4 October 2023

Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600

Community.Affairs.Sen@aph.gov.au

Dear Committee Members,

**Re: Inquiry into the assessment and support services for people with ADHD | Written Question on Notice**

Thank you for your invitation of 12th September 2023 to respond to the above-mentioned Question on Notice. Further to email correspondence with of 21st September, we were kindly provided with an extension from 28th September to the 6th of October to respond. This response is further to our original submission to the Inquiry of 8th June 2023.

The Question on Notice to the Institute for Urban Indigenous Health (IUIH) sought our organisation's expert advice on:

1. What IUIH considers to be the best practice approach for all stages of the ADHD assessment and treatment process—from initial assessment and diagnosis, through to medication (as required) and other treatment, as well as ongoing support and treatment plans.

   Mindful that -

2. Any proposed pathways should take a person-centred approach, with IUIH's response to indicate our views on which body or organisation should be responsible for providing the service or support, and where government support should be provided (e.g., Medicare, PBS).

IUIH and its five Member Services are guided by two IUIH Protocols that underpin and guides our best practice ADHD assessment and treatment approach to and for Aboriginal and Torres Strait Islander peoples living in the South East Queensland (SEQ) region:

- IUIH Protocol | ADHD in Children and Adolescents (May 2021)
- IUIH Protocol | ADHD in Adults v2 (August 2022)

We have attached and commend these 'living' Protocol documents to the Committee in terms of best practice ADHD assessment and treatment approaches for Aboriginal and Torres Strait Islander children and adolescents and Aboriginal and Torres Strait Islander adults living in an urban Queensland environment.

Additionally, we have reviewed the content of our original submission to the Committee of 8th June and reworked our responses; presenting them in a table, below, under the four care pathway stages

set out in Coghill and Seth's ADHD Best Practice Approach Flow Diagram.[1] This is per the Committee's suggestion in your Question on Notice invitation email of 12th September. We note that the following table must be read in conjunction with the *Human Rights Act 2019* (Qld), specifically that everyone has the right to access health services without discrimination (section 37) and the importance of upholding the interconnected and specific cultural rights of Aboriginal peoples and Torres Strait Islander peoples (section 28).

**Best practice approach for all stages of the ADHD assessment and treatment process for Aboriginal and Torres Strait Islander peoples**

| | Children & Adolescents | Adults |
|---|---|---|
| **STAGE 1: Referral & Pre-Assessment Screening** | - GPs in the IUIH Network's 19 primary healthcare clinics make referral to an IUIH paediatrician or externally to Queensland Health (QH) paediatricians.<br>- GPs are to be mindful that girls are less likely to be referred for diagnosis & treatment & should avoid stereotyping ADHD behaviours based on a child's gender.<br>- If child or adolescent is being excluded from educational opportunities or experience interrelated stigma & marginalisation, ADHD assessment prioritisation should be activity sought by the GP or referring person/agency. | - IUIH GPs in IUIH Network's 19 primary healthcare clinics make referral to IUIH psychiatrist or to private psychiatrist. |
| | *Shorter waiting times for ADHD Assessment & Diagnosis*<br>- IUIH recommends that with suitable training, there is an increase in health professionals who can assess, diagnose & provide long-term ADHD treatment i.e., GPs, psychologists, specialist trained nurses. | *Shorter waiting times for ADHD Assessment & Diagnosis*<br>- IUIH recommends that with suitable training, there is an increase in health professionals who can assess, diagnose & provide long-term ADHD treatment i.e., GPs, psychologists, specialist trained nurses. |
| | *Culturally safe ADHD clinicians* | *Culturally safe ADHD clinicians* |

[1] D Coghill & S Seth (2015) Effective management of attention deficit/hyperactivity disorder (ADHD) through structured re-assessment: the Dundee ADHD Clinical Care Pathway. *Child & Adolescent Psychiatry & Mental Health* 9:52.

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| **STAGE 2: Assessment, Diagnosis & Treatment Planning** | - Strengths-based culturally appropriate & competent assessment & treatment planning is critical. | - Strengths-based cultural appropriate & competent assessment & treatment planning is critical. |
| **2a. Information Gathering** | - Treating clinician understands ADHD difficult to assess given ADHD may be confounded with poor mental health, trauma & other co-morbidities in First Nations children & adolescents.<br>- Treating clinician to factor in holistic considerations i.e., environment, place, impact of trauma, intersectionality (i.e., gender, disability), First Nations culture, kin & country connections, and cultural groups.[2]<br>- Treating clinician mindful of power differentials in relationship between the child & adolescent patient, the parents/carer/kin, & themselves as practitioners when information gathering. | - Treating clinician understands ADHD can be difficult to assess given ADHD may be confounded with poor mental health, trauma & other co-morbidities in First Nations adults.<br>- Treating clinician to factor in holistic considerations i.e., environment, impact of trauma, intersectionality (i.e., gender, disability), First Nations culture, kin & country connections & cultural groups.[3]<br>- Treating clinician mindful of power differentials in relationship between the adult & themselves as practitioners when information gathering. |
| **2b. Diagnosis & treatment planning** | - Recommended culturally & psychometrically validated symptom questionnaire is developed for ADHD presenting First Nations children & adolescents.<br>- Criteria in ADHD diagnosis tools should provide guidance on variation in common symptoms based on sex.<br>- An ADHD diagnosis is a significant event in the life of every First Nations child &their parent/carer. Because of the well-documented vulnerability & structural power differentials & discrimination experienced by First Nations peoples,[4] the treating clinician must take due care & consideration of how the diagnosis might impact on the child/adolescent's life journey moving forward, and on their or their parent/carer's ability &/or willingness to access ADHD supports. Treating practitioners need to be aware of, & sensitive to, the multidimensional cultural complexities that may impact on effective treatments & other social | - Recommended culturally & psychometrically validated symptom questionnaire is developed for ADHD presenting First Nations adults.<br>- Criteria in ADHD diagnosis tools should provide guidance on variation in common symptoms based on sex.<br>- An ADHD diagnosis is a significant event in the life of every First Nations adult. Because of the well-documented vulnerability & structural power differentials & discrimination experienced by First Nations peoples,[6] the treating clinician must take due care & consideration of how the diagnosis might impact on the adult's life journey moving forward, and on their ability &/or willingness to access ADHD supports. Treating practitioners need to be aware of, & sensitive to, the multidimensional cultural complexities that may impact on effective treatments & other social |

[2] We refer to other cultural health and wellbeing priorities and considerations regarding ADHD assessment and diagnosis for Aboriginal and Torres Strait Islander peoples raised by the Australian ADHD Professionals Association. See: Australian ADHD Professionals Association. Australian Evidence-Based Clinical Practice Guidelines for ADHD Factsheet: ADHD and Aboriginal and Torres Strait Islander Peoples. Available: https://adhdguideline.aadpa.com.au/adhd-and-aboriginal-torres-strait-islanders/.

[3] As Above.

[4] See the *National Agreement on Closing the Gap, July 2020*.

[6] As Above.

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| | interventions for First Nations children & adolescents with ADHD.<br>- A careful physical health assessment is also required, including a hearing check as hearing problems may present similarly to ADHD inattentive symptoms.[5] | interventions for First Nations adults with ADHD.<br>- A careful physical health assessment is also required, including a hearing check as hearing problems may present similarly to ADHD inattentive symptoms.[7] |
| **STAGE 3: Initiating Treatment** | - Integrated treatment services & supports for FASD & ADHD to improve provision of effective, targeted therapy & management strategies for First Nations children.<br>- First Nations children & adolescents in out-of-home care in Queensland must not experience delays in accessing off-label ADHD medications and related treatments.[8] 'Blanket approval' for specified off-label medications for ADHD should be included in State Government Child Safety protocols, to ensure timely provision of treatment for First Nations children with ADHD in out-of-home care.<br>- First Nations children & adolescents who are in detention &/or interface with the youth justice system should access timely, appropriate & affordable ADHD medications and treatments in a safe & controlled environment. | - Integrated treatment services & supports for alcohol and drug services and ADHD services.<br>- First Nations adults who are incarcerated should access timely, appropriate & affordable ADHD medications and treatments in a safe & controlled environment. |
| **STAGE 4: Continuing care/Monitoring Treatment** | - GPs and suitable clinicians (i.e., psychologists, specialist trained nurses) in community-controlled health sector can play a significant part in maintaining *timely & accessible* continuity of ADHD care for First Nations children & adolescents.<br>- In the IUIH Network context, the IUIH System of Care (ISoC),[9] grounded in Aboriginal Terms of Reference, promotes & embeds a multidisciplinary approach to ongoing care & treatment for First Nations children & adolescents with ADHD.<br>- The Aboriginal and Torres Strait Islander community-controlled health sector | - GPs and suitable clinicians (i.e., psychologists, specialist trained nurses) in community-controlled health sector can play a significant part in maintaining *timely and accessible* continuity of ADHD care for First Nations adults.<br>- In the IUIH Network context, the IUIH System of Care (ISoC), grounded in Aboriginal Terms of Reference, promotes & embeds a multidisciplinary approach to ongoing care & treatment for First Nations adults with ADHD. |

[5] Australian ADHD Professionals Association. Australian Evidence-Based Clinical Practice Guidelines for ADHD Factsheet: ADHD and Aboriginal and Torres Strait Islander Peoples. Available: https://adhdguideline.aadpa.com.au/adhd-and-aboriginal-torres-strait-islanders/.

[7] As Above.

[8] Some medications can be prescribed to First Nations children & adolescents with ADHD under an off-label recommended use. However, this means that First Nations children with ADHD who are in out-of-home care in Queensland require additional approval from the Department of Child Safety for the use of the off-label ADHD medication, with delays in Child Safety approvals resulting in treatment delays & other flow on effects.

[9] For more information on IUIH's ISoC, see: https://www.iuih.org.au/our-services/iuih-system-of-care/

| | | |
|---|---|---|
| | should be appropriately funded to provide the necessary significant wrap-around, care-coordination supports to guide parents/carers/kin to access Medicare & NDIS entitlements, as well as other important services & supports that relate to the social determinants of health, on behalf of affected children & adolescents with ADHD, and their families.[10] The provision of such supports is vital to support successful ADHD treatments and interventions in the short & longer term.<br>- First Nations children with an ADHD diagnosis < 6 years of age should be able to access an early intervention support package through the NDIS scheme. Young First Nations children with an ADHD diagnosis should not also have to present with co-morbidities to successfully access these support packages.<br>- Dedicated funds, services &/or appropriate transition supports should be provided for First Nations adolescents with an ADHD diagnosis transitioning to an adult ADHD service for re-diagnosis or ongoing care (i.e., adolescents 15-17 years of age, & for younger children depending on the service).<br>- should ensure culturally safe mental health services are available for First Nations children & adolescents with ADHD.[11] | - The Aboriginal and Torres Strait Islander community-controlled health sector should be appropriately funded to provide the necessary significant wrap-around, care-coordination supports to support First Nations adults with ADHD.[12] The provision of such supports is vital to support successful ADHD treatments and interventions in the short & longer term.<br>- Given First Nations peoples often experience a disproportionate number of co-morbidities that impact on their collective & individual needs, access to the NDIS scheme should be available to First Nations people with ADHD across the life course.[13]<br>- Culturally safe mental health services should be available for First Nations adults with ADHD.<br>- Non-stimulant medications for ADHD treatment should be considered for the PBS, to reduce costs for people with ADHD who require non-stimulant medications due to concerns about substance misuse, or who prefer non-stimulant medications. |

[10] E.g., a First Nations child with an ADHD diagnosis will likely require additional person-centered educational and wellbeing supports from their primary school or from Child Safety if the child is in out-of-home care; or mothers of children with ADHD may more likely be out of the workforce compared with mothers whose child is without an ADHD diagnosis. When overlaid with the multidimensional challenges First Nations women and girls already often face, including access to education and employment, the potential impact of ADHD on the social determinants of health and household wellbeing becomes more amplified.

[11] A Queensland study examining child (1-14 years) and adolescent (15-17 years) deaths by suicide between 2004 and 2012 found that conditions such as ADHD were significantly more common among children compared with adolescents who died by suicide: R Soole, K Kolves, D De Leo (2014) Factors related to childhood suicides: Analysis of the Queensland child death register. *Crisis* 35(5):292-300.

[12] E.g., a First Nations adult in the workplace may require additional workplace supports.

[13] Making additional supportive therapies more financially and logistically accessible and cultural safe for all First Nations peoples with ADHD is beneficial, whether by or through the NDIS platform or other program mechanism, i.e., MBS or increased funding to the community-controlled health sector to deliver holistic and multidisciplinary primary care.

We thank the Committee for their attention to our response to the Written Questions on Notice.

We continue to welcome the opportunity to work with Government on constructive responses to the barriers and opportunities to access assessment and support services for Aboriginal and Torres Strait Islander people with ADHD.

If you require any further information, please contact policy@iuih.org.au.

Yours

Dr Carmel Nelson

Clinical Director, IUIH


# IUIH Protocol |

## Attention Deficit Hyperactivity Disorder (ADHD) in Children and Adolescents

May 2021

ADHD, characterised by core symptoms of persistent inattention and/or hyperactivity/impulsivity, is the most common neurodevelopmental disorder diagnosed by paediatricians. It affects 5-7% of school-age children and is caused by an interplay of genetic, environmental and social factors. Unmanaged ADHD can lead to poor educational, social and employment outcomes.

Diagnosis occurs through observation and symptom analysis in multiple environmental settings. Collateral history should be sought from family, school and health professionals. The diagnostic requirements are listed in the DSM-V and ICD-10. Generally, the DSM-V criteria is more widely used in Australia.

Management of ADHD may involve:

- Building capacity for self-management, via psychology and/or occupational therapy
- Environmental adjustment at school
- Medication: Although counterintuitive, stimulants have good evidence for improving symptoms of ADHD. Initial prescription must be by a paediatrician or psychiatrist, and ongoing management can be via a GP and specialist partnership. Medication must be considered as part of an overall management plan which includes non-medication strategies.

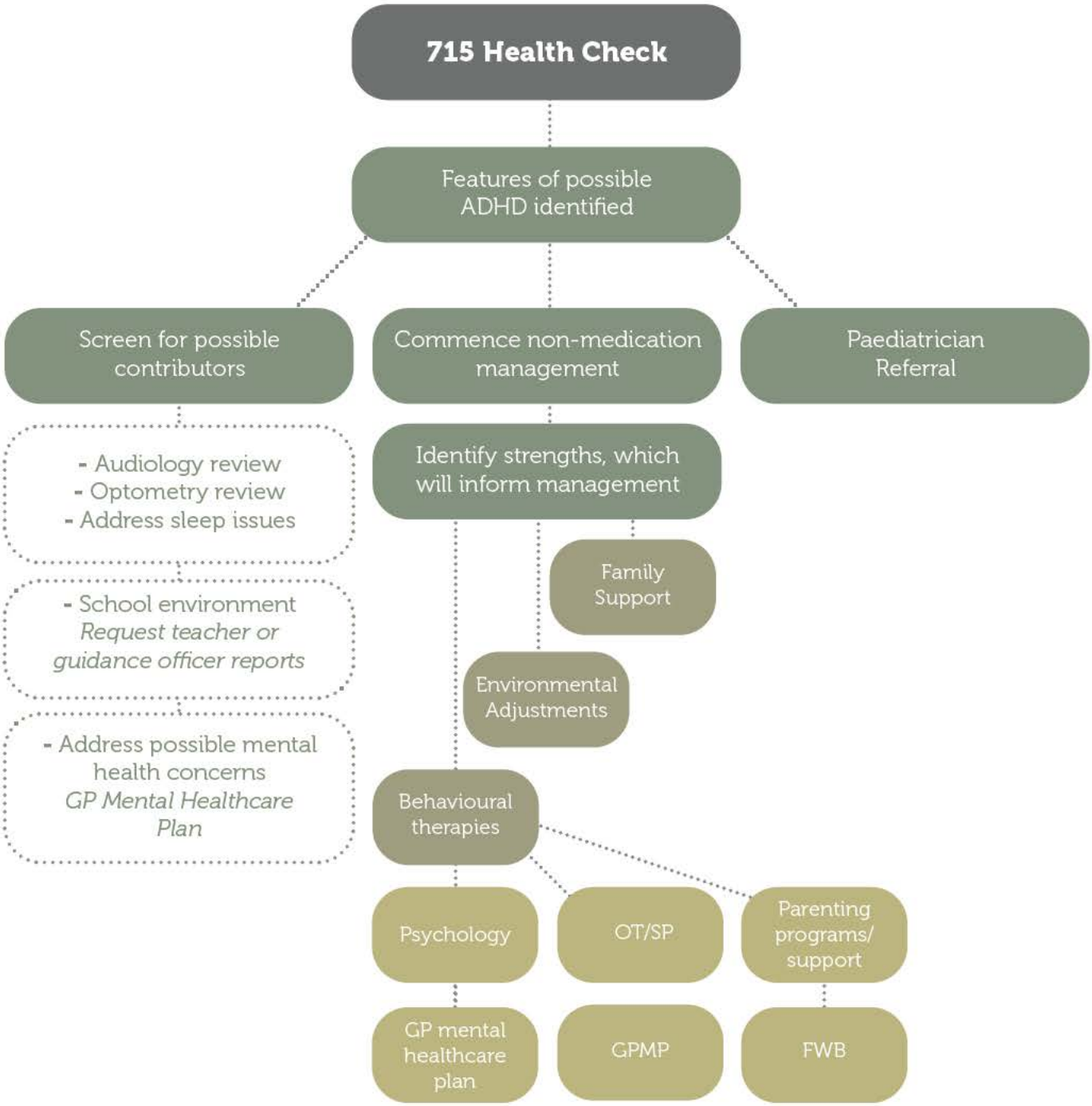
Abbreviated DSM V criteria for ADHD

- Persistent inattention and/or hyperactivity/impulsivity, for at least 6 months
- Symptoms present before 12 years old
- Symptoms occur in at least two environmental settings
- Clear evidence of symptoms impacting social, academic or occupational functioning
- Symptoms are not better explained by another mental health disorder

Common Comorbidities

- Oppositional defiant disorder
- Learning disabilities
- Conduct disorder
- Anxiety
- Depression
- Speech problems
- Autism spectrum disorder
- Sleep disorders

Interventions aim to reduce the core symptoms of ADHD which cause functional impairment. The effectiveness of interventions should be reassessed at least yearly, as the core symptoms can change with normal maturation




**Considerations prior to paediatrician referral:**

- Recent vision and hearing assessment
- Specific learning difficulties
- Strengths due to possible ADHD symptoms
- Screening for co-morbid or underlying mental health disorders
- Family history of ADHD diagnosis or symptoms
- Address sleep hygiene or potential underlying sleep disturbance
- Collateral history from school teacher, guidance officer and allied health

**Non-medication management options**

- Behavioural therapies: psychology, occupational therapy, parenting programs
- Environmental adjustment: consider home, school and recreation
- Family support: family well-being service

**Reasons to consider paediatrician referral:**

- Symptoms of Inattention
    - Overlooks or misses details
    - Frequent careless mistakes, inattentiveness during tasks or play
    - Difficulty hearing or following through on instructions
    - Disorganisation and forgetfulness
    - Easily distracted
    - Frequently loses possessions
- Symptoms of Hyperactivity
    - Constant fidgeting
    - Inability to stay seated
    - Inappropriate running or climbing
    - Excessive talking and interrupts others
- Functional impairment
    - Symptoms impacting family, academic and social functioning

| **Ongoing management following paediatrician diagnosis:** | | | |
|---|---|---|---|
| GP review within **4 weeks***. Consider use of CLO and AHW to maintain connection with family | GP and/or paediatric nurse review at **2 months*** | Paediatrician review at **2-3 months**. Consider dual consultation with GP, as per Dual Model of Care guideline [link to guideline]. | GP review every **3-6 months** and Paediatrician review at least yearly |

***Items to monitor at each consult if prescribed ADHD medication:**

- Benefits and adverse effects of medication
- Duration of medication effect
- Growth parameters
- Blood pressure (use appropriate reference range https://www.nhlbi.nih.gov/files/docs/guidelines/child_tbl.pdf)
- Heart rate and rhythm
- Appetite
- Sleep
- Change in mood (NB rare suicide risk with atomoxetine)
- Medication adherence

*Additional resources:*

*NHMRC ADHD guideline: https://www.nhmrc.gov.au/about-us/publications/clinical-practice-points-adhd-*children-and-adolescents

## Medications:

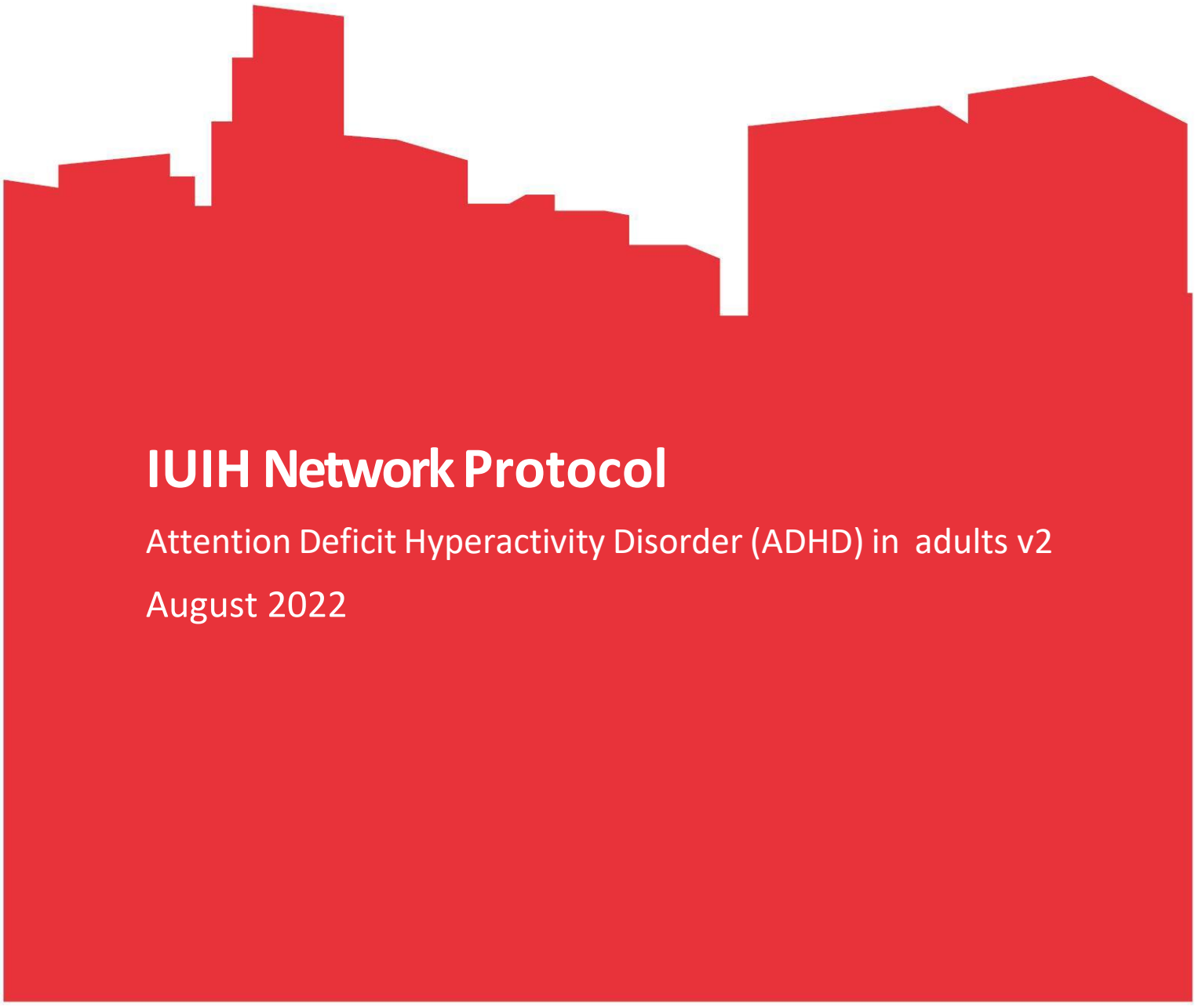
The medication advice provided as part of this protocol is for guidance purposes only and prescribers should refer to appropriate online databases for the most current medication information.

| | Stimulant Medication Used for Treating ADHD in Children Aged 6 to 16 | | | | |
|---|---|---|---|---|---|
| | **Methylphenidate** | | | | |
| | Methylphenidate 10 (Immediate release) | Methylphenidate long acting (50% Immediate release and 50% Delayed release) | Methylphenidate long acting (22% Immediate release and 78% Delayed release) | Lisdexamfetamine (Extended release prodrug of dexamfetamine) | Dexamfetamine (Immediate release or short acting) |
| Australian Formulations | Ritalin 10 | Ritalin LA | Concerta | Vyvanse | Dexamfetamine (Aspen) |
| Strengths (mg) | 10 | 10, 20, 30, 40 | 18, 27, 36, 54 | 20, 30, 40, 50, 60, 70 | 5 |
| Starting Dose | 5-10 mg daily in single or divided doses, with 3-4 between doses | Must have demonstrated safety with Immediate Release, use this to guide initial dose | Must have demonstrated safety with Immediate Release, use this to guide initial dose | 6 years and over - 30 mg/day, in the morning | 4 to 6 years - 2.5 mg/day<br>Over 6 years - 5 mg/day in 2 doses with second dose given 4 to 6 hours from first dose |
| Dosage Adjustments | Wait at least one week between dose adjustments | | | | |
| Onset of Action | ½ - 1 hour | | | | |
| Duration of Action | 2 - 4 hours | 3 - 8 hours | 10 - 14 hours | 10 - 14 hours | 4 - 5 hours |
| Common Side Effects<br>(Refer to PI for other side effects) | Insomnia, reduced appetite, abdominal discomfort, tachycardia, palpitations, increased BP, reduced weight gain, anxiety, irritability, headache, dry mouth, nausea, exacerbation of tic disorders (conflicting evidence) | | | | |
| Contra-Indications | If history or examination is suggestive of structural heart disease (including RHD) or arrhythmia, investigate further and consider cardiology referral prior to commencing medication.<br>Contraindicated if Monoamine Oxidase Inhibitor (eg phenelzine, tranylcypromine) has been taken in the preceding 2 weeks. Can precipitate hypertensive crisis.<br>Uncontrolled hyperthyroidism<br>Contraindicated in severe depression, anorexia, psychosis, agitation, suicidal tendencies and substance misuse.<br>Consider non-stimulant medication in co-morbid tic disorder (eg atomoxetine, clonidine)<br>Patients with glaucoma should only be prescribed stimulants with ophthalmology specialist involvement. | | | | |
| Interactions | Certain antiepileptics: can decrease seizure threshold<br>Ethanol: increases CNS effects of ethanol | | | Opioids: increases risk of serotonin syndrome<br>Tricyclic antidepressants: increases risk of serotonin syndrome | |
| Pregnancy | No clear evidence of congenital malformation (limited evidence)<br>Drug misuse may result in prematurity, IUGR or neonatal withdrawal.<br>Assess need for contraception and manage as indicated | | | | |
| Breastfeeding | No adverse effects reported for babies of mothers taking methylphenidate (limited evidence) | | | | |
| Additional | Contains lactose<br>Contains gluten | Lactose free<br>Gluten free | Contains lactose<br>Gluten free | Lactose free<br>Gluten free | Contains lactose<br>Contains gluten |

| | Non-stimulant Medication Used for treating ADHD in Children aged 6 to 16 | |
|---|---|---|
| | **Atomoxetine** | **Guanfacine** |
| Australian Formulations | Atomerra, Strattera, Atomoxetine | Intuniv (controlled release) |
| Strengths (mg) | 10, 18, 25, 40, 60, 80, 100 | 1, 2, 3, 4 |
| Starting Dose | 0.5 mg/kg (max 40mg) OD | 1 mg NOCTE (due to drowsiness) |
| Dosage Adjustments | Wait at least one week between dose adjustments | |
| Onset of Action | 2 days - 4 weeks | 5 days - 8 weeks |
| Duration of Action | 24 hrs | 6 - 12 hours |
| Common Side Effects<br><br>(Refer to PI for other side effects) | Dry mouth, vomiting, insomnia, somnolence, decreased appetite, abdominal pain, dizziness, nausea, increased BP, aggression, irritability<br>Rare but important: suicidal ideation and hepatic dysfunction | Drowsiness (40%), hypotension, bradycardia, sedation,, fatigue, headache, nausea, abdominal pain, dizziness, dry mouth, weight gain |
| Contraindications | If history or examination is suggestive of structural heart disease (including RHD) or arrhythmia, investigate further and consider cardiology referral prior to commencing medication.<br><br>Uncontrolled hyperthyroidism<br><br>Contraindicated if Monoamine Oxidase Inhibitor (eg phenelzine, tranylcypromine) has been taken in the preceding 2 weeks. Can precipitate hypertensive crisis.<br><br>Patients with glaucoma should only be prescribed stimulants with ophthalmology specialist involvement. | None documented |
| Interactions | Fluoxetine: increases atomoxetine concentration<br><br>Bupropion: increases atomoxetine concentration<br><br>Paroxetine: increases atomoxetine concentration | Ethanol: increases CNS effects of ethanol<br><br>Oral ketoconazole: increases guanfacine concentration<br><br>Rifampicin: decreases guanfacine concentration<br><br>Valproate: increases valproate concentration |
| Pregnancy | Minimal information, seek pharmacist advice<br>Assess need for contraception and manage as indicated | No clear evidence of congenital malformation (limited evidence)<br>Assess need for contraception and manage as indicated |
| Breastfeeding | Minimal information, seek pharmacist advice | Minimal information, may reduce serum prolactin in breastfeeding mothers |
| Additional | Use second line after stimulants (see PBS requirements)<br><br>Lactose free<br>Gluten free | Use second line after stimulants (see PBS requirements)<br><br>Must be swallowed whole<br><br>Do not cease abruptly due to risk of rebound hypertension<br><br>Contains lactose<br>Gluten Free |


institute for
urban indigenous health

www.iuih.org.au



# IUIH Network Protocol

Attention Deficit Hyperactivity Disorder (ADHD) in adults v2

August 2022

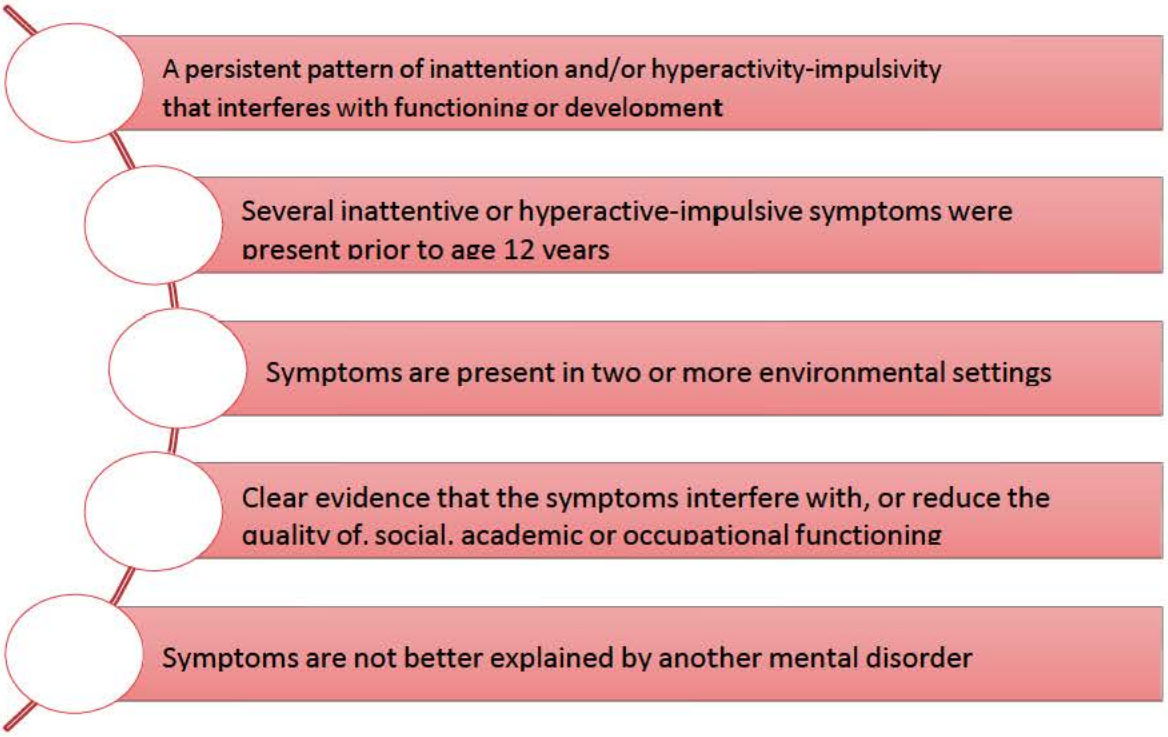
## Key Facts

Attention deficit hyperactivity disorder (ADHD) is characterised by the core symptoms of:

- Persisting inattention,
- Hyperactivity, or
- Impulsivity

ADHD is often a lifelong condition with its symptom onset in childhood, but the impact and presentation of ADHD can change over time. It is estimated that ADHD affects around 5% of children and 2.5% of adults, and more commonly diagnosed in males with the gender rate of 2:1 in children and 1.6: 1 in adults. It is important to note, however, females with ADHD are often undiagnosed as they tend to have less obvious or socially disruptive symptoms than men.

## Abbreviated DSM 5 Criteria for ADHD:




Some adults may present with symptoms suggestive of ADHD for the first time including functional impairment as well as family concerns (although at least some of the symptoms had to be present before the age of 12). Others may have been treated for ADHD in childhood/adolescence and have symptoms suggestive of continuing ADHD associated with moderate or severe impairment.

### Common comorbidities in adults

- Anxiety
- Depression
- Substance use disorder
- Borderline personality disorder
- Learning disabilities
- Antisocial personality disorder
- Bipolar disorder
- Autistic spectrum disorder
- Obsessive compulsive disorder

## Prior to the psychiatrist assessment

- ☐ The patient and family member should complete a self-report questionnaire such as the Adult ADHD Self-Report Scale (ASRS) version 1.1 as a screening measurement tool (ASRS V1.1 ).
- ☐ People with an active alcohol and drug use disorder usually require treatment for their substance use before they can be assessed for ADHD
- ☐ **We are unable to make the diagnosis of ADHD in adults without the collateral information regarding childhood behaviour (before age 12)** such as a family report and/or school reports or other written evidence.

A full medical history and physical examination to be conducted including:

- ☐ Assessment of history of exercise syncope, undue breathlessness and other cardiovascular symptoms
- ☐ Heart rate and blood pressure
- ☐ Weight
- ☐ Family history of cardiac disease (including sudden, unexplained deaths) and examination of the cardiovascular system
- ☐ Blood test – FBC, thyroid function test, LFT, EUC
- ☐ ECG
- ☐ Risk assessment for substance misuse and drug diversion
- ☐ Self and family history regarding use of alcohol and drugs (especially dates last used)
- ☐ A recent negative urine drug screen result (can be requested through Mob Link)
- ☐ Check Q-Script System for monitored medicine use
- ☐ Collateral information regarding childhood behaviour (before age 12) such as family report/collateral or school reports

## Diagnosis

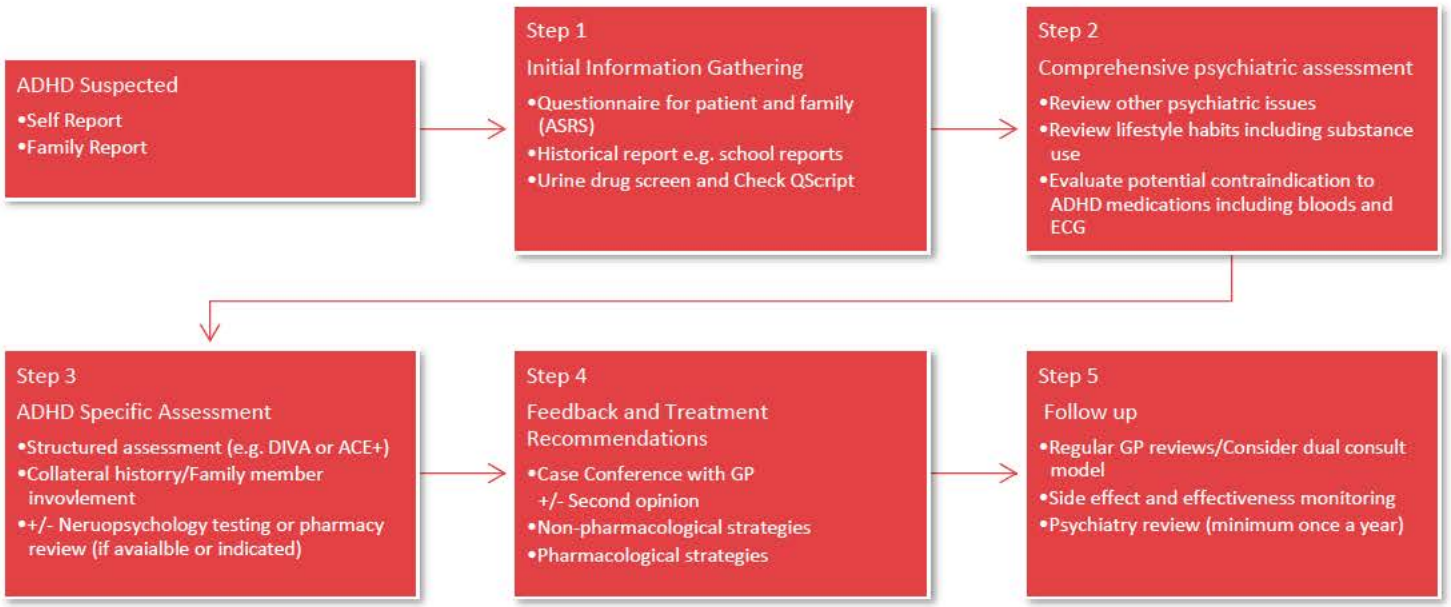
Diagnostic tasks are to ensure

- Current ADHD symptoms (inattention and hyperactive-impulsive symptoms) present sufficiently
- Age of onset of (many of) these symptoms is by age 12
- Impairment in two or more roles due to these symptoms has been present for the last six months or more
- A lack of alternative explanation for the symptoms or impairment including a broad range of alternate medical and psychiatric as well as circumstantial conditions

Psychiatric assessment:

- usually takes three sessions (usually 45 to 50 minutes each).
- The assessment aims to assess psychiatric issues comprehensively, obtain collateral history, and formulate management recommendations.
- A parent or caregiver should be encouraged to be involved in the assessment process where possible.
- The assessment will be followed by a case conference with the referring GP to plan out the ongoing management.

## Diagnosis and treatment flowchart:




## Management

- Education and feedback on diagnosis
- Building capacity for self-management
- Pharmacological strategies including psychostimulants and non-psychostimulants
- Ongoing follow up

Many adults with ADHD suffer from a co-morbid psychiatric issue/disorder in addition to vocational, educational and social problems. Therefore, treatment for ADHD needs to address these issues in a holistic way.

## Pharmacotherapies

**Started only under the guidance of a psychiatrist**

- In practice, it will usually be started by the treating GP after the case conference with the psychiatrist (with ongoing follow up and titration as per protocol by GP with consultation with the psychiatrist as required/indicated)

**Part of a comprehensive treatment program**

- The treatment program should address psychological, behavioural and educational or occupational needs (there may be some employment specific considerations/restrictions in some occupations e.g. military, heavy vehicle operations, police force or aviation industry)

There are two medication options for ADHD in adults:

1. Stimulant – Lisdexamfetamine (Vyvanse)
2. Non-stimulant – Atomoxetine (to be used if there are concerns about substance misuse* or if the patient prefers a non-stimulant medication – off PBS label use)

***Generally, substance misuse should be considered "active" if used regularly within the last two years.***

*Consider changing to the alternative medication if symptoms do not respond to the first choice, or the person is intolerant to it after an adequate trial (usually about six weeks).*

## Precautions with ADHD medication

- Absolute contraindication: Known hypersensitivity or allergy to the products
- Relative contraindication: Pre-existing cardiac disease, bipolar disorder, psychosis, and pregnancyand lactation

| Drug | Absolute contraindication | Relative contraindication |
|---|---|---|
| Psychostimulants | ▪ Treatment with Monoamine Oxidase Inhibitors (MAOI) and for up to 14 days after discontinuation<br>▪ Glaucoma (narrow angle)<br>▪ Untreated hyperthyroidism<br>▪ Moderate to severe hypertension<br>▪ Pheochromocytoma<br>▪ Symptomatic cardiovascular disease<br>▪ History of mania or psychosis<br>▪ Current illicit substance use (regular use within the past two years)<br>▪ Risk of drug diversion (e.g. Parents/carers/siblings/self) | ▪ History of substance abuse<br>▪ Anxiety<br>▪ Renal impairment<br>▪ Tic disorders<br>▪ Epilepsy<br>▪ Peripheral vasculopathy including Raynaud's Phenomenon |
| Atomoxetine | ▪ Treatment with MAOI and for up to 14 days after discontinuation<br>▪ Glaucoma (narrow angle)<br>▪ Untreated hyperthyroidism<br>▪ Moderate to severe hypertension<br>▪ Pheochromocytoma<br>▪ Symptomatic cardiovascular disease<br>▪ Advanced arteriosclerosis | ▪ Asthma<br>▪ CYP2D6 poor metabolizers<br>▪ Peripheral vasculopathy including Raynaud's Phenomenon |
| Additional information for **Atomoxetine** - Closely monitor for the following particularly during the initial months of treatment or a dose change:<br>▪ Agitation or irritability<br>▪ Suicidal thinking or self-harming behaviour or unusual changes in behaviour<br>▪ Signs of acute liver damage (e.g. abdominal pain, unexplained nausea, malaise, darkening of the urine or jaundice) | | |

## Initiation and titration of medication

- Commence on low doses and gradually increase the dose until there is no further improvement in symptoms, behaviour, or impairment, and side effects are tolerable
- Record symptoms and side effects at each dose change after discussion with the patient and if possible, a family member or friend
- Review progress regularly (e.g. weekly contact and at each dose change)
- Dose titration should be slower if tics or seizures are present
- Consider dose reduction if side effects become troublesome

## Initial titration and recommended maximum doses for adults

| Drug | Initial Dose | Titration | Maximum Dose | PBS |
|---|---|---|---|---|
| Lisdexamfetamine | 20mg mane | Increase dose according to response in increment of 20mg or less at two weekly intervals | 70mg per day | Authority required (retrospective diagnosis of childhood ADHD) |
| Atomoxetine | Up to 70kg body weight – use a total starting dose of 0.5mg/kg/day (usually twice a day) | Up to 70kg body weight – increase dose according to response in small increments at weekly intervals | Up to 70kg body weight – 1.2mg/kg/day | Not approved on PBS for ADHD in adults |
| | Over 70kg body weight – use a total starting dose of 40mg/day (i.e. 20mg BD) | Over 70kg body weight – increase dose according to response in increment of 20mg at weekly intervals | Over 70kg body weight – 100mg/day (the usual maintenance dose is 80 to 100mg per day) | |

## Stimulant Monitoring

- Under the Medicines and Poisons Act, 2019 (MPA), health practitioners will have direct access to QScript and are required to review the system before prescribing any monitored medicine (this will include all S8 psychostimulants).
- All psychiatrists will be authorised to treat adults with ADHD with S8 psychostimulants, within certain dosage limits without approval from the Department
- Treatment for adult ADHD with S8 psychostimulants, above the limits set in Regulation, will require individual approvals
- **Treatment for adult ADHD with S8 psychostimulants by any other medical practitioners than psychiatrists will require individual approvals**

Useful website:
https://aadpa.com.au/adhd-stimulant-prescribing-regulations-in-australia-new-zealand/#qld

To reduce the risk of stimulant misuse and diversion, the following recommendations are proposed:

If there is a recent history of illicit substance misuse (i.e. in the past 2 years), atomoxetine should be trialled first

A negative urine drug screen should be obtained before commencing on stimulant

One pharmacy should be nominated for each patient for psychostimulant dispensing, and the prescription needs to be faxed directly to the pharmacy.

Consider adding the pharmacy contact details as an "alert" in the Alerts/Allergies tab in Mmex

Consider using the Drug of Dependence Agreement template on MMEX or staged supply/pick up from the pharmacy

Urine drug screen should be conducted every 12 months to confirm the psychostimulant medication is being taken and that there is no continuing use of other drugs (request through IUIH Connect)

Lost medication – can be guided by the Drug of Dependency Agreement or consider reducing the pickup interval. If the problem persists, consider ceasing psychostimulant treatment

If there is any suspicion of misuse, stimulant treatment should be ceased (discuss with the psychiatrist/pharmacist re: discontinuation plan)

### Duration of treatment

*Continue treatment if it is effective – adopt an individual treatment approach for adults.*

## Follow up

- Regular reviews by GP every four to eight weeks are recommended.
- A yearly review by a psychiatrist should be conducted – the frequency can be increased, or
- case conference can be utilised if any concern
- Consider reviews by dual consultation model if appropriate

In all reviews, assess:

- Clinical need, benefits and side effects
- Assessment of exercise syncope, undue breathlessness, and other cardiovascular symptoms
- Heart rate. blood pressure, weight
- Bowel habits
- Co-existing conditions - treat or refer as needed
- The views of the person with ADHD and family member/friend as appropriate
- The effect of missed doses, planned dose reductions and brief periods of no treatment (if indicated)
- The need for psychological, social and
- occupational support for the person
- Urine drug screen (approximately twelve monthly) to confirm that the psychostimulant is being taken and there is no use of other drugs

### Stopping psychostimulants

All psychostimulant medication should be ceased slowly over several weeks to avoid problems associated with withdrawal symptoms (e.g. decrease dose by 20mg or less at weekly intervals)

## Non-pharmacological Treatment

Consider referral to psychology team for cognitive behavioural therapy for adults who:

- Are stabilised on medication but have persisting functional impairment associated with ADHD
- Have comorbid symptoms of anxiety or depression
- Have partial or no response to drug treatment or who are intolerant to it
- Have made an informed choice not to have pharmacological treatment
- Have remitting symptoms and psychological treatment is considered sufficient to treat mild to moderate residual functional impairment

Consider referral to occupational therapy team for those who are having challenges with any of their daily activities. For example:

- Organising themselves and/or their environment whether this be at home or work
- Establishing and planning daily routines or schedules
- Working memory difficulties (for example, remembering important things such as appointments and taking medications)
- Self-regulation or sensory modulation

Additionally:

- ➢ Consider referral to exercise physiology team for those who may benefit from exercise intervention for self-regulation
- ➢ Refer to social health team for issues associated with vocational, education, and social problems
- ➢ External services such as ADHD coaches may be helpful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