people interim move through this system and how we provide care to the adults with ADHD is what our panel are going to help us understand here. So I might start perhaps with you, Corin and my first question. Could you talk us through how Raj or Tina's options might differ depending

on which state they're in, but also whether they're in a metropolitan area or in more regional, sorry, or rural location?

Dr Corin Miller (00:03:34):

Yeah, sure. So the first contact with the health system is most commonly delivered by primary care. So by primary care, we mean the first contact with the health system. We know that GPs see nearly 90% of the Australian population per year. And so chances are it could be a GP that is the first port of call in terms of seeking help, but that differs depending on where you live in Australia. So we know that access to all medical staff, so an allied health and anyone to do with the healthcare system, the concentration of providers, it gets smaller the further you are away from a metropolitan centre. And so what I'm trying to say is the proportion of people per health professional changes depending on where you live. Now we have to work within the health system that we have, but it's not equitable. And we know that for example, priority populations can really struggle to access care in a timely way, closer to home.

(00:04:47):

But yeah, most of the time it would be a GP statistically speaking that you see first and certainly with the way that the Medicare system is set up before you could see someone like Kyle, you would need a GP referral unless you're willing to pay privately out of pocket. And the same with Beck or yourself, Maddi. We do have certain ways to access Medicare for psychology sessions, but it involves seeing the GP first. Now in terms of ADHD care specifically, that does vary state by state territory by territory and it's a rapidly evolving space at this point. So we know that with policy changes, they're all different depending on where you are. And for example, Queensland GPs have been able to initiate stimulants for children for a long period of time comparatively, whereas New South Wales is only just initiating the changes that are needed.

(00:05:54):

So we now have continuation prescribers that are GPs. So the client or patient, whatever you want to call them with ADHD has already got their diagnosis and then the continuation prescribers that have done additional training can then continue those prescriptions. And there's now training for what's going to be called endorsed prescribers, which will be GPs who have done additional training and developed their skills to be able to make the diagnosis as well. And there's differing versions of that across the country. Now that's only referring to pharmacological management and obviously good quality care for ADHD is not just medication, it's multifactorial, it's collaborative, and it's best done with a team. Whether or not you have the gold standard team or not, it depends on where you're located and whether or not you have the financial means to pay privately for that, unfortunately. Thanks,

Dr Maddi Derrick (00:07:02):

Corin.

Dr Corin Miller (00:07:03):

Welcome comments from the other panellists if they want to.

Dr Maddi Derrick (00:07:07):

Yes. Perhaps Kyle, did you have any ... I know that you see people right around the country as a psychiatrist. Did you have anything to add to Corin's comments around

Dr Kyle Hoath (00:07:19):

The team?

(00:07:20):

Yeah, I guess it is pretty important to understand the context for where you are working and or sometimes more importantly if using telehealth where you're seeing the patient because it will be different. And I think as much as there's been an attempt or ongoing attempt from the government out of the centre quarry to have some sort of national strategy around how we approach this, we're still in a phase where states do it very differently. I think it really is one of these great examples where a team helps though, as you'd be aware, Maddi, but sometimes it's about providing a specialist opinion from my perspective to help a GP and a local psychologist manage a patient rather than necessarily having to do all of the work that we may have historically done as specialists. And I think that's an excellent example of how collaborative care can work even just across borders.

Dr Corin Miller (00:08:15):

Okay. Thank

Dr Maddi Derrick (00:08:15):

You.

Dr Corin Miller (00:08:16):

And as a GP, having those escalation pathways available and having psychologists to work with absolutely makes life easier for us as clinicians and also for our clients or patients, definitely.

Dr Maddi Derrick (00:08:31):

And just with everything that's changing, I imagine for the GPs themselves, it's difficult to keep up with where things are at, let alone be able to access the training, et cetera, for them to feel comfortable with whatever their role is. Bec, I might come to you as a psychologist when we've got fragmented care because perhaps of maybe seeing a GP or others unaware of what options are within their state, for example, who makes sure that nothing falls through the cracks?

Rebecca Alexander (00:09:04):

Thanks, Maddi. So that's a litle bit of a tricky question in itself because it really depends on who's part of their care team. So for example, if they're seeing a psychologist and they're seeing a psychologist regularly, that person can often explain what's going on, where's their pathways, the need to engage with a GP or a psychiatrist. But from the other side and using a multidisciplinary team, then we rely on the GPs as well, as well as our psychiatrists. But we rely on those GPs as well who have a lot of contact with the clients to be able to navigate where they need to go, what they need to do, what their options and avenues are for them. And again, this can be quite tricky from what both Corin and Kyle were saying

is that depending on your location will depend on your acces. So the changes that are happening at the moment with the reforms is quite great that we can get some better access, but when we're coming through clients, I've had a number of clients that have come through where they're not sure where to go, who to see.

(00:10:24):

And for a psychologist providing that education of who else they can tap into from a multidisciplinary team, mental health nurses, for example, GPs, like I've said, by having others around us, it can help support the client themselves as well and not just trying to fall back on who's responsible. If we're having these conversations with everybody, then aren't we working as a team as opposed to having that on one person? So for example, if I have a client that comes to me and I've noticed that they're not doing as well as they should be, their mood has changed. We've noticed other things in their presentation. Then for example, as me in my role, I would be most definitely going to, who's your psychiatrist? Who's your general practitioner? Can you please go and make an appointment with them? Can you ask them to have a look at these symptoms and see what happens from that perspective?

(00:11:37):

Yeah,

Dr Corin Miller (00:11:37):

Sure. Sorry, if that's okay, because part of a GP's role is to coordinate the care of their patients and we have the added benefit of longitudinal relationships with not just the person in front of us, but often their whole family. And so we know about those dynamics and things and I really appreciate when my psychology or psychiatry colleagues reach out and let me know, "Hey, can you keep an eye on this person because this has changed?" And you're like, "Okay, great." And again, that's where that real collaborative model is the best. It's the gold kind of standard because I don't have an hour each time I see my patients. I might have 15 minutes, I might have 20 minutes, but I certainly don't have that depth that you would get Beck and Maddi, but I do have that longitudinal kind of relationship and sometimes I can see that the person in front of me isn't doing so well and being able to, on the flip side, reach out to their psychologist or psychiatrist, it's patient-centered care and that's really what we want to do.

Dr Maddi Derrick (00:12:53):

As you're talking, Corin, I was just reflecting on being where I am in Tasmania, we've had big shortage of GPs in recent years and for a lot of people that there's no such thing as their regular GP. It's such

Dr Corin Miller (00:13:06):

A shame.

Dr Maddi Derrick (00:13:08):

Yes. Although their regular GP hasn't been willing, they don't feel confident yet to take over co-prescribing. So it does get a little disjointed, but what I'm hearing and perhaps adding to what you were saying, Bec, maybe it is the reaching out doesn't necessarily have to start with the GP. Maybe it's the

spokes reaching back into the hub and the will to the GP to help get that cohesion started. But yes, Carl, did you have anything to add?

Dr Kyle Hoath (00:13:43):

No, no. I was just going to reaffirm that. I actually had a couple examples this week, including one this morning where it's the psychologist who's been seeing my patient for a relatively new psychologist for my patient, but someone I'd seen for a while and she goes, "Yeah, if you changed something with the medication." I was like, "Oh, I did." And I haven't told you, my apologies, but it put some things in context to her with the patient interaction. So one, naughty me for not letting her know in the first place, but it shows that power of working together because we do all see patients at different points in this journey and as Corin said, for different reasons sometimes in different periods of time. So the more on the same page we are, the more collaborative the care is, the more opportunity for one, getting the care right and two, picking up things that might not be going so well.

Dr Corin Miller (00:14:33):

Can I also just add in there that our system, although one of the best in the world is really complex. And so if you are someone like our patients, Raj and ... Oh, I've forgotten her name.

Dr Kyle Hoath (00:14:49):

Tina. Tina.

Dr Corin Miller (00:14:50):

Tina. I even made up that name. If you're someone like Tina who is juggling caring responsibilities like ageing parents and teenage children and perimenopause and all of that, to then also have to be responsible to know how to navigate this very complex system, let alone if you happen to be of non-English speaking background or you might be an Aboriginal and or Torres Strait Islander and there's cultural barriers, there could be a number of things. And so I think again, that's where us as professionals working collaboratively is really so essential because otherwise people do fall through the cracks despite our best intentions.

Rebecca Alexander (00:15:37):

And most definitely, Corin, and I agree with that and having that conversation with the GPs or the psychiatrists and other allied health professionals around us and our clients and educating them as well of, we can do this, we can support the client in this way, we can support the client in that way. We can come back to you for a conversation. And that's really important. And as you guys have given examples of, we all have many examples of where collaborative care has been actually quite beneficial for our clients.

Dr Maddi Derrick (00:16:18):

Thank you, Panel. I can imagine for Raj or Tina, if they did enter in the system and perhaps had the experience of talking to whichever discipline first and were then sort of sent away to go find out where to go next, find a psychiatrist, et cetera, I imagine that could be a bit where the journey stops. So

certainly say that with clients of mine in the past, say that we're doing non-pharmacological intervention, but now they're wanting to look into medication and I think we are going to be getting a lot better with this, but in the past it hasn't been clear where to go from our area. And then you see the client again a month later and nothing's happened because it was all too overwhelming that- Or

Dr Corin Miller (00:17:11):

They do get put on a wait list, but it's two years long or there is no publicly available adult psychiatry service that will see neurodivergence. So there's access barriers, so many access barriers in the system still.

Dr Maddi Derrick (00:17:26):

Yes.

Dr Corin Miller (00:17:27):

Well,

Dr Kyle Hoath (00:17:28):

Sometimes worse than two years, it's one year and one week and their GP referrals expired so they get kicked and have to start again. It is a horrible system. It is so complex. There are so many ways into it. There is no clear path. And to be honest with you, most mental health doesn't have a clear path in treatment anyway and that makes it really tough for people trying to find help because sometimes they just want to understand rather they don't actually know what they need help with. We know people come often asking, "Do I have ADHD?" But just as frequently, if not more frequently, they come and saying, "I don't know what's wrong," or, "Things aren't okay," or, "I'm struggling." And we have this whole journey of, am I the right person? How do I point them in the right direction? And I think one of the themes of this is how do we navigate them through that system because it's really complex for people.

Dr Corin Miller (00:18:15):

I think also keeping in mind, sorry, using a trauma-informed lens as well. So if something's overwhelming, particularly if it's triggering for a person with, let's say, complex PTSD, it's just too hard. And so having the follow-ups scheduled and working as that team, we can then go, "Okay, well, I'm seeing you a month later. How did you go with that? I was too overwhelming. Okay, well, let's work on that together." Yeah, I think that's really important too.

Dr Maddi Derrick (00:18:49):

I think all the extras that we need to do off the side of our desk that can become overwhelming, that can chew up our time, meaning the wait lists get bigger, it makes access harder. But what strikes me often is that maybe if we spend that principle of a stitching time says nine, if we spend that little bit of time write that letter, say back to the GP or to the psychiatrist, then we might cut out some of the extra work that then happens down the track with chasing things up and perhaps circumstances getting more difficult for the person. But yes, I think that you've all been obviously fans of collaborating, which is

definitely what we'd want. If we do get that team going, just to our next slide, please, in terms of building that team, finding those supports, if we can get those in place, we know that can make a really big difference, a huge difference.

(00:19:53):

Curious from your perspective, what that actually looks like in practise and might start with you. Kyle, for Raj or Tina, what would make a good team?

Dr Kyle Hoath (00:20:04):

Oh, just a psychiatrist and everybody else.

Dr Maddi Derrick (00:20:08):

Sorry?

Dr Corin Miller (00:20:10):

You're fired. Oh,

Dr Kyle Hoath (00:20:11):

Nobody

Dr Corin Miller (00:20:11):

Else.

Dr Kyle Hoath (00:20:16):

I think it's a great question because it is going to be very different depending on the person in front of us and I think that's important as well. It's never going to be a one size fits all. And for the longest time, I've tried to live by the philosophy that the patient is the most important team member in the team because they really are the person we want to empower through this, whether it be taking control of their life, but also taking control of their options and their pathway. And I'll tell patients, "You're the expert in you. I know a little bit about some of these psychiatry and medicine things, and together we'll be able to figure out what'll work." And so the person and empowering them, that's probably the piece I always say is number one and central to a team. Look, obviously we have a GP, psychology, psychiatry representative on the panel today and they have complimentary, overlapping, similar, different roles.

(00:21:09):

And again, I think it depends on what for. I work with GPs who work very similar to the way I do and focus a lot on assessment and diagnosis and treatment of ADHD. And I also work with GPs who are the primary care physician for an entire family and have longitudinal history and care coordination across multiple competing medical conditions and medications analogies that sometimes at a real challenge to the way we might think of or treat ADHD. And look, similarly, I have psychiatry colleagues who are much more therapy focused, psychologists who are much more skills acquisition, coach focused versus psychotherapeutic or assessment focused. So we all bring a range but with a bit of an overlap. And I think that's a good thing. I think that's where having the patient at the centre and making sure we have

the right people around them, not just tick boxing professions and sometimes maybe get accused of just being a litle bit on the controversial side, but I ultimately think that a lot of people don't or shouldn't need a psychiatrist because there are, on GPs see far more mental health conditions than psychiatrists do by volume, but two, psychiatrists are a limited resource and not being able to access a psychiatrist for a complex or for consulting, for input, for weighing in on a tough case and giving an opinion when other things haven't worked, that should be really accessible in a perfect healthcare system.

(00:22:48):

I know we're never going to be perfect, but I think it's really important to have some of those philosophies in the way we build our care teams around people. From my perspective, where I work, we use psychologists to do a lot of our assessments. We think it's a really awesome entry point after a GP or a person identified that they want to explore ADHD as a possibility because of the time and the thoroughness in exploring overlaps with traumas, with anxieties, with coping mechanisms, with trying to uncover what is there and often in a really thorough way that's difficult to replicate in the pure medical model. And so I think brings an important lens. So as we expand out into treatment though, like I said, I think Raj and Tina are going to need very different things. Some people benefit from having an ADHD coach and that's a real practical thing that will work well for people depending on their age, maybe it's an OT, maybe it's school support, good pharmacists can be hard to come by, but they'll make an absolute massive difference to your life when they know what medications you're on and the interactions and things that you may have forgotten in the past.

(00:24:01):

Family, workplace, friends, partner, it gets pretty big as we start to think of who would fit into a care team. And I guess at different stages, along this journey, people will need different things. So yeah, I'm keen to hear what others would say, and I'm sure I've missed a crucial clinician or care team member somewhere along that ramble.

Dr Maddi Derrick (00:24:23):

Well, I might actually come to you, Bec, if that's all right. And just from your perspective, from the non-pharmacological side of things, what would make a good team, a good ADHD care team?

Rebecca Alexander (00:24:38):

Like Kyle said, it really depends on the person in front of you as well and what their needs are. Kyle touched briefly on a ... Well, not briefly, but Kyle touched on an array of people, but social workers, for example, their day-to-day could potentially be part of their care team or part of the family system when we're looking at those greater and wider supports that are coming through mental healthcare nurses as well. There's an abundance of team people and like you said, Kyle will probably miss someone and I apologise as well, but it's not just about that one person. And again, coming back to that person centred, they're a human What do they need

Dr Kyle Hoath (00:25:34):

What

Rebecca Alexander (00:25:34):

Do they need? They're an everyday person just like you and me. What's hard in their life? What do they need? And then how can we get that care team involved? Is it a social worker that they just need? Is it a counsellor? Do they just need someone to talk to and do the, I don't know about you guys, but it's the two minute info dump, I just need to get this out. I just need to have someone to listen to. That's great. Who else can we leverage on and use within this team?

Dr Corin Miller (00:26:05):

Yeah, that comes down to what is available in your area and what again, suits the patient in front of you, the person in front of you. I know that I have some people that absolutely online is great because we live in a small community, they don't want someone that they're going to run into down the road. They're happy with telehealth. Great. If they're not though and they need that human connection and that face-to-face setting, then our options are more limited. However, when you do get someone moving to the area that happens to be a clinical psychologist or we've got a fantastic art therapist, trauma therapist, she's counsellor by background, I wish we had more mental health nurses, I wish we had more mental health trained social workers, I wish we had social workers to link in with. It's really about knowing what you have available, what the person in front of you would find helpful and useful and what they can afford too.

(00:27:10):

So that is a rate limiting step unfortunately for many people that I work with. And so you've just got to work with what you got

Rebecca Alexander (00:27:20):

And

Dr Corin Miller (00:27:21):

Make it work well.

Rebecca Alexander (00:27:22):

What I tend to see as well, because I am in a rural location is that using some of the peer support networks or the mentoring programmes that some of the other facilities have, it could be a hospital or volunteer service where they have mentors where we don't actually have the access to the professionals in our area, that there's this bigger community workforce that we can tap into as well, which I have found to be beneficial to some of my clients I'm sure you guys have as well.

Dr Corin Miller (00:27:58):

Definitely. Yeah.

Dr Maddi Derrick (00:28:01):

I mean, reading through the lines a litle bit with what you've all said, it sounds like it's less important about what discipline, what draining qualification background someone's coming from to join the care

team and perhaps more, I suppose the rapport. We know that in psychological space that 50% of the progress someone makes can be accounted for just by the rapport they have with the clinician. I didn't

Dr Corin Miller (00:28:30):

Know that, but that makes sense. Yeah. Yeah.

Dr Maddi Derrick (00:28:33):

It's a rule of thumb 50. I'm sure there's more specific statistics somewhere, but I imagine that that's not just in the area of psychology that would apply across the board and the stage of change, where the client's at or the patient's at, what they're ready to look at, whether it's strategies or whether it's processing the little or the micro traumas across the years that will determine things. But I guess what is less important about what discipline, but perhaps important that a professional does have good ADHD knowledge

Dr Corin Miller (00:29:10):

Absolutely. I was going to say earlier, Maddi, some GPs don't want to upskill in ADHD and that's fine because I don't want to upskill in certain things because we have such a broad remit, certain GPs may be that subject matter expert in an area and it's about knowing what's available and

Dr Kyle Hoath (00:29:35):

Who

Dr Corin Miller (00:29:35):

Is that person to refer to. So if you don't have a psychiatrist readily available because we work in the system that we do, who is that local kind of GP or whomever with that knowledge that you can tap into or how can you access that remotely or whatever.

Dr Maddi Derrick (00:29:55):

And that takes us to my next question actually for you, Corin. I'm like,

Dr Corin Miller (00:29:59):

How do

Dr Maddi Derrick (00:29:59):

You How do you find build those referral networks? Have you got any hot tips when

Dr Corin Miller (00:30:06):

Areas

Dr Maddi Derrick (00:30:06):

With

Dr Corin Miller (00:30:06):

Delivered

Dr Maddi Derrick (00:30:07):

Options?

Dr Corin Miller (00:30:08):

I thought about this one. I thought about all of them, don't get me wrong. But in terms of trying to build a good referral network, I wanted to just remind people about health pathways. So it's a clinician focused online platform run by the primary health networks rather, PHNs. And as far as I know, it's Australia wide and then it's localised to each area. And so you can go onto health pathways. You'll need to register, but it's free if you're a clinician. It's not for patients, but that then has referral pages. So you can search by condition and then you can go and you can see what's actually available in your area. The other thing I would suggest is good old fashioned networking. So make sure you go to join your professional organisations such as MHPN and ADPA. If ADHD is what you're interested in, absolutely you should do that.

(00:31:10):

You should go to conferences relating to the topic because you'll meet a whole host of professionals outside your discipline as well as within it. And the other thing would be making sure if there are more local kind of ... We sometimes have training nights over a dinner at a restaurant kind of thing and you'll get to know the people in your area by doing that kind of thing. And I would also say that making sure that if a psychologist is reaching out to you and you're a GP or some other kind of profession, take the call and take it seriously because they are part of your team also. And make sure that you're not that doctor that's like, oh no, I don't talk to those people because that's not in the person's best interest that you're trying to help. So I absolutely respect my colleagues of other disciplines, be whatever it may.

(00:32:12):

And if they're worried about someone, so am I. So yeah, it's a two-way street. And then you develop that trust with the other clinicians as well, which again benefits. Sorry, my computer just did something weird. It again just benefits the person in front of you.

Dr Maddi Derrick (00:32:30):

Yeah. Thanks so much, Corin. I can give a plug to the Australasian ADHD Professional Association conferences too. When I started working in this space myself, it was fairly isolated in my area and I actually started connecting with people through those conferences around the country and then started being able to send our clients to them for various aspects of their care. So it is a good networking event in itself. Great tip on the health pathways. Thanks, Corin. I'm curious, I won't open the can of worms due to time, but I'm curious about how often the MBS case consult items get used because I imagine again, Stitching Time Saves nine, if you can get everyone on a call, it might make the more efficient as well as effective care for people. Just before we move on, we're a little bit ahead in our slides. Just before we

move on to assessment formulation and understanding the full picture, we've been talking about that first contact, seeking help, entering the system, then finding the right supports and building a team.

(00:33:47):

Lots of great discussions so far. And hopefully for our audience, we've had the learning objective of being able to describe how system reform affects shared accountability in collaborative care models for adults with ADHD and the objective of applying practical strategies for building effective professional networks and referral pathways. So I think we've had some good tips there. If people in the audience have any other hot tips to share, please do pop them in the chat. So moving on now to assessment, formulation, understanding that full picture.

(00:34:30):

Oh, I do need ... No, not the next slide because we're there already. We really need that assessment and formulation to lay the groundwork for the actual intervention treatment or support we're providing. And it is a real balancing act with the demand, access issues, trying to make ourselves as accessible as possible, but also sustaining our practise. But we have this need for really holistic information gathering to do that assessment and formulation well. So I want to find out from you, Kyle, about how we get the balance right, but I'll just check in with Bette. Just firstly, as a clinical psychologist, if you had Raj or Tina presenting to you first, they'd self-screened and came to you saying, I think I have ADHD, what would your approach be from the get- go there?

Rebecca Alexander (00:35:29):

Ask them which TikTok person they've been speaking to or following. No. Got to love social media.

Dr Maddi Derrick (00:35:36):

Check the quality.

Rebecca Alexander (00:35:38):

That's it. In all seriousness though, Maddi, they're obviously coming to us for some reason. And just because social media has maybe brought them to our door, fantastic. Let's now go and explore that. Let's work collaboratively about why they believe or feel, not even believe but feel. Why are they feeling as though that ADHD explains them? Tell me, take me on your journey, show me, give me some examples. How does that resonate with you? And look, I'd be doing that very collaboratively, very compassionately. I haven't met this person before and again, touching on what Corin was said earlier around trauma and having that trauma lens as well. Again, I don't know why this person's here. Tina, for example, she's been doing really well and she's at 48 years old and has got some life changes. She may not be coping now that she's coming to see us and thinking that ADHD explains her whole entire life because maybe she's in perimenopause.

(00:36:54):

So I would be exploring that with them, but also getting some really explicit and concrete examples as much as they can. So I know that it's them and not whatever they've found on social media. But then I also want to know what's it stopping you from doing? How's that now impacting on your life? Has it always been like that? Has it been like that for a very long time or has it just been since you've been

doomscrolling? What's this been like for you over your lifetime? And I know that when we're looking at ADHD, we're looking for symptoms being present for a very long time. If we ask the right questions and explore this with them, being curious with this open mind and wondering, you'll actually get, most times, you'll get deeper information about things that they may not have thought about without kind of saying, so okay, you lose focus and I've lost my car keys 16 times on my phone like I did three times before our session today.

(00:38:05):

Did you always lose your phone? Well, no, when I was in grade five, I didn't have a mobile phone, but do you know what I mean? So then if you ask them a little bit more and do a bit more of a deeper dive, I'm sure that you'll find something that they may not have realised because they've put a strategy in place. So I really want to talk to them about why they feel that way. But then secondly, I would also like to further explore their symptoms. And it's not just because they ... Sorry, let me take that back. When we're looking at ADHD, there could be a number of other explanations for ADHD. There are a lot of other comorbid other diagnoses and comorbid diagnoses. There's a lot of symptom overlap to other diagnoses as well. So I would like to explore that with them again compassionately and collaboratively with them and look at alternatives.

(00:39:08):

So I might be exploring, oh, I don't know, autism. I could be explaining anxiety. I could be looking at depression. Is this burnout? What's happening all about this? And I would be just gently seeing if maybe something else fit if it's not just ADHD, because that's what they've seen. And what we know is that there's a lot of information in the public domain around ADHD and it's just exploding and that's great. I'm all for it as long as that you're informed, which is when you have your multidisciplinary team involved to help with that information and that navigation and walking through that journey with you. And so I would also explore some other symptoms with them and what else might explain that, not just ADHD.

Dr Maddi Derrick (00:40:18):

There's a lot of complexity, isn't there? Because when we're working with adults, they've picked up other little co-occurring things or potentially if they do have ADHD, there's secondary impacts, what anxiety and depression that have developed over time because of the difficulty with ADHD. And it's a lot to pull apart, isn't it? And simply asking about diagnostic criteria I find, and I'm gathering you do too, Beck, that it's not enough to just focus on those. You've got to really unpack lots in their life to find all those little interactions and try and make sense of that picture. I'm curious, Kyle, for you, we had that last year. Let me just jump

Dr Corin Miller (00:40:59):

In super quickly because I'm a specialist. But can I also say that we also need to think about what medical conditions might be underlying your presentation, like the perimenopause, or like a thyroid dysfunction, or like there's so many different things. And so I love it when someone's had a thorough psychology assessment, but we also need to make sure that it's not a mimic as well. Over to you,

Dr Maddi Derrick (00:41:24):

Kyle. And it is when someone's come to you with a mental health treatment plan, that's very handy because you know that's done. And often if they haven't and they're coming privately, that is always something we want to suggest going back and having a chat with the GP. Cole, for you, you don't have the luxury of 10, 50 minute sessions like we do. I'm not sure what you do get, but just with the demand alone, I imagine that you've got to really focus on being efficient. So how do you get the balance? How do you get

Dr Kyle Hoath (00:42:03):

A

Dr Maddi Derrick (00:42:04):

Lot thorough information in short time?

Dr Kyle Hoath (00:42:08):

Yeah, look, there is no compromise for good. The assessments have to be good. They have to be thorough. And as Bec and Corona both said, needs to explore not just what else it might be, but what else might be there because it complicates our treatment and really changes how we address things. Things are just labels if we don't understand the person and get a fuller picture. So there is no compromise for that. And if that means it takes more time, particularly when people are learning, it should take more time. It's important and it's important to do right. And it's the thing that helps us reduce stigma. It's a thing that ultimately helps us ensure the right people are getting the right help. Obviously there's a tension there because we want to help more people with a bunch of conditions, not just ADHD, and we already have an access problem.

(00:42:53):

And so we have this other pressure, which is how do we get more people through the system.

(00:43:00):

So again, fast is not the problem. I'm big on things just need to be good, thorough, high standard. So as an example, if you or Rebecca have done a psychological assessment and I know you well and I've read your asessment and it's phenomenal and Corin's done a GP referral and it's made a diagnosis of ADHD or confirmed your diagnosis of ADHD and give me a fantastic medical history and said, "What do you think about our options for starting stimulants?" Then I'm there to give an opinion on starting stimulants. I'm not going to spend an hour confirming a diagnosis of ADHD because that's replicating something that's been done. That's a silly use of anybody's time. And so I think that gets back to that care team and some of that is trust and there are people that I've worked with and sometimes you meet people through the work that they send you and you definitely get a sense for people who are spending the time and putting the effort into what they're sending you.

(00:43:59):

I can remember through COVID getting some what I thought was a good referral only to get another one, sorry, what I thought was just only get another one a week later that was exactly the same just with a different patient name. And then I was like, "Oh, okay, so this is going to have to put effort in here and make sure that I do the work in diagnosing that person." So yeah, look, I've definitely spent a

little bit of time making sure that I'm comfortable with what I've got in front of me, but if somebody's done an assessment, if somebody's made a diagnosis, me as a psychiatrist, I don't go and do that again because it's been done. And I can focus then on that next step in their care journey. And the same I think with our GP specialist colleagues, I think often if I've made the assessment and diagnosis and I've started treatment, I'm quite happy for a GP who is comfortable to take over the next steps.

(00:44:46):

We don't need to replicate each other. And so that thorough isn't good, doesn't have to compromise on FAST. FAST is okay if we're efficient and it's very okay if we're working together as a team.

Dr Maddi Derrick (00:45:02):

Something really

Dr Corin Miller (00:45:03):

Quickly?

Dr Maddi Derrick (00:45:04):

I'll come to you in just one moment. And Beck too, this is everyone's favourite topic, isn't it? I can see everyone's getting excited. It was really great to hear, Kyle, that for those that you do know you have that trust and it can speed up the process. So it can be rapid, but potentially higher quality say than a rapid assessment that has been really based on screening tools, which we all know is hugely insufficient. Yes, Carin, I'll come to you and then up to you, Bec. I

Dr Corin Miller (00:45:40):

Was going to echo some of Kyle's sentiments just really briefly in that when you have those trusting relationships with other members of the care team and they give you something that says, "This is the diagnosis you're like, fantastic." But when you don't know that person, you might need to do a little bit more digging like Kyle said. You did mention something about Kyle, and I know that you would never do this as a psychiatrist ever, but some of those rapid assessment services for ADHD sometimes make the diagnosis and then ask the GP to do everything else, please order your in drug screen, ECG, blah, blah, blah, blah, blah, blah, blah, blah, blah, blah, blah, blah, blah. And I'm like, "You just got thousands of dollars for this assessment. You should do that. " Anyway, I know you would never do that.

Dr Kyle Hoath (00:46:30):

No, Maddi can attest, I do the opposite actually. When I see patients in Hobart, I charge them the smallest gap in the world. And yeah, I do give the GP the things that I would suggest doing, but that's because they're in a different state to me and my stigma manometer doesn't work too good over telehealth. But again, it's the testosterone. Which is

Dr Corin Miller (00:46:47):

Fine, but it's not like a, "Hey, I'm just cherry-picking what I want. " And

Dr Kyle Hoath (00:46:53):

Then you do everything

Dr Corin Miller (00:46:54):

Else. Correct. GP to Chase. No, don't do that.

Dr Kyle Hoath (00:46:58):

It comes back to that good bit, which is there's nothing good about somebody looking at a screening tool saying, "Yes, it's ADHD after five minutes," and then sending all the work to somebody else.That's not good.

Dr Corin Miller (00:47:08):

100%. 100%.

Dr Kyle Hoath (00:47:10):

And so that quality of the assessment is ... And really, I say assessment, but for me it is at every step along the way. And look, but the trust does make that a bit easier. And I think we mentioned here a few times, and I know that the health system's not perfect, but we do build with our networks by getting to know other clinicians, referring to other clinicians. And if we can have some trust in that, we can actually start to see efficiencies that help us help more people, which is ultimately why everybody got into any of these health or health adjacent professions, I assume.

Dr Maddi Derrick (00:47:42):

Super quick question for you, Kyle, then I'll go to Beck who's waiting very patiently. Just in terms of the information that is useful to you, do you find, this is a bit of an area of controversy for me, do you find that the 20-page reports outlining all the history, explaining all the psychometrics to you is good, or do you find some other approach that's shorter, sharper, specific area, more detail around differentials, for example? Can you talk us through what is most useful?

Dr Kyle Hoath (00:48:13):

Yeah, look, I'm going to be cheeky and say it depends because it really does. And sometimes, and I don't know if I would necessarily feel bad about this, but sometimes if I'm starting with less information from a trusted source and we're going down just maybe only two or three pathways, I'll start from a medication point of view, we can start and then we can adjust and learn more and fine tune as we go. So we always have to get it right 100% of the time the first go. And so there is sometimes that little bit of ability to learn with a patient. So doesn't need to be every single piece of information, but again, it depends. I mean, if there are complexities there that are going to change the treatment outcome, or perhaps I have a philosophy around what I think is important to treat first because of experiences I've had or because of other cases I've seen.

(00:49:07):

And again, it won't be the only way people do things. It just might be my way of doing things. So I might need that information. I might prioritise trauma as being something that we really want to address alongside starting treatment for ADHD rather than maybe depression. I like to, let's treat the ADHD first and then see if we need to still treat the depression. And so those approaches might inform, I really need to know if there's a trauma history there because that's really important to me because I want to make sure they're connected with the right people and that I'm providing, trying to always provide trauma and for care, but make sure that I'm also looking at their medication choices through the lens of what other symptoms might I be trying to help with there. So I'm going to go with, it depends, which is a cop out answer.

(00:49:51):

I'm okay with it. Suffice to say I personally very rarely feel like I need a 20-page report. And from somebody, again, who I've worked with, I'm very happy with a one-pager that tells me the diagnosis, because what I'm really interested in is everything else. So it's the diagnosis, they have ADHD. Excellent. This is how it's impacting them. These are the things they've tried. These are other things going on in their lives, these are their medications, this is their medical history. That's the stuff that would really, really matter to me.

(00:50:19):

But yeah, often these reports are focusing on proving somebody has ADHD, which is really important step and this again gets back to good. But once somebody has ADHD, really again, onto the next step.

Dr Maddi Derrick (00:50:34):

Yeah, thank you. I haven't forgotten you, Bec, I'm coming to you and perhaps you could also share with us what information you have learned to be most valuable, say sending that through to a psychiatrist, for example, or a GP.

Rebecca Alexander (00:50:48):

Yeah. And not to do the cough out, but again, it depends because of our professional networks and who we're working with. And I'm a psychologist, I can't prescribe medication. So it's about what my colleagues are looking for. What do my colleagues need to know? So for example, I might pick up there's potentially a mood disorder sitting under here. Yes, they're ADHD, but I'm a little bit concerned there might also be a mood disorder. To me, that's what I would be flagging to my colleagues because they're the ones that's going to give medication. And even though I'm not trained, I'm not allowed to prescribe, et cetera, we do have a level of understanding, or I do as a psychologist, knowing that medication for different presentations are not really good. So we would like our colleagues to know this so they can then do what they need to do from prescription land.

(00:51:51):

Again, Kyle makes a very good point around we have to prove they meet criteria. And this is an unfortunate part of all of this is there are still some practitioners, and I know Corin touched on this slightly previously, but there are some practitioners around that don't have the knowledge or understand that like you and me, Maddi, we can diagnose.

(00:52:24):

We can say you have ADHD or anxiety, depression, bipolar, we can diagnose. I feel that for some of the people that our reports go to, that we do really have to prove that even though it's a good robust assessment. Moving on from that though of where I was going to comment, Maddi, was around-

Dr Maddi Derrick (00:52:54):

Being very patient

Rebecca Alexander (00:52:56):

Was around the assessment process itself and then coming back to this self-screening, these quick assessments we've got lots of years of training in this or all of us here today. We've got lots of training in mental health and assessments and some of us will have more training than others, but we're trained in this. It's like me kind of going, "Oh, I've got a bit of a red rash here. Dr. Google, what do I have? " And then going to the chemist. We are actually-

Dr Corin Miller (00:53:34):

It's a brain tumour.

Rebecca Alexander (00:53:36):

It is.

Dr Maddi Derrick (00:53:38):

Always a brain tumour.

Rebecca Alexander (00:53:42):

Should it really look like that? It's the same for ADHD. Guys, I didn't go to university for six years. Like you, Maddi, I don't have spreadsheets all about specificity of assessment questionnaires, okay? We're trained in this stuff. We know what we're doing and those hard and quick ADHD quizzes that we see online or for even anything, they can actually do more harm than good. And I have seen that with some of the clients that I've seen before where it's like, it's got to be this, it's just got to be this because Google said so. And it's a double-edged sword. Yes, it's great if it brings somebody to us and they get the care and support that they need, but it can also be very detrimental and non-confirming for them as well. It

Dr Maddi Derrick (00:54:50):

Does sound like this is another reason to develop those referral pathways, those networks, those care teams. Each discipline is going to be able to save each person in the care team will save someone else a bit of time if they do things that they do in their area really well and pass that information on. And I'm with you, Bec, the screening tools don't cut it. And it can go both ways and we get a lot of false positives, of course, but we also get false negatives. And for someone like Tina, that the older someone

Dr Corin Miller (00:55:27):

Is- Females, right? Females didn't have 80 back in the day, not.

Dr Maddi Derrick (00:55:31):

Yes. So the complexity at her age with the way that the ADHD symptoms would be presenting as a female, diagnostic criteria based around little boys mostly, then we can often get false negatives, but when we start unpacking what's behind the ratings they gave, why higher, why lower considering those interacting co-occurring conditions, we really need to make sense of it. So I think working with the team as much as you can, and I imagine for a lot of GPs out there who might be feeling a bit uncertain about taking on the roles that their state is allowing, perhaps it is that collaboration that is going to mean we can get these things happening. I'm just conscious of time, so I should probably move on to our next section. We can have a next slide, please. We are looking at now treatment planning, shared care, ongoing support after assessment, and Kyle gave us a great start on this with the support for adults, it's a range of strategies and can involve lots of different professionals.

(00:56:50):

This is a question for you, Corin. How can we be clear within the care team around whose role stops and starts where so that they can work together effectively. We don't have that duplication, confusion for the client, et cetera. Again, any hot tips for us,

Dr Corin Miller (00:57:08):

Corinne? Great question. Great question. As we've already commented, there can be and there should be some crossover between disciplines. And so again, it's about communication. Communication is key, developing that support network and referral pathways. But also I just wanted to point out in the context of policy and the law, this will depend for prescribers, this will depend on where you're located and if you've done the additional training, if that's relevant for you. And so for prescribers out there, just make sure that you've checked your region's rules that might have been changing since you've trained. And the ADPA website actually has a page called ADHD Stealant Prescribing Regulations in Australia and New Zealand, and it goes through place by place. And if you're not sure, make sure you check with your prescribing body in New South Wales, it's the pharmaceutical regulatory unit, but whoever it is in your area.

(00:58:18):

But yeah, in terms of the shared care, collaborative care, it needs to stay focused on the client or patient as well. And so some people are always going to want medication, some people are never going to want medication and there's a bunch of people in the middle and same deal. Some people might want to try naturopathic type remedies or homoeopathic or whatever they choose and we just need to make sure ... So for me as a medical person, I need to make sure there's no red flags, nothing medical that we need to address and then make sure that the person that I'm collaborating with to get what they need can access that, making sure we're not missing anything. So there's a bit of a safety net there too. Yeah.

Dr Maddi Derrick (00:59:10):

Yeah. Kyle and Bec, I'll come to both of you. If you could in one sentence, if possible, describe for us how you explain to patients or clients what medication can help with versus what a non-pharmacological intervention could help with or when it might be needed. It's a challenge

Dr Kyle Hoath (00:59:31):

In

Dr Maddi Derrick (00:59:31):

One sentence, but give it your best shot, Carl.

Dr Kyle Hoath (00:59:34):

Yeah, as if I'll try. It's not going to be one sentence. Look, I'd describe medications and ADHD as being the best treatment for the core symptoms. So these are the symptoms that people are often listing or naming that are causing their impairment or their challenges or their depression or anxiety, everything else. So their mean attention, their impulsivity, their emotional reactivity, sensitive inter restlessness, task initiation, you name it. There's quite a few, but those core symptoms, chances are between one of our three big stimulants, 90% of people will have a response in core symptoms. So that's awesome. And a lot of people, for a lot of people, that's life-changing because that's a huge unlock for their wellbeing. However, it is still just addressing symptoms. So it's not addressing relationships. It's not addressing work. It's not addressing ... I often have people who have a sense of shame or guilt or imposter syndrome even when they're on medication and that's not something in your 30s or 40s that'll just disappear overnight because you've got medication and your impulsivity is better.

(01:00:53):

So whilst it can help with the core symptoms, there is a lot that it doesn't do, which is why good care is more than just medications, but is those non-pharmacological supports as well, which I won't answer in one sentence, Rebecca.

Dr Maddi Derrick (01:01:07):

Lots of punctuation to make that one sentence, Kyle. For Bec, have you got one sentence with perhaps not quite as many commas and semicolons?

Rebecca Alexander (01:01:18):

Let's see. So Kyle, I love how you pointed out how medication can help with symptoms but not everything. I love that. I think that gets a lot lost in translation of medication can fix. So this is where we can use our team around us as our support. So whether that be our work colleagues body doubling to help us get through a really hard project using our occupational therapists who can help us do functional visual charts getting us through our day. Sorry, I'm trying to be quick here, Maddi. So we can rely on these other disciplines. So what can our occupational health therapists set up for us where we are lacking or where we are finding things challenging? What can we use such as alarm clocks, 15 different reminders and alarms? What can we use our social workers for our counsellors? How can we bring all of these people in together for what our client needs?

(01:02:32):

So remember they're driving this, not us.

Dr Maddi Derrick (01:02:36):

Yes. Thanks, Veck. And if I can checkly add a little something just from the lived experience- One sentence

(01:02:43):

Though. One sentence. Put a comma in. I think as well, whilst we might have all these different disciplines with different things to offer, our client or patient can only often do one thing at a time, approach one thing at a time. So I need to just get medication sorted and let that sit before I've got the mental space to actually make another appointment with someone else to start the next load of work. So I think that looking at this as over a time, there's shared care over time through the different stages is helpful, but that doesn't stop the communication being just as useful. Thanks so much, everyone. We have been talking about that treatment planning side of things and then we have the learning objective to identify how shared, caring, clear role boundaries and they will best practise. I suppose maybe the answer is that the boundaries aren't clear in ... We can't give an answer to say what clear boundaries are now, but they will happen in the context of each patient or client with that communication along the way.

(01:03:54):

Hopefully I've synthesised that for everyone in a fair way there. Now we do just the last little section here for our Q&A. We've received lots of live questions and we have a team in the background reviewing those that have told us that we've covered a lot of what is there. So I hope that is to your satisfaction. We do have a few questions we'll have time to address very quickly, perhaps zero commas for these ones, but we have a question submitted earlier from Susan about how to address stigma around ADHD labels or medication in adulthood. Kyle, a phrase phrase.

Dr Kyle Hoath (01:04:42):

Yeah, I like examples and I like reassurance, I guess. And I don't pretend like just because I say something, people will internalise it and believe it, but sometimes people do need to hear that, no, you do have ADHD and that's okay. And I need glasses and you might need similar medication. It's all okay. This is about getting the most out of your life. This is about what was the problem you came here for and trying to take away that sense of there's something wrong that needs to be fixed and more about their wellbeing, more about what their next chapter looks like in life. And I guess normalising particularly medication for people who maybe have never had any medication in their life and why it might be at least worth a go. And for that one, comma, I will throw in as facts. I like to be very doctory and evidencey and talk around what can go wrong with medication, how often medication can go right and why you might want to try it.

(01:05:42):

And often that's just to give people an informed decision, a platform to make an informed decision.

Dr Corin Miller (01:05:52):

I love using a neuropositive lens and I love telling people that I have lived experience, my family's all Neurospicy or Neurosparkly, whatever you choose. Really turning it into a, it's not a bad thing, it's a different thing. It's

Dr Kyle Hoath (01:06:08):

Just a

Dr Corin Miller (01:06:09):

Different thing, exactly.

(01:06:10):

It's a different operating system. And I often use the phone analogy like an Android and an iPhone, they're both great at what they do, but you can't assume that the App Store for one's going to work the same on the other. It's just a different operating system. I also let them know that so many doctors and CEOs and lawyers have ADHD because it can be a superpower. It's just tricky to learn how to control and sometimes ... So in kids, I think Maddi, you're on the webinar where I said this previously, but you've got a racing car brain but bicycle breaks. And so we just need to strengthen up the brakes. And medication is one of the ways that we can help you to do that. I think reducing stigma is all of our responsibility because it wasn't that long ago that mental health in itself was so stigmatised that people weren't seeking care.

(01:07:02):

Depression.

Dr Maddi Derrick (01:07:03):

Yes.

Dr Corin Miller (01:07:03):

Exactly. So it's just a matter of I normalise it. I'm like, oh yeah, heaps of people have it. It's

Dr Maddi Derrick (01:07:09):

Awesome. There's a question here from Ben, which is how do you combine client-led or neuro-affirming approaches with evidence-based clinical care? Because we know the evidence, it's very much a medical model in a lot of the research where it is really focused on deficits. We've only in the last few years

Dr Kyle Hoath (01:07:30):

Started

Dr Maddi Derrick (01:07:30):

Looking at strengths. How do you incorporate those ideas of being neuro-affirming, but treatment, evidence-based

Dr Corin Miller (01:07:41):

Treatment?

(01:07:41):

To your comment previously about rapport, the power of rapport. And so if you are coming at someone with a deficit model, this is wrong with you and blah, blah, blah. I don't want to be told that. I want to be told this is why you might find this challenging and this is what we can do to help strengthen that bit, but you're also probably really creative and blah, blah, blah, blah, blah. The world's doomy and gloomy enough without us taking a deficit approach to everything, right? So I mean, you will have some struggles potentially if you are neurodivergent, that's true, but also your brain is probably going to be one of those brains that can think about things differently and notice things that other people don't. And also following the ad per clinical guideline for ADHD, obviously we need to make sure that it's evidence-based, but I think bringing the humanness into the consult, because these are people, they're not ... Yeah.

(01:08:50):

They're members of my community that come to see me and we just chat.

Dr Kyle Hoath (01:08:54):

Sometimes the numbers actually help though in a way, Maddi, often when people say to me, "But doesn't everybody have ADHD?" And I was like, "Well, no, not everybody, but maybe as many as 6% of adults do. " And that's a lot of people. And I don't think people, even if it is two or 4%, there's still a lot of people. I think that's lost on us sometimes when the algorithms knows very well and there is lots of evidence around neurospicy, clustering with neurospicy. And so yeah, maybe there are a lot of people in your world and in your gene pool and in your lastly curated TikTok feed. We're way more fun,

Dr Corin Miller (01:09:36):

Way more fun, way more entertaining.

Dr Kyle Hoath (01:09:39):

So again, it's kind of like, well, actually, no, that sounds perfectly normal and reasonable to me. It's trying to counter that negativity that can add layers of shame and can add new trauma to individuals that is not helping them, and that is not what we're there for.

Dr Corin Miller (01:09:56):

I think just really quickly, I know, one sentence maybe, often it's about unpacking the missed or misdiagnoses that people have had over time, particularly women. So I've had a bunch of women that have been diagnosed depression, anxiety, borderline, type two bipolar so many things and actually if you drill down to it to their childhood, you go, "Ah, you know what? You're neurodivergent and you've had ADHD this whole time and sure you've been depressed and anxious and maybe you've also got bipolar type two." But yeah, it can be really validating for some people to go, "That's why I'm different."

Dr Maddi Derrick (01:10:50):

And I think just hearing you talk about the iPhone versus the Android, these similar one, PCs and MAX, that even just thinking square pegs, round holes, we've got 6% square pegs, but 94% of round pegs, then society's going to be made up of those round holes. And we can talk about the challenges or the deficits as such, can't we? If we're using that social model of disability and recognising that interaction between being a square peg, trying to go through round holes, that for me is my way in. And I know for yourselves and for a lot of other clinicians, everyone's got their little go- to analogies to help with that. I imagine that Beck does as well, but Bec, I do want to ask you a different question if that's okay. This is a question from Monique about how can treatment sessions be structured? So adults with ADHD get the most from their care.

(01:11:54):

Hot tips, what have you got?

Rebecca Alexander (01:11:56):

Tips, two minute info dumps. Start off the session with, tell me everything on your mind, get it all out, let me hear it because they've got a burning desire, not everybody, but some people have a burning desire just to sit there and talk. So hit me, two minute info dump, let me hear it.

Dr Maddi Derrick (01:12:17):

Yep. A hyperfocus. Hyperfocus topic they're coming with. Yes.

Rebecca Alexander (01:12:22):

And they get it all out because they're not going to forget. But I try and set goals with them. What are you looking for? What are you hoping for? And then from there, I ascertain where the sessions are going to go with them, of course. So structuring the sessions, having an agenda, bringing them all the way back to where we started sessions on ADHD, whether you be inattentive, hyperactive, combined and don't forget everything else, comorbid that might be going on for that person. I find a lot with my clients, we start here, we go across seven different countries, continents and seas, and then I bring them back to where we started. So for me, I always have it in my mind. I have something visual up there for what they wanted to talk about, what they wanted to get out of the session and then I'm always bringing them back.

(01:13:26):

But I'm also checking in with them and I'm getting an understanding of what they're looking for. Do they understand what we've just discussed? Do I need to explain anything differently? The other thing is when I have an ADHD person in front of me, my room is full of things, full of distraction, fidgets, sensory, you name it, I more than likely have it, but they can actually pay attention.

(01:14:01):

Craft. Craft seems to be the latest one going. Origami, I'm very bad at it. Some of my clients are really good at it. Drawing. So the little mandelas, like lots of drawing, lots of fidgeting. There's lots and lots and lots of craft activities, painting, anything that keeps them busy because there is nothing more boring

than sitting in a therapy room and going, "And how do you feel today, Maddi? And tell me about those keys that you lost and how many alarms you were sent today." No, my clients want to be heard, but they also want to be doing something. And I find that that's not just an ADHD person that will work with a lot of different presentations of doing something and taking the focus directly off them.

Dr Maddi Derrick (01:15:03):

Sounds like a lot of flexibility around how things are approached. We want to be client centred, but then I'm always struck with the, if we're too client centred in the session and don't have structure, then we might be, I suppose, colluding with the tangents that our client or patient might be really frustrated by and they want us to help bring it back as you were saying just as an ADHD, a practitioner where we've got the blind leading the blind sometimes in our session. So we're very reliant on a whiteboard to actually map that out, externalise that for us as we go.

Dr Corin Miller (01:15:45):

Maybe just really quickly, I was

Dr Maddi Derrick (01:15:47):

Afraid that

Dr Corin Miller (01:15:49):

Different disciplines obviously have differing amounts of time and different focus. I encourage my patients to write a shopping list of all of the things that they wanted to talk to me about because I go off on the tangent with them. I'm probably on a tangent already when they come in. That's why we're never boring. But if they come in with something written down, then we know that I can look at the list in my limited amount of time and we can prioritise. We'll be like, "Okay, well, we're going to deal with the crushing central chest pain today, but I can see that you really want to talk about this. I'm going to write it in my notes and neither of us forget. And next session, let's try and make sure that we deal with that. " So different style of consulting completely. Yeah,

Rebecca Alexander (01:16:33):

No, that's definitely one that I get them to do definitely in between session, use notes on your phone, no point using paper, or I'll give them a book, however, that tends to go missing. And when they are actually doing things, take a photo of the whiteboard so it's in your phone, put notes in your phone, set alarm. So I do a lot of things with them whilst they're in session as well, not the, "Oh yeah, when you get home, go and do that. " It's, "No, let's do that now. Let's put that in your calendar now. Let's set that up reminder now." And doing the here and the now also helps and supports them.

Dr Maddi Derrick (01:17:13):

And making sure- Anything left for later is

Dr Corin Miller (01:17:16):

Gone, isn't it? I like to tell people that most pharmacies have an app now and that is a game changer because it'll send you reminders, you can keep track of where you're up to with your scripts, you can see. Yeah. So little tips that can make life easier.

Dr Maddi Derrick (01:17:35):

Yes. Thank you so much, everyone. I'm sure we could fill a whole webinar with just answering Monique's question there about how we structure sessions to get the most out of them. Perhaps that can be for another time. We do need to finish up so that people can get on with winding down in their evening. If we go to next slide, please, for our key takeaways, have covered a lot of ground tonight. We've seen that we've got this evolving landscape and with policy and regulation changes state by state and the need for that clear communication and coordination between the roles is so important to give to the good quality care. Having that good, thorough history, context, functional impacts is really important for assessment. We definitely don't want to be relying on quick questionnaires at all and to help us get that extent of thorough information we need.

(01:18:42):

Again, those trusted relationships, those networks are really key. We have talked about the differing roles of pharmacological, non-pharmacological intervention and that there's certainly a syntax there. Someone we all know says pills don't teach skills, but sometimes you need the pills to learn the skills or to apply the skills. And then that is very true people from the prescribing and non-prescribing disciplines that really feel the synergy there. And with our disciplines, it's probably not so important about who is in that care team, but that the rapport is there and they have good knowledge of ADHD and we've got that communication. So from any discipline, we can have someone making a really great contribution to the care team. So these takeaways, these themes here, they align with our objectives. We've come at those objectives at lots of different angles, hoping for the audience that that's given some starting points or some confidence to keep going in the direction you have strategies for engagement, continuity, to reduce barriers to accessing services, to apply practical strategies to help with that.

(01:20:07):

These are all someone with lived experience, these would help so much if we're not having to navigate and try and do all of that for ourselves when we really struggle with that side of things. If you've enjoyed tonight, the Australasian ADHD Professionals Association has their conference coming up. It will take place in Melbourne 25th to 26th of July. I know that there is on the 24th as well, there's a day of workshops, really good entry level workshops of people new to the space as well as some covering more complex workshop for people that are covering more complex issues. And the conference title is Embracing Change for Every Mind. More information can be found in the chat or you could Google the Australasian ADHD Professional Association Also invite you to join Mental Health Professionals Network next Monday, 18th of May at 7:15. That's Australian Eastern Daily Time, Standard Time for the next webinar where you'll hear how to support new parents and infants in the neonatal intensive care unit and into community through a unique offering of lived experience expertise as well.

(01:21:22):

I'll leave you just with a little reflection question here from everything you've heard tonight, what's one small change that you could start doing tomorrow to enable better clarity and collaboration when

supporting adults with ADHD. Got more than one small change. Excellent. Thinking on that as you're heading off into your evening, relax, let that digest overnight and hopefully that that's going to get things rolling in the direction you like. Thank you so much to our panel, to Bec, to Corin and Kyle. It's been really, really interesting. I'm sure we'll keep talking about this at the conference. I hope to see others from the audience there. Thank you very much everyone and enjoy your evening.