Chief Psychiatrist's Community of Practice Summary

Co-morbid ADHD in community teams with Professor David Coghill

Welcome - Dr Nathan Gibson, Chief Psychiatrist

This session came from a conversation with Prof. Coghill about the fact that we know there are patients with comorbid ADHD, as well as their other diagnoses, already within our public mental health services.

How do community mental health services provide useful care for this cohort?

There is now an Australian Evidence-Based Clinical Practice Guideline for ADHD (2023) endorsed by the National Health Medical Research Committee (NHMRC). It includes clinician factsheets and is available online.

Australian Evidence-Based Clinical Guideline for ADHD - AADPA

ADHD Prescribing Guide for Australian Healthcare Professionals, 2024,

FAQs address co-morbidities, populations.

ADHD Consumer Companion

There has been historical caution in the public mental health sector about ADHD, however there is robust research evidence that treating ADHD can significantly contribute to maintaining employment, housing and relationships, and reduce car accidents, other accidental death and imprisonment. Many of us will have experience of ADHD in our own lives and families and understand the impact.

Key messages – Professor David Coghill, University of Melbourne, Psychiatrist at Orygen

1. **ADHD is common in youth, children and adults. The prevalence is 2% in adults and 7% in children.**
2. **ADHD has a significant impact on functioning.**
3. **ADHD is more common in people with another mental health condition.** People with ADHD are more likely to experience trauma, anxiety and depression.
4. **ADHD is no more difficult to assess** than other mental health conditions (once you are taught how to do it)**.**
5. **ADHD can be distinguished from other mental health conditions.**
6. **ADHD can be effectively and safely treated –** even in the presence of other mental health conditions. Caution is required in people with bipolar disorder.
7. **'Is ADHD part of the clinical picture I am seeing?', and 'Is ADHD contributing to any other mental health problems?' are questions we should all ask in our clinical practice.** They are a risk factor for each other, and so considering both is important.
8. **ADHD is easily treatable with good outcomes for most receiving treatment –** co-morbidity adds complexity, but it can be managed well.
9. **The consequences of not treating ADHD are well-researched and preventable with treatment** - increased risk of criminality (higher in girls), substance abuse, premature death, suicide and poor school performance.
10. **Prevalence now is the same as 20 years ago.** We are diagnosing more; be wary of diagnostic error**.**

The WA stimulant code is changing in the coming weeks- see WA Health.

'Missed diagnosis' and 'misdiagnosis' are common.

Girls and women with ADHD are more likely to have their ADHD misrecognised as another mental health condition. Ask yourself – 'Is it anxiety or is it inattention in ADHD?' 'Is it trauma or is it ADHD?' Often it is both.

'In the Pilbara wait times for adult clients for diagnosis with ADHD are 12 months or more to get an appointment with a private psychiatrist.'

'There is no absolute barrier to public psychiatrists treating ADHD – there is no reason you can't start treating them. If you can start someone and stabilise them, which can happen quickly, then you can look at GP shared-care. But it is really important to get it started right.' Professor David Coghill.

Co-morbidity is common - ADHD does cluster with some other disorders.

A high-quality systematic review suggested that:

- 1 in 13 (8%) people with ADHD have bipolar disorder as well.
- 1 in 6 (17%) with bipolar disorder have ADHD.

Risks of not treating ADHD

Evidence of real world benefits: hospitalisations, suicide attempts and completions reduced when ADHD was treated. Studies also show that children were less likely to be abused when they were treated for ADHD. People in prison are 10 times more likely to have ADHD than those not in prison (Maudsley Hospital London).

ADHD medications reduce rates of depression.

Bipolar disorder- There are risks and benefits of treatment of ADHD so treat the bipolar first.

1. First stabilise the bipolar disorder with a mood stabiliser, then add the stimulant.
2. Both the bipolar and the ADHD need to be treated for the greatest benefit and to prevent hospitalisations.

Avoid under-prescribing.

Look for maximum benefit at the minimum dose. One of the biggest problems is under treatment. Often prescribers are too cautious or too slow and the person is not seeing a benefit. Then, if needed, try other medications.

Psychosis - It is not a simple 'no' for stimulants. There can be good benefits.

In a psychotic episode, first stop stimulants and review other medication for ADHD.

1. Treat the psychotic or manic episode as necessary.
2. Then consider alternate treatment for ADHD after the episode has resolved.
3. Consider costs and benefits of reintroducing stimulant medication. If it is to be reintroduced, take extra precautions in monitoring, such as admitting the person to a hospital/clinic for observation.

"'I see a lot of people with ADHD and first episode psychosis at Orygen. Mostly we are treating them with stimulants and very few have worsened." ***Prof Coghill***

ADHD stimulant medications are effective in 19 out of 20 cases. Add-in the non-stimulants, and we can treat almost everyone with ADHD well – if we do it carefully.'. Professor David Coghill.

Question: Are there valid and culturally appropriate assessments tools for Aboriginal people? We are just at the *very* beginning and would like to do research in WA. But while the core features of ADHD tend to look the same across the world, culturally, it's interpreted in a different way. To identify it we need to know how it is interpreted and what it means for First Nations people. Professor David Coghill.

What about Telehealth? Yes, it can be helpful but you can't diagnose ADHD in 30 mins. Ensure access and quality.

Next Steps? We need to get creative about how we use our workforce. Mental health staff need training to be able to reliably identify, assess and manage this common condition.

Social Worker – 'I was trained to do the Conners Assessment in Scotland – if I can do it, anyone can.'.