COMORBIDITY GUIDELINES

# Neurodiversity and substance use: what clinicians need to know

## Webinar attendee questions with answers from Dr Eddie Mullen

**Question: Does the increase in medication prescribing in the last ten years indicate to you that rates of ADHD have increased in this same timeframe, or has there been a change in the attitudes of prescribers towards use of medications?**

I've definitely seen a change in attitudes in Psychiatry towards ADHD over the past few years. There are many more Psychiatrists particularly in private who feel suitably skilled to assess and treat ADHD using stimulants. There is still a large gap in the public sector, likely reflecting the resource challenges.

The role of The Royal Australian and New Zealand College of Psychiatrists and Australasian ADHD Professionals Association in terms of providing training and expert guidance has probably made a large difference.

**Question: When/how do we choose between the terms 'autistic person' vs 'person with autism'?**

Language is important and I try to reflect the feedback that I have received about preferred terminology including terms like "autistic person" to try and use Neuroaffirming language.

Preference can change over time and differ between groups but I try to look at good quality online resources such as:

https://clinikids.thekids.org.au/information-hub/resources/neuroaffirming-language-preferences/

**Question: Interestingly there are so many people that believe they have ADHD or ASD, AuADHD and don't get diagnosed due to costs associated, or unavailability of services. Any ideas how/where clients may be able to access cheaper diagnostic assessments?**

There are some low cost options available out there, I'm mostly aware of Victorian resources through the University Clinics.

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**Question: Dr Eddie, do you think disordered eating, e.g. restricting food and/or bingeing then purging, can also be a form of behavioural addiction, e.g. to manage negative emotions? Any thoughts on sensitivity of people with autism to refined sugar?**

Agree, clinically I see big overlaps between conditions such as OCD, obsessional personality and eating disordered behaviours. In my PD work, I see a definite link between negative emotional states and impulsive eating.

I'd direct you to a good website for more info:

https://nedc.com.au/eating-disorders/types/neurodivergence

**Question: The lack of screening is sometimes because there are no / limited onward referral options if the client scores above threshold on these screeners. What would be your suggestion to services / systems to address this?**

More investment in Medicare funded services and training for GPs, Psychology and Psychiatry to be able to conduct clinical assessments and recommend treatment when possible.

I'd also advocate for Public Services in Adult to offer treatment when possible given the potential functional impairment and harm associated with unsupported and untreated symptoms.

**Question: Do you have any advice in supporting a client who misuses their ADHD medication - is this common? Are they prescribed the wrong medication for their needs if they are overusing their prescribed medication?**

That is a common fear for clinicians when prescribing any potential medicine that can be misused. I would argue that it is no different to our practice when we use other medications of potential misuse such as benzodiazepines, opioids, quetiapine: established agreed goals of treatment, expectations of how to dispense, manage situations such as lost scripts, running out earlier than expected and real time monitoring on Safescript.

An interesting concept whether they are on the correct medication, would need to consider what we think is their reason for misusing and whether it is connected to a mental health condition that has an evidence based medication treatment.

**Question: Dr Eddie, can you please talk about the ND differences in males and females. E.g. the diagnostic criteria may be different as females might not have the same behaviours because they are 'socialised' to mask.**

This is a great topic of interest, it used to be the wisdom that there were gender differences in terms of identification of issues between genders, young girls might not be picked up in school as they would be seen as shy or quiet in the case of Autism or day dreaming in ADHD inattention whereas boys would come to attention sooner.

This is a good article from the APS that talks about this:

https://psychology.org.au/insights/why-are-so-many-neurodivergent-women-misdiagnosed

**Question: You mentioned screening. Any tips on ways to do this?**

We use some common free to use screening tools:

ADHD (under 18s) - SNAP-IV 26-Item Teacher and Parent Rating Scale

ASD (over 18s) –Adult ADHD Self-Report Scale (ASRS-v1.1)

Under 18s - ASDASQ Nylander and Gillberg 2001

**Question: The research on the intersection of ADHD and SUD seems a bit dated, was there anything more recent?**

There a more recent papers looking at that association but nothing really new to report! Would have been nice to have more time present but there are whole day symposia on these topics

Anything from Frances Levin or Tim Wilens, Dave Coghill is good quality.

My talk today the focus is more on the translation into clinical practice and thinking about co-morbidity, unfortunately no real new developments in the last decades.

I'd recommend keeping up to date with expert practice in Australia/NZ context, again I would advise people to check out Australasian ADHD Professionals Association who organise National Guidelines, online training and host conferences annually. A good mix of academics and clinicians in both private and hospital settings who represent the field.

https://aadpa.com.au/

https://adhdguideline.aadpa.com.au/wp-content/uploads/2023/10/AADPA-ADHD-And-Co-Occurring-Substance-Use-Disorder-Factsheet.pdf

**Question: Have there been enough studies to support the level of success with the use of medicinal cannabis (i.e. CBD oil) as an enhancer for people with ADHD?**

Very scarce research, not enough to make any strong recommendations. Similarly the popularity of using CBD for any mental health condition has been based around personal positive experiences, not borne out in any large studies yet.

I always say that if someone is using it and finds it helpful to relax or calm, there are likely much more harmful things out there they could be using than prescribed CBD.

**Question: What's your thoughts on TMS, ketamine, psychedelics, DBT, and neurofeedback. Also, should you manage SUD or ADHD symptoms first (or concurrently)?**

More novel agents are currently being investigated; TMS, ketamine, psylocibin etc. Still waiting to see any trials past small pilot studies but would be exciting to add to the limited existing treatments that we have.

Any structured psychological treatment such as DBT, etc is good to help identify triggers, manage stress, grow healthy patterns of behaviour. As some ADHD clinics say, it should be a combination of "Pills and Skills" for optimal treatment.

**Question: I'm wondering if Eddie could please provide his thoughts on how we can improve care of people with autism when they are in a mental health inpatient unit.**

Something I'm very interested in, I would say early identification of suspected of previously assessed Autism is important with adaptation in collaboration with the individual thinking about language, visual aids, communication style, sensory preferences, need for predictability to name a few things!

Quite often in-patient units have allied health teams with wonderful OTs who might be able to conduct Sensory assessment, adapt comms early on.

I'd also recommend medical teams think about the effect of medication on neurodivergent brains in terms of dosing, exposure to side effects, amongst other consideration and transferring back to the community in familiar environments as soon as possible.

**Question: My client was diagnosed ADHD but the Dex triggered her to use amphetamines, can you speak to that?**

There is generally less abuse liability with prescribed stimulants than illicit drugs as the doses are much lower, their onset of action reduced. Not to say it couldn't happen, we are always worried about a rare new emergent compulsive behavior as a result of introducing new neuroleptic medication but one might also wonder about any prev history of misuse of substances that may be known or not disclosed.

**Question: If a person accessing Mental health support has not been screened for ADHD, is there a possibility that there could be a contra-indication for some mental health medication?**

ADHD is often co-occurring with other mental health disorders and often not the primary cause of referral to services.

I would recommend a treatment strategy of good assessment of difficulties and a collaborative plan offering evidence based psychosocial and possible medication treatment for the primary mental health disorder.

The clinical history, presentation or developmental history may be suggestive of an undiagnosed Neurodevelopmenal condition that can be considered as a differential or co-occurring disorder.

Offering treatment for the primary presenting problem if appropriate would be a reasonable decisions while thinking about ADHD/ASD.

**Question: Do you think health services should be screening for diversity routinely in our services?**

I believe that anyone who attends a health service should be offered care that meets their needs including meeting clinicians who have been supported to access training to identify and screen and even assess and treat patients who may be Neurodivergent.