Tonight’s webinar will begin shortly

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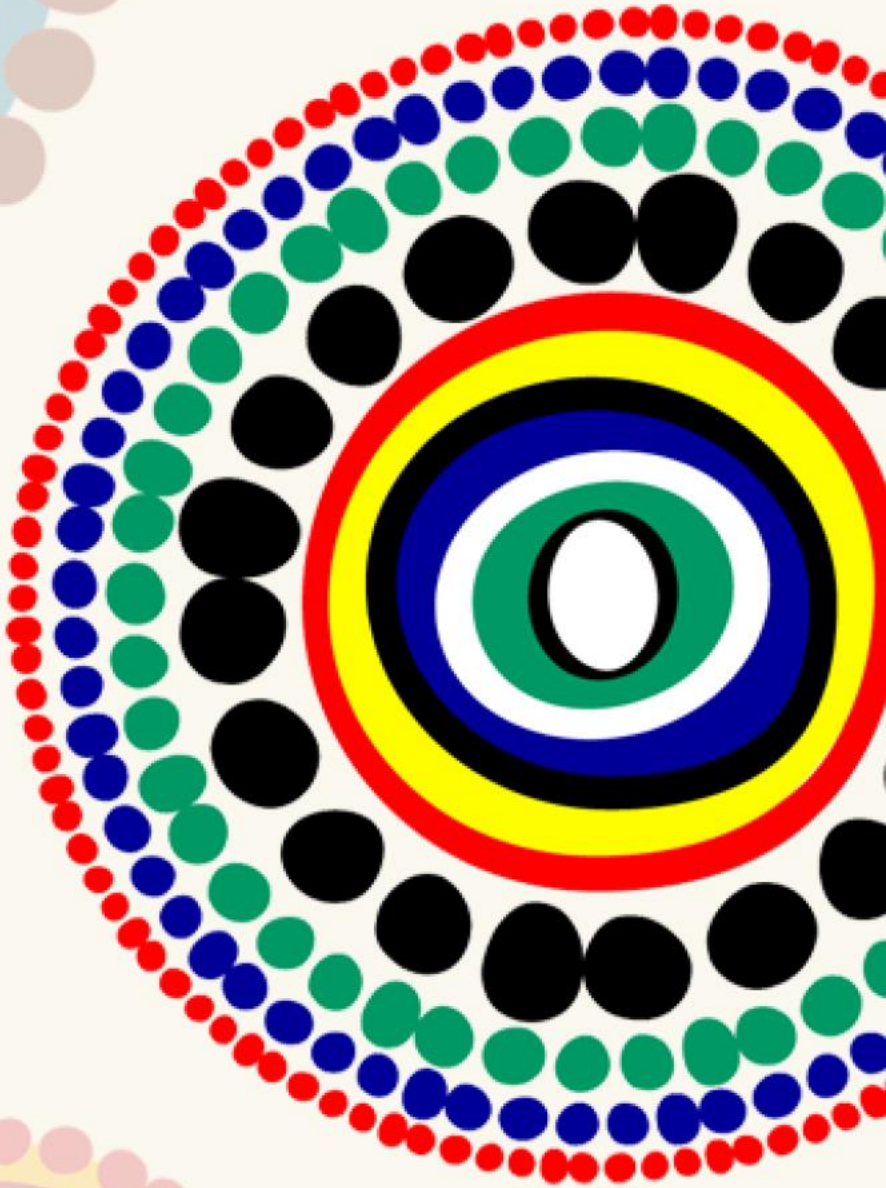

After six years of diabetes check-ups, you notice that pigmentation on her cheek.

You decide to excise the lesion and find early melanoma.

General practice – everything you've trained for and more

become a GP

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We will begin in 30 seconds

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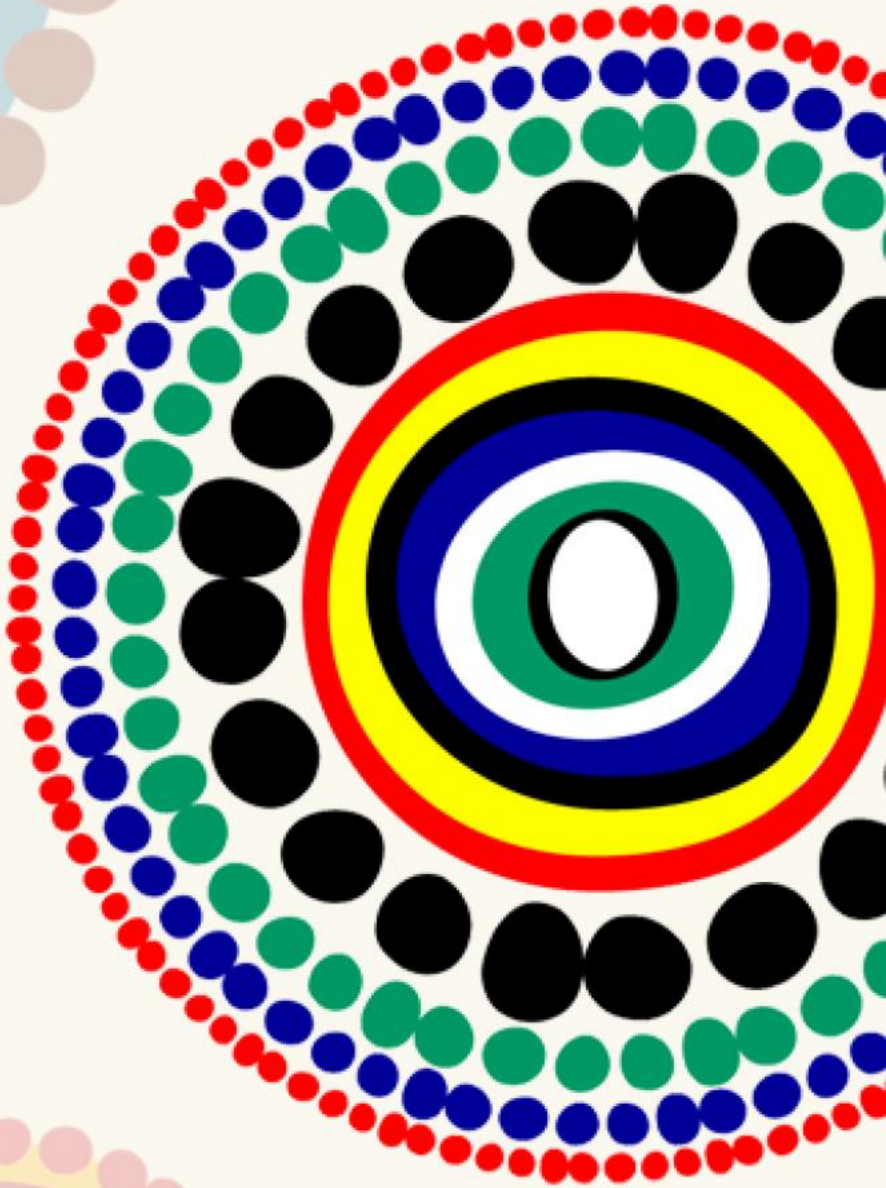

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You decide to excise the lesion and find early melanoma.

General practice – everything you've trained for and more

become a GP

RACGP

Welcome to tonight’s webinar

RACGP

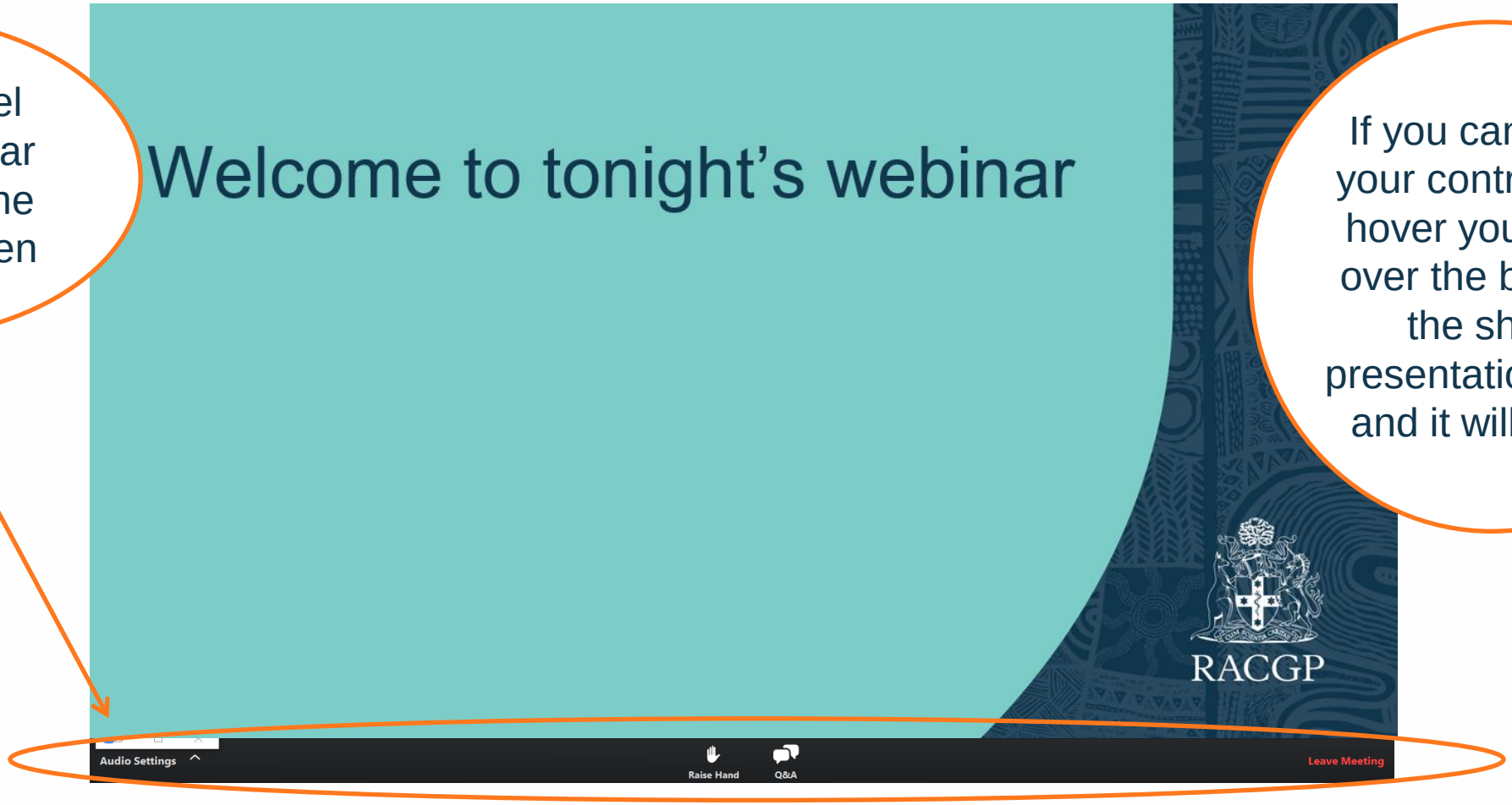
Adult ADHD in general practice

RACGP Specific Interests

RACGP

Where is my control panel?

Your control panel will appear as a bar at the bottom of the presentation screen



If you cannot see your control panel, hover your cursor over the bottom of the shared presentation screen and it will appear

RACGP Specific Interests

Healthy Profession.
Healthy Australia.

Dr Carmel O’Toole

GP Host

Founding member –

RACGP, ADHD, ASD and Neurodiversity specific interest group

RACGP

Healthy Profession.
Healthy Australia.

Acknowledgement of Country

I would like to acknowledge the traditional owners of the lands from where each of us are joining this webinar today.

I wish to pay my respects to their Elders past, present and emerging.

Learning outcomes

1.Discuss the role of general practice in identification and co-management of adult attention hyperactivity disorder (ADHD)

2.Outline resources available for GPs and patients whilst treating adult ADHD

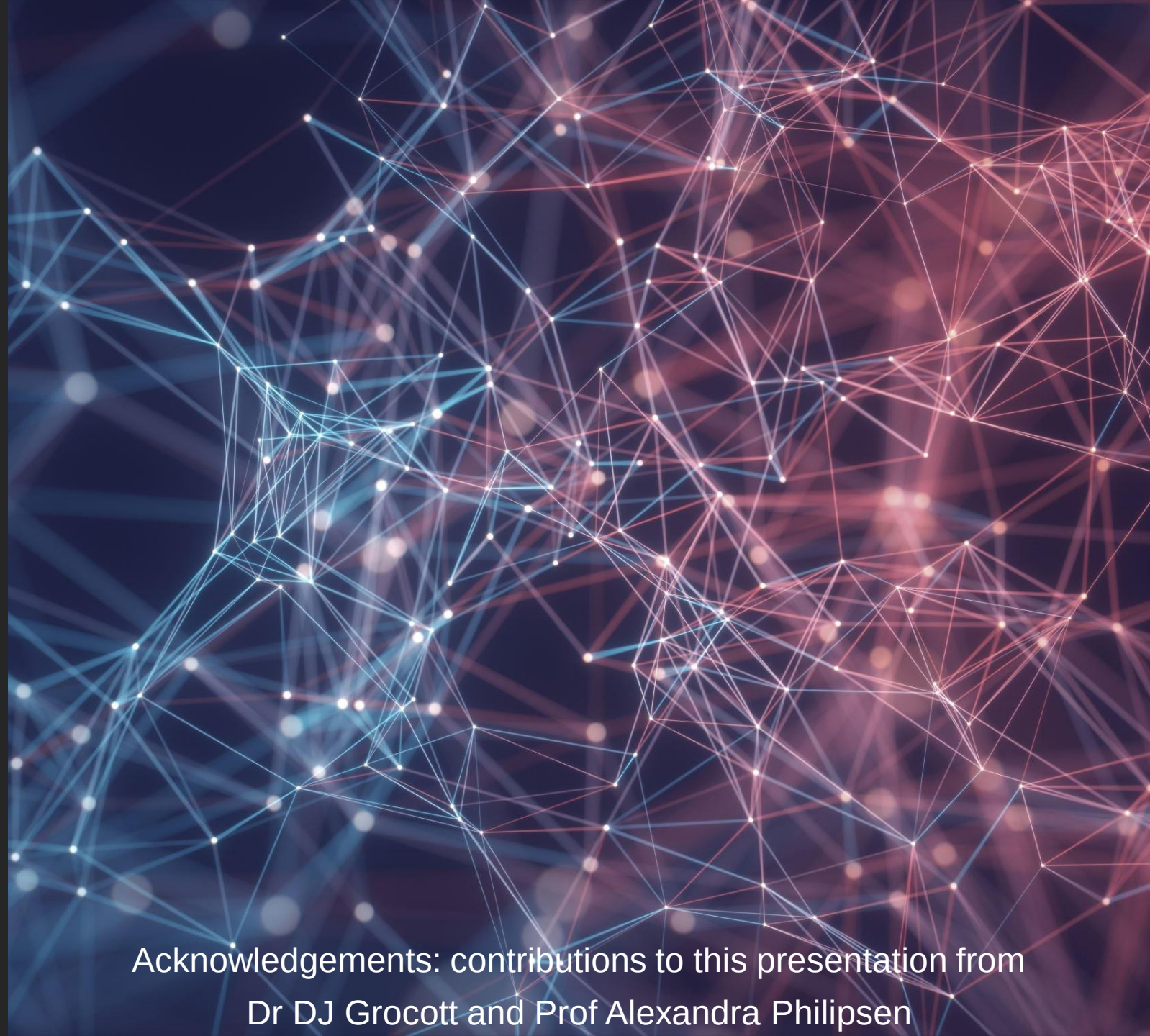
Dr Jörg Strobel
Adult Psychiatrist
Senior Consultant Psychiatrist at Country Health SA LHN Mental Health Division

Adult ADHD- an overview

DR JÖRG STROBEL

CONSULTANT PSYCHIATRIST

29 MARCH 2023



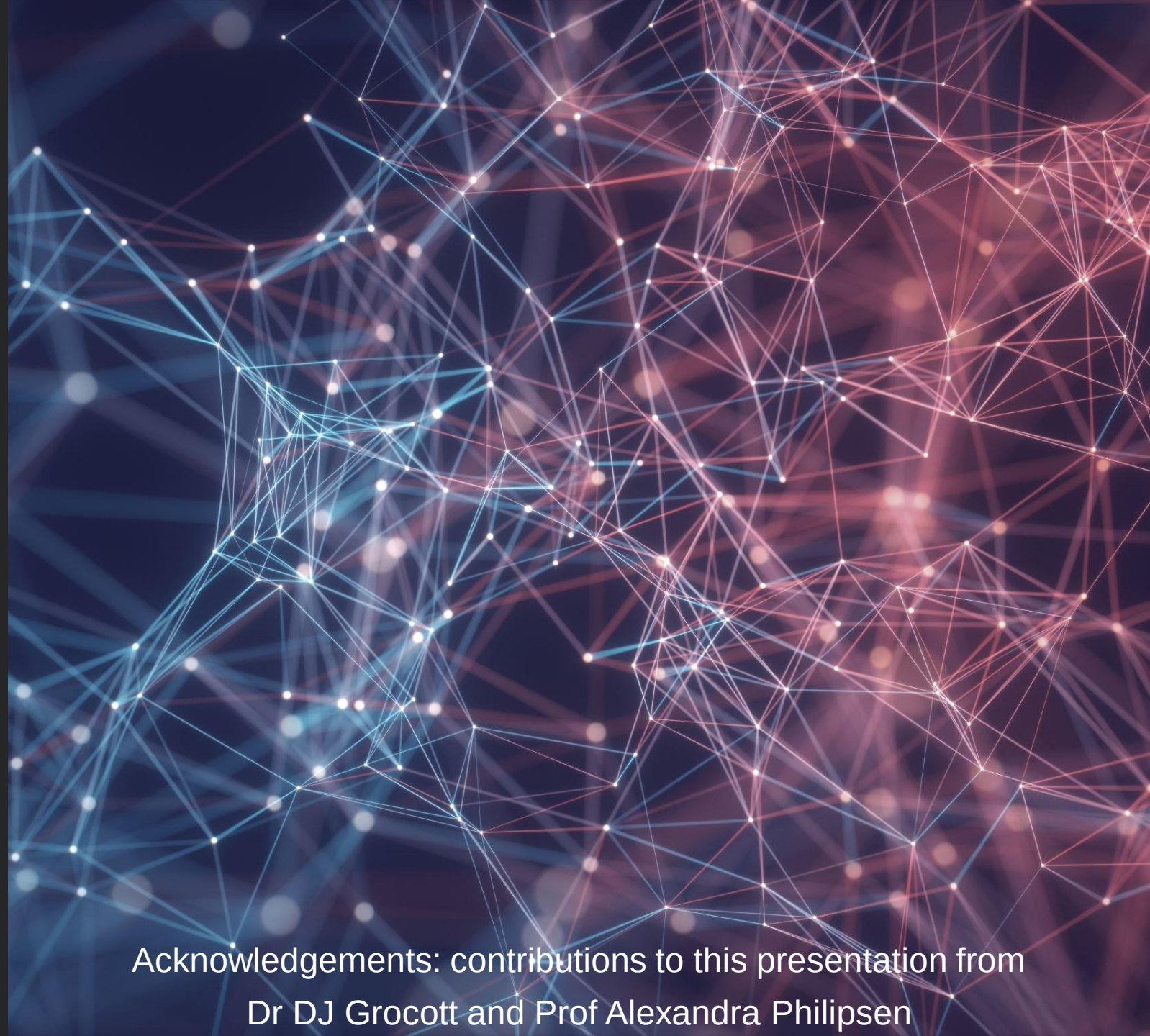
Acknowledgements: contributions to this presentation from Dr DJ Grocott and Prof Alexandra Philipsen

Adult ADHD- an overview

DR CARMEL O'TOOLE

GENERAL PRACTITIONER

29 MARCH 2023



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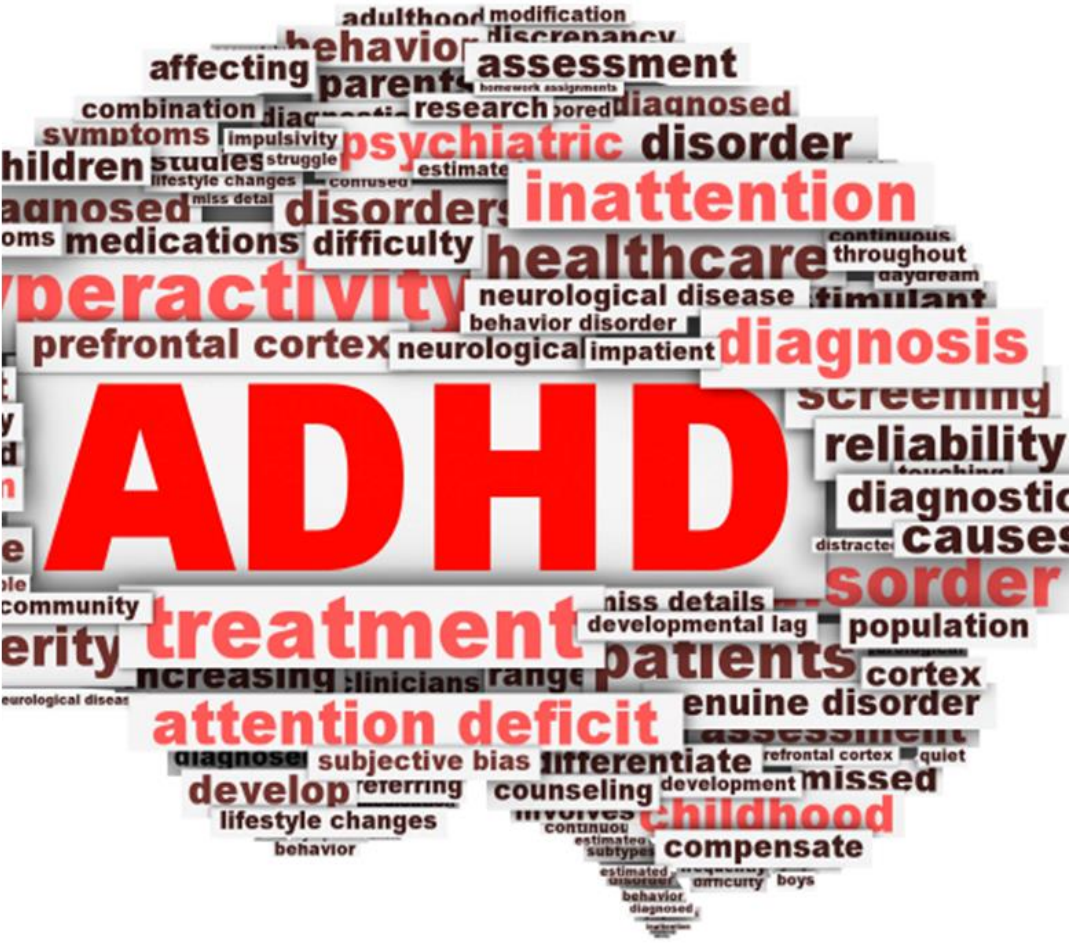
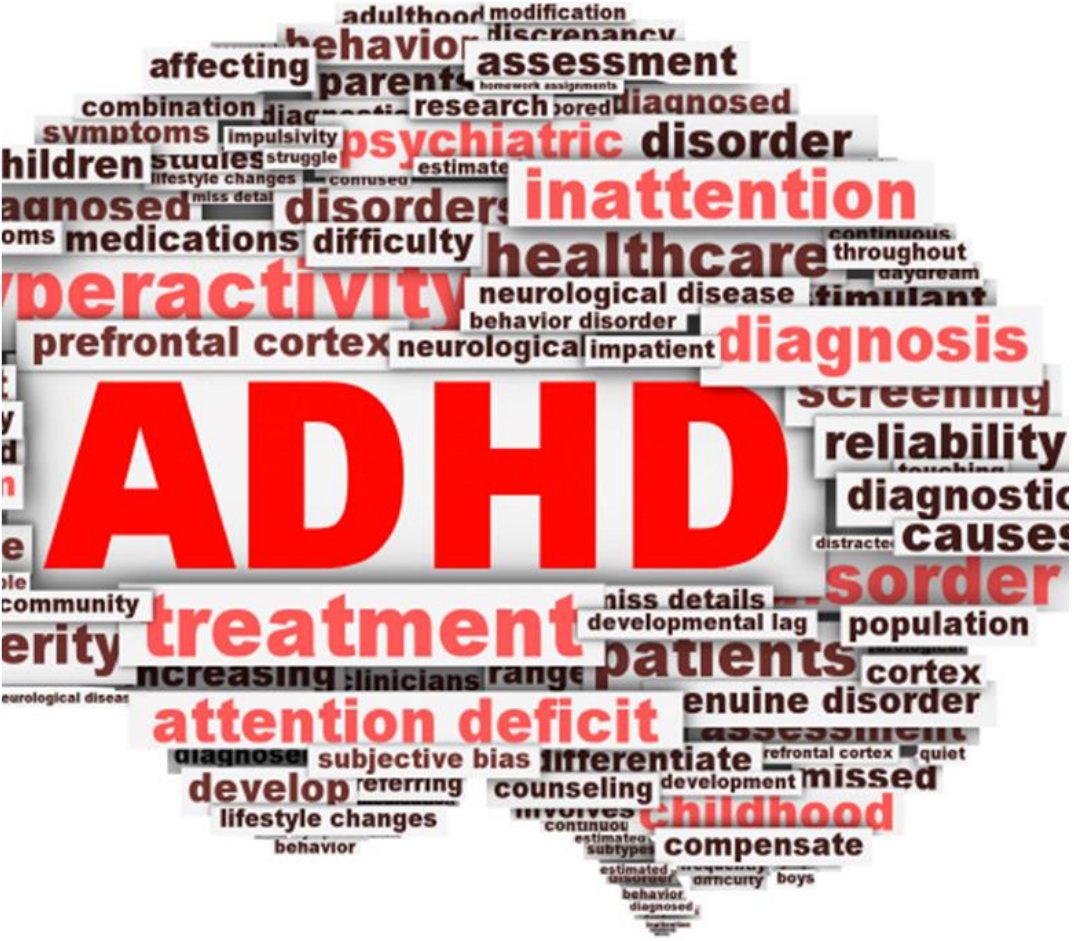
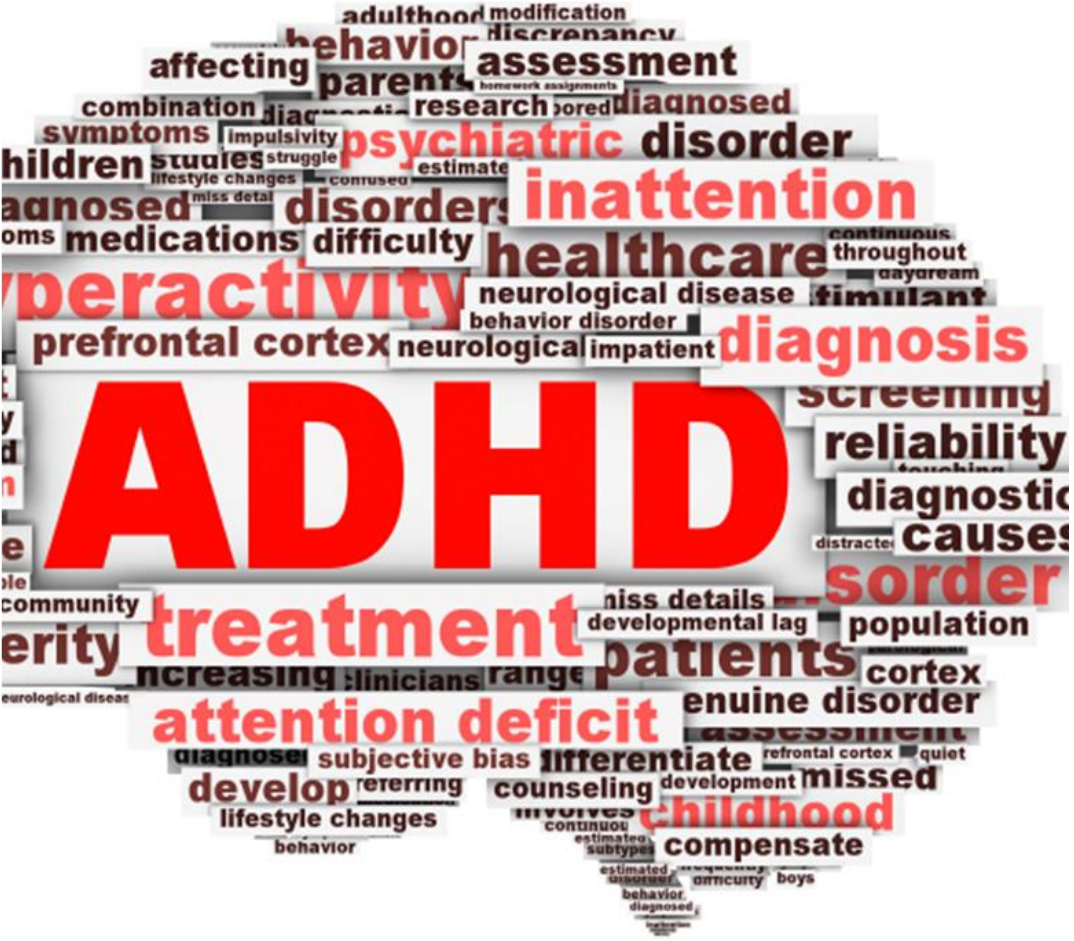


. . . is a
Neurodevelopmental
Brain Disorder
which is …

Common
Serious
Recognisable
Treatable

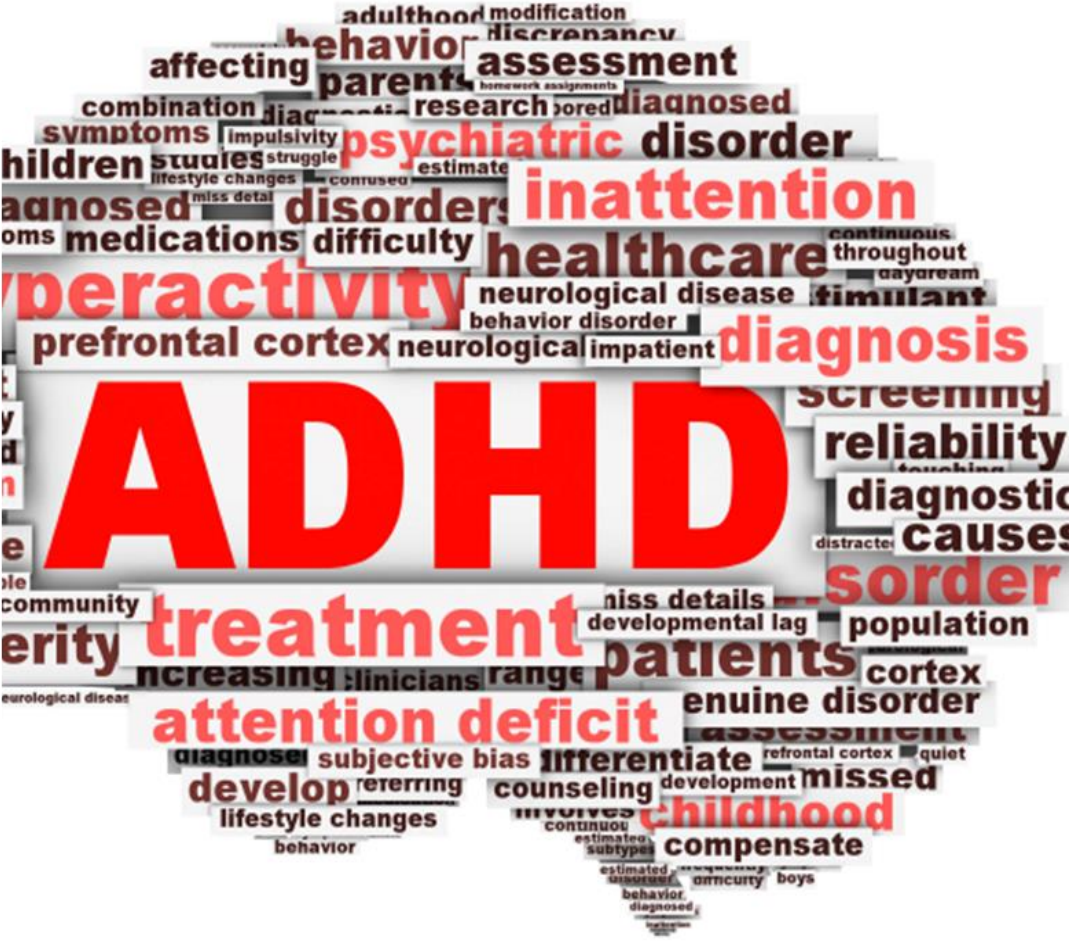


We will pose the following questions to highlight the GP perspective in this Webinar



What does Adult ADHD look like in General Practice?

How is Adult ADHD different from Childhood ?



How do the differences play out?: In presentation? In assessment? In treatment?


DING!
FLASH!
GLUE
WHAT'S DUE TOMORROW?
STINKIEST GARBAGE EVER!
I WONDER WHAT'S IN THAT NOTE?
FLAP! FLAP! FLAP!
CLICK! CLICK!
JAKE HAS CLICKED HIS PEN 29 TIMES - SINCE LUNCH.
ITCHY TAG!
IMPORTANT ASSIGNMENT
BEEP!
WHERE IS MY PENCIL?
JENNY'S FOOT TAPPING SOUNDS LIKE A SONG I KNOW HMMM.....
TAP! TAP! TAP!
MOST UNCOMFORTABLE CHAIR-EVER!
I CAN'T SIT STILL I CAN'T SIT STILL I CAN'T SIT STILL!
PLOP!
SCREECH!

Overview

Politics

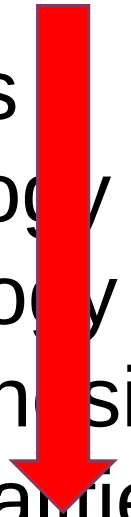
Epidemiology in Adults

Definition / Phenomenology

Aetiology / Neurophysiology

Diagnosis Differential diagnosis

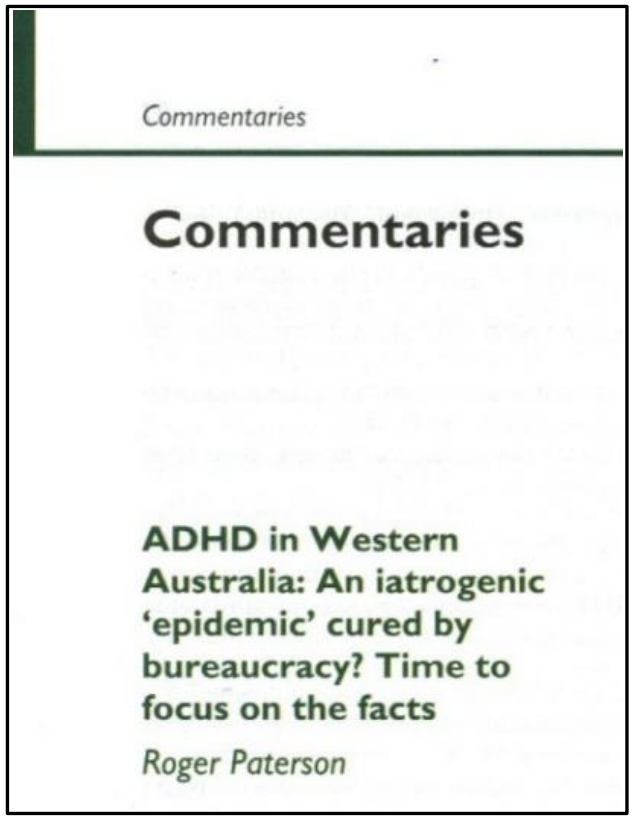
Treatment – legalities and modalities



Adult ADHD – common misperceptions

- **Media reporting generally raising doubt about the validity of the disorder (scientologists)**
- **Common belief ADHD burns out at end of adolescence so can't be a valid diagnosis in adults**
- **We all have symptoms of ADHD (trouble concentrating, procrastinating, not finishing things…)**
- **Everyone would function better on stimulants**
- **Easily faked, trying to get stimulants to enhance performance**
- **A creation by pharma to market drugs**

ADHD – medical controversy


Commentaries

Commentaries

ADHD in Western Australia: An iatrogenic 'epidemic' cured by bureaucracy? Time to focus on the facts

Roger Paterson

(ANZ JP, Jan 2013)

"There is stronger evidence in WA for under- rather than over-prescribing of stimulants in children with ADHD (and adults for that Matter*)."

* ADHD rates 2012 - children 1.24% (expect 5%)
- adults 0.53% (expect 3%)

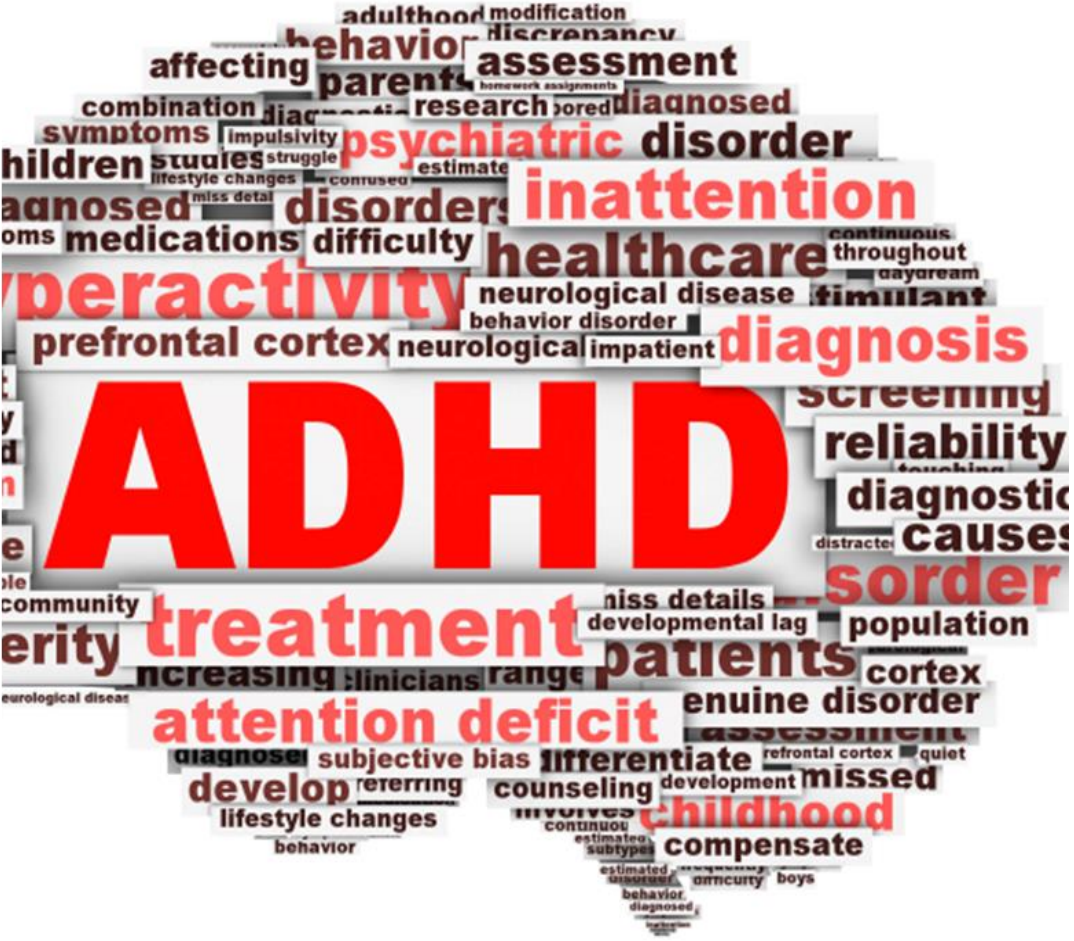
Stigma: Most psychiatrists don't see people with ADHD, The referral form for ETLS explicitly excludes such referrals

People with Diabetes shouldn't be expected to just "try harder" to regulate their blood sugar levels.

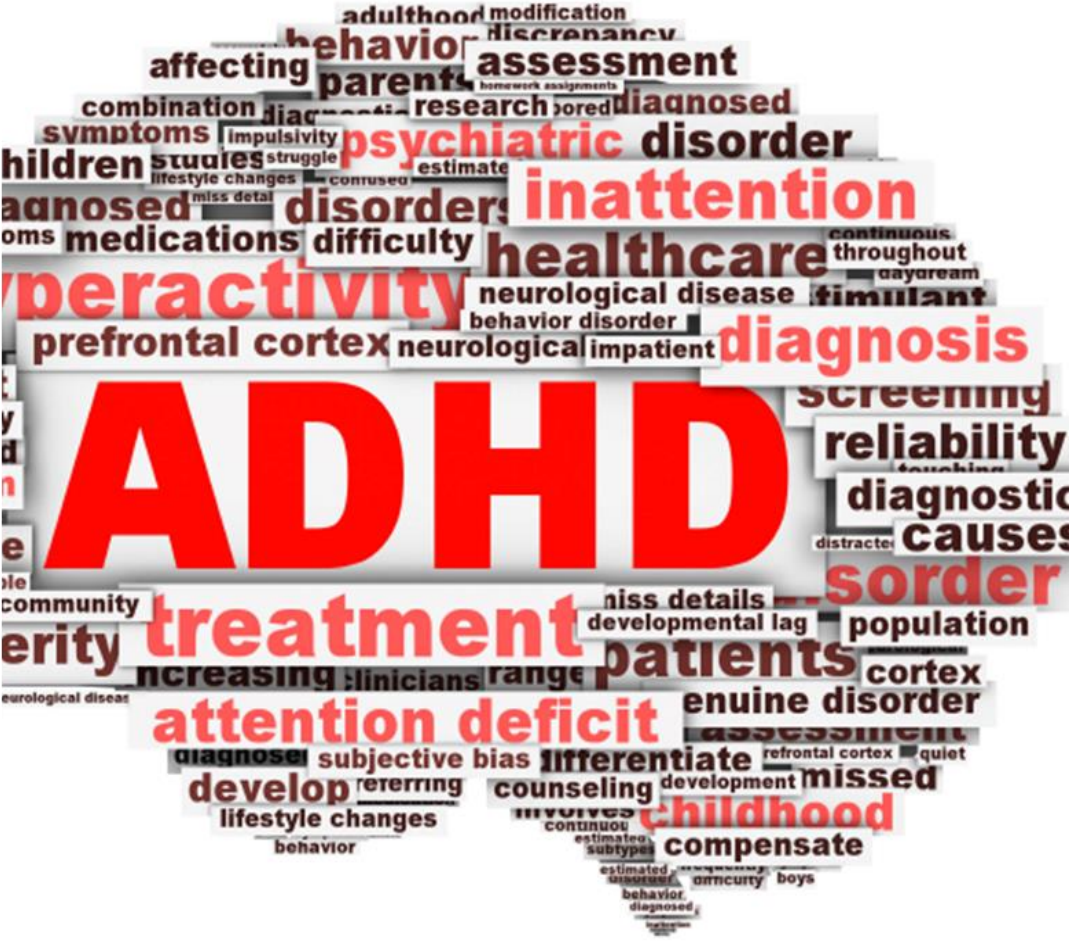
They are given Education, Medication and Coaching for Lifestyle Change – so should people with ADHD

ADHD cost Australia $20 billion in 2019

- 281,200 children and adolescents (aged 0-19) 533,300 adults (aged 20+) in Australia.
  - The total cost - $20.42 billion
  - Financial costs - $12.83 billion
  - Wellbeing losses - $7.59 billion.
- Productivity losses of ADHD associated with absenteeism, presenteeism, reduced workforce participation and premature mortality were $9.98 billion in 2019, or $17,483 for every Australian living with ADHD.
- Costs of crime and to the justice system of jurisdictions are estimated to be $307 million



If we consider the Deloitte data carefully, we will see that an estimate of 4% incidence in the Australian adult population is likely an underestimate.
If that is the case, how will all these people, 1.25 million roughly, be seen and treated?



As we progress through the webinar, consider
What is the appropriate role of GPs?
What are the barriers to filling that role?
How can we address those barriers?
We will revisit these questions at the end

Other costs of ADHD – suicide

The British Journal of Psychiatry

Risk of suicide attempts in adolescents and young adults with attention-deficit hyperactivity disorder: a nationwide longitudinal study

Part of: ADHD Collection

Published online by Cambridge University Press: **04 March 2018**

Kai-Lin Huang, Han-Ting Wei, Ju-Wei Hsu, Ya-Mei Bai, Tung-Ping Su, Cheng-Ta Li, Wei-Chen Lin, Shih-Jen Tsai, Wen-Han Chang and Tzeng-Ji Chen ...Show all authors

Show author details

Article | Figures | Supplementary materials | eLetters | Metrics

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Article contents

Abstract

Background

Attention-deficit hyperactivity disorder (ADHD) increases the risk of suicidal behaviours through psychiatric comorbidities; however, a significant direct association has not been observed between ADHD and suicide attempts.

Aims

To evaluate the risk of suicide attempt in adolescents and young adults with ADHD.

Result:

ADHD was an independent risk factor for any suicide attempt (hazard ratio = 3.84, 95% CI = 3.19–4.62) and repeated suicide attempts (hazard ratio = 6.52, 95% CI = 4.46–9.53).

Long-term methylphenidate treatment was associated with a significantly decreased risk of repeated suicide attempts in men (hazard ratio = 0.46, 95% CI = 0.22–0.97).

What is ADHD according to DSM 5

1. **≥5 symptoms of inattention** and/or **≥5 symptoms of hyperactivity/impulsivity** for **≥6 months** to a degree that is inconsistent with the developmental level and negatively impacts social and academic/occupational activities.
2. Several symptoms (inattentive or hyperactive/impulsive) were present **before the age of 12 years**.
3. Several symptoms (inattentive or hyperactive/impulsive) must be **present in ≥2 settings** (eg, at home, school, or work; with friends or relatives; in other activities).
4. Symptoms **interfere with** of social, academic, or occupational **functioning**.
5. Symptoms are **not better explained by another mental disorder** (eg, mood disorder, anxiety disorder, dissociative disorder, personality disorder, substance intoxication, or withdrawal).

Core symptoms and subtypes in adults

ADHD

- Inattention
- Hyperactivity
- Impulsivity

- Inattentive subtype (ADD) — 30%

- Combined subtype ADHD — 60%
- Hyperactive-impulsive subtype — 10%

Inattention actually "Dysregulation of Attention"

Your brain is so busy

- Easily distracted
- Can't concentrate
- Can't pay attention
- Can't listen or remember
- Disorganised and overwhelmed

But you can hyperfocus

- When the topic is exciting, frightening, urgent or emotional, with a deadline, you hyperfocus

So sometimes you feel really bright

- and other times, for no reason, you feel *lazy or stupid*?

Hyperactivity actually "Dysregulation of Movement"

You always feel restless

- Fidgety
- Can't easily sit still
- Driven by a motor
- Always talking

And this irritates others

- but you can't stop it

But you feel really normal when you are moving

Impulsivity actually "Dysregulation of Impulses"

You can't wait your turn

You often interrupt

- Because you care
- You'd forget the first idea if you waited for the next one
- And you knew what they were going to say

You blurt out things

- that you regret later

You make impulsive decisions

- that you regret later

You are accident-prone

- And you regret that too

Emotional Dysregulation

Not on the diagnostic list

- Because occurs in other disorders
  - But causes much grief

Your emotions are

- Hypersensitive
- Out of proportion to the trigger
  - Are harder to manage

Examples are extreme

- Anger, impatience, rage
  - Embarrassment
- Rejection Sensitivity Dysphoria
  - Social anxiety, panic
    - Insensitivity

Gender differences

Young et al. BMC Psychiatry (2020) 20:404
https://doi.org/10.1186/s12888-020-02707-9

BMC Psychiatry

RESEARCH ARTICLE Open Access

Females with ADHD: An expert consensus statement taking a lifespan approach providing guidance for the identification and treatment of attention-deficit/ hyperactivity disorder in girls and women

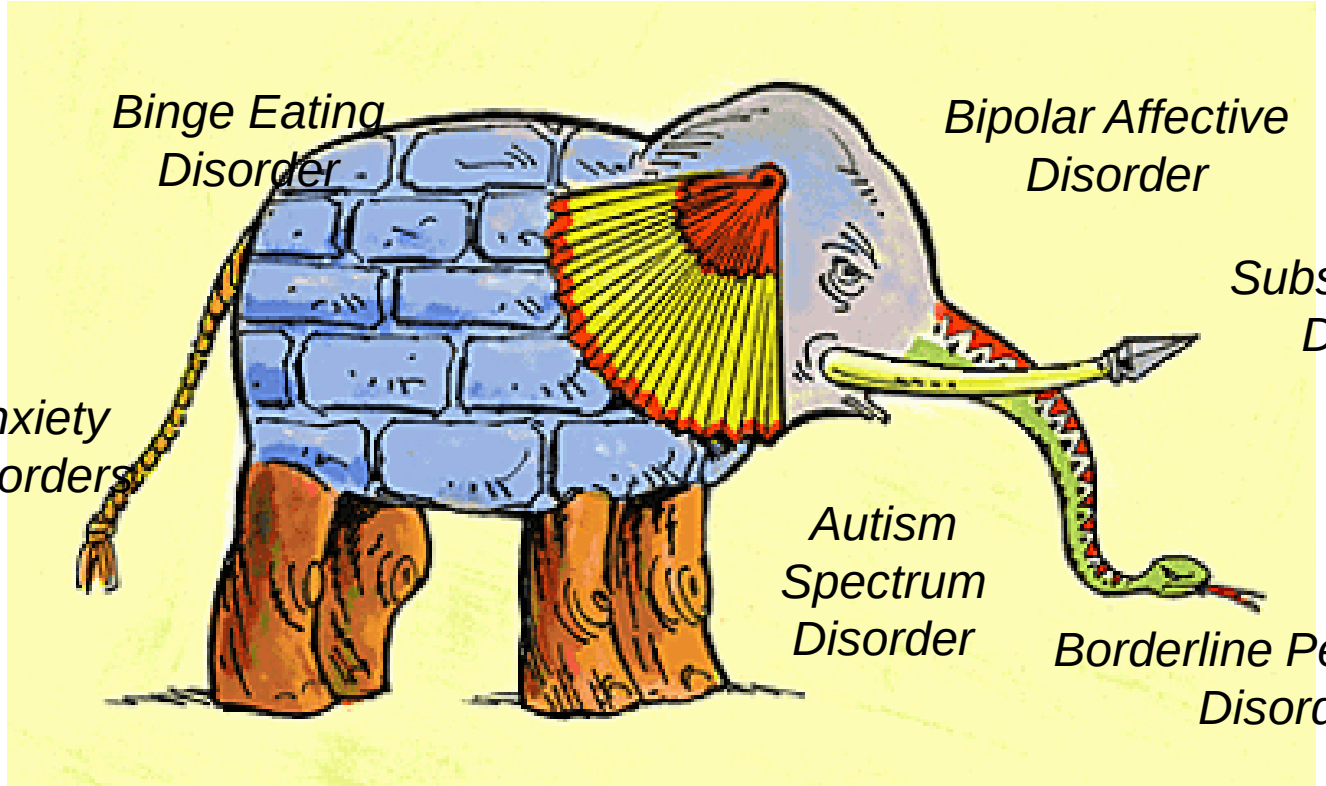
Susan Young[1,2*], Nicoletta Adamo[3,4], Bryndís Björk Ásgeirsdóttir[2], Polly Branney[5], Michelle Beckett[6], William Colley[7], Sally Cubbin[8], Quinton Deeley[9,10], Emad Farrag[11], Gisli Gudjonsson[2,12], Peter Hill[13], Jack Hollingdale[14], Ozge Kilic[15], Tony Lloyd[16], Peter Mason[17], Eleni Paliokosta[18], Sri Perecherla[19], Jane Sedgwick[3,20], Caroline Skirrow[21,22], Kevin Tierney[23], Kobus van Rensburg[24] and Emma Woodhouse[10,25]

Conclusions:

- It is important to move away from the prevalent perspective that ADHD is a behavioural disorder and attend to the more subtle and/or internalised presentation that is common in females.
- It is essential to adopt a lifespan model of care to support the complex transitions experienced by females that occur in parallel to change in clinical presentation and social circumstances.
- Treatment with pharmacological and psychological interventions is expected to have a positive impact leading to increased productivity, decreased resource utilization and most importantly, improved long-term outcomes for girls and women

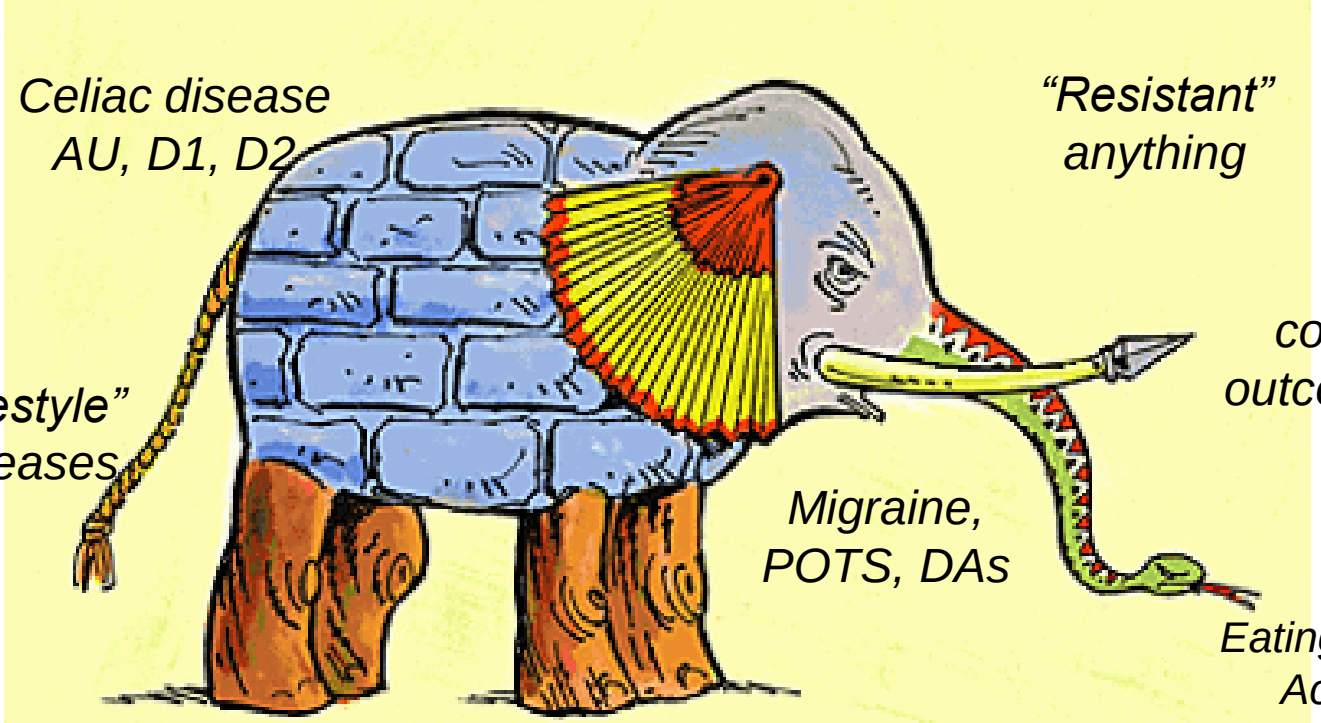
Why is the diagnosis of ADHD so often missed in Adults?

Because it is the Elephant in the Room, camouflaged in plain sight



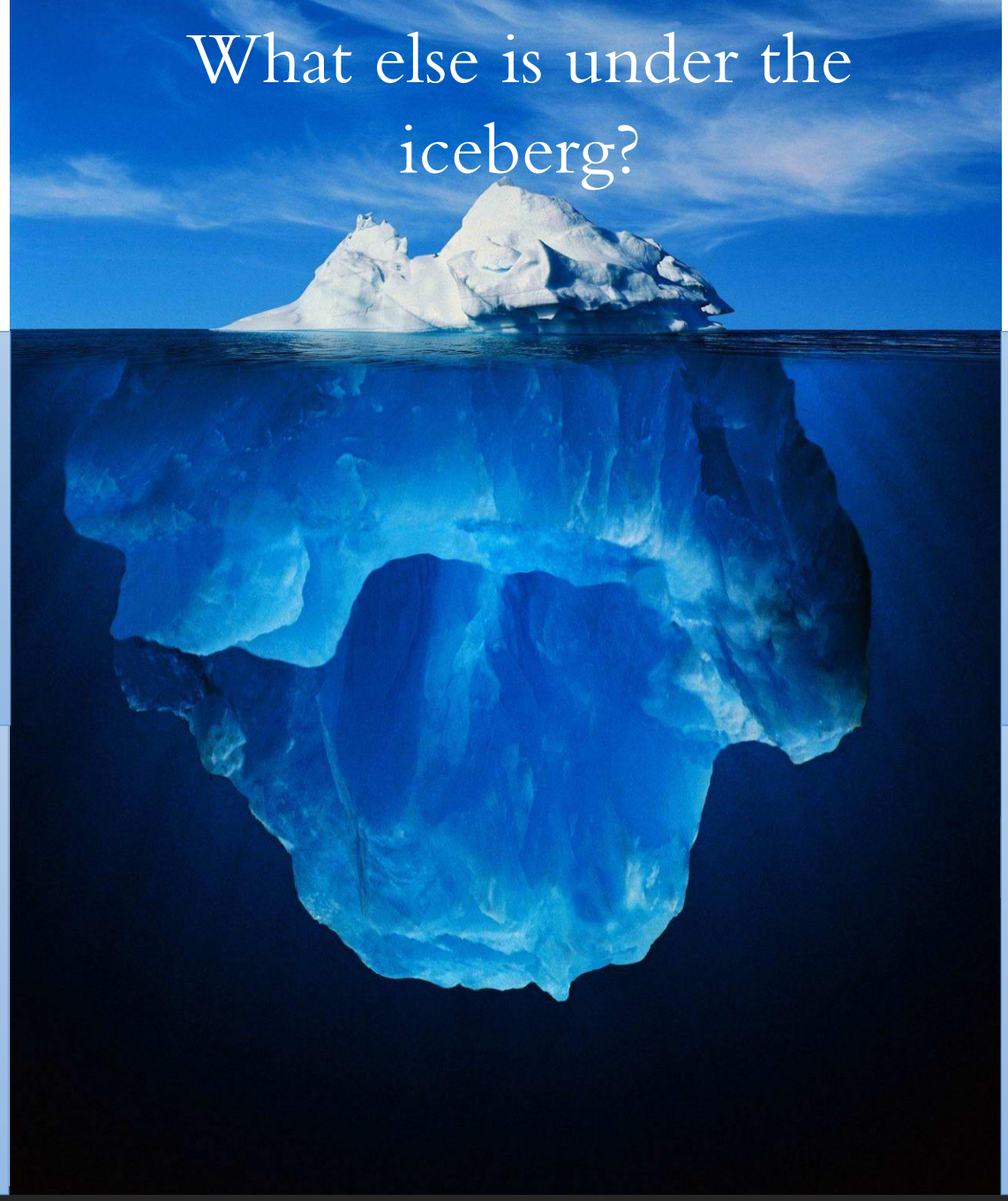
Six blind men who had never met an Elephant described a Rope, a Wall, a Tree trunk, a Spear, a Fan and a Snake.

What labels could we attach to presentations in GP land? Refer "Faraone" in Resources



Six blind men who had never met an Elephant described a Rope, a Wall, a Tree trunk, a Spear, a Fan and a Snake.

What else is under the iceberg?



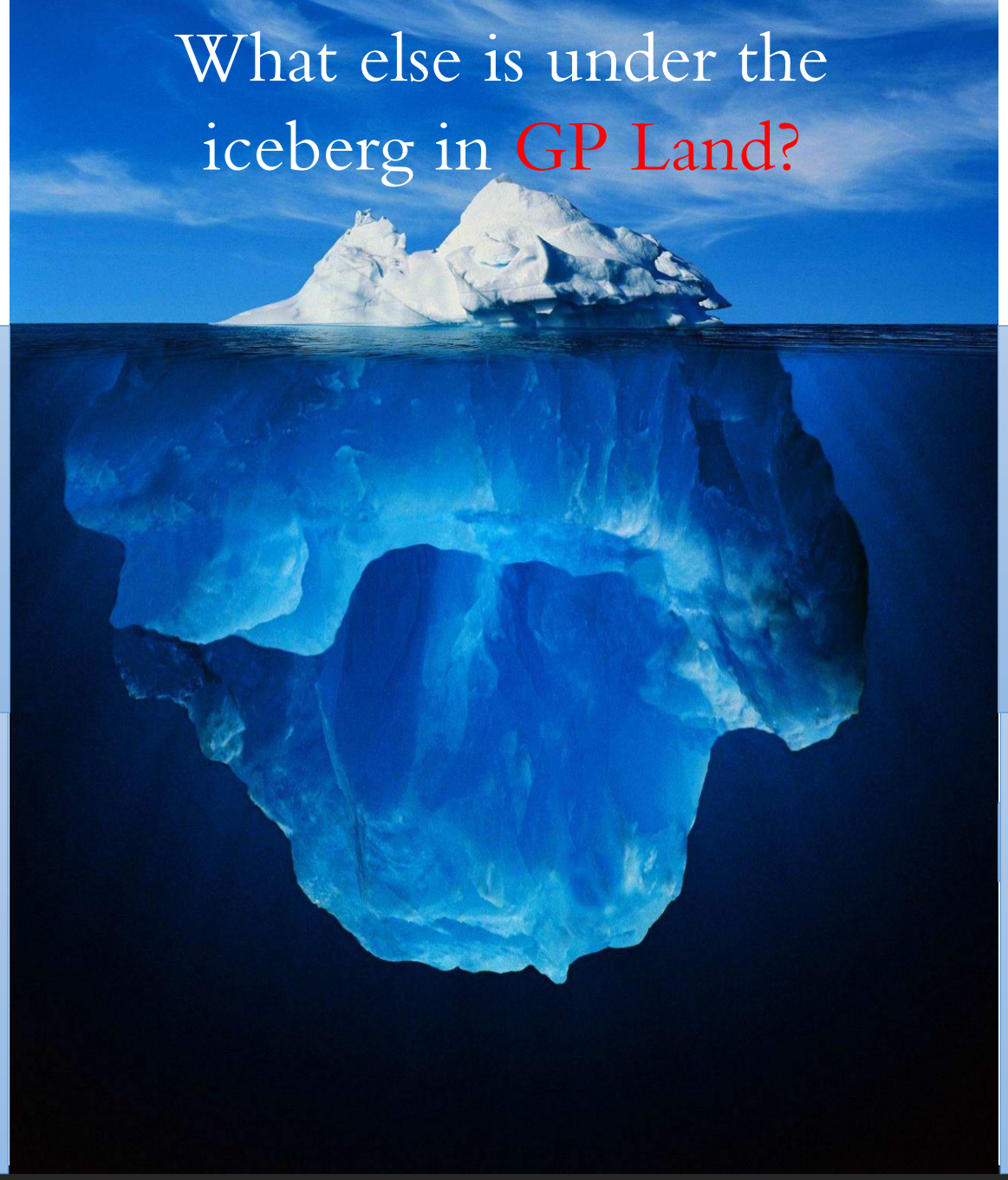
Self esteem issues
Lack of confidence
Shame
Embarrassment

Addictions
Impulsive behaviours
Obesity
Metabolic syndrome
Skills deficits

Relationship issues in intimate and social / work relationships
Parent/child conflicts

Lack of career progression
unemployment
Financial troubles
Legal troubles
Centrelink

What else is under the iceberg in GP Land?



Shame, Lack of Interoception, Inability to discern/articulate what is wrong:

Complicating our ability to form rapport, imagine, and understand the problems

GPs:

Busy, pressurised, time poor

Look, Think : Take a step back:

Ask yourself, could it be ADHD?

Ask the patient to come back!

Do an ASRS!

Chaotic / Poor executive functioning

Complicating our ability to

See, Engage, Formulate and Treat

OVERALL:

Reduced life expectancy

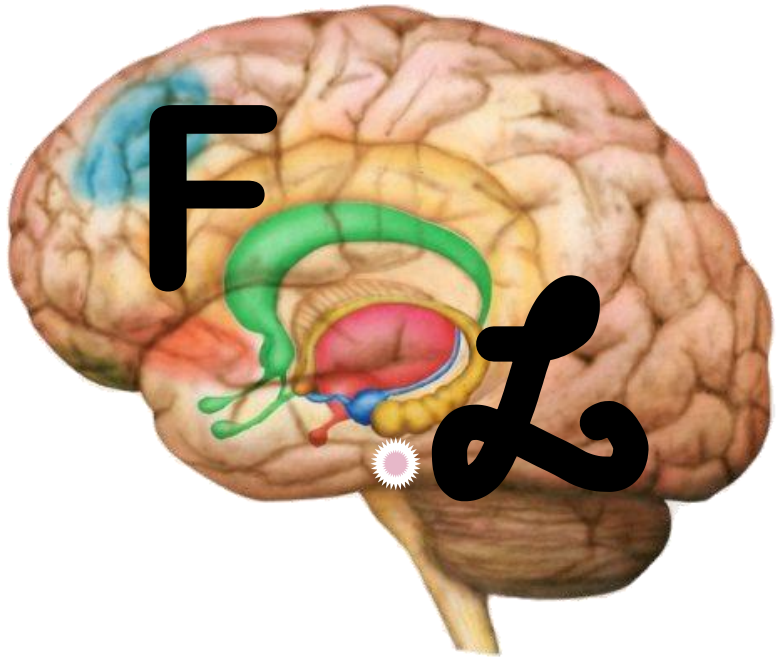
Massively reduced quality of life

Refer “Barkley” in Resources

“Parent” and “Child” parts of the brain

PARENT = FRONTAL LOBE

Conscious awareness
“We” = 2 different perspectives
Calm thinking
Problem solving, Peace
Long-term survival
Chosen thoughts
Time
Executive, Planning
Judgement, Error correction
Self-Awareness Mirror
Calms Limbic Activity

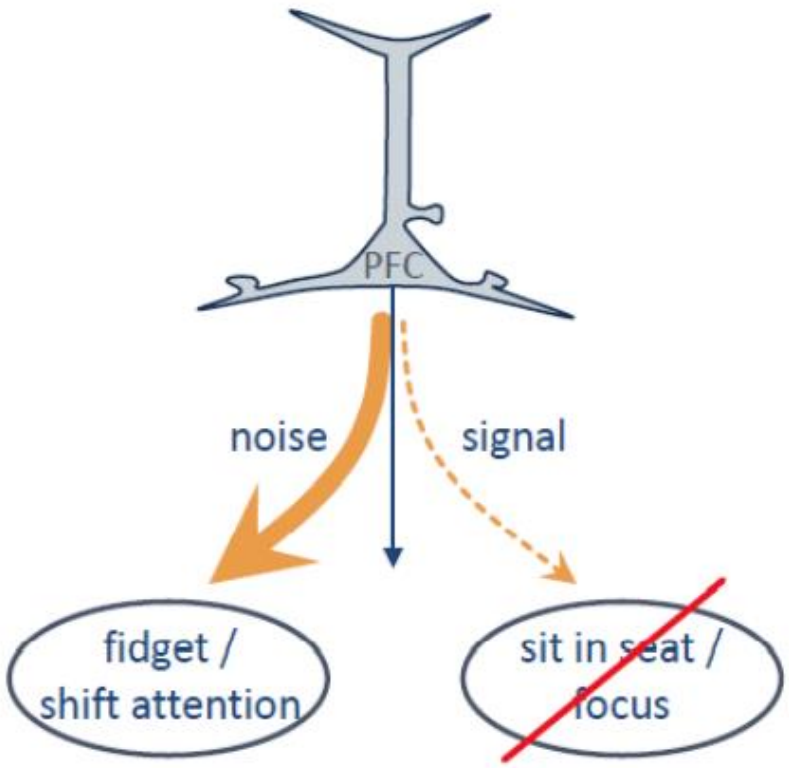


CHILD = LIMBIC SYSTEM

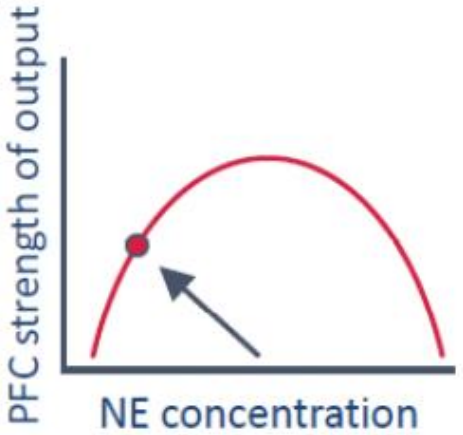
Subconscious awareness
Me, only! Now!
Fright/Flight/Fight/Freeze/Frolic
Problem noting, War
Short-term survival
Automatic thoughts
Timelessness
Feelings
Habits
Desires
Can overwhelm Frontal Lobe

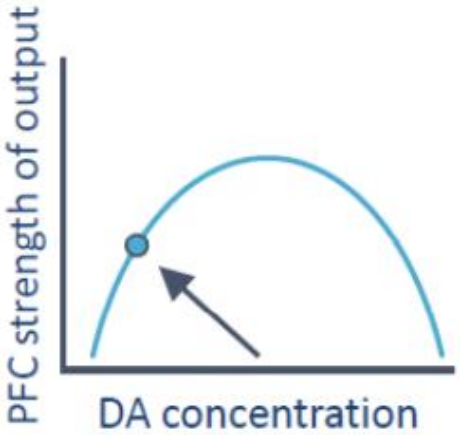
Neurobiological mechanism of ADHD

Importance of NE and DA levels in the PFC in ADHD



ADHD: Hypothetically low signals and/or high noise in PFC





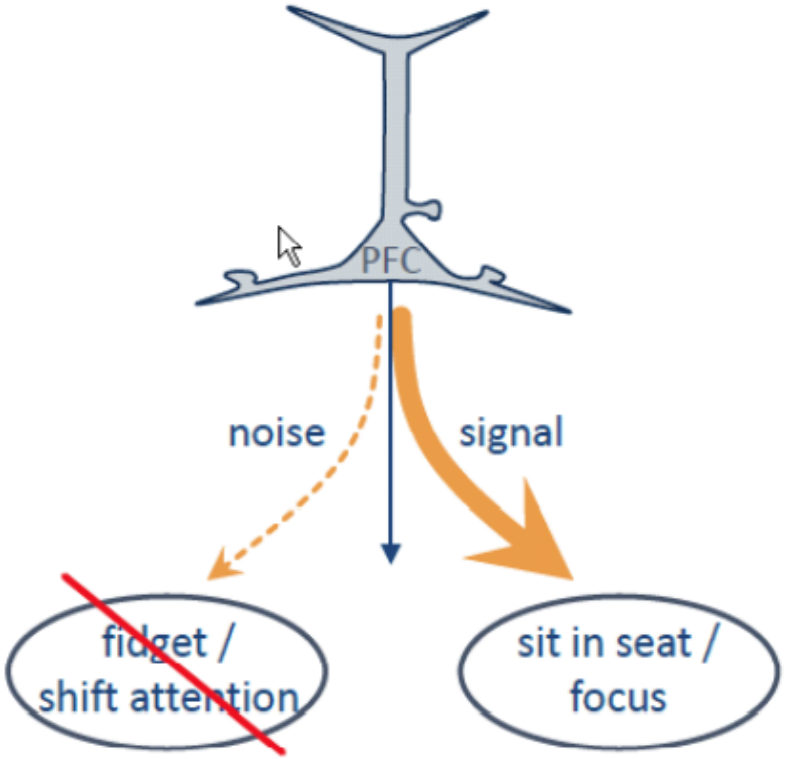
NE low - signal reduced
DA low - noise increased

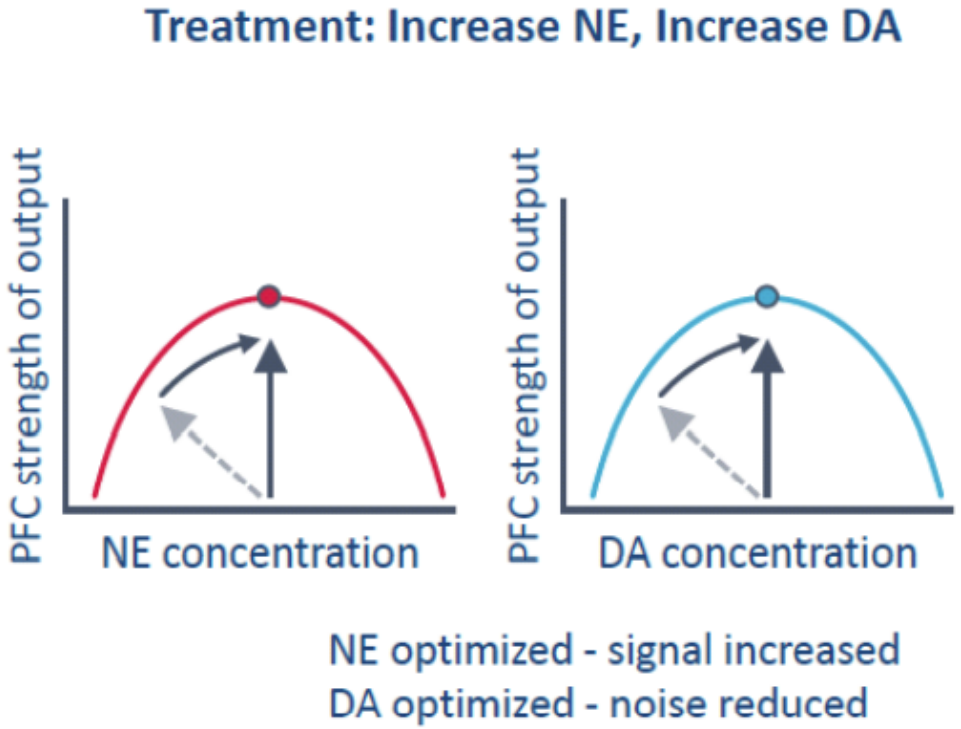
Stahl and Mignon. Stahl's Illustrated Attention Deficit Hyperactivity Disorder. Cambridge University Press 2009.

Neurobiological mechanism of ADHD

Importance of NE and DA levels in the PFC in ADHD

This is the basis for psychostimulants mode of action





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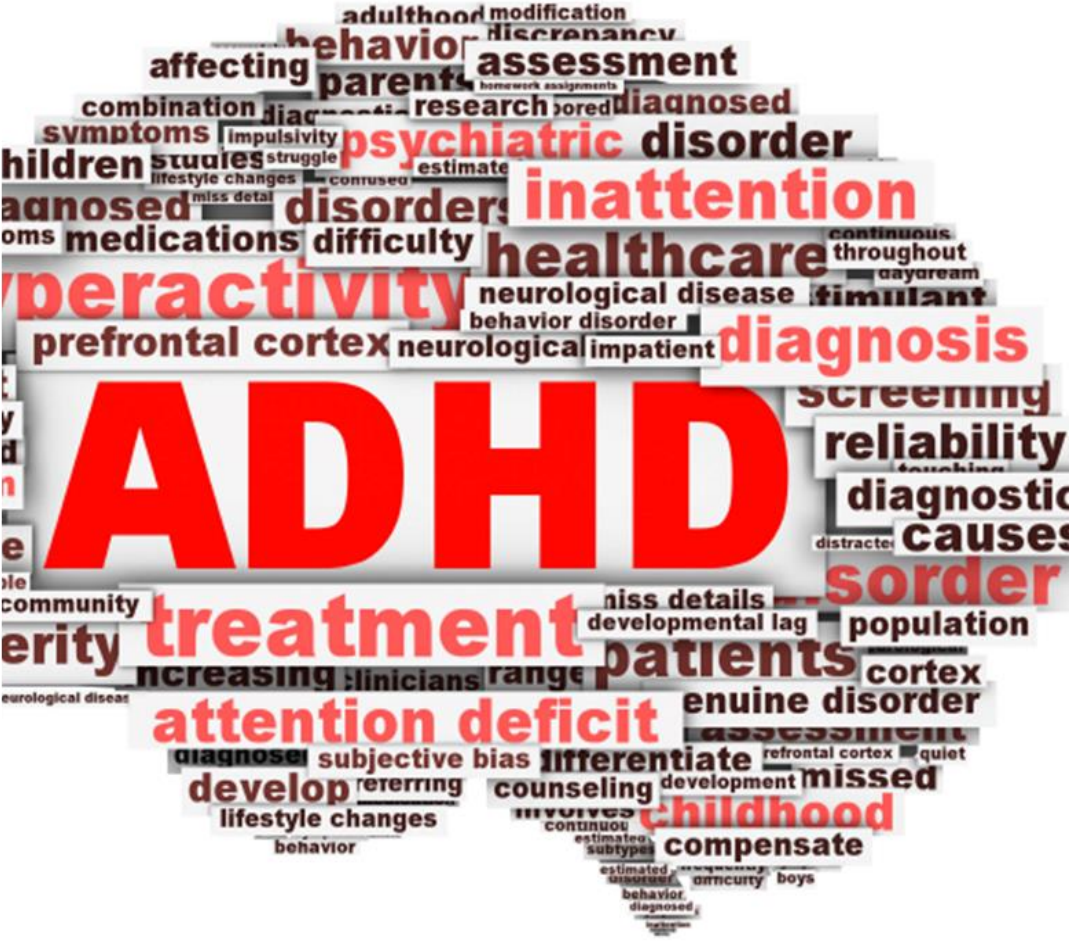
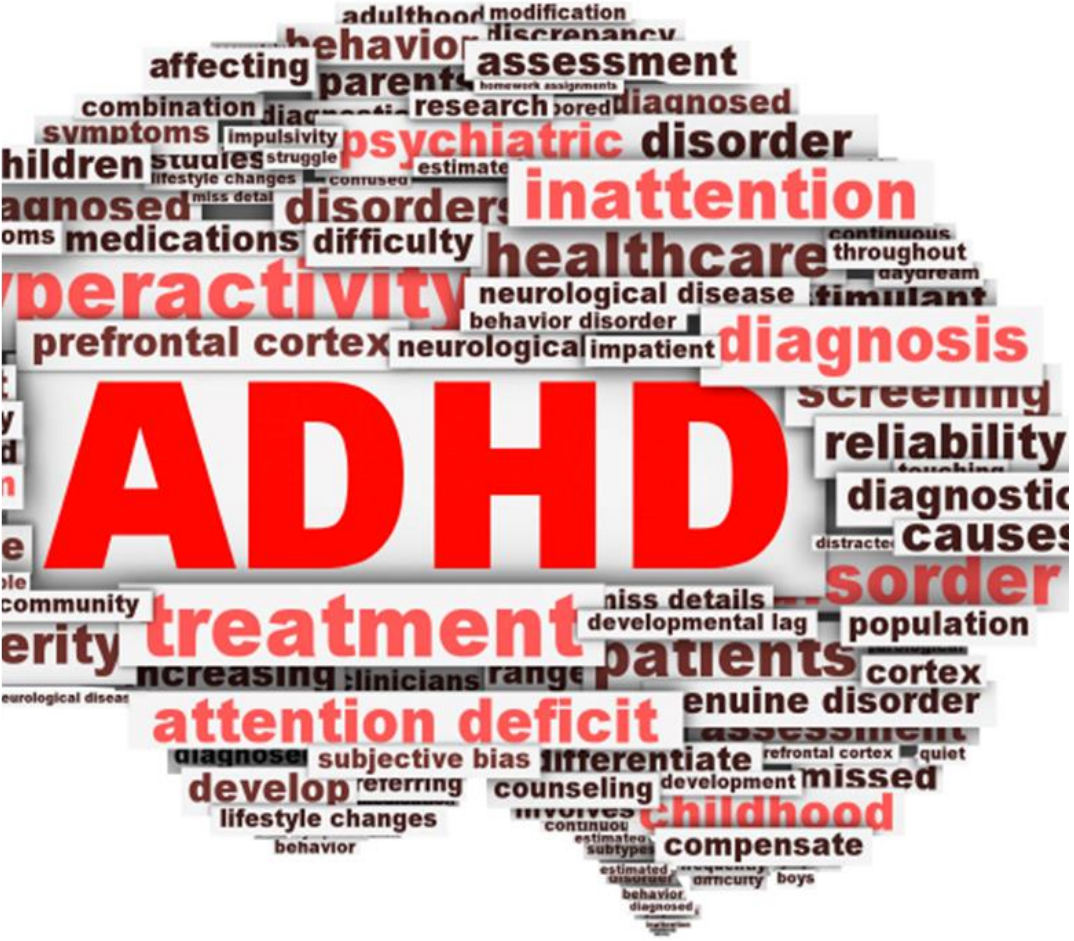


GP Role: Now that we have a (brief) background, Public Health view, understanding the seriousness and prevalence of the disorder, consequences, neurobiological basis…

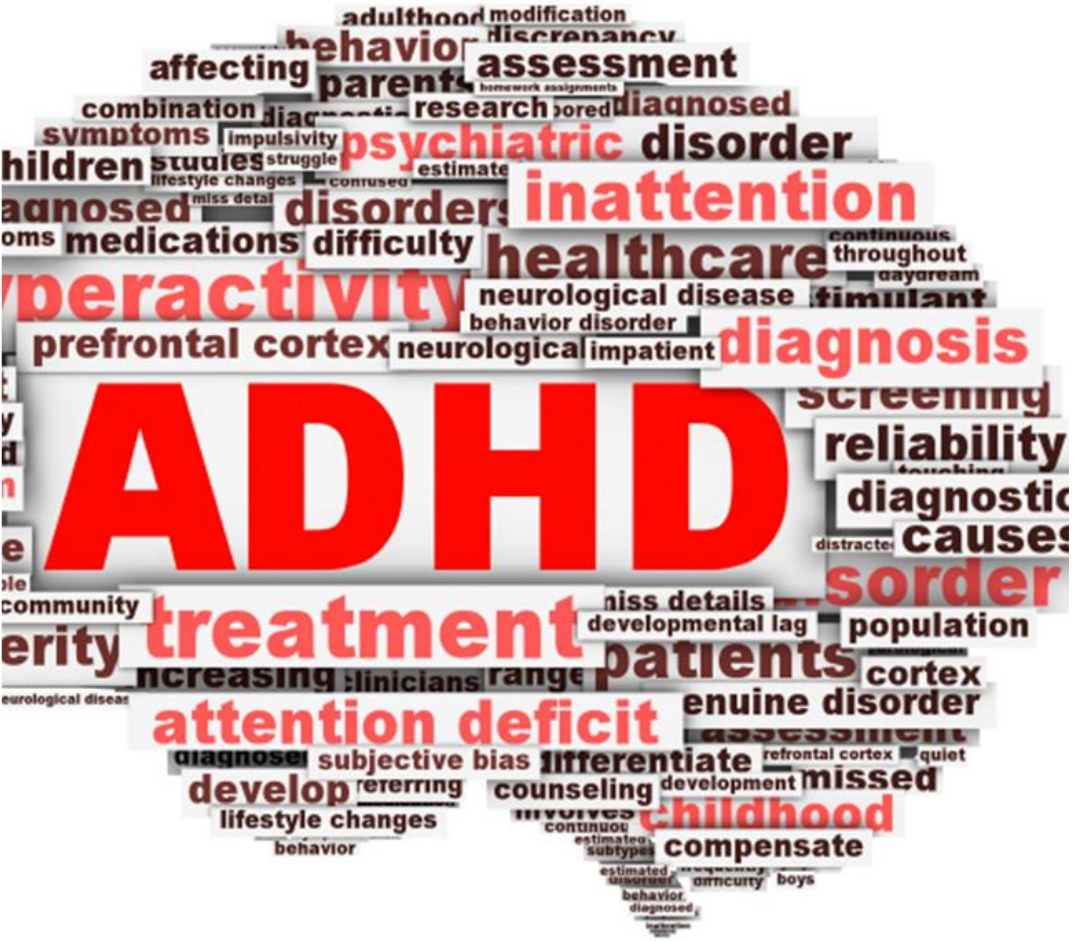


GP Role: Overview

Prior to the patient seeing a psychiatrist

What do we GPs need to do? What can we do?

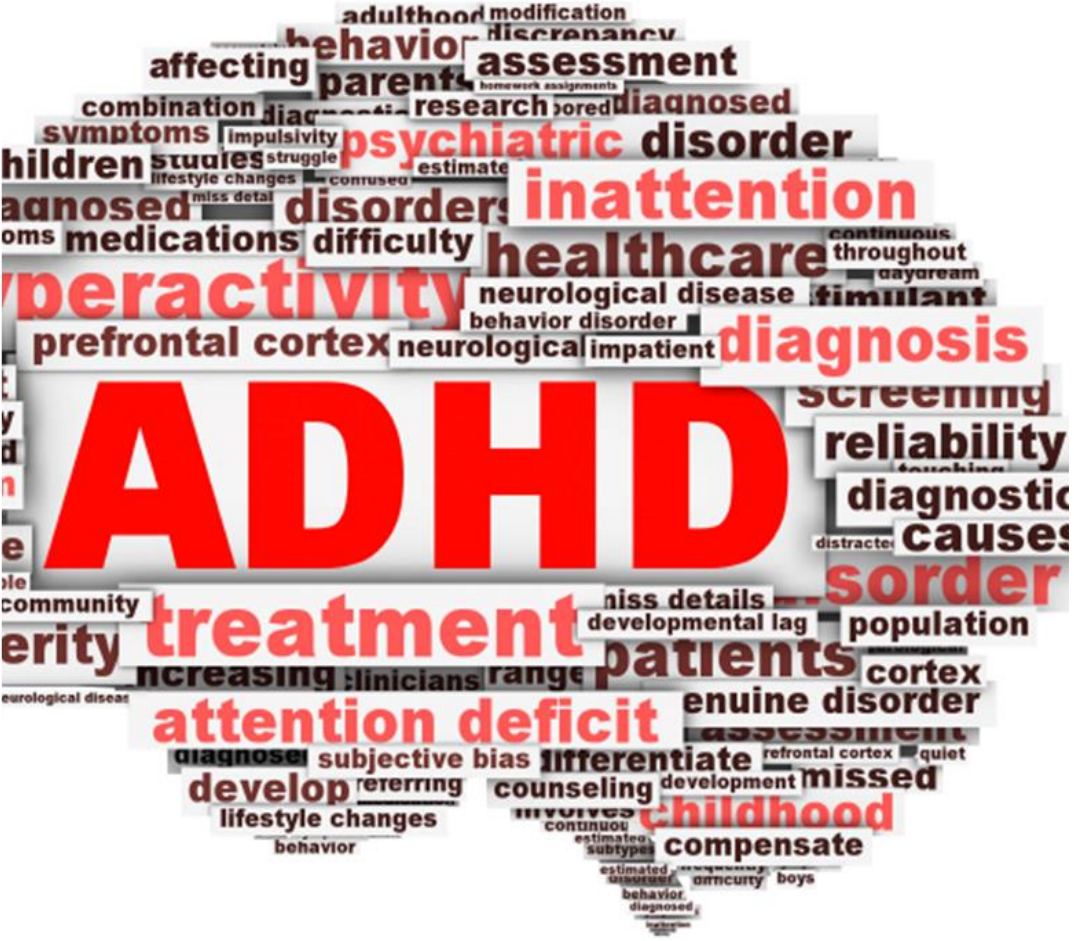
This, usefully, can be done while we are waiting for an appointment…..



GP Roles:

1. Most importantly- Ask yourself: "Could it be ADHD?"

2. Schedule an elective appointment (make sure the patient gets reminders++ etc)

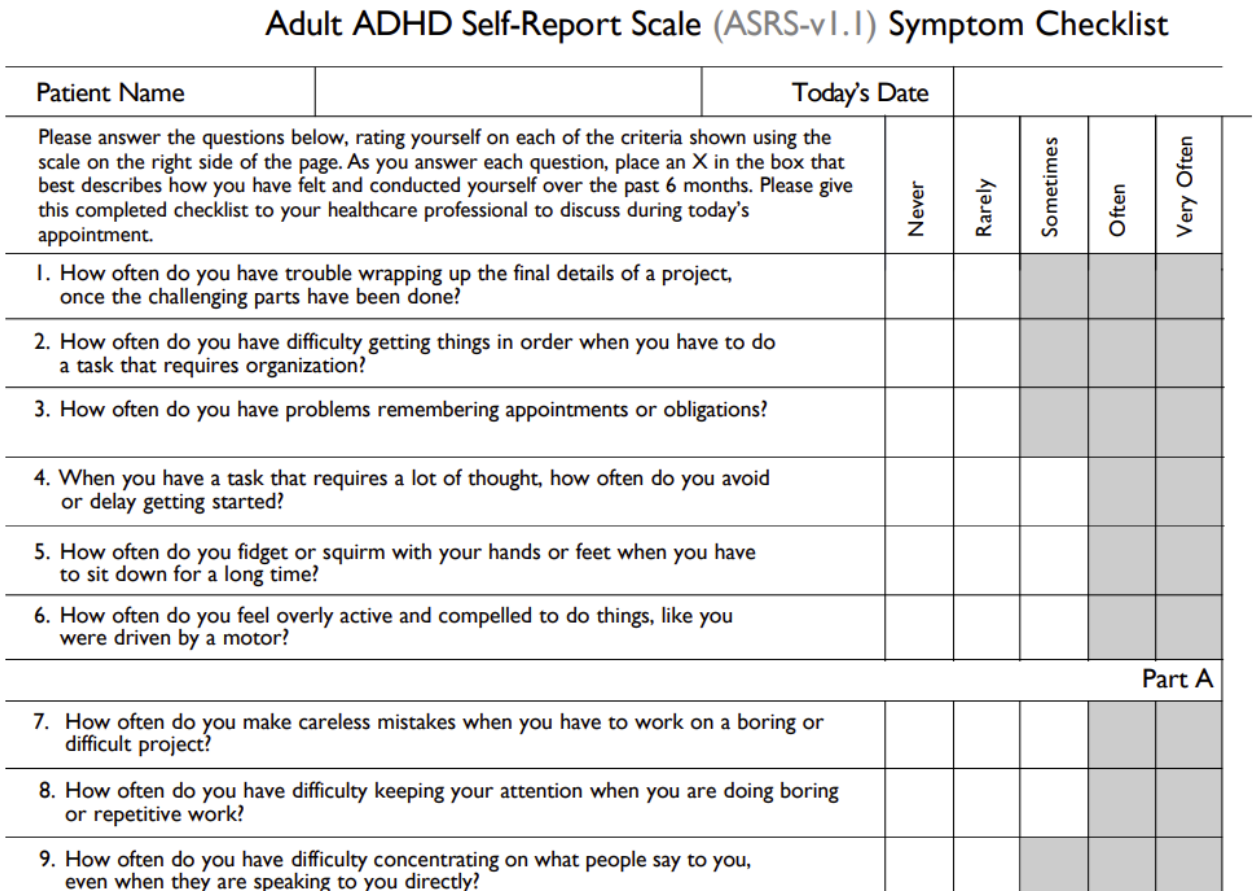


GP Roles: *(See Resources)*

3. Administer Screening and Assessment Questionnaires

- ASRS (Screener)
- Jasper Goldberg(ED Screener)
- DIVA(Validated assessment tool)

Screening tools in GP practice ASRS

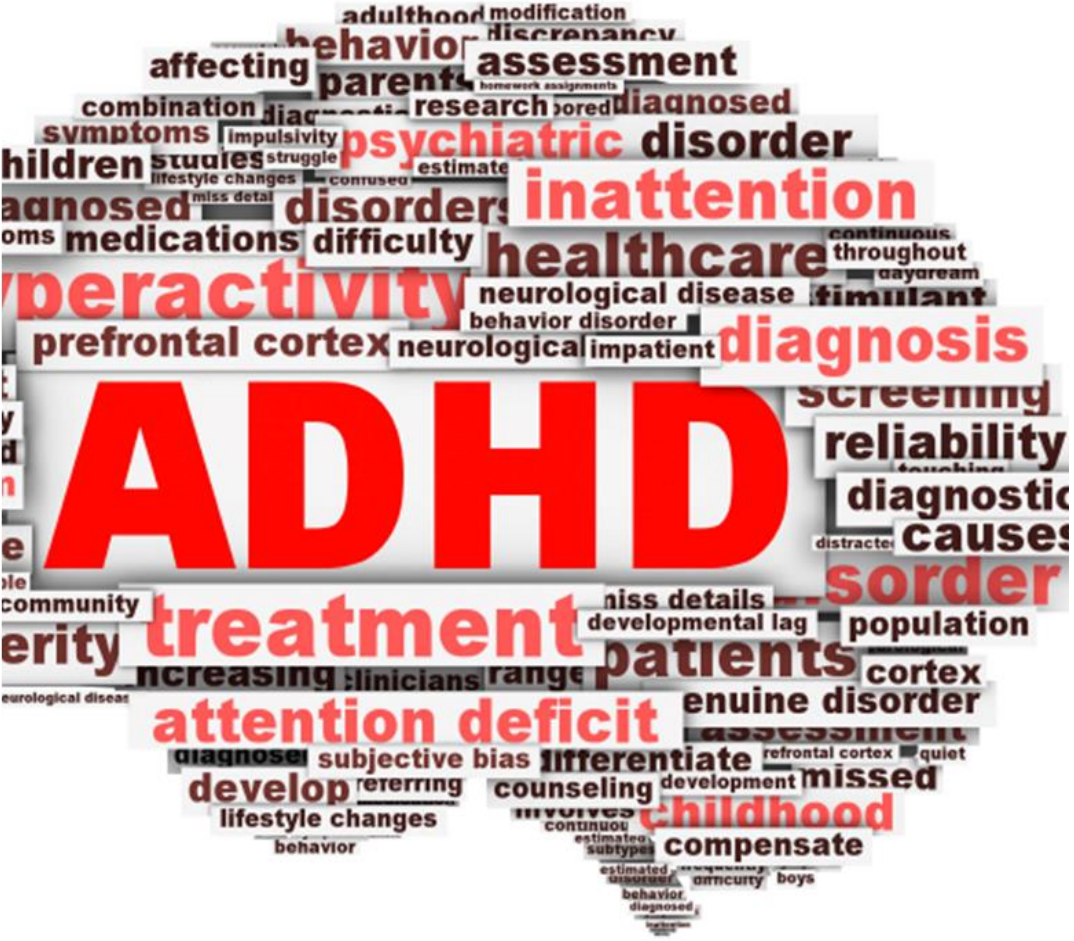


Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

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

Part A: 4/6 strongly suggestive
Part B: Confirmatory
NOTE: Design Fault
and MANY FALSE NEGATIVES
!

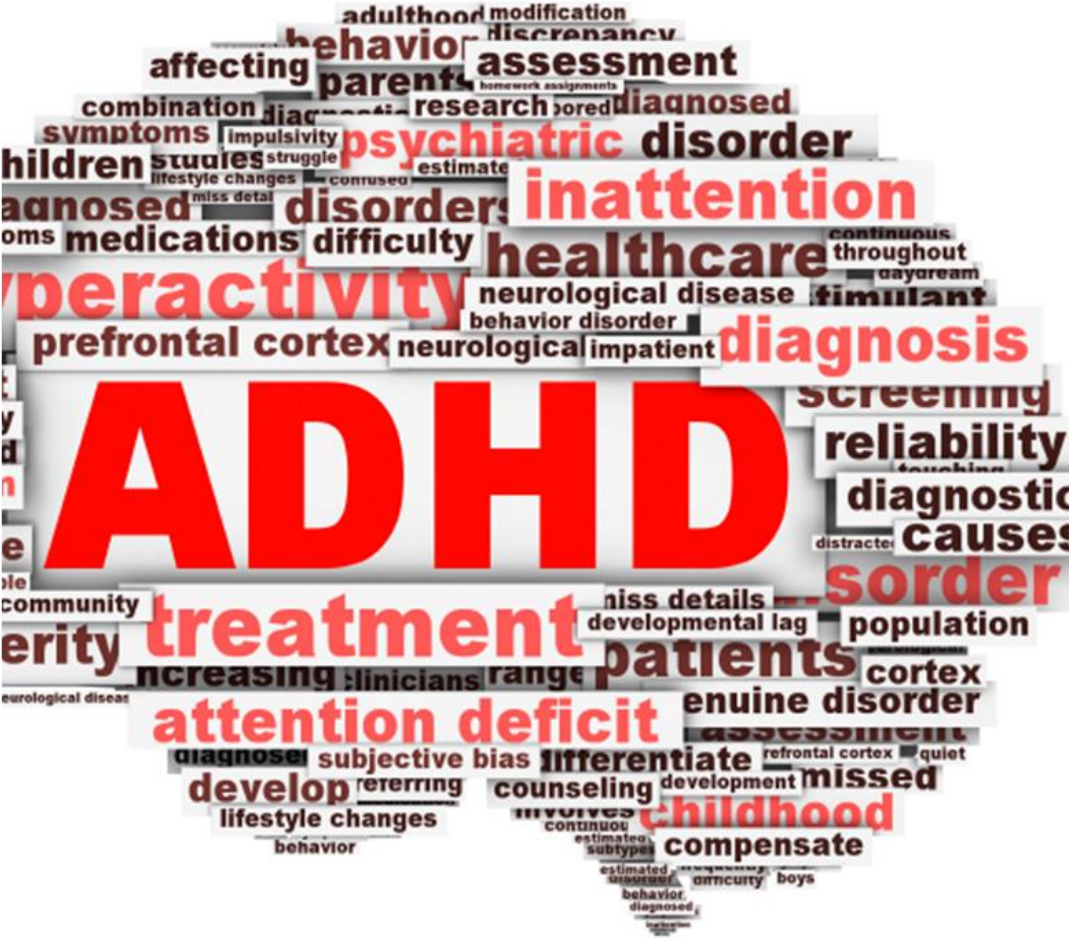
More than 14 out of 24 = maybe ADHD



GP Roles:

4. Full history including:

- Developmental Hx
- Exclude ABI, other explanations
- Mandatory to meet DSM 5 Criteria:
- Get Third party corroboration



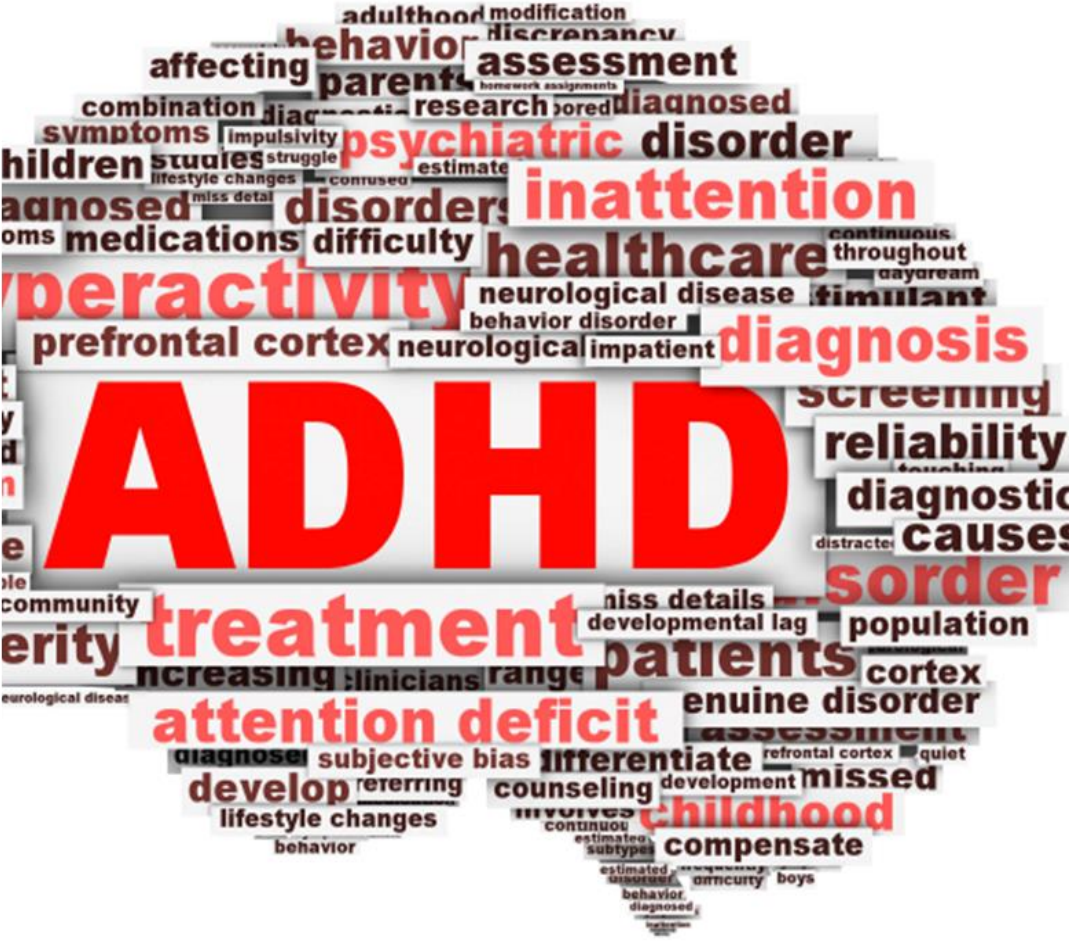
GP Roles:

5. Examine for

- Co-morbidities
- Co-occurring
- Consequences

Refer: Faraone et al in Resources

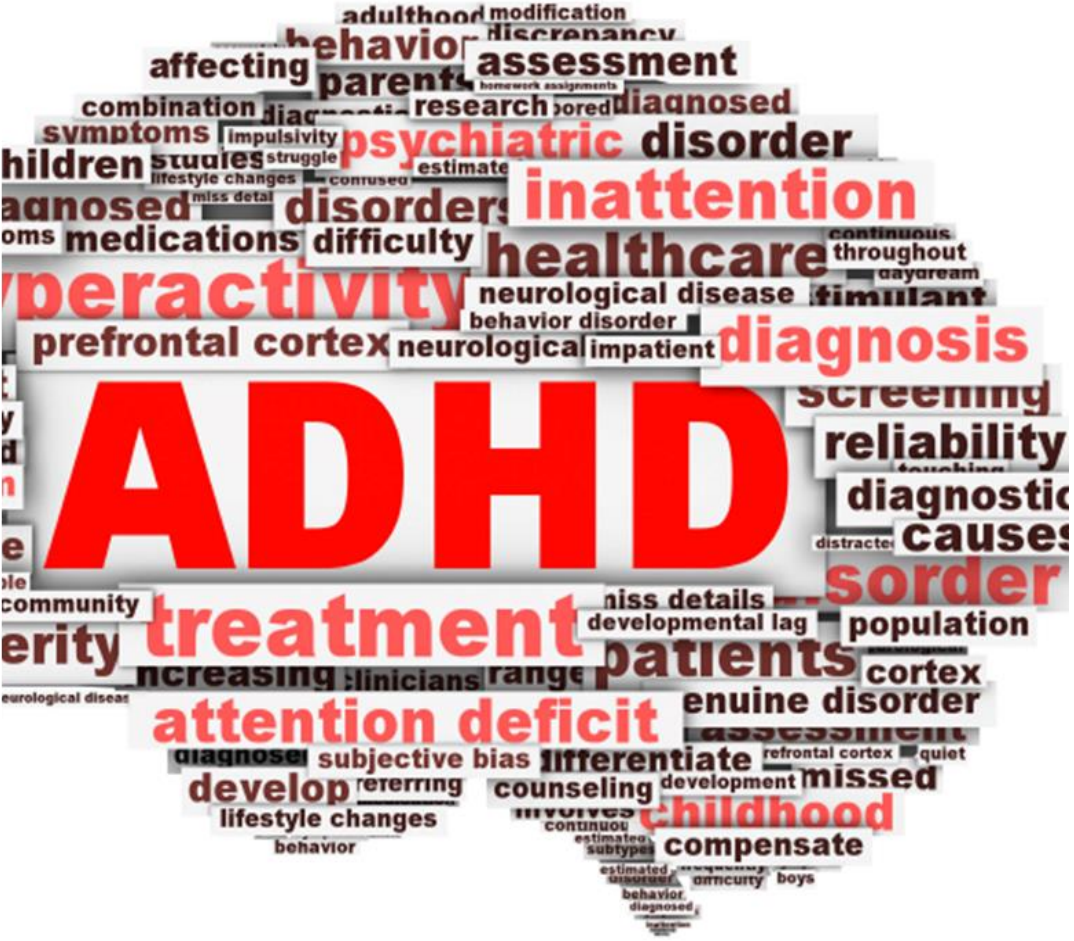
RACGP Specific Interests



GP Roles:

6. Full Physical check up

- Identify Neglected Conditions
- Investigate for and treat the 3 C's

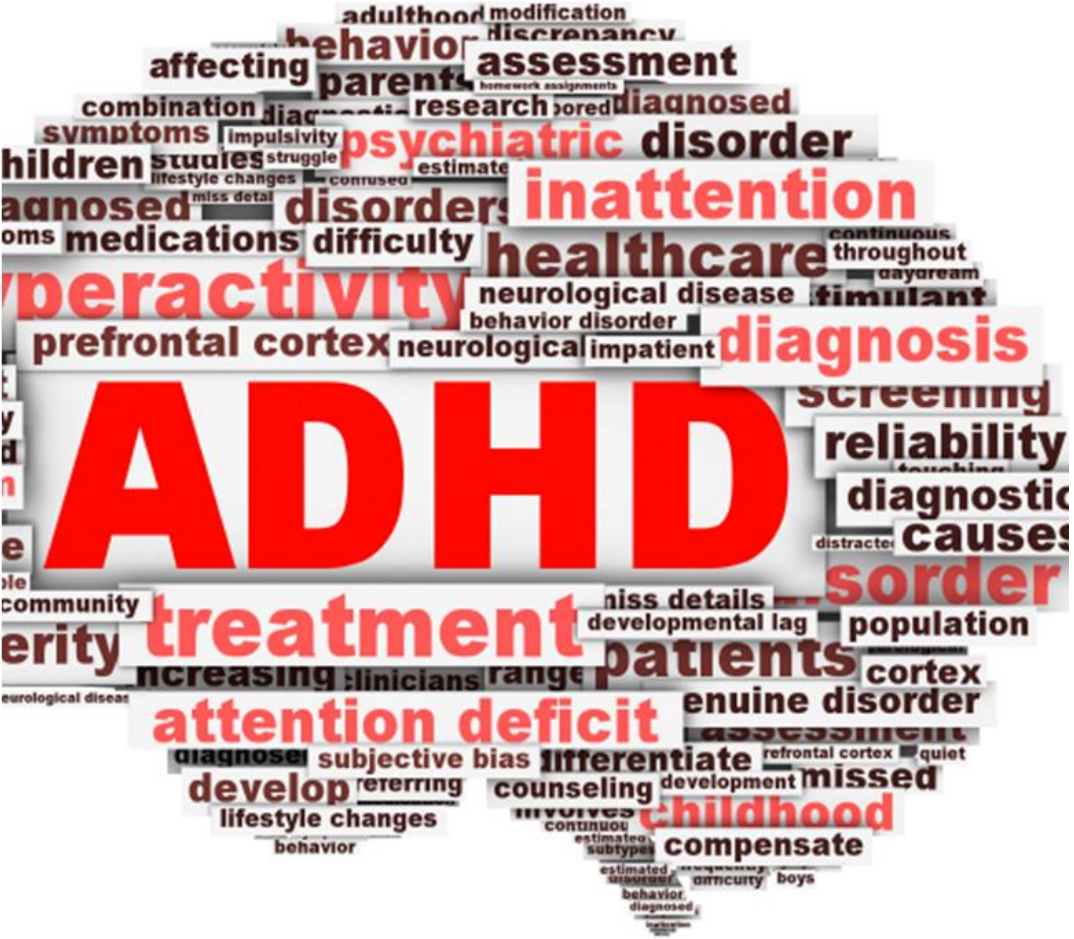


GP Roles:

7. Any Contra-Indications for Psychostimulants?

- Identify
- Diagnose
- Treat(Pre referral)

See Resources

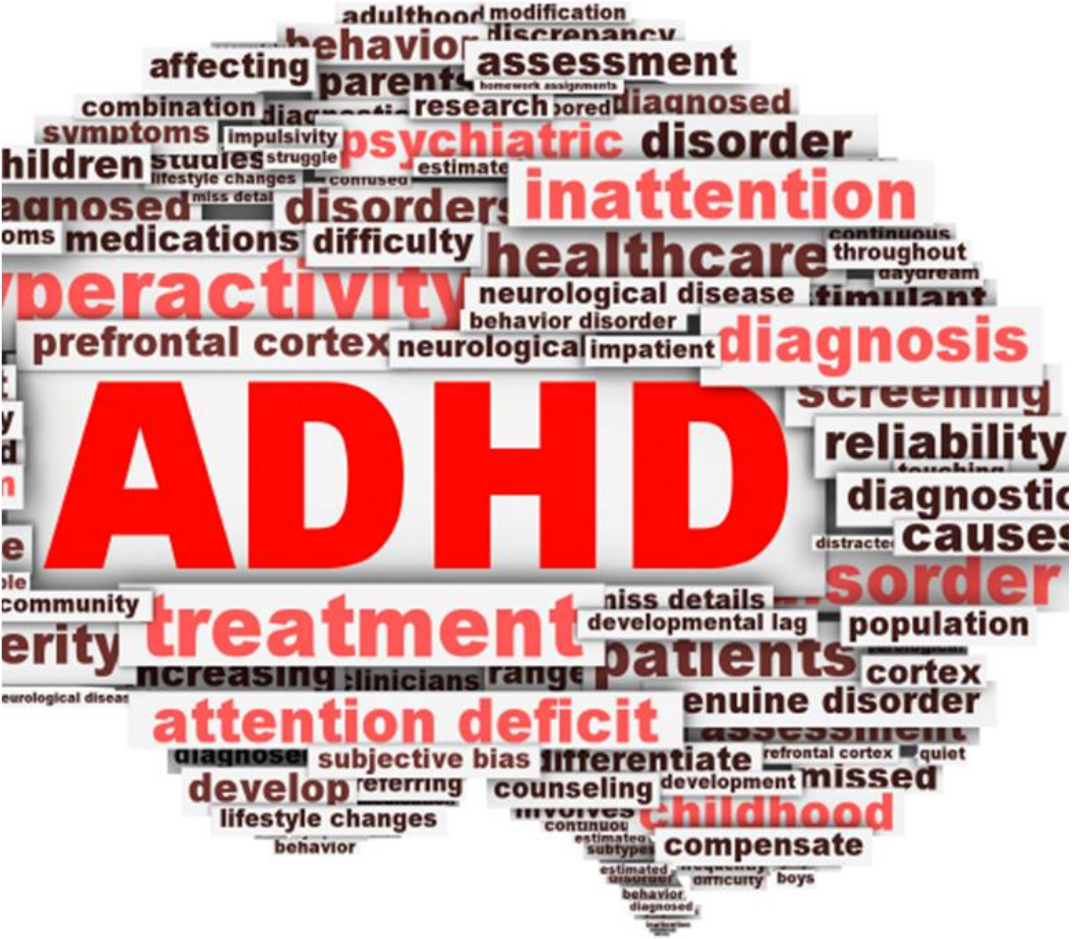


GP Roles:

8. Carefully Review MHA and CPs

Identify conditions mandating expert Consultant Care Pre ADHD and /or Ongoing

RACGP Specific Interests



RACGP Specific Interests

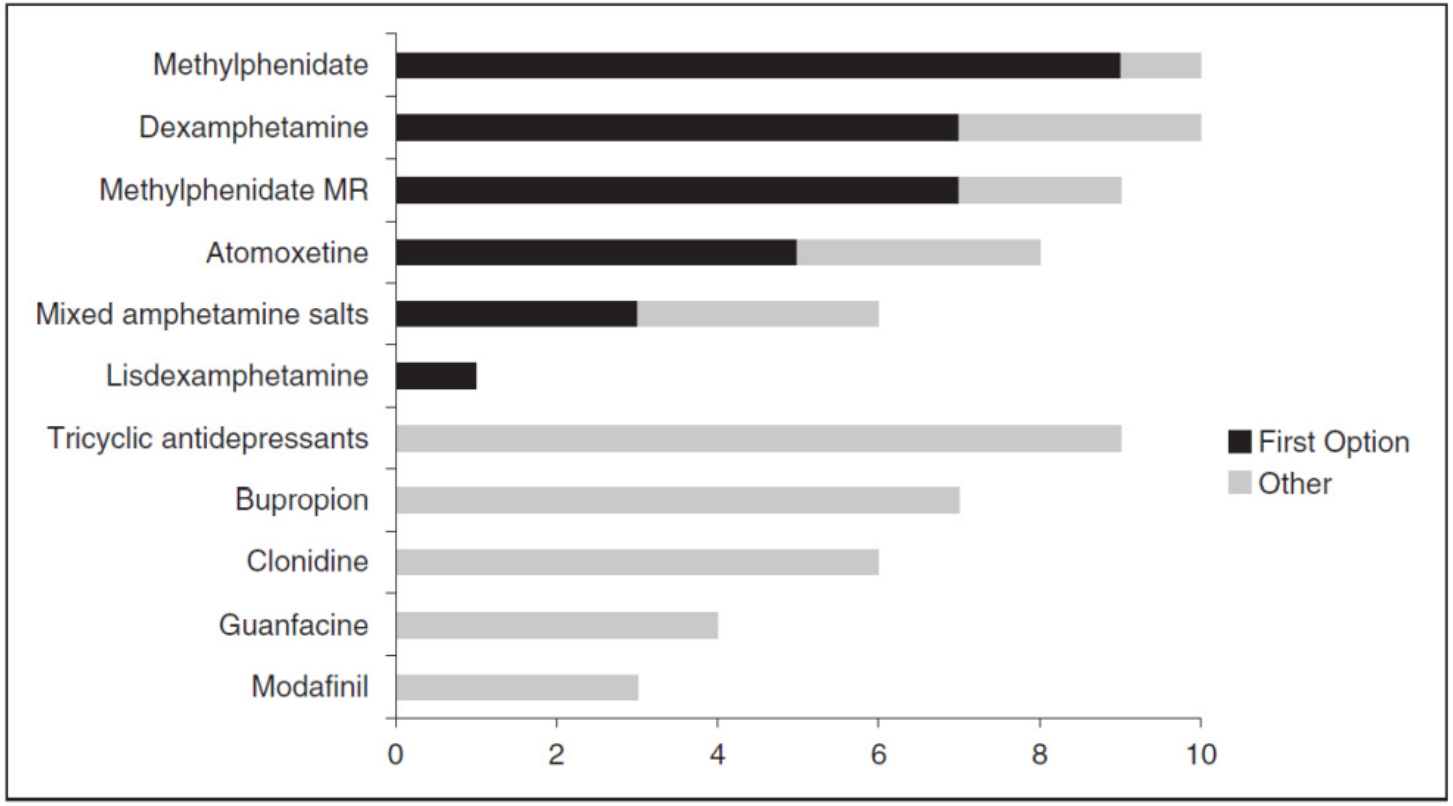
Treatment of Adult ADHD

1. Medication

   first option

   stimulants

2. Multimodal



Seixas et al. Systematic review of national and international guidelines on attention-deficit hyperactivity disorder. J Psychopharmacol, 26(6):753-65, 2012.

Meta-analyses of medication effectiveness

Cochrane

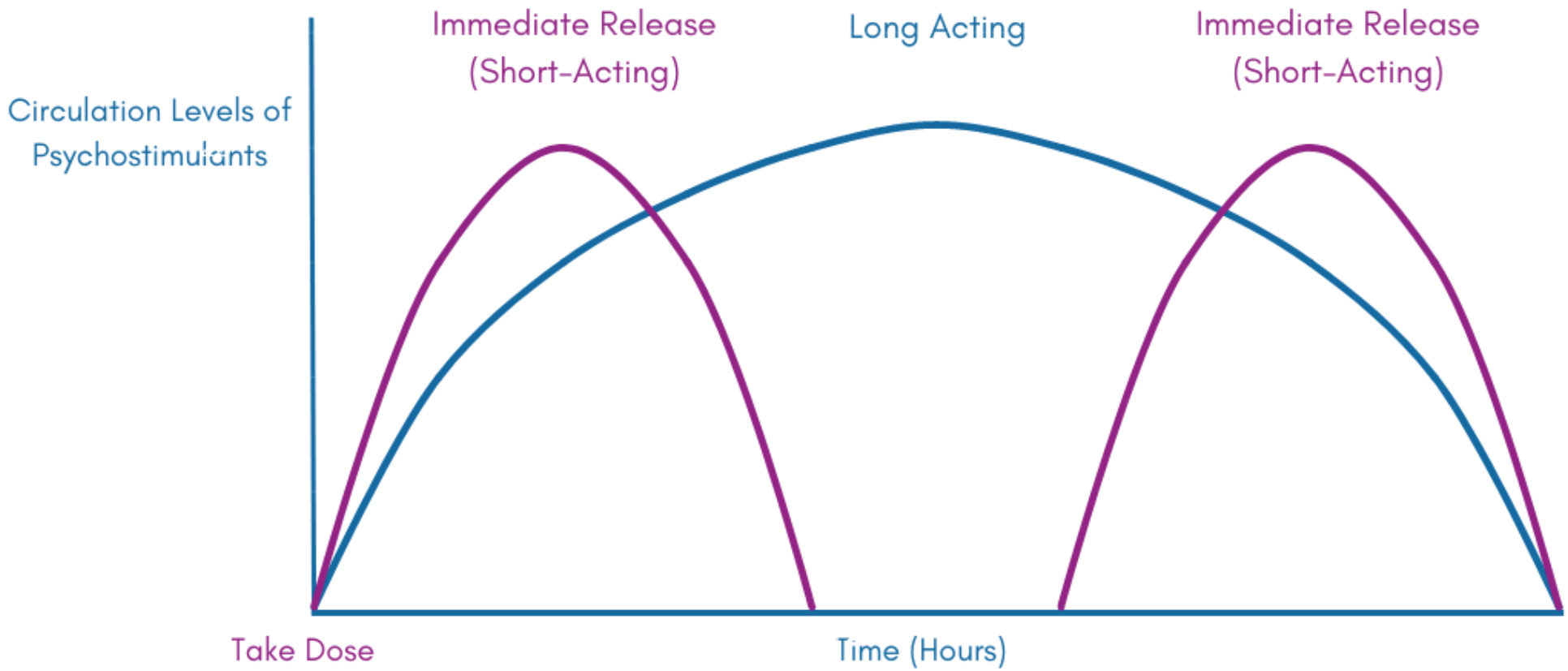
Autor	Anzahl Studien	Anzahl Patienten	Substanz vs. Placebo	Effektstärke	Publikationsbias
Faraone et al. 2004	6	253	MPH	0.9	0.5
Mészáros et al. 2009	7 6	1991	Stimulanzien Nicht-Stimulanzien	0.67 0.59	Nicht sign.
Faraone et al. 2010	7 5 9	2064	Stimulanzien kurzwirksam Stimulanzien langwirksam Nicht-Stimulanzien	0.96 (korr. 0.86) 0.73 0.39	Sign. (p<0.001) Nicht sign. (p=0.5) Nicht sign. (p=0.9)
Castells et al. 2011	18	2045	MPH	0.49	Nicht sign.
Cunill et al. 2013	12	3375	Atomoxetin	0.33 (Patienten) 0.40 (Kliniker)	Nicht sign. (p=0.64)
Epstein et al. 2014 (Cochrane)	**11 (10)**	**474**	**MPH unretardiert**	**0,6-0,7**	

Combinations

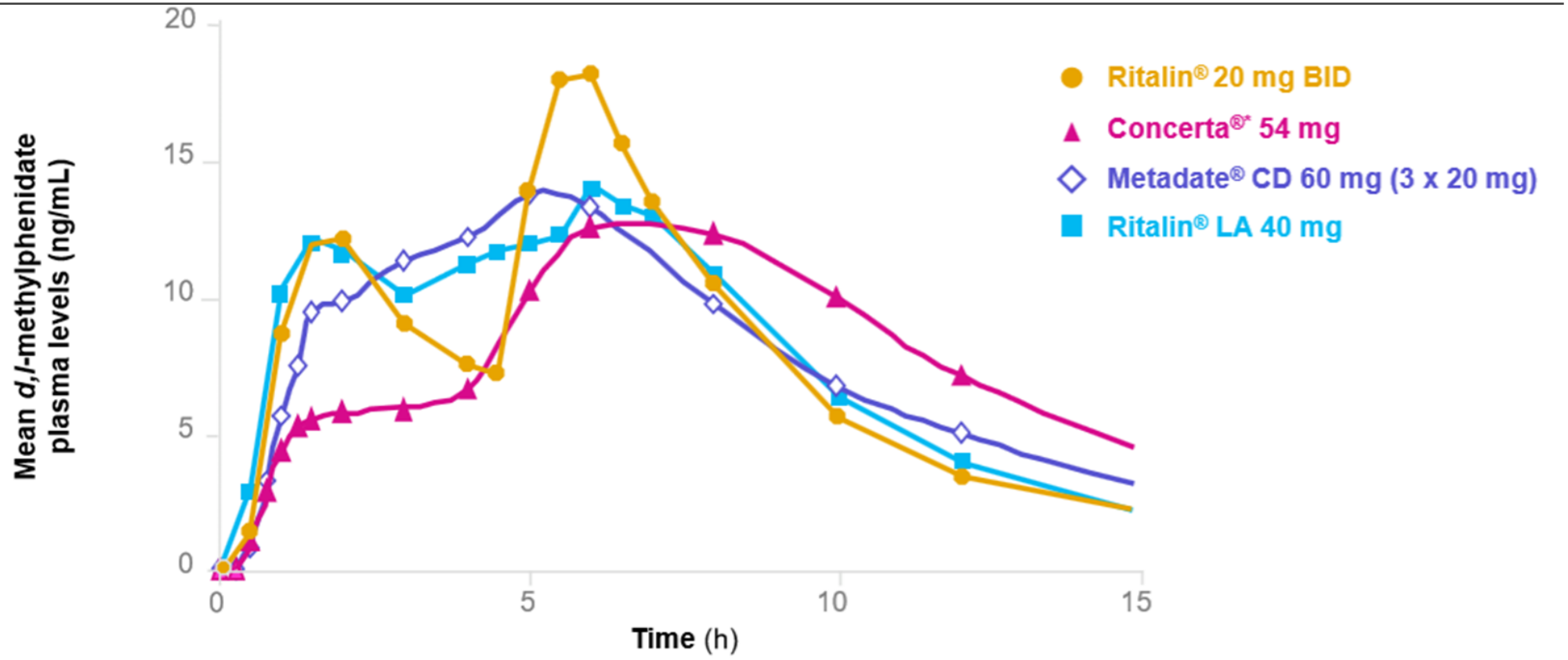
Immediate- and modified-release preparations of stimulants could be offered together to optimise effect (e.g. a modified-release preparation of methylphenidate in the morning and an immediate-release preparation of methylphenidate at another time of the day to extend the duration of effect).

RANZCP draft guidelines 2022

Combined Prescribing



Comparison of extended-release MPH



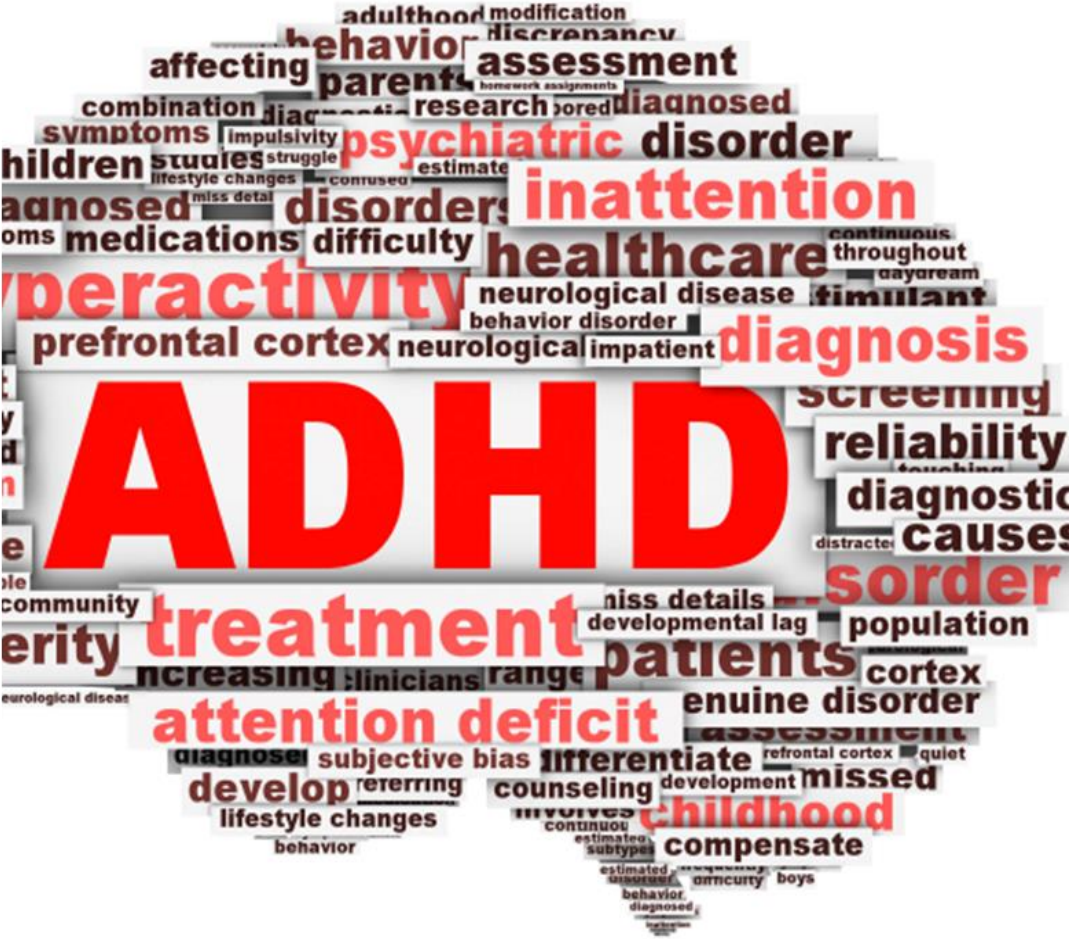
- *For comparative purposes only, not the results of a single head-to head trial
- Metadate® not available in Australia

Adapted from Gonzalez MA, et al. Int J Clin Pharmacol Ther. 2002;40:175–184.

GP prescribing of stimulants

Adult ADHD – State regulations

	Notification Form Type	GP Co-prescribing: Review?
WA	Specific stimulant form, proceed with treatment (with prior general approval)	Yes, when stable. Annual review
NSW	Specific stimulant form, proceed with treatment (with prior general approval)	Yes (rarely under 18). Annual review
QLD	As for all S8 forms, approval required beyond 2 months treatment.	Yes. Annual review
VIC	As for all S8 forms, approval required beyond 8 weeks treatment	Co-manage (only one prescriber at a time), Biannual review
SA	As for all S8 forms, approval required beyond 2 months treatment.	After specialist initial appt if deemed suitable. Review up to 5 years



GPs can prescribe under delegation from a psychiatrist unlike in childhood ADHD

See Resources
"Sample Delegation Letter"

RANZCP Draft guidelines: Before starting medication for ADHD…

… a comprehensive assessment should include:

- confirmation that ADHD diagnostic criteria are met (see recommendations 2.1.1, 2.1.2)
- evaluation of current educational or employment circumstances
- risk assessment for substance misuse and drug diversion
- assessment of physical health, including:
  - o a medical history, considering disorders that may be contraindications for specific medicines
  - o current medication
  - o height and weight (measured and recorded against the normal range for age, height, and sex)
  - o a cardiovascular assessment, including baseline pulse and blood pressure (measured with an appropriately sized cuff and compared with the normal range for age).

Before starting medication for ADHD... continued

People with ADHD should be referred for a cardiology opinion if any of the following is present:

- a history of congenital heart disease or previous cardiac surgery
- a history of sudden death in a first-degree relative under 40 years suggesting a cardiac disease
- shortness of breath on exertion compared with peers
- fainting on exertion
- palpitations that are rapid, regular and start and stop suddenly
- chest pain suggesting cardiac origin
- signs of heart failure
- a murmur heard on cardiac examination
- hypertension.

Before starting medication for ADHD...

GP Comment

"People with ADHD should be referred for a cardiology opinion if any of the following is present:"

- Closer scrutiny shows that competent GPs can screen for risk factors in their patients, and often eg) a cardiology review is not needed.
- These recommendations were adopted by the AADPA guidelines group, from the NICE Guidelines.

Starting medication for ADHD…

The dose should be titrated against symptoms, functional impairments and adverse effects until the optimal dose has been identified (i.e. the dose at which symptoms are reduced and functional outcomes are improved, with minimal adverse effects).

Dose titration should be slower and monitoring more frequent if any of the following are present:

• other neurodevelopmental disorders (e.g. autism spectrum disorder, tic disorders, intellectual disability),

• other mental health disorders such as anxiety disorders, Schizophrenia or bipolar disorder, depression, personality, disorder, eating disorder, post-traumatic stress disorder, substance misuse and

• physical health disorders (e.g. cardiac disease, epilepsy or acquired brain injury)

Monitoring

When monitoring medication use, effects on all the following areas should be considered:

- height and weight
- cardiovascular function
- tics
- sexual function
- seizures
- sleep quality
- worsening symptoms
- the risk of stimulant diversion

Clinicians should be aware …

…that the following groups of people, including children, adolescents and adults, have an **increased prevalence of ADHD**, compared with the general population:

Children: • in out of home care • diagnosed with mood disorders • diagnosed with oppositional defiant disorder and conduct disorder

Children and adolescents: • diagnosed with anxiety disorders • with epilepsy • history of substance abuse

Adults: • with a history of substance abuse • with a mental health disorder (including borderline personality disorder, intermittent explosive disorder, internet addiction, psychotic disorders) • who experience suicidal ideation

Clinicians should be aware …

…that the following groups of people, including children, adolescents and adults, have an **increased prevalence of ADHD**, compared with the general population:

People of all ages: • with neurodevelopmental disorders including autism spectrum disorder, intellectual disability, tic disorders , language disorders and specific learning disorders • born preterm • with a close family member diagnosed with ADHD • born with prenatal exposure to substances including alcohol and other drugs • with acquired brain injury • who are imprisoned • with low birth weight

Clinicians should be aware …

…that ADHD could be under-recognised in girls and women and that they:

• are less likely to be referred for assessment for ADHD
• may be more likely to have undiagnosed ADHD
• may be more likely to receive an incorrect diagnosis of another mental health or neurodevelopmental disorder

Methylphenidate in pregnancy?

Young women with ADHD engage in higher risk sexual behaviours

Hosain et al. (2012) J Womens Health

- sexually active before age 15 ↑
- number of sexual partners ↑
- inconsistent use of condoms ↑
- sexually transmitted diseases ↑

Generally limited Data

No data related to trans-placental transport of Methylphenidate in humans

Methylphenidate in pregnancy?

Category D

The safety of methylphenidate for use during human pregnancy has not been established.

Data from a cohort study of in total approximately 3,400 pregnancies exposed in the first **trimester do not suggest an increased risk of overall birth defects.** There was a small increased occurrence of cardiac malformations in women who receive methylphenidate during the first trimester of pregnancy, compared with non-exposed pregnancies.

Methylphenidate should not be prescribed for pregnant women unless, in the opinion of the physician, the potential benefits outweigh the possible risks.

Approved Rx for ADHD in Australia

Medication	Initiation	Dose
Methylphenidate IR	Start at 5-10mg morning the first day; Increasing to another 5-10mg at lunch time for a week then; Further increments weekly	Total daily dose typically varies between 10mg and 60mg/day Doses over 80mg/day uncommon (The NICE Guidelines maximum recommended dose - 100mg)
Methylphenidate longer-acting formulations	ER formulation - Concerta: Start at 18 or 36 mg/day, taken once daily in the morning	Increase in 18 mg increments to a maximum of 72 mg/day Adjust dosage at weekly intervals
	LA formulation – Ritalin LA: Recommended initial dose is 20mg/day taken once daily in the morning	Adjust dose weekly in 10mg increments Daily dose usually would not exceed 60mg
Dexamphetamine	Start at 2.5-5.0mg morning the first day, Increasing to another 2.5-5.0 mg at lunch time for a week then; Further increments weekly	Total daily dose typically varies between 5mg and 30mg/day Doses over 40mg are uncommon (The NICE Guidelines maximum recommended dose – 60mg)
Atomoxetine	For adults or children >70kg, start at 40mg/day taken once daily for 3 days then increase to target dose of 80mg.[3]	Target dose 80 mg/day Maximum dose 100mg[3]
Lisdexamfetamine	Recommended starting dose is 30 mg taken once daily in morning. [5]	Dose my be adjusted by 20 mg weekly up to 70 mg daily. [5]
Guanfacine (TGA approved only in children aged 6-17 years inclusive)	Recommended starting dose is 1 mg morning or night. [6]	Increase dose by 1 mg weekly up to max of 7 mg daily in monotherapy. Adjunctive therapy with stimulants – dosing 1-4 mg. Doses above 4 mg/day have not been evaluated in co-administration trials.

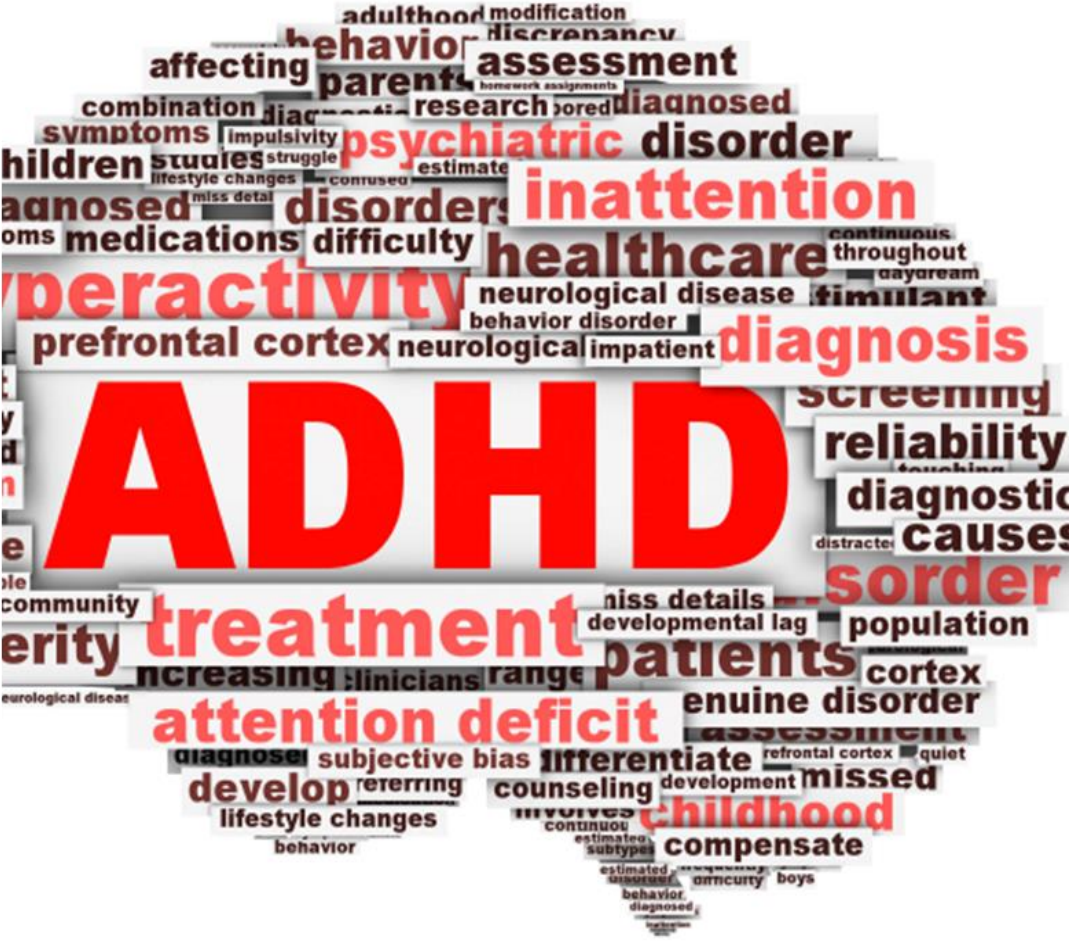
Collated from: 1. https://www.nice.org.uk/guidance/ng87/chapter/Recommendations#medication . 2. Canadian Attention Deficit Hyperactivity Disorder Resource Alliance (CADDRA): Canadian ADHD Practice Guidelines, Third Edition, Toronto ON; CADDRA, 2011 3. STRATTERA Australian Product Information 2011
4. CONCERTA Australian Product Information 5. https://www.tga.gov.au/sites/default/files/auspar-lisdexamfetamine-dimesilate-131023-pi.pdf
6. https://www.tga.gov.au/sites/default/files/auspar-guanfacine-180503-pi.pdf

Comments on Atomoxetine (Strattera)

- Initial dose 0,5mg/kg body weight, titrating to 1,2 mg/d/kg body weight
- slower effect than Methylphenidate

- Indications
  - when MPH is contraindicated
  - with comorbid Depression und Anxiety
  - If a more continuous effect is desired

Wilens et al.: Correlates of alcohol use in adults with ADHD and comorbid alcohol disorders: exploratory analysis of a placebo-controlled trial of atomoxetine. Curr Med Res. 2012



The AADPA Prescriber manual is currently in development

Release is anticipated to be July 2023

RACGP Specific Interests

Non-pharmacological interventions

- Psychoeducation — MIND
  - ADHD coaching
  - CBT
  - Mindfulness etc.
  - Wim Hof Method
- Nutrition — BODY

Psychoeducation

Mindfulness vs psychoeducation in adult ADHD: a randomized controlled trial

E. Hoxhaj, C. Sadohara, P. Borel, R. D'Amelio, E. Sobanski, H. Müller, B. Feige, S. Matthies & Alexandra Philipsen
European Archives of Psychiatry and Clinical Neuroscience volume 268, pages321–335 (2018)

In the current study, MAP was not superior to PE regarding symptom reduction in adult ADHD. Both interventions, mindfulness meditation and PE, were efficacious in reducing symptom load in adult ADHD.
Furthermore in exploratory post hoc tests the study provides evidence for a potential gender-specific treatment response in adult ADHD.*

*Women benefited more compared to men irrespective of treatment group. Men showed the most pronounced changes under MAP.

ADHD coaching

Efficacy of ADHD coaching for adults with ADHD

Joyce, Kubik

J Atten Disord. 2010 Mar;13(5):442-53. doi: 10.1177/1087054708329960. Epub 2009 Mar 10.1

This is perhaps the first outcome study on the efficacy of ADHD coaching for adults with ADHD and its long-term effect.

Conclusions:

ADHD coaching had a positive impact on the lives of people with ADHD.

Mindfulness etc, my take:

Typically, people with untreated ADHD find it hard to meditate, however once treated I would recommend, she gives it a go as there can be significant health benefits gained. I recommended the Headspace meditation app and Heartmath, a well-researched and evidenced bio-feedback technology (www.heartmath.com). Alternatively, practices that integrate mind and body such as Yoga or martial arts can be beneficial in gaining mastery over an unruly mind.

Wim Hof Method

personal testimony from a friend

I can't really believe how profound it has been for me …

I feel calmer than I ever have in my life and have the capacity to regulate my mood, including lowering my heart rate at will via conscious breathing.

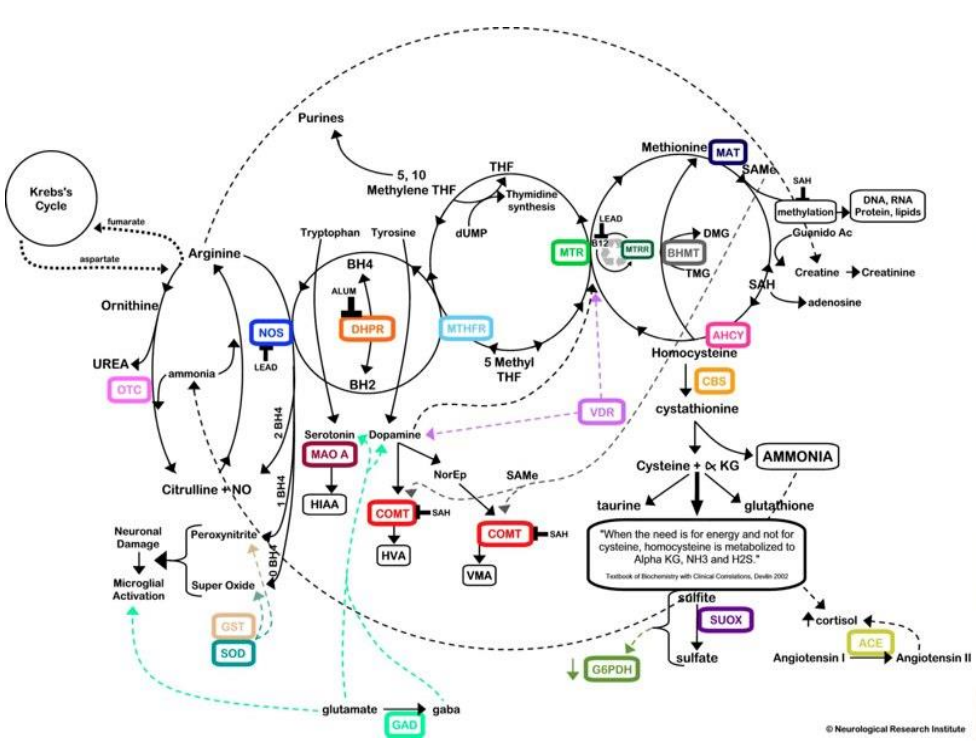
It seems miraculous to me that these simply practices can have such a powerful impact. It feels like the cold exposure has taught me to be in the moment, and more decisive, while the breathing is how I imagine a perfect anti-anxiety drug would work.

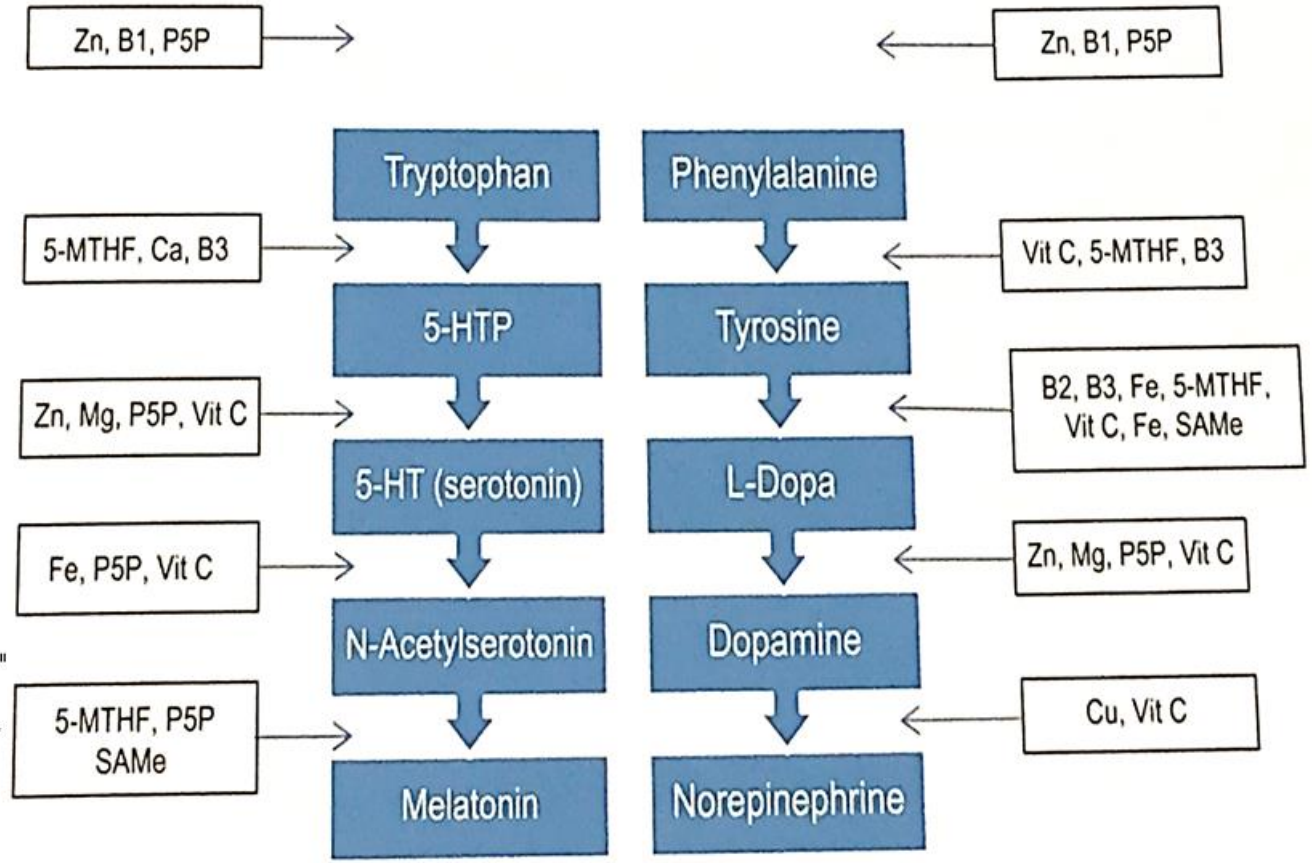
I feel solid in the world in a way that I never have - I always felt **flighty, fidgety, distracted**. I don't have that anymore.

I feel like more people should know about it. I'm pondering writing something myself for publication.

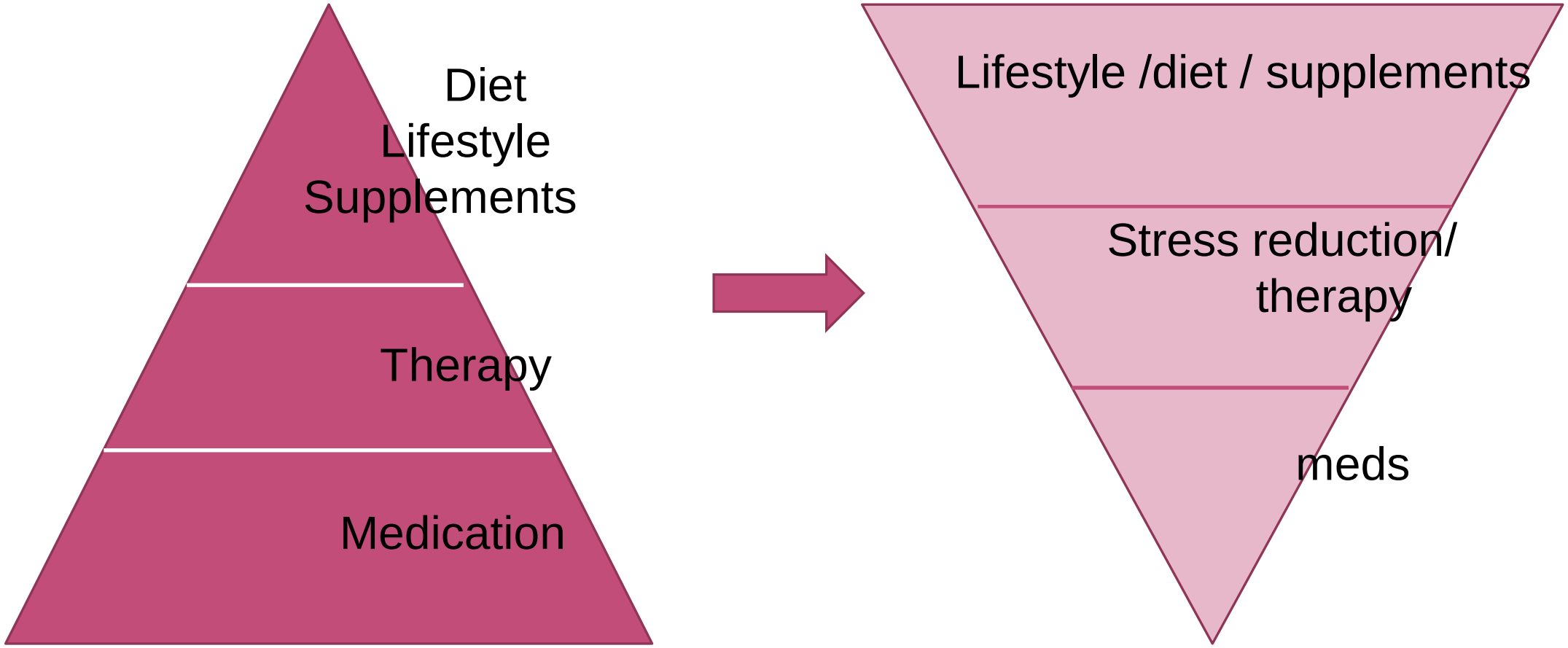
Nutrition

Micronutrients and their catalytic effect on neurotransmitter synthesis

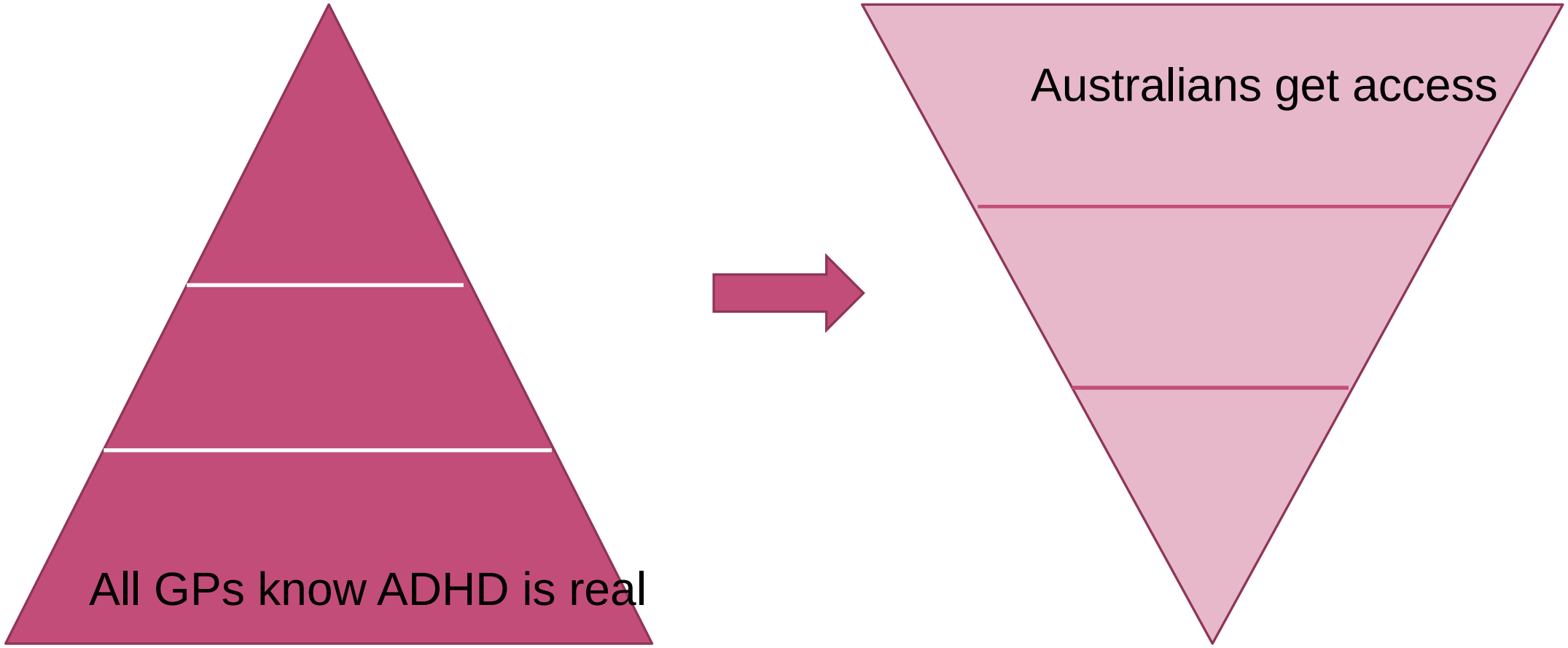


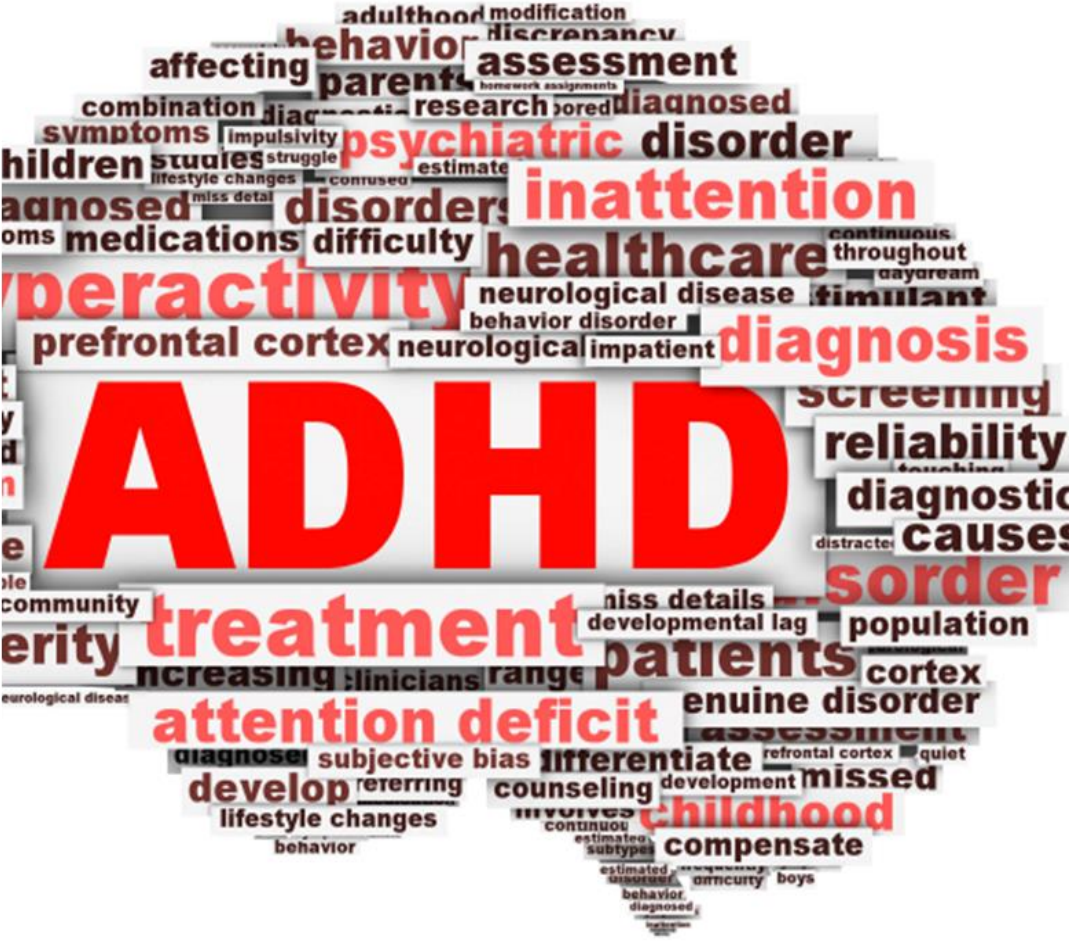


Inverting the pyramid



Inverting the pyramid GP WISH LIST

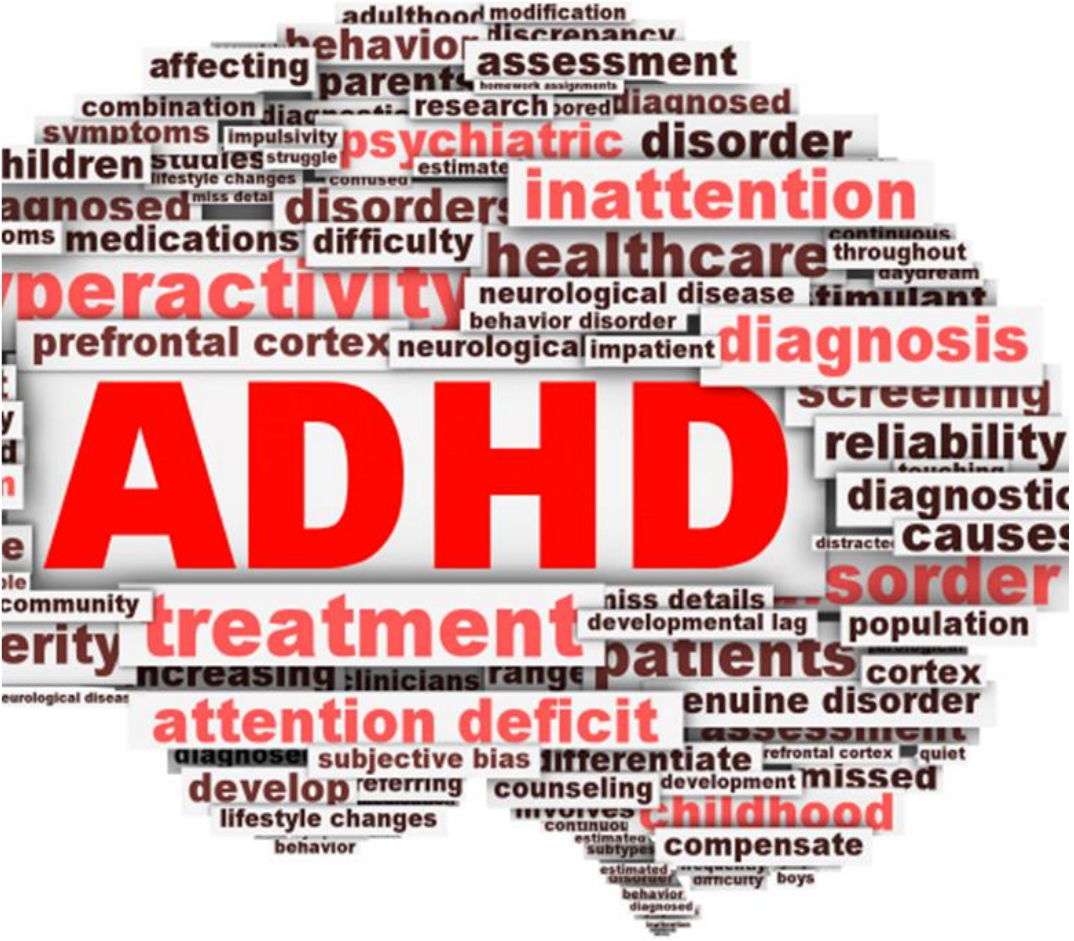




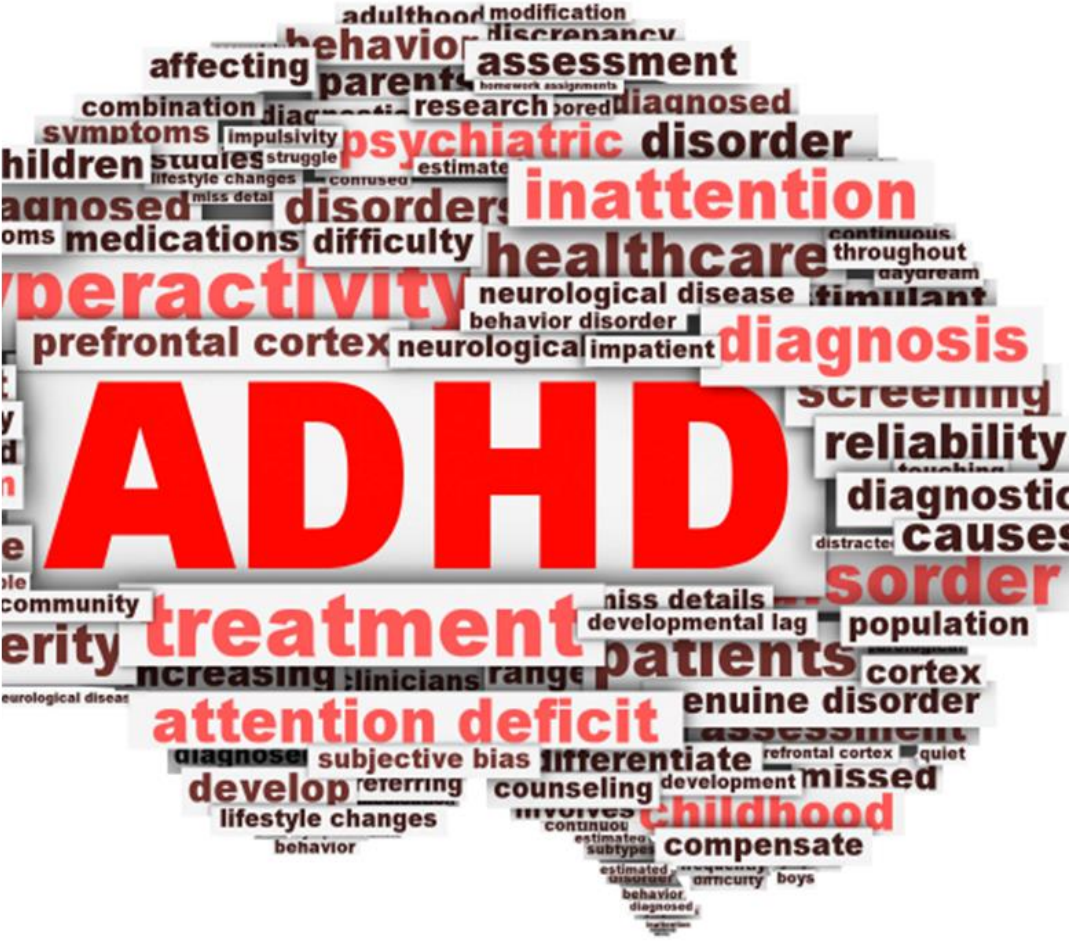
What is the potential role of GPs?

What are the barriers to that role?

How can we address those barriers?

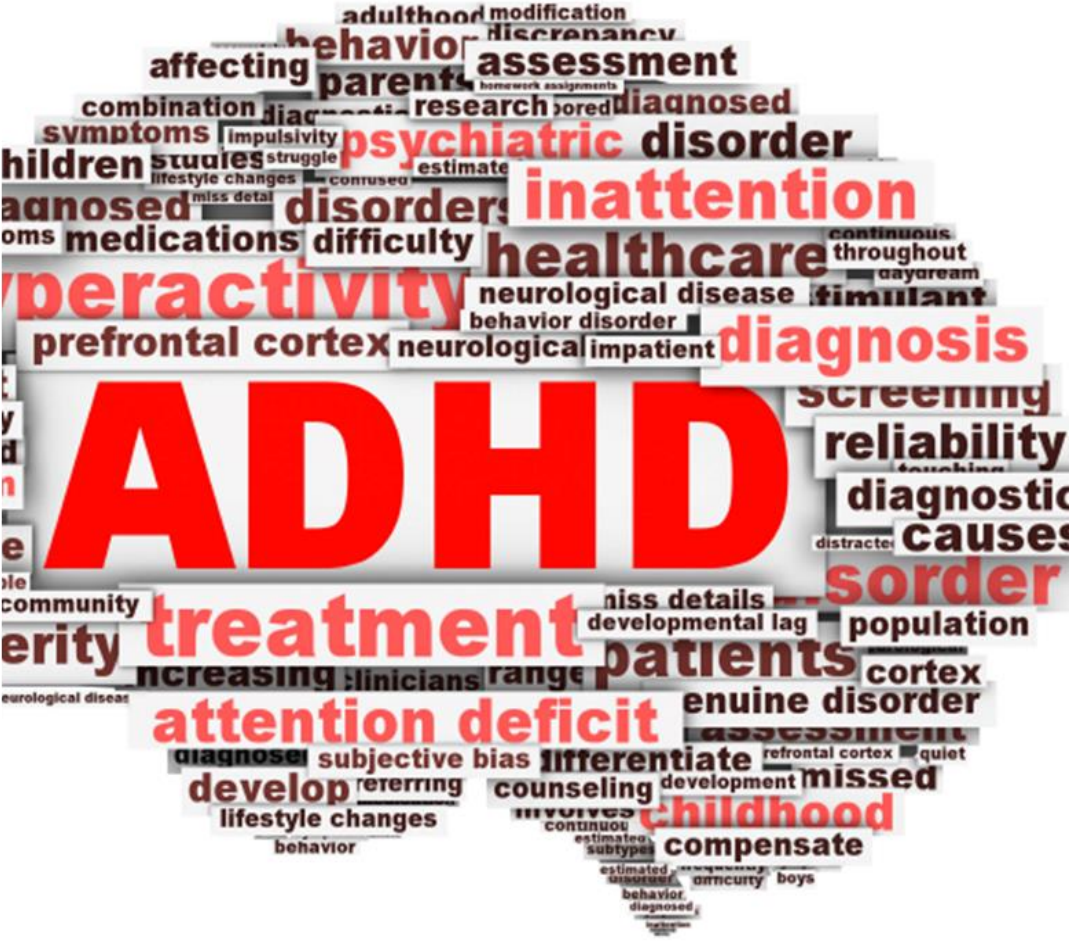


What is the potential role of GPs? Large
What are the barriers to that role?
Numerous, including regulatory, state based



How can we address those barriers?

- Greatly increasing GP-Consultant connections and communications
- Building a system like we have for diabetes
- Advocating for regulatory change



You can Contact the RACGP SIG in ADHD and Neurodiversity for details of State based advocacy /regulatory reform initiatives

RACGP Specific Interests
RACGP Specific Interests

GP prescribing of stimulants

It is NOT a requirement for psychiatrists to hold the authority for a minimum period of 6 months before transfer to a GP can occur.

Diagnosis and initial application for authority to prescribe Schedule 8 stimulants should be made by a relevant AHPRA recognised specialist medical practitioner (eg. paediatrician, psychiatrist, neurologist or respiratory physician).

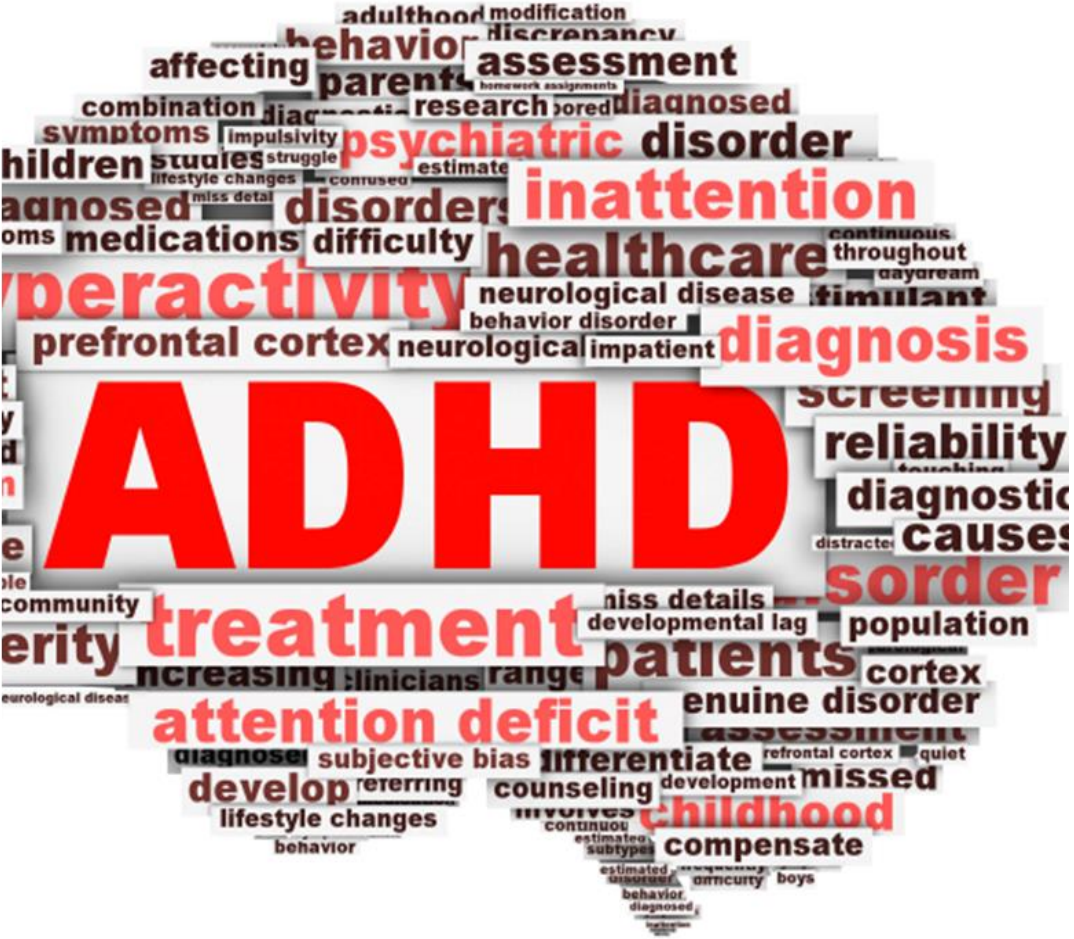
Maintenance and continued prescribing

A general practitioner (GP) will not usually be granted an authority to prescribe schedule 8 stimulants without the explicit written support of a relevant specialist medical practitioner and; diagnosis and treatment stability has been established, and/or for individual patients with special needs (including those living in regional areas) where a specialist retains clinical oversight of the patient's care.

Dose

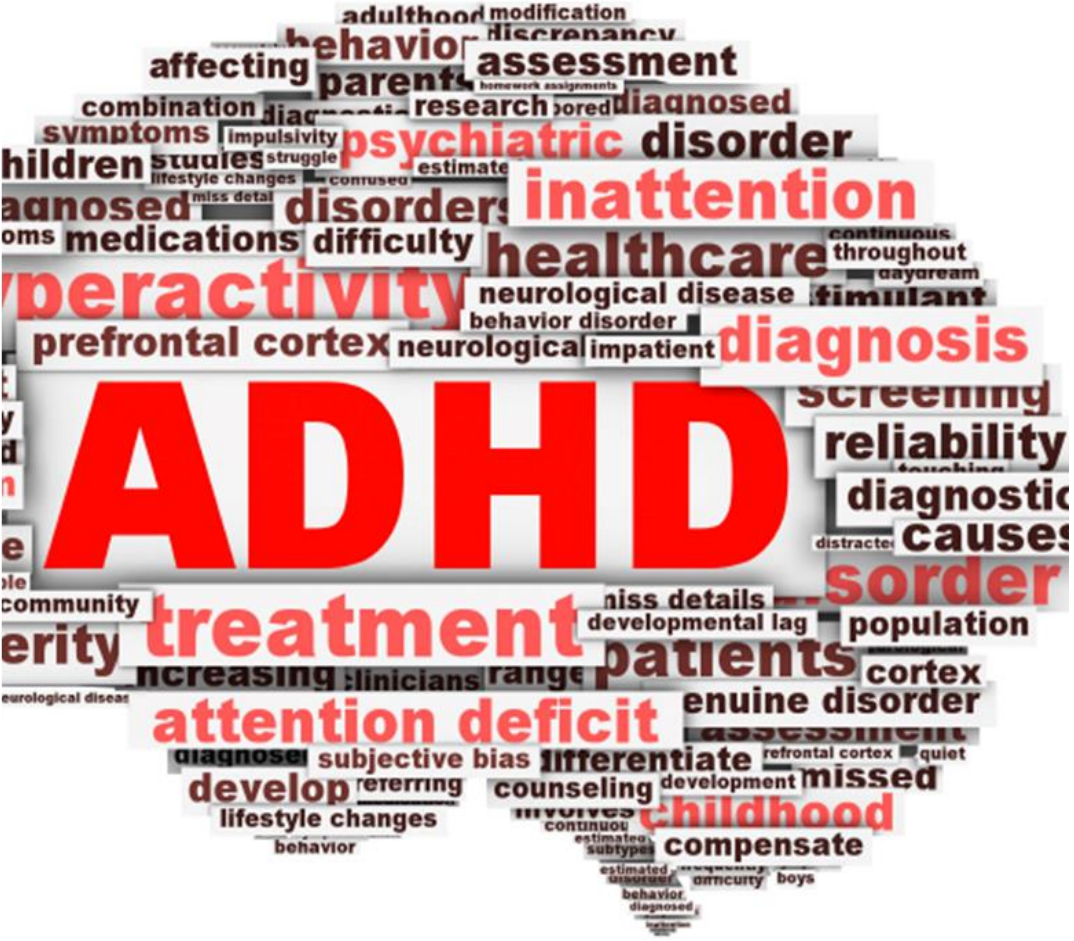
Determining the severity of ADHD is a matter for clinical judgement, taking into account the severity of impairment, pervasiveness, individual factors and familial and social context.

Stimulant dose should be titrated against the patient's clinical need and treatment should be part of a comprehensive program addressing psychological, behavioural and educational or occupational needs.



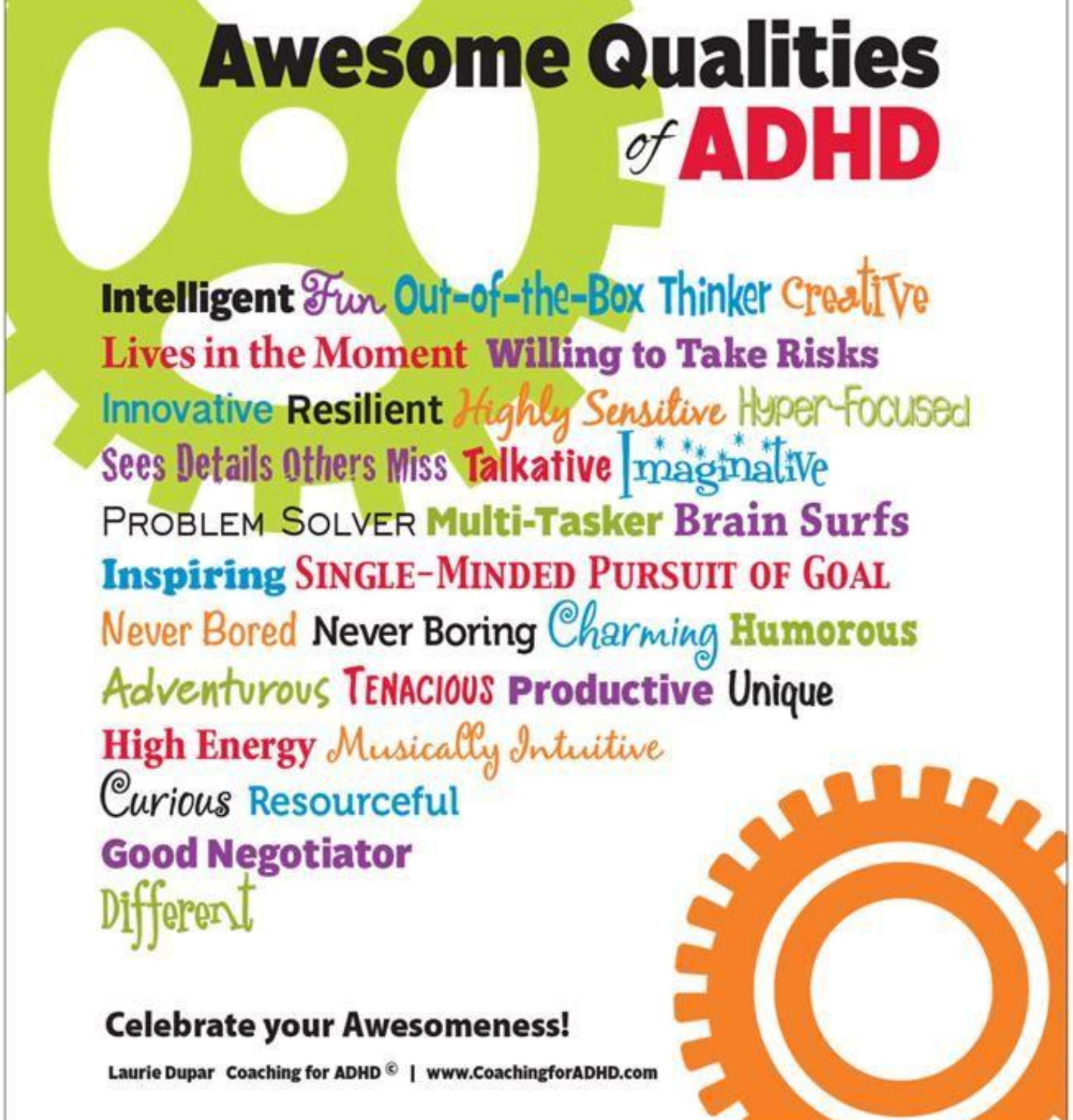
Dr Dianne Grocott, Reflex Health Geelong Victoria: Pioneering a new GP-Psychiatrist model of care

RACGP Specific Interests



BUT DON'T FORGET…..
ITS NOT ALL BAD
Far from it

The upside of ADHD



The End