Primary health strategies for working with children who present with ADHD concerns

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Panellists:

- Carla Koay, Occupational Therapist, SA
- Dr Andrew Leech, General Practitioner, WA
- Amanda Peters, Lived Experience/ Child and Family Partner, SA

Facilitator: Nicole Rollbusch (Practice Development Officer, Emerging Minds)

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Nicole Rollbusch (00:00:03):

Hello everybody and welcome to all and thank you so much for joining us for tonight's webinar. And hello to those of you who might be watching this as a recording later, my name is Nicole Rollbusch. I work with Emerging Minds as a practise development officer and I'll be facilitating tonight's session. Next slide, please. Before we begin, I'd like to acknowledge all of the different lands that we're coming from today across Australia. I'm on a beautiful Kaurna country here in Adelaide, and I'd like to pay more respects to the elders past, present, and emerging, and recognise the deep connection that Aboriginal people have with land culture, community, waterways and spirituality and family, and how important that is for the wellbeing of all Aboriginal and Torres Strait Island to people. And if you would like to share where you are coming from tonight, the land that you are on, please feel free to do that in the chat box. Next slide please.

(00:01:14):

So this is actually the third webinar in the sixth series on Infinite Child Mental Health that has been presented by Emerging Minds and MHPN. We've got a few more webinars in this series coming up next year. So we have Child Mental Health in First Nations community, which will be kicking off in March, 2024, followed by understanding children's mental health in culturally diverse communities in April, and practise strategies for Children that focuses on bullying behaviour in June, 2024. If you want to receive an invitation to any of these, please subscribe via the Emerging Minds link there or sign up to the NHPN portal as well. And we hope to see you at one of our future webinars as well. Just a little bit of housekeeping here, so if you haven't seen this platform before, you just want a bit of a reminder to interact with the webinar platform and to access resources.

(00:02:19):

So we do have some extra resources for you available tonight. You can select the following options, so you'll see three dots on the lower right corner of your screen. That's how you can access information.

And under the information tab, that's where you'll find links to the slides for tonight. The three sources I mentioned, the survey about their webinar tonight, as well as technical support if you have any troubles with the platform this evening. And you can access the chat in the top right, so you'll see the speech bubbles and in the chat, that's where you can share the country you're coming from tonight as well as with the other participants as well. And if you'd like to ask a question that we'll cover in the q and a later this evening, in the lower right of your screen, you can submit a question and I'll be monitoring that throughout the webinar. Next slide please.

(00:03:20):

So these are our learning outcomes for this evening. So these would've been sent out to you when you registered for the webinar, so I won't go into them in great detail just to say that I think our presenters that are joining us this evening do an excellent job of meeting these learning outcomes. So I hope that you enjoy their presentation. Next slide please. So without any further delay, I'll introduce tonight's panellists. I'm really pleased to be joined by Amanda Peters. She's our childhood family partner for tonight, Dr. Andrew Leach, our general practitioner and Karl Quai occupational therapist. So just wanted to introduce each of them to you. So Amanda, I know that you are really passionate about this topic in particular of ADHD. Can you tell us a bit about why it was important for you to be a part of this webinar tonight?

Amanda Peters (00:04:23):

Sure. Thank you for having me to begin with, but definitely I wanted to be a part of it. ADHD is such an important topic for me. Having a child with ADHD, she's quite often misunderstood or judged, and so I really wanted to be a part of this tonight so I can help advocate for children with ADHD and to help educate those that aren't familiar with it, and particularly from a lived experience as well for what that's like.

Nicole Rollbusch (00:04:52):

Fantastic. Well thank you for being here. Thank you. And Andrew, so in the case study that we are looking at tonight, it might seem like the GP maybe is a little bit dismissive of the teacher and the family's concerns in particular, what do you find is really important to you when a family like Liam's first comes to your practise?

Dr Andrew Leech (00:05:18):

Yeah, thanks Nicole and great to be here tonight. I think we're seeing a lot of presentations like this at the moment, which is why this will be a great webinar and it's very difficult to navigate and hard to know what to do next. So I think as primary healthcare doctors, we should be open to all possibilities and maybe not necessarily just narrow down to one and think about all the potential influences on this child's life and get all that information. It's great to have feedback from the school, but also good to think about what else might be going on for that child.

Nicole Rollbusch (00:05:54):

Yeah, great. Thanks Andrew. And welcome. Thanks. And finally Carla, so when we were talking about content for tonight, I noticed that you referred to heavy work strategies, which is something I'm not familiar with, but I have heard other OTs use this term before. What do you mean by heavy work for those of us who might not be familiar with the term?

Carla Koay (00:06:24):

Hi Nicole, and thank you for having me tonight. OTs love heavy work. It involves strong activation of the muscles and the joints and usually through pulling or lifting or pushing, and it can also be known as proprioceptive input heavy work input helps to give us feedback about what our body's doing in space and it also can be inherently really regulating and organising. So it can be both calming and alerting and I tend to talk about it as a great leveller can bring our alertness up if we're sluggish or down if we're heightened and usually involves activities using a child's body weight like hanging from the monkey bars. Or it can be more like doing animal walks or carrying something heavy. For that we normally recommend no more than 10% of the child's body weight. Thank you.

Nicole Rollbusch (00:07:20):

Great, thank you and welcome to you as well. So what will happen now is each panellist will give a short presentation followed by our question and answer between the panel. So I'll throw to Amanda who's presenting first, and just so the audience is aware, Amanda will have a camera off while presenting so there's no glitch of your internet and please stay with us. So over to you Amanda.

Amanda Peters (00:07:50):

Thank you. So as I said earlier, I do have a daughter with ADHD. So she was first diagnosed at age seven with ADHD and anxiety and then at depression at 14 and she's currently 15 now. So when you have a child with ADHD, people tend to make judgements about you and your child. This is primarily due to your child's behaviour, their lack of self-control, their inability to listen and follow directions, not reaching the norms or generally what I like to call having no brain breaks. People assume it's your parenting, your lack of discipline that your child is naughty, but the truth is your child is not deliberately acting in this manner, this is just the way their brain is wired and that's okay. We use this terminology of brain wiring a lot in my house. It helps my daughter and her sibling to understand that her behaviour is not always something she chooses to do on purpose. Rather this is just how brain is wide and that's okay. And the more we learn about this worrying including what works and doesn't work, the better all our lives will be, especially hers. ADHD impacts our entire family on different levels. Next slide please.

(00:09:02):

So I want to tell a little story to illustrate this. Many years ago I remember being so hung up on my daughter's bedtime. I remember having this somewhat elaborate bedtime routine for her to go to bed at a particular time so she would get X amount of hours sleep and be fresh and ready for the next day. Like children her age. What ended up happening was she was awake for hours longer than I anticipated, full of energy. But you know who wasn't me. I was exhausted and constantly tired. I remember going to our paediatrician completely frustrated with her lack of sleep for the paediatrician to simply tell me she my

daughter, she just doesn't need as much sleep as me, even at her young age. That's not how her brain is wired. It was like someone dropped the mic, flipped the switch and took a massive pressure off my shoulders, a pressure I had placed there.

(00:09:54):

This was such an important moment for me. I learned an incredible lesson about parenting my child, not the idea of a child, a neurodivergent child, not a neurotypical child. Now bedtime isn't a stress. I say goodnight and she tucks me into bed. Well, not quite. We have the rule that she can go to bed when she's ready, but she can't disturb other members of the household while they're sleeping and she needs to be a functioning human for school the next day. Full disclosure, she does have medication to help her sleep. If she chooses to take it, she's old enough now to self administer it if she feels she needs it. The moral of my story is when parents embrace the child that they do have, it helps to take away some of the challenges. Next slide, please.

(00:10:39):

When I first read the case study, I nodded along and I thought, yep, been there, done that. Any medical journey generally starts with the GP, the first port of call, and then you get your referrals to see a wide variety of professionals such as OTs, speech pathologists, psychologists, nutrition, nutritionists and so on. Anyone you think may give you the magic solution to fix your child's behaviour, but there are no quick fixes. It's an ongoing journey of professionals supporting you to help your child help. I want to take the time to mention something here I feel is incredibly valuable for all the practitioners to take into consideration and that is to keep an eye on the parents of the child that you are treating, especially if you're a GP. Let me explain why. Often when I take my daughter to the GP or any appointment for that matter, we are all cranky.

(00:11:28):

By the time the appointment starts, the practitioner is generally late and my daughter hates to wait. She's bored. She'll constantly interrupt the conversation between the practitioner and myself. I say, the sky's blue. She'll argue, what's green? I am tired, I'm frustrated and I exhausted on so many levels, but I need your help. Please remember this. When a parent may come across as rude or blunt or frustrated or whatever they don't mean to be, chances are they're running on an empty tank. So check in with them. How are they coping? I'm so thankful that my GP does this. It gives me a safe space to cry or laugh or whatever I need. Nothing is going to positively impact that child more than a parent taking care of themselves, it helps them to be a better parent. Next slide please.

(00:12:18):

As a parent, I've listed some key ideas that really help me create positive collaborations with the practitioners we've seen that may help your families such as encouraging families to ring the practise first to see if the practitioner is running on time so the family can adjust their arrival and wait times if needed. Offer a variety of visits including telehealth appointments or the first appointment of the day suggests other ways parents can provide information such as short videos to demonstrate behaviours or areas of concern rather than the parent trying to describe them. I've done this numerous times. I'm not

very good at describing what is happening or what I'm seeing, but a quick little video can help to really quickly illustrate to the practitioner what I mean. Next slide. Please read the information you have. It's incredibly frustrating to waste half of the visit going over old information.

(00:13:13):

Often these visits have a long waiting time and can be really expensive for the parent. Can this old information be reviewed via the phone? First, share information between other practitioners, talk to each other and keep me in the loop. I will happily sign any form to share information between service providers and give the parent something to take away from the appointment such as a strategy, an idea to try or what the next step in the process will be. We need to positively look ahead. Next slide please. For me personally, I have learned most about what I know about ADHD through my own research such as reading books, internet searches, podcasts, and talking to other families in my position. But most of all, and most importantly, I have learned the most valuable information from listening to and talking to my daughter. After all, she's the expert on herself. It is from these sources and our own reflections as a family that we decide what actions and strategies to put place for me. Sorry, let me break that down further. For those wanting to share this strategy with families that they work with. One step at a time is our family mantra. Rome wasn't built in a day. Pick one or two main goals or behaviour and start with these. You can not do everything at once.

(00:14:32):

Break these challenges down and reflect on them. What's working, what's not working, what could be changed. You may need to try several strategies as it takes time to find the right thing. These strategies may also change as the child ages involve your child in the process. It's likely to work better, especially if they do have a DHD. There's less resistance and defensive behaviours. Talk to your child. You might pick up on what the issue is. Often it can be small and easily rectified. Next slide please. Some general strategies we use, and this is regardless of whether it's at homeschool or public places are regular movement breaks. This can look like getting a drink of water at school, picking the back row of a movie theatre so she can get up and walk around or shaking our facilities out before we sit down at a restaurant.

(00:15:23):

Lots of exercise in general. Breaking tasks down into one to two manageable steps and not just limiting the steps in the process, but also the number of words you used within the instructions. Eliminating, eliminating any unn. I'll start again. Eliminate any unnecessary steps such as putting dirty dishes straight into the dishwasher without having to rinse them first. Decluttering on a regular basis, making sure items have a home clear containers make it easy to see the contents. People with ADHD are very visual, so the more visuals the better. This can be colour coding items where possible such as tower sheets, cups, school books, et cetera. Excuse me. I would also encourage practitioners to validate what a parent is already doing and use this knowledge to work together to tweak strategies based on this shared knowledge. Also to give the parent adequate time to make changes and be understanding with them as often progress is slow. And finally, I would just like to finish by saying any child's health with any child's health journey, there are so many positive steps and strategies we can take to promote best outcomes for children. And this is with or without a diagnosis. Thank you.

Nicole Rollbusch (00:16:40):

Thank you Amanda. Really appreciate you sharing your experiences and particularly the things that you've learned. And I love that phrase, no brain breaks. I think that's quite a good metaphor to use. So thank you for sharing on our hand over to Andrew. Andrew.

Dr Andrew Leech (00:17:03):

Thanks Nicole. So I was going to use Liam as our reference for today's discussion about this topic. It's such a broad topic and we could talk about it for quite a long time. So I wanted to cover some of the key points from my perspective as a GP who sees a lot of children with developmental difficulties and try to give some practical tips. Now when we see someone like Liam and we are seeing lots of kids like Liam at the moment around that five or six years of age as first entering into primary school and being noticed by the teachers as having quite a difficult time sitting still or being very distracted, we need to sort of think about this child as a whole. There are very normal developmental milestones around that age where children are very busy and there's quite a wide spectrum of what might be normal and is this a potentially normal situation? But on the flip side, it's important not to miss something as important as ADHD or autism or anxiety or mental health difficulties. So we're sort of in the middle of that and we need to work out and get the information to try and make an accurate assessment of Liam. So we'll talk a little bit about that through the next couple of slides. Next slide.

(00:18:27):

One thing to start with is the close correlation between mental health and ADHD. Anxiety in particular can very much look like ADHD. And I see many children who present with these sorts of challenges of being busy fidgeting and struggling to even be dropped off at school where the teachers have observed these behaviours and thought, well, this really looks like a learning problem or a learning difficulty and should be assessed. So it's important not to miss anxiety and to assess appropriately and accordingly around is this actually an anxiety disorder that's emerging and anxiety in kids often? Well, it does. It presents really differently to how it does in adults as a behaviour or an emotional response or a very difficult emotion. So weaning out those differences can be tricky and it's very closely crossed over sometimes as well. It's almost like a chicken and an egg scenario.

(00:19:23):

Is it the anxiety that's causing the distractibility or is it the distractibility that's causing the anxiety? So there's no need to answer that in that first consult. It's just thinking about it. And I often draw this for parents just to show that overlap and maybe even just tackling one of those things first and seeing what sort of left after that and the impact of biology, the impact of that child's health and the impact of their genetics that can't be underestimated. Their health is so important. So is there anything we can do on the outside on the periphery of these issues that will help us to work with these issues as a whole? Next slide.

(00:20:01):

So touching on those biological influences is something that gps are very good at and it's something we can do with every child we see is to take that holistic broad approach before we narrow down and say,

okay, this is definitely ADHD, we need to now go forward and manage it. The problem with the system at the moment is it's basically at capacity, especially here in Western Australia where we are having trouble getting into paediatricians. So we need to do a little bit more background work I think before we actually refer on and get the help. And I think some of that background work will help us also to understand the child better before we make a referral simply just to see if they've got ADHD. So there's long wait lists across the board and I think that's across the country because we often just accept, okay, this child's having trouble at school, let's just do the referral and let's just see what happens.

(00:20:52):

There's a bit of fear of missing out from parents as well who don't want to miss out on getting into a paediatrician. So as a result, the system's just blown up. So looking first at nutrition, I mean obviously Liam's eating sort of white foods and that's really common, but do we need to check his iron and check other factors like his B12, other things that might be missing in his diet or does he need some kind of vitamin or replacement to help him or does he need some support around his nutrition? Just simple tips. Do the parents need to see a dietitian? Sleep's crucial and we could spend the whole hour on sleep as well, but easily watching iPads before bed, watching screens, and we need an hour at least before bed where we don't use screens. And having a really good wind down routine and routine is crucial for bedtime.

(00:21:38):

And it's okay if he wakes up and sometimes goes into his parents' room. We accept what some things won't always work perfectly, but getting good quality sleep. The other thing is not missing a sleep disorder. And I've often had kids with tonsil, large, big, large tonsils who end up getting them out and end up being a lot better and happier at school and learning that obstructive sleep apnea can be a very hidden and easy to miss. Problem screens we've already talked about, but just keeping an eye on screens and accepting again that we're all dealing with screens now everyone even down to the age of four or five have got a screen. So how do we manage that and how do we give parents advice that's not judgmental, but it also lets them know that sometimes screens can impact a child's behaviour and often it does. So having limits and having boundaries on screens. Some kids are better than others at dealing with screens and then checking the overall health and development of that child, the background history, the conception, the antenatal period, the birth history, the growth and the developmental milestones so that we know, okay, where are we at in terms of the longitudinal side of things? Next slide.

(00:22:55):

My next question for Liam's family when they come in with these questions, when they come in with these concerns, a letter from the school is what are you actually needing right at this moment? What can we do to help you right now? Because obviously there's a lot going on for you and it's quite overwhelming to hear this from your teacher after the first year at school and suddenly, Liam, it needs to be referred for an assessment for ADHD. So what do you think would help? And so these are some of the things that parents will tell me, I just need some reassurance. Am I on the right track? Am I missing something? Do I need a diagnosis? Does Liam need medication? Parenting advice? Parents will ask, well, what do you think I should do when he's melting down at home? What do you think I should do when he's clinging to me on the way to school?

(00:23:40):

Just simple strategies and we're good at listening, so even if we don't know the answer, we can at least listen and refer on for the help that might be helpful, like an OT or a psychologist or simple support groups for parents, the parenting groups like Triple P or Circle of Security or any other local support parenting group just to get them on the right track and it doesn't take much, but it might just be getting some tips and strategies in place. So many parents come in confused and not sure what is actually going on. And it takes multiple appointments, so you can't do this in 15 minutes. I end up spending multiple long appointments till we get to where we need to be. Next slide. And then coming back to the school, really closing that loop. The school has sent Liam into us for advice and a referral to a paediatrician, so it may not come to that, but I'd like to let them know what we're doing so they don't feel left out.

(00:24:36):

Very easy. I just write a quick summary or I sometimes have a template, but a very quick summary that just says we've started the journey, we're working on some strategies. Please do what you can at school to help Liam focus. And that might be just sitting up the front of the classroom, giving him the opportunity to have a fidget toy or to have more breaks. It depends on the school and it depends on the teacher and lots of positive reinforcement because Liam's already now noticed he's being targeted in this sense because he's always in trouble. He can't sit still, he can't listen. So just giving him the occasional reinforcement to help boost his self-esteem and enjoyment at school. Next slide.

(00:25:18):

Some psychologists now are doing these educational academic assessments, which are really great. They're very comprehensive in WA. I've seen them ranging from a thousand dollars up to $3-$4,000. So I know they're quite expensive for some families, but they do offer a more comprehensive overview of where Liam might be sitting at and that is certainly an option when you're stuck and you can't get a paediatrician and the schools just need some guidance on what we do next. It can be helpful when we're trying to work out learning difficulties as well, but I do tend to just keep it a little bit more simple than this at this early age. Next slide. And in that sort of third column there, I might just give out some free screening tools just to start with like the snap, the Vanderbilt or the strengths and difficulties questionnaire. I did end up purchasing the Connors four just because I'm seeing so many of these and I use the Connors and that's a really sort of great overall view.

(00:26:15):

And I know as gps we may not necessarily have the training in these sort of questionnaires, but they're not hard to interpret and then they give us a really clear direction for where to go next. The psych profile is another great tool. It's online, it's $5, it was developed here in wa and it gives you a similar sort of guidance on what are the key issues. And so then we can work with those and before we end up getting a more comprehensive review. So where to from here? We've said, let's do some medical tests mate. Let's check Liam's Health. Let's check that he's okay, hearing vision, maybe a blood test, nutrition and sleep check the mental health, do we need to do a mental health care plan to refer on to a psychology or an OT with mental health skills? And then let's go forward now and follow up Liam over time and start to

involve the parents and the school and help them out with building a team. Next slide. That's it. Thank you.

Nicole Rollbusch (00:27:12):

Thanks Andrew. Really appreciate you sharing your experience and I liked that crossover that you showed around ADHD and anxiety. We did get quite a few questions pre-registration around differential diagnosis, so thank you for sharing that and everything else and I'll hand over to Carla now. Thanks Carla.

Carla Koay (00:27:38):

Thanks Nicole. As Amanda and Andrew also touched on, I'm mindful that by the time they see a therapist, a family and child might already have experienced a lot of negative messaging. So when establishing a relationship with Liam and his family, I'd aim to gather any pre-information before arranging a time to speak with the parents over the phone, even if it's a relatively short conversation. To further unpack the challenges and the problem story while identifying priorities to focus on first, then I'd arrange to meet with Liam and his family at the clinic before planning a visit to observe Liam at school and also meet with his teacher. When it comes to meeting Liam, I'd start by having a couple of activities set up for him to choose from. They might be connected to his interests and will usually offer a movement and heavy work component to help start connecting through doing this might look like activities lying over a big inflated ball, a game of crab, walk, soccer or using therapy. The scope of occupational therapy is really quite broad and in the following slides I'm going to be talking about just a couple of the factors I'd be considering when working with Liam, his family and his teacher. Next slide please.

(00:28:56):

We are all sensory beings. Our sensory preferences impact what we notice, what we love, what we hate, what we avoid, and they also influence which environments and activities we thrive in. We take in sensory information from our bodies and from the world around us process and then respond to it. As practitioners, we can get really curious about how someone's sensory preferences influence the way they move throughout their day and what might support them to engage successfully with their everyday activities. For some of us, a lot of sensory input feels like a little bit and in Liam's case with the teacher reporting, he finds it difficult to sit still and he fidgets a lot. I do wonder whether he may need more movement and touch incorporated into his activities. These signs are likely an attempt to regulate his nervous system and he's not intentionally being disruptive. On the other hand, it's possible that just a little bit of visual input feels like a lot for Liam making it much easier to get distracted. This may also be the case for oral sensory input, which could impact and contribute to his particular food preferences and also auditory or sound input. Next slide.

(00:30:17):

Liam is likely going to benefit from regulating heavy work and ideally rhythmic movement input woven throughout his day. We can work with Liam, his family and teacher to collaboratively identify achievable ways to do this as a part of Liam's routines. Some examples might include using natural transition points

like incorporating a 10 minute play on the playground before school or time on the trampoline before dinner. Others might include using animal walks to increase that heavy work in short bursts. We can also consider furniture at home and school. Many children respond well to alternative seating options like wobble stools to help increase their access to movement in the classroom. However, I'm mindful that some children need more postural support and for these, some of my favourites are the how to hug chair or an inflated cushion on a chair with a back rest. Generally classrooms are sensory rich environments and teachers are often dealing with competing demands in their classroom setup.

(00:31:22):

Acknowledging this, I encourage teachers and parents to do a visual check of the child's environments. What is the additional visual input that Liam's needing to screen out in order to tune into the teacher at the front of the class or to be able to find his foreclosed in the morning? I invite teachers and parents to consider if there's any way to reduce the amount of visual input or visual noise whilst also highlighting important visual information. We know that seating a child at the front of the class and help reduce the amount of additional visual and auditory input they need to screen out. One of my client's teachers also uses a talking spot at the front of her class. This is where she can record 30 seconds of instructions on a large button as she gives them and then students can use the button to listen to them again if needed. Whole of class strategies like this are generally easier for teachers to be able to implement and also don't single out individual children. Next slide please.

(00:32:25):

Organisation and predictability can be calming, help reduce stress and help us stay on task. We all use visual schedules to aid our memory and get things done. So if you use a diary or a calendar, then you use a visual. Imagine trying to put together flat packed furniture with all the instructions only given verbally at the start. Having the task or routine broken down into small steps with a visual of what it looks like really helps for a visual schedule such as the one shown on the slide of a morning routine. In order for it to be meaningful and motivating for the child, it's really important for the child to be consulted and involved in its creation. We can connect the visuals to their interests or use photos of the child themselves engaging in the tasks. Just like with any new skill, the child will need to practise referring to the visual schedule and using it alongside a supportive adult.

(00:33:25):

I also prepare parents that they may need to regularly revisit and update these schedules as they can become less helpful as needs and interests change. Teachers will usually have visual schedules for their class already. The child might need some elements of the day further broken down into smaller chunks or it might need to be made more personalised for it to be effective. Consistency of the images and words used across home and school can also make a big difference to their success. It can be helpful to give a picture too of what Dunn looks like. For example, like in the photo on the slide, we might use that photo of Liam dressed and ready with his uniform, his backpack and his shoes on as a way of representing what ready for school looks like. Next slide.

(00:34:17):

And lastly, I acknowledge it can be sometimes be really difficult to find services, especially with wait lists and for those in rural areas. So I've included a link to the OT Australia find an OT tool where you can screen for practitioners offering telehealth services as well as by location and area of practise. This tool doesn't include all OTs in Australia, so it can be also helpful for families to ask their GP or their child's teacher for local options. Often a teacher will already have a good connection with local therapists working with other students in their class while waiting for services. It can be helpful to connect with the school's wellbeing supports. This might be a wellbeing leader or a pastoral care worker who can link families into community resources and services. Finally, for children who are younger than six, I'd also be considering whether developmentally they might be eligible for NDIS, early childhood early intervention funding in order to support further access to services. Thank you.

Nicole Rollbusch (00:35:29):

Thank you Carla. I enjoyed all the sensory practical strategies that you shared and I love talking spot idea around the instructions and the children in class being able to access that after it's been said. So thank you and thank you all for sharing your experience. Now we're ready to move on to the q and a session. So as a reminder, feel free to submit some questions and we do have a lot of questions that were submitted in the registration at registration, sorry, so we won't be able to get to everything. I do hope that some of your questions have been answered by our presentations and I just wanted to jump in first, Andrew, Chrissy asked in the chat about screening tools for teens and I was just wondering if any of those screening tools that you mentioned were suitable for teens and also what ages they might be suitable for?

Dr Andrew Leech (00:36:40):

Yes, so they all would be suitable. So the Vanderbilt is a commonly used one, which is available freely online and is quite applicable to teenagers. The psych profiler as well, similar where the teenager can self complete that online. As I said though, they just need to pay $5, but it's quite useful and produces a really nice report. The SNAP screening tool for ADHD also applicable across all ages. So I think it just depends if they're younger it'd be more the parents and the teachers that complete it. But for teenagers I really encourage them to complete it as well because then we get their insights and how they're feeling about what's going on for them.

Nicole Rollbusch (00:37:28):

That's great, thank you. And Carla, I wanted to ask you a question about how you would work with teachers in particular to potentially incorporate some of those environment changes and task adaptations that you were talking about in your presentation. What's important for you when you do that,

Carla Koay (00:37:52):

Nicole? I'm really mindful that teachers are working in busy and demanding roles and the classroom is their domain. They've often spent a lot of time and a lot of effort. It put a lot of effort into setting up the classroom environments. So when I'm coming in, building a really strong partnership with the teacher is

key and I want to speak with them first about what are their priorities for the child and get some feedback on that. I'm to be quite flexible around when I come in because when teachers are teaching, if I'm trying to meet with them then it's not easy to have a conversation during those times. And also thinking about what can I notice that's going really well. Often teachers are doing some really great things and it's about building on those strategies already for children. I'm also really mindful of them with their busy and demanding role if I am sending any written information that it's kept really concise so that it's accessible for them.

Nicole Rollbusch (00:39:04):

Great, thanks Carla. And I wanted to jump to you, Amanda, and ask you about some of the strategies that might've been put in place at school for your daughter that have been useful that you might be able to share.

Amanda Peters (00:39:16):

Yeah, definitely. So throughout all my daughter's schooling years, both primary and high school put in individual learning plans for her. So I would have meetings with the school, her teacher and usually the school support teacher as well where they would set goals for her and then come up with strategies that were able to support her. No surprise, a lot of that was visual learning and how they could put strategies in the classroom for her to be able to do that. Definitely movement breaks as well. So throughout the day, giving her jobs as well to do so she had a reason to leave the classroom so she wasn't looking as though she was being singled out. Seating played a huge part. So funny kind of story when Carla was talking about the seating arrangement. So when my daughter went from primary school to high school, she went to a high school that was designed for neurodivergent children and one of the things she said in the first week is she said, I can feel like I can just learn.

(00:40:20):

I'm like, well why is that? And two things. One was the room was cold, so it had really great air con and the two, she did her learning sitting in a beanbag with a soft blanket on her so her sensory needs were being met, she was cool, she was comfortable, she had something soft and it just took away all those challenges that she was able to focus on what the teacher was saying and she was also able to get up and move without having to ask or an explanation as to why she needed to move. She would just get up and start walking around the classroom and that was completely acceptable. So having definitely someone at school that understands a DHD and what the needs are makes a world of difference to the children.

Nicole Rollbusch (00:41:06):

Yeah, that's fantastic Amanda. I like that. What the difference that makes when those challenges, as you say are taken away and that ability to focus is more accessible I suppose, for the child

Amanda Peters (00:41:21):

Just meeting their needs and their needs just happen to be a little bit different from the norm.

Nicole Rollbusch (00:41:27):

Yeah, that's a great way to put it. Andrew, I wanted to ask you something that's come up a little bit in pre-registration and we did have a couple of questions come through on the chat as well. So there is a lot of talk of over-diagnosis and use of medication in young children and that is present in the case study that we looked at tonight as well. Do you think this is the case and why do you think that might be happening?

Dr Andrew Leech (00:41:59):

It's a big question, Nicole. The case alludes to this particular GP being very cautious about the diagnosis of A DHD in Liam. And the thing I highlighted here was particularly due to the potential over-diagnosis of A DHD and the associated use of medication in young children. So the first thing is that I think there's a wide variety of experience and a wide variety of opinion and a wide variety of how GPS might approach a child like this. And just through what they're seeing and what they think about A DHD, even A DHD can be very controversial and it can be topical, it doesn't need to be. It is an important diagnosis to make. It's a very important diagnosis to understand and to learn about. So hopefully tonight raises some of that awareness. I think that's been a very interesting time. We're seeing a significant rise in presentations, particularly families seeking a diagnosis or seeking support around learning difficulties in A DHD.

(00:43:07):

There's possibly multiple reasons around that and still research to be done about why that might be. Some theories around the impact of covid and how that might've affected some children learning in their own home and what parents might've observed during that time through to the impact of screens through to the impact of our diet and our sleep and how busy we all are now and the lack of ability for us to even just regulate ourselves and slow down and stop. There's many factors and I think the biggest one is probably just the awareness, it's just in social media, it's on TikTok, people are talking about A DHD. So it seems like that the understanding and awareness, which is good, but it is making us very busy and it's also very hard now for GPS to try and just work out, well how far do we need to take this and how serious is this potentially for this child?

(00:44:07):

So I guess it's just important to not miss it, to not make any judgement just to accept these are the problems that are coming up for this family at this point in time. Now let's work through it systematically and try and come up with an answer that helps them. The other thing just to finish on that is we don't necessarily need a diagnosis. And I tell a lot of families this, it may or may not be a DHD, Liam ticks all the boxes for the DSM criteria, but he's six. Yes. So let's work with those challenges. Let's get an OT involved now and see if we can help him for the next 12 months whilst we get more feedback from school. It doesn't matter either way, whether this is a DHD or not, there's no NDIS funding except for those early intervention type methods that Carla's spoken about. But it may or may not make a difference at this early stage. So if all else fails, just get the help you need.

Nicole Rollbusch (00:45:07):

Yeah, thanks Andrew. Yeah, I like that point about diagnosis. That was a question that someone actually did ask in pre-registration was does getting that diagnosis make a difference? But all of these strategies that we've talked about tonight could be used regardless of whether there is that diagnosis or not. And I wanted to follow up that question with you, Andrew, around when should medication become part of the conversation though when there is a diagnosis?

Dr Andrew Leech (00:45:45):

Well, I've heard many starts around this and there's again the same sort of thing. It really is child dependent and the severity of impact on that child's learning and wellbeing. But one that I did here is that medication is probably 60 to 70% of the treatment for A DHD. It's actually very, very rewarding when you get the correct treatment plan and the correct combination of treatment. And it sometimes happens first go with the medication, but it can take a bit of trial and error as well. And we don't have a way of predicting how a child might react to a certain brand or a certain type of medication. So sometimes we do have to allow for that and give that child a chance to just adapt in terms of ages. There is no real right or wrong age, but probably most paediatricians seem to start treatment from around that five or six if it's very significant. But most kids I see start to get treatment a little bit old, maybe 8, 9, 10. But I think if it's impacting schooling and it's impacting learning, the treatment needs to start earlier. So it really depends. So that's probably my answer to that, Nicole.

Nicole Rollbusch (00:47:12):

Yeah, case by case,

Dr Andrew Leech (00:47:14):

Definitely case by case

Nicole Rollbusch (00:47:17):

And yes, and still those strategies can be put in place that we've talked about tonight as well.

Dr Andrew Leech (00:47:23):

Just with that, Nicole, just with that, some people find that the strategies don't work until the child has medication in place. So I've had a number of families come in saying, oh, we've done a year of OT or a year of psychology and it just didn't click with this child. So then we really know for sure, look, okay, we have to take all angles at this. It's not all just about medication, it's not all just about ot, it's all those other things I've mentioned, but let's also add the medication in and let's see if that helps these concepts that this child is learning in play therapy in OT or with psychology. Let's see if this helps by having that background by having that medication in place.

Nicole Rollbusch (00:48:06):

Fantastic, thanks Andrew. I wanted to jump back to you, Amanda Lee in the chat has asked about how you feel the best way to touch base with new teachers in primary school in the new school year. How do you do that without sounding too helicopter or too demanding?

Amanda Peters (00:48:29):

That's a great question. So one of the tactics I would definitely say was encourage the child's teacher from the previous year to do a handover. So they learn and they know so much about your child already, so they're spent a year with them, what works, what doesn't work in the classroom where they sit that visual stimuli, everything, ask them could they do a handover and pass that information on. And also you as a parent, you have to be the biggest advocate for your child. You have to be somewhat of that helicopter parent because they need someone to stand up for them, they need someone to advocate for them. So you just have to do it. You just have to make an appointment. Generally, I wouldn't spring it on the teacher. I'd say, you've got my child this year. I'd really love it if we could just sit down and have a bit of a chat and be honest with them and say either they should already know if your child has a diagnosis or you think they do or they're in the stages of, and this is what we're currently doing, we'd love it if you could support us or if you come up with strategies to let us know so we can work together.

(00:49:39):

What teacher doesn't want to hear that we want to work together.

Nicole Rollbusch (00:49:44):

Yeah, yeah. That's great. Yeah, that's a great question. Thanks Lee. And thanks Amanda. Carla, I'm going to throw back to you now because something that's come up tonight as well, and prior to the webinar was this conversation around A DHD and a SD or autism spectrum disorder. And so the overlap between that, but also how you might support a child where they may have a dual diagnosis of A DHD and SD, is there anything that you would do differently when you were working with a child like that?

Carla Koay (00:50:28):

Nicole? My response to that is really to take that step back and to think about what are the needs of the child, what are the priorities and what are they presenting with and how can I help identifying those next steps and breaking it down into small chunks for yourself as a practitioner as well as the family. So it really depends on the child and how we look at them. So I wouldn't say I'd necessarily tackle it too differently. We also know that a number of, there is a lot of crossover in terms of what are the general strategies that support children with a diagnosis of autism and A DHD.

Nicole Rollbusch (00:51:15):

Thanks Carla. Andrew, did you have any insights into that around the similarities of A DHD and A SD and what you might do differently?

Dr Andrew Leech (00:51:29):

Yeah, so this comes up quite a lot and I try to just be patient and also to allow some time because it's not always clear which one it might be. It can be a combination. We know there's a lot of overlap and that goes again with circles with anxiety as well. So I think we just need to be patient and allow lots of input from different people like the allied health professionals that we've referred to, the teachers, the parents, the family, and start to build up a picture of what might be going on. I try to tell parents there's no rush again for a diagnosis or a label as such. I know it does allow more funding potentially, but I do think if we were going to make a diagnosis, it's very important to get it right and to make sure we're doing it for the right reasons and to help that child. So autism can be clear cut, but it can be very hard as well and take time. So there is sometimes just those extra consults of make it easier to get to that.

Nicole Rollbusch (00:52:42):

Great, thank you. And that kind of makes me think of another question I had for all of you actually came through quite a lot pre-registration was how do you explain A DHD to families? And I'd love it if each of you kind of had some input on this one and see if these explanations are different. But I'd love to hear how you might explain it to families in, I suppose in a way that is informative but also succinct. Who wants to jump in first?

Carla Koay (00:53:25):

I can go first, Nicole, and it kind of comes off of what Amanda has said about no brain breaks as well. So I really like the analogy of the brain being like a race colour and it really likes to go extra fast. And I've come across this analogy or this really comes down to a brain being like a race car has its own strengths and it has its own challenges. And I came across this analogy through a book called My Brain is a Race Car, and we've got some information about it, I think in the resources. I don't have any affiliation with the author, but it's just a really lovely way of explaining to children and to families what an A DHD brain might look like as well as some of the strategies that might support that brain as well.

Amanda Peters (00:54:24):

Can I jump in? Yeah, do you want to jump in, Amanda? My daughter loves the book. It's called All Dogs Have A DHD, and she first read it when she was little and 10 years later we are still talking about that book. She loves it. I explain a DHD to people as, like I said, we talk about brain wiring, so I just say that her brain is wired a little bit different and that's okay. That's literally something I say a lot is that's okay. So yeah, it's just definitely, and then I'll talk a little bit more about that impulsiveness, that little bit of hyper focus and then just trying to explain it that they're just wide, that little bit different. I guess that probably wasn't the best explanation, but that's what I do say is just that the brain warring is just a little bit different. And so we have to make a few accommodations, I guess for it, just a few strategies in place that we can help to support people with it.

Dr Andrew Leech (00:55:31):

From my side, Nicole, I find it's good to be empowering, especially to children, that this is a superpower for them. They have many abilities. Often the kids I see with A DHD and autism are highly creative, very ambitious, very smart, and have many, many skills. It's just that they're so busy in their mind or in their

body that it has hard to figure out where to start or where to finish. And so as a result, that support that we give them will help them reach the potential over time. And I think just giving them that hope that this is not something that's going to hold them back. This doesn't change who they are as a person. They're still the same person. It's just a part of how their brain likes to operate. And many famous people who've gone on to create some incredible things have a DHD, and I think I try and relate back to what the potential is for them in their future.

Nicole Rollbusch (00:56:35):

Yeah, thanks Andrew. I think I really like all of the strengths, focus explanations that you all had. I think that oftentimes there can be this fear around the diagnosis or when those concerns come up. And yeah, I love that framing of it in those ways that you talked about. And also the metaphors I think are always so helpful for parents and for kids to understand. So thank you all for that. I wanted to ask, so Annabel, I was asking in the chat whether the panel would recommend sports and joining sports clubs as an option for children with A DHD and how these clubs might best cater for children with A DHD. How do they ensure their inclusive practises? I suppose there was lots of talk in the presentations around movement and exercise. So yeah, really interesting question from Annabel. Did someone want to tackle that one? What they thought about that?

Amanda Peters (00:57:48):

I'm happy to, so definitely. But I think you've got to come back to the child. So what they're interested in as well. So my daughter has a DHD and anxiety, so her doing group sports is torture for her. There is no way that she would be a part of that. But having said that, she does like to do independent or individual sports, so she's happy to say if it was on a treadmill or the gym because she is that bit older where she's more independent. That's definitely a bit more likely I guess to happen. Even just walking the family dog is a really good opportunity for us. Gives her that exercise, gives us time to talk as well. But it is just kind. You've got to find your tribe and you've got to find your people and your support networks within your community. So whilst my daughter doesn't like to play team sport, my son does.

(00:58:48):

And so my daughter will volunteer in the canteen and she has a canteen lady that kind of takes her under the her wing and helps her support her, which has been really great with her social skills and stuff like that. So she still gets to experience being a part of a club and a part of a team, but without that pressure of having to perform with everybody else. But I think it really comes down to what the child is interested in and finding your community and finding the right coach or person as well. Because some people are just absolutely brilliant with children that have diverse needs. It just comes natural to them without no training and they can just go, yep, it's okay. I've got them, I've got her, don't worry, and I really don't have to. And other people you're like, yeah, this isn't going to work. But I would say definitely take your child's leave if there's something they're interested in and then investigate it, see what's out, and you'll find the right place or that right community for you.

Dr Andrew Leech (00:59:52):

I think that one parent told me that I suggested going into a team sport, I thought it'd be really great just to get moving. And they did basketball and the child was doing cartwheels throughout the game and totally not involved in the game at all. So I think you're right with what you've just said there, Amanda, that it needs to be led by the family, the child, what are they interested in? And it is not always going to work. So it's a bit of trial and error. See, try things each term and see which one that child fits into, find their purpose. That's really an ultimate goal. What makes them buzz, what makes them happy and get them into that. It can involve online gaming as well. It can be good in some situations where children have that social anxiety.

Nicole Rollbusch (01:00:41):

Thanks, Andrew.

Carla Koay (01:00:44):

And I might just jump in and echo what Amanda and Andrew have said. It's about getting that goodness of fit between the child and the activity, and I have worked with children who have absolutely thrived in structured sports. So it's really about giving the child an opportunity to have a go if they're interested and motivated.

Nicole Rollbusch (01:01:10):

Thanks everyone. I want to ask you, Carla, because you talked a lot about the sensory side of things. So someone submitted a question around olfactory sensory sensitivity or overwhelm, which is really considered as a major impact. We often focus on visual and auditory and those sorts of things. Can you talk a little bit about, I suppose the smell overwhelm?

Carla Koay (01:01:40):

Sure, I'd love to. So I have really just honed in on mainly movement or vestibular input and proprioceptive input tonight. But we are sensory beings with eight different sensory systems and we can have, like I said about a little bit of sensory input, feeling like a lot, it can be different across different senses and certainly work with children with sensitivity around olfactory or smell input can often be connected to children who are more picky with their eating. I'm trying to think back to some strategies that I've found helpful. Sometimes I have found for some children to have a scent that they really like on a hanky or something in their pocket that can help to mask sense that they do tend to find more noxious or unpleasant can be really helpful. I think having opportunities to have a break, so say if it's smells in the classroom, to be able to get away from them or for people in that child or that person's environment to be mindful of using sprays or deodorants or cleaning products can also be really helpful. So yeah, very interesting and great question because it's a huge topic and I've really just honed in on a couple of things tonight, so I appreciate the question.

Nicole Rollbusch (01:03:20):

Great question. Thank you. Thanks Carla. And there is something, a final question before we wrap up. Start wrapping up in a couple of minutes. There has been a fair bit of interest in gender differences in A DHD. So we actually did have a question from Belinda tonight and some questions from registration as well around how it can present differently in boys and girls and whether your approach would be different. Is that someone want to chat on that for a couple of minutes?

Dr Andrew Leech (01:04:08):

Probably Carla, it'd be good to hear from you. But what I've noticed is, I mean it's more common in boys. That's the first thing. The boys that I see tend to get themselves caught up in trouble a bit more in school and a bit more distracted with their friends and easily sort of angered, maybe a little bit more emotional, a little bit few more outbursts, a bit more physical as part of their hyperactivity and their impulsivity. And that other label of oppositional defiance disorder is often thrown around in this setting where the boys are seen as being very oppositional and not doing tasks that they're asked to do. So I think that's probably a general way that I, it's not always the same. Some boys are a bit quieter and a bit more inattentive, but that's sort of what I've been noticing. And in the girls, again, very much a generalisation but possibly a bit more of a daydreaming type situation, they just sort of out, they talk to me about just looking out the window and thinking about anything but what is going on at school and that can then lead to that distraction.

(01:05:28):

But girls can equally be hyperactive and fidget and move around and move in their chair and talk to their friends and things as well. So it's variable. One thing that we haven't mentioned today that some kids try really hard to hold this together at school, they put a lot of energy into just learning the basics and just keeping up so they feel part of that class and part of their friendship group so they don't feel different. Then at home it comes out as an explosion. It's like shaking up a bottle of Coca-Cola and then off comes the lead. It's an explosion. So the emotions and the outpouring and the meltdowns and things is what parents come in with. And that might be the first presentation is parents saying that this is what's happening at home, but school says they're perfect. They're just listening and sitting there and doing their work. So A DHD can actually present like that as well. Very different to what we've said in this story here with Liam, but just something to be aware of that might not be across both home and school.

Carla Koay (01:06:36):

And with that, I can only really speak to my experience in practise, but a number of the girls that I've worked with tend to be more tactile and potentially seek still fidgety and moving, but tend to be more about having something in their hands a lot of the time and having more objects in their pockets too. That's probably been the main difference that I've noticed. But again, it's very individual for each child and that's my experience.

Nicole Rollbusch (01:07:13):

So very individual. There can be some gender differences, but always taking it by the individual case. I would love to keep talking about this, but we are running out of time unfortunately. But I would really

love for each of you to share just one takeaway message from tonight for the audience because we have offered a lot of ground, so it might throw to you, Amanda, and if there one takeaway message that you might have for the audience tonight.

Amanda Peters (01:07:49):

I think it would be that often with children with a DHD progress can be really slow. And so I think looking back at my journey is I would encourage whether it's families or practitioners to start with your goal or where you are at. And so if you do decide to go down the track of different practitioners and medication and things like that, then you can look back because sometimes it doesn't feel like you're getting anywhere because progress is so slow where that's not the case. It just takes quite some time to get there. So you might look back at the start of the year and go, oh my goodness, this isn't happening now. Or we've achieved that and really celebrate those successes because they are huge things. Children with A DHD, they do, they work so hard to keep it together throughout the day to try and meet those social norms to learn, to fit in, to do it.

(01:08:46):

And then we are teaching these additional skills and strategies on top and I think that they really need to be recognised and to celebrated. And the other thing is, sorry, I know it's too is, but just to listen to your child as well and involve them in as much as possible, have them lead the way. Talk to them about what's not working and what's is working because then you can quite often void a lot of anxiety or meltdowns and stuff like that just by making those adjustments, by learning about them and advocate for them. That's it. I know that was three, definitely advocate for them because they get so many negative messages that they need people in their corner. They need the GP saying that you are a superhero, they need the OT going, let's stay back and let's just work on this one thing. We can do it together. We need the parent go going, well tell me how can I help you? How can I support you? What can I do to make this better for you? They need all those people in their lives. Thank

Nicole Rollbusch (01:09:47):

You. Thanks Amanda. Thank you. And Andrew, what about for you?

Dr Andrew Leech (01:09:53):

For me, look, a DHD is such an important neurodevelopmental condition that we need to be aware of and need to understand. And it is something that we're seeing present more to us now that the awareness is increasing, which is good, but to be also thinking holistically, broadly. Each child is so unique and so different in how they might present with something like a DHD. Think about what comorbidities might be going on, think about the underlying biological influences and sort of then narrow down the key goals of care. Building a team as well. Really good because we can be quite isolated as gps. Great to have others involved if you can, if you're in an area where you can refer on and get some help from Allied Health and involve the school.

Nicole Rollbusch (01:10:41):

Thanks Andrew and Carla.

Carla Koay (01:10:45):

Lucky last. I guess for me it's really about noticing those behaviours that may be seen as more disruptive and thinking about them in terms of what are the needs that the child's trying to meet and how can we support to meet those needs in ways that may be more adaptive. Like Amanda said, really working with the child and with their family to just talk to them, ask them what's helpful and what's not. Because going to be trialling things along the way. And through that trialling and feedback, we are going to start to work out some things that are helpful.

Nicole Rollbusch (01:11:33):

Thank you and thank you to all three of you for spending time with us this evening. I've really appreciated hearing all of your experience and sharing with us tonight. And I only wish we could have spoken for a bit longer. So thank you to Carla and Amanda and Andrew. I really appreciated all of your wisdom that you shared tonight. Just before you log out, thank you to all of you who participated in tonight's webinar. It's fantastic to have you all here with us. If you wouldn't mind, we would love you to complete the exit survey and provide some feedback to us. You can click the banner above or scan the UR code or go to the SurveyMonkey address provided at the end of the webinar. We love hearing what worked for you and so we can always make these better. And the recording of their webinar, you'll receive a follow-up communication from MHPN with the recording of this. So look out for that. You'll also get a statement of attendance that'll be emailed within one week. So the next webinars that MHPN are hosting are strategies to support client and patients with chronic pain to participate in work that benefits their health and wellbeing. And that will be in February next year. And identifying and treating agoraphobia will be held sometime in March, 2024.

(01:13:10):

So keep an eye out for the notifications and you'll be able to register for those webinars and MHPN podcast programme Alicia episodes on a fortnightly basis as well. So look out for those. So MHPN supports over 350 networks across the country where mental health practitioners meet. They either meet in person or online to discuss issues of local importance. And you can visit the MHPN website to join or register your interest in starting a new network in your area. And just a reminder that this webinar was co-produced by MHPN and Emerging Mines, or the emerging mines National Workforce Centre for Child Mental Health Project. The National Workforce Centre is funded by the Australian Government Department of Health under the National Support for Child, youth and Mental Health Programme. And yes, again, please do share your valuable feedback with us. We look forward to receiving that. And thank you again for joining us and thanks again, Tola, Amanda, and Andrew. Goodnight.