

Dear Senator Janet Rice,

Re: Best practice approach for improved access to ADHD assessment and treatment.

We appreciate the opportunity to further elaborate on the best practice approach to the assessment and treatment of people with ADHD.

It is our firm belief that the diagnostic and treatment process should be mainstreamed to primary health care, like many other chronic medical conditions, where GPs can diagnose and treat within their scope of practice and refer on for specialist advice where necessary. Calls for this approach have been made internationally already (4).

With an incidence of greater than 4% of the population (6) and rising, ADHD's incidence is similar to asthma or diabetes and is simply unable to be managed by the existing workforce using the current treatment paradigm. General Practitioners are often the first point of contact for individuals seeking medical care, including those who suspect they or their children may have ADHD. Recognizing the significance of GPs in this process is paramount to improving the overall experience and outcomes for individuals affected by ADHD.

In outline,

1. We summarise here and on the next page the main **roles that GPs can play and our recommendations.**
2. On pages 3-7 we demonstrate in more detail the **rationale for a comprehensive, person-centred primary health care approach to ADHD**, as the foundation of a reformed system.
3. Finally, we have created **flow charts** for enhanced primary health care for adults and children with ADHD (see pages 8-10).

Roles of GPs in ADHD in Diagnosis and Treatment:

1. **Early Identification:** GPs play a critical role in the early identification of ADHD. They are ideally positioned to recognize potential symptoms during routine check-ups or when patients express concerns about attention, behaviour, or academic performance.
2. **Diagnosis:** Upon suspecting ADHD, GPs with appropriate training can facilitate timely diagnosis if the case is clear or arrange referral if there is any doubt.
3. **Coordinated Care:** GPs can act as coordinators of care for individuals with ADHD. They can help develop individualized treatment plans that integrate medical management and behavioural interventions, ensuring a holistic approach to care. GPs can also treat any of the common co-morbidities and can manage ADHD across the lifespan from childhood into adulthood.
4. **Medication Management:** GPs with appropriate training can provide ongoing medication management for patients with ADHD, which includes monitoring side effects, dosage adjustments, and ensuring the continuation of appropriate treatment.
5. **Patient and Parent Education:** GPs can educate patients and parents about ADHD, its management, and available support services. This empowers families to make informed decisions and advocate for their needs. GPs are also very familiar with local private and public psychology and coaching services.

6. Community Resource Awareness: GPs are well-connected within their local communities and can provide information about available ADHD support groups, counselling services, and educational resources.

Recommendations:

1. GP Training: Invest in training programs for GPs (face-to-face/online/hybrid models) to enhance their understanding of ADHD diagnosis and management, including the use of evidence-based guidelines (6) validated assessment tools (1, 3, 7), and (soon to be released) AADPA prescribing guidelines. We favour some introductory training for all interested GPs, as well as more advanced training (eg 10 hours) to develop capacity for diagnosis and treatment (see clinical flow charts, pages 8-10). Communities of practice (eg local GP, psychiatrist, ADHD coach, clin psychologist meetings) is a strategy that is worth exploring, for ongoing learning and collaboration.

2. Clear Referral Pathways: Ensure that clear and efficient referral pathways exist for GPs to connect patients with appropriate specialists for comprehensive evaluation and diagnosis.

3. Fund case discussion between GPs and non-GP Specialists: GPs will often need phone advice from ADHD specialists for aspects of management. MBS funding to facilitate this would be invaluable.

4. Establish a specific ADHD assessment item number: the long consultations required to make an accurate diagnosis and treatment plan for ADHD are not well supported by the MBS. We advocate for a specific item number that is available only to GPs who have done the necessary ADHD training.

5. Medication Access: Support GPs in prescribing and managing ADHD medications, while promoting adherence to guidelines for responsible prescribing. This could be facilitated by harmonising the state laws on stimulant prescribing and allowing GPs to initiate and titrate these medications.

6. Public Awareness: Launch public and professional awareness campaigns to educate individuals and families about the role of GPs in ADHD care and encourage early intervention. This could include educators, psychologists and parents.

By emphasizing the crucial role of GPs in the ADHD diagnosis and treatment process, we can streamline access to care, reduce diagnosis delays, and ultimately improve the lives of those affected by ADHD.

We appreciate the dedication of your committee to this important issue and look forward to continued collaboration in our efforts to enhance ADHD assessment and support services for all Australians.

Sincerely,

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Appendix Enhanced Primary health care rationale and clinical flow for persons with ADHD

In response to your letter, we aim to show here in more detail how the primary healthcare sector can play a comprehensive role in the ADHD clinical flow that

- improves access,
- is simple,
- is person-centred, and
- is evidence-based.

In addition, we aim to highlight the key role played by specialists, allied health and peak and community bodies, such as ADHD WA.

Background

As many submissions to the current Senate Inquiry have pointed out, the current system for ADHD diagnosis and treatment, relying in large part on non-GP specialists, is not working well for the Australian population. This system failure is true not just in Australia, but internationally(8). There is wide variation in availability of service and significant under-servicing.

Increasing specialist care is not only unrealistic but is likely to be unaffordable. Fortunately, there is an alternative.

Primary health care can and should be the foundation of a better approach to the diagnosis and treatment of ADHD.

Primary health care (PHC) is the obvious alternate pathway to diagnosis and treatment for the majority of patients seeking care.

There are several reasons for this.

1. ADHD is a common, chronic condition, affecting 6-8% of children and 3-5% of adults(6). Organisation of health care should be organised as for other common, chronic conditions.
2. In Australia, like other OECD countries(9), primary health care is the foundation of care for chronic, common conditions throughout the lifespan. It has a track record of improving access to affordable, quality care for the greatest number of people.
3. Making PHC the foundation for ADHD care would allow specialists to play a more useful role as collaborators and for complex cases.
4. There is already a well-established movement to mainstream ADHD care in Canada, the UK (4) and increase the use of primary care in the USA (10).

Primary health care is the Australian health system sector which is most likely to comprehensively and affordably address Strategic priority areas in the Australian strategy for chronic conditions(11). Here are some of the strategic priority areas related to a focus on prevention for a healthier Australia. Given research on the impact of delayed diagnosis, and the fluctuating course of ADHD, the capacity of PHC in these areas is relevant:

“Strategic Priority Area 1.1: Promote health and reduce risk

Strategic Priority Area 1.2: Partnerships for health

Strategic Priority Area 1.3: Critical life stages

Strategic Priority Area 1.4: Timely and appropriate detection and intervention”

What is more, primary health care offers access to groups who are disadvantaged, marginalised or have difficulty accessing services. It is available across Australia, and in culturally safe settings eg Aboriginal community-controlled health services (thus addressing a part of *Strategic Priority Area 1.2 Partnerships for health*).

PHC is available to the whole family, and at all transition times of life (see *Strategic Priority Area 1.3 – Critical life stages*). It is available to patients who already have risk factors for ADHD, including family history, developmental issues, epilepsy, mental illness, substance use disorders (*Strategic Priority Area 1.1 Promote health and reduce risk*).

It's important to note that GPs are already seeing many patients with ADHD – children, adolescents and adults, diagnosed and undiagnosed.

How can Primary health care transition from its current “supportive” role to be the main vehicle for diagnosis and treatment?

For many Australian doctors, *including many specialists*, undergraduate and early career teaching in ADHD has been minimal. However, many GPs have sought out further learning as part of their continuing professional development. Training opportunities have increased significantly recently (1000 GPs recently attended a RACGP webinar on childhood ADHD diagnosis and treatment). There are now Australian ADHD evidence-based clinical practice guidelines(AEBCPG)(6), available online, and soon-to-be-released prescribing guidelines.

ADHD is “easy to treat, but hard to treat well” (12). It is clear that PHC providers who wish to provide comprehensive ADHD care will need some upskilling. Many GPs are keen to upskill and will appreciate opportunities to continue to improve. Further detailed suggestions for training are included below.

From all the above, it should be clear that PHC can play a major role in ADHD care in delivering on *Strategic Priority Area 1.4 Timely and appropriate detection and intervention*.

Primary health care has various system factors which allow it to adapt to change, including participation in Primary health networks, access to (modifiable) Health pathways and GP networks (eg RACGP Whatsapp, Neurodiversity Special Interest group, etc).

Primary health care can and should be Person-centred

Person-centredness has long been recognised as a core value of Primary health care(13). PHC can provide many, if not all aspects of what is agreed to be best practice “whole-person”(14-16) or “person-centred” care(17).

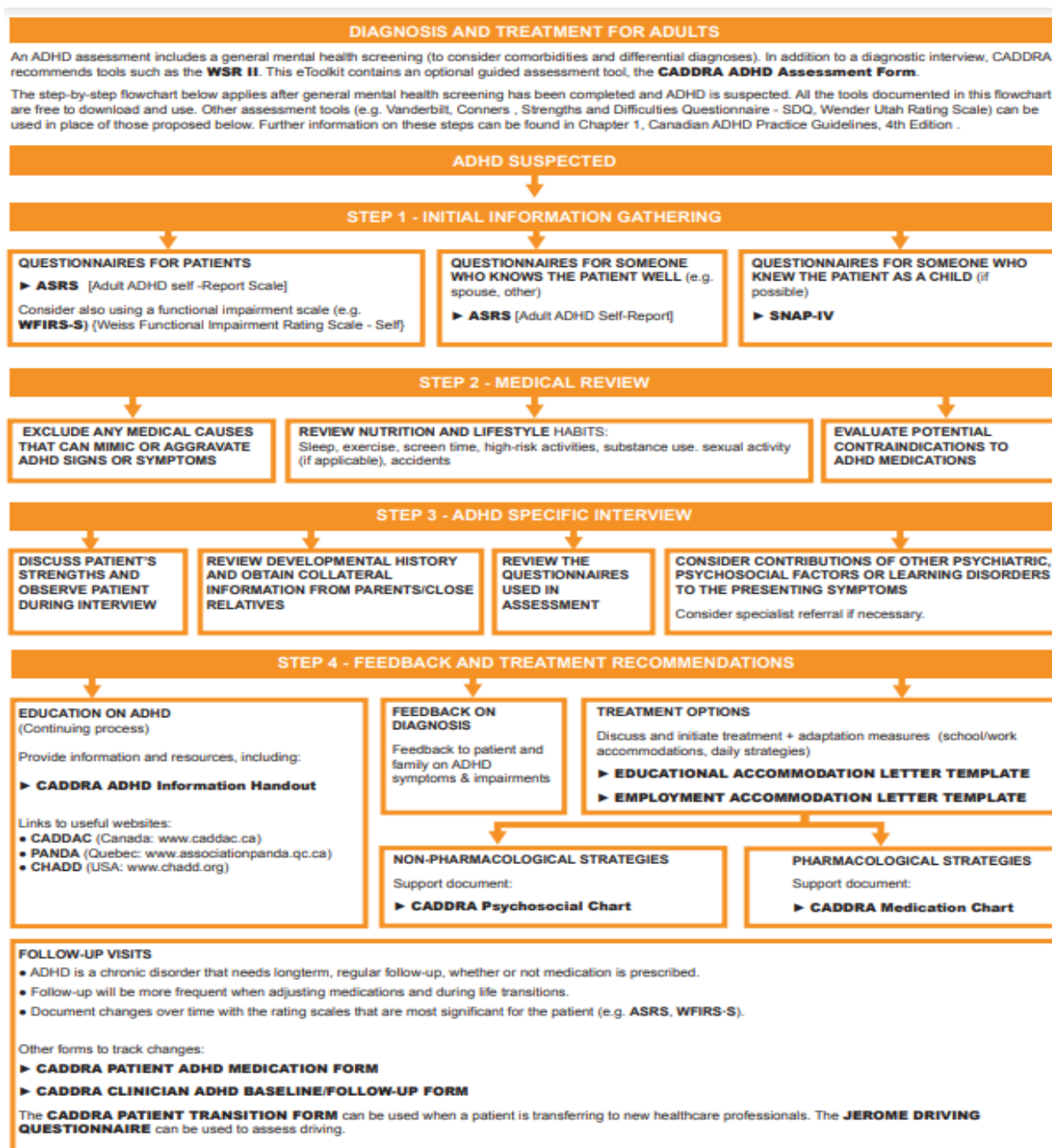
One of the foundations of a person-centred approach is a trusting, collaborative and professional relationship. In a recently published survey of trust and ethical behaviour, General Practitioners were noted to be the highest-rated professional group, that Australians are likely to encounter in their daily lives(18).

Shared decision making, a commonly cited example of person-centred care, can be delivered for persons with ADHD in primary care(19, 20), even potentially with decision aids for ADHD(19).

Patient-friendly guides to appropriate use of language(21), guides to treatment options(2), and questionnaires for patients, family members and key informants (eg teachers) for gathering information are all freely available (1). Familiarisation with these should be part of GP training.

Clinical flow charts for child and adult ADHD

Clinical flow charts for ADHD care are available in various jurisdictions (including Dundee in Scotland, in the USA states of Missouri, Arizona and Massachusetts and in Canada). Copied below is the Adult flow chart from the Canadian ADHD Resource Alliance (CADDRA), available online at <https://www.caddra.ca/wp-content/uploads/adult-key.pdf>. This flow chart clearly shows for an adult the steps from suspected diagnosis to treatment, as well as free resources available from CADDRA (**in bold**). It is simple and could be used for educating both patients and clinicians. On a practical level, it guides both patient and clinician to follow a standardised sequence.



Clinical flow charts based on the Australian guidelines are also now available for an overview of treatment options, and to assist decision making -<https://adhdguideline.aadpa.com.au/clinician-flowchart-factsheet/>. The recommended approach to diagnosis is also available online, but only in summary form, not as a flow chart - <https://adhdguideline.aadpa.com.au/diagnosis/adhd-diagnosis/>

Summarised in a list below from the Australian evidence-based ADHD guidelines (AEBPCG)(6) are key elements of a best practice approach to improved diagnosis, treatment and support at all stages of the lifespan.

The numbering represents one possible order of clinical flow for an adult. Some steps may not be relevant to some patients.

1. Awareness-raising, especially amongst higher-risk groups
2. Patient navigation to interested provider
3. Brief risk assessment
4. Comprehensive assessment
5. Assessment for co-morbidities
6. Diagnosis and recommendations
7. Psycho education
8. Discussion and shared decision making of treatment options
9. Initiation of medication treatment
10. Initiation of non-medication treatments
11. Allied health or education supports – coaching, learning and teaching accommodations
12. Review and Monitoring
13. Family supports
14. Specialist referral – referrals for opinions or ongoing care.

Who plays which role?

PHC can play a comprehensive role in the clinical flow of adult ADHD through a series of tailored, person-centred consultations.

There is no doubt that primary care, specialist care, allied health, ADHD support organisations and wider public health and system support organisations (such as primary care networks), **will all have one or several roles**, in assisting patients get the support they need.

In table form, the comprehensive role of PHC, and the role of other sectors, can be represented below. Following the table, a **clinical flow chart** demonstrates how this could work in primary health care. The flow chart uses the stepped approach and listing of resources, similar to the CADDRA flow chart.

It includes all the key elements of the Australian ADHD guidelines (6).

Table 1 – Elements of improved access to ADHD diagnosis and treatment, demonstrating that primary health care can play a comprehensive role.

	Primary health care	Specialist eg psychiatrist, paediatrician	Allied health, including coaching, ADHD psychoeducation	Advertising “?ADHD – see your GP”, “Can’t focus? Can’t get going? – go to your GP” navigation, etc
Awareness-raising	Yes			Yes
Navigation to interested provider	Yes	Yes	Yes	Yes
Brief risk assessment	Yes		Yes	
Comprehensive assessment	Yes	Yes	Yes	
Assessment for co-morbidities	Yes	Yes	Yes	
Diagnosis and recommendations	Yes			
Psychoeducation	Yes	Yes	Yes	
Discussion and shared decision making of treatment options	Yes	Yes	Yes	
Initiation of medication treatment	Yes	Yes		
Initiation of non-medication treatments	Yes	Yes	Yes	
Review	Yes	Yes		
Monitoring	Yes	Yes	Yes	
Family supports	Yes	Yes	Yes	
Allied health or education supports – coaching, learning and teaching accommodations,			Yes	
Specialist referral – referrals for opinions or ongoing care.	Yes		Yes	
System supports available for providers	Yes	Yes	Yes	Yes

Enhanced adult ADHD primary health care flow chart, based on GP upskilling

1. GP upskilling -
 - a. Basic upskilling, enabling evidence-based introductory consultations (most GPs/ practices, approx. 3 hours duration, now can do Step 1), and ongoing care after Step 4, **see oval green box below**)
 - b. Advanced GPs with special interest in ADHD (some GPs, at least 2 per practice, 10 hours duration, can do Steps 1-12, can bill for ADHD assessment and plan item number after doing steps 2 and 3, can refer back to usual GP after step 4, **see square boxes below**).
2. Enhanced GP care for persons and families with ADHD, as follows
(with potential examples of supporting resources highlighted)

Step 1 Patient presents with ADHD symptoms or red flags or high-risk conditions associated with ADHD. GP engages in usual patient/family care, raising awareness of ADHD and recognising high risk groups (eg childhood ADHD, history of learning difficulties, epilepsy, etc, as per AEBCPG) - <https://adhdguideline.aadpa.com.au/identification/high-risk-groups/>). If patient interested, GP offers brief risk assessment at that visit, a subsequent visit or with another GP in the practice.

Use ASRS (free at CADDRA website)(1) or

ASRS-5 (free at https://www.hcp.med.harvard.edu/ncs/ftpd/ADHD/ASRS-5_English.pdf)

Step 2 Subject to patient consent, commence ADHD assessment, including history, developmental history, family history, substance, use, mental health history. Assess for OSA, anaemia, depression, anxiety, other masquerades and co-occurring conditions. Assess for "high risk conditions"

Check for contra indications or interactions with ADHD treatments. Gather history of functional impacts (work, study, accidents, etc) and from partner. Assess patient strengths, preferences.

Use CADDRA etoolkit for assessment forms(1), functional impact assessments etc. eg WFIRS - **Weiss functional impairment rating scale**

Focused physical examination (Wt, Ht, PR, BP, etc)

Step 3 Communicate findings to collaborating specialist eg psychiatrist (first 10 patients, and subsequent patients if indicated)

Formulate findings, explain diagnosis to patient/family and educate regarding implications and treatment options.

Psychoeducation,

Shared decision-making regarding options, medication, non medication options (CBT, coaching, etc).

Use AADPA education materials eg companion guide(2), factsheet for lived experience with ADHD and clinicians (5))

Step 4 Commence treatment if indicated and patient consents, follow up, optimise, monitor, review, especially at critical life stages.

Refer for further psycho education eg to local ADHD peak body, CBT eg local psychologist, ADHD coaching, specialist psychiatrist referral as required, eg if complex, not responding.. Organise further assessments/ discussions/ recommendations eg regarding learning accommodations for students. **If patient stable, refer back to usual treating GP for ongoing review, monitoring.**

Use CADDRA etoolkit (1)for accommodation letter template, use symptom monitoring sheets eg CADDRA clinician ADHD baseline/follow up form, Jerome driving assessment form, etc

Enhanced child and adolescent ADHD primary health care flow chart, based on GP upskilling

1. GP upskilling –

a. Basic upskilling, enabling evidence-based introductory consultations (most GPs/ practices, approx. 3 hours duration, now can do Step 1), and ongoing care after Step 4, see **orange box** below)

b. Advanced GPs with special interest in ADHD (some GPs, at least 2 per practice, 10 hours duration, can do Steps 1-4, can bill for ADHD assessment and care planning item numbers after doing steps 2 and 3, can refer back to usual GP after step 4, see **square boxes** below).

c. An advanced GP would be accredited after showing evidence of 10 'shared ADHD assessments' with a child and adolescent paediatrician or psychiatrist and deemed competent based on these assessments and treatment plans.

A shared assessment incorporates step 3 where a GP will present findings to the specialist and summarise the management plan.

2. Enhanced GP care for persons and families with ADHD, as follows

(with potential examples of supporting resources highlighted)

Step 1 Child presents with ADHD symptoms or red flags or high-risk conditions associated with ADHD. GP engages in usual patient/family care, raising awareness of ADHD and recognising high risk groups. In children and adolescents, this included history of anxiety disorders, autism spectrum disorder, epilepsy, family history of ADHD, imprisoned, intellectual disability, children in out-of-home care, mood disorders, oppositional defiant disorder, premature birth, substance use disorders, and tic disorders (<https://adhdguideline.aadpa.com.au/identification/high-risk-groups/>).

If time permits, assess the key foundational areas of a child's health and wellbeing such as sleep, nutrition, social connections, physical activity, screentime, resilience and academic performance. To assist in assessment for ADHD, for common differentials and other commonly co-existing conditions, impacts and educational disorders, request that the family completes a Child and Adolescent Psychprofiler (CAPP) assessment(7). (This is available online at <https://www.psychprofiler.com/>, costs \$5 and takes 15 minutes to complete. This Australian tool is described as "a reliable and valid instrument that screens for over 20 of the most common, psychiatric, psychological and educational disorders").



Step 2 Subject to appropriate consent from parent or legal guardian, commence full ADHD assessment, including history, developmental history, family history, substance, use, mental health history. Assess for primary or secondary medical conditions such as obstructive sleep apnoea, anaemia / vitamin deficiencies, endocrine problems (thyroid disorders), hearing loss, visual loss or and mental health conditions such as depression, anxiety, other masquerades and co-occurring conditions.

Check allergies, current symptoms and current medication list for contra indications or interactions with ADHD treatments. Gather history of functional impacts (learning and school) and from parent or caregiver for that child.

Focused physical examination (Wt, Ht, PR, BP, ECG).

Arrange screening tool to be completed by family members (parents) and the child's school teacher. (For example, use the Conners assessment tool- Conners 4 (3))

Assess patient strengths and preferences for treatment (pharmacological vs non pharmacological).

Step 3 Communicate findings to collaborating specialist ie. developmental paediatrician or child psychiatrist through a multi-disciplinary collaborative approach involving the practice nurse, specialist, GP and any other relevant members who may be important to include (psychologist, OT, teacher).

Formulate findings, explain diagnosis to patient/family and educate regarding implications and treatment options.. Psychoeducation and resources to be provided (The ADHD Go-To Guide book). Shared decision-making regarding options, medication, non medication options (psychology, OT, ADHD coach, tutoring etc).

Use AADPA education materials eg companion guide(2), factsheet for lived experience with ADHD and clinicians(5)

Step 4 Commence treatment. Follow up the child at regular intervals, ideally 2 weeks, 6 weeks, 3 months and then 6 monthly ensuring compliance and managing any side effects such as mood changes, insomnia or appetite reduction. Optimise treatment through referral to most relevant providers eg. local ADHD peak body, local psychologist, occupational therapist, ADHD coaching, tutoring services. It may be appropriate to utilise additional Medicare item numbers such as a mental health care plan or care plan to provide collaboration and funding.

Refer to a developmental paediatrician, child and adolescent psychiatrist or child development services if complex or not responding. Organise further assessments/ discussions/ recommendations eg regarding learning accommodations for students. Document diagnosis and suggestions to provide suggestions to school. **If patient stable, refer back to usual treating GP for ongoing review, monitoring.**

Use CADDRA accommodation letter template, use symptom monitoring sheets eg CADDRA clinician ADHD baseline/follow up form, Jerome driving assessment form, etc(1)

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