Optimising care for patients with Adult ADHD – A Guide for GPs

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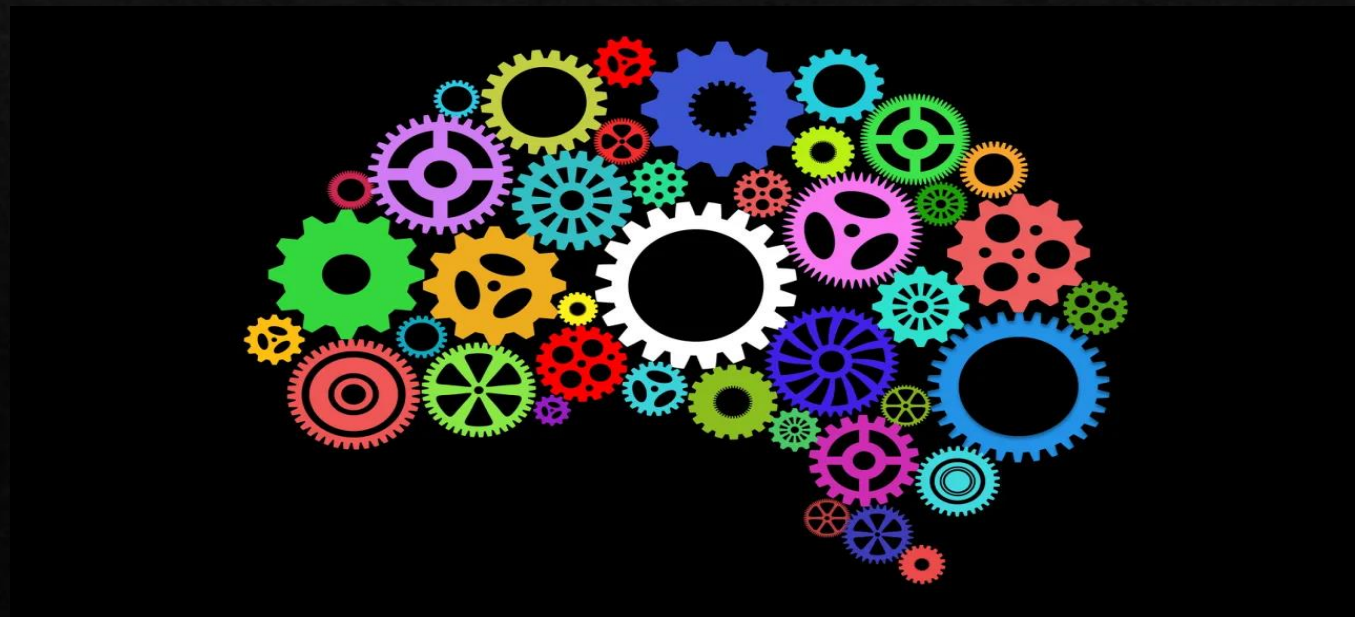
RBWH

Learning Objectives

- Develop an approach to assess and identify patients requesting an ADHD assessment
- Develop a knowledge base on making referrals and ADHD management options
- Develop skills and confidence in monitoring patients who are on ADHD medications under guidance of a specialist psychiatrist



What is ADHD?

- Clinical neurodevelopmental syndrome
- Early onset (5%)
- Persistence into adolescence and adulthood (2.5%)
- Functional impairments (academic, occupational, relational, forensic)
- Co-occurring disorders are common

DSM 5 - criterion A

- **Inattention -** Min 6 (*or 5 for adults*) of:

- a) Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities
- b) Often has difficulty sustaining attention
- c) Often does not seem to listen when spoken to directly
- d) Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace
- e) Often has difficulty organizing tasks and activities
- f) Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
- g) Often loses things necessary for tasks or activities
- h) Is often easily distracted by extraneous stimuli
- i) Is often forgetful in daily activities

- Hyperactivity/Impulsivity – min 6 (*or 5 in adults*) of:

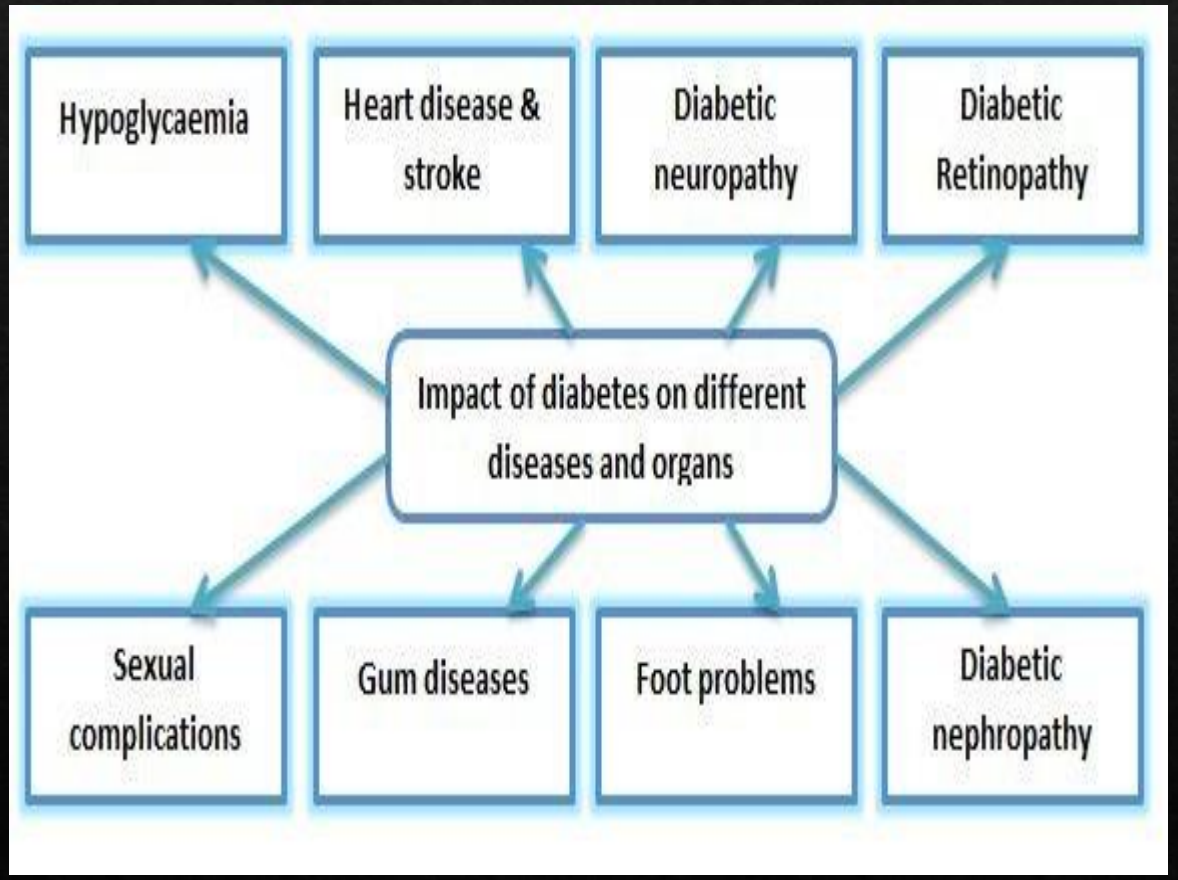
- a) Often fidgets with hands/feet or squirms in seat
- b) Often leaves seat in classroom or in other situations in which remaining seated is expected
- c) Often runs about or climbs excessively
- d) Often has difficulty playing or engaging in leisure activities quietly
- e) Is often "on the go" as if "driven by a motor"
- f) Often talks excessively
- g) Often blurts out answers before questions have been completed
- h) Often has difficulty awaiting turn
- i) Often interrupts or intrudes on others

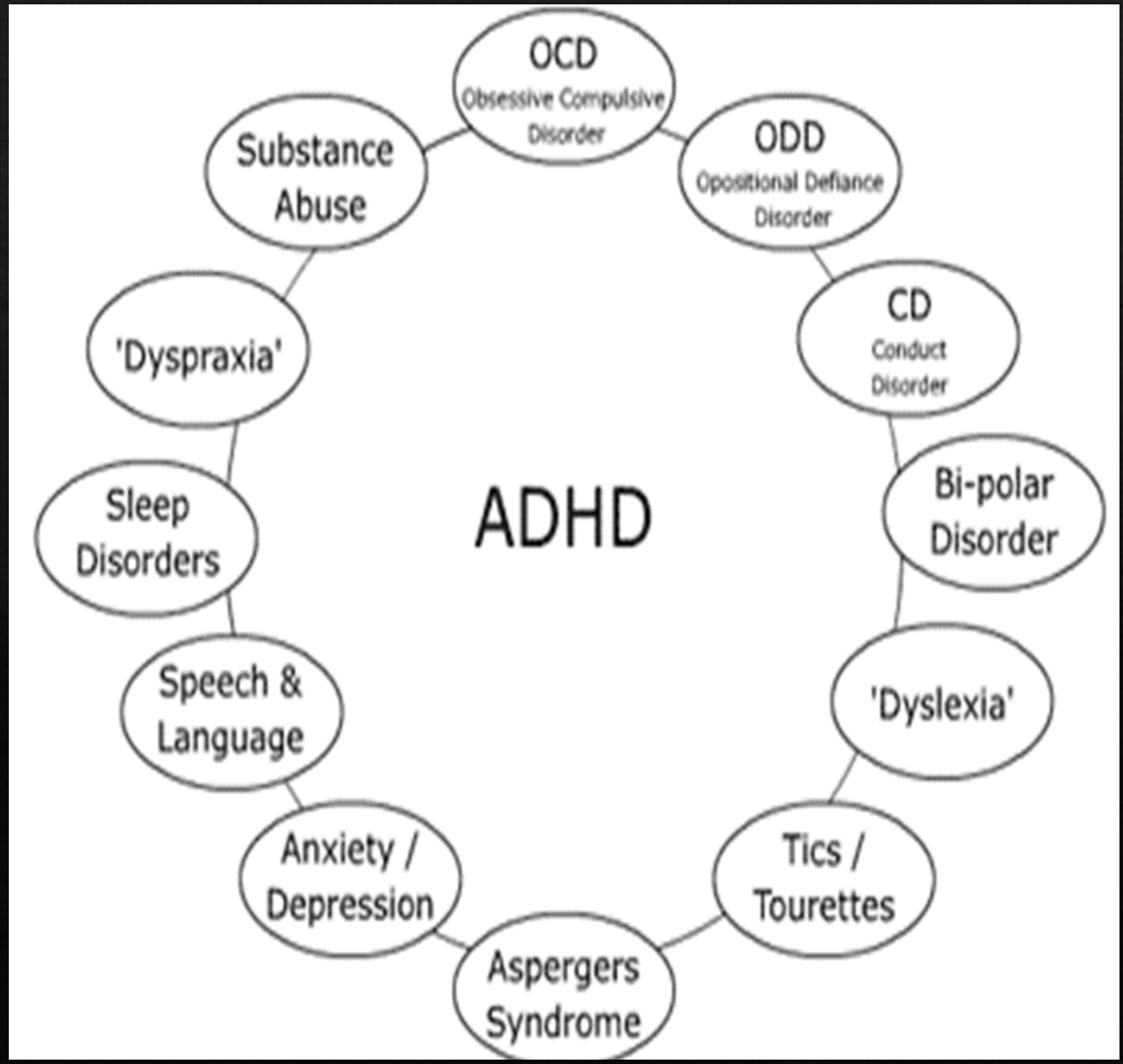
Criteria B-E

- B. Symptoms present *before 12 years* of age.
- C. Some impairment from the symptoms is present in 2 or more settings (eg, at school [or work] or at home)
- D. There must be clear evidence the symptoms interfere with, or reduce, the quality of social, academic, or occupational functioning.
- E. The symptoms do not occur exclusively during the course of a schizophrenia, or other psychotic disorder and are not better accounted for by another mental disorder *(allows comorbid ASD)*

Potential traps in diagnosis

- ADHD symptoms may not be apparent in the clinical setting (sensitivity to novelty and stimulation)
- Differentiating ADHD from other mental disorders (symptoms are trait-like; mood instability is extremely common)
- Age of onset (clear history of impairment may not be marked until mid-late childhood or teen years)
- Stigma


Hypoglycaemia
Heart disease & stroke
Diabetic neuropathy
Diabetic Retinopathy
Impact of diabetes on different diseases and organs
Sexual complications
Gum diseases
Foot problems
Diabetic nephropathy


ADHD
OCD
Obsessive Compulsive Disorder
ODD
Opositional Defiance Disorder
CD
Conduct Disorder
Bi-polar Disorder
'Dyslexia'
Tics / Tourettes
Aspergers Syndrome
Anxiety / Depression
Speech & Language
Sleep Disorders
'Dyspraxia'
Substance Abuse

Key principles

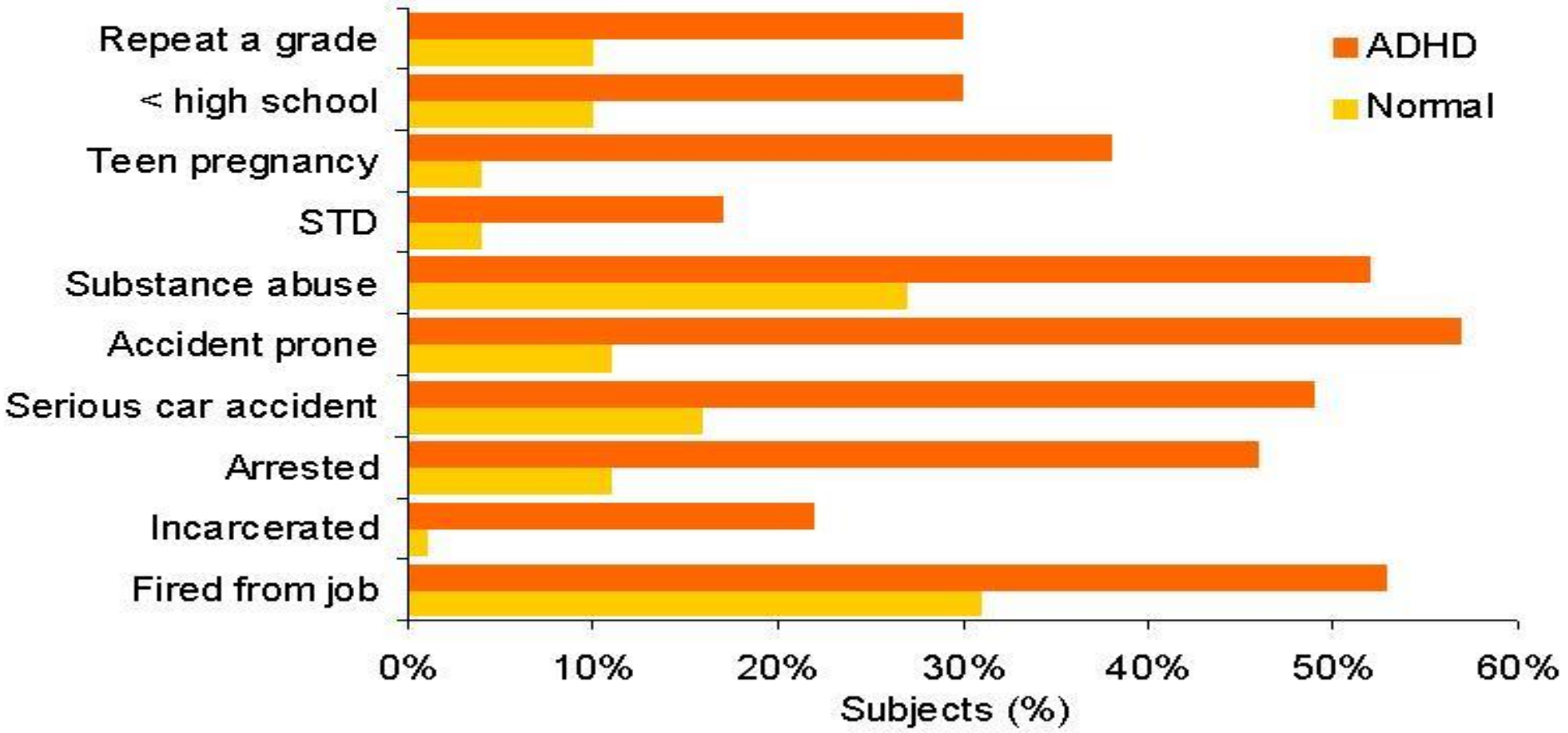
- Diagnosis is no more difficult to make than the evaluation of other mental disorders
- Adult ADHD has characteristic descriptions by patients of mental states that reflect the psychopathology; it is not just behavioural problems
- In adults, it is commonly misdiagnosed for other mental disorders; take note of early onset and trait-like course of symptoms and impairments
- ADHD is treatable

Why does ADHD present later in Adults?

- Lack of awareness
- Stigma; Shame
- Fears about medication
- Misdiagnosis (Diagnostic overshadowing)
- Internal (Higher IQ) & External scaffolding (parents, partner, occupations geared to impulsivity/risk-taking, excessive preplanning, electronic aids)
- Self-Medication (Alcohol, Drugs, Exercise)

Why treat ADHD?

Functional Impairment in Patients with ADHD



Barkley RA. *Attention-Deficit Hyperactivity Disorder. A Handbook for Diagnosis and Treatment*, 1998. Barkley RA, et al. *JAACAP*. 1990;29:546-557. Biederman J, et al. *Arch Gen Psychiatry*. 1996;53:437–446. Weiss et al. *J Am Acad Child Psychiatry*. 1985;24:211-220. Satterfield, Schell. *JAACAP*. 1997;36:1726-1735. Biederman J, et al. *Am J Psychiatry*. 1995;152:1652-1658.

Table 2.8 Occurrence of comorbid disorders in ADHD

	Clinical study of adults	Epidemiological study of adults	Clinical study of children
Some comorbidity	75 %	66 %	66 %
Average number of comorbid disorders per patient	3	Chances of ADHD increased 8.3 times with three comorbid disorders	–
Depressive disorder	25–66 % (60 % of which displayed a seasonal pattern)	31 %	20–25 %
Bipolar disorder	10 % (mostly type II)	Chances of bipolar disorder increased 6.2 times in ADHD	20 %
Anxiety disorder	25–63 %	51 %	15–25 %
Addiction	25–55 %	14 %	10–25 %
Smoking	40 %	Each ADHD symptom contributes to an earlier onset of smoking and to more smoking	20–30 %
Sleeping disorder (predominantly delayed sleep phase disorder)	80 %	–	73 %
Behavioral or personality disorder	6–25 % cluster B	–	45–50 % ODD or CD
Eating disorder (predominantly bulimia)	9 %	–	4 %
Autistic spectrum disorder	–	–	22 %
Tic disorder	11 %	–	50 %

References: Amons et al. (2006); Biederman et al. (1991, 1993, 2002, 2005a ; Brown (2000); Elia et al. (2008); Gau et al. (2007); Kessler (2007); Knell and Comings (1993); Kollins et al. (2005); Kooij (2006); Kooij et al. (2001a, 2004, 2008); Ronald et al. (2008); Spencer et al. (2000); Van Ameringen (2008); Van der Heijden et al. (2005); Van Dijk et al. (2011, 2012); Van Veen et al. (2010); Weiss et al. (1985); Wilens (2004) ; Wilens et al. (1994)

ADHD & Suicide

- Incidence of death from suicide nearly 5x higher among adults who had childhood ADHD compared to controls (N=367)

Barbaresi et al, Mortality, ADHD and psychosocial adversity in Adults with childhood ADHD: A Prospective Study. PEDIATRICS Vol 131; No 4, April 2013

- Young women with ADHD were 3-4x more likely to attempt suicide; 2-3x more likely to injure themselves compared to controls

Hinshaw et al. Prospective follow-up of Girls with ADHD into early adulthood: continuing impairment includes elevated risk for suicide attempts and self-injury. Journal of Consulting and Clinical Psychology. American Psychological Association. 2012, Vol 80, No 6, 1041-105

Clinical Presentation of Adult ADHD

- **Hyperactivity** changes to **inner restlessness**

- Ceaseless mental activity
- Talks excessively
- Initial Insomnia
- Impatience
- Avoids situations of low activity

- **Impulsivity** often carries **more serious consequences**

  - Low frustration tolerance (lose temper, driving, work and relationship problems)
  - Interrupt others; impatient
  - **Mood** lability

- **Inattention can overwhelm adults**

- Difficulty sustaining attention
  -Meetings, reading, paperwork
- Paralysing procrastination
- Avoidance behaviours
- Slow, Inefficient
- Poor time management
- Disorganized – completing tasks, multi task

Case Study 1: Helen

- 44 yr mother; teacher assistant in special school
- Her daughter had a neurodevelopmental assessment
- Paediatrican suggested she get assessed
- She went away and read up further on ADHD
- Recognising features she went to see her GP to get a referral

Case Study 2: Shaun

- GP referral – relapse of bipolar disorder
- 27 year old male
- Bipolar 2, social anxiety, developmental dyspraxia
- University student
- Anxiety, mood lability, insomnia, concentration difficulties
- ?early signs of relapse – referral to optimise mood stabilisers

Initial work-up & Screening for Adult ADHD

- Comorbidities – physical, substance use and psychiatric
- Mood disorders/Anxiety disorders – start or optimise treatments
- Blood pathology – FBC, CHEM20, TFT, VIT B12, D3, FOLATE
- ECG if indicated
- Wt, BP, PR
- Identify and treat any cautions/contraindications for psychostimulants

Part A (items 1-6. Scores range from 0 to 6) If the respondent scores 4 or more in Part-A, then the symptom profile of the individual is considered to be highly consistent with an ADHD diagnosis in adults (Adler et al., 2006; Kessler et al., 2007)

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

Patient Name _____ **Today's Date** _____

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

	Never	Rarely	Sometimes	Often	Very Often
Part A					
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 B					
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?					

Range 0 - 120

Positive score >70

Jasper / Goldberg Adult ADD Screening Examination - Version 5.0

The items below refer to how you have behaved and felt DURING MOST OF YOUR ADULT LIFE.
If you have usually been one way and recently have changed, your responses should reflect HOW YOU HAVE USUALLY BEEN.
Circle one of the numbers that follows each item using the following scale:
0 = Not at all 1 = Just a little 2 = Somewhat 3 = Moderately
4 = Quite a lot 5 = Very much

1. At home, work, or school, I find my mind wandering from tasks that are uninteresting or difficult.	0 1 2 3 4 5
2. I find it difficult to read written material unless it is very interesting or very easy.	0 1 2 3 4 5
3. Especially in groups, I find it hard to stay focused on what is being said in conversations.	0 1 2 3 4 5
4. I have a quick temper...a short fuse.	0 1 2 3 4 5
5. I am irritable, and get upset by minor annoyances.	0 1 2 3 4 5
6. I say things without thinking, and later regret having said them.	0 1 2 3 4 5
7. I make quick decisions without thinking enough about their possible bad results.	0 1 2 3 4 5
8. My relationships with people are made difficult by my tendency to talk first and think later.	0 1 2 3 4 5
9. My moods have highs and lows.	0 1 2 3 4 5
10. I have trouble planning in what order to do a series of tasks or activities.	0 1 2 3 4 5
11. I easily become upset.	0 1 2 3 4 5
12. I seem to be thin skinned and many things upset me.	0 1 2 3 4 5
13. I almost always am on the go.	0 1 2 3 4 5
14. I am more comfortable when moving than when sitting still.	0 1 2 3 4 5
15. In conversations, I start to answer questions before the questions have been fully asked.	0 1 2 3 4 5
16. I usually work on more than one project at a time, and fail to finish many of them.	0 1 2 3 4 5
17. There is a lot of "static" or "chatter" in my head.	0 1 2 3 4 5
18. Even when sitting quietly, I am usually moving my hands or feet.	0 1 2 3 4 5
19. In group activities it is hard for me to wait my turn.	0 1 2 3 4 5
20. My mind gets so cluttered that it is hard for it to function.	0 1 2 3 4 5
21. My thoughts bounce around as if my mind is a pinball machine.	0 1 2 3 4 5
22. My brain feels as if it is a television set with all the channels going at once.	0 1 2 3 4 5
23. I am unable to stop daydreaming.	0 1 2 3 4 5
24. I am distressed by disorganization.	0 1 2 3 4 5

Positive results may result from anxiety, depression or mania. These conditions must be ruled out before a diagnosis of Adult ADD can be made.

Referral for Diagnostic Assessment

- Barriers – exclusively in private sector
- Financial costs
- Availability – Not all psychiatrists; many closed books or long wait lists;
- Telehealth psychiatry services have improved access

- RANZCP website – Find a Psychiatrist link
- AADPA – ADHD Professionals Directory (early stages)

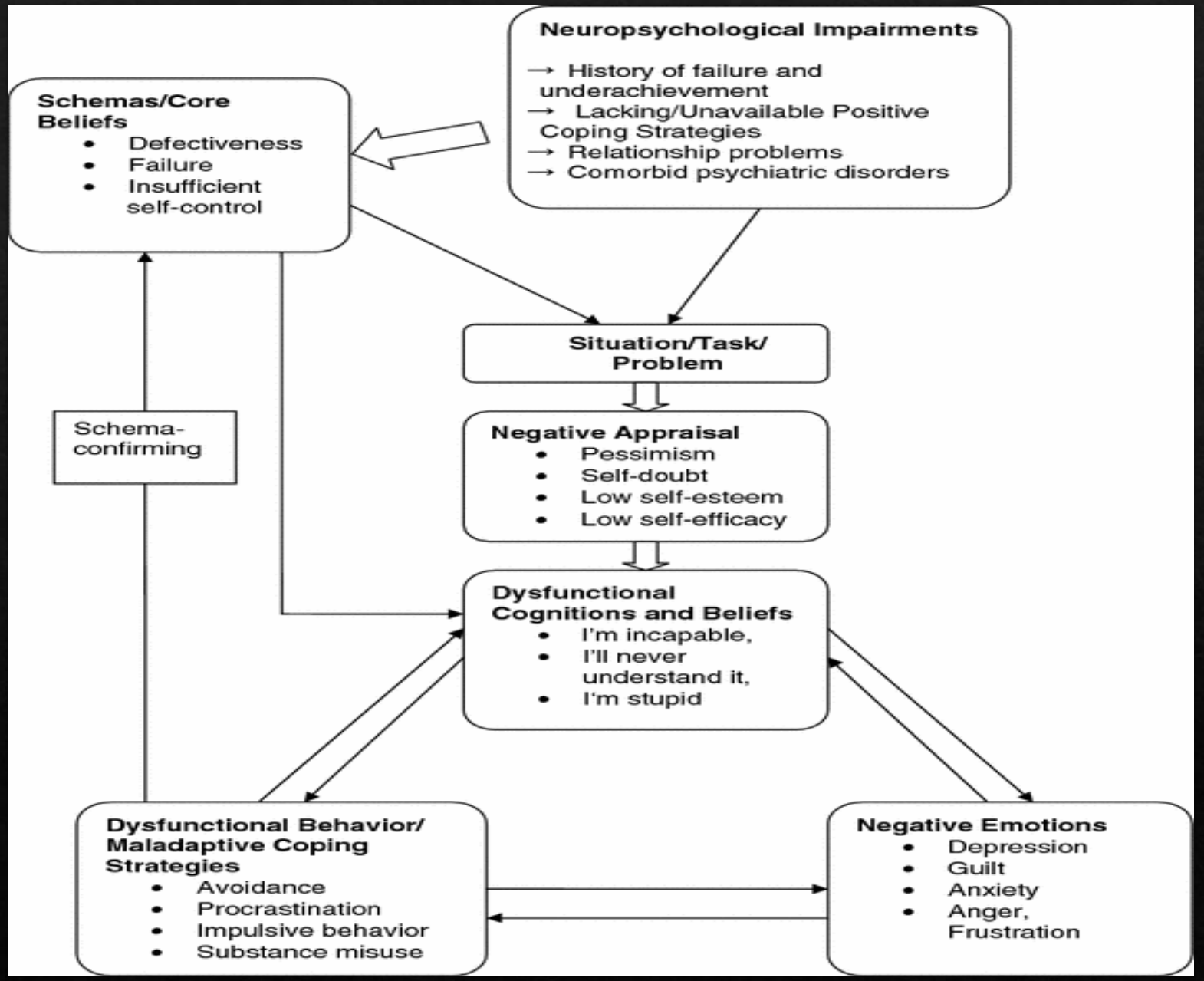
Additional Referral Information

- If past diagnosis, any reports or correspondence
- ASRS
- Pathology results
- ECG
- Wt, BP, PR

Role of GPs following Diagnosis

- Treatment initiation – monitoring of physical parameters (Wt, BP, PR) and then 3-6 monthly once on stable dose.
- Once clinically stable for 6 to 12 months, GP could be approached to continue prescribing treatment
- **Form for Application for a prescribing approval for (Schedule 8) psychostimulants (Medicines and Poisons Act 2019) that is available on the Queensland Health website. This approval permits GPs to prescribe for a period of up to two years with specialist approval.**
- **QScript**

CB model of ADHD (Young & Bramham)



Psychology - CBT

- Maladaptive personality and coping strategies; low self esteem
- Common comorbid conditions
- Neurocognitive, Problem solving, Emotional control, Pro-social skills, Critical reasoning
- Improve QoL

ADHD COACH

- A **coach** helps people with **ADHD** carry out the practical activities of daily life in an organized, goal-oriented and timely fashion.
- Many have lived experience
- Psychoeducation, Planning, Prioritisation, Relationships, Time management
- Electronic tools, Apps, Online sessions
- ADHD Coaches Australasia

What to do whilst on a wait list?

- Optimise management of any co-occurring conditions
- Medications vs Psychology referral
- ADHD Support Organisations and Groups
- ADHD Australia; ADHD Foundation; ADHD Support Australia
- A life with ADHD – University of Geneva:
- MOOC Trailer - What is ADHD? Challenges and strengths | Coursera
- Mild vs Mod-Severe Severity

What happened to Helen and Shaun?

- Helen – underwent diagnostic assessment
- Shaun – after optimising mood stabiliser medications, underwent diagnostic assessment; finally managed to complete Uni studies – with Honours!

References

- AADPA Australian Guidelines https://adhdguideline.aadpa.com.au/
- Factsheet: Prescribing Psychostimulants https://www.health.qld.gov.au/__data/assets/pdf_file/0021/1160391/fs-prescribing-psychostimulants.pdf
- Application for Prescribing Approval https://www.health.qld.gov.au/__data/assets/pdf_file/0016/1112704/form-prescribing-s8-psychostimulants.pdf

Summary

- Clinical Features of Adult ADHD and its presentation
- Importance of treating ADHD
- Clinical issues to consider at time of referral to a psychiatrist (& barriers)
- Role of GP during treatment initiation and on discharge from the psychiatrist
- Roles of Psychology and ADHD Coach

Questions?