aadpa | australian ADHD professionals association

Monday, 2nd October 2023

Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600

Dear Members of The Senate Community Affairs References Committee,

Thank you for the opportunity to make a further contribution on behalf of the Australian ADHD Professionals Association (AADPA) to the committee.

We have attached our recommendations for best practice across all stages of the ADHD assessment and treatment process.

Our recommendations are structured to cover the different aspects of the care pathway including assessment, treatment planning and psychoeducation, initiating and delivery of non-pharmacological and pharmacological interventions and monitoring progress. Our recommendations are aligned with The Australian Evidence-based Guideline for ADHD and also draw on the lessons learned during the development of the Dundee ADHD Clinical Care pathway which is the only published care pathway for ADHD that has demonstrated real world clinical outcomes that are in line with those seen in clinical trials. We have included as appendices to this letter a list of the key lessons learned from those experiences.

We would like to highlight three key needs that we believe have to be addressed in order to improve outcomes for people with ADHD in Australia.

1. Improved education and training.
2. Improved multidisciplinary collaboration.
3. New approaches to funding that support improved access to care and multidisciplinary working.

Improved education.
Our recommendations are detailed. While it would have been possible to simplify these into much more generic and less detailed comments, we feel this would fail to acknowledge that the assessment and management of ADHD is a skilled task which requires high levels of skills and knowledge. This does not however mean that the assessment and management of ADHD should be restricted to a small group of highly specialised clinicians. Rather it highlights that, while a broad group of healthcare professionals including paediatricians, psychiatrists, GPs, psychologists, nurses, other allied health professionals and pharmacists can all make valuable contributions to ADHD care, they all need to be adequately trained and supported for this to be effective.

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Unfortunately, in Australia, training in ADHD is not currently part of the basic training for and of these disciplines, nor is it readily available as part of continuing professional development for those already qualified.
We are aware that various Colleges and professional associations have told the inquiry that they intend to improve their ADHD education. While we have not yet seen any concrete proposals, AADPA welcomes these indications of intent. It will be important that there is a degree of harmonisation between these educational and training approaches. AADPA is already aware that several groups of individuals are producing their own education packages. We are concerned that many of these groups have little experience in developing educational programs and that these, once produced, may not all speak with a united voice. If we are to proceed in an evidence-based way it will be important that clinicians are working in comparable ways and using the best evidence-based approaches. AADPA, is the only organization with members from all professional groups. We developed, and will continue to update, The ADHD Guideline and include in our Board senior academics with strong track records in the development of educational programs. We therefore believe that AADPA is in a strong position to lead the development of high-quality educational packages that are applicable *across the different professional groups* and that can ensure that clinical care proceeds in a seamless and evidence-based manner.

Improved multidisciplinary collaboration.
In a related issue we noticed when reading the submissions to the inquiry and listening to the various oral submissions made to the committee that several professional groups made strong representation about why they as a professional group, were best placed to provide care for those with ADHD. As described in our own submission and emphasised again in our proposed care pathways we strongly believe that effective clinical care for ADHD, at all stages of the journey, need to be multi professional and that no one professional group should or indeed needs to claim primacy over any other. We would therefore argue that it is important to recognise the important role that AADPA as a professional association that draws its membership from all professional backgrounds and holds improved multidisciplinary practice as a core belief. As highlighted above a key problem with access to services for those with ADHD is the low numbers of professionals, across all disciplines, trained in the assessment and management of ADHD. ADHD is a common condition, there is always going to be enough work to go around. It is therefore essential that professional groups look for ways to work together more effectively rather than trying to seize as big a slice of the pie as they can for their members.

New approaches to funding clinical care for ADHD.
Further to this the funding and organisation of healthcare services in Australia tends to promote siloing rather than multidisciplinary team working. We are aware that many of our recommendations for optimising clinical care for those with ADHD would be difficult to fully implement within current funding models. While it is very important that people with ADHD are not asked to complete unnecessary assessments or attend unnecessary clinical visits it is also the case that good quality ADHD assessment and care requires considerable clinical time. Most ADHD care is currently provided through private specialist settings, which for many people with ADHD,

makes it impossible to afford. While psychiatrists can access Medicare codes for the long appointments needed to conduct a comprehensive assessment this is not the case for GPs and paediatricians. While some psychologists can access appropriate codes for assessment and treatment others who have the skills (e.g. neuropsychologists) cannot easily do so. After assessment there need to be adequately funded codes for treatment (non-pharmacological and pharmacological) and follow up. There also needs to be incentives for public health services to support those with ADHD. Of course, funding goes beyond health and should consider the role of education and the NDIA. While the professional colleges and organisations need to take a lead in developing these new funding models, AADPA has an important role in making sure that these work as a whole and that funding meets clinical needs. This has, to a degree already happened for autism has a key role in ensuring this happens.

Yours sincerely

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Appendix 1

Lessons Learned from the development and implementation of the Dundee model:

1. A comprehensive assessment for ADHD is complex and often time consuming. Those conducting these assessments need to be well trained.
2. The purpose of an 'ADHD' assessment is not only to confirm or exclude the presence of ADHD but also to identify whether there are any other problems or disorders that are causing impairment.
3. At the end of the assessment process the clinician should have developed a comprehensive formulation that comprehensively describe the patient's problems
4. Clinicians from a wide range of clinical backgrounds, can effectively and accurately collect and collate the information required for assessment of ADHD.
    a. This can include specialist medical practitioners (generally paediatricians and psychiatrists), GPs, psychologists, and nurses.
    b. It does however required training and is best achieved using a structured approach to information gathering.
5. Using this information to make a diagnosis is also a skilled task and needs to be conducted by someone with good training and experience.
6. Similarly, treatment planning requires good quality training and experience and an understanding of the different treatment options available.
7. When delivering care for ADHD high quality psychoeducation is the key to a good treatment experience and time spent here can pay great dividends down the road.
8. While prescribing clearly needs the involvement of a medical doctor or qualified nurse practitioner, the initiation and optimisation of medication treatments can be safely and effectively be managed by non-medical personnel if there is high quality oversight.
9. Measurement based care improves titration/treatment optimisation and continuing care.
10. Measurement based care is delivered within a chronic disease model that is like that used in the management of diabetes and hypertension.
11. While there are many models of care that claim to be effective the Dundee model of care is the only one we are aware of that has demonstrated long term effectiveness in a real world setting that matches that seen in research studies.
12. People with ADHD move in and out of complexity and this means that it is helpful to have close relationships between primary and secondary care.

Appendix 2

Lessons learned from the development of the Australian ADHD Guideline:

1. When assessing and managing ADHD the level and quality of training someone has is more important than their profession or craft group.
2. Assessment for ADHD should not be seen in isolation as coexisting neurodevelopmental, mental health and physical conditions are the norm and should always be considered. This is equally important across the whole lifespan. Single disorder assessments, as often happens for ASD and more recently from some 'specialised' ADHD clinics, are not supported.
3. From this perspective assessing for ADHD should be a core component of developmental and mental health assessments and assessments that focus on ADHD should always consider coexisting conditions.
4. Assessments need to be based on a clinical interview. This can be conducted face to face or online but does take time and cannot be rushed through. The core components of an assessment are described in the guidelines as:
    a. a full clinical and psychosocial assessment, including discussion about symptoms and strengths and how these present across the different domains and settings of the person's everyday life.
    b. All 18 core symptoms of ADHD should be systematically enquired about.
    c. a full developmental, mental health and medical history
    d. observer reports and assessment of the person's symptoms and mental state
    e. a medical assessment to exclude other causes of the symptoms and identify any associated disorders that also require investigation, intervention, and support.
5. Despite the need for a comprehensive clinical assessment is it also important that people with ADHD are not asked or expected to undergo unnecessary assessments
    a. You cannot assess for ADHD using questionnaires alone.
    b. Medical investigations (including ECGs) are not routinely required and should only be performed if clinically indicated.
    c. Similarly neuropsychological assessment is not required for a diagnosis of ADHD and should only be conducted if clinically indicated.
6. Treatment for ADHD should be multimodal and there should be a clear recognition that different treatment approaches have different strengths:
    a. Psychoeducation forms the bases of all treatment interventions. To do this well requires:
        i. Well educated clinicians
        ii. Hi quality educational materials
        iii. Adequate time dedicated to ensuring all issues are covered and questions answered
    b. Medication treatments are the most effective method of reducing core symptoms of ADHD

   c. Non-pharmacological treatments such as parent training and cognitive behavioural therapies are most effective at proving additional supports to minimise the daily impact of ADHD symptoms and associated difficulties.
   d. ADHD coaching is also believed to provide support to those with ADHD.
7. Safe and effective prescribing of ADHD medications requires the prescriber to be properly trained and to have an in depth understanding of the medications they are using. This is important as.
   a. Paediatricians, psychiatrists, GPs, and nurse practitioners are not currently taught about ADHD medications during their core training.
   b. The ADDPA Prescribing Manual, that is close to completion, will provide an important source document for training.
   c. But the key colleges and associations need to action their commitments to integrate training in ADHD and ADHD prescribing into their core curricula and provide catch up training for those already practicing in specialist roles.
8. When titrating medication, it is key to measure outcomes and adverse effects using a measurement-based care approach such as that described in the Dundee model. It is important that funding models support this more intensive period of treatment.
9. While ongoing monitoring is less intensive it still requires time to collect outcome data during sessions and this needs to be recognised withing funding models.

AADPA- Best practice approach for all stages of the ADHD assessment and treatment process

ASSESSMENT- Aims

To assess whether person meets diagnostic criteria for ADHD.
To distinguish ADHD from other disorders and exclude other explanations for behaviours.
Where ADHD is confirmed there should also be confirmation or exclusion of any coexisting mental and somatic conditions.
Where a diagnosis of ADHD is excluded, there should be a formulation of an alternative explanation for the presentation.

ASSESSMENT- Tasks

Like other neurodevelopmental and mental health conditions an assessment for ADHD is complex and often time consuming.

Assessments need to be based on an interview. This can be conducted face to face or online but does take time and cannot be rushed through.

An assessment for ADHD by a trained, skilled, and experienced practitioner will usually take at least two hours of face-to-face clinical time with additional time required to compile information and reports.

Clinicians from a wide range of clinical backgrounds, can effectively and accurately collect and collate the information required for assessment of ADHD.

- This can include specialist medical practitioners (generally paediatricians and psychiatrists), GPs, psychologists, and nurses.
- It does however require training and experience and is best achieved using a structured approach to information gathering.

The core components of an assessment are:

- A full clinical and psychosocial assessment, including discussion about symptoms and strengths and how these present across the different domains and settings and impact on the persons person's everyday life.
- All 18 core symptoms of ADHD should be systematically enquired about.
- The assessment should also screen for other commonly cooccurring mental health conditions (e.g., anxiety, depression, oppositional defiant disorder/conduct disorder, personality disorder, substance use disorder, psychosis, bipolar disorder, and an assessment of mental state.
- A developmental, mental health and medical history.
- Collateral history, observer reports, school reports where available.
- A medical assessment to exclude other causes of the symptoms and identify any associated disorders that also require investigation, intervention, and support.

It is essential to note that:

- You cannot assess for ADHD using only questionnaires.
- Medical investigations, including ECG, are not routinely required, and should only be performed if clinically indicated.
- Similarly neuropsychological assessment is not required for a diagnosis of ADHD and should only be conducted if clinically indicated.

A key barrier to accessing high quality ADHD assessments is financial.

- Many people with ADHD are not able to afford the cost of a private assessment.
- Publicly funded paediatric and psychiatric services are very limited and the funding systems for public care systems do not support quality ADHD assessments.
- Current Medicare rebates are not structured to allow GPs to spend the time required to conduct a good quality assessment for ADHD.

TREATMENT PLANNING AND PSYCHOEDUCATION-Aims

The clinician(s), the person with ADHD, and for children their families/caregivers should determine and agree on the aims of treatment and the desired outcomes.
The clinician should deliver evidence-based psychoeducation.
Based on this shared understanding the clinician(s), the person with ADHD, and for children their families/caregivers should agree on which treatments should be started and in which order.

TREATMENT PLANNING AND PSYCHOEDUCATION-Aims

Following diagnosis and prior to initiating treatment the clinician and the person with ADHD and, in the case of children, their family/caregivers, need to discuss and agree the aims of treatment.

This discussion should include consideration of:

- Core symptoms of ADHD.
- Associated symptoms (e.g., emotional lability).
- The impact of ADHD symptoms and associated difficulties on day-to-day functioning.
- Other neurodevelopmental conditions and specific or general learning difficulties (where present).
- Other mental health conditions (where present).
- Physical health conditions (where present).

To assist the person with ADHD and their caregivers make decisions about which treatments are most appropriate for them it is essential that they are offered the opportunity to learn about ADHD and the evidence base around the different interventions available to them.

This requires the clinician to be familiar with the evidence base. In Australia the best starting point for this is The Australian Evidence-Based Clinical Practice Guideline for ADHD and for those with ADHD the Consumer Companion Guide to the Guideline.

The Guideline provides detailed guidance to the key information needs after diagnosis of ADHD and this should be used as a template for psychoeducation.

It is essential that Information provided by clinicians should be:

- in plain language, clearly presented and free of jargon.
- culturally appropriate and available in the person's first language.
- multimodal, taking into consideration different information processing preferences and needs.
- non-judgemental, inclusive, affirming and focused on personal empowerment.

Treatment planning and psychoeducation are skilled tasks and, like the assessment should not be rushed or squeezed into the last few minutes of the consultation. Current funding models do not typically allow clinicians to spend adequate time on this part of the clinical journey. Evidence suggests that time spent in providing adequate high-quality information at this time improves decision making and engagement in ongoing care. It is therefore a false economy to skimp on this process. It is therefore essential that funding explicitly allows for good quality treatment planning and psychoeducation.

Once this information is shared a shared treatment plan should be agreed.

Clinicians should offer multimodal treatment and support.

This means that clinicians should suggest that people with ADHD use pharmacological and non-pharmacological treatments concurrently, unless:

- ADHD symptoms are likely to be adequately supported by only one mode of treatment.
- The severity of ADHD symptoms necessitates pharmacological treatment as the first-line treatment, to reduce symptoms as quickly as possible, and enable later engagement in non-pharmacological treatment, if needed.
- One mode is more accessible than the other, based on cost, location, and service availability including waiting times to access services.

When there are multiple clinicians and/or educators involved, clinicians should suggest that a care coordinator is appointed.

While there is a clear rationale for providing psychoeducation as part of ADHD care there is currently little evidence to identify what the core components and active ingredients are. **The inquiry should consider recommending funding for further research into this.**

INITIATING AND DELIVERING INTERVENTIONS- Aims

Non-Pharmacological

To deliver evidence-based non-pharmacological treatments aimed at minimising the daily impact of ADHD symptoms and associated difficulties. Monitor progress and adjust interventions accordingly.

INITIATING AND DELIVERING INTERVENTIONS- Tasks

Non-Pharmacological

There are four main non-pharmacological interventions recommended in the Australian Evidence-Based Guideline:

- **Lifestyle changes**
- **Parent/family training**
- **Cognitive behavioural interventions**
- **ADHD Coaching**

The main focus of these is to minimise the daily impact of ADHD symptoms and associated difficulties rather than improve core ADHD symptoms.

While supporting lifestyle changes is a more generic approach the other three approaches require specialist training and knowledge. They can be delivered by healthcare professionals from a range of backgrounds and as is the case for assessment having adequate training, support, and supervision is more important that being a member of a particular craft group.

Lifestyle changes appropriate for ADHD include those aimed at improving:

- Sleep
- Diet
- Physical activity
- Engagement in social and community activities

Parent/family training:

- Aims to improve positive parenting, reduce negative parenting, improve parent/child relationships, and reduce oppositional behaviours.
- Should be offered to parents/families of children with ADHD (including those under 5 years of age).
- Can be delivered in either a group or individual format with ADHD.
- Should be provided with sensitivity and awareness of the stigma and misunderstandings that parents/carers of children with ADHD may have experienced.
- Should be specific to the needs of parents/families with ADHD and be balanced between focus on individual strengths, values, and interests as well as challenges.
- Should include environmental modifications to promote a positive, predictable, and structured environment, and to reduce impacts of ADHD symptoms.
- Should also include advice on behaviour modifications to help minimise the impact of symptoms and impairments associated with ADHD and positive parenting practices.

Cognitive behavioural interventions:

- Should be offered to adolescents and adults with ADHD.
- Need to be developmentally appropriate.
    - Younger children may benefit from a foundational focus of emotional literacy, proactive help-seeking, problem-solving and self-esteem growth.
    - Those approaching adolescence may benefit from simple behavioural techniques.
    - Through adolescence to adulthood, increasingly sophisticated behavioural and cognitive restructuring techniques are likely to be of benefit.
- Examples of the components of cognitive behavioural interventions for ADHD are described in the AADPA ADHD Guideline (Box 4, page 123).
- Cognitive-behavioural interventions can be delivered in an individual or group format, depending on the availability of services and person's/family's preference.

ADHD Coaching:

- ADHD coaching shares common elements with cognitive behavioural interventions, particularly with environmental modification and behavioural modification.
- ADHD coaching combines three key coaching skill sets.
    - Collaborative, client-centred, client-driven process to support the person's empowerment.
    - Education about ADHD and related topics, as well as tools and resources.
    - Skills coaching to build on the person's strengths and resources, and develop conscious competence of new systems and strategies.

Monitoring progress:

It is as important to properly monitor progress for those receiving non-pharmacological interventions as it is for those receiving medications.
Before treatment, baseline ADHD symptoms and level of functioning should be recorded using standardised rating scales.
Progress should be assessed periodically as described in the section on monitoring treatment (see below).
If outcomes are not optimised the care plan should be reviewed and there should be consideration about whether increasing dose or changing to another type of intervention is required.
A detailed description of how to assess whether outcomes are optimised is available in The Dundee ADHD Clinical Care Pathway.

INITIATING AND DELIVERING INTERVENTIONS- Aims

Pharmacological*

Determine who will prescribe and titrate initial medication.
Choosing the right medication for initial treatment.
Titrate to optimal dose.
If first medication not effective or poorly tolerated agree on next steps.
Once treatment is optimised move to ongoing monitoring.

* These processes are described in detail in the AADPA Prescribing Manual which will be published in November 2023

INITIATING AND DELIVERING INTERVENTIONS

Pharmacological*

Clearly the prescriber will need to be a medically qualified doctor or nurse practitioner. At present while there are some situations where a GP can initiate prescribing for ADHD, in most states and territories and circumstances this needs to be a paediatrician or child and adolescent psychiatrist for children or a psychiatrist for adults.

As for assessment we believe that the skills and training of the prescriber are more important than their professional group. **Best practice suggests that those who prescribe medications for ADHD should:**

- Have adequate skills and knowledge to ensure treatment is tailored effectively to the individual needs of the person with ADHD. This requires an in depth knowledge of all medications available for ADHD.
    - They should be familiar with the pharmacokinetic and pharmacodynamic profiles of these medications and be able to use these different profiles to optimise outcomes and avoid excessive adverse effects.
    - They should be able to take account of pharmacodynamic interactions with other prescribed medications.

While this sounds relatively basic such education is not routinely given to doctors in training and is not currently part of the core skill set of most psychiatrists, paediatricians, or GPs. There are relatively few nurse practitioners with these skills.

It is therefore essential that more formal approaches to training are made available to doctors in training and current specialists in paediatrics, psychiatry and general practice and nurse practitioners intending to work in ADHD. **The AADPA Prescribing Manual will provide a structure for such training*.**

Before starting medication for ADHD, a comprehensive assessment should include:

- confirmation that ADHD diagnostic criteria are met.
- risk assessment for substance misuse and drug diversion.
- assessment of physical health, including:
    - a medical history, considering disorders that may be contraindications for specific medications.
    - current medication.
    - height and weight (measured and recorded against the normal range for age and sex).
    - a cardiovascular assessment, including baseline heart rate and blood pressure (measured with an appropriately sized cuff and compared with centile for age and height).
    - An electrocardiogram (ECG) is **not** needed before starting ADHD medications unless the person has any of the features listed below or a co-occurring condition that is being treated with medications that may pose an increased cardiac risk.

People with ADHD should be referred for a cardiology opinion before commencing stimulant medication if any of the following are present:

- a history of congenital heart disease or previous cardiac surgery.
- a history of sudden death in a first-degree relative under 40 years suggesting a cardiac disease.
- shortness of breath on exertion, compared with peers.
- fainting on exertion.
- palpitations that are rapid, regular and start and stop suddenly.
- chest pain suggesting cardiac origin.
- a heart murmur (not including innocent heart murmurs in children).

If blood pressure is consistently above age-based normal values, referral to an appropriate physician is recommended.

* These processes are described in detail in the AADPA Prescribing Manual which will be published in November 2023.

INITIATING AND DELIVERING INTERVENTIONS- Tasks

Pharmacological *- continued

Medication Choice for initial treatment

Children under 5 years:

Medication should be used cautiously, and monitored closely, in this age group and only prescribed by a specialist with expertise in child development and treatment of ADHD in young children (either a paediatrician or a child psychiatrist) when other approaches to treatment have been unsuccessful. Choices of medication are the same as those for other children but starting doses are lower and titration slower.

Children and adolescents 5 – 17 years, and adults of all ages:

Methylphenidate or dexamfetamine or lisdexamfetamine should usually be offered as the first-line pharmacological treatment for people with ADHD. There are no evidence-based preferences for one stimulant over the other and both short and long-acting formulations can be considered.

The non-stimulants atomoxetine, guanfacine or clonidine should be offered to children and adolescents if stimulants are contraindicated.

Note: In most instances for people with ADHD who also have co-occurring conditions (e.g. anxiety disorders, mood disorders, tic disorder or autism spectrum disorder), clinicians should offer the medication choices as listed above. However particular care should be considered where there is a history of acute psychotic or manic episodes, co-occurring eating disorders or other medical conditions contributing to weight loss, a history of or risk for substance misuse or a significant risk of diversion. In these situations, specialist care is highly recommended.

Initiation and titration of medication

Before titration, baseline ADHD symptoms and level of functioning should be recorded using standardised rating scales. This should include an assessment of baseline sleep habits.

During titration, adverse effects should be monitored and recorded at each dose change using a standardised approach.

The treating team should review progress regularly during the dose-titration period. While this will necessarily involve the prescribing clinician other clinical team members e.g. nurses and allied health professionals can, if trained, play a key role in this process (as described by Coghill and Seth in The Dundee ADHD Clinical Care Pathway).

The dose should be titrated against symptoms, level of functioning and adverse effects until the optimal dose has been identified (i.e. the dose at which symptoms are reduced and functional outcomes are improved, with minimal adverse effects). A detailed description of how to assess whether outcomes are optimised is available in The Dundee ADHD Clinical Care Pathway and the upcoming AADPA Prescribing Manual.

Typically dose increases can be made relatively rapidly (e.g. weekly for stimulant medications), dose titration should be slower, and monitoring more frequent, if any of the following are present:

- other neurodevelopmental disorders (e.g. autism spectrum disorder, tic disorders, intellectual disability).
- other mental health conditions such as anxiety disorders, schizophrenia or bipolar disorder, depression, personality disorders, eating disorders, post-traumatic stress disorder, substance misuse.
- physical health disorders (e.g. cardiac disease, epilepsy or acquired brain injury).

Progression from the initial titration is dependent on the outcome of this process:

- Those with good response and optimised outcomes should move to the continuing care phase of treatment (see separate section below).
- For those with a partial response to treatment with a first stimulant there should be a discussion with the person with ADHD and their family/carers about whether to:
    - try the second class of stimulants (methylphenidate or amphetamines).
    - augment the current stimulant with extended release guanfacine.
- For those with no response to the first stimulant the usual approach would be to trial the other stimulant class.
- For those who did not tolerate the first stimulant due to adverse effects there should be a discussion with the person with ADHD and their family/carers about whether to:
    - try the second class of stimulants (methylphenidate or amphetamines).
    - switch to a non-stimulant medication (atomoxetine or guanfacine).

Non-stimulant medications (atomoxetine or guanfacine) should be offered if:

- Stimulants are contraindicated.
- The person cannot tolerate methylphenidate, dexamfetamine or lisdexamfetamine.
- Symptoms have not responded to separate trials of dexamfetamine or lisdexamfetamine, and of methylphenidate, at adequate doses.
- For Guanfacine the clinician considers that the medication may be beneficial as an adjunct to the current regimen.

Once treatment is stabilised management should move to the continuing care phase (see separate section below).

* These processes are described in detail in the AADPA Prescribing Manual which will be published in November 2023.

CONTINUING CARE, MONITORING PROGRESS*- Aims

To ensure that longer term outcomes are optimised for all people with ADHD with respect symptoms, functioning and the avoidance of adverse effects.

CONTINUING CARE, MONITORING PROGRESS*- Tasks

While these processes are most commonly described for medication interventions, they are relevant to all people receiving care for ADHD including those receiving non-pharmacological interventions. The Australian ADHD Guideline explicitly states that:

"People receiving treatment for ADHD should have regular review and follow-up according to the severity of their condition, regardless of whether or not they are taking medication." Funding arrangements for ADHD care need to take this into account.

Clinicians should arrange regular and frequent follow-up until treatment is optimised and stabilised.

Once treatment is stabilised, clinicians should proactively arrange individualised monitoring based on a chronic disease management model

- The optimal frequency of follow-up during this continuing care phase depends on individual factors such as co-occurring conditions, medical complications, compliance, response to treatment, social supports, and lifestyle factors.

At all stages of care (initiation, titration, and continuing care) monitoring is most effective when a measurement-based care approach is utilised. An effective approach to measurement based care for ADHD is described in detail by Coghill and Seth in The Dundee ADHD Clinical Care Pathway.

- Measurement based care for ADHD involves the routine administration of symptom and adverse effect rating scales throughout the course of treatment.
- This requires adequate time to be available within the clinical meetings. For this to work in the Australian context requires adequate funding for routine follow up appointments of at least 30 minutes and often longer for more complex cases.
- Monitoring within the measurement-based care model may be conducted by a range of different clinicians and is most efficient when conducted within an interdisciplinary team model of care.
- **In addition to medical practitioners, psychologists, nurses and other allied health professionals, pharmacists can make an important contribution to ongoing monitoring of people with ADHD who are receiving medication treatment.**

Monitoring for those with ADHD who are taking medication should include assessment of: height (for children and adolescents) and weight (for all), pulse and blood pressure, tics, sexual functioning, sleep quality, worsening symptoms, worsening of mood or increased anxiety and the risk of stimulant diversion.

Adherence to medication treatment

Clinicians should be aware that people with ADHD (or parents/carers) may have difficulty adhering to treatment plans (e.g. remembering to attend appointments on time, complete homework or organise repeat prescriptions and collect medication) due to the symptoms of ADHD or their effects.

Good quality ongoing psychoeducation can assist with optimising treatment adherence, and it is therefore essential that the treating clinicians ensure that people are fully informed of the balance of risks and benefits of any treatment for ADHD and check that problems with adherence are not due to misconceptions.

Strategies that can help optimise adherence to medication should be employed as necessary. These include:

- individuals being responsible for their own health, including taking their medication as needed.
- following clear instructions about how to take the medication in picture or written format, which may include information on dose, dosage schedule, adverse effects. The instructions should stay with the medication (e.g. a sticker on the side of the packet).
- using visual reminders to take medication regularly (e.g. apps, alarms, clocks, pill dispensers, or notes on calendars or fridges).
- taking medication as part of their daily routine (e.g. with/after meals or after brushing teeth).
- attending peer support groups (for both the person with ADHD and for the families and carers).
- making regular appointments with their prescribing clinicians to ensure timely reviews and prescriptions.
- considering the use of electronic medical records and apps to remind and track medication usage.

Review of need for continuing medication and discontinuation

People with ADHD should be encouraged to discuss their preferences for continuing, stopping or changing medication, and be actively involved in any decisions about their treatment.

ADHD medication should be reviewed and discussed with the person with ADHD (and their families and carers as appropriate) at least once a year. At each review the following should be comprehensively assessed:

- the preferences of the child, adolescent, or adult with ADHD (and their family or carers as appropriate).
- benefits, including how well the current treatment is working throughout the day.
- the clinical need and whether medication has been optimised.
- current impact of ADHD on education, employment and participation.
- adverse effects of medication and effects of missed doses, planned dose reductions and periods of no treatment.
- effect of medication on existing or new mental health, physical health or neurodevelopmental disorders.
- need for support and type of support (e.g. psychological, educational, social) if medication has been optimised but ADHD symptoms continue to cause a significant impairment.

Trial periods of stopping medication or reducing the dose should be considered when assessment of the overall balance of benefits and harms suggests this may be appropriate.

* These processes are described in detail in the AADPA Prescribing Manual which will be published in November 2023.