How to AHPRA-Proof your Practice
(ADHD and medicolegal issues)

Brisbane, 2019
Dr Roger Paterson
Declaration of Interest:

• Speaker’s fee received from Janssen, Lilly, Novartis, Takeda and Servier.
• Advisory Board paid member- Lilly and Takeda.
• Conference sponsorship: Astra-Zeneca, Janssen-Cilag, Lilly, Novartis, Pfizer, Shire, Solvay and RANZCP.
Psychiatrists keep medical defence associations busy - Avant

- Avant insures half the doctors in Australia.
- One in 7 psychiatrist members had a claim last year.
- 4/5 complaints were to regulatory authorities or coronial matters.
- Civil compensation claims extremely rare (because no physical injuries are involved).
- Communication issues are a common cause of complaint.
- Psychiatrists are the specialty group most likely to be supported by Avant for coronial matters. Why? Increasing suicide rates, and increase in psychiatrist members preferring to contact their medical defence association to prepare a coronial statement.
• Health professionals trying to help patients with ADHD find themselves working in an area which can be controversial, with ADHD critics complaining about overdiagnosis and unnecessary treatment—particularly about the use of what they claim to be dangerous stimulant medications.

• It behoves practitioners to ensure that they are practising in a way which limits their exposure to criticism and legal action against them.

• We will discuss today various scenarios in which conflict may arise.
Panel Members

- Dr Susan O'Dwyer (Chair, Queensland Medical Board).
- Rachele Mitchell (Solicitor, MDA Queensland, claims manager).
- Dr Tony Mander (psychiatrist in private practice, Perth, and a medicolegal expert).
Are medical boards checking on ADHD practice particularly?

There is a sentiment nationally suggesting that ADHD practice is a particular focus of national medical boards. After all, medical board members are only human and cannot help but be affected by the ADHD controversy.

• My 2 case experience with AHPRA suggested that also: patients made a relatively circumscribed complaint but I was then asked to defend my entire style of practice – assessment, diagnosis, management, et cetera.

Denial by AHPRA:
“we would like to confirm publicly that the Medical Board of Australia is not targeting any one group of doctors, including practitioners who work in the challenging field of ADHD diagnosis, assessment and management” Dr Joanne Katsoris, executive officer, MBA, 18/1/19, personal communication.
RP will explain the background of ADHD within Australia, trying to understand why ADHD has some areas of controversy and medicolegal potential conflict.

RP will outline various scenarios as below and then invite others to add their scenarios.
Figure 3: Total number of patients on ADHD therapy per quarter
Source: DHS prescriptions database, extracted February 2018
Figure 9: Number of people supplied an ADHD medicine per 1000 population in 2017 by patient state/territory and age group
Source: DHS prescriptions database, extracted February 2018
Figure 10: Number of people aged ≤17 years supplied an ADHD medicine per 1,000 population in 2017 by patient state/territory and medicine (age adjusted\(^b\))

Source: DHS prescriptions database, extracted February 2018
\(^b\) based on 2017 ABS estimated residential population data
Figure 11: Number of people aged ≥18 years supplied an ADHD medicine per 1,000 population in 2017 by patient state/territory and medicine (age adjusted)

Source: DHS prescriptions database, extracted February 2018

Based on 2017 ABS estimated residential population data
Attention Deficit Hyperactivity Disorder: Utilisation Analysis
Drug Utilisation Sub-committee (DUSC), May 2018

DUSC consideration - DUSC noted that clinical practice guidelines for the management of ADHD have not been updated with the addition of new medicines to the market (i.e. lisdexamfetamine and guanfacine). Patients requiring ADHD treatment are usually commenced on a low dose of dexamfetamine, lisdexamfetamine or the short-acting formulation of methylphenidate and up-titrated to optimal doses. Once dose stabilised, patients may switch from short-acting to long-acting methylphenidate. While a co-administration analysis was not performed in this review, DUSC noted that there is a degree of co-prescribing of short and long-acting formulations in clinical practice. The dosing of ADHD therapy is complex and dependant on multiple external factors (e.g. timing required for symptomatic control during school hours). DUSC considered that input from clinicians and consumers would help understand the patterns of use for future reviews of ADHD medicines.

The utilisation of ADHD medicines increased between 2013 and 2017 in terms of both prescriptions and patients. **DUSC expressed concern that the average rate of growth during this period was high. DUSC considered that the growth in the market could be due to improved diagnosis and recognition, but may also be due to overdiagnosis and overtreatment of ADHD. Additionally, DUSC discussed potential off-label use (e.g. fatigue and depression) or diversion and abuse as factors that may contribute to the growth in the market.** DUSC also noted that the listing of lisdexamfetamine contributed to the market growth.

Although more males than females were treated, DUSC commented on the higher rate of growth in females, as evidenced by the almost doubling of the number of females treated between 2013 and 2017 (Table 5 of the report).
- My training in child psychiatry - ADHD very rare, medication prescribed reluctantly, teenagers grow out of it.
- 1989 - Public and private child psychiatry revealed that it was not rare, and I needed to up-skill (paediatricians to the rescue!)
- Stimulant medication helpful for all ages, everyone happy.
Treating ADHD so much fun!

- The patients are keen on treatment.
- The treatment works.
- The medication is relatively “clean”.
- There are clear benefits to be seen in school, work, family life and society in general.

- What could go wrong?
Hot Topic!

ADD drugs abused: study

WA doctors again push ADHD drugs

ADD an adult problem, too

Doctors in ADHD firing the AMA

The West Australian Thursday August 16 2004
The West Australian

The most heartbreaking note in Martin Place

MY TIME SPENT WITH A MADMAN GUNMAN’S LINKS TO WA

THE SYDNEY SHOOT SPECIAL REPORTS PAGES 4-7

DRUGGED KIDS
Surge in WA children given stimulants to combat ADHD
Only a WA problem?

- Perhaps this negativity is just local?
- Solution – attend international conferences on ADHD.
- Off I went to Milan for the ‘4th World Congress on ADHD’ (June 2013) to be greeted by …..
“E’ ADHD

E’ UNA GRANDE BUFALA!”

4th World Congress on ADHD, Milan 2013.
More kids on anti-psychotics

The number of WA children on anti-psychotic medication has risen 75 per cent in four years — the highest increase in Australia.

Figures from the Department of Human Services show 13,655 Australian children under the age of 17 were on anti-psychotics in 2012-13, 60 per cent more than four years earlier.

WA had the biggest increase, with 778 children prescribed the medication, compared with 445 in 2008-09. Queensland had the highest prescribing rate overall.

The figures, obtained by the Citizens Commission on Human Rights, also show 1106 children under seven — 42 of them in WA — were among those on anti-psychotics.

Child health experts remain divided about their use. Some believe they are overprescribed while others say the rise reflects more children needing help to deal with issues such as aggressive behaviour.

Child psychiatrist Jon Jureidini said there was no doubt anti-psychotic medicine was the only option for some troubled children but in other cases it was being wrongly prescribed, with not enough monitoring of potentially serious side effects.

"The figures I've seen suggest their use is increasing but rather than saying they're being over-prescribed, I'd say in cases they're being badly prescribed in the sense of not being sufficiently thought through," he said.

"They're not being integrated into other interventions and there's insufficient vigilance in monitoring for adverse effects once they're prescribed."

"I don't have a problem with children being given these drugs if the alternative for them is far worse. My concern is some children are being given them when the alternative isn't worse."

Royal Australian and New Zealand College of Psychiatrists chair Nick Kowalenko said caution was taken when prescribing the medications to children.

They were classically prescribed for autistic children who had behavioural difficulties.

"There is a strong obligation on the prescriber to make sure informed consent is in place, especially for younger kids, and that means being absolutely clear with parents about potential risks and side effects as well as the benefits," Dr Kowalenko said.

"A lot of people think medication will fix everything, but it needs to be part of a comprehensive framework."
Therapy Stress from Negativity

- “ADHD does not exist” - community and peers.
- Stimulants - mostly referring to dexamphetamine, were “dangerous and best avoided”.
- But non-stimulant treatment for ADHD acceptable.
  - That is, the medication was the problem, especially dexamphetamine: induced psychosis, addictive, abused, dangerous.

Welcome to the world of...
Demonising Dexamphetamine (DD)

eg WA government in 1994- allowed adults with ADHD to have treatment. They were comfortable with Ritalin for ADHD, but no research on dexamphetamine in adults and therefore were suggesting they may possibly curtail supply.

• Solution - research project, combined private psychiatry practice and Health Department support:

• Problem solved?

• I don't think so!
More DD

- “Psychostimulants, adult ADHD and morbid jealousy” ANZJP, February 2000.

Case report, with summary:

- “We believe that it is only a matter of time before legal forces are brought to bear against practitioners who prescribe these medications for a controversial disorder (ADHD).”

- October 2000, my response: a single case report “allowed to be used as a Trojan Horse to release the author’s attack on misdiagnosis of ADHD and consequent misuse of stimulants in WA”. No general evidence provided.

  No unique features of the case - why published?
  Denial of ADHD persisting into adulthood.
  The patient also abused methamphetamine.
More DD

- AMA WA psychiatry spokesperson in early 2000s repeatedly asserting in the one and only WA newspaper “The West Australian” that “many cases of ADHD are misdiagnosed”.

- I wrote directly (perhaps too directly) to him suggesting that he might want to try:
  - attending ADHD interest groups,
  - attending the Department of Health Stimulants Committee quarterly meetings,
  - approaching the Medical Board if he has evidence of malpractice.
  - Relevant literature - NHMRC ADHD report 1996.
More DD

- ANZJP, June 2003
- ‘Correspondence’ section- six cases of adult ADHD treatment with dexamphetamine resulting in psychosis.
- Five lines on each patient– complex cases.
- Authors stated “no causal association between prescribed dexamphetamine and psychotic disorder but just suggesting caution”.

Mischief Making
Following laudable papers in the ANZJP 2002 on child ADHD, six excellent papers but one from psychiatrist Dr George Halasz pondered: whether ADHD exists, misdiagnosis, over-diagnosis?

My response - data is patchy in Australia, but there may well be under-diagnosis, but that is never mentioned as a problem.

Solution - data - WA began collecting excellent data from notification forms for all ADHD patients from 2003 onwards, and produced an annual report. Other states have similar data but do not produce reports.

Result - ADHD prevalence (2015): 1.6% children, 0.6% adults.

ALL IS WELL?
NO, the demonisers persisted.

- Community - Dr Martin Whitely (ex-teacher, ex-politician now health consumer advocate, PhD topic “ADHD policy, practice and regulatory capture”).

- Psychiatrists eg – Dr Jon Jureidini in Adelaide(always search for a “better” diagnosis than ADHD).

- Prof Gin Malhi - As ANZJP editor, he allowed the publication in 2013 of the (still) one and only lay ‘Viewpoint’ from Martin Whitely. Many responses were prompted, outlining that ADHD does exist and treatment (inc.stimulants) is helpful.
He cured WA’s ADHD “epidemic”, and gave a dire warning: “In the absence of effective external controls, enthusiastic prescribers may create a child ADHD epidemic which facilitates the widespread abuse of prescription amphetamines and exposes children to the risk of permanent cardiovascular damage and academic failure.”

“Illegal… and… reckless prescribers… resulted in children being hospitalised”
“There is stronger evidence in WA for under rather than over prescribing of stimulants in children with ADHD (and adults for that matter)…. bureaucratic intervention has assisted with both ADHD research and improved clinical services**.”

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

** Paterson et al (ANZJP, 1999). First RCT of dexamphetamine treatment of adult ADHD
Other DD battles

- PBS 2010 - precipitously reduced the allowed dose of dexamphetamine from 12 tablets down to 8 tablets on the PBS – my protest for 6 months led to reinstatement.

- Obstetrician letter back to GP (I was copied in) with several medical disorders mentioned in the problem list, but only the ADHD diagnosis put in italics. Robust exchange ensued inc. highlighting joint research (at the women’s hospital where he worked) on stimulant lactation levels, involving my patients.

- Emergency Department Drs phone calls and letters, reporting (often gleefully) that my patient taking dexamphetamine had presented in a psychotic state - no mention of polysubstance abuse, no urine drug screen done.

- Psychiatric hospitals feedback - notification to the WA Health Department of a stimulant induced psychosis, done even before the discharge summary. Polysubstance abuse ignored. And failure to comply with WA Health Department regulations - methamphetamine psychosis should be reported and often not.

- Psychologists avoiding suggesting to the referring GP that it might be helpful for the patient to discuss with the GP the possible benefit of seeing a psychiatrist and trying stimulant medication – many psychologists are wary of the GP reaction.
Dr Nick Kowalenko (Chair of the RANZCP Faculty of Child Psychiatry) Jan 2017:

• Discussing stimulant medication prescribers: “there must be some maverick practitioners and rogue prescribers but they would be very few”.

• No data backing up this claim.

• Request from me to Nick via the RANZCP College: please avoid public criticism of colleagues, especially where no data is provided. More measured responses appreciated.

• Many promptings to the RANZCP later, finally a reply from Dr Kowalenko in May 2017 (after I threatened a formal complaint): admitted he ‘may’ have used the term “maverick prescribers” as one of several possible data interpretations – unfortunately not mentioning the other possible data interpretations.

• Agreed to be more mindful and judicious. (good!)
Medical Board of Australia & Paterson (May 2016)
(A case largely revolving around ADHD diagnosis and management; prosecuted by the Board, not the patient).

Result: Application Dismissed.

‘The Tribunal prefers the evidence of Drs Mander and Combrinck (WA peers with extensive ADHD experience) in any area where the evidence conflicts with Dr Jureidini and Prof Kalucy’.

Re Dr Jureidini:

‘He does not subscribe to the prevailing mainstream view on ADHD but, in giving evidence, he is operating from what is the mainstream view about ADHD’. Thus, his ‘experience and expertise in treating patients with ADHD is very limited’ and ‘it was very difficult for Prof Jureidini to comment on a diagnosis of ADHD and its treatment, other than in the theoretical sense’.

‘The fact that Prof Jureidini was prepared to make such an extraordinary allegation without any evidence puts into doubt the opinion he has given in other areas’.

Re Prof Kalucy:

‘Professor Kalucy’s experience and expertise does not compare… in the particular area that the tribunal is considering’.
• Criticism should be constructive.

• Destructive criticism leads nowhere, other than obscurity.

• "You do not go up by putting other people down".

• Critics should offer alternatives which are realistic and evidence-based.

• Rather than alternatives which are unrealistic, for example…
Let children cry

Better to be good at feelings than to feel good

Our society is intolerant and disrespectful of young people's distress. We seem to dislike it when young people are angry, ashamed, frightened, sad or disappointed. There is strong encouragement to consider such distress as being a precursor of disease, so that parents, doctors and teachers are prone to label and intervene rather than sit with ordinary, healthy, but distressing feelings. Distressed children are already inclined to numb themselves, whether with drugs, phone or screen time. Prescribing medication to lessen mental pain potentially adds to this numbing, creating a reduced state in which children are not fully themselves, and are less able to get on with the task of growing up.

We would do better to trust children's capacity to survive and benefit from strong uncomfortable feelings more respectfully of the time and space that is required to do so and tolerate and manage the anxiety we experience through not intervening.

This less interventionist approach presents a substantial challenge because the distress that young people experience is a big deal. Adolescent suffering should not be dismissed as just adolescent turmoil; this turmoil can lead to a kind of madness. But it is most often an ordinary madness that requires support and containment, not diagnosis and treatment. (The term 'madness' is used in keeping with the preference of many people with lived experience.)

That somebody is distraught doesn't mean that they are sick.6 Giving priority to catching psychiatric illness early risks disrespecting an adolescent's need to go through hard times in order to emerge as a mature functioning adult, as occurs in situations such as these:

Jane's parents underestimate the intensity of grief she experienced at her grandmother's death and the space needed to deal with it.

Robert is quietly and bitterly preoccupied with the disappointment of always falling short of his father's expectations, and it will be some time before he can come to terms with this.

Amy's quiet, compliant and apparently positive adjustment to the violence of his childhood comes unstuck as he becomes more cognitively mature. These around him misunderstand the changes as a deterioration in his mental health.

All of these scenarios are consistent with developmental breakdown.7 As bad as the experience might be for adolescents and those around them, staying with and passing through significant dysfunctions can be required to reach positive outcomes.

Confronted with potentially fatal behaviour ("she is cutting; will she kill herself?"; "he smokes dope every night; will he end up being a junkie"), a parent might easily confuse the imperative to take these things seriously with a need to intervene on behalf of the child. It is desirable to understand and explain a young person's distress8 but this is not always possible, and even when it is, suffering often continues. Sometimes there is a need to take distress seriously without trying to take it away.

Of course, confronted with a distressed young person (our own or someone else's), we need to make sure that they are adequately protected from those dangers that we can and should remove (such as domestic violence) and adequately informed about their choices, and we need to confront them when we think they are making bad choices. But going too far in any of these areas creates problems; if we overprotect, if we stray from informing to berating, if we confront in a way that is humiliating, then these apparently positive parental activities can do more harm than good.

So having done our best to make meaning from the child’s distress, and instituted sensible safety measures, we will still often feel powerless and frightened; the task for parents, carers and professionals is to “face off” that fear, acknowledging and trusting in those capacities that were apparent before the young person became distressed.

We also need to tolerate this fear and uncertainty for more than a couple of days, making space and time to stay with feelings and experiences through to completion, possibly over many months. While a sensitive well-trained therapist can be helpful, engaging with the mental health system risks interrupting this completion, diagnoses and treatments (especially but not only medication) aim to put an end to distress, rather than see it through.

Another challenge to completing emotional experience is the high level of distraction through social media and multiple screens. Those old enough to have had a boring childhood might remember how boredom facilitates inventive, turn generating creativity. That world cannot be recreated, but young people can be helped to accept that they need not fill every empty moment with relatively meaningless activities, and encouraged to make the time required for resolution of their strong feelings. Respecting and making space for them requires parents to tolerate unpleasant fears and anxiety. Parental duties include sleepless nights, not just with a restless toddler, but lying awake wondering what an adolescent is up to.

Distressed young people need empathy ("ability to understand and appreciate another person's feelings, experience") rather than sympathy ("a feeling or frame of mind evoked by and responsive to some external influence"). A sympathetic father experiences his own pain in response to his daughter's predicament and desires to remove that pain; an empathic father also feels his own pain but gives higher priority to the child's experience, and to understanding and/or containing her pain rather than removing his own.
Jureidini Quotes:

• If we can find a way to do nothing, I think that is the ethically most admirable thing we can do as therapists. Doing nothing is actually the least imposition on a person's autonomy… Doing nothing therapeutically – is watchful waiting¹.

• With the aim of developing a narrative that explains their predicament².

• Seek a better explanation as to why their child is hyperactive, inattentive or impulsive, rather than calling it ADHD³. (that is, ADHD is a ‘low value’ diagnosis)

References:
2. Paediatric Mental Health Training Unit website: Making Meaning.
3. Think twice before prescribing for ADHD. MJA InSight, 4 April 2016
Let children cry. MJA 4 May 2015

“To THE EDITOR: We believe that Jureidini challenges one of the fundamental ethical principles of medicine; namely, a doctor's duty to relieve suffering whenever possible. While we willingly accept this principle when dealing with physical pain, why should it be called into question when dealing with mental suffering?......

Indeed, the majority of *headspace* clients receive these (*psychological and behavioural*) interventions rather than psychotropic medication. Newly available data highlight the functional gains associated with these approaches.”

Patrick D McGorry MD, PhD, FRANZCP  
Debra J Rickwood BA(Hons), PhD, FAPS  
Ian B Hickie MD, FRANZCP, FASSA
Adolescent psychopathology and the death of meaning in psychiatry

Edwin Harari

While Professor Jureidini (2012) rightly urges psychiatrists to explore the meanings of patients' behaviours, he ignores the psychodynamic foundations of the narrative frame that can contribute to understanding such meanings.
And it’s not just DD in ADHD – also in Depression.

Do the old psychostimulant drugs have a role in managing treatment-resistant depression?'

Gordon Parker, Acta Psych. Scand 2010

Significant outcomes:

• In a case series of 50 patients (aged 20-87) with a treatment-resistant depressive condition, some two-thirds benefited from a low-dose psychostimulant (mostly methylphenidate) prescribed as monotherapy or as an augmenting drug.

• Side-effects were uncommon and generally slight.

• In those who improved, reports of tolerance were rare.
Dexamphetamine in Depression

RANZCP “mood disorders guidelines” ANZJP, Dec 2015
• Monotherapy? No
• Augmentation? No

But…suddenly, stimulants have a role in depression, granted by their harshest critics!

ANZJP, Mar 2016
• “Stimulants for depression: on the up and up?” Gin Malhi et al
• Psychostimulant usage in depression acknowledged, without research evidence.
• Therefore, “they should only be prescribed if absolutely necessary, and even then their prescription should be facilitatory and time-limited unless it is for investigational purposes”. (Facilitatory being a new term that Malhi et al. invented)
• Facilitatory means use in the early stages of treatment and withdrawal “once antidepressant treatment has been successfully established”. Wary of ongoing treatment running the risk of “dependence and serious adverse effects”.
• What are these adverse effects? - “addiction……actually research suggests they are relatively well tolerated… up to 9 weeks.”
• Longer-term – uncertain, Malhi states, but ADHD usage trials have been up to 2 years in research settings (and clinically 20 - 30 years worldwide) without reports of problems
How to get involved while maintaining a level head?
• Solution - fight back, steadily, politely, firmly, eg:
  “Praise sandwich” =“I appreciate your interest. I wonder if your suggestions of malpractice and incompetence on my part could be thought through more analytically. I look forward to constructive debate.”
  When replying to GP letters, copy in any other doctors involved, i.e. spread the ADHD word.

Be evidence-based, eg:
• National Health and Medical Research Council (NHMRC) updates : ADHD draft report 2009, and Clinical Practice Points on children/teens 2012.
• Health Department Stimulant Panels - best to work with them, get a good working relationship.
• RANZCP Psychiatry College – guidelines on ADHD and stimulants……
Royal Australian and New Zealand College of Psychiatrists (RANZCP) have three guidelines on ADHD and stimulant medication (open to the public, Google RANZCP Guidelines and Resources, two under ‘ADHD’ and one under ‘Treatment’).

• Government support – The Hon. Roger Cook (Deputy Premier and Health Minister in WA), and son of an eminent child psychiatrist - his letter following complaint about the “mockumentary”: ‘ADHD is BS’.

• Many complaints from consumer groups and individuals about Martin Whitely to the WA Health Consumers Council, and to the WA Medical Board about Dr Joe Kosterich.
Thank you for your email dated 15 May 2017 regarding the ‘ADHD is BS’ video.

I agree that this video provides irresponsible and misleading information, and furthermore is not satirical but mocks and stigmatises mental illness and developmental disabilities. Attention Deficit Hyperactivity Disorder (ADHD) is a well-validated disorder supported by scientific research, including epidemiological, genetic, neuroimaging, medical, neuropsychological and treatment evidence.

Please be assured that I share your concerns that this video may cause harm by confusing or distressing children and their families, as well as adults with ADHD, and prevent them from seeking evidence-based treatment.

Thank you again for taking the time to bring this important matter to my attention.

Yours sincerely

[Signature]

HON ROGER COOK MLA
DEPUTY PREMIER
MINISTER FOR HEALTH; MENTAL HEALTH
11 JUL 2017
ADHD drug use on rise

KATE CAMPBELL

THE number of WA children prescribed medication to treat ADHD continues to soar and has reached its highest level since 2004.

The Stimulant Regulatory Scheme's latest report reveals that 8857 children were prescribed drugs for attention deficit hyperactivity disorder, a 59 per cent spike from the 5580 youngsters and teenagers on stimulant drugs in 2009 and an 11 per cent jump compared with 2015.

In 2004, amid community concerns, the Health Department started monitoring the number of children prescribed these medications, leading to a dramatic drop over several years. But the latest figure has returned to the same level recorded in 2004 of 8859 children.

Overall, 21,840 West Australians — adults and children — were prescribed ADHD drugs in 2016, a rise of 6 per cent over 12 months and a 44 per cent increase over the past 12 years.

The number of adults on this medication has sharply increased since 2004, from 6304 people more than a decade ago to 12,983 in 2016.

Two-thirds of the people prescribed medication in 2016 were males. Nearly 60 per cent were adults.

Those prescribed ADHD drugs in 2016 represented 0.84 per cent of the WA population, compared with 0.64 per cent in 2011.

While 6.6 adults out of every 1000 are dispensed ADHD medication, that ratio is much higher for children, at 14.2 per 1000.

The Health Department must be notified of all patients prescribed dexamphetamine or other similar stimulant drugs for the treatment of ADHD.

While the debate remains over whether ADHD, particularly in children, is over or under-treated by the medical profession, Australian Medical Association WA GP spokesman Dr Simon Torvaldsen stressed the prescription of these drugs was "rigorously assessed and monitored".

"To be prescribed ADHD medication you need to be assessed and managed by a specialist, with follow-up consultations to assess response and regular specialist reviews," Dr Torvaldsen said. "It also requires a special authority from the Health Department."

He said the ability of teachers to recognise ADHD signs and symptoms had greatly improved, as had the assessment process and management.

Dr Torvaldsen said ADHD, if treated, usually got better with age, but in some cases treatment was needed into adulthood, while some people were not diagnosed until they were an adult.

"In the past, symptoms of ADHD were often missed or ignored, resulting in children falling through the cracks and missing out on education and employment," he said.

"It was under-recognised and under-treated, sometimes with sad consequences."
Cast out the demons, Let there be light!

- ADHD Australia (ADHDA) - community voice very important.

- State support groups (eg ADHD WA – dynamic board supported by a learned Professional Advisory Body).

- Australian ADHD Professionals Association (AADPA) - professional voice very important:
  
  “bad practice anywhere is a threat to good practice everywhere”.
Education on Dexamphetamine dangers:

A. Psychosis - rare, based on many years of clinical experience and HDWA statistics (eg 20,000 people in WA on stimulants and only a handful become psychotic). If psychosis develops, it is brief. No causal link to chronic psychosis.
B. Are stimulants addictive and often abused?

- No, not addictive ("but I wish they were so my patients would remember to take them!").

- Addiction issue- published clinical guidelines are vague. In clinical practice, there are few issues re craving, tolerance or withdrawal.

- But…..Abuse occurs and needs to be acknowledged, but in the context of general prescription drug abuse, eg:
  

Minimise abuse potential by using long-acting formulations: Ritalin LA/Concerta, Lisdexamfetamine (Vyvanse).
Conclusion

- Dexamphetamine is a clinically useful drug, especially in ADHD, but also in other conditions.
- Like all medications, there are benefits and side-effects which need to be balanced.
- “Demonising” dexamphetamine (and by extension conditions that it treats eg ADHD) is to be resisted -firmly, politely and learnedly.
- Encourage critics to be constructive, otherwise they run the risk of drifting off into obscurity.

Get with the angels!
Thank You
The medical expert. Who are they and how they appointed/deemed to be experts?

- In any particular case, there can be many different expert opinions.
- They seem to range from the highly moral where anything below perfection is deemed to be professional negligence, to more moderate views where there is an acceptance that in the day-to-day hurly-burly of clinical life, imperfections and practice may exist but not beyond the bounds of generally accepted practice. RP has highlighted his experience of defending himself against “experts” whose evidence fell apart under the scrutiny of a Tribunal where cold, hard facts were required, not just opinion.
Criticising colleagues

- Rule Number 1, do not criticise colleagues.
- Rule number 2, if you have to criticise colleagues, see Rule number 1!

- Constructive criticism – direct approach probably best.

- Concern about dangerous practice – involve AHPRA?

- Case example: psychologist’s website containing critical comments about the use of medication, e.g:
  
  “(medication) only helps a small percentage of the symptoms….. as experts in this area we have seen the damage that medications can sometimes create socially and in relationships”.

- Best to remember, “you never go up by putting others down”.
  Instead……Help them come up.
Assessment

• GP referrals – how to filter? How to say no politely? If referral accepted, how much information should be provided to patients prior to first appointment?
• Cost of treatment needs to be advised?
• Do third-party informants need to be invited? Reason for their attendance needs to be explained?
• Once the assessment and diagnosis is made, if treatment involves medication, how much consent to treatment is required?
• How much explanation of costs and benefits of medication?
Dr Tony Mander

- Medicolegal experts – the value of experience and common sense.
- The relevant standard – what should be comparative data/regulations/guidelines (State and professional)?
- Treatment algorithms.
- Evidence-based practice versus accepted practice.
- Case assessment process.
- Case examples.
Requests for background information on patients

- If transferring to a colleague, need written permission?
- Information requests from insurance companies, employers, sporting regulatory authorities, schools, etc.
- How to comply? Advise patient of contact and invite them to view the material prior to being sent?
Psychologists – don't think you can avoid AHPRA!

- Suicidal patients, information requests, complaints about inappropriate termination, etc.

- Complaints of poor communication to GPs, especially about serious situations (e.g. suicidal risk)
The problem with using a complaint to try to resolve an issue.

- Case example – my patient who suicided. Ongoing “free” consultation between myself and family was offered. Not taken up – AHPRA complaint made, dismissed 7 months later…………and then?

No chance of resolution/mediation.

Possible role for AHPRA e.g. at notification, a polite suggestion to the complainant that an attempt at direct resolution with the health professional may achieve more in terms of education and understanding, and best practice.

The problem with a formal complaint as the 1st response when things go wrong?

Drs practice very defensively and avoid taking on higher-risk patients:
The “Charlie Teo” syndrome – Sydney neurosurgeon Dr Teo would operate if there was one in 10 chance of success whereas many of his colleagues would not(it would spoil their success rate statistics when audited), and would criticise Dr Teo for being reckless. Results – patients with slimmer chances of success are not being treated.
How should patients communicate with their doctors?

• Always face-to-face?

• Go modern eg email, phone, text, facebook, Skype?
Documentation

- My experience of "aide memoir" style of notetaking was seen to be inadequate when exposed to the "blowtorch" of an AHPRA enquiry.

- Solution: transition to digital records, with a typed record made of every consultation (face-to-face or phone). Emails filed. Transition from an old fashioned filing system to an electronic digital record took some effort but was very worthwhile.

- The gold standard for medical records – if the clinician was to disappear overnight, could another clinician step in the next morning and carry on the practice by having access to fulsome medical histories and plans of action?
Group email forums (eg AADPA)

1. Inappropriate postings –
   • criticising colleagues,
   • advertising,
   • researchers looking for subjects without review of their research.

2. Who is responsible for the postings (i.e. who can be sued?!)?
   • The organization hosting? (Facebook et al opt out)
   • The moderator?

3. Solution? Forum rules, and participants confirm they have read the Policy of the host and agree to abide by conditions?
AADPA NETIQUETTE

• At AADPA we cultivate the sharing of, and respect for, our membership's diversity of knowledge, experience, and opinion.

• The AADPA Group Email is a forum for the benefit of AADPA members created specifically for the discussion of professional issues. Although this is a private group, before you post remember that the Internet is NOT a private place. Everything you post is on the record, permanently available to current and future members.

• To cultivate respectful professional discussions on ADHD and related topics, the rules for this group follow. Members who do not abide by these rules may be placed on moderated status or removed from this group.

• 1) Please refrain from advertising your services or products. Please refrain also from discussing your personal situation / diagnoses.

2) Express your opinion but note that derogatory or defamatory remarks will be removed as they do not promote the aims of AADPA. The moderators of this group email endeavour to remove any comments which are considered inappropriate. If they inadvertently cause offence, then that is the responsibility of whoever made the post, and not the moderators or AADPA.

3) Respect confidentiality. Do not forward AADPA Group emails to any third party. Also, do not forward any emails to the AADPA group without the permission of the original sender.

• 4) AADPA takes no responsibility for any views expressed on the Group Email. It is provided to promote information exchange which may be useful to members in their efforts to help the ADHD community.

• 5) Views expressed are from individual respondents who may be giving advice on how they might manage a clinical situation, but again they are taking no responsibility for a patient's management.
Thorny Issues

• If referral accepted, how much information to provide to patients prior to first appointment?

• Failure to attend after one or two years, advice to State Health Department and GP is adequate?

• Termination of patients who do not seem to be suitable for stimulant medication eg poor attendance, poor compliance with dosage schedules, worsening of clinical situation.

• Concurrent substance usage.
  – How much is tolerable? professional opinion varies quite markedly e.g. from daily marijuana allowed to never.
  – Does it depend on the substance eg alcohol, marijuana, methamphetamine?
Confirmation of Appointment: 10:40 am - September 20, 2017

This appointment is for assessment of possible ADD or ADHD:

• Fill in the attached questionnaires and bring to your first appointment.

• **A relative or close friend** who knows you well **MUST accompany you** to assist me with assessing your history. (If this is a problem, please ring my Secretary **BEFORE** the appointment explaining why).

• Bring any school reports or other assessments you may have, regardless of your age.

• Please note **you must be free of all non-prescribed (ie illicit) drugs for at least six months** so that any prescribing can be made in accordance with the WA Health Department regulations which include the necessity for urine drug testing.

**Payment of accounts must be made on the day of the consultation.**

Your initial assessment fee is $ and with the Medicare rebate deducted the final cost to you is about $. (No Diners or American Express). Follow up appointments are charged by time taken - usually $ - $. Once stabilised, patients are seen at least on an annual basis by me, and the fee for the Annual Review is $ (after Medicare rebate final cost to you about $).

You will appreciate that we are reserving 20-60 minutes for your consultation and that we receive many requests for consultations, some of which are medically urgent. If for any reason, you are unable to attend on that date, we request **one working days notice**. If there is no notice, **you will be charged a cancellation fee which may be any amount up to and including the full fees as above**.

Please remember to bring your a referral letter from your GP and your Medicare card.

**Map Link:** [http://goo.gl/maps/OuoC](http://goo.gl/maps/OuoC)
Questionnaires

• Which ones should we use and how often shall be use them?

• Physical tests (pulse, blood pressure, ECG).
• When should they be checked?
• Any special investigations?
• Do patients need to consent to treatment formally?
• Which treatment to use – medication or other?
• Which stimulant to use? What to do with the 1st choice does not work?
Are rating scales useful in ADHD?

1. Yes  
2. No
# Behaviour Rating Scale

**Patient Name:** ____________________________  **DOB:** ____________________________  **Date:** ____________________________

**A:** Circle the number that best describes your behaviour over the last six months or more. People who know you well can help you fill out the form - if you disagree over which number best fits, circle the highest number.

<table>
<thead>
<tr>
<th></th>
<th>Never or Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Fail to give close attention to details or make careless mistakes.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Have difficulty sustaining attention in tasks or leisure activities.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Have problems listening when spoken to directly.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Have problems following through on instructions and fail to finish work.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Have difficulty organising tasks and activities.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Avoid tasks that require sustained mental effort.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Lose things necessary for tasks or activities.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Easily distracted.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Forgetful in daily activities.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10. Fidget with hands or feet.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11. Have trouble remaining seated when it is expected.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12. Feel restless or move about excessively in situations in which it is inappropriate.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13. Have difficulty doing leisure activities quietly.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14. ‘On the go’ or act as if ‘driven by a motor’.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15. Talk excessively.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16. Blurt out answers before questions have been completed.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17. Have difficulty awaiting turn.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>18. Interrupt or intrude on others.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**For FIRST APPOINTMENT ONLY:**

**B:** If you circled some of the above behaviours as ‘often’ or ‘very often’ were they present before age 12? __________ / __________

**C:** Have the behaviours which you circled as ‘often’ or ‘very often’ caused you significant problems for a long time in your everyday life in different settings (eg school, work, home, socially)? __________ / __________
Notes for Clinician to assist with scoring Behaviour Rating Scale

• Answers in the “often” and “very often” columns are positive scores
• Questions 1-9 rate Inattention.
• Questions 10-18 rate Hyperactivity/Impulsivity.
• DSM-5 Criteria Symptom scores for ADHD:
  – Age 0-16, a score of 6 or more in either the Inattention section or 6 or more in the Hyperactivity/Impulsivity section (standard DSM-5 criteria)
  – Aged over 16, a score of 5 or more in either section.
• If criteria are satisfied for just the Inattention section, the diagnosis is ADHD, predominantly inattentive type.
• If criteria are satisfied for just the Hyperactivity/Impulsivity section, the diagnosis is ADHD, predominantly hyperactive/impulsive type.
• If criteria are satisfied for both sections, the diagnosis is ADHD, combined type.
• The diagnosis should only be made “if several symptoms were present before the age of 12”, but sometimes they are not always obvious eg, a supportive school and home environment can mask symptoms.
• Impairment from the ADHD symptoms should be significant by impairing and “present in two or more settings”, eg school/work and at home.
• The ADHD symptoms are “not better explained by another mental disorder”.

SNAP-IV Teacher and Parent 18-Item Rating Scale  
James M. Swanson, Ph.D., University of California, Irvine, CA 92715

<table>
<thead>
<tr>
<th>Patient/Client Name:</th>
<th>Gender:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of birth:</td>
<td>Gender:</td>
</tr>
<tr>
<td>Grade: Type of class:</td>
<td>Class size:</td>
</tr>
<tr>
<td>Completed by:</td>
<td>Date:</td>
</tr>
<tr>
<td>Physician Name:</td>
<td></td>
</tr>
</tbody>
</table>

For each item, check the column which best describes this child/adolescent:

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Just a little</th>
<th>Quite a bit</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Often fails to give close attention to details or makes careless mistakes in schoolwork or tasks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Often has difficulty sustaining attention in tasks or play activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Often does not seem to listen when spoken to directly</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Often has difficulty organizing tasks and activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Often avoids, dislikes, or reluctantly engages in tasks requiring sustained mental effort</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Often loses things necessary for activities (e.g., toys, school assignments, pencils or books)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Often is distracted by extraneous stimuli</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Often is forgetful in daily activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Often fidgets with hands or feet or squirms in seat</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Often leaves seat in classroom or in other situations in which remaining seated is expected</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Often runs about or climbs excessively in situations in which it is inappropriate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Often has difficulty playing or engaging in leisure activities quietly</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Often is &quot;on the go&quot; or often acts as if &quot;driven by a motor&quot;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Often talks excessively</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>16. Often blurts out answers before questions have been completed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Often has difficulty awaiting turn</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Often interrupts or intrudes on others (e.g., butts into conversations/games)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Scoring guide for SNAP-IV 18-Item Teacher and Parent Rating Scale

The SNAP-IV 18-item scale is an abbreviated version of the Swanson, Nolan, and Pelham (SNAP) Questionnaire (Swanson, 1992; Swanson et al., 1983). Items from the *DSM-IV* criteria for attention-deficit/hyperactivity disorder (ADHD) are included for the two subsets of symptoms: Inattention (items 1–9) and Hyperactivity/Impulsivity (items 10–18).

Symptom severity is rated on a 4-point scale. Responses are scored as follows:

- Not at all = 0
- Just a little = 1
- Quite a bit = 2
- Very much = 3

The scores in each of the two subsets (inattention, and hyperactivity/impulsivity) are totalled. A suggested scoring guideline is below:

**Questions 1 – 9: Inattention Subset**

- < 13/27 = Symptoms not clinically significant
- 13 – 17 = Mild symptoms
- 18 – 22 = Moderate symptoms
- 23 – 27 = Severe symptoms

**Questions 10 – 18: Hyperactivity/Impulsivity Subset**

- < 13/27 = Symptoms not clinically significant
- 13 – 17 = Mild symptoms
- 18 – 22 = Moderate symptoms
- 23 – 27 = Severe symptoms

**Suggested Targets:**

- < 13/27 for inattention
- < 13/27 for hyperactivity/impulsivity

If desired, the average rating for each subset can be calculated by totalling the scores for the items in the subset and dividing by the number of items. The average can be compared with cut-off scores suggestive of ADHD reported in the literature.
Adult ADHD Self-Report Scale (ASRS-v1.1) Rating Scale

**Symptom Checklist Instructions** - The questions on the back page are designed to stimulate dialogue between you and your patients and to help confirm if they may be suffering from the symptoms of attention-deficit/hyperactivity disorder (ADHD).

Description: The Symptom Checklist is an instrument consisting of the eighteen DSM-IV-TR criteria. Six of the eighteen questions were found to be the most predictive of symptoms consistent with ADHD. These six questions are the basis for the ASRS v1.1 Screener and are also Part A of the Symptom Checklist. Part B of the Symptom Checklist contains the remaining twelve questions.

**Instructions:**

**Symptoms**

1. Ask the patient to complete both Part A and Part B of the Symptom Checklist by marking an X in the box that most closely represents the frequency of occurrence of each of the symptoms.
2. Score Part A. If four or more marks appear in the darkly shaded boxes within Part A then the patient has symptoms highly consistent with ADHD in adults and further investigation is warranted.
3. The frequency scores on Part B provide additional cues and can serve as further probes into the patient’s symptoms. Pay particular attention to marks appearing in the dark shaded boxes. The frequency-based response is more sensitive with certain questions. No total score or diagnostic likelihood is utilized for the twelve questions. It has been found that the six questions in Part A are the most predictive of the disorder and are best for use as a screening instrument.

**Impairments**

1. Review the entire Symptom Checklist with your patients and evaluate the level of impairment associated with the symptom.
2. Consider work/school, social and family settings.
3. Symptom frequency is often associated with symptom severity, therefore the Symptom Checklist may also aid in the assessment of impairments. If your patients have frequent symptoms, you may want to ask them to describe how these problems have affected the ability to work, take care of things at home, or get along with other people such as their spouse/significant other.

**History**

1. Assess the presence of these symptoms or similar symptoms in childhood. Adults who have ADHD need not have been formally diagnosed in childhood. In evaluating a patient’s history, look for evidence of early-appearing and long-standing problems with attention or self-control. Some significant symptoms should have been present in childhood, but full symptomology is not necessary.
## Adult ADHD Self-Report Scale (ASRS-v1.1) Rating Scale

### Symptom Checklist

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Today's Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

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?
10. How often do you misplace or have difficulty finding things at home or at work?
11. How often are you distracted by activity or noise around you?
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?
13. How often do you feel restless or fidgety?
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?
15. How often do you find yourself talking too much when you are in social situations?
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?
17. How often do you have difficulty waiting your turn in situations when turn taking is required?
18. How often do you interrupt others when they are busy?

### Part B
ASRS 0-4 scoring.

- 0-16, unlikely to have ADHD.
- 17-23, likely to have ADHD.
- 24 or greater, highly likely to have ADHD

- No distinction between inattentive symptoms and hyperactive/impulsive symptoms in scoring
The Value of Screening for Adults with ADHD

Research suggests that the symptoms of ADHD can persist into adulthood, having a significant impact on the relationships, careers, and even the personal safety of your patients who may suffer from it.\textsuperscript{1-4} Because this disorder is often misunderstood, many people who have it do not receive appropriate treatment and, as a result, may never reach their full potential. Part of the problem is that it can be difficult to diagnose, particularly in adults.

The Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist was developed in conjunction with the World Health Organization (WHO), and the Workgroup on Adult ADHD that included the following team of psychiatrists and researchers:

\begin{itemize}
  \item Lenard Adler, MD Associate Professor of Psychiatry and Neurology New York University Medical School
  \item Ronald C. Kessler, PhD Professor, Department of Health Care Policy Harvard Medical School
  \item Thomas Spencer, MD Associate Professor of Psychiatry Harvard Medical School
\end{itemize}

As a healthcare professional, you can use the ASRS v1.1 as a tool to help screen for ADHD in adult patients. Insights gained through this screening may suggest the need for a more in-depth clinician interview. The questions in the ASRS v1.1 are consistent with DSM-IV criteria and address the manifestations of ADHD symptoms in adults. Content of the questionnaire also reflects the importance that DSM-IV places on symptoms, impairments, and history for a correct diagnosis.\textsuperscript{4}

The checklist takes about 5 minutes to complete and can provide information that is critical to supplement the diagnostic process.

References:

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past few months. There are no right or wrong answers. Do not spend too much time on any statement.

<table>
<thead>
<tr>
<th>MOOD RATING SCALE</th>
<th>Name:</th>
<th>Date:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Never or Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I found it hard to wind down.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2.</td>
<td>I tended to over-react to situations.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3.</td>
<td>I felt that I was using a lot of nervous energy.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4.</td>
<td>I found myself getting agitated.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5.</td>
<td>I found it difficult to relax.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6.</td>
<td>I was intolerant of anything that kept me from getting on with what I was doing.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>7.</td>
<td>I felt that I was rather touchy.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>8.</td>
<td>I couldn’t seem to experience any positive feeling at all.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>9.</td>
<td>I found it difficult to work up the motivation to do things.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>10.</td>
<td>I felt that I had nothing to look forward to.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>11.</td>
<td>I felt down-hearted and blue.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>12.</td>
<td>I was unable to become enthusiastic about anything.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>13.</td>
<td>I felt I wasn’t worth much as a person.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>14.</td>
<td>I felt that life was meaningless.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>15.</td>
<td>I was aware of dryness of my mouth.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>16.</td>
<td>I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion).</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>17.</td>
<td>I experienced trembling (eg, in the hands).</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>18.</td>
<td>I was worried about situations in which I might panic and make a fool of myself.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>19.</td>
<td>I felt I was close to panic.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>20.</td>
<td>I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat).</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>21.</td>
<td>I felt anxious without any good reason.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
GENERAL HEALTH QUESTIONNAIRE:

Patient Name: ___________________________  DOB: ___________________________

Date: ___________________________

Over the last few months, have you had any problems with the following (please comment)

1. General physical health
   - Weight change
   - Sleep
   - Energy levels
   - Pain

2. Feeling anxious, stressed or “on edge/panicky”

3. Feeling less enjoyment in life/depressed

4. Feeling persistently over-excited/over-energised

5. Repetitive thoughts or actions which are hard to control

6. Feeling people are against you

7. Losing touch with reality

8. Heavy alcohol drinking

9. Using illicit drugs (eg marijuana, “Speed”)

Your current medications are? (Name of medication, how many tablets you take and when you take them)
Beyond a full history and examination, are diagnostic tests useful?

1. Yes  2. No
What diagnostic tests are useful in ADHD?
Diagnostic Tests:

• In practice, lab tests and x-rays are rarely useful. Functional Brain tests: SPECT scans (Dr Daniel Amen, US) and quantitative EEGs (↑ slow waves = ↓ alert, inc. theta/beta ratio) have a small following amongst clinicians (recent US FDA approval relates to safety not validity).

• Psychometry - more useful for children and adolescents where there is a suspicion of cognitive deficit/disparity and/or learning difficulties - useful for getting extra educational help in the classroom/exams.

• Allied Health involvement if associated speech, coordination or psychological issues require further assessment.
Is stimulant medication first-line treatment in moderate/severe ADHD?

1. Yes 2. No
Yes. Treatment involves stimulant medication as a first-line for moderate/severe cases, complemented by educational/behavioural therapy.

Other medications may be helpful
- eg atomoxetine, clonidine, antidepressants (bupropion, fluoxetine)

Prescribing of stimulants (ie dexamphetamine and methylphenidate) require abiding by State Regulations ie phone your local Health Department if contemplating stimulant prescribing. In practice, this is not a difficult process.

Pre-prescribing physical checks:
- Baseline pulse, BP, weight (and height if still growing).
- ECG not routine, only if indicated from past medical/family history or physical examination.
Re:
Thank you for referring this XX-year-old first-year XXX student, doing a three-year (arts/politics, philosophy) degree and then assured of a place in the law school for another three-year degree course. He lives at home with father XXX (occupation) and mother XXX (occupation). Only child.

Father and XXX attended today and confirmed a long history very typical of attention deficit hyperactivity disorder (ADHD): overactivity, impulsivity, inattention, distractibility, disorganisation, emotional lability, stress intolerance, inefficiency and struggling to achieve full potential. **DSM-5 symptom checklist** revealed 7/9 inattention and 4/9 hyperactivity-impulsivity. These symptoms have been present all his life when thinking about it, although did not cause many problems as he is very bright and managed to cruise through his early schooling without much effort. No developmental issues. Moving to year 11 was stressful but he coped, but first-year uni where there is a lack of support/"scaffolding" has led to some struggles. Still managed to pass but can see stress in front of him, in fact describes a low-grade, "mild depression". I note a trial of Lovan 0.5×20mg tablet each morning for the last 3 months with no great benefit and I advised cessation.

I think he would benefit from stimulant medication and can see no contraindications. Is generally in good health, no allergies, with no significant past medical history except for occasionally breaking bones (eg skateboarding). He has been on Roaccutane 2 tablets daily for the last few months, and this may have been a factor in his mild depression. But it is helping, side effect of dry lips and suggested Bepanthen plus a mild steroid used sparingly. **No personal or family history of heart disease, unexplained sudden death or syncope.**

Generally of sober habits, social drinker, rarely smokes, heavy caffeine user (probably self-medicating his ADHD) and no illicit drugs – rarely THC. **Urine drug screen clear.**
BP 117/77, pulse 69, weight 76kg.

No other psychiatric problems, socially integrated, no current girlfriend (“looking”), plays in two bands (and has aspirations).

In the family, father thought both parents had some minor attentional problems but learnt how to cope. Mother had postnatal depression, initially treated with Cipramil and later Lovan 20mg daily, and still on this. MGM had some depression and MGF had World War II PTSD and was a “functioning alcoholic”.

Mental State Examination revealed normal appearance and appropriate behaviour. Complained of stress and dysthymia as above. Spoke quietly but with normal rate and coherence. No evidence of abnormal preoccupations or perceptions. Keen to fine-tune his grossly intact cognitive state. Some reading problems in early primary but overcame them. Weak at maths. Displayed mature insight into both his deficits and also consent to treatment offered. Discussed treatment options, likely treatment duration and side effects, especially the rare but severe side effects of psychosis, depression and suicidality.

I will trial him on: Dexamphetamine 5mg tablets, starting low and building up to a level which suits him (given 100). I provided psychoeducation, including a suggestion to join **ADHD WA.** May benefit from seeing a psychologist, or **ADHD coach** to help with organisation/procrastination difficulties. Review in 2 weeks
**Consent to Treatment**

1. I agree to the following medication treatment conditions between myself and Dr Roger Paterson.
2. I confirm that I have been given the Confirmation of Appointment form which outlines the assessment process (questionnaires to fill out, a third-party informant, background information, drug-free status and Dr Paterson’s fee structure).
3. I understand my medical condition and why I am being treated with medication.
4. I understand that all medications have risks and benefits and I have received a separate "Medication Side-effects" form.
5. I understand that I may be subject to urine drug testing at any time to satisfy WA Health Department regulations.
6. I understand that it may be necessary from time to time for Dr Paterson to speak with a third-party about my health. Wherever possible, my confidentiality will be respected and I will be advised of the contact details.
7. Certain medications have greater restrictions about their prescribing. For instance, I may have received the form entitled "Important Information About Your Stimulant Medication" which contains details about minimum dispensing intervals and procedures for lost/stolen/damaged/unavailable stimulant medication.
8. I acknowledge I have received both verbal and written information about my medication. I have received the "Product Information" about my medication from Dr Paterson. I have also been advised to read the "Consumer Medicine Information" pamphlet found in each medication box dispensed at the pharmacy or provided by Dr Paterson. For stimulant medication, Dr Paterson has provided "Information on Attention Deficit Hyperactivity Disorder".
9. I understand that Dr Paterson has the right to terminate my medication at any time should he think it is necessary. Wherever possible, he will take steps to advise me of this process.
10. I understand I need to use the medication as prescribed, and not to vary the dose without making contact with Dr Paterson; and to be careful not to mix it with other psycho-active substances such as alcohol or illicit drugs.
11. I am aware of the Federal Drug Authority (US) "black box" warning about stimulant medications: “chronic abusive use can lead to marked tolerance and psychological dependence with varying degree of abnormal behaviour. Frank psychotic episodes can occur, especially with parenteral abuse. Should be given cautiously to patients with a history of drug dependence or alcoholism. Careful supervision required during drug withdrawal from abusive use since severe depression may occur. Withdrawal following chronic therapeutic use may unmask symptoms of the underlying disorder that may require follow up”.
12. In the event of pregnancy, the safety of my medication needs to be discussed with Dr Paterson. Most medications are safe in pregnancy and lactation.
13. My consent permits the medication dose to be changed within such parameters as discussed with Dr Paterson.

14. I have been given adequate time to study this information and I find the information to be specific, accurate and complete.

15. I have had the opportunity to have my questions answered by Dr Paterson.

16. This medication consent is effective immediately. The need for, and continued use of this medication, will be reviewed by Dr Paterson at least annually if co-prescribing, otherwise at least six monthly. The goal of medication is always to arrive at the most beneficial effect at the least effective dose.

17. This Consent to Medication Treatment form is necessary in the context of modern medical practice being subject to greater medico-legal review. Questions about this process can be directed to the WA Medical Board (Executive Director Ms Pamela Malcolm, Board Chair Prof Con Michael, Level 1, 541 Hay Street Subiaco; Post: c/- AHPRA, GPO Box 9958 Perth WA 6001, phone 1300 419 495).

- Patient Name: ____________________________

- Patient Signature: ____________________________ Today’s date: ____________________________

OR

- Parent/Guardian Name: ____________________________

- Parent/Guardian Signature: ____________________________ Today’s date: ____________________________

- Child’s Name : ____________________________

- Child’s Signature: ____________________________
Information on Attention Deficit Hyperactivity Disorder (ADHD)

BASIC FEATURES:

Poor concentration – Being easily bored, having trouble maintaining interest (especially with repetitive tasks), poor task completion, distractible, forgetful, ‘daydream’, disorganised.

Impulsive – Seek immediate gratification, show impatience, (eg in queues or traffic jams), can be tactless and blurt things out in public, interrupt, talkative, tend to seek stimulation and thrills.

Overactive – Obvious in children but in adults may be persistent but less obvious (eg tapping, twirling, doodling), vacations are action-packed. The technical term for overactivity (hyperactivity) is sometimes used.

These three basic features are evident from early childhood onwards and occur in different situations, eg at home and at school/work. Some people only have the poor concentration and do not display the overactivity/impulsivity behaviour. Hence, some people divide ADHD into:

ADD – Concentration and memory problems without hyperactivity/impulsivity, and
ADHD - Attention Deficit Hyperactivity Disorder - poor concentration together with hyperactivity/ impulsivity

In practice, the term ‘ADHD’ is used to cover both ADHD and ADD

ASSOCIATED FEATURES:

Children - Learning difficulties (eg fail to achieve their potential), persistent pestering, clumsy, disorganised, moody, socially awkward.

Adults - Disorganised, moody, intolerant of small problems, temper problems. Adults may find that their ADHD leads them into many job changes, law-breaking behaviour (eg speeding fines) or drug abuse (especially alcohol, marijuana and ‘speed’/methamphetamine).

GENERAL FEATURES:

This is a common condition (about 1 in 20 children) and persists into adulthood in about half of the cases, but with varying severity. It is more common in boys and is somewhat genetic (ie can be passed from parent to child but can appear without any family history previously). It is probably becoming more noticed now as society places more emphasis on education and sophisticated work skills in order to gain employment.

TREATMENT:

Understanding – It is important to read/talk about this condition with professionals and self-help groups (eg. ADHD WA, phone number: 6457 7544).

Behaviour therapy – There are a number of techniques which can aid concentration (eg decrease distractions, work in a quiet area, short work periods, carry out one instruction at a time), impulsivity (stop…think!), overactivity (alternate work with exercise/relaxation), disorganisation (use lists, diaries). School and work should have structure, be interesting, be supervised and rewards should be frequent and immediate. Psychologists and ADHD coaches help with all these issues.
Cont.

**Medication** – Stimulant medications are the best (they stimulate the under-active organising part of the brain to fine-tune some erratic brain function). Two are available in Australia: Methylphenidate (brand name ‘Ritalin’) and Dexamphetamine. If one does not suit, the other should be tried. The medications can be taken just for school/work periods and not on holidays or weekends, or may need to be taken all the time. It is unclear as to who will grow out of it and who will not, and so extended periods off the medications (eg one month) should be trialled occasionally (eg Christmas holidays) to see if it is still necessary.

They work quickly (about 30 minutes) and last half a day (hence taken after breakfast and lunch). Longer acting (ie once daily) versions are available and they avoid lunch time dosing which is especially handy for school children. Types available include methylphenidate as ‘Ritalin LA’ or ‘Concerta’, and dexamphetamine as “Compounded” or “lisdexamphetamine/Vyvanse”. (Note: Ritalin LA, Concerta and Vyvanse are more expensive if the ADHD was diagnosed over the age of 18).

Other medications can be used but are less effective compared with stimulants.

Atomoxetine (‘Strattera’) can be useful in that it does not have the on/off effect of stimulants and does not have some of the potential side effects (eg decreased appetite/sleep). However, it takes a few weeks to see if it is working (compared to a few days with the stimulants) – cheap if under 19 but more expensive for newly diagnosed adults.

Guanfacine (Intuniv) is mainly used in children, often as a monotherapy. Again, takes a few weeks to work.

Clonidine is useful for the hyperactivity/impulsivity problems and is often used with stimulant medication. Some antidepressants may be useful for their anti-ADHD effect, not for their antidepressant effect.

Currently in WA, only psychiatrists are able to start stimulant medication for adults (ie 18 and over). For children, both paediatricians and child psychiatrists are authorised to start stimulant medications. Once children and adults are started on stimulants and are stable, GPs can sometimes share the prescribing, as a ‘co-prescriber’.

**Instructions for taking Dexamphetamine or Methylphenidate**

Please start with one tablet in the morning with food, and then see how you feel. If nothing much happens, it is likely that you will need a higher dose to get the benefit from the medication and should therefore increase to two tablets per day, either by taking two in the morning, or one in the morning and one at lunchtime (so that the effect will last longer during the day). If still nothing happens, you may need to take three or more tablets per day (split morning/lunchtime doses). The increases in dose can be daily, or slower if preferred, and do not go to more than 6 tablets per day without phoning/seeing me.

Watch out for the common side effects such as losing your appetite, trouble getting off to sleep, dry mouth, nausea or headaches. These side effects usually appear in the first few days and then settle but, if they don’t, you will probably have to reduce the dose to a level where you are still getting good effects from the medication but without unpleasant side effects. The full list of side effects is available from me on a separate sheet, or can be downloaded from the internet. It appears that these medications are relatively safe but, like all stimulants, can be abused and need to be taken as directed by me. Rarely, suicidal thoughts, hallucinations or paranoid thoughts can develop - usually when taken in high doses or mixed with illicit drugs. In this case, the stimulants should be ceased immediately and my advice sought asap. These medications have been taken for many years without major problems, in children and adults. In particular, addiction issues with these medications are not prominent. But they can be misused and abused, and need to be handled responsibly.

The final dose that suits you is a balance between the good effects (eg improved concentration, organisation and mood) and the side effects listed above.

NB: ADHD does have positive characteristics: energy, drive, creativity, lateral thinking - it just needs to be harnessed and fine-tuned.
ADHD Medication Treatment:

1. STIMULANT MEDICATIONS – are the best. They stimulate an underactive part of the brain to become more active and organise the rest of the brain activities. If you like, the ‘sleepy conductor’ is stimulated to wake up and take charge of the brain ‘orchestra’

The two best stimulant chemicals for ADHD are: dexamphetamine and methylphenidate.

- Dexamphetamine was the original, being in clinical use since 1937.
  a) The immediate-release type is called dexamphetamine and only comes in 5mg tablets. They are useful, but only last about half a day and hence longer versions are now available. They are safe, non-addictive and have few significant side effects. But they can be misused for non-therapeutic reasons and hence are restricted to prescription by medical specialists (usually paediatricians and psychiatrists) who may co-prescribe with GPs after treatment is stabilised.
  b) There are two types of slow release dexamphetamine:
    - Compounded dexamphetamine – made up by specialist compounding pharmacies of which there are about 25 in Perth/Bunbury/Albany. Any size from 5 to 60mg can be made, in capsule form. They last longer because it takes longer for the dexamphetamine to be absorbed from the stomach as it is bound with a substance that is harder to digest (Methocel).
    - Lisdexamphetamine/Vyvanse – this can be dispensed at any pharmacy, comes in 3 capsules sizes (effectively small, medium and large, 30/50/70mg capsules) and last longer because the dexamphetamine is bound with lysine (an amino acid found in ordinary food) which slows down the dexamphetamine metabolism in the liver and in the blood.

- Methylphenidate, again available in immediate release and slow release formulations
  a) Immediate release formulation is known as Ritalin and comes in 10mg tablets. It was invented in about 1950 to be very similar to dexamphetamine, but not exact. For most people, it has a similar action to dexamphetamine, but some people might find it much better, or much worse.
  b) Again, Ritalin only lasts about half a day, and there are two slow release formulations which last all day:
    - Ritalin LA, comes in 10/20/30/40mg capsules.
    - Concerta, comes in 18/27/36/54mg capsules. Concerta lasts a bit longer than Ritalin LA (12 hours compared to 10 approximately).
2. NON-STIMULANT MEDICATIONS –

a) "Stimulating antidepressants" – these medications take a week or two to work, and probably a month or two to be fully effective. The most popular is atomoxetine (trade name Strattera) which comes in various sized capsules. Other popular ones are bupropion (Zyban) and fluoxetine (various trade names including Prozac and Lovan).

b) Clonidine (Catapres) – especially useful as a calming agent, mostly taken at night, but occasionally useful during the day for hyperactive patients.

c) Guanfacine (Intuniv) – similar to clonidine, calming but also helps with concentration.

The stimulating antidepressants and clonidine may be combined with stimulant medications.
ADHD Medication Treatment cont

Other medications commonly used by ADHD patients for co-occurring conditions.

a) Hypnotics (ie sleeping pills) - for comorbid insomnia. Common ones include temazepam, zopiclone (Imovane) and zolpidem (Stilnox) - useful but addictive and therefore best used short term or intermittently. Non-addictive hypnotics include old-fashioned antihistamines (no prescription needed), melatonin (natural, and cheaply sourced online) and a few sedative antidepressants.

b) Antidepressants - for comorbid anxiety and/or depression. They combine well with stimulants.

c) Tranquilisers - for calming and mood stabilising. There are two types: addictive and non-addictive. Addictive tranquilisers include diazepam (Valium), lorazepam (Ativan), and alprazolam (Xanax). Common non-addictive types include risperidone (Risperdal), olanzapine (Zyprexa), quetiapine (Seroquel) and aripiprazole (Abilify). Both types can be used in the short-term (ie days/weeks) for controlling such things as agitation, sleep problems, temper and mood instability. If tranquilisers are needed long-term (ie months/years), non-addictive types are preferred. But they can have longer term side-effects (eg weight gain, movement disorders) and need to be monitored.

d) Mood stabilisers - psychiatry ‘borrows’ neurological medications which stabilise epilepsy and uses them for in psychiatry for stabilising mood. Popular ones include lamotrigine (Lamictal), sodium valproate (Epilim) and carbamazepine (Tegretol). They take a few weeks to work and blood levels need to be checked to make sure the dosage is at the right therapeutic level.

e) Occasionally, all of the above medications may be combined so that the patient may be on a combination of a stimulant medication, an antidepressant, a tranquiliser or a mood stabiliser. Obviously, the fewer the medications the better, but sometimes multiple medications (known as polypharmacy) are necessary.
Medication Side Effects

- I acknowledge that Dr Roger Paterson has explained to me that the medication that he prescribed for me/my child has both benefits and risks associated with it.
- The benefits are that it will improve my medical condition.
- The risks are that it may have side effects. Hopefully, these side effects will be absent or minimal. If moderate or severe side effects develop, it is clear that I can contact Dr Paterson urgently for advice on what to do, and that if for some reason I cannot contact him, I should cease the medication until I have been able to contact him.
- For most medications, side effects are minimal and transient (eg nausea, headaches) but some side effects may be more severe and persist. Side effects differ depending on the type of medication is prescribed.
- *Tranquilisers* may produce excess sedation as a common side effect and therefore be wary of driving or undertaking any technical activity. Some tranquilisers may be addictive.
- *Antidepressants* have the very uncommon side effect that they may induce suicidal thoughts. This is rare but if it does occur, the medication should be ceased.
- *Further details about antidepressants overleaf* *
- For all medications, it is advisable to read the information sheet that comes with the medication packet (Consumer Medicine Information).
Medication Side Effects cont

Antidepressants

• Some side effects are likely (e.g., nausea), but most will go away after 1-2 weeks.
• If you are concerned about the side effects you are experiencing, talk to Dr. Paterson rather than stopping treatment. It may be possible to reduce side effects or to find another medicine that suits you better.
• You may feel more anxious or agitated at first. If you are concerned about this, or if your mood gets worse or you have thoughts about suicide, talk to Dr. Paterson as soon as you can.
• You will not feel better immediately. It can take up to 4-6 weeks to feel the full effect, so don't give up too soon. Most people start to feel better within 1-2 weeks.
• You may have to try more than one treatment to find one that works for you.
• Don't stop taking antidepressants as soon as you start to feel better. You will need to take antidepressants for several months. Studies suggest that people who stop treatment too early are more likely to relapse.
• Antidepressants are not addictive. Even so, don't stop taking them abruptly, because it can cause unpleasant side effects. Talk to your GP or Dr. Paterson about how to reduce the dose gradually.
• Some medicines (including herbal and natural medicines) are not safe to take with your antidepressant; for example, St John's Wort and many cough and cold medicines. Tell your doctors and pharmacist about all the medicines you take.
Important Information about your Stimulant Medication:

This medication is restricted and requires doctors to follow the WA Health Department requirements. (web search “Stimulant Medications - Healthy WA”).

1. Do not increase the dose beyond that which I have prescribed without first contacting me, otherwise you will run out of tablets too soon and I will not be able to reissue a new prescription any earlier than when it was due, ie you will end up going without medication for a period of time which is not satisfactory.

2. On the prescription, I write that the minimum time between picking up repeat prescriptions is 21 days, this does not mean that you should pick them up every 21 days. Most repeat prescriptions will last between 30 and 40 days but I write 21 days so that anyone wanting earlier supply has some flexibility eg because of work (FIFO etc) or leaving for holidays etc. So if you pick up your medication every 21 days repeatedly you will be stockpiling which is unnecessary and may lead to losing some, and you may end up going without medication.

3. Policy on lost/stolen/damaged/unavailable stimulant medication = NO EXTRAS:

   If you run short of your medication for any of the above reasons, your missing medication will not automatically be fully replaced but I can allow early access to the next repeat of an existing prescription at your chemist. Call our rooms to explain the reason, then go to your chemist and ask them to phone me so that I can authorise early access.

   Because these are highly regulated medications, my policy is not to make a full replacement, only to allow early supply of your next repeat. This means that the next repeat will have to last for the ‘lost period’ as well as the next scheduled period. In effect, this means you will have to get by at a reduced dosage for several weeks. This way, you remain on your scheduled time for the next follow-up visit with me (or your GP if you are co-prescribed).

   If you have no more repeats at your chemist, you will have to make an appointment to see me to get another prescription but, again, this will have to cover the ‘lost period’ and the next scheduled period by reducing your dose.

   General Points:

   Guard your tablets carefully, keep them locked away at home.

   Only take small quantities in unmarked pillboxes/bottles with you when you leave home. (Only take labelled bottles away from home when you are travelling interstate or overseas when pill bottles must be labelled to satisfy authorities).

   Do not leave medication in a car, or anywhere likely to get warmer than 25°, as they are inactivated by heat.
Which stimulant is your first choice?

1. Methylphenidate short acting
2. Methylphenidate long acting
3. Dexamphetamine
4. Vyvanse (lisdexamfetamine)
Which stimulant is first choice?

- In children, unclear guidance from RANZCP or NHMRC Clinical Practice Points.
- In adults, methylphenidate is preferred in most guidelines as the first-line drug over dexamphetamine because, historically, methylphenidate has been used more internationally and hence more research evidence accumulated.
- **Comparative efficacy meta-analysis** – **methylphenidate for C&A, dexamphetamine for adults (efficacy and tolerability assessed), Cortese 2018**

  In practice, US and Aust. long-term data show methylphenidate most favoured in children and dexamphetamine most favoured in adults. (Unclear why, ? due to dex LA less available – until now.)
- NB: MP LA require SA trial first for PBS. Not so with Vyvanse(Lisdexamfetamine) – can start straight away without initial D5 trial.

Research:

Which stimulant is 1\textsuperscript{st} choice?

- Compared amphetamines (including lisdexamfetamine), methylphenidate, atomoxetine, bupropion, clonidine, guanfacine, modafinil.

0-17: amphetamines marginally more efficacious than methylphenidate but less well accepted and tolerated (increased diastolic BP), therefore methylphenidate 1\textsuperscript{st} choice.

18+: amphetamines more efficacious and equally well-tolerated, and therefore 1\textsuperscript{st} choice.

All medications (except modafinil in adults) were more efficacious than placebo for the short-term (12 week) treatment of ADHD, and they were less efficacious and less well-tolerated in adults than in 0-17.

Atomoxetine had the lowest mean effect size in 0-17 but in adults it was comparable to methylphenidate.
If one stimulant does not work, try the other?

1. Yes  2. No
If one stimulant does not work, try the other?

- Some clinicians don’t, surprisingly.
- If one stimulant is effective, but only partially, should the other one be tried?
  Obviously yes, but surprisingly not done quite often – based on my personal experience of reviewing cases transferred to me by paediatricians for ongoing adult care.
  Some strong avoidance of dexamphetamine in younger children- why?
Starting dosages of stimulant medications:

milligram per kilogram?

or start low and build up?
Dosing - milligram per kilogram or start low and build up?

- Dosage is determined by titration, starting at 0.25-1 tablet daily for R10 and D5, increasing over a few weeks to a ‘sweet spot’ balance of maximum efficacy with minimal side-effects.
- For Vyvanse (lisdexamfetamine), the PI recommended starting dose is 30 mgs daily, titrate up by 20 mgs at not less than weekly intervals to a TGA-indicated maximum of 70 mgs daily.
- Maximum doses – International guidelines allow up to 8-12 R10/D5 tablets daily, of either stimulant alone or in combination. In Australia, state guidelines vary. (In WA, the average dose for children is 3 tablets daily and for adults 6 tablets daily).
- BP and weight should be monitored, all ages (plus height if still growing).
- Review 3-6 monthly when stable, repeat rating scale.
- Long-term use is justified as long as it is clinically effective ie trials of lower dose or cessation for a few weeks every year is recommended (recommence if ADHD symptoms recur).
My Dosing System

Stimulants

• Everyone starts very low but increases fairly quickly.
• Children - half a tablet (R10/D5) after breakfast and increase by half a tablet every few days, bd dosing if mane dosing is wearing off. Up to 4 tablets daily, review in two weeks.
• Adolescents - the same but start with one tablet.
• Adults - again start with one tablet, but increase every day or two to a maximum of 6 tablets daily before a review after two weeks.
• Average dose - children 3 tablets per day, adults 6 tablets per day.
• Choice – Children-R10 traditionally( why?, LA options enticing, ? Impact of Dex LA, Vyvanse), but late teens/ adults seem to prefer to start and stay on dexamphetamine.
• Endeavour to change all patients to the long-acting formulations to increase compliance and reduce misuse/diversion.

Strattera (atomoxetine) and Intuniv (guanfacine)

• If stimulants do not work, or occasionally first-line eg comorbid substance abuse, anxiety and tics. Give out sample packs, weekly increases and then three-week review.
## Maximal Daily Stimulant Doses -
### Three major international guidelines & RANZCP & PI

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### Maximal Daily Stimulant Doses -
Three major international guidelines & RANZCP & PI

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<tr>
<td><strong>CADDRA</strong></td>
<td>60mg</td>
<td>60mg (80mg SR)</td>
<td>100mg(108mg SR)</td>
</tr>
<tr>
<td><strong>Draft</strong></td>
<td>80mg</td>
<td>100mg</td>
<td>40mg</td>
</tr>
<tr>
<td><strong>NHMRC</strong></td>
<td>100mg</td>
<td>80mg (&gt;60mg, 2nd opinion)</td>
<td>40mg (&gt;30mg, 2nd opinion)</td>
</tr>
<tr>
<td><strong>RANZCP</strong></td>
<td>?</td>
<td>?</td>
<td>40mg/60mg (Adult ADHD PG / NICE)</td>
</tr>
<tr>
<td><strong>Product Information</strong></td>
<td>60mg (Concerta, C&amp;A 54mg, adults 72mg)</td>
<td></td>
<td>40mg (Narcolepsy 60mg)</td>
</tr>
</tbody>
</table>
**Table A.2. Summary of state and territory regulations for maximum quantities of dexamphetamine and methylphenidate that may be prescribed for the treatment of ADHD, with comparison to the maximum recommended doses in the Product Information.**

<table>
<thead>
<tr>
<th></th>
<th>Max daily dose of dexamphetamine</th>
<th>Max daily dose of methylphenidate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Children and adolescents</td>
<td>Adults</td>
</tr>
<tr>
<td>NSW(^28;29; b)</td>
<td>1 mg/kg up to 50 mg</td>
<td>30 mg</td>
</tr>
<tr>
<td>SA(^33; b)</td>
<td>-</td>
<td>(30 mg) July18:unfixed</td>
</tr>
<tr>
<td>TAS(^34;35; b)</td>
<td>0.9 mg/kg</td>
<td>30 mg</td>
</tr>
<tr>
<td>WA(^37; c; d)</td>
<td>1 mg/kg up to 60 mg</td>
<td>60 mg</td>
</tr>
<tr>
<td>Product Information(^7;8;9)</td>
<td>40 mg</td>
<td>-</td>
</tr>
</tbody>
</table>

**Abbreviations:** IR: immediate release methylphenidate; MR: modified release methylphenidate

**Notes:**

- ACT, Victoria, Queensland and the NT do not have specific regulations on maximum doses of psychostimulants that can be prescribed.
- NSW, SA and Tasmania allow applications for increased doses of psychostimulants beyond the maximums listed, but there are additional regulatory requirements (+ WA).
- The maximum dose of lisdexamphetamine that may be prescribed in WA is 70 mg/day.
- Where both dexamphetamine and methylphenidate are prescribed, the maximum dexamphetamine equivalent dose must not exceed 1 mg/kg/day or a maximum of 60 mg/day for children and adolescents, or 60 mg/day for adults. The maximum dexamphetamine equivalent dose is determined by dividing the methylphenidate dose (in mg) by two and adding to the dexamphetamine dose (in mg).
<table>
<thead>
<tr>
<th></th>
<th>Max daily dose of dexamphetamine</th>
<th>Max daily dose of methylphenidate</th>
</tr>
</thead>
<tbody>
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<td>Product Information(^{7;8;9})</td>
<td>40 mg</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Are side-effects a major worry with stimulants, especially psychosis?

1. Yes  2. No
Are side-effects a major worry with stimulants, especially psychosis?

- No.
- Everyone starts very low but increases fairly quickly.
- Usually well tolerated. Common side-effects include: anorexia/weight loss, insomnia, dry mouth, nausea, headaches, dysphoria, lethargy, erectile dysfunction, Raynauds.
- Use with care if comorbid with tics or epilepsy.
- Side effects often lessen or disappear completely after the first week or two. If still there after a month, likely to persist and therefore require action eg anorexia- diet change (tasty, liquid), insomnia- add hypnotics (melatonin, clonidine, antihistamines, sleeping tablets prn), dry mouth (chewies, Biotene products).

- Paranoid ideation: uncommon, stimulant/dose dependent.
- Precipitate psychosis? : Brief – rare
  Chronic – no causal link
Are stimulants addictive and often abused?

1. Yes  2. No
Are stimulants addictive and often abused?

- No.

- Addiction-guidelines vague. *In practice, few issues re craving, tolerance or withdrawal.*

- Abuse occurs:
  - Minimise abuse potential by using long-acting formulations: *Ritalin LA/Concerta, Lisdexamfetamine (Vyvanse).*
Are stimulant medications expensive which limits their usefulness?

1. Yes 2. No
Are stimulant medications expensive which limits their usefulness?

- No
- **Ritalin and dexamphetamine:**
  - CHEAP (PBS or private eg depression)
- **Ritalin LA, Concerta, lisdexamfetamine, atomoxetine, guanfacine:**
  - CHEAP/PBS if ‘diagnosed’ under 19 for lisdex and guanfacine; ‘diagnosed by a specialist’ under 19 for the others.
  - private/month(NB, private health funds may provide rebates):
    - Ritalin LA $50
    - Concerta $60
    - lisdexamfetamine $110+
    - atomoxetine and guanfacine $100-$200
Are drug holidays useful?

1. Yes  2. No
Are drug holidays useful?

- Maybe, but some find weekends off/‘holidays’ disruptive.
- Advantages of breaks: lessens side-effects, potentiates effectiveness (a cure for tolerance).
- May reveal medication no longer needed.

- When to stop stimulants forever?
  Unclear. In practice, most patients stay on stimulant medication until they have stopped their education, and brain has matured (females 25, males 30).
Prescribing medication in the context of substance use disorder

• SUD population has a high rate of ADHD, but how to prescribe stimulant medication in this population in a safe manner?

• And how not to expose practitioners to claims of throwing just more drugs into the "cocktail"?
Prescribing in the context of comorbidities such as borderline personality disorder, bipolar disorder, psychosis.

• How to judiciously weigh up the pros and cons of treating ADHD in the context of significant other psychiatric problems?

• A treatment focus on a patient’s ADHD may help the patient’s other psychiatric problems, but they may worsen e.g. stimulant medication destabilising mood or psychotic symptoms.
Follow-up

- Timing of follow-up appointments?
- What is considered good practice in short, medium and longer term appointment structure?
- Should patients be seen weekly, monthly, quarterly, 6 monthly, annually, or just is referred back to the GP at the first opportunity and only review as required?
- Medication dosages – what is considered a responsible dosage range?
- If patients do not respond to a low doses, how to use extra-ordinary doses, and ensure compliance with health Department authorities?
Are alternative therapies often useful in treating ADHD?

1. Yes  2. No
Are alternative therapies often useful in treating ADHD?

• No.

• Therapies which do not work (NHMRC: CPPs and Draft RANZCP guidelines):
  – Elimination or restriction diets.
  – Chiropractic treatment.
  – Behavioural optometry.
  – Biofeedback, including neurofeedback (but recent research suggests it may be useful).
  – Homoeopathy.
  – Acupuncture.
  – Massage.
  – Sensory integration therapies.

• Draft guidelines say essential fatty acid supplements and physical activity warrant further investigation, suggesting some promise. (Cognitive remediation, eg CogMed program?)
NOW TREATING
ADD * ADHD * aggression *
alcoholism * Alzheimer's * anorexia
* anxiety * acquired brain injury *
arthritis * Asperger's * asthma *
avtism * cancer * child birth * Crohn's
* disease * dental pain * depression *
diabetes * domestic abuse *
drug dependence * dysfuction *
edometriosis * epilepsy * focus *
fibromyalgia * glaucoma * heart
disease * hepatitis C * HIV/AIDS *
hopelessness * immune deficiency *
infammation * insomnia * leukaemia *
libido * loneliness * lupus * Lyme's
disease * lymphoma * menstrual
pain * migraine * morning sickness *
multiple sclerosis * nausea * obesity *
OCD * opiate addiction * osteoporosis *
pain * Parkinson's * psychosis *
PTSD * spastictiy * stress * Tourette's *
trigeminal neuralgia * many more

STAND UP TO GREED AND VESTED INTERESTS LIKE
POLICE JOBS AND BIG PHARMA GROWTH

MARIJUANA

REGULATE IT * TAX IT * PROBLEM SOLVED

REMEMBER
Voting is ANONYMOUS
you won't lose your job!

VOTE THE HEMP / SEX JOINT TICKET - SENATE BALLOT - GROUP S

LUNCH
Position Statement 55, ADHD in Childhood and Adolescence (2014)

This is a gentle introduction to the concept of ADHD, multimodal treatment recommended, including use of psychostimulants, but few details.

• Definition – ADHD symptoms and impaired functioning (ie in excess of that typical for developmental age). 2–5% prevalence, boys four times greater than girls. Persists into ‘adolescence and sometimes into adulthood’.

• Comments – a significant issue, comorbidity common, genetic/neurobiological but caseness dependent on psychosocial context.

• Assessment – paediatrician or child/adolescent psychiatrist.

• Treatment – stimulant medication, behavioural management. Review at least every 6 months. No particular medication recommended: ‘an approved treatment such as a psychostimulant or… atomoxetine’.

• Resources:
  – NHMRC Clinical Practice Points on ADHD in children and adolescents.
  – NHMRC Draft Australian Guidelines on ADHD (‘not endorsed by the NHMRC, but are a useful reference’).
Adult ADHD practice guidelines (2012).

Two pages, 9 minute video, no references. Basically, refers the reader to consult the Canadian (CADDRA) and the UK (NICE) ADHD lifespan guidelines.

- Basically recommends following two other national practice guidelines:

- Comments - ‘general guide… subject to the clinician’s judgement’.
  - ‘consideration should be made for psychiatrists who are practicing in isolation without appropriate access to training, support and supervision’.
  - family members should form part of the assessment and ADHD education process.

- Treatment – multimodal.

- Medication – first-line in moderate/severe cases. NICE – methylphenidate first-line.

- ‘Further information’ in CADDRA: *in fact, all long-acting preparations first-line (ie amphetamines, methylphenidate, atomoxetine) and short-acting as second line. Same for children and adolescents. (NICE guidelines for children/adolescents – methylphenidate, atomoxetine dexamphetamine, in that order).*

- A curiosity – a video with two experts, Dr Mark Kneebone in Sydney and Dr Rosemary Edwards in Wellington: Specific mention that maximal doses of either stimulant was 8 tablets per day.

- BP and weight should be monitored.

Practice Guideline 6
Guidelines for the use of dexamphetamine and methylphenidate in adults (2015)


Also, mentions the use of stimulants in non-ADHD conditions such as major depression or ‘secondary’ ADHD as seen in post-traumatic brain injury.
RANZCP supports methylphenidate, dexamphetamine and ‘other’ psychostimulants in ADHD and narcolepsy – ‘sound evidence base’.

‘Should’ get a second opinion prior to stimulant treatment if:

- Concerns about the diagnosis.
- History of schizophrenia, psychosis or substance use disorder.
- Dosages greater than 6 tablets daily of either stimulant.
1. ADHD

- A life-long disorder in many instances.
- DSM-5 or ICD 10 can be used.
- Corroborative evidence – past and present from family, educational and employment sources.
- Stabilise comorbidity prior to ADHD treatment.
- Multimodal treatment best.
- ‘International guidelines recommend that methylphenidate should be the first medication trialled and then atomoxetine or dexamphetamine’ – higher risk of misuse/abuse with dexamphetamine. But evidence that dexamphetamine may be more useful than methylphenidate (Faraone and Buitelaar, 2010, in children and adolescents).
- Use standardised scales for initial assessment and subsequent response.
- Beware of stimulant side-effects, especially cardiac (consider ECG), monitor BP.
- Doses – methylphenidate: start low and titrate, maximum mostly under 60mg, occasionally 100mg.
- Dexamphetamine again titrate, usual is no more than 30mg daily (maximum ?).
2. ‘OTHER’ stimulant responsive conditions – limited evidence:


- Stimulants for ‘other’ conditions should only be considered if:
  - treatment failure, and
  - second opinion supportive, and
  - a recent literature review, and
  - informed consent obligatory.

(this is as per RANZCP's Practice Guideline for ‘off-label’ prescribing, 2015).
Draft guidelines, 2009, the Royal Australasian College of Physicians.

Wow! Comprehensive, Australasian relevant, 211 pages, 914 references. Also on the RACP Paediatrics & Child Health Division website which is open to the public.

What happened to these excellent guidelines?

Clinical Practice Points on ADHD (2012)

22 pages, 112 references. Only children and adolescents, very general.

At second glance, very useful:

The CPP Expert Working Group (EWG) were a mixed group, some ADHD critics. They all signed off on the final conclusions which were:

ADHD exists in children, adolescents and into adult life.

Stimulants are considered useful and safe, short and long term.