HealthPathways Melbourne

Putting knowledge into practice

CASE STUDY 24:

Attention deficit hyperactivity disorder (ADHD) in children and youth

Oliver, 8, is brought in to his regular GP by his parents. After being informed of disruptive behaviour in school, they are concerned about a potential diagnosis of ADHD and want advice.

The GP opens the ADHD in Children and Youth page on HealthPathways Melbourne to help with the assessment. He notes that the initial consult should focus on the parents' main concerns, and then ask about the child's strengths. It should then move on to an examination.

He takes a thorough history, exploring behaviour at school, home and socially. He also discusses Oliver's positive qualities and strengths.

The GP notes that Oliver is mildly fidgety in the room, but is attentive and otherwise not disruptive. The parents and the boy interact well with each other.

The GP performs the rest of the examination as suggested on the HPM page. The site also contains the Parent and Teacher Vanderbilt Assessent Scale, which the GP prints out and gives to the parents to take home and complete. He provides a second copy for Oliver's teacher to complete as well.

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- Ask the carer about the child's strengths and qualities.
- Ask about any suspected hearing or vision impairment, and issues with sleep and diet.

- Engage the child and perform an examination.
  - Note if the child is overly restless, disruptive, impulsive, or inattentive. These behaviours may not be observed in the consultation, even if they occur at home and school.
  - Observe parent-child interaction.
  - Record vital signs including heart rate and blood pressure (BP). See RCH for acceptable ranges for age.
  - Perform an ear, nose, and throat examination.

They plan to make an appointment to see an optometrist for a vision check as part of the examination for contributing factors in the coming week.

Two weeks later, the GP sees Oliver with his parents again. He reviews the completed Vanderbilt assesments. Oliver is then taken to wait ouside the room with his dad, while the GP continues the consult with mum. They explore the symptoms in more depth, as suggested by the page, including a biopsychosocial assessment.

It is agreed that Oliver has a possible diagnosis of ADHD. Mum agrees to a referral privately to a paediatrician for formal diagnosis and management. The GP includes the completed Vanderbilt Assessment in the referral.

During the consult, the mother expressed concerns that Oliver's possible ADHD was caused by parenting, or the food they'd been feeding him. The GP reassured her that there was no evidence behind those common fears.

He gave her a printout of the '13 Myths about ADHD' fact sheet from ADHD Australia, which is also embedded on the HPM page. The GP also referred her to other useful online resources to peruse while awaiting the paediatrician appointment.

- Parenting and school support – provide online resources for carer to access.

  Online resources for carer

  - RCH – ADHD: Ways to Help Children at School and at Home
  - Raising Children – How to Support Your Child with ADHD: 5-11 Years or How to Support Your Child with ADHD: 12-18 Years
  - Other useful online sites include ADHD Australia, ADHD Foundation, Parents for ADHD Advocacy Australia

The GP explained that the best outcome was from a combination of pharmacological and non-pharmacological management. Pharmacological management would be initiated by the paediatrician after formal diagnosis, but non-pharmacological treatment could start immediately.

3. Start non-pharmacological supportive treatment while awaiting formal diagnosis.
   - Parenting and school support – provide online resources for carer to access.
   - Psychological treatment – consider Mental Health Plan for ongoing paediatric psychology referral to provide:
     - Behavioural strategies, social skills training, parental support

The mum asked about the medications that might be started by the paediatrician.

The GP opened the HPM ADHD Medications for Children and Youth page to hep discuss these with her. He explained that stimulnts were first line for ADHA management, but non-stimulant options also existed.

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He advised that initial monitoring and adjustment will be done by the paediatrician, but once stable, the medications could be prescribed by the GP, subject to paediatrician reviews. These generally took place annually, but could be up to 24 months.

He explained the requirement for a S8 permit through SafeScript if the GP was to prescribe.

They talked briefly about what Oliver would be monitored for if he started on medication.

5. Arrange ongoing monitoring – at least every 6 months check:

- medication effectiveness.
- for side-effects.
- for drug diversion and use of recreational drugs.
- blood pressure and heart rate (see Royal Children's Hospital – Acceptable Ranges for Physiological Variables). If new cardiac signs or symptoms occur after starting stimulant medication, including new hypertension for age, increasing tachycardia or syncope (very rare), seek paediatric medical advice.
- growth – height and weight. If concerns about growth delay or excessive weight loss (monitor using growth charts), seek paediatric medical advice.
- for any cardiac concerns.

Mum was comfortable with the plan, and they arranged another follow up to further discuss the non-pharmacological management and arrange allied health input.