Western Health

phn NORTH WESTERN MELBOURNE

An Australian Government Initiative

Paediatric ADHD – an update for GPs

Thursday 8th May 2025

The content in this session is valid at date of presentation

Acknowledgement of Country

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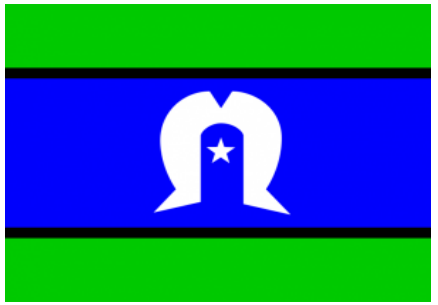
We pay respects to Elders past, present and emerging as well as pay respects to any Aboriginal and Torres Strait Islander people in the session with us today.



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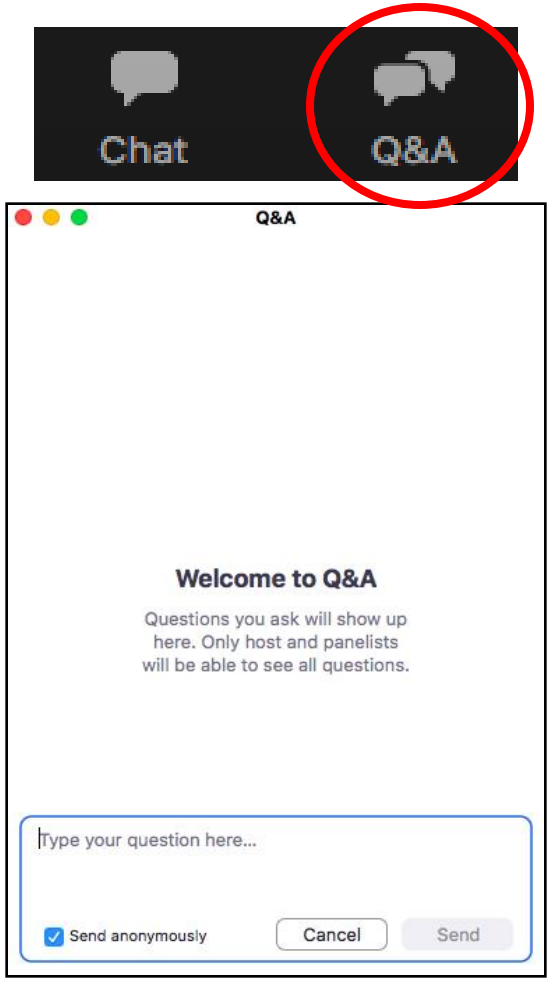

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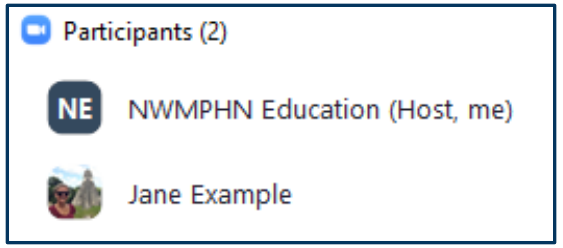

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HealthPathways Melbourne

Paediatric ADHD – an update for GPs

08 May 2025

Pathways are written by GP clinical editors with support from local GPs, hospital-based specialists and other subject matter experts

- clear and concise, evidence-based medical advice
- Reduce variation in care
- how to refer to the most appropriate hospital, community health service or allied health provider.
- what services are available to my patients

HealthPathways – Paediatric ADHD

HealthPathways – Psychological Trauma in Children

HealthPathways – Relevant and Related Pathways

Relevant Pathways

ADHD in Children and Youth
Borderline Personality Disorder (BPD)
Behavioural Problems in Preschoolers
Child and Youth Mental Health
Child Mental Health and Wellbeing Aged 2 to 12 Years
Depression in Children and Adolescents
Psychological Trauma in Children
Self-harm
Suicide Prevention
Anxiety in Children and Adolescents

CPD Hours for HealthPathways Use

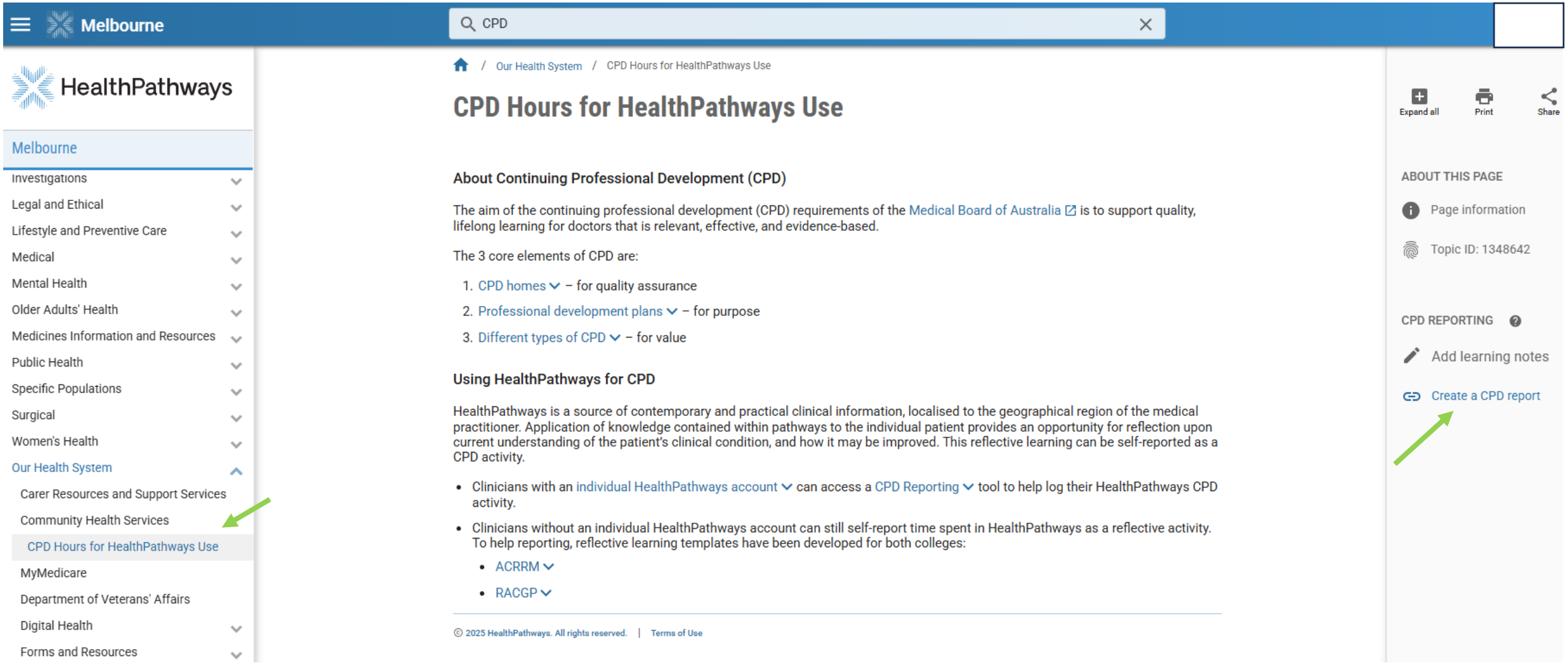
Referral Pathways

Acute Child and Adolescent Psychiatry Referral or Admission (Same-day)
Child and Adolescent Eating Disorders Specialised Referral
Child and Youth Mental Health Support Services
Non-acute Paediatric Medicine Referral (> 24 hours)
Non-acute Child and Adolescent Psychiatry Referral (> 24 hours)
Paediatric Psychology and Counselling Referral
Paediatric Speech Pathology Referral
Tips and Resources in Adolescent Health
SafeScript

Related Pathways

Carer Support - Mental Health
E-Mental Health Services
GP Mental Health Treatment Plan
Mental Health Community Support Services

HealthPathways – CPD Hours for HealthPathways Use



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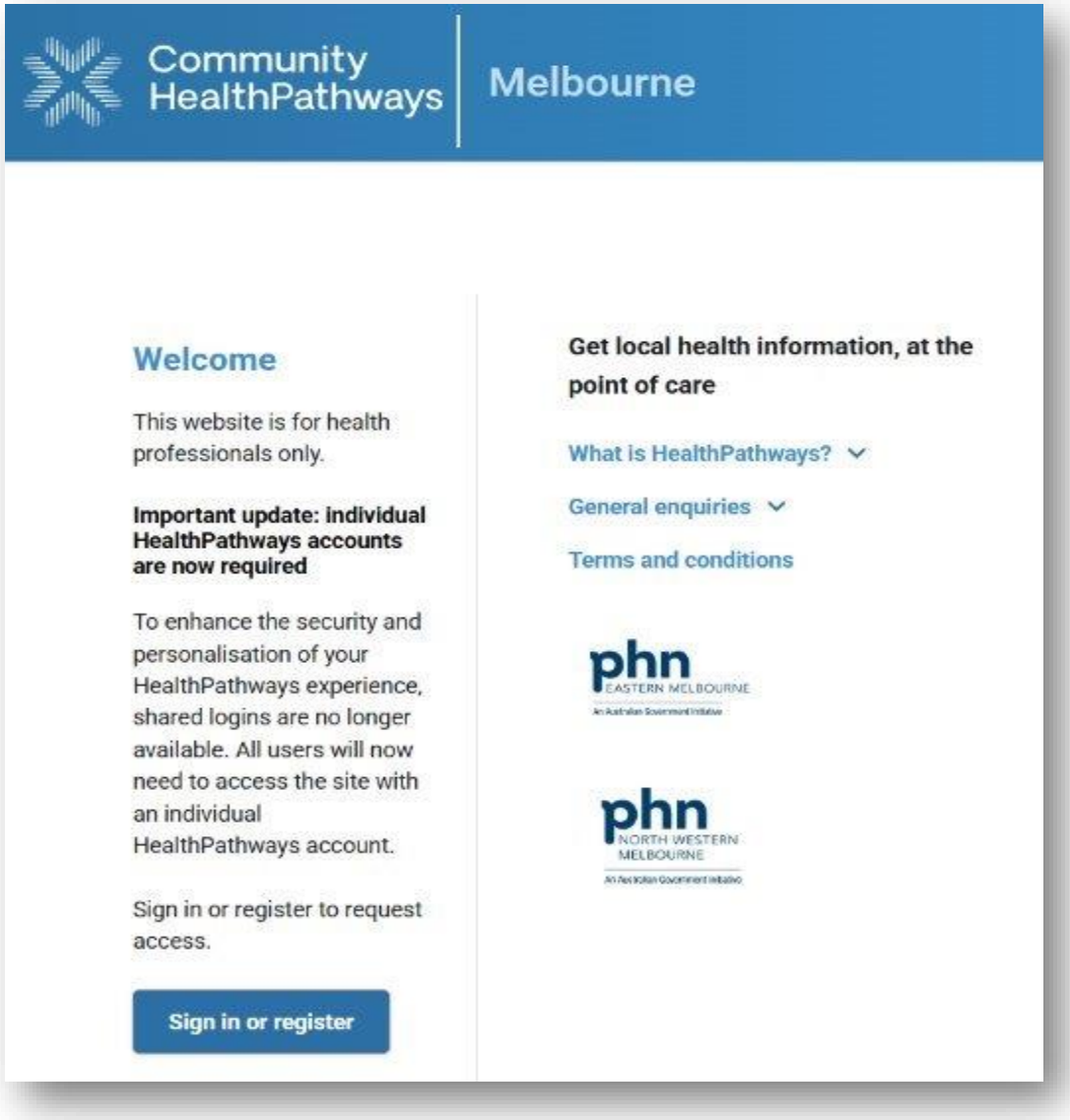

HealthPathways Bulletin

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Speakers

Dr Riju Mittal – General paediatrician

Dr Riju Mittal brings over 24 years of experience in paediatrics in Melbourne, specialising in addressing the complex developmental and behavioural needs of children. Her expertise covers a wide range of conditions including developmental and intellectual disabilities, autism spectrum disorders, and ADHD.

She holds dual qualifications in general paediatrics and community child health. Dr Mittal's practice is firmly grounded in evidence. She stays current through active participation in relevant conferences and memberships in professional societies such as the Australasian Society for Developmental Paediatrics (ASDP), Australian ADHD Professionals Association (AADPA) and American Academy of Child and Adolescent Psychiatry (AACAP).

Dr Mia West – General practitioner

Dr Mia West is a general practitioner in Geelong, with a special interest in all areas of paediatrics. She works in private practice in North Geelong, but also in the Barwon Regional Adolescent and Child Health Share-Care (BRANCHS) clinic, a public general paediatric service for children and families. Through these practices she understands both sides of shared care and co-prescribing for those with ADHD.

She is passionate about children's health and wellbeing, having taken regular opportunities to upskill in paediatrics, parenting, and enhancing communication skills with children and families.

Shared care in non-complex ADHD

A collaborative approach

Dr. Riju Mittal Dr. Mia West Dr Jo-Ann Silva

8th May 2025

Presenters

- **Dr. Riju Mittal, General and Developmental/ Behavioural Paediatrician**, Western Health and Western Children's Health Centre, Laverton
- **Dr. Mia West, Specialist GP**, North Geelong Medical Clinic
- **Dr Jo-Ann Silva, GP Advisor**, General Practice Integration Unit, Western Health

Overview

- Introduction to ADHD
- Diagnostic criteria
- How is ADHD assessed
- Management options
- Case studies
- ADHD for GPs- how to feel more confident
- Shared care model
- Data from recent survey

Introduction to ADHD

- Prevalence in Australian children: 6–10%
- Increasing recognition and diagnosis
- Global prevalence 2% - 7%, average of around 5%
- Another 5% of children have substantial difficulties with overactivity, inattention, and impulsivity but just under the threshold to meet full diagnostic criteria (Sayal Lancet, 2018)

Why is ADHD important to diagnose

- Negative impacts include:
  - Poorer academic outcomes and lower income
  - Impact on self-esteem and social functioning
  - Higher risk of accidents, substance use, and offending behaviour

- In both public & private health it is very difficult to get an appointment for initial assessment & follow up

Australian evidence- based clinical guidelines (AADPA) for ADHD

- Based on DSM-5
- Symptoms: Significant inattention and/ or hyperactivity and impulsivity
- Duration: >6 months, onset before age 12
- Pervasive (occurring in two or more important settings) including social, familial, educational and/or occupational settings
- Must cause impairment - psychological, social and/or educational or occupational impairment
- Should not be better explained by another psychiatric condition

Inattentive symptoms

- Displays **poor listening** skills
- **Loses** and/or misplaces **items** needed to complete activities or tasks
- **Sidetracked** by external or unimportant stimuli
- **Forgets** daily activities
- Diminished **attention span**
- **Inability** to **complete schoolwork** and other assignments or to f**ollow instructions**
- Avoids or is **disinclined to begin homework** or **activities requiring concentration**
- **Fails to focus on details** and/or makes **thoughtless mistakes** in schoolwork or assignments

Hyperactive and Impulsive symptoms

Hyperactive	Impulsive
• Squirms when seated or **fidgets** with feet/hands • Marked **restlessness** that is difficult to control • Appears to be driven by “a motor” or is often “on the go” • **Inability** to play and engage in leisure activities in a **quiet** manner • Incapable of staying seated in class • Overly **talkative**	• Difficulty waiting turn • **Interrupts** or intrudes into conversations and activities of others • Impulsively **blurts** out answers before questions completed

Diagnostic criteria for ADHD

- Symptoms further classified by severity: mild / moderate / severe
- Symptoms should be seen in the context of the person’s age, developmental level and intellectual ability
- Inattentive symptoms may not be identified until secondary school (or later)

What is functional impairment?

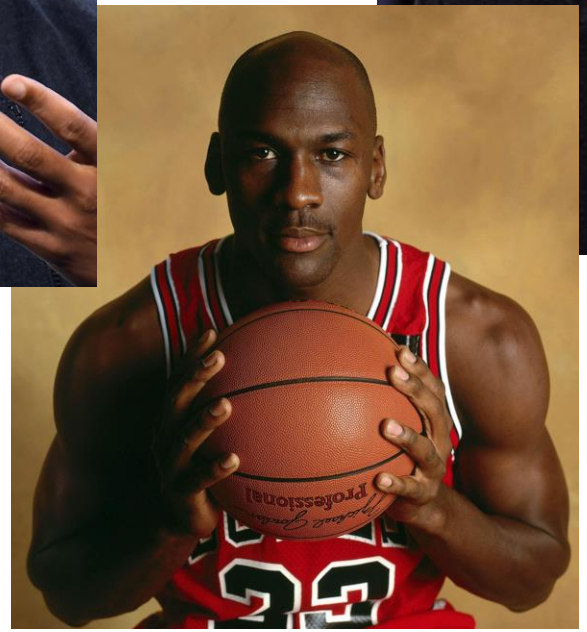
- Detailed history
- Info from school about learning, social skills
- Cognitive TEST – WISC/ WIAT, mainly reflects learning (does not give clear indication about critical thinking, social skills, creativity, persistence)
- Adaptive function tests – Vineland, ABAS

POSITIVES OF ADHD

- Being **highly energetic**
- Being **highly creative**
- Having **innovative ideas**
- Being **resilient**
- Being **great conversationalists**
- Having **high social intelligence**
- Being **adventurous**
- Having the **courage to transcend** restrictive social norms.
- Having the **ability to hyperfocus** on things they're passionate about

www.hallowellbrainhealth.com

Famous people with ADHD



ADHD assessment

How is ADHD diagnosed

The p… a list of symptoms

➔ Clinici… tory, talk to school, tick some b…

➔ Dia…

➔ Pr… e Ritalin

How is ADHD diagnosed

- Take a history of the concerning behaviour at school and home
- IMPORTANT - Ask the carer about the child's strengths and qualities
- Explore the background home and family situation
- History of birth, development, social and family history
- Ask about sleep and diet
- Engage the child, observe behaviours such as too restless, disruptive, impulsive or inattentive
- Perform examination including ENT and growth centiles

How is ADHD diagnosed

- Collateral information from school, carers/ therapists/ extracurricular activity teachers
- Provide screening tools for home and school (e.g. behaviour check lists, Conners, Vanderbilt, CBCL's)
- Cognitive test, adaptive function tests, sensory profile, language assessment
- Blood tests (iron, thyroid, microarray)
- Arrange audiology and vision testing
- Generally neuroimaging not needed
- Rule out differentials

Resist pressure to diagnose

Resist school or parental pressure (and own internal pressure) to quickly give a diagnosis – this can potentially cause longer-term harm

ADHD - High risk group

- Close family member diagnosed with ADHD
- OHC
- Diagnosed with oppositional defiant disorder, anxiety disorder
- Epilepsy
- Preterm/ low birth weight, prenatal exposure to substances including smoking, alcohol and other drugs
- Acquired brain injury
- Neurodevelopmental disorders including autism spectrum disorder, intellectual disability, tic disorders, language disorders and specific learning disorders

Conditions that present similarly to or exacerbate ADHD symptoms

- Hearing or vision impairment
- Thyroid disease
- Anaemia
- Sleep apnoea
- Anxiety/depression
- Intellectual disability
- Sensory processing difficulties
- Trauma or psychosocial stressors

ADHD management

After ADHD diagnosis

Assess patient and carer’s understanding of ADHD
Assess family functioning and parents' mental health to enable provision of support for carers at the time of diagnosis
Offer information in simple language that is culturally appropriate, respectful and empowering
Strength based approach - identifying and building on individual strengths
Provide information about local and national support groups and voluntary organisations
Check for eligibility for government benefits and allowances, including Carer Allowance
Direct to reliable and reputable websites

Online resources

- AADPA
- RCH – ADHD – Ways to Help Children at School and at Home
- Raising Children Network
- Other useful online sites include ADHD Australia
- Australian Family Physician (AFP): Struggling at school- A practical approach to the child who is not
- Letter of support to school for an Individualised Learning Plan

Non-Pharmacological Management

Home				
Building on strengths and confidence – positive reinforcement	Positive attitude	Routine – helps with focus and attention • Sleep hygiene • Eating breakfast • Exercise	Supervising screen time to ensure balance between benefits and potential harms.	Task rehearsal and visual charts – to make muscle memory

Non-Pharmacological Management

School		
Clear communication between parents and teachers	Environmental modifications to meet realistic goals • Classroom accommodations such as ILP and other reasonable adjustments at school	Further assessment and management of secondary impacts of ADHD such as learning difficulties

Non-Pharmacological Management

Additional support

Psychology for associated: • anxiety • oppositional symptoms • depression • reduced self-esteem	OT to help with: • organisational skills • independence • routine • emotional regulation • sensory differences	Speech therapy for: • literacy • language delay • social skills	Social skills group	Parenting support programs e.g. Triple P Parenting (free currently)

Pharmacological Management

- Stimulant mode of action involves enhancing dopaminergic and noradrenergic neurotransmission improving executive function
- Acts by improving the child's sustained focus, and lessening impulsivity and hyperactivity
- Addressing common concerns from parents shown to be safe and effective when combined with home and school support
- Prescription can be initiated by a Psychiatrist or Paediatrician for children 4-17 years
- Psychostimulant prescription can be continued by a GP
- Stimulants are non-addictive

Pharmacological Management

Stimulants	Non-stimulants
SHORT ACTING Methylphenidate (4 hrs) Dexamphetamine (4-6 hrs)	**SNRI** Atomoxetine (24 hrs)
LONG ACTING Ritalin LA (8 hrs) Concerta (10-12 hrs) Vyvanse (10-12 hrs)	**Alpha-1 Agonist** (used alone or in combination with stimulants) Clonidine (SA) Guanfacine – Intuniv (24 hrs)

Pharmacological Management

- **Guided by the goals of treatment**
- Start LOW and go up SLOW
- **Good enough control** with least side effects

Pharmacological Management

Methylphenidate (immediate release) 10 mg tablets

- Start 5mg morning and lunchtime and titrate after 1 to 2 weeks as required
- Small dose can be administered after school if symptoms problematic at home
- Onset – within 30 mins
- Duration – 2 to 4 hours
- Usual total maximum daily dose – 1mg/kg

Pharmacological Management

Methylphenidate – extended release (Ritalin LA and Concerta)

- For steady levels (avoids peaks and troughs)
- Eliminates need for dosing at school
- Child must be able to swallow tablets (can't crush or compound)
- Only permitted to prescribe on PBS after the child has shown a response and tolerance to immediate-release methylphenidate
- Onset – within 1 hour
- Duration of action for Ritalin LA – 8 hrs, Concerta – 10-12 hrs
- Dose usually equivalent to total daily dose of immediate-release methylphenidate reached after titration

Pharmacological Management

Dexamfetamine 5mg tablet

- Found to be more effective in adolescents or in those who have not responded to methylphenidate
- Start 5 mg morning and lunchtime and titrate after 1 to 2 weeks as required
- Administered 1-3 times a day to ensure consistency of effect
- Onset is within 30 mins and duration is 3 to 6 hours
- Maximum total daily dose – 0.5 to 1 mg/kg (maximum 40 mg)

Pharmacological Management

Lisdexamfetamine (also known as Vyvanse)

- Long-acting form of dexamphetamine
- Give once a day at breakfast
- Capsule can be opened and mixed with food (handy for those kids who need long-acting coverage but can’t swallow)
- Onset is within 1 hour and duration is about 12 hours
- Maximum total daily dose – 70 mg
- No requirement to have trialled on short acting meds to be able to prescribe this on PBS

Pharmacological Management

Common side effects of stimulants

- Appetite suppression
- Delayed sleep onset
- Worsening of tics
- Headache
- Abdominal pain
- Sometimes can exacerbate anxiety/ aggression or dulls mood

Pharmacological Management

If **weight loss/insufficient weight gain**, consider:

- Taking medication with or after food (rather than before a meal)
- Taking a planned break from treatment
- Changing or stopping medication
- Encouraging food intake when appetite suppression wears off (typically after school)
- Consuming high-calorie foods of good nutritional value
- Obtaining dietary advice

Pharmacological Management

Cardiovascular disease – Children with ADHD should be referred for cardiology review prior to medications if:

- History of sudden death in 1st degree relative <40yo
- History of congenital heart disease or previous cardiac surgery
- Shortness of breath or fainting on exertion
- Palpitations that are rapid, regular and start and stop suddenly
- Hypertension
- Heart murmur (excluding innocent heart murmurs in children)
- Recommend baseline ECG if there is a history of some cardiovascular disease in the family history

Pharmacological Management

Non-stimulants: Atomoxetine (known as Strattera)

- Is a selective noradrenergic reuptake inhibitor
- Is usually used when stimulants not tolerated, and may be particularly useful if co-morbid anxiety or problematic tics
- Give once daily
- Target dose is 1.2mg/kg a day, maximum is 1.4mg/kg a day (up to 100mg)
- Can take up to 6 weeks to show effect (has a low abuse potential)
- Side-effects: Sedation (generally started at nighttime)
- Use with caution if known prolonged QT syndrome, hypertension, or family history of cardiovascular or cerebrovascular disease

Pharmacological Management

Non-stimulants: Guanfacine (Intuniv)

- Selective alpha-2A receptor agonist
- Can be used as monotherapy or adjunct to stimulants (when stimulants not suitable, not tolerated or ineffective)
- Administer once daily in the morning or evening
- Initial dose 1 mg daily and adjusted in increments of 1 mg per week
- Should not be crushed or chewed or given with a fatty meal
- Side effects include sedation or hypotension. Monitor blood pressure and heart rate, especially during dose adjustments up and down

Pharmacological Management

Clonidine

- An alpha-2 noradrenergic agonist
- Can be useful in preschool kids with ADHD, markedly aggressive children or those with problematic sleep disturbance on stimulants. Less helpful for inattention
- Once to three times daily
- Dose range 1 to 4 microgram/kg daily (maximum 300 microgram)
- Doses used do not generally cause sedation or low blood pressure
- Don’t use Guanfacine and Clonidine together without specialist support

Each visit

- Screening drug side effects – Weight, height, Heart rate, BP, appetite, sleep, tics
- Co-morbidities – anxiety, mood etc
- Build on strengths and family supports
- Routine health screening

Psychostimulants + SSRI/SNRI

- SSRIs may inhibit metabolism of stimulants
- Monitor for increased stimulant effects or side effects
- Both medication classes can affect heart rate and blood pressure
- Typically start with one medication, stabilise, then add the second
- May need to adjust doses of both medications when used in combination

Psychostimulants and Melatonin

- **Melatonin**
  - Typically, 1-6mg for children (commonly 3mg)
  - Start with lowest effective dose of melatonin
  - Consider controlled-release melatonin for sleep maintenance issues
- **Used in combination**
- Generally well-tolerated combination
- No significant pharmacokinetic interactions between stimulants and melatonin
- Melatonin has minimal side effects at recommended doses

Case Studies

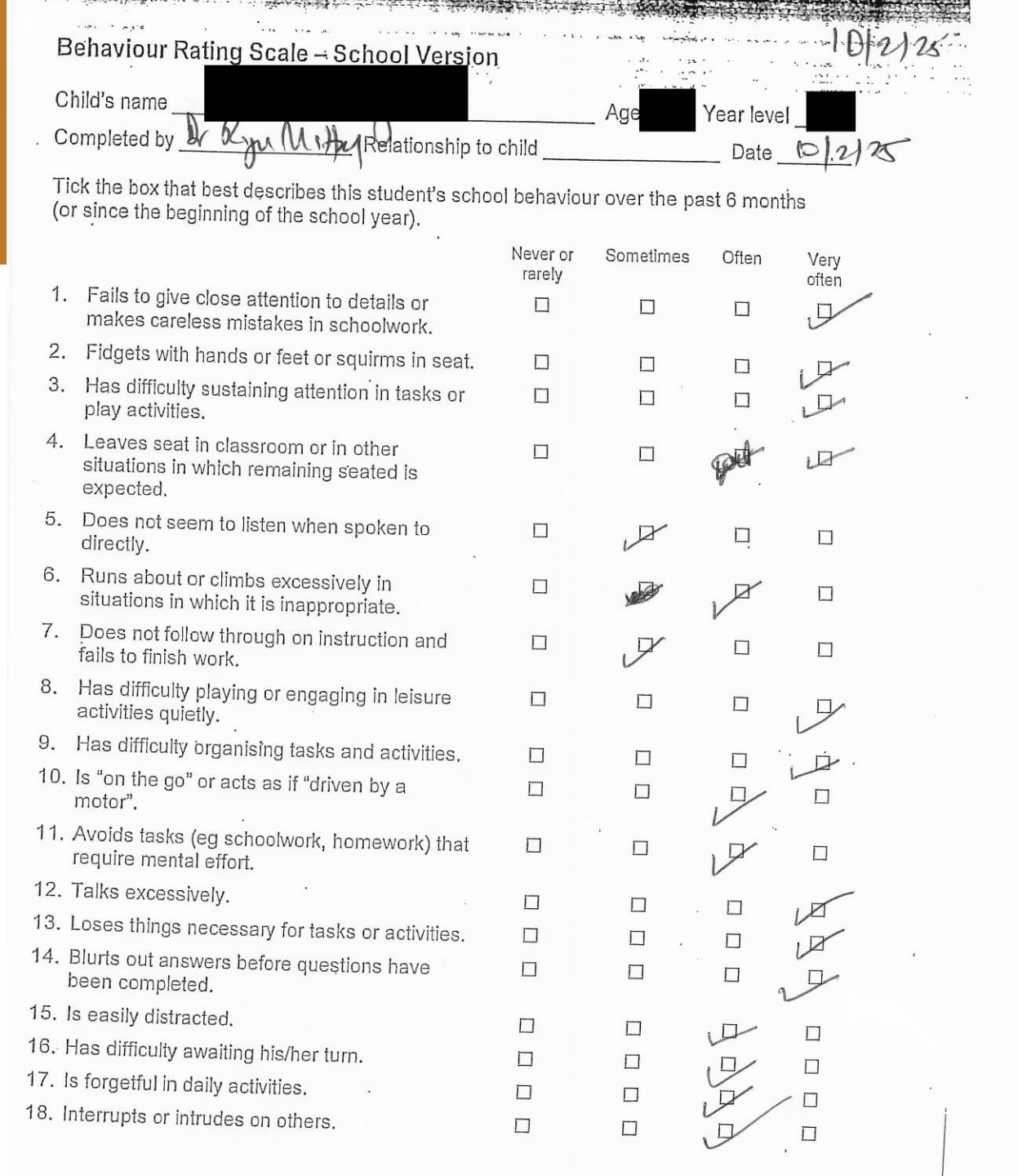
Case Study – Jacob

- 8-year-old, Yr 3 boy with concerns from school - poor attention, daydreaming, impulsivity
- Capable and smart but declining learning and frequently getting in trouble
- Parents noticing this more since the school raised concerns - takes long to get chores done, needs frequent reminding and supervision, antagonising siblings
- Happy go lucky child, feels bad for getting into trouble and responds to discipline
- Further history – good appetite, delayed sleep onset, Dad was treated for ADHD when younger
- Normal hearing and vision

Case Study – Jacob

Outcome:

- Diagnosis of non-complex ADHD, treatment started (Occupational Therapist and Ritalin), school adjustments
- Responded extremely well, now teacher wants a ‘class full of Jacobs’!



Behaviour Rating Scale – School Version

10/2/25

Child's name [redacted] Age [redacted] Year level [redacted]

Completed by Dr Ryan Mistry Relationship to child _____ Date 10.2.25

Tick the box that best describes this student's school behaviour over the past 6 months (or since the beginning of the school year).

	Never or rarely	Sometimes	Often	Very often
1. Fails to give close attention to details or makes careless mistakes in schoolwork.	☐	☐	☐	☑
2. Fidgets with hands or feet or squirms in seat.	☐	☐	☐	☑
3. Has difficulty sustaining attention in tasks or play activities.	☐	☐	☐	☑
4. Leaves seat in classroom or in other situations in which remaining seated is expected.	☐	☐	☑	☑
5. Does not seem to listen when spoken to directly.	☐	☑	☐	☐
6. Runs about or climbs excessively in situations in which it is inappropriate.	☐	☑	☑	☐
7. Does not follow through on instruction and fails to finish work.	☐	☑	☐	☐
8. Has difficulty playing or engaging in leisure activities quietly.	☐	☐	☐	☑
9. Has difficulty organising tasks and activities.	☐	☐	☐	☑
10. Is "on the go" or acts as if "driven by a motor".	☐	☐	☑	☐
11. Avoids tasks (eg schoolwork, homework) that require mental effort.	☐	☐	☑	☐
12. Talks excessively.	☐	☐	☐	☑
13. Loses things necessary for tasks or activities.	☐	☐	☐	☑
14. Blurts out answers before questions have been completed.	☐	☐	☐	☑
15. Is easily distracted.	☐	☐	☑	☐
16. Has difficulty awaiting his/her turn.	☐	☐	☑	☐
17. Is forgetful in daily activities.	☐	☐	☑	☐
18. Interrupts or intrudes on others.	☐	☐	☑	☐

Case Study – Austin (Feb 2023, 2 years ago)

- 6 yo boy/ referred by mum (doctor) in 2022 with attentional issues, problem sitting still, getting distracted easily, disruptive in class.
- Mum believes that Austin has ADHD
- At home, he is aggressive towards family as he needs to be in control and must do things his way
- He interacts well with the siblings most of the times, as long as they let him win
- He is reliant on a routine
- His current interest is Nerf Guns and Minecraft and watches a favourite youtuber on loop. He has a great memory and learns a lot from YouTube. His vocabulary can often surprise his parents.
- He is affectionate when it suits him
- Attends Year 1 at a private school, performs satisfactorily but dislikes science and writing, no set group of friends, enjoys football and online gaming
- Sensory sensitivities: texture, clothing, haircuts
- He stiffens up when excited and he often toes walks
- Ritualistic behaviours: touching genitals
- Delayed sleep onset
- Both parents' doctors, Brother, 3 has speech delay, Family history of ASD/ADHD (paternal side)
- Early developmental milestones age appropriate

Case Study – Austin (Feb 2023, 2 years ago)

Clinic Observations

- Entered with hands in pants, poor eye contact, played with his mother's hair, extremely fidgety, poor conversational flow, tangential speech, corrected mother

Strengths

- Intelligent, kind, honest
- Enjoys reading and maths
- Creative and good hands-on skills

Impression

- Likely ADHD with possible ASD
- Consideration of co-morbid anxiety

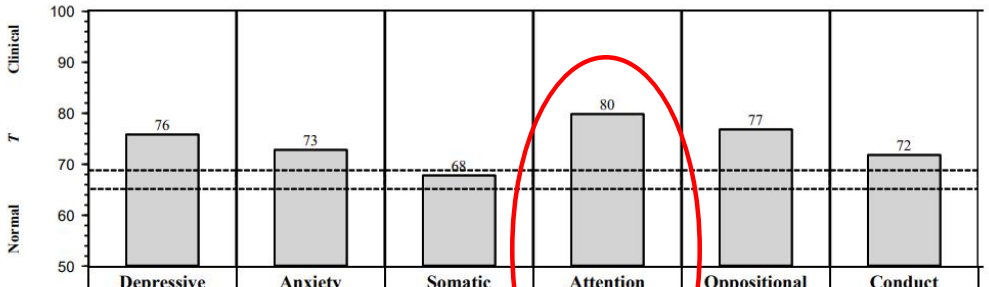
Next Steps

- **Referrals**: Bloods, audiology, vision, psychology assessment for IQ test and ASD assessment
- **Resources**: Raising Children, Amaze Victoria
- **Multidisciplinary Plan**:
  - Medication trial (stimulants)
  - Eligible for NDIS funding for allied health support
  - Occupational therapy:
    - focus, sensory issues, routine, hygiene
  - Speech therapy:
    - communication and social skills
  - Psychology
    - perfectionism, emotional insight
  - Social skills group
    - better understanding of his place in the social world and understanding other people's perspective

Case Study – Austin (Feb 2023, 2 years ago)

CBCL/6-18 - DSM-Oriented Scales

ID: Austin [redacted] Gender: M Date Completed: 2023-05-01 Clinician: Dr Riju Mittal, Informant: [redacted]
Name: Austin [redacted] Age: 6 Birth Date: [redacted] Agency: Relationship: Biological parent



	Depressive Problems	Anxiety Problems	Somatic Problems	Attention Deficit /	Oppositional Defiant Problems	Conduct Problems
Raw Score (Sum)	11	9	4	14	9	11
T Score	76-C	73-C	68-B	80-C	77-C	72-C
Percentile	>97	>97	97	>97	>97	>97
	0 5.EnjoysLittle	1 11.Dependent	0 56a.Aches	2 4.FailsToFinish	2 3.Argues	1 15.CruelAnimal C*
	1 14.Cries	1 29.Fears	1 56b.Headaches	2 8.Concentrate	2 22.DisobeyHome	0 16.Mean
	0 18.HarmsSelf C*	1 30.FearsSchool	0 56c.Nausea	2 10.SitStill	1 23.DisobeySchl	0 21.DestroyOther
	2 24.NotEatWell	1 31.FearDoBad	1 56d.EyeProb	2 41.Impulsive	2 86.Stubborn	0 26.LacksGuilt
	1 35.Worthless	1 45.Nervous	0 56e.SkinProb	2 78.Inattentive	2 95.Temper	2 28.BreaksRules
	0 52.Guilty	1 47.Nightmares	1 56f.Stomachaches	2 93.TalkMuch		0 37.Fights
	2 54.Tired	1 50.Fearful	1 56g.Vomits	2 104.Loud		0 39.BadFriends
	2 76.SleepsLess	1 71.SelfConsc				2 43.LiesCheats
	0 77.SleepsMore	1 112.Worries				2 57.Attacks C*
	0 91.ThinksSuicide C*					0 67.RunAway C*
	2 100.SleepProb					0 72.SetsFires C*
	0 102.LacksEnergy					1 81.StealsHome
	1 103.Sad					1 82.StealsOther
						0 90.Swears
						1 97.Threaten
						0 101.Truant
						1 106.Vandalism

B = Borderline clinical range; C = Clinical range; Broken Lines = Borderline clinical range

C = Critical Item*

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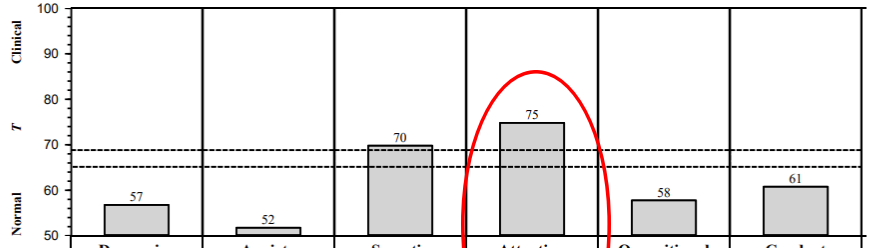
TRF/6-18 - DSM-Oriented Scales

ID: Austin [redacted] Gender: M Date Completed: 2023-03-31 Clinician: Dr Riju Mittal, Informant: [redacted] Society: ASEBA Standard
Name: Austin [redacted] Age: 6 Birth Date: [redacted] Agency: Relationship: Classroom teacher Verified: No



	Depressive Problems	Anxiety Problems	Somatic Problems	Attention Deficit /	Oppositional Defiant Problems	Conduct Problems
Raw Score (Sum)	2	1	5	24	2	6
T Score	57	52	70-C	75-C	58	61
Percentile	76	58	>97	>97	79	87
	0 5.EnjoysLittle	0 11.Dependent	2 56a.Aches	2 4.FailsToFinish	0 3.Argues	1 16.Mean
	0 14.Cries	0 29.Fears	1 56b.Headaches	2 8.Concentrate	2 6.Defiant	0 21.DestroyOther
	0 18.HarmsSelf C*	1 30.FearsSchool	1 56c.Nausea	2 10.SitStill	2 23.DisobeySchl	1 26.LacksGuilt
	0 35.Worthless	0 31.FearDoBad	0 56d.EyeProb	1 15.Fidgets	0 86.Stubborn	1 28.BreaksRules
	0 52.Guilty	0 45.Nervous	0 56e.SkinProb	2 22.Directions	0 95.Temper	0 37.Fights
	1 54.Tired	0 50.Fearful	1 56f.Stomachaches	2 24.Disturbs		1 39.BadFriends
	1 60.Apathetic	0 71.SelfConsc	0 56g.Vomits	2 41.Impulsive		0 43.LiesCheats
	0 91.ThinksSuicide C*	0 112.Worries		2 53.TalksOut		0 57.Attacks C*
	0 102.LacksEnergy			2 67.DisruptDisc		2 73.Irresponsible
	0 103.Sad			2 78.Inattentive		0 82.StealsOther
				2 93.TalkMuch		0 90.Swears
				2 100.FailsToDo		0 97.Threaten
				1 104.Loud		0 101.Truant

C = Critical Item*

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Attention Problems Subscales

Inattention (I)

Hyperactivity-Impulsivity (H-I)

I	AD/H Problems	H-I
2	4.FailsToFinish	[redacted]
2	8.Concentrate	[redacted]
[redacted]	10.SitStill	2
[redacted]	15.Fidgets	1
2	22.Directions	[redacted]
[redacted]	24.Disturbs	2
[redacted]	41.Impulsive	2
[redacted]	53.TalksOut	2
[redacted]	67.DisruptDisc	2
2	78.Inattentive	[redacted]
[redacted]	93.TalkMuch	2
2	100.FailsToDo	[redacted]
[redacted]	104.Loud	1
10	Raw Score (Sum)	14
>=98	Percentile	97

Borderline = 93rd-97th %ile
Clinical = >97th %ile

B = Borderline clinical range; C = Clinical range; Broken Lines = Borderline clinical range

Case Study – Austin (April 2025)

- Diagnosed with ASD and ADHD
- Currently in Grade 3
- NDIS in place – OT and psychology. Previously did speech therapy
- Meds – On Concerta 36 mg and intuniv 2 mg mane
- Sleeping well with melatonin
- Growing adequately, doing well with learning and exceptionally well managed behaviours and no overt anxiety

ADHD - for GPs
How to feel more confident!

Dr Mia R West - GP North Geelong

Services & Departments

Barwon Regional Adolescent and Child Health Shared-Care Clinic (BRANCHS)

The Barwon Regional Adolescent and Child Health Share-Care (BRANCHS) clinic is a public general paediatric service for children and families within the Barwon South West region.

The service operates using a shared care model, where all patients seen will have a GP who has agreed to be the ongoing primary provider for the patient. Following a period of assessment within the outpatient service, the patient is discharged back to GP care with a clear formulation and plan. The GP will have ongoing access to support and advice from the outpatient clinic team after their patient has been discharged and will be able to re-refer as required.

Enquiries: Branchs@barwonhealth.org.au

ADHD for GPs

Family comes in with child and opens with:

- The teacher said I have to come to the GP
- The school won't have him unless something is done
- I need a referral to a paediatrician (unsure exactly why)
- I think my child has ADHD

How do you respond?

- Heartsink??

Start with history

We know how to do this!

Don’t be overwhelmed by the enormity of the statements…

Home in on the issues - when, where, when not?

- Don’t forget eyes, ears, learning disorders
- Family history

Other contributing family issues

Start with basics - sleep, family distress, school environment, diet

Tips for a good referral

- As much detail as you can get
- Consider screening questionnaires to assist
- Vanderbilt questionnaire for parents and teachers
- Helps to better define the issues, screens for DDx
- Revised Children's Anxiety and Depression Scale (RCADS)

What to do whilst waiting

- RCH Fact Sheets
- Raising Families Network
- Website for Geelong parents- what to do whilst waiting for your appointment

Stimulant Co-prescribing - why do it?

What's in it for you - as the GP?

- increase access for your patient
- learn something new
- better get to know your patient

Stimulant Co-prescribing - why do it?

What's in it for the paediatrician?

- reduce appts allocated to review
- tackle the wait list
- relationship development with colleagues

Stimulant Co-prescribing - why do it?

What's in it for the system

- improved functionality for children
- improved functionality for families
- improved functionality for the community

Stimulant co-prescribing for ADHD

General

Specialist involvement is necessary for the diagnosis and ongoing management of all ADHD patients

GPs require a S8 permit to prescribe stimulants

Co-Prescribing

General practitioners will only be issued with permits to prescribe stimulants where there is evidence of

- a specialist diagnosis of ADHD
- a specialist review has taken place within a specified period (2 years)

Stimulant co-prescribing for ADHD

Follow-Up Interval

If patients are being co-managed with the GP, the GP must ask for a specialist review at least every 2 years

Maximum Doses Scheduled

No maximum doses scheduled in Victoria. Doses are written on the notification form, and high doses will be queried.

Stimulant co-prescribing for ADHD

Multi-practitioner clinics

At multi-practitioner clinics, more than one medical practitioner might be involved in the management of some patients. For this reason, each practitioner is not required to obtain a permit, provided a valid permit is held by one practitioner at the clinic and the prescribing is consistent with and does not exceed the permit limits or conditions.

How to apply for an S8 Permit

- Safe Script
- Like any other permit (e.g., for opioids)

Good website describing requirements for each state and territory

Details on S8 forms

2022 ADHD National guideline

Stimulant co-prescribing for ADHD

Shared care

Shared Care Pilot – Proposed Model

Model	Description
Option 1	Paediatrician sends a letter to the GP with the assessment report and a tick-box to indicate willingness to participate
Option 2	GP consent is obtained at the initial referral stage allowing for early involvement
Option 3	For noncomplex ADHD, Paediatrician contacts the GP directly after the first appointment to invite participation

Participation is entirely voluntary

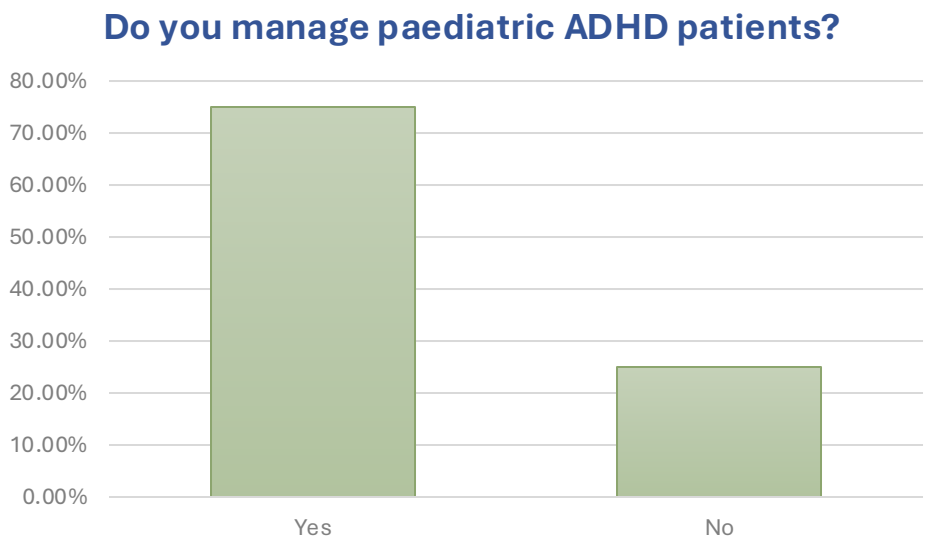
Pilot Details and Mentorship Plan

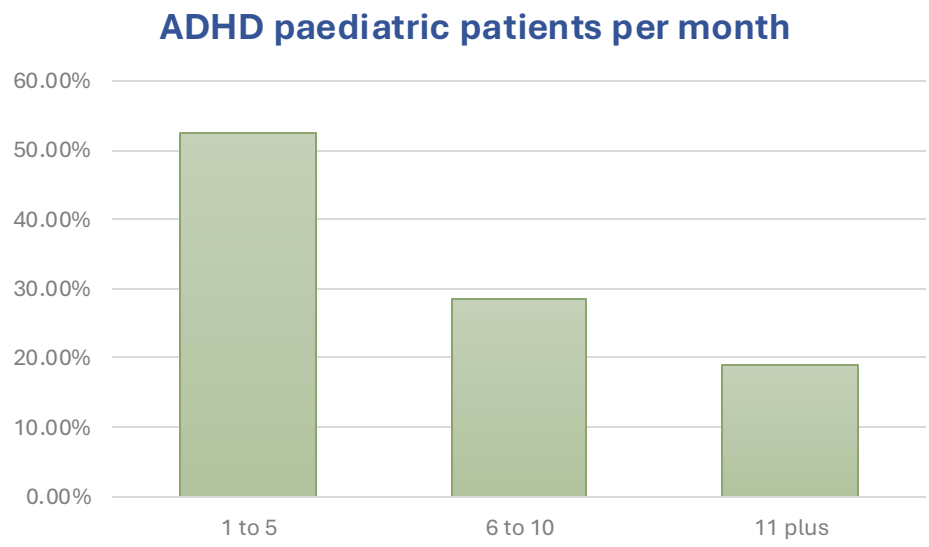
- Clear individualised written guidelines will be provided to GP at handover about dosing regimen and anticipated side effects
- Paediatrician contact provided for troubleshooting
- 4-6 weekly online mentoring for participating GPs
- Treating GP writes back to Paediatrician and regular GP
- Planned yearly follow up of child with Paediatrician
- Audit and feedback loop to refine model

Survey results

Western Health Paediatric Shared Care- Survey for General Practitioners

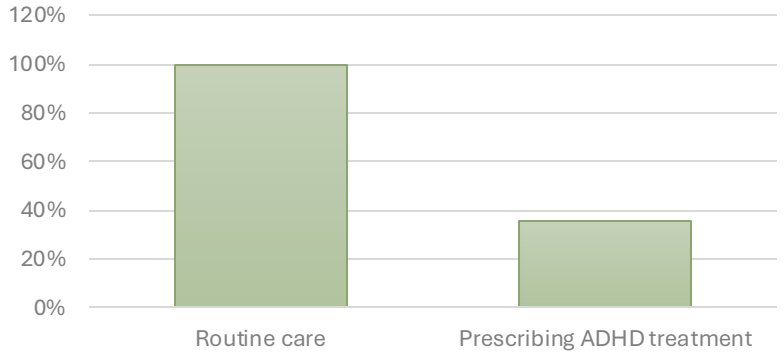
- Total respondents: 28 (4 incomplete)
- Total clinics: 22



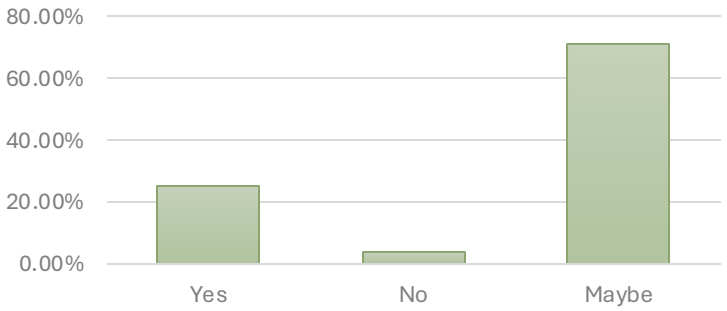


Survey results

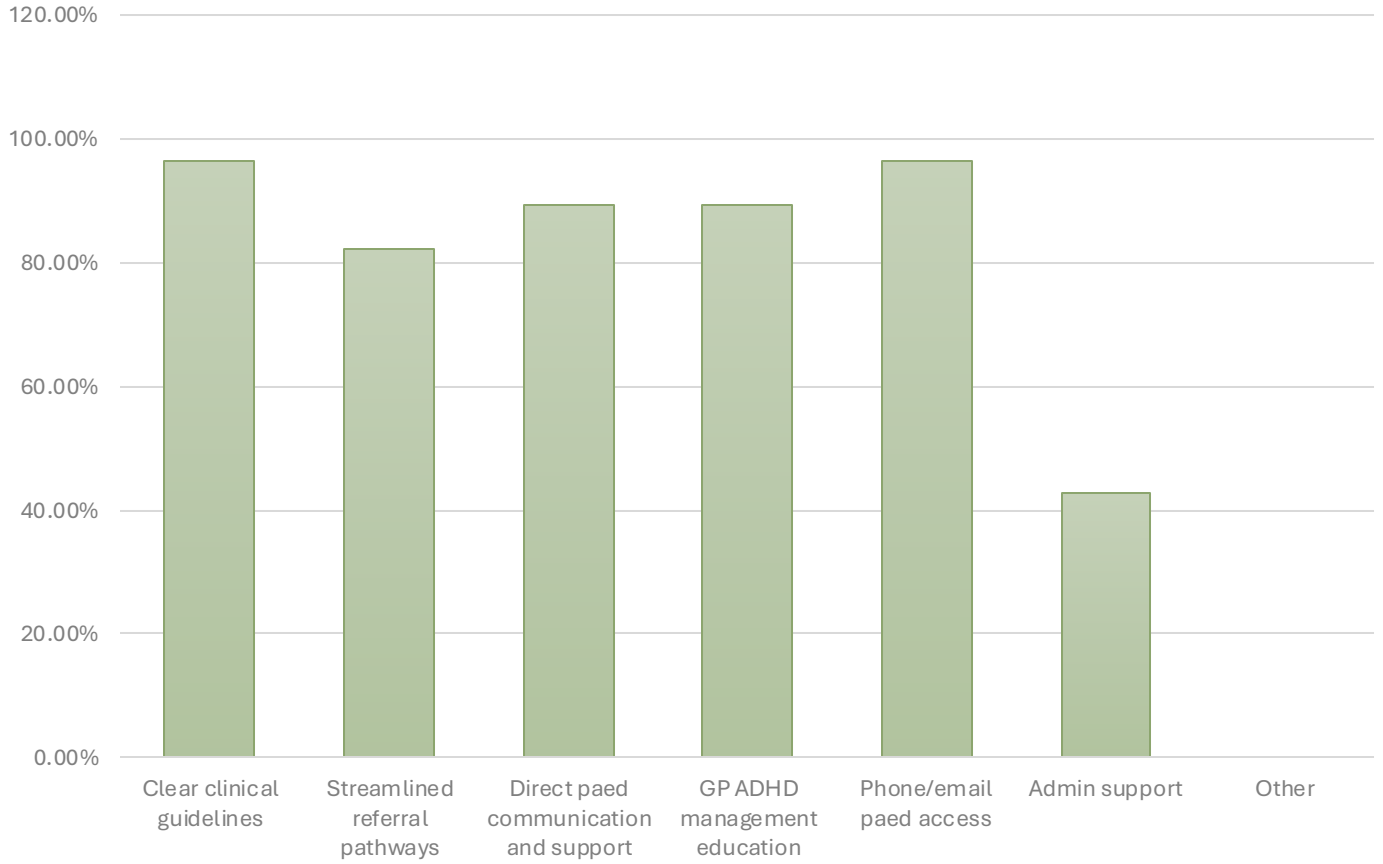
What ADHD care do you provide?



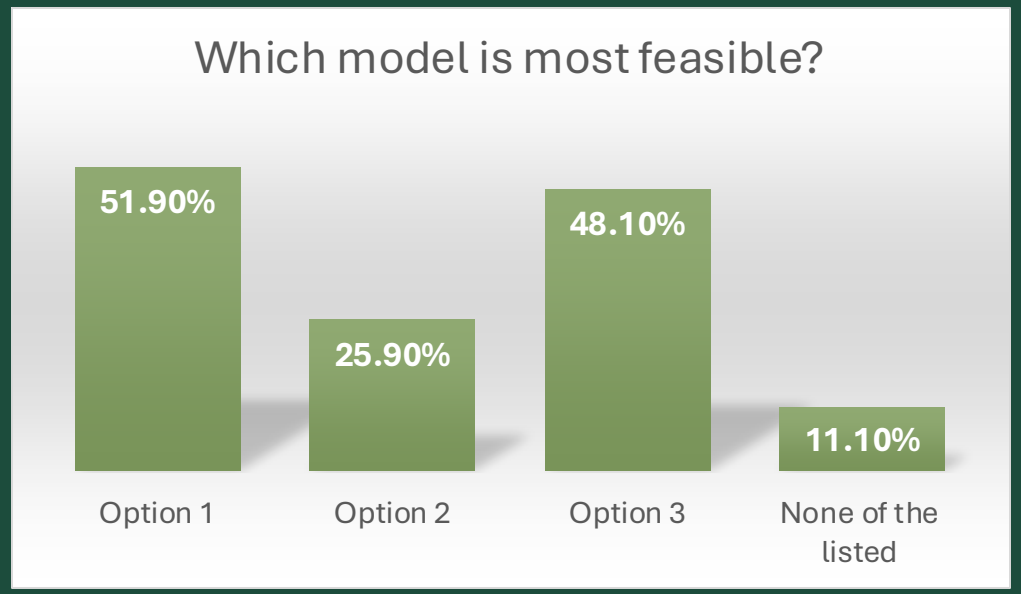
Are you interested in ADHD shared care with Western Health?



What would encourage your participation?



Which option is the most feasible?



1

Option 1= the paediatrician sends a letter to the GP with the assessment report and a tick-box to indicate willingness to participate

2

Option 2= GP consent is obtained at the initial referral stage, allowing for early involvement

3

Option 3 = For straightforward ADHD cases, the paediatrician contacts the GP directly after the first appointment to invite participation

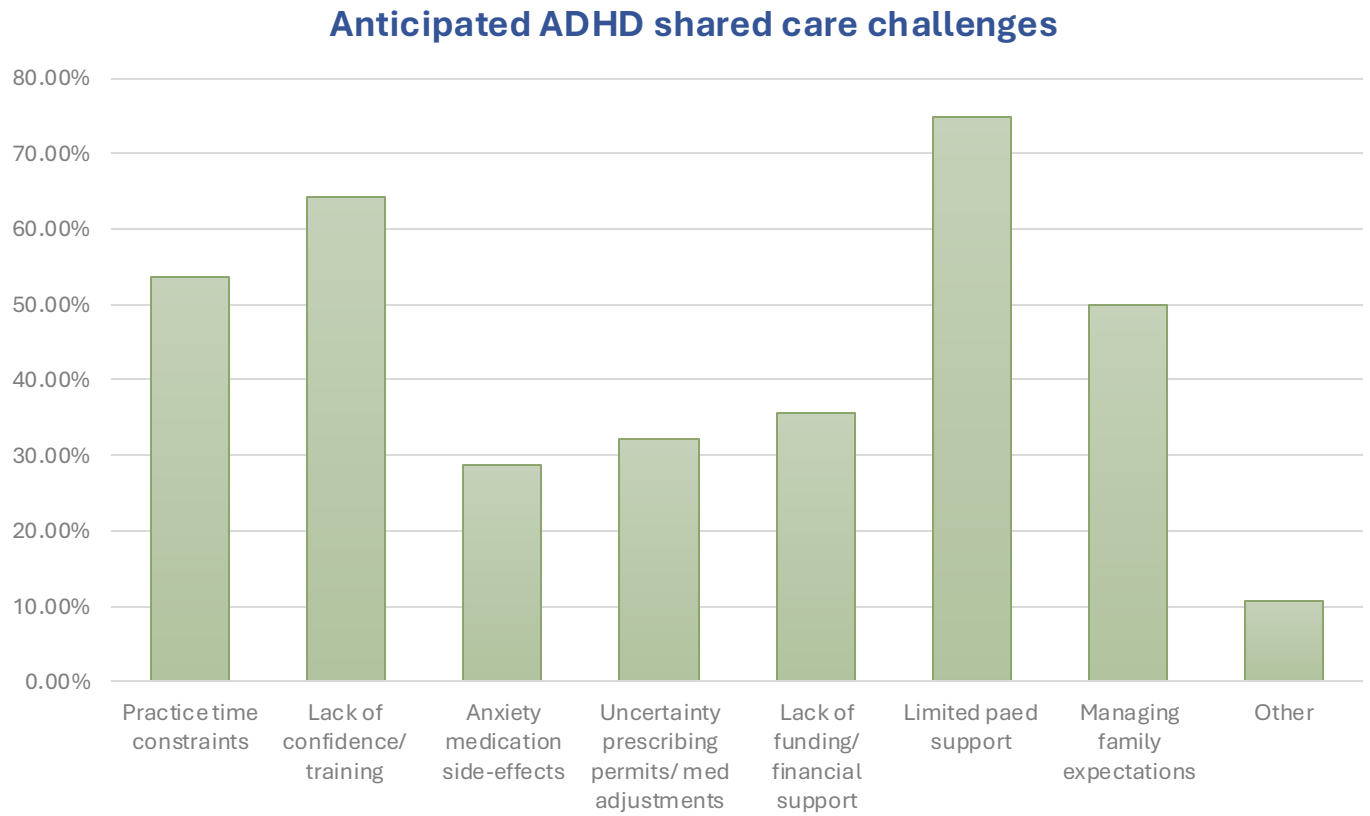
Survey results

‘Other’ comments

‘ADHD in children is very tricky, and I have had no formal training whatsoever.’

‘Increased paperwork and bureaucracy.’

‘Medication titration and transitions between medications would be most difficult.’



Survey results- additional feedback

- *Happy to participate, as long as parents are aware that Bulk Billing in general practice is not feasible to provide high quality care. So, there is a fee for appointment and patient needs to attend for appointments and scripts in person.*
- *The easy availability of specialist advice for review and follow up would need to be clear before I'd participate.*
- *Open communication and consent for communication between specialist, GP, parents and school. Involvement of school for feedback and monitoring.*
- *Paediatric back up is paramount -with thanks.*
- *If it were to turn out like the adult psychiatrists that just diagnose it and leave it all up to the GP to manage, I am not interested at all.*
- *Looking forward to this model.*
- *I think it has to be close shared care rather than a leave it all to the GP. The GP's biggest fear is managing something completely out of their realm, and we all know how long it takes to manage ADHD much less Paediatric ADHD. Renumeration is particularly poor as well, so I am not as keen.*

Summary – The Role of GPs

- GPs are ideally placed to assess context and co-occurring conditions
- Can manage straightforward ADHD within scope
- Better outcomes when primary care is engaged

ADHD is not a constant

- Optimisation of a moving target - Presentation varies over time and context
- Symptoms can wax and wane with life events, developmental changes, maturity and cognitive development
- Level of expectations
- Effects of sleep, hunger, fatigue
- Effects of anxiety
- May appear differently in boys vs girls
- Comorbidities often emerge later
- Ongoing review is essential

Thank you

- My patients
- Dr Nadia Coscini, Paediatrician, ADHD shared care, Centre for Community Child Health, RCH
- South Australian Government- ADHD Shared Care Webinar
- Australian ADHD Professionals Association. (2022). The Australian Evidence-Based Clinical Practice Guideline for Attention Deficit Hyperactivity Disorder (ADHD). Melbourne, Australia: Australian ADHD Professionals Association
- Melbourne Community Health Pathways

Help shape the future of ADHD care

Join our pilot!

ADHD survey available for feedback and suggestions

Questions and expressions of interest welcome

Shared Care- Survey for General Practitioners

This survey should take approximately 5 minutes to complete and is **open until Thursday 15th of May 2025**.

To access the survey, choose **one of the following options**:

1. Complete the survey here.
2. Go to this web address: https://survey.wh.org.au/redcap/surveys/ and enter the code **XPRCLAK8N.**
3. Scan the QR code:

Session Conclusion

We value your feedback, let us know your thoughts.

Scan this QR code

You will receive a post session email within a week which will include slides and resources discussed during this session.

Attendance certificate will be received within 4-6 weeks.

RACGP CPD hours will be uploaded within 30 days.

To attend further education sessions, visit,

https://nwmphn.org.au/resources-events/events/

This session was recorded, and you will be able to view the recording at this link within the next week.

https://nwmphn.org.au/resources-events/resources/