ADHD: DIAGNOSIS AND MANAGEMENT

FOR THE GP NOW AND 6 MONTHS' TIME

Thankyou

Chief Medical Officer WA Dr Simon Towler

Psychiatrist Dr Seth

Paediatrician Dr Jehangir

Doctor Geoff Noonan

Midwest GP network, Dr Richard Taylor, Jacqui Dicks

WACRH, Richard De Trafford

VDMC, Mikayla, Josie

Helpinp kids with dehaviour and learninp bifficulties

An Evidence Based Approach

Dr Kim Pedlow, GP principal VDMC Geraldton, Chair NFP Abrolhos Group

Current ADHD diagnosis management and medication for the GP

GP suspects ADHD diagnosis and refers to specialist
If the specialist wishes the GP can be included in a very restrictive co-prescribing
GP practice helps with other things such as measurements, ECG, urinary drug screens
GP checks for the common comorbidities. Is able to treat some of these for example emotional dysregulation
Coordinates various caregivers

08 9921 6099 josie@gvdmc.com

Kim Pedlow - Personal Timeline - Including declaration of interest

•1979-2018 - GP obstetrician in Geraldton, practicing old-fashioned cradle to grave medicine; I found myself caring for many young families

•A significant number of these children developed behavioural and adjustment problems that were not being effectively managed.

The overworked, underskilled services available at the time were GPs, counsellors, psychologists and visiting paediatricians.

Formal testing for IQ, ASD, specific leaning or attentional disabilities was seldom performed.

•1992 I became involved in the diagnosis and management of Neurodevelopmental disorders.

•President of the Geraldton branch of Learning and Attentional Disorders Society (LADS) now ADHDWA.

•Manager…….Youth Mental Health Programme, ADHD project of 1997/98. Mid West Division General Practice

•2014 chair NFP Abrolhos group.

•2025 …….75% of my office time spent in the management of Neurodevelopmental disorders

•2026……..???

08 9921 6099 josie@gvdmc.com

Dr Trevor Parry - Director of Child Development Centre PMH

&

Doctor Ken Whiting Private Paediatrician, Chidley school

- Visited Geraldton 1992 and introduced the Geraldton health community to the concept of - Neurodevelopmental disorders in children - **ADHD, AUTISM, FASD**

  - And the common comorbidities

  SLDs eg, Dyslexia, Dysgraphia, Dyscalculia, Central Auditory Processing Disorder, emotional dysregulation

- Midwest Division GP set up shared care program

  - Co-prescribing specialist paediatrician, psychiatrists, GPs.

- Local health professionals gave it a mixed reception

- I was convinced re efficacy of medication by the following writing samples before and after Ritalin

08 9921 6099 josie@gvdmc.com

Appendix 5

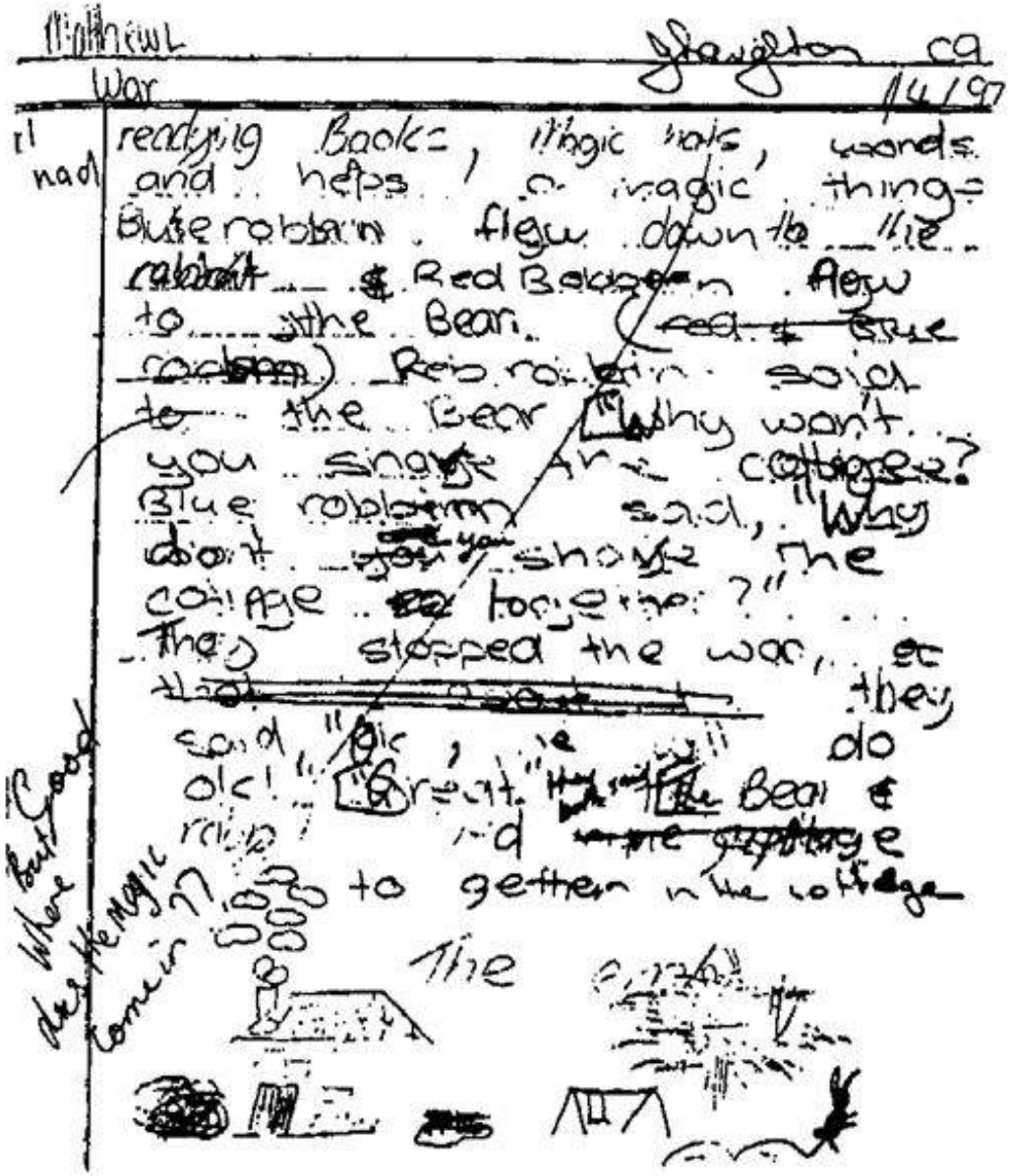
Writing Samples following are two examples of writing produced by a mid-primary child

Sample 1 produced prior to treatment

Sample 2 was produced just nine days after the child was diagnosed with ADD and treatment (Ritalin) was commenced

08 9921 6099 josie@gvdmc.com

Sample 1:
Before Treatment



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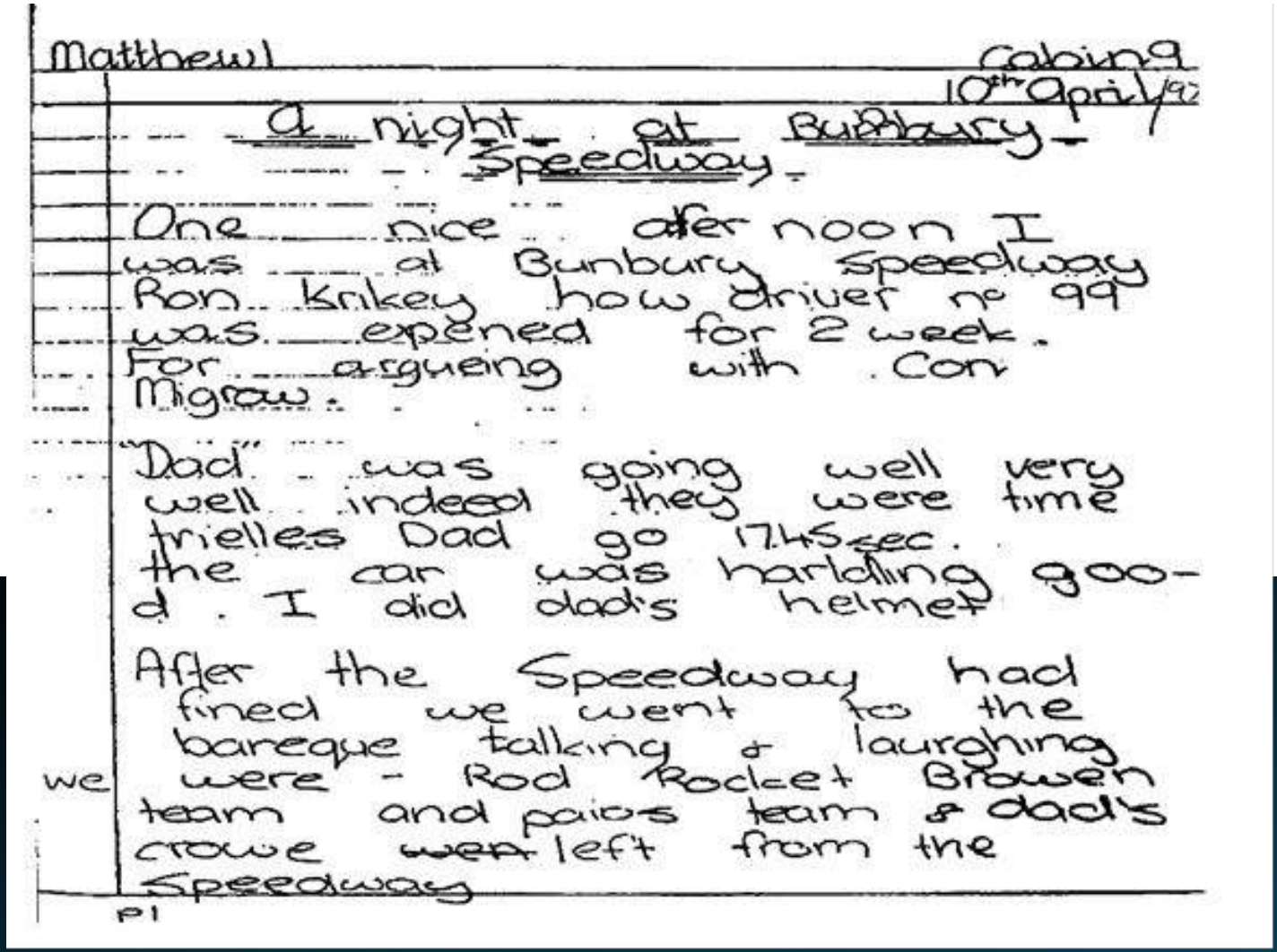
Sample 2:
9 days after treatment



Matthew 1 Cabin 9

10th April 92

A night at Bunbury Speedway

One nice afternoon I was at Bunbury Speedway Ron Krikey how driver nº 99 was epened for 2 week. For arguing with Con Migraw.

"Dad" was going well very well indeed they were time trielles Dad go 17.45 sec. the car was harlding good. I did dads helmet

After the Speedway had fined we went to the bareque talking & laurghing we were - Rod Rocket Brawen team and paios team & dads crowe ~~wer~~ left from the Speedway

P1

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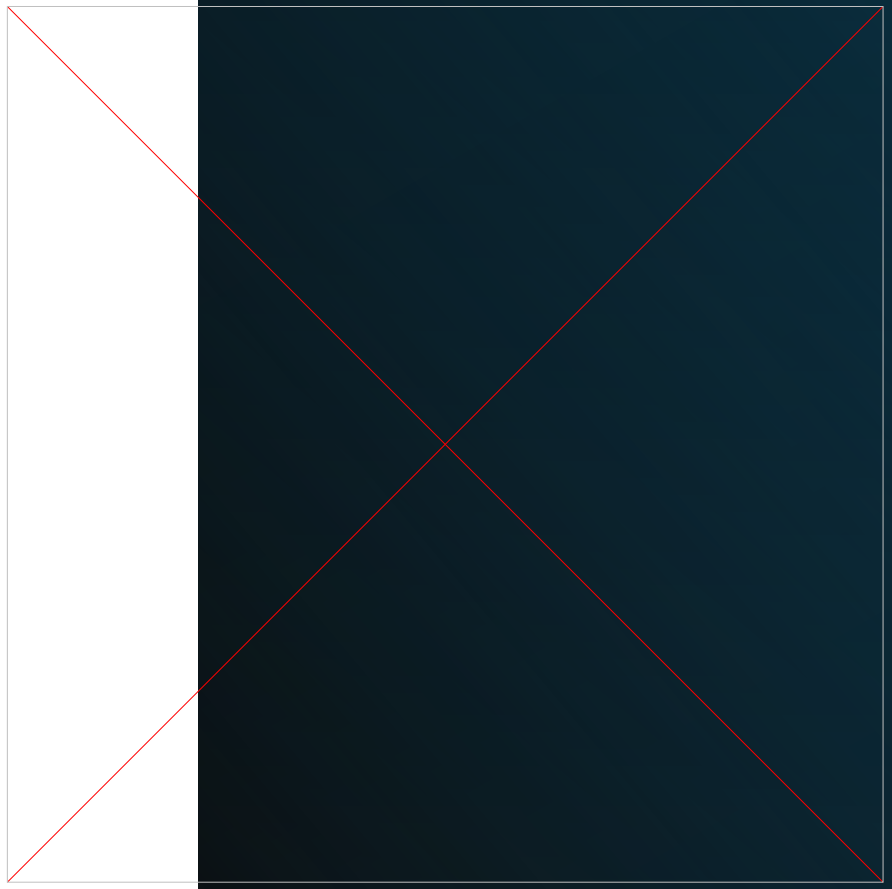
ADHD in AUSTRALIA
A Regulatory Disaster



STATE RULES	Where to apply?	Auth valid	Dex Daily Max	Lisdex Daily Max	Methyl-phenidate Daily Max	Sitewide Approval for Individ Auth?	Approval Time-frames?	Drug Dependent Persons Policy	Can multiple authorities co-exist?	GP Shared Care Age Range	Can GPs change stim type/dose with supportive documentation?	Notes (slide updated 11.9.25)
ACT	Canberra Script	12-24 Mth	40 mg	70 mg	IR 60mg AND LA/XR 60/72mg	No	5-10 biz days, Urgent 1-3d	Yes, Mandatory Notification	Yes	≥4	Yes	
NSW	Safescript NSW	12 mth	50 mg	70 mg	108 mg	No	2-7 biz days, Urgent ~24h	Yes, Mandatory Notification	No	Indiv Auth ≥4, *Continuation prescriber 6-17* [Paed ≤ 25]	Indiv Auth: Yes, *Continuation prescibers: only dose, NOT TYPE*	No need to upload supportive evidence Continuation prescriber authority with extra training
NT	NTScript	2 Yr	No max	No max	No max	No	5-10 biz days, Faster if urgent	Yes, Mandatory Notification	Yes	[Paed ≤ 4]	Yes	
QLD	QLD MARU Website +email +Approvals on Qscript	2 Yr	40 mg	70 mg	80 mg	No	2-3 biz days, Urgent ~24h	No	Yes	4-17 NO authority required ≥18 Authority required	Yes	Forms: www.health.qld.gov.au/system-governance/licences/medicines-poisons/medicines/prescribing-approvals Email to: medicines.applications@health.qld.gov.au Approvals on Qscript
SA	Scriptcheck SA	5 Yr	30 mg	70 mg	IR 60mg AND LA/XR 60/72mg	No – but all GPs may just prescribe for <2/12	1-2 months	If DDP, ALWAYS need specific Authority, ie no 2/12 exemption	No	Any [Paed ≤ 25]	Yes	May prescribe without a permit for **up to 2 months**, also if pt > 70yo Technically… no max doses, but these doses are enforced internally
TAS	TASscript	12 mth	No max	No max	No max	Colleagues can be listed too	5-10 biz days, Faster if Urgent	Yes, Mandatory Notification Specific form	Yes, but only ONE practice	Any [Paed ≤ 18]	Yes	
VIC	Safescript Vic	12-24 mth	No max	No max	No max	Colleagues may prescribe	3-5 biz Fays, Urgent ~1-2d	Yes, mandatory Notification	No	Any	Yes	
WA	Scriptcheck WA	12 mth	60 mg	70 mg	120 mg	No	5-10 biz days	Yes, Mandatory Notification	No	>2 [Paed ≤ 25]	No	MUST do a UDS before prescribing **Max 60mg/day of dex equivalent** Conversion to Dex Equivalent: MPH 0.5, Lisdex 0.4
NZ	NZ MoH Website +email	2 Yr	40 mg	70 mg	80mg	No	5-10 biz days Faster if Urgent	Yes, Specific Form	No	Shared	Dose, not type	GPs/NPS will get class approval >18, Feb '26 **Email:** medicinescontrol@health.govt.nz **No Real Time Prescription Monitoring yet**

08 9921 6099 josie@gvdmc.com

2014 THE ABROLHOS GROUP

Assisting children with learning difficulties – including psychometric assessments (WISC V)

For suspected:

- ADHD Hyperactive or Inattentive
- Autism
- Dyslexia/ Dysgraphia/Dyscalculia

08 9921 6099 josie@gvdmc.com

08 9921 6099 josie@gvdmc.com https://abrolhosgroup.org.au

•3 June 1999 Geraldton LADS Branch
Well attended meeting of paediatricians, psychiatrists, GPs, teachers including principals suggested the following guidelines for educational psychometric assessments:

- Suspension or threatened suspension
- Remedial teaching or consideration of such
- Repeating a year or consideration of such
- Significant under performance –
- School refusal

•Suggested Guidelines for content of Educational Psychology Assessment

- Assessment of Intelligence eg. WISC or SLOSSON.
- Testing of specific Learning Difficulties, particularly language based
- Assessment for Attentional Problems
- It is deemed desirable to assess each child' potential in the above manner prior to engaging on any therapy such as behavioural modification.
- DR Kim Pedlow……. PRESIDENT

08 9921 6099 josie@gvdmc.com
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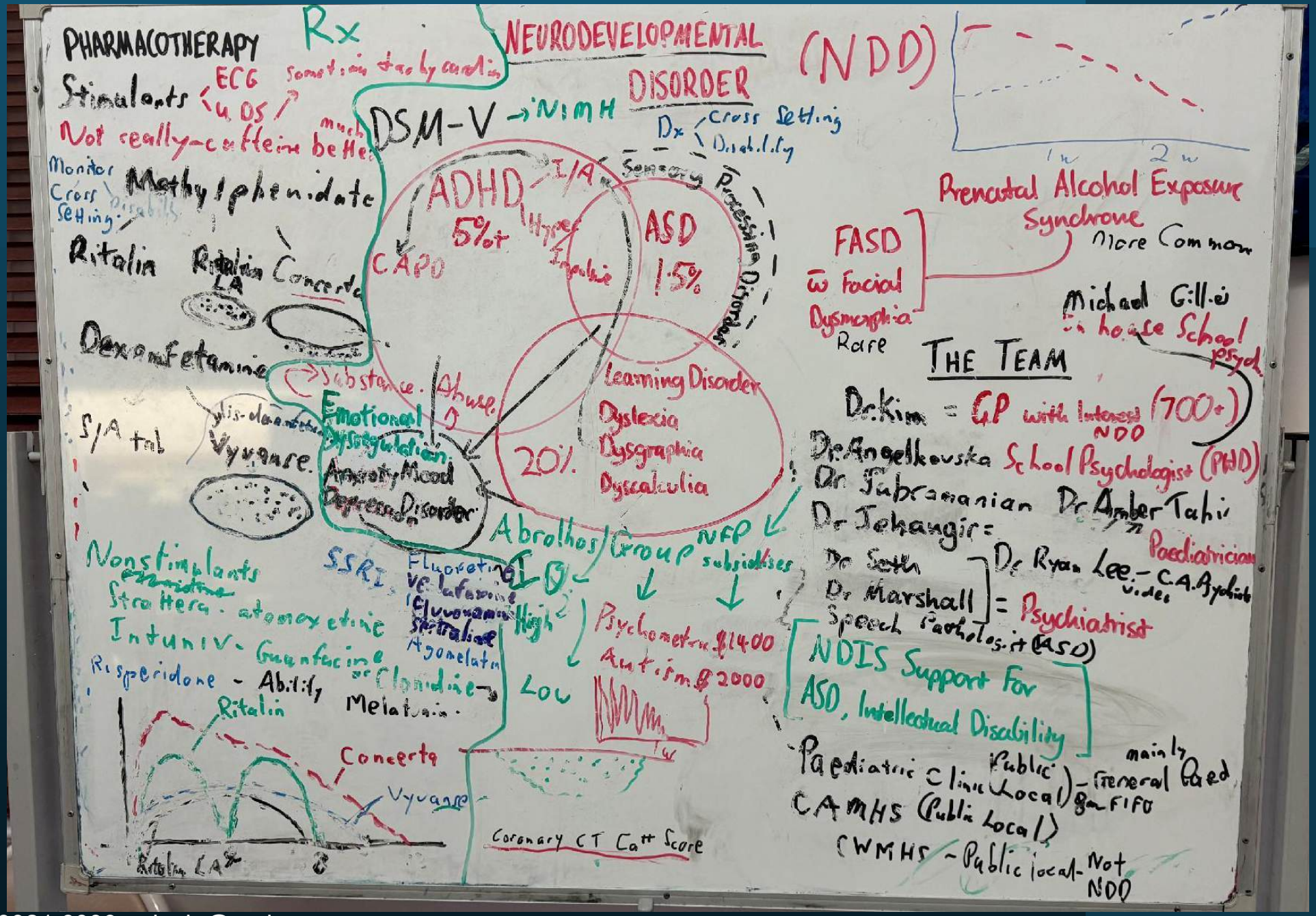

08 9921 6099 josie@gvdmc.com

The Numbers @ VDMC
Best Practice Audit

January 2024 – October 2025

~ 1084 Patients with ADHD

08 9921 6099 josie@gvdmc.com

ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

DEMOGRAPHIC BREAKDOWN

1084 patients

448 Females

- Ages 3-17 = 136
- Ages 18+ = 312

636 Males

- Ages 3-17 = 298
- Ages 18+ = 338

08 9921 6099 josie@gvdmc.com

AUTISM SPECTRUM DISORDER (ASD)

DEMOGRAPHIC BREAKDOWN

208 Patients

73 Females

- Ages 3-17 = 43
- Ages 18+ = 30

135 Males

- Ages 3-17 = 97
- Ages 18+ = 38

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DYSLEXIA DYSGRAPHIA A SPECIFIC LEARNING DISORDER

DEMOGRAPHIC BREAKDOWN

143 Patients

52 Females

- Ages 3-17 = 28
- Ages 18+ = 24

91 Males

- Ages 3-17 = 61
- Ages 18+ = 30

08 9921 6099 josie@gvdmc.com

ADHD DSM-5 diagnostic criteria

Inattentive or hyperactive-impulsive symptoms present prior to age 12 years, versus age 7 years in DSM-IV

- A. A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development, as characterized by (1) and/or (2):
  - 1. Inattention – Six (or more) of the following symptoms have persisted for at least six months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities:

    Note: The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least five symptoms are required. The patient often:
    - a. Fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities (eg, overlooks or misses details, work is inaccurate).
    - b. Has difficulty sustaining attention in tasks or play activities (eg, has difficulty remaining focused during lectures, conversations, or lengthy reading).
    - c. Does not seem to listen when spoken to directly (eg, mind seems elsewhere, even in the absence of any obvious distraction).
    - d. Does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (eg, starts tasks but quickly loses focus and is easily sidetracked).
    - e. Has difficulty organizing tasks and activities (eg, difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganized work; has poor time management; fails to meet deadlines).
    - f. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (eg, schoolwork or homework; for older adolescents and adults, preparing reports, completing forms, reviewing lengthy papers).
    - g. Loses things necessary for tasks or activities (eg, school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).
    - h. Is easily distracted by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts).
    - i. Is forgetful in daily activities (eg, doing chores, running errands; for older adolescents and adults, returning calls, paying bills, keeping appointments).
  - 2. Hyperactivity and impulsivity – Six (or more) of the following symptoms have persisted for at least six months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities:

    Note: The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or a failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least five symptoms are required.
    - a. Often fidgets with or taps hands or feet or squirms in seat.
    - b. Often leaves seat in situations when remaining seated is expected (eg, leaves his or her place in the classroom, in the office or other workplace, or in other situations that require remaining in place).
    - c. Often runs about or climbs in situations where it is inappropriate. (Note: In adolescents or adults, may be limited to feeling restless.)
    - d. Often unable to play or engage in leisure activities quietly.
    - e. Is often "on the go," acting as if "driven by a motor" (eg, is unable to be or uncomfortable being still for extended time, as in restaurants, meetings: may be experienced by others as being restless or difficult to keep up with).
    - f. Often talks excessively.
    - g. Often blurts out an answer before a question has been completed (eg, completes people' sentences; cannot wait for turn in conversation).
    - h. Often has difficulty waiting his or her turn (eg, while waiting in line).
    - i. Often interrupts or intrudes on others (eg, butts into conversations, games, or activities; may start using other people's things without asking or receiving permission; for adolescents and adults, may intrude into or take over what others are doing).
- B. Several inattentive or hyperactive-impulsive symptoms were present prior to age 12 years.
- C. Several inattentive or hyperactive-impulsive symptoms are present in two or more settings (eg, at home, school, or work; with friends or relatives; in other activities).
- D. There is clear evidence that 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 schizophrenia or another psychotic disorder and are not better explained by another mental disorder (eg, mood disorder, anxiety disorder, dissociative disorder, personality disorder, substance intoxication or withdrawal). (See 'Differential diagnosis' below.)

SUMMARY AND RECOMMENDATIONS

- Attention deficit hyperactivity disorder (ADHD), one of the most common neuropsychiatric disorders of childhood and adolescence, often persists in adults. Many studies have found that a majority of people diagnosed with ADHD in childhood continue to meet criteria for the disorder as adults. More recent findings show that a substantial proportion of those with adult ADHD did not have the condition in childhood. (See 'Course' above.)
- Epidemiologic studies of adult ADHD have estimated the current prevalence to be 4.4 percent in the United States and 3.4 percent internationally; however, individual study results have varied widely. Other psychiatric disorders often co-occur with ADHD in adults, including mood and anxiety disorders, substance use disorder, and intermittent explosive disorder. (See 'Epidemiology' above and 'Comorbidity' above.)
- Clinically significant impairments in neuropsychological functioning have been found in some studies of adults with ADHD, although those with adult-onset ADHD may be much less likely to show impaired neuropsychological function and impact on IQ compared with adults who had childhood-onset ADHD. No specific deficit or group of deficits is pathognomonic for the disorder. Impairment has been shown on neuropsychological measures of vigilance, perceptual-motor speed, working memory, verbal learning, and response inhibition. (See 'Pathogenesis' above.)
- ADHD in adults is characterized by symptoms of inattention, impulsivity, and restlessness, resulting in functional impairment. Impairment in executive function is common. Emotional dysregulation is often seen in these patients. (See 'Clinical manifestations' above.)
- DSM-5 diagnostic criteria were developed to diagnose ADHD in children, and this is reflected in their content. In assessing possible ADHD in adults, the clinician should additionally ask about common adult manifestations of the disorder. (See 'DSM-5 diagnostic criteria' above and 'Adult manifestations' above.)

08 9921 6099 josie@gvdmc.com

What are the advantages of having a GP as ADHD lead clinician in a medium or large general practice

- Cost
- Accessibility both for intake and follow-up
- Smooth transition from paediatrics to adult medicine
- Less stigma going to a general practice than psychiatric clinic
- Easy availability of needed support such as blood pressure, pulse, ECG, urinary drug screen
- More holistic patient care likely, Neurodiverse individuals seem to get all sorts of things wrong with them, sleepwalk into infection, inadvertently pass it on. Even greater need for immunization than the general population.
- Lower the load in general paediatric clinics so they can see the things that GPs really want them to see.
- What else?

08 9921 6099 josie@gvdmc.com

VDMC/AG Intake System

- **Initially nurse practitioner Natalie**
- Past History , Family History , Meds, Allergies Social
- Who initiated referral and why? Are Sx causing disabilty?
- Antenatal/Birth - Gestational age, gestational complications, exposure to drugs/alcohol, birth history (trauma/CPAP/SCN), developmental milestones.
- Education - Y ? School ?
- (behaviour, attention span, focus, concentration, academic performance, school attendance, socialisation, teacher feedback)
- Friendships and social interaction - Socialisation at school and how many friends at school, socialisation after school, on weekends, can demonstrate empathy, ?social isolation, ?able to interpret social cues and respect personal space, ?invited to birthday parties c
- SUBSTANCES, ALCOHOL, SMOKING
- Home - (Behaviour, Family relationships, ability to carry out instructions, sensory issues, amount and type of screen time)
- Sleep - onset, duration, quality
- Social/Emotional - (Tantrums/meltdowns, emotional regulation/triggers, sleep pattern, social networks, affinity with animals/pets)
- Gross Motor - (Sports, outdoor play, balance, coordination)
- Fine Motor - (Handwriting readable? drawing, colouring, painting, using scissors, Lego, building, craft)
- Nutrition - (Appetite, ?wide variety of foods? food preference, sensory issues i.e textures or colours, Dental care)
- Hearing and vision - ?any parent concerns, recent testing.
- Speech - Clarity, vocabulary, comprehension (understands and follows instructions), participation in conversation.
- Referral to Dr Kavita Seth - Dokotela

08 9921 6099 josie@gvdmc.com

PSYCHIATRIST - REFERRAL

- Dr Seth - **for video link at VDMC**
- Please see 42yo female who likely has ADHD, dysthymia, emotional dysregulation. Some question in the past about personality disorder, PTSD, even bipolar was suggested but from what I can gather not confirmed.
- Please also see by separate email the report
- We shall arrange UDS and ECG..... not used substances for several years.
- Patient will complete ADHD adult rating scales for herself and her partner walking in her shoes.
- I have explained the plethora of fake news in this area and pointed her towards the following trusted sources of information. Particularly ADHD, Vyvanse, atomoxetine so that she is well educated for your appointment. Shall access recent blood tests.
- *Please educate yourself, family, caring circle and loved ones.*
- Be aware of the USA study 2023 on older Americans taking Adderall (dexamphetamine and racaemic amphetamine).Adderall is similar to the Australian medications dexamfetamine and lis-dexamfetamine. <https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2811812> The study suggested slight increase in cardiovascular risk. Not confirmed. Untreated ADHD is associated with likely 12 year reduction in average lifespan. The National Institute of Mental Health in the USA <National Institute of Mental Health <https://www.nimh.nih.gov>>, is generally recognised to be the lead organisation in the area of neurodevelopmental disorders, that is ADHD, autism and learning disorder. Please access for accurate up to date information follow the links to ADHD, autism and medication. Other useful websites include, CHADD <www.chadd.org> and ADHDWA <https://www.adhdwa.org/>, https://www.autism.org.au/, Reach Out, This Way Up, Beyond Blue or CRUfAD
- Missed doses of some medication provides an opportunity to assess the value of the medication.
- Close observation at home and school for effect, duration of action and side effects can provide helpful management information.
- For Geraldton information please access Abrolhos Group <http://www.abrolhosgroup.org.au>.
- Google AI on the standard Google search is very good for health related matters

08 9921 6099 josie@gvdmc.com
https://abrolhosgroup.org.au

Neurodevelopmental Assessment Notes

•NP Nat.

•Referred by Dr Sabbioni was referred to Dr Sabbioni by GRAMS GP due to being on high dose of Fluoxetine. Dr Sabbioni feels Lisa had traits of ADHD/ASD.

•Has copies of school reports that were scanned to Midwest Mental health

•Taking multiple herbal remedies Ashwaganda, Gurana, ginseng, Shilajit, mushroom powder blend., sea moss

•2024 - Lives with daughter (16), son (18) lives in Bunbury with his partner. Partner Michael. Was unemployed after losing cleaning business due to COVID 2 years ago, lost rental house and became homeless. Moved to Geraldton 2 years ago and lived with Grandmother. Distant relationship with Mum who lives in Geraldton. Now owns her own house due to inheritance.

•Education - Attended 23 different primary school, Ballajura Community College and finished year 11. Started but not completed eight different TAFE courses. Started animal care four times but lost her licence (demerit points) car impounded. Still paying for unfinished course.

•Family History - Father - Polysubstance abuse, depression. Mother - ?ADHD, ?ASD. Brother - ASD. Brother - ADHD, substance abuse. Sister - ?ADHD. Paternal Cousin X2- ADHD. Paternal nephews X2 - ASD. Daughter - ?ASD

•Early Childhood/ Education - Very unhappy childhood with extreme abuse, socially isolated and excluded at school, quite, polite and shy. No behavioural issues. did not achieve at expected standard. Difficulty focussing and concentrating.

•Friendships and social interaction - One good friend, otherwise dislikes socialises, can demonstrate empathy, social isolation, difficulty interpreting social cues, observes he daughter (suspected ASD) and feel she is similar in term of being awkward, not invited to social gatherings. Will go out to dinner with partner who she feels safe with. Feels comfortable at Barnacles as Mum owns it

•SUBSTANCES - former substance abuse (meth), no current

•ALCOHOL - Very light

•SMOKING - No

08 9921 6099 josie@gvdmc.com

Home - Procrastinate with tasks, has no confidence to do anything, many unfinished projects, purchases items to start project but never start them, walls half painted. Cannot finish household tasks, starts but cannot finish, promises herself tomorrow will be different but it never is. Counts her food when she is shopping, had to have a certain amount of each object, washes tunds over and over, knives and forks need to be a set, glass sets need to be entire otherwise cannot be in cupboard, towels need to be same colours, sheets have to be matching, Always moving, clenching feet and toes. Cannot sit still. Poor memory, unable to concentrate, behind in paying bills, has many notebooks and lists, whiteboards, lists on phones, takes photos of lists, sensitive to repetitive noises - buzzers, ringers. Current earthmoving opposite her house creating anxiety, sensitive to foods particularly foods. Impulsive spending - on JObseeker allowance. Prioritised care for her animals

Sleep - Exhausted but cannot sleep, will fidget and move around, has conversations with self, overcrowded thoughts, will not fall asleep until 2am, wakes

Social/Emotional - Previous anxiety and depression, tearful during consult, mood variable, has lost several family members in a short period of time, Victim of FDV, was abusing Methamphetamine at this time (2020), makes inappropriate jokes in serious situations, feels generally awkward, finds personal contact uncomfortable, irritated with people easily, can be blunt and honest. Self confessed OCD and perfectionist. Always the clown and masks her emotions. Angry, frustrated and irritable. No recent Psychologist in Geraldton, was seeing Dr Shaun Powell. Does Lego as therapy and mindfulness to satisfy OCD trait and resolve restlessness. Frequent Tic - clicking noise, clenches jaw. Feels that she is so busy doing "nothing"

Gross Motor - Occasionally walks dogs, no sport, constantly curling feet and legs.

Fine Motor - Neat handwriting, Lego, has large amount of craft at home but cannot start, Lego frequently. Previously enjoyed furniture restoration and can build aviary's etc, scrapbooking

Nutrition - Large appetite, craves sugar, eats at night, obsession with cheese and chocolate, cannot eat yogurt, tomatoes, jelly or anything with patterns of circle and seeds i.e. passionfruit

Hearing and vision - No issues, sometimes hear thing that are not there - whispers

Speech - Clear, very takative, very expressive with gestures. Constantly interupts before she forgets what she is going to say. Changes subjects. Others have difficulty following different threads of conversation.

Pulse: 80 Height: 164cm Weight: 69kg BMI: 25.7 BP (sitting): 140/80

Neurodevelopmental Assessment Notes Cont.

•PAST HISTORY

•1999 Anxiety/Depression
•1999 Post Traumatic Stress Disorder
•2014 Borderline personality disorder
•2019 Gastric bypass
•2020 Victim of domestic violence
•2020 Substance abuse Methamphetamine
•2021 Type 2 Diabetes Mellitus

•Allergies

•Metformin - Diarrhoea, Severe

•Current Medications

•Ozempic 1mg/dose Pen device (Semaglutide) 1mg weekly.
•Pantoprazole 20mg Tablet (Pantoprazole Sodium) 1 Tablet Daily.
•Quetiapine 100mg Tablet ½ In the evening.
•Rosuvastatin 5mg Tablet 1 Tablet Daily.
•Vitamin B12 1000mcg Oromucosal spray (Cyanocobalamin) 2 Sprays Daily.
•Vitamin D 1000IU Tablet (Cholecalciferol) 1 Tablet Daily.

08 9921 6099 josie@gvdmc.com
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PAEDIATRICIAN - REFERRAL

PAEDIATRICIAN SHARED CARE - 2020

Dear Mohammad,

Please see 6yo male

New case ADHD. See below and attached documents. The school rating scale is from his classroom teacher and not so positive for hyperactivity impulsivity as the home one but when you look at the report from the school principal she strongly supports hyperactive impulsive behaviour.

I support commencing a trial of psychostimulant medication. Initially short acting Ritalin five – 10 mg twice daily, graduating to the longer acting Concerta may be 18.

Prior Notes

Back with rating scales, very detailed report from principal Geraldton primary and semester two kindergarten report from St Lawrence.

All of this shows a clear pattern of combined ADHD with disability of increasing behavioural difficulties both towards other students and teachers. He receives literary support, benefits one-to-one, as a rough player, distracting and distractible. Please indices attendance was 98% last year. His dad seems look after him very well. Unfortunately some trauma from marital breakup.

08 9921 6099 josie@gvdmc.com

PAEDIATRICIAN – REFERRAL Cont.

Presented with his father who works in a mineral analysis laboratory servicing the local iron ore industry. Separated and divorced from mother in 2016. Apparently she has been diagnosed with schizophrenia and more recently bipolar disorder. Also uncle with schizophrenia. No obvious cases of ADHD or learning difficulty in the extended family.

Reason for this consultation is children primary school year one and particularly the principal Jackie Quartermain has sent family in my direction. Teacher Mariah Jeffcoat. I thought maybe some PTSD related to marital breakup.

They've been on the paediatric waiting list from May 2019 to their appointment in August 2020. That is 15 months. There have been behavioural issues, attention seeking, acting out, physical and verbal abuse of other students which has resulted in three school suspensions. Formerly at St Lawrence as primary school K and preprimary.

There is a violence restraining order against the mum who has sent death threats to her former husband and son.

Socially lives with his father and partner/fiancé Sara. Plan is for the family to do rating scales at home and school as per below. See me in a few weeks.

Suspected ADHD

Given rating scales snap for home and school .

Mum to organise collection of information from home and school. Return with semester reports and both rating scales

•Check websites google NIMH and follow prompts - local info www.abrolhosgroup.org.au and follow prompts to ADHD manual

•Reason for visit:

•Behaviour difficulty

•Examination:

•General:

•Height: 114.7cm

•Weight: 18.6kg

•PAST HISTORY Not recorded.

•Allergies Nil known.

•Current Medications No long term medications.

08 9921 6099 josie@gvdmc.com

Current ADHD diagnosis management and medication for the GP entails

- GP suspecting the diagnosis and referring to specialist
- if the specialist wishes the GP can be included in a very restrictive co-prescribing.
- GP practice helps with other things such as measurements, ECG, urinary drug screens.
- GP checks for the common comorbidities. Is able to treat some of these for example emotional dysregulation

08 9921 6099 josie@gvdmc.com

2026 WA

•Cohorts of GPs the first one including myself of 15 are being trained up to RACGP WA and AADDPA standards.

•Details are sketchy at this stage - But likely

•For patients 10 years and over

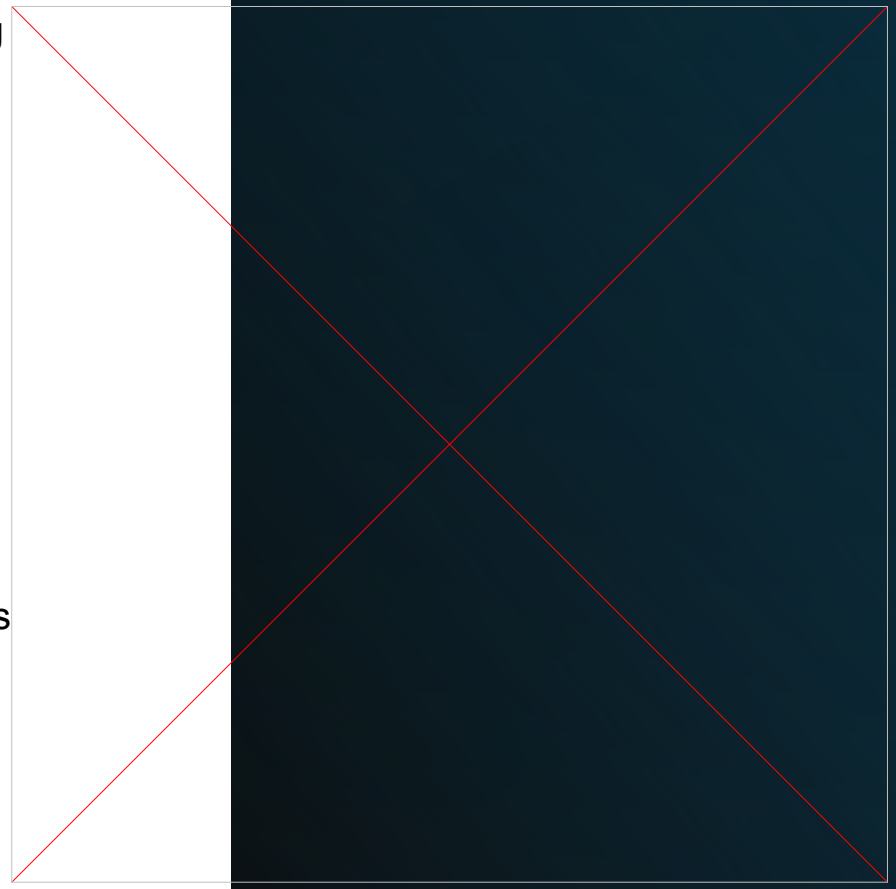
•We shall be able to diagnose, manage and prescribe medication to ADHD patients. No compulsory specialist review.

•Usual GP/specialist arrangement applies for referral and consultation. Not compulsory.

08 9921 6099 josie@gvdmc.com

PROFESSIONALS REQUIRED

- Doctors or nurse practitioners with interest in ADHD. We have a working model at VDMC. Fits well with maybe 25 -50% doing ADHD with all its variations and other GP work including procedures.
- We are not territorial. Happy to help anybody including other practices. Could be GP, could be another nurse practitioner.
- We have found a way of making it pay using the various item numbers including care planning.
- Educational psychologist for subsidised psychometric assessments. Could be face-to-face at the practice or remote video link.to have access to our treasure trove of notes



QUESTIONS?

08 9921 6099 josie@gvdmc.com

THE CLASS SYSTEM SKETCH

https://www.youtube.com/watch?v=9XmB59Ax4cE

08 9921 6099 josie@gvdmc.com