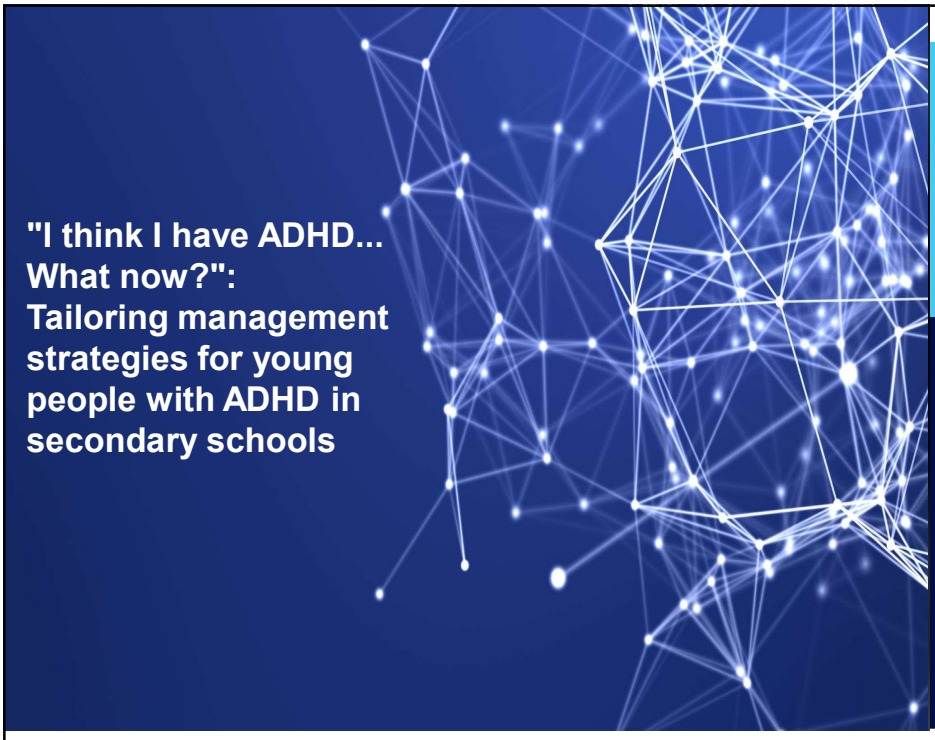
"I think I have ADHD... What now?": Tailoring management strategies for young people with ADHD in secondary schools



THE UNIVERSITY OF MELBOURNE

Department of General Practice and Primary Care

Doctors in Secondary Schools (DiSS) Clinical Training and Support Program

Dr Bianca Forrester and Dr Nadia Coscini

Term 4, 2025

1

THE UNIVERSITY OF MELBOURNE

The University of Melbourne acknowledges the Traditional Owners of the unceded land on which we work, learn and live: the Wurundjeri Woi-wurrung and Bunurong peoples (Burnley, Fishermans Bend, Parkville, Southbank and Werribee campuses), the Yorta Yorta Nation (Dookie and Shepparton campuses), and the Dja Dja Wurrung people (Creswick campus).

The University also acknowledges and is grateful to the Traditional Owners, Elders and Knowledge Holders of all Indigenous nations and clans who have been instrumental in our reconciliation journey.

We recognise the unique place held by Aboriginal and Torres Strait Islander peoples as the original owners and custodians of the lands and waterways across the Australian continent, with histories of continuous connection dating back more than 60,000 years. We also acknowledge their enduring cultural practices of caring for Country.

We pay respect to Elders past, present and future, and acknowledge the importance of Indigenous knowledge in the Academy. As a community of researchers, teachers, professional staff and students we are privileged to work and learn every day with Indigenous colleagues and partners.

2

Department of General Practice and Primary Care DiSS Training Team

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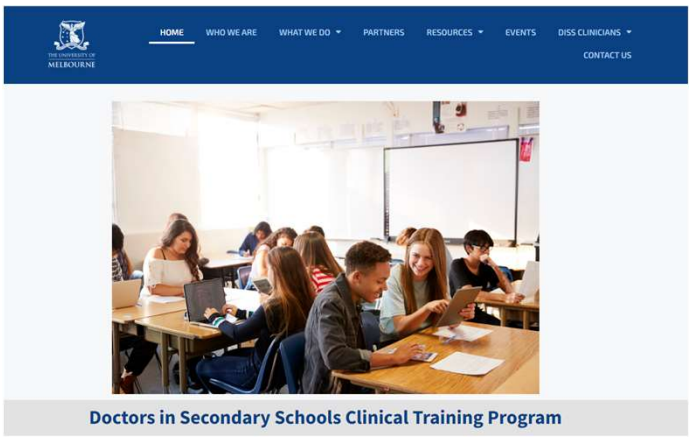
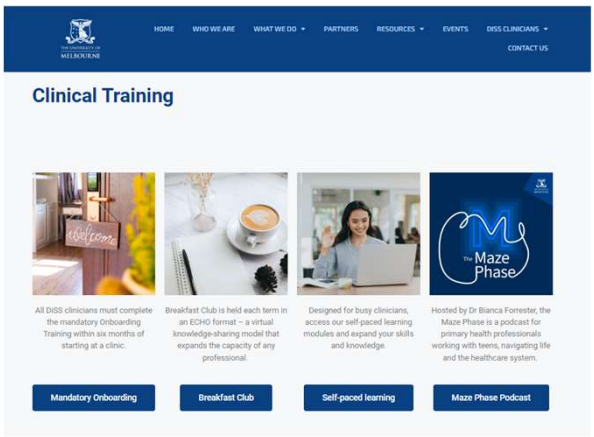
3

Healthcareinsecondaryschools.com





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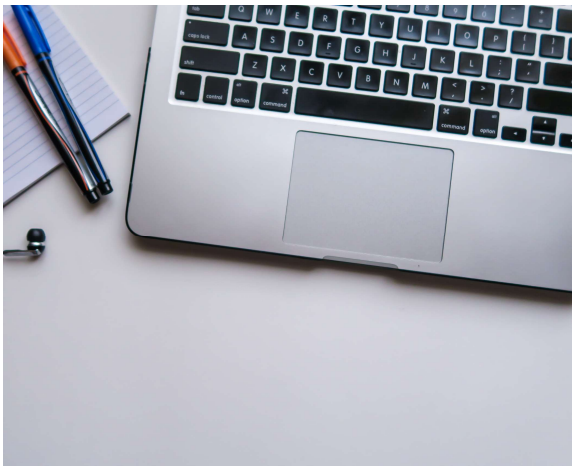
Housekeeping



Please remain on ‘mute’ during the speaker presentation – we will have time for questions afterwards

The ‘Chat’ can be used to ask a question or make comments

Session will be recorded so please hold your questions till signaled by facilitator

After the speaker presentation, “Raise hand” function/or simply signal come off mute or to ask a question

For DiSS GPs: Statements of attendance will be issued following this session - you can self-submit to RACGP/ACRRM for CPD points

5

Agenda for Session

Introductions
- Facilitator: Dr Bianca Forrester
- Presenter: Dr Nadia Coscini, Centre for Community Child Health, Royal Children’s Hospital

Didactic Presentation 30 minutes

Questions and Discussion 20 minutes

Summary and wrapping up
- We’ll send you slides after this session
- Content will be made available online on our website

6

I think I have ADHD.. What now?": Tailoring management strategies for young people with ADHD in secondary schools

Assessment tools, Co-occurring Conditions & Management

Doctors in Secondary Schools Webinar

4th December 2025

7

We acknowledge the traditional owners of the land on which we live and work, the Wurundjeri people of the Kulin nation, and pay our respects to their Elders, past, present and emerging.

8

Agenda

- AADPA Assessment tools and interpretation
  - Vanderbilt and Conner's
- Co-occurring conditions
  - Anxiety, Autism, Depression, Sleep
  - Stimulant vs non-stimulant framework
  - Medication interactions
- Weight management in ADHD + Eating Concerns
  - First principles: ADHD medications, ARFID, eating disorders
  - Monitoring and management strategies
- Opportunities for further support for young people with ADHD

9

Assessment Tools for Adolescents

Key Principles

- Thorough assessment by trained clinician is essential
- No single test can diagnose ADHD
- Multiple information sources needed
- Consider developmental history and current functioning

Recommended Tools

- **Vanderbilt Assessment Scales***
- Conners Rating Scale
- ADHD Rating Scale-5
- Clinical interviews (structured/semi-structured)

* Freely downloadable

10

Vanderbilt Assessment

- Parent and teacher rating scales
- 18 symptom-based items (DSM criteria)
- Performance items across settings
- Screening for co-occurring conditions

Interpretation

Requires ≥6 symptoms in one domain AND impairment across ≥2 settings

11

The Questions on the Vanderbilt

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3

12

Screening questions on behaviour

19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

13

More screening questions on behaviour and mood

33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

14

Impact on performance

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

15

Parent Assessment Scale	Teacher Assessment Scale
Predominantly Inattentive subtype ■ Must score a 2 or 3 on 6 out of 9 items on questions 1–9 AND ■ Score a 4 or 5 on any of the Performance questions 48–55 **Predominantly Hyperactive/Impulsive subtype** ■ Must score a 2 or 3 on 6 out of 9 items on questions 10–18 AND ■ Score a 4 or 5 on any of the Performance questions 48–55 **ADHD Combined Inattention/Hyperactivity** ■ Requires the above criteria on both inattention and hyperactivity/impulsivity **Oppositional-Defiant Disorder Screen** ■ Must score a 2 or 3 on 4 out of 8 behaviors on questions 19–26 AND ■ Score a 4 or 5 on any of the Performance questions 48–55 **Conduct Disorder Screen** ■ Must score a 2 or 3 on 3 out of 14 behaviors on questions 27–40 AND ■ Score a 4 or 5 on any of the Performance questions 48–55 **Anxiety/Depression Screen** ■ Must score a 2 or 3 on 3 out of 7 behaviors on questions 41–47 AND ■ Score a 4 or 5 on any of the Performance questions 48–55	**Predominantly Inattentive subtype** ■ Must score a 2 or 3 on 6 out of 9 items on questions 1–9 AND ■ Score a 4 or 5 on any of the Performance questions 36–43 **Predominantly Hyperactive/Impulsive subtype** ■ Must score a 2 or 3 on 6 out of 9 items on questions 10–18 AND ■ Score a 4 or 5 on any of the Performance questions 36–43 **ADHD Combined Inattention/Hyperactivity** ■ Requires the above criteria on both inattention and hyperactivity/impulsivity **Oppositional-Defiant/Conduct Disorder Screen** ■ Must score a 2 or 3 on 3 out of 10 items on questions 19–28 AND ■ Score a 4 or 5 on any of the Performance questions 36–43 **Anxiety/Depression Screen** ■ Must score a 2 or 3 on 3 out of 7 items on questions 29–35 AND ■ Score a 4 or 5 on any of the Performance questions 36–43

16

An example…

	Parent	Teacher
Inattentive symptoms	9 / 9	6 / 9
Hyperactive/impulsive symptoms	7 / 9	5 / 9
Additional concerns	Anxiety symptoms at home	Anxiety symptoms in class
Functional difficulties	Difficulty with peer relationships and academics (esp. writing)	Difficulty with academics (literacy), peer relationships and work completion

17

Conner's Interview

A structured interview designed to assess ADHD symptoms and related behavioural issues in children and adolescents.

- Inattention
- Hyperactivity/Impulsivity
- Emotional and behavioural problems

Format: Interviews with parents and teachers, supplemented by self-reports from teenagers.

- Rating scales (e.g., frequency of behaviours)
- Open-ended questions (to explore context and impact)

Scoring and interpretation:

- Higher scores = more severe symptoms
- Need to compare scores against normative data for interpretation.

Administration

- Currently only sold to psychologists currently, with recommended 80 mins of training

18

Vanderbilt vs Conner's

Vanderbilt	Conner's
Screens for ADHD, includes academic performance	Broader assessment of behavioural issues beyond ADHD
Short, suitable for quick screening	More comprehensive with multiple informants
Identifies ADHD symptoms	Can be used for differential diagnosis (anxiety, depression)
Anyone can use it	Need to be trained/comfortably interpreting against normative data

19

Follow up in practice

D5 NICHQ Vanderbilt Assessment Follow-up—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. Please think about your child's behaviors since the last assessment scale was filled out when rating his/her behaviors.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3

20

Co-occurring Conditions

60-80%

of individuals with ADHD have at least one co-occurring condition

- Anxiety Disorders (25-50%)
- Autism Spectrum Disorder (20-50%)
- Depression (10-30%)
- Sleep Disorders (25-50%)
- Learning Disabilities
- Oppositional Defiant Disorder

21

Anxiety & ADHD

- Excessive worry and restlessness (overlapping symptoms)
- Difficulty concentrating may worsen
- Physical symptoms common (headaches, stomachaches)
- School can't or avoidance behaviors

Assessment Tip

Differentiate primary anxiety from secondary to ADHD challenges

Management Considerations

- CBT effective for both conditions
- Stimulants generally well-tolerated
- Monitor for anxiety exacerbation
- Consider atomoxetine or guanfacine if stimulants worsen anxiety
- Address environmental stressors

22

Autism & ADHD

Overlap & Distinction

- 20-50% of autistic individuals have ADHD
- Both involve executive function difficulties
- Distinct: social communication patterns differ
- Sensory sensitivities common in both

Key Point

Both diagnoses can and should be made when criteria are met - DSM-5 removed exclusion criteria

Treatment Considerations

- Medications effective for ADHD symptoms in autism
- May need lower starting doses
- Monitor for increased irritability or emotional dysregulation
- Structured behavioral interventions beneficial
- Address sensory needs in treatment planning

23

Depression & ADHD

Clinical Features

- 10-30% of adolescents with ADHD develop depression
- Overlapping symptoms: concentration difficulties, low motivation
- Depression may develop secondary to ADHD-related challenges
- Risk increases in adolescence

Clinical Pearl

If depression emerges, reassess ADHD treatment adequacy

Treatment Approach

- Treat severe depression first
- ADHD medications generally safe with antidepressants
- Monitor for serotonin syndrome with some combinations
- Psychological interventions target both conditions
- Address self-esteem and academic support

24

Sleep Disorders & ADHD

Common Sleep Issues

- Delayed sleep phase syndrome (circadian rhythm disorder)
- Restless legs syndrome
- Sleep-onset insomnia
- Difficulty waking in the morning
- Reduced total sleep time

Management Strategies

- Sleep hygiene education (screen time, routine)
- Time stimulant dosing appropriately
- Consider melatonin for sleep onset
- Rule out sleep apnea if indicated
- Address anxiety contributing to insomnia
- Brief Intervention Tookit (Orygen)

Sleep problems can worsen ADHD symptoms and impact treatment response

25

Stimulants and sleep

Varying effects

- Some people can develop sleep interference
- Some see no effect
- Some have improved sleep

If people are able to nap after taking a stimulant, then a short-acting stimulant may actually help with sleep onset and management

Management Strategies

- Sleep hygiene education (screen time, routine)
- CBT
- Distraction techniques
- Melatonin: slow release (2mg) for sleep maintenance issues

Switch from a long-acting stimulant to a short-acting one if sleep is significantly affected

26

Stimulants and rebound effect

Rebound effect

- Symptoms of:
  - Restlessness/hyperactivity
  - Emotional lability or agitation, crashing feeling
- Symptoms occur at predictable times when medications wears off
  - SA: typically late morning or early afternoon
  - LA: usually late afternoon or early morning
- Clear connection between when the medication effect ends and problems begin

Vs other sleep issues

- Problems occur regardless of medication timing
- May be present even when medication is still active
- Often consistent pattern not tied to medication pharmacokinetics

Consider adding a small dose (5mg) of short-acting methylphenidate in the evening

27

Medication Framework

Stimulants (1st Line)

- Methylphenidate (Ritalin, Concerta)
- Dexamphetamine
- Lisdexamfetamine (Vyvanse)

70-80% response rate
Rapid onset of action

Non-Stimulants (2nd Line)

- Guanfacine (Intuniv)
- Atomoxetine (Strattera* now only generic available)
- Clonidine (Catapres)

Lower response rate but beneficial for:
Tics, anxiety, substance use concerns

28

Medication Interactions

Antidepressants

- SSRIs/SNRIs generally safe with stimulants
- Monitor for serotonin syndrome (rare)
- May increase stimulant levels (CYP2D6 inhibitors)
- Bupropion may lower seizure threshold

Melatonin

- No significant interactions with ADHD medications
- Safe to use for sleep-onset insomnia
- Typical dose: 1-3mg, 30-60min before bed
- Consider if stimulants delay sleep onset

Important Considerations

Proton pump inhibitors and antacids can affect absorption of some extended-release formulations

MAO inhibitors are contraindicated with stimulants

29

Weight Management & Eating Concerns

Key Issues

- ADHD medications can affect appetite
- Higher rates of eating disorders in ADHD
- Impulsivity may contribute to disordered eating
- ARFID particularly relevant in ADHD populations

2-6×

Higher prevalence of autism and ADHD in individuals with ARFID

30

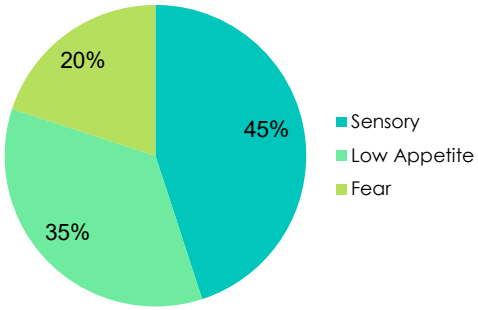
Avoidant/Restrictive Food Intake Disorder (ARFID)

Definition & Features

- Eating/feeding disturbance with inadequate nutrition
- NOT driven by weight/shape concerns
- Can present at any age (not just childhood)
- May require supplemental nutrition

Three Main Drivers

1. Sensory sensitivity
2. Lack of interest/low appetite
3. Fear of aversive consequences



31

ARFID & ADHD Connection

Why the Overlap?

- Sensory sensitivities common in both ADHD and autism
- Executive function deficits affect eating routines
- Impulsivity vs rigid preferences
- Stimulant medications may suppress appetite
- Inattention during meals

Clinical Implications

- Screen for ARFID in ADHD patients with feeding concerns
- Monitor weight and nutritional status
- Time medications around meals strategically
- Consider non-stimulants if appetite suppression severe
- Multidisciplinary approach (dietitian, OT, psychology)

ADHD medication effects on eating vary - may improve OR worsen existing difficulties

32

Monitoring & Management Strategies

Monitoring

- Regular weight and height measurements
- BMI percentiles for children/adolescents
- Assess nutritional intake and dietary variety
- Monitor for signs of malnutrition
- Screen for electrolyte abnormalities if indicated

Management Approaches

- Optimize medication timing (give after meals)
- Encourage high-calorie snacks
- Gradual exposure to new foods (CBT-ARFID)
- Address sensory sensitivities
- Consider appetite stimulants if severe

Red Flags for Specialist Referral

Significant weight loss, BMI <75%, nutritional deficiencies, severe restriction

33

Opportunities for support

Transition Planning

- Coordinate child-to-adult services
- Prepare for self-management
- Ensure continuity of care

NDIS & Support

- NDIS for functional impairments
- Therapeutic supports
- Educational advocacy

34

Resources

Source	Description
Australasian ADHD Professionals Association	Australian ADHD Clinical Practice Guideline
	ADHD Factsheet for GPs
	ADHD Prescribing Guide (paid)
	ADHD Treatment overview - Factsheet for clinicians
	ADHD Treatment - Factsheet for people with lived experience of ADHD
	ADHD Information Sheets – What It's Like To Have ADHD ADHD Lived Experience Post Diagnosis How To Talk To My Child About Their ADHD
	ADHD Guideline Consumer Companion
Royal Children's Hospital	Factsheet – Attention Deficit Hyperactivity Disorder
	Kids Health Info : ADHD – ways to help children at school and home
Raising Children The Australian Parenting Website – Supported by Australian Government Department of Social Services	School age: ADHD Teens: ADHD •ADHD: children & teens | Raising Children Network •ADHD: supporting teenagers •Friendships: children and pre-teens with attention deficit hyperactivity disorder (ADHD) •Friendships: teenagers with attention deficit hyperactivity disorder (ADHD)
	Webinar recording: Attention deficit hyperactivity disorder (ADHD) in children and teenagers
	Parent Guide: Therapies - Stimulants

35

Resources

Stimulant Prescribing & Applying for a S8 Permit:

- SafeScript and information page & step-by-step guide: Apply for an S8 Permit
- Department of Health - Schedule 8 permits and notifications

For GPs

- **Melbourne HealthPathways**
  - ADHD in Children and Youth
  - ADHD Medications for Children and Youth
- **Australian ADHD Professionals Association**
  - Australian Evidence-Based Clinical Practice Guideline for Attention Deficit Hyperactivity Disorder (ADHD)
  - ADHD Guideline Factsheet Clinical Treatment Overview
    Australian Evidence-Based Clinical Practice Guideline For ADHD: FACTSHEET FOR CLINICIANS
- **raisingchildren.net.au – The Australian Parenting Website**
  - Attention Deficit Hyperactivity Disorder (ADHD): Children and Teenagers

36

Resources

For families

- **The Royal Children's Hospital Melbourne (RCH) factsheet** – Attention Deficit Hyperactivity Disorder (ADHD)
- Support and information on ADHD – MyCareSpace: Children with ADHD – Help for Australian Parents and Teachers
- **Support groups**
  - Australian network - Support groups - ADHD Australia
  - ADHD Support Australia: for parents and children via online communities and expert talks online
- **Ways to help at school and home**:
  - RCH Fact Sheet – Ways to Help Children at School and at Home
  - Behavioural strategies: How to support your child with ADHD: 5-11 years
- **Parenting Support**
  - ParentWorks
  - Triple P (Positive Parenting Program): support your child's development, grow closer and solve problems – positively.
  - The BRAVE Program – from the University of Queensland
    - Free interactive, online program for the prevention and treatment of childhood and adolescent anxiety. The programs are for both parents and caregivers.
      - Young child program – for parents and caregivers of children aged 3 to 7 years whose children are experiencing some form of worry, anxiety or fear.
      - Child Program – for children agreed 8-12 years. For any child who worries about things and any parent wanting to learn more about how to help their child overcome worries.
      - Teen Program – two programs. One for teenagers aged 12-17 years old and another for parents of teens.
    - BRAVE Program - Guide for professionals

37

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1. ADHD Guideline Development Group (2022). Australian evidence-based clinical practice guideline for Attention Deficit Hyperactivity Disorder (ADHD). Melbourne: Australasian ADHD Professionals Association. Available at: https://adhdguideline.aadpa.com.au
2. Nitsch, A., Knopf, E., Manwaring, J., & Mehler, P. S. (2021). Avoidant/Restrictive Food Intake Disorder (ARFID): Its Medical Complications and Their Treatment—an Emerging Area. *Current Pediatrics Reports*, 9, 21–29. https://doi.org/10.1007/s40124-021-00239-8
3. Thomas, K. S., Keating, J., Ross, A. A., Cooper, K., & Jones, C. R. G. (2025). Avoidant/restrictive food intake disorder (ARFID) symptoms in gender diverse adults and their relation to autistic traits, ADHD traits, and sensory sensitivities. *Journal of Eating Disorders*, 13, 33. https://doi.org/10.1186/s40337-025-01215-z
4. Australasian ADHD Professionals Association (2022). Vanderbilt ADHD Assessment Scales. *Australian ADHD Clinical Practice Guideline Resources*. Melbourne: AADPA.

38

Please complete the webinar evaluation:

39

DiSS Nurses and GPs only: Have your say in the 2025 Teaching and Learning Survey – your voice matters!

40

41