THE HOUSE OF ASSEMBLY GOVERNMENT ADMINISTRATION COMMITTEE B MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART ON FRIDAY, 18 OCTOBER 2024

INQUIRY INTO THE ASSESSMENT AND TREATMENT OF ADHD AND SUPPORT SERVICES

The committee met at 9.00 a.m.

Professor DAVID COGHILL, PRESIDENT, AUSTRALASIAN ADHD PROFESSIONALS ASSOCIATION, MADE THE DECLARATION AND WAS EXAMINED VIA WEBEX

CHAIR - Would you like to make an opening statement before we commence?

Prof COGHILL - Yes, I will. I'll try and keep it as brief as I can. First off, thank you. It's an honour to come and speak to you today. I thank the Tasmanian government for having the courage and taking the opportunity to talk about ADHD in this way. I think you're the first of the state or territory governments to do so, and we really appreciate that.

Many of the things that we'll talk about today are not unique to Tasmania. There are many problems in accessing and delivering care for people with ADHD. Many of those are across Australia, and many of them are across the world. I think that Tasmania has its own particular issues. Part of that is due to size and scale. With the workforce shortages I understand are there, combined with insufficient training of the workforce that is there, I think makes your services in Tasmania very vulnerable. Very small changes in the number of people who are providing can have a very big impact on the care that's available to people. That goes across the whole of the age range, and between public and private services.

Things that we wanted to highlight are the current overwhelming waitlist for public assessments for ADHD, particularly in child and adolescent psychiatry - sorry, for children and adolescents, not specific to psychiatry. There is the fact that there's very little available in the public services for adults with ADHD. I was fortunate enough to be asked to come to do a day's training for psychiatrists in ADHD, and it was really well attended. At the moment, my understanding is there aren't any publicly available services for the assessment or management of ADHD.

I think there is a need for joined-up thinking. It's one of the other things. When I came to visit Tasmania I had some wonderful visits, and each person I spoke to gave a great account of themselves and their understanding. Often it was their understanding of their difficulties, but often they would look to others and say actually they've got bigger problems than us. I think that the key to providing good-quality opportunities for ADHD has to be with multidisciplinary, interdisciplinary joined-up thinking. I would highlight the need for that between paediatrics and child and adolescent mental health services, between the pharmaceutical services branch and clinicians - I hear there are some issues there, between primary and secondary care, and between public and private.

One thing we noticed, and I think I submitted a brief summary of these in our report to you - our submission to you - was rates of prescribing for ADHD in Tasmania. They were really quite interesting to look at. When you look at the under six-year-olds - actually, we don't think many under-sixes at all should be receiving medication - Tasmania was the highest prescriber in Australia, when you look by state. Similarly, for the six to 12-year-olds, the rate of prescribing for ADHD medications in Tasmania was the highest in Australia. They were about average for adolescents, for 13 to 18-year-olds. They were much lower for adults. I think it really highlights the very different levels of access to care that people are getting.

What worries me about the child figures is that here alongside those, there are many Tasmanian children and young people who cannot access care. About the number of children and adolescents who we would expect from the epidemiological data, how much ADHD we expect there to be in Tasmania - the rates of prescribing in primary school-aged children are about right. We could see that as being really positive, but when I also hear that many children are unable to access care, it means we've got to think about whether the right children and the right people overall are being treated.

One of the reasons I think that's a particular issue currently is that we hear - and I'm sure you've heard - in the press about services popping up that offer a kind of quick route to ADHD assessment and online assessment that's usually not followed up by proper treatment plans. It's: see, assess, do a very quick assessment, and then refer to the GP for prescribing. My concern is that because the waits in all other aspects of - probably very good-quality - care, when you get to it, in Tasmania are so long, that Tasmanian families are at risk of using those quick fix services more often. That may mean that you've got people who are what I call 'misdiagnosed', as well as a lot of people who have missed - m-i-s for the misdiagnosed and m-i-s-s-e-d for the 'missed-diagnosed'. I think that language is much more helpful than talking about under- and over-diagnosing. You can have both missed and misdiagnosis at the same time.

A couple of other very brief points: I think that one of the things that is an opportunity for Tasmania, two opportunities - one is to really invest in training, in workforce training. Secondly, alongside that, to think about how can other professionals - I would highlight GPs, but not only GPs, GPs and nurses - how could they contribute to the care pathways for ADHD? I worked in Scotland before coming to Australia and we ran our service in actually a part of Scotland that's not too unlike Tasmania in that it was outside of the main centres. We had difficulty recruiting. We ran our service very much with nurses - not prescribing nurses, but regular nurses who we've taken time to train providing a lot of the face-to-face care with the medical staff, who we didn't have many of, providing support and backup to that. That service demonstrated better clinical outcomes than any other publicly funded service in the world has ever demonstrated. There are real opportunities, to think laterally, to think broader about how you fund and design services for ADHD. Unfortunately, it has not been possible yet to get that into Australia.

The last thing I'll say is to remember that managing ADHD is not all about prescribing medication. Prescribing medication is and will always be a big part of managing ADHD. In Tasmania I also hear that it's difficult for people to access good-quality what we call psychoeducation. The kind of building block of managing your own health problems is to understand what they are. Good-quality psychoeducation for younger children is parent training programs, for older adolescents and adults it is cognitive behavioural therapy and ADHD coaches. Thinking about ADHD in education is also very important. That might be something you want to discuss further, although maybe you're coming at it from the health perspective. I'll finish there. Thank you for that opportunity. I'm happy to discuss any of those points in more detail or answer any of your specific questions.

CHAIR - Thank you very much, Dr Coghill. It's a very comprehensive submission and your evidence just now elaborates on that further. We're very grateful. I had one quick question I wanted to ask. Seeing the opportunity, you've outlined a relation to nurse-led clinics or the role they might play. You talked about non-prescribing nurses. Have you seen any examples where nurse practitioners have played a role in those multidisciplinary teams, and could you comment on that?

Prof COGHILL - Yes, they have. We didn't have the luxury of having a lot of nurse prescribers in our service. We did have two just before we finished. They make a fantastic contribution. I think that they are often as - if not more - diligent than some of the medical staff who we work with, because they've taken very specific training. I think that is an opportunity. I think my - not concern, I have no concern about nurse practitioners and nurse prescribers - but my concern over the practicality is they're very expensive to train and there aren't that many of them. When you're looking at services that need to be high volume, it's similar to relying just on psychiatrists or paediatricians. I think that you hit a barrier with numbers that you'll get. From a theoretical perspective, if you're able to find enough well-trained, well-motivated nurse practitioners, then that's a great part of a solution.

CHAIR - Thank you. I open up to the committee for questions.

Mr BEHRAKIS - Thank you, professor, and thanks so much for taking part in this. On the topic of the multimodal model for approaching this, I know that there are roles where you do need to have psychiatrists - such as the assessment, you need specialists to have that role. Can you explain how that multimodal, including nurses, including GPs more in that process would benefit when you still have that need for specialists?

Prof COGHILL - I don't question the need for specialists, but I would question the need for specialists in every case, or them having a core central role in every case. Per ADHD guidelines, when we were thinking about who can do an assessment for ADHD, our line was very much that there are many types of health professionals who can do an assessment as long as they're well enough trained and well enough supported.

Doing an assessment for ADHD is not just about saying - does this person have ADHD, yes or no? It's also about taking the person holistically into consideration, thinking about any other coexisting problems they have. These may be other mental health conditions or other physical and developmental conditions. It's not an easy job, but I don't think that there's a reason other people can't be trained to play a big role in that.

I gave the example of our nurse-led service. In our nurse-led service, all of the assessment information was gathered by the nurses. Then a psychiatrist came in at the end of that process, reviewed that information and had a relatively brief meeting to fill in any gaps that were there, to discuss the diagnosis, do the psychoeducation and do the treatment planning. When we came to delivering the treatment, the nurses were much better placed to deliver the non-medication treatment. They were also extremely good at monitoring the medication treatments. That's just one example. Psychologists, occupational therapists, other allied health professionals, as well as general practitioners, nurses, psychiatrists, paediatricians, all can play complementary roles. The key is them working together. Often what we have in Australia is people working in relative isolation. If they want someone else to be involved they have to make another referral. There's a dislocation, a siloing of care. I don't know if that answers your question. I'm happy to come back to it if it doesn't. I think those roles shouldn't be fixed by discipline; they should be fixed by skills and training. There are many complementary works. That would be my response to that.

Mr BEHRAKIS - Thank you. Chair, I have enough questions to probably fill the whole session so feel free to stop me when I've had enough. On the Australasian ADHD Professionals Association's (AADPA's) guidelines, because I think they're a great place to start the conversation about how to improve things generally: I and others have raised or suggested or asked about these guidelines. One of the responses I or somebody received was to suggest raising with AADPA any potential discrepancies between the guidelines and nationally approved product information and scheduling classifications of psychostimulants in Australia. It was almost, not dismissive, but suggesting that the AADPA guidelines aren't in line with some of those things.

My understanding is that Tasmania's prescribing guidelines are in many cases more onerous than a lot of the other states, and are more difficult to navigate than a lot of the other states. Whenever questions are asked, it's that Tasmania's best practice from the safety and risk management perspective. How would you respond to all that? What is the best way? At the end of the day, I think most people are interested in the outcomes more than anything else.

Prof COGHILL - I think it's a really good question, quite a difficult one to answer simply, because there are strengths and weaknesses in the prescribing guidelines in Tasmania. I think the ability to include general practitioners more in prescribing, that I understand was recently introduced, is a good thing. I think you're also right that the Tasmanian prescribing guidelines have been much more difficult to navigate for people who have more complex problems. For example, what seems like at times - it may not be stated that way, but almost blanket bans for anyone who has ever had a substance use problem to be prescribed stimulant medications doesn't fit -

Mr BEHRAKIS - Or requirements that are so onerous they may as well be banned, like going to the pharmacist every so many days, or going and taking the medication in front of the pharmacist and stuff like that.

Prof COGHILL - Yes, you probably know much more detail than I do. I've got a colleague at AADPA who does all of that part with us, and so I let him do it. One of the issues we face, we wanted national prescribing guidelines, we were told by the federal Department of Health, that it is not possible because it's against the federal law. There have to be state-based prescribing guidelines. What we've been trying to do, and I've been trying to go around and meet with the chief pharmacists in the different states, is to get a situation where we can get all of the states together. It will really be pharmacists and chief psychiatrists, I guess, to try and talk about - we can't unify them in law, but can we bring them together? I think you have some positive things in Tasmania that other states could learn from, but you've also got some bits where it is much more onerous. I think that that's led to issues.

It also leads to problems for clinicians. They become scared to approach certain patient groups, certain groups of consumers, and therefore those groups get marginalised. These have big knock-on effects. I think it's right that people like you at the government level who think about Tasmanians from all the different angles can actually bear these things. I take your point: it's not all bad, but there are some bits that really could do with changing.

Mr BEHRAKIS - Last question before I share the love. Back to the guidelines, my experience, apart from the long wait times of me going through that assessment and treatment phase, the one thing I realised afterwards was that everyone's experience was very different. People went through different channels; there was no real consistency. I went to a GP first up, who was very cynical about the whole idea, thought that I had an iron deficiency and didn't want to refer me, then referred me to someone who said that they weren't a psychiatrist so they couldn't prescribe me or assess me. I had to go back to another GP to get referred to the right person. Having untreated ADHD means when you do get your referral, it might be two or three weeks before you actually act on it because you're procrastinating so much on it. It's almost like the system as it exists is configured to be as difficult as possible, specifically to somebody with the symptoms of untreated ADHD.

Last year I had an accident and ended up in the hospital just to get checked out because I hit my head. I was fine, for the record. They gave me a huge, very comprehensive pamphlet. This is what you do if you've had a concussion. These are the things. This is what to look out for. If this happens, do this. This is what you do for care over the next few days as you recover. That pamphlet that I got for donking my head is more information than I got through that whole process of going through that ADHD diagnosis and assessment.

Other people have tried to go through that assessment process and they've had a completely different experience. They've gone through a completely different channel. It seems that there's no consistency. People are having to figure it out as they go, with symptoms that make that as difficult as possible.

Is there a sort of standardisation that's possible as far as you go there, you tick these boxes or you have these sorts of symptoms and this is the sort of algorithm to follow? So there is some sort of consistency and there is, I don't want to say informational, some sort of education that can be provided to people going through that process as well? So I can say, 'Okay, this is what I need to do, this is who I need to call'. I'll leave it with you. I can ramble forever.

Prof COGHILL - The reason for having evidence-based guidelines is to improve consistency and reduce variability. It's not to make everything uniform so that every person has to go through exactly the same process. That wouldn't actually be doable or suitable. It is designed so that there are a certain set of hurdles. Maybe I shouldn't call them hurdles because that makes it hard, but a certain set of processes that everybody should go through. I think the guideline does that very well in a theoretical sense.

We've been back to the federal Minister for Health on many occasions. I wrote very recently to him, I think, for me, a strong letter to a government minister, saying, 'You've had the Senate inquiry report on your desk, you've had a Department of Health set of recommendations from that on your desk, and we've heard absolutely nothing'. I've still to get a reply. We've been trying at AADPA. Writing guidelines is the first step. The next step is actually to implement them. Implementing them takes money.

I'm not sure if this is appropriate and please tell me off if it's not, but if Tasmania wants to do some more work implementing those guidelines at a state level, then we would be very happy to work with Tasmania to do that. I think that would be a great thing to do.

We would much rather work with the whole of Australia to do that, so that things that happened in Tasmania were not unique and gold standard where everyone else was behind.

We've been trying that and we haven't had that. I think there is an opportunity here to do some work implementing the guidelines. We're not naive enough to think that just telling people what they should do will actually change behaviour.

Early at the beginning of this week we submitted a grant request to the Department of Health for education packages in ADHD and the Quality Use of Medicines scheme that they have. We at AADPA already have plans for a whole series of educational interventions for healthcare professionals to help with that implementation. We're a not-for-profit, maybe a charity soon, but not yet. We don't have deep pockets. We need funding to do those things.

Again, it may be inappropriate to say this, but we are very happy to work with you as a state government to try to do that. We think we've got the content, but we know that you've got the clout.

Ms JOHNSTON - Thank you, professor. It's Kristie Johnston here. I hear quite clearly your plea that there's an opportunity in Tasmania to particularly invest in the workforce training. I want to go back to your comments earlier - I hope I haven't misinterpreted them - around the prescribing rates in Tasmania. I think you highlighted that for under six, it is a bit of an anomaly in Tasmania. However, for the six- to 12-year range, for the primary school years, the rates are what you would expect for our demographic. You highlighted that there is a concern that there might have been a mis- and missed diagnosis around that. From our understanding, there is a long waiting list for people to be diagnosed.

If the prescribing rates are at, I think, 8 per cent in Tasmania for six to 12, and yet we still have long waiting lists, then there is an issue about the pathway to diagnosis and assessment. Can you speak a little bit about how you can provide quality assurance that those pathways to assessments are good and quality pathways? If we are getting misdiagnosis, how can we ensure that when people are desperate to seek help that they are actually getting quality help?

Prof COGHILL - Yes, we would probably need to do a piece of research in order to demonstrate that. I cannot actually disclose it, because this will be public, but we are doing a similar piece of research as part of an NHMRC-funded project to look at what people are offering as far as assessment goes. I think to do a piece of - what I would call qualitative - research with consumers, let's say, consumers in Tasmania who have received a diagnosis of ADHD, and to ask them or find out with them about what the process was that they went through; how rigorous it was. Really, it's an audit. To audit whether that process met the process that is laid down in the AADPA guidelines? Because, the AADPA guidelines have defined what a good-quality assessment should look like.

I say it's relatively simple but it's not simple in terms of the numbers and the funding of it. However, it's a relatively simple study to design or audit to design to find out whether the people who are receiving medication actually go through that quality assessment.

Ms JOHNSTON - I suppose my follow-up question then, until that body of work is done - and I will be interested to see the outcome of that research, if that is possible - is what should parents or caregivers, particularly for those young children - we are talking in primary school - what should they be looking for? In terms of trying to figure out whether the health care, the assessment that they are getting, is quality at the moment? We understand that there are long waiting lists and people obviously are trying to find ways of getting help quicker.

What should family members or parents be looking for in those guidelines and whether the assessment that they are getting is appropriate?

Prof COGHILL - The simple answer to that is we actually published a consumer guide to the guidelines that is freely available to download from the AADPA website. It really puts the evidence-based guidelines - the hundreds and thousands of pages if you go all the way in - into a usable package. One of the things that we've applied to the Federal government for, and one of the things that I am trying to develop, is what we call QPLs - or question problem lists. That's a set of questions that you give to consumers and say, 'These are the things that you should or could be asking your practitioner. These are the kind of things you should expect and these are the kind of questions that you ask'.

We are on a journey to develop those at the moment. As I was hinting at, the problem is getting the right kind of finance to do that. We have all of the willingness; it's just getting the bodies there to do it. A couple of weeks ago, in October, we published a prescribing guide for healthcare practitioners. That's a really comprehensive guide to how you should prescribe for ADHD. It doesn't tackle the consumer side, but a second grant we put into the Quality Use of Medicines Program, the federal one, was a consumer program. This said, 'Let's translate that guide into consumer-facing information'.

Ms JOHNSTON - Thank you.

Prof COGHILL - But the answer to your first question would be the consumer companion to the guideline.

Ms JOHNSTON - That's something that we can perhaps get for this committee to consider?

Prof COGHILL - It's there and you can freely download it. You don't need to register or pay anything.

Mrs BESWICK - Good morning, Professor, it's Miriam Beswick here. I was quite interested in your comments about trials that you're doing in New South Wales for some of the multimodal things. How are they going? You are encouraging us to maybe do some. How could that look?

Prof COGHILL - AAPDA is involved in those, but not running them. It's members of our board who are running them. One of our board members, her name is Dr Alison Poulton but she goes by the name of Sally Poulton, in the last few weeks published a paper of her pilot work with bringing GPs in New South Wales into the ADHD management. That's actually there to see.

The other ones I'm not involved with. We've done quite a lot of work developing education for those pilot studies. We have an education package for primary care in New South Wales. My understanding is that the trials are still very much in the development phase. I'm not actually involved in those. We can find more detail and get you more detail. I can find the people to give you more detail if you would like that. If someone contacts me - I see you nodding your head and I'm happy to do it but I'll forget as soon as I go off and something else happens.

Mr BEHRAKIS - I know that feeling.

Prof COGHILL - Please - what do you call it? I'll take it on advice.

Mrs BESWICK - That sounds wonderful, thank you.

CHAIR - I have a question about workforce development options. You've outlined some of those in the paper that you submitted to us. We've talked a little bit about it too. I am keen to understand what you know of the Tasmanian context and what workforce development or training options currently exist for health professionals looking to better understand how to support patients with ADHD?

Prof COGHILL - I have to declare a slight conflict of interest here. You have a Dr Anna Seth, who is one of the GPs in the primary care network who's my sister-in-law. I know some of this stuff through Anna. I don't think it's a conflict that should rule me out of this. I know that the primary care network has done a lot of work in developing a kind of prototypical pathway for primary care. I came myself and did a day training with psychiatrists in training. Also your colleague, sorry I've forgotten your name, was at a meeting I did in the evening which was really well attended by general practitioners for talking about ADHD - yes, yourself.

Mr BEHRAKIS - Yes. Was that me? Yes.

Prof COGHILL - Sorry, I am just not good remembering names. Apart from that, I am not aware that there is any practical and official plan to training. Training for ADHD is very poor at medical school, in psychology basic training, but also then for psychologists, psychiatrists and paediatricians, as well as those in primary care and nurses. My assumption would be, because I don't know any different, is that in Tasmania, as in much of the rest of Australia, it's ad hoc. It's not really done in a structured way. Professor David Castle, who's just come as an adult psychiatrist, got very interested in bringing the groups together to talk about where they can go, bringing primary care, secondary care. I know Dr Anna Seth was involved in those discussions. You would need to check locally as to where they dock. We have said we will support that but I have not got details.

Ms HADDAD - My name is Ella Haddad, my question follows on a bit from Rebecca's question just now. You touched on it in your opening statement, about training and knowledge and awareness about ADHD in the education setting. I wondered if you're aware of any other jurisdictions where there might be training available, or better understanding within schools and other education settings around young people and students with ADHD.

Prof COGHILL - There are some variations. There are some states where there seems to be better understanding. I would actually highlight the New South Wales education site and their resources for teachers around ADHD. We are just about to look for funding. We actually think it's a big problem. One of my research group colleagues I've worked with her for many years is doing her training as an educational developmental psychologist. She said, 'Wow, the training we get in ADHD in Victoria on that course, which should actually be one of the courses where it's heaviest, is still really rather rudimentary'.

One of the other research opportunities that we're looking at, very practical, is actually to develop virtual reality training for teachers to be able to better recognise and understand what is and what isn't ADHD in the classroom. That would be on the recognition side. A second module in that, we hope, would be to look at then how do you manage ADHD behaviours in the classroom and how do you monitor outcomes. If I'm being totally transparent and honest, the Tasmanian Education department was one of the places we thought might be interested in thinking about whether or not they could part fund or fund some of that research. We have a team to develop it, but obviously again, research needs developing.

We think that will be a huge opportunity because there is a huge gap. Teachers don't get training. The training they get is rather cursory. We know from talking with teachers that they feel pretty much at sea when it comes to, 'How do I recognise what's ADHD and what's anxiety, and when I've got someone with ADHD, how do I manage them without disadvantaging the rest of the class', et cetera. It's a big gap. That's something we thought - we have an excellent VR group who are really interested in doing that work.

Ms HADDAD - Thank you.

CHAIR - Thank you very much, Professor. We've come to the end of our time for discussion with you, but I'm sure there might be questions that arise from your presentation. If so, we'll make contact and follow up if you're happy for us to do that.

Prof COGHILL - Yes, very happy to take any other questions on advice, anything that you want. As I said, it's actually a real pleasure and an honour to come to talk to a government about this and know that you're taking it seriously, so thank you.

THE WITNESS WITHDREW

The Committee suspended from 9.58 a.m.

The Committee resumed at 10 a.m.

CHAIR - Thank you very much, Dr Derrick, for joining us today. What I'll ask you to do first is to state your name and the capacity in which you're presenting to the committee, please.

Dr DERRICK - My name is Madelyn Derrick. I'm presenting as a clinical psychologist working in the space, but also as someone with lived experience of ADHD myself, and as a parent and as having been involved in a lot of advocacy.

CHAIR - Can I confirm that you've received the guide sent to you by the Secretariat and understand the details about appearing before the committee today?

Dr DERRICK - Yes

Dr MADELYN DERRICK CLINICAL PSYCHOLOGIST AND DIRECTOR, HOBART ADHD CONSULTANTS, MADE THE DECLARATION AND WAS EXAMINED

CHAIR - Thank you for your submission. It was very comprehensive. I will introduce members at the table, which was something I forgot to do for the professor. I'm Rebecca White. I'm the Chair of the committee. Simon Behrakis is the Deputy Chair. Miriam Beswick, Ella Haddad, Kristie Johnston and Cecily Rosol are also members of this committee. Thank you very much. Do you want to make an opening statement before we commence.

Dr DERRICK - I wrote a quick little statement in the car on the way in. It's just brief because I don't want to repeat what's in the submission. My apologies for reading off my phone with this one.

We're at a point now where we have enough understanding and enough of a sense of intervention needs for ADHD to mean that it would be nonsensical to not make strategic and significant change now. We have more than enough evidence of the cost of ADHD. This is a cost to individuals and others in their lives, as well as to society more broadly economically. This is a cost that comes about when ADHD is not recognised and not appropriately supported right across the lifespan. It's about early intervention, but also about recognition for people who have been missed and jumping straight in from there.

So much of the cost to quality of life and the economic costs is really preventable. It really is. We don't have the firm evidence, we don't have randomised control trials to specifically say how these things work, but that from the collective clinical knowledge in the space it's very clear and evidence-based from all the various disciplines, and general principles of practice and what works in public health. There's no debate there on the general things that are going to work.

It would be nonsensical to continue as we have up until now. We need to make some bold changes in health, in education, in justice even. We really need to be shifting away from reactive responding to the secondary outcomes of ADHD particularly. We need to move more to proactive and effective intervention.

As someone with lived experience, I'm very grateful to the Tasmanian government. I feel quite proud to be Tasmanian right now in getting this inquiry going. The little state that could. I'm very hopeful that our small size allows us to take advantage of opportunities, like Professor Coghill was talking about, becoming a pilot state that can be the model that other states follow.

CHAIR - Thank you. You've obviously got extensive knowledge and experience in this area. Your submission covers a broad range of matters to do with ADHD in Tasmania.

I think what we're trying to understand is how we meet the objectives you've outlined: which are to act sooner, provide clearer information, better education, so that we support people to live a good life without the stress that Simon and others have spoken and shared with us. What do you think are the key intervention points that Tasmania could make?

Dr DERRICK - In education, we have this a lot when we consult with schools through either an individual student or more broadly the concern is from teachers, who are understandably very pressured. The concern is, 'I don't have time and headspace to do more'. What we try to communicate to them is that this is not about doing more. This is about doing different. Then you'll find you're doing less. It takes up a lot more of their resources to respond to when things have gone wrong than it does to put the right environment in place to support teachers. I know there are a lot of teachers out there who do have the knowledge and the capacity to do a great job, but they're impeded by what's above them, the lack of TA assistance or LSO assistance in the classroom, and just simple things, like - well, it's not simple - but being overloaded in the teaching profession. I come from a family of teachers; most of our friends are teachers. They do not get paid anywhere near enough, thank you, for what they do. They are very much all hanging on the edge of burnout. I think the sorts of things that we would be wanting to get in place to improve the situation for kids with ADHD would improve the situation for all kids. We know from research that if you put appropriate adjustments in place for the kids with learning needs, all students benefit.

CHAIR - Can you elaborate on that and help us understand what you mean in a practical sense?

Dr DERRICK - For example - just bear with me, I'm going to try to come up with a really straightforward example. Say we have an impulsive student with ADHD in grade 2. They're very excited by the question the teacher is asking and they're calling out the answers. The teacher has two of the kids that are calling out, plus another child with sensory needs in the corner in their tent who they're worried about. They know they have to call mum in a moment, and mum gets upset when she gets called, and they know they will have a meeting to explain why this other parent has complained. They have all this load about them. Then they've got this child who's calling out over and over again. Of course, they are going to hit their own limit and go to the headspace of, 'I need this child out.' Then it's threatened relocation - 'You go off to the grade 6 classroom'. The child experiences humiliation in that. They come back to the classroom, and then the next time they get that feeling, 'The teacher's looking at me that way, now I'm going to be humiliated again'. Stress drains their resources, reduces their self-regulation neurochemically, and then they're more likely to not be able to stop themselves. This time what they're not stopping themselves saying is 'I effing won't' or something, or picking up a chair and throwing it. That seems dramatic - in reality, it builds up over more time than that.

However, if the teacher had been given just a little bit more room and a bit more support to manage the multiple things in the classroom, the teacher might have had the space to be able to say to the student, 'I can see you've got a great answer coming. I can't wait to hear it so you don't lose it, can you write it down for me? And then I'm coming to you first'. Simple as that. The ADHD student: 'Yes, excellent, she likes what I'm going to say'. It's so simple. It helps in that moment, but it helps in every other moment, across the school and in all other classrooms. Realistically, at the moment, for a teacher to have that level of emotion regulation and headspace themselves to come up with that, it's not fair to expect that. I hope that helps.

CHAIR - It's a great example. Thank you. What kind of education are you aware of that occurs in our education system so that teachers have those tools?

Dr DERRICK - Very little. At our practice at Hobart ADHD Consultants we've done all the staff presentations and staff meetings over the years. Very, very few state schools. Very few. It's been mostly the independent schools that are taking up that opportunity. Even when they do, in the 60 to 90 minutes we're given, all that does to a tired teacher at 3.30 in the afternoon is tell them, 'You don't know what you think you know and there's something else on your plate'.

It doesn't achieve anything except perhaps create stress and defensiveness. Naturally, humans will want to start blocking things out that are adding stress. We really need at least one full day of training to sit and do this sort of thing. I put something together for a school recently, I haven't heard back yet, but ongoing and actually having case examples from students, and teachers working in teams, like a year group. The grade 3 teachers will get together and work on solutions, apply the principles, so they're actually developing their skills as they go, and can see and check back in later to see how that's panned out. They can actually see and feel the difference that makes. Then there's going to be a lot more motivation and hope.

CHAIR - A final question. I do want to pass it around to the other members of the committee. You are talking about once teachers are in the classroom and they're already practising their craft - what happens at university? How are we able to support them so they have the skills before they head into the classroom?

Dr DERRICK - I can't say for certain what happens in education courses at the moment for any teachers I speak to. Even for new grads it wasn't a lot. It certainly seems to be more than there is in health though. I think probably we absolutely need that education for people coming through university, but it's kind of pointless if they get into a school and the school isn't resourced or doesn't have the right priorities and attitudes to allow them to put those things in place.

Mr BEHRAKIS - On that, I know this probably applies to children, adults and everything, but just on this line, about being proactive rather than reactive, I know that teachers are at the front line of this often when you're talking about ADHD in childhood - are there things that people and teachers can look out for, be mindful of? Are there ways to test for ADHD before it becomes a problem? I know, for me personally, I was taken to a paediatrician after I was disrupting the class and my marks were going all over the place. It was a problem at that point. Teachers would see my parents were pulling their hair out. It was at that point where it was like, 'What do we do? Crisis'. Is there a way to test before that happens? Because as a kid in school and as an adult, and you hear from so many other people, when it's undiagnosed, all those symptoms of ADHD when people don't know that they're ADHD people treat as a moral failure. 'You chose to disrupt the class or you didn't do this'. That's a difficult thing for a lot of people.

Dr DERRICK - Yes. We've got two cohorts to consider here. We've got your typical naughty little boy gets diagnosed as the naughty little boy. It's assumed it's bad attitude, parenting, all those sorts of things. Then the adrenaline-driven response by the teacher actually exacerbates and make those things worse. To be dramatic, that's our classic school-to-prison pipeline. There, I suppose there's your basic ADHD education and the understanding that a student can have knowledge, values and goals that aren't reflected in the way they're responding at that time because ADHD symptoms will prevent that refinement. It's just all knee-jerk responses at that time. The inconsistency that happens is not a sign that today they can't, but yesterday they could, so they were obviously choosing not to today. Knowledge of the inconsistency is really important.

The other cohort is, I'll say, our girls, and I'll say non-binary as well; whether that's assigned female at birth or assigned male at birth, we don't know the extent of the environmental versus biological factors that would determine how ADHD plays out for non-binary people. Anyone non-cis-male, we'll say, going through schooling - what we are more likely to have is subtle symptoms of ADHD that are masked by and compensated for by the very strong developmental urge of little six and seven-year-old girls to be a good girl. That's social-emotional development of girls versus boys; boys are still throwing balls around the classroom not caring so much, while the girls are there wanting to plait the teacher's hair. They're playing the social game early, and that gets in the way of being able to see the symptoms before they become large enough to detect.

In clinical practice, we struggle to differentiate quite severe anxiety in little kids from ADHD. It's hard to tell so it's probably unrealistic to expect teachers to be able to pick up on those signs. Having said that, a lot of the intervention component is still the same. It's still the approach of, 'How do I make this student feel safe? How do I have the rapport with them that allows them to tell me what they're worried about?' - and then making space for maybe it's not just you need to have more confidence in yourself and try, maybe opening up then to maybe your working memory is overloaded, or maybe you can't keep your attention focused here.

I forgot the question. I apologise, Simon. I should have written it down.

Mr BEHRAKIS - I can only talk about my experience as a boy growing up with it, but when you're smart and quick enough, you get given work in the moment. You do your work and then you finish it before everybody else and then you start bouncing around the walls. Or you don't do your assignments, but you do your work in class and your teachers think you can do the work - you're just choosing not to do it at home, so you're clearly just not taking this seriously. That's something that - say it to people and they start wildly nodding. It's addressing it before it hits that sort of point where, 'Maybe that kid's not a little bugger, maybe he actually should be referred on to somebody'.

Dr DERRICK - That is probably a broader cultural shift we need in general in terms of immediate assumptions about parent blame and the like. Perhaps starting with a default of - does this child have a differing neurotype here, meaning the cookie cutter classroom, the round hole of the classroom isn't going to fit for them as a square peg. We've got an attitude shift there, I suppose.

One other cohort I've got, if we're going to go back to the last question, whatever it was, is your highly intelligent student, whatever gender, who can sufficiently compensate so the academic effects don't appear. Perhaps the impulsivity side isn't so large, it's more inattentive, and then they get to high school and then the grades start dropping off. Then what is seen is anxiety, depression, disengagement with school. They're treated for anxiety, depression and disengagement for school, which is not actually treating the core problem. Then we're picking them up as 30, 40, 50-year old adults with substance use problems and broken families and all the other suite of issues that there would be. I'm in private practice, so it's a certain subset of the population I see. In certainly talking to colleagues in the forensic area, it's an enormous part of the prison population.

Mr BEHRAKIS - I made it to uni before mine started dropping.

Dr DERRICK - Yes, a very high intelligence, then.

Mr BEHRAKIS - Last question, share the love a bit, just on the awareness and understanding and misinformation and stigma. There's a lot of talk about that in the broader community, but in your submission, you talk about the misinformation and stigma that exists within the medical profession. I've experienced a bit of that myself. I've had GPs just, like I said earlier, 'I don't think - you've got an iron deficiency', or 'I don't think you need to be referred on to somebody else'. It's like, 'I was previously diagnosed with it, I think I know what I've got. Thank you very much'. People just refuse to see people on that, or people have had very, there's a lot of you know - obviously that impacts on people trying to go through that, especially if you have that.

For me, because I was diagnosed at an early age and then sort of fell off and have got rediagnosed, I went into that process knowing from day one what was wrong. But I imagine so many people, the majority of people that go through that process as an adult, are like, 'Something's not right. What's going on?' If they go to a GP or any medical professional who is cynical or has problematic views about ADHD, if that's the right terminology, that would be where their journey ends in that regard. For a profession where we talk about people who are well educated in matters of medicine and psychology and psychiatry, what are those stigmas and misunderstandings and how do we address that?

Dr DERRICK - Yes, well-educated, lots of skills, but also not time and incentive to put their waitlist on further hold and make time in their day for training to update their knowledge based on what we currently know. The knowledge space around ADHD has changed dramatically since neuroimaging studies in the 2010s started coming out showing clear differences. Then it was like, 'Ah, now it's not a debate anymore. We can see this.' When you're looking at however many weeks it takes to get into your regular GP at the moment, let alone find a new one, when that's how much our health professionals are pushed, what's the likelihood of them taking their time out for training?

I agree with what Professor Coghill said earlier about the fear around prescribing and not wanting to put a flag on their back for prescribing a high level of stimulants. I'm aware of a particular case, probably about 10 years now, of a psychiatrist in Hobart. That was probably the event that put the fear in a lot of psychiatrists, and, 'Why would I bother doing that when I've got more than enough patients here? I don't want to have to go through that risk'. We do have stigma around drug-seeking, which to me is ridiculous because if it's much easier to find stimulants on the streets, on the black market, than it is to put yourself through this whole process. Why would you do it?

Ms HADDAD - Good point.

Dr DERRICK - There's still a lot of talk within professionals in the ADHD space about exposing themselves to risk of being investigated, and there not being a committee that reviews their prescribing practices that is ADHD-equipped. I 'm not sure of involvement of state versus federal level there, but I think that would be something that would assist. I think at university-level we need to be careful of what we are training as well and make sure that we have an up-to-date attitude and culture coming through. Is it plausible to go in camera for a moment?

CHAIR - We would need to discuss that, but it is. Do you want to come back to that at the end of the session? We have 15 minutes before the next witness.

Dr DERRICK - It's not incriminating anyone or anything. It's just talking in a more frank way.

CHAIR - Yes, we might be able to do that at 10:45 a.m.

Ms HADDAD - I want to come back to education setting - just bear with me, because what you described is very much my daughter's experience - starting with classroom exclusion, probably not up to chair throwing, but it's a very familiar story. I really like the language that you used in your written submission around parents feeling like it is a David and Goliath conversation with schools. I feel like there is another cohort that I want to explore with you a little bit in more detail, which is young people waiting for assessment. Every submission that we have received talks about the delays and the wait times and children waiting on waitlists a really long time.

This is not meant to be disparaging to any schools or teachers because I think there are many who are doing amazing things. However, something that I have heard from parents of young people who are waiting for diagnoses is that once there are children who have been diagnosed and they have a learning plan, the school feels like there is a plan; there is a pathway to deal with that young person. However, there are a growing number of children who are waiting and there is a little bit of stigma and discrimination - I think - within some schools of almost feeling like, 'Oh, for goodness sake, every child is on a bloody learning plan these days'. There are young people who are in a school setting for whom some schools will make accommodations while they are waiting for assessment, but others are very cynical about it.

I just wondered if you could explore that a little bit more in terms of general culture change within schools. It was really compelling what you said at the beginning of one of your other answers around how making accommodations for some neurodiverse children actually benefits all children, whether they are neurodiverse or not; just around how we might be able to explore that more as a committee, in terms of general attitudes across schools, including for those children who are waiting on waitlists for diagnoses?

Dr DERRICK - Okay. There are a few parts to this. It is a good question. I suppose in my practice area in psychology, our framework for thinking about what is happening is the interaction between environment and the individual. The schooling environment is kind of the opposite of every good fit environment for someone with ADHD in every single way.

Ms HADDAD - Yes, the 'square peg, round hole,' I have used that phrase with my daughter multiple times over her education.

Dr DERRICK - Whilst we are talking 'square peg, round hole,' in reality, we have got a continuum of ADHD traits and whether someone meets diagnostic criteria depends on whether there is impairment. That impairment depends on the environment they are interacting with. Whilst I am not, in any way, suggesting over-diagnosis based on that at all, but in terms of the need for accommodations like those being identified, that's not just about what is happening for the student. Rather, that is about what is happening in the environment. If it seems like there are too many kids with a learning plan, that's telling you that the environment isn't right. We are very stuck in an industrial model of education. I know it seems too big to change but we could be brave and bold in Tasmania. Who knows? Think like an ADHDer - go for it.

Mr BEHRAKIS - I know plenty of people who I see with symptoms that I've got, but they have lifestyles and jobs and - they don't need to complicate their lives by thinking about this. They have a good thing going.

Dr DERRICK - Yes, that's a good fit.

Mr BEHRAKIS - I'm not an expert, but 100 per cent, they've got it. But, they're on a good thing, so they don't need it. Like you said, it's the environment.

Dr DERRICK - Absolutely. I think our medical model for diagnosis - which is all focused on deficits - it doesn't set us up well to tackle a neurodiversity-affirming perspective that allows us to go, 'That person on those traits is at very far end of the continuum and there are going to be strengths and challenges there'. Challenges we want to support, but strengths we want to make use of.

Ms HADDAD - That's a really beautiful thing to hear, for the committee to hear. That's some of the language that I've used with my daughter too - that it's actually a superpower. It's just that the environment that you're in isn't set up to accommodate that. I'd love to see ways for us to make recommendations around accommodating that for young people.

Dr DERRICK - I'm not an economist but I suppose there's got to be a bit of a leap of faith in that we're valuing the collective wisdom of people in all these sectors to say this is what we need and to go, 'Okay, let's invest'. I know - four-year terms, I suppose, make things tricky, but there are some bold changes that could be done. I think there are more than enough teachers in schools that are hungry for it. They just need to be given the go-ahead from above. Everyone's just hanging on, white-knuckling it.

Mrs BESWICK - At the end of your submission you touched on the value of some of the strengths. I'd love to hear a little bit more about that because I think we often can get stuck in the deficits.

Dr DERRICK - To help your understanding - the hunter-gatherer hypothesis on ADHD is a really useful framework to get your head around this. That sort of suggests that the hunter-gatherer lifestyle was very well-suited to the ADHD cognitive profile, and the range of profiles within that. That used to be very much a theoretical thought. We've now got some studies starting to come out showing that people with ADHD outperform others, like on a virtual reality task where they need to go find berries.

If something wasn't of use to humans, it would have died out for evolution purposes. It didn't with ADHD because it serves a purpose to have a section - we refer to it as 5 per cent of the ADHDers and hunter-gatherers, 95 per cent the farmers, neurotypical brains, or 94 per cent - that works well. There are contrasting skill sets. Comfort with risk and being innovative, going and finding new resources, new ways of doing things, composure in a crisis - all these things are really common strengths. Conversely, we need people who will be more conservative, pump the brakes, do the daily repetitive things and the follow-through, and be organised in planning for the future. Put those together and you've got an awesome team. We're taking one out of our teams of 20, taking them and subjecting them to all sorts of things through their developmental stages and taking away their capacity to contribute. It's not only not fair, but it's not smart.

Ms HADDAD - It's a disbenefit to everybody, really.

Dr DERRICK - That's right. There are organisations springing up in other countries, probably Scandinavia because they're always doing it there, where - say there's a coding company that proactively employs people with autism, for example, because they know that's a good fit, and they're going to get the most if we create the right environment. I always joke about having a dream of packing a bus with ADHDers and touring the country and providing brainstorming skills. I'm sure a realistic version of that could be done. There's a skill set to be made use of, as well as to ensure that we're not actually taking that away from people.

Mr BEHRAKIS - One more question, noting the time. Going back to - you were talking about some of the worries that some medical professions have with the prescribing and the risks there and whatnot. I know the PSB's mandate, rightfully, is to reduce or mitigate the risk of drug-related harm and misuse and whatnot. Then we end up in some of these situations where you have medical professionals hesitant to prescribe and you have people with difficulties getting access to those prescriptions, especially if they've got a history of any drug-taking behaviour. One of the symptoms of untreated ADHD is a higher proclivity to drug-taking behaviour or drug abuse. I know prescription isn't the whole model of care, but if one of the core treatments for ADHD is appropriate medication, then reducing access to those medications with somebody who expresses symptoms of the condition seems counterintuitive to me. If you're comparing it to nothing, there is a level of risk above zero of prescribing ADHD stimulants, but are we comparing that risk to zero or are we comparing it to the risk of not prescribing, and the risks that are entailed in people continuing life without that support?

Dr DERRICK - We would want it to be the latter.

Mr BEHRAKIS - Is that what's occurring at the moment? As in the prescribing, there's a risk that's greater than zero. We'll just stick to zero. Is that what's -

Dr DERRICK - Yes. There's also evidence to the contrary to show that the risk of substance abuse or substance dependence is drastically reduced if someone with ADHD accesses pharmacological intervention.

My personal experience of working the drug and alcohol area is people were there for a range of issues with substances, but amongst them, the methamphetamines they took, that wasn't to party - that was just to get some stuff done, go to Centrelink. There was a lot of that going on.

Mr BEHRAKIS - To pay the bills, yes.

Dr DERRICK - You look at how someone rebuilds their life from that point when their whole life they haven't had the experience of being able to be organised, engage with services in a way that's positive and reinforcing for them. It's not only difficult for them, but they're starting as an adult with the skills that others would develop much earlier. Trajectories can be very much switched at that point. This is from the very severe end of difficulties that are very costly for the state purse.

I suppose we also have a wasted opportunity that creates a revolving door where we're treating part of what is happening for someone. We're maybe treating pharmacologically. They're bipolar, they're OCD, they're anxiety, all these things that someone with ADHD has a higher risk of having, but we're not treating the ADHD. Then because of the impacts on cognitive functioning, the capacity to make the most of the benefits of any other treatment for any other conditions, it's just wiped away. You need your self regulation. That's the set of cognitive functions of ADHD. You need those to remember to take medication, to show up to appointments, to organise supports for yourself to get help getting a job.

Mr BEHRAKIS - To not be late to committees

Dr DERRICK - It's like - we'll fix your broken leg, but we won't give you antibiotics for the raging infection. That's just going to keep going and going and going, which means the broken leg's never going to heal.

Mr BEHRAKIS - For clarity then, the risk reduction in providing someone that treatment is greater than the risk of providing that treatment in your view?

Dr DERRICK - Yes, absolutely. The risk of providing the treatment is that someone might divert their medication - might. For someone who has had good psychoeducation, understands what ADHD is, how it's impacted them, the small amount of money they're going to get for diverting their medication is not going to be enough to compete with 'Oh my gosh, there's hope for my future and I can change my life'. That's just not practical. That doesn't make sense.

Even with diversion, unless we're talking about short acting dexamphetamine - a long acting lisdexamfetamine, Vyvanse, you can't tamper with it. My knowledge is limited, but my understanding is you can't tamper with it and turn it into something fun.

Mr BEHRAKIS - I'm on the slow release Vyvanse, and I think I'm on the strongest available one. I don't think anyone's going to take that and have a wild rager. I don't think it works, especially with the slow release stuff.

Dr DERRICK - No. There may be a market - truck drivers, maybe - but that market's already there, and truck drivers doing that isn't costing the Australian economy $20 billion a year. ADHD is. It's such a tiny risk compared to the potential gains. We're so far. It doesn't make sense what we do.

Ms HADDAD - Can I ask something else that you covered in your submission that not a lot of the others have gone through, which is the lack of availability for adults for diagnosis and treatment. Could you explore that a little bit more?

Dr DERRICK - Yes. I think I'd said in the submission, I'm not sure if it's written policy amongst public mental health to not treat ADHD or it's just practice, but when ADHD is a genetic condition and there's going to be intergenerational patterns of disadvantage, we are going to have a skew of ADHD in lower socioeconomic groups. Arguably there are more things to have to fight against. It's a harder climb up to a level of functionality from there. It doesn't make sense that assessment and intervention is more accessible to those who have more resources and less levels of challenge. That's in a very generalised sense, taking averages.

Again, it's the same thing of you can't treat the OCD or schizophrenia effectively if you're not actually treating the ADHD. You're creating a revolving door through the public health system. Much like in the drug and alcohol sector, if we don't get in and treat the mental health, then we've just got that revolving door. When I was in the drug and alcohol area, there was all the comorbidity funding that was actually running the comorbidity project at the Bridge there. That was really key. Once we've got them here, we've got them thinking straight and sober and straight, let's do all the mental health work while we can cause otherwise we're just sending them back out with a 'see you soon'.

Ms HADDAD - The root causes.

Dr DERRICK - We can make the same case for ADHD, with more complex mental health co-occurring.

CHAIR - Tell me about the lack of services for adults in Tasmania in the public system. You said you're not sure if it's because they don't want to or if it's policy. Did I understand that correctly from what you just said?.

Dr DERRICK - I'm not sure if it's actually a policy written anywhere, but in public mental health we don't treat ADHD. I'm not aware of that. It's just the rhetoric.

CHAIR - We've got the minister coming in today, so we can ask that question.

Dr DERRICK - Oh good. It's the rhetoric that said that our public mental health won't treat it. Certainly some clients have said that.

CHAIR - What are the options available for somebody who doesn't have the resources to see a private practitioner? Where do they go in Tasmania? Anywhere?

Dr DERRICK - Black market.

Mr BEHRAKIS - They just deal.

Dr DERRICK - Or they don't even know they've got ADHD, and they just think they're a terrible person. They just stay in their satellite suburb doing the things there because they feel that's their lot in life. There's nothing more than that. That sounds very dismal, saying it like that, I know, but I feel like that is the reality.

Ms HADDAD - Even outside the public health setting, with the delays in accessing treatment, even in the private health sector, is there more of a reticence, do you think, from health professionals to - well, Simon's described his experience as an adult. Are health professionals perhaps more aware of looking for these things in children and a little bit more hesitant or sceptical about potentially diagnosing adults with ADHD, or recognising that as a root cause for other things that you mentioned like OCD, bipolar, anxiety?

Dr DERRICK - Yes. I think our paediatricians in Tasmania do a great job. I don't think there's a big problem there. I think it's fair to say in psychiatry more broadly it is recognised that there's an issue with acceptability of ADHD, despite the evidence. In terms of what clients report on from ringing around and finding out who they can see, there are certainly lots of practices where they're told: 'No, the doctor doesn't treat ADHD'.

I'm aware, if you do a run around people's websites, having a look at what they list, ADHD isn't mentioned on the very vast majority. There's the odd one I come across that has been seeing a psychiatrist for something else and they do diagnose with ADHD. If I'm really honest, for every one of those, I've probably had about five to 10 where the psychiatrists have been working with someone for a long time and has refused to consider it. I don't know what their assessment process is. I can't comment on the quality of that. They might be completely right. Though people will come to us for a second opinion. There are cases where we've said, 'Yes, can see the complexity, but we do think it's there for these reasons which are not reasons spelt out in diagnostic criteria' - they're reasons that come about through understanding ADHD and training and experience. We've certainly then heard back from our client, where they've shown us a letter, where between the GP and the psychiatrist, they've overturned the diagnosis, they've said, 'We've taken a different path, thank you', and that was without a conversation.

Ms HADDAD - That's quite common?

Dr DERRICK - Yes, no conversation, just decision there, and dismissed.

Ms HADDAD - Dismissed by the psychologist as served, okay.

Dr DERRICK - Yes. The psychologist - that's their thing.

Ms HADDAD - Training and expertise. Alright, that's really telling, thank you for that.

CHAIR - We do have time to consider evidence in camera. The process for us now is we'll stop the broadcast.

The committee suspended at 10.40 a.m.

The Committee resumed from 11.02 a.m.

CHAIR - What I would ask you to do first, please, is to introduce the other witnesses who are guests at the committee Table

Mr BARNETT - At the Table we have Dale Webster, the Acting Secretary for the Department of Health, who is in person with you, and George Clarke, Chief Executive of Public Health Services. In Launceston we have with me Michelle Searle, who is Acting Deputy Secretary of Community Mental Health and Wellbeing, and likewise, Melissa Snadden, a senior Health adviser.

CHAIR - Thank you. Can I confirm for those witnesses that you have received and read the guide sent to you by the committee secretary? Can I ask you to make the declaration?

Hon GUY BARNETT, DEPUTY PREMIER, MINISTER FOR HEALTH, MENTAL HEALTH AND WELLBEING, WAS CALLED AND EXAMINED.

Mr DALE WEBSTER, ACTING SECRETARY, and **Mr GEORGE CLARKE**, CHIEF EXECUTIVE, PUBLIC HEALTH SERVICES, DEPARTMENT OF HEALTH, WERE CALLED, MADE THE DECLARATION WERE AND EXAMINED.

Ms MICHELLE SEARLE, ACTING DEPUTY SECRETARY, COMMUNITY MENTAL HEALTH AND WELLBEING, DEPARTMENT OF HEALTH, **Ms MELISSA SNADDEN**, SENIOR HEALTH ADVISER, WERE CALLED, MADE THE DECLARATION AND WERE EXAMINED VIA WEBEX.

CHAIR - Thank you very much, minister, for appearing before the committee today. We are pleased to receive your submission. I will make the comment that it is disappointing we did not receive it until yesterday evening, given there had already been extensions provided. Unfortunately, it has put a lot of pressure on committee members to be able to thoroughly digest the submission before meeting with you today. We thought it was important to proceed given that there will be further hearings and the opportunity to also ask you or the department officials back should that be necessary. I will ask, in the first instance, if you wanted to make an opening statement?

Mr BARNETT - Yes, thank you very much, Chair. Firstly, thank you very much for the opportunity to address the committee. Secondly, I would like to apologise for the late submission to the committee and understand the pressure that has put on the committee members. I know it is an important process and I am sorry about that delay. Likewise, certainly on behalf of the government, we are certainly very pleased to be here and would like to support the committee and the important work that you are undertaking.

We are committed to making it easier for people with ADHD to get the right care, in the right place, at the right time. Just as other states and territories, Tasmania is seeing rapidly increasing demand for specialist assessment of children with behavioural and development management issues, including ADHD. As well as adults seeking assessment and treatment, which is generally done through the private sector with referral via GP to a private psychiatrist.

In recognition of this growing demand, we have taken action and I can advise that the department has increased the number of paediatricians employed by 45 per cent in the five years to 2022, which is positive and has made a real difference to many people and families across the state. Furthered at this and building on this increased resourcing, the Tasmanian government is developing a statewide paediatric strategy under the Long-Term Plan for Healthcare in Tasmania 2040. This is an implementation plan to improve access to healthcare services in the community and hospital for children and young people.

In line with our election commitment, this will see the delivery of new GP specialist service for children with ADHD to ensure families can access a GP with a specialist interest sooner, with $2.5 million committed in the recent Budget to progress this important service. We have also increased the time frame that GPs with a special interest and other specialists can prescribe medications from two to three years, reducing, the number of specialist appointments that families are required to attend.

In 2023, we launched the Kids Care Clinics, and I was at Bridgewater last Tuesday at a Kids Care Clinic. They provide targeted health care and support to Tasmania's most vulnerable children and their families, with a focus on early identification of health and wellbeing concerns, including ADHD. Through Kids Care Clinics, we are also trialling parent and school education sessions on ADHD. The first of these two sessions has been trialled in rural communities and will be further developed and rolled out more widely if successful.

Further, I am pleased to announce to the committee that we are taking ction to improve access to medication for Tasmanians with the Poisons Act 1971 to be amended to allow prescriptions issued interstate to be filled in Tasmania. Currently, the act restricts interstate prescriptions of certain medicines, including the psychostimulants commonly used to treat ADHD. We've heard feedback loud and clear from those frustrated with the current situation; I've heard that directly on many occasions over a period of time. We're taking action to rectify it to ensure Tasmanians can access the medications they need.

With appropriate safeguards, the proposed changes will mean that Tasmanians can access medicines that have been legitimately prescribed by an appropriately qualified health professional interstate. Consultations on these changes will commence shortly, with legislation expected to be considered by parliament early in the new year. In the meantime, Tasmanian GPs can continue to work with interstate specialists to apply for an authority to prescribe those medicines and have them dispensed by Tasmanian community pharmacies.

Delivering better healthcare is an essential component of our 2030 Strong Plan for Tasmania's Future and legislative changes, such as this, will have a big impact for many Tasmanians. These changes will occur while a comprehensive review of the act takes place, which will ensure we have contemporary and user-friendly legislation that continues to ensure the right balance between access and controls to high-risk prescription medicines.

In conclusion, work is already underway on this review. I expect public consultations to take place next year to ensure all interested stakeholders have the opportunity to have their say on potential changes. This will ensure we can continue to provide the right care, in the right place, at the right time. Thank you.

CHAIR - I appreciate that, thank you so much. I'm sure we have lots of questions. I will start with one about adult services in the state. You have spoken a lot about paediatric services and I'm sure we'll have questions about that. The question I had is about access to adult services in the public health system. In your overview then, you spoke about how it's primarily provided in the private health system. Is there a policy within the public health system to not provide services to ADHD patients through mental health services in Tasmania?

Mr BARNETT - Thank you for the question. I might refer that to the acting secretary.

Mr WEBSTER - The mental health services model that we deliver in the public health system is an acute mental health service and diagnosis, early diagnosis, et cetera, actually sits in the primary health sector. It sits with the federal government part of the equation with mental health. Certainly, those with ADHD who are having acute episodes or chronic episodes would come to mental health services. But, generally, it is done through GPs and psychiatrists in the private sector as per the model which splits primary funding to the Australian Government through Medicare and the acute sector through the state government.

CHAIR - What avenue is there for someone in Tasmania who doesn't have the resources to go to a private practitioner, as an adult, to access diagnostic and treatment services for ADHD in the public health system?

Mr WEBSTER - They are limited through the public health system. However, through the changes in model of service that we're implementing starting with Peacock Centre in the south and to roll out across the state, there is now access on a drop-in basis to those centres. This can result in appointments and diagnosis through those changes in their model of service which allows people to actually self-nominate or self-refer into our services and picked up through those. It is at the present time limited because of that split between acute services being with the state government and federal services.

Having said that, we have been actively working with the federal government around changes to Medicare Benefits Schemes and the Pharmaceutical Benefits Scheme that we believe are necessary to make sure that everyone has access through the primary care sector and not having it split on dollars and cents.

CHAIR - Through you, minister, with the model of care you're creating for the Peacock Centre and then presumably other facilities outside of Hobart, can you describe what that might look like for somebody? How they might find out about the ability to access that type of service in the first place. If they do present, what treatment would be provided to them and how soon they might be able to access that if it's not currently available?

Mr WEBSTER - The Peacock Centre was a fundamental change to our model of service. Our model of service traditionally has been direct referral from GPs or from the private sector into the public, because of changes in circumstance of clients. With the Peacock Centre it is a full drop-in arrangement; self-referral. Then within the Peacock Centre we have our health professionals who operate through the centre who can then work with the client and if necessary refer across into our community teams, which are now split into continuing care and acute care. Around 40 per cent of our clients through Peacock are self-referrals. We pick them up and if they require treatment, treatment commences there.

In the ADHD space, if they're not exhibiting chronic or acute, then the treatment they're getting is limited in that they may be referred back to their GP or to the private sector. Again, because if they don't require acute services, then they fall outside of our core group of patients or consumers.

CHAIR - Do you imagine a time when that will change that people who don't have the resources to go to see a private practitioner might be able to access diagnostic and treatment services for ADHD in the public system?

Mr WEBSTER - I envisage a time where we've worked with the government to actually address these gaps. These gaps exist because of the Medicare Benefits Scheme not properly funding the primary sector, particularly around psychosocial issues like ADHD. Then you have a group that can afford treatment, and then you have a group that gets chronic or acute that ends up in the in the public sector. There is this gap in the middle which health ministers at recent meeting in Sydney actually said about directed health chief executives to be working with the Commonwealth about how we can address that gap in the middle between the affordable primary care and the acute or continuing care that currently sits with state governments. There were recent reports that identified the quantum of that is quite massive. There is an urgent piece of work commissioned by the ministers, through the chief executives, to say how can we change the system so we don't have a gap in the middle.

CHAIR - When is that piece of work due to be completed by?

Mr BARNETT - Could I please add to that answer?

CHAIR - Yes, and if you could also indicate when you expect that piece of work to be completed by?

Mr BARNETT - Dale has indicated that we had that meeting in Sydney a couple of months ago. That's our first meeting with health ministers and mental health ministers. This is a significant issue around Australia. There is a bit of an assessment needs analysis, as Dale has indicated, and that work is underway. I'll check with Dale on when it's expected to be completed, but it's a very important piece of work. We've already received a broad needs analysis, but there's more work to do.

We have agreed to meet twice a year as mental health ministers with the health ministers. There has been that gap and now we're coming together twice a year to flesh out and work together as health ministers and mental health ministers on these important matters. We've already received a needs analysis, which Dale, you might want to flesh that out and then more work's been done in terms of how we can address that. The Mental Health Council of Tasmania is very much across it. I'm not sure when they might be appearing before the committee, but that's a matter you could ask them.

I'll just pass back to Dale if that's okay on that one.

Mr WEBSTER - In terms of when it will be iterative as in we'll work out what we can do quickly, but it's incredibly complex given we need to work with the federal government, particularly around the Medicare Benefit Scheme and proper funding. The very first step in fact happens on Monday next week, which is changes to how we bring international medical graduates and create them as specialists within the Australian system. APERA and the Australian Medical Board recommended your health ministers and mental health ministers approved that four priority medical areas which will be able to come from international into Australia, be supervised within the Australian system for a period and then made specialists without having to go through the colleges and do an Australian fellowship starts Monday.

Two of the four groups that are relevant today, the first four include GPs and psychiatrists. An increase in the number of GPs and psychiatrists is expected through that methodology and for completeness, the other two groups are OBGYN and anaesthetists.

Mr BEHRAKIS - In the submission, there's the mention of the evidence-based clinical practice guidelines published by Australasian ADHD Professionals Association who we heard from just earlier, and the government submission does state that these guidelines have informed the approach taken to section 59E authorisation. To what extent and what has been adopted from those clinical practice guidelines? I ask that because a few people have provided me with the responses that they've received from government when asking about the AADPA guidelines and the suggestion was, I want to say dismissive, but you might want to ask AADPA about the discrepancies between what they're recommending versus best clinical practice, and there's been responses like that. What's the department or the government, what's the position on those clinical practice guidelines from AADPA when you say you've used it to inform government's approach? To what regard has that happened?

Mr BARNETT - Thank you for your advocacy in this area and you sharing your story. I acknowledge that and put it on the record. It's really appreciated and it's a leadership role for sure. That's more of an operational question. I'll pass to the acting secretary.

Mr WEBSTER - Thanks, minister. Under the Tasmanian Poisons Act there is a number of regions that the secretary of the department is given authority to actually make decisions. Given that I'm not a clinician, I have delegated all of those powers to a position in our pharmaceutical services branch and the role is called the chief pharmacist. The chief pharmacist has developed, adopted those guidelines, but then said okay in respect of 59E applications, the majority go through fairly quickly; he says to me 99 per cent - don't accept that it's exactly 99 per cent - but a vast majority go through very quickly because the risk is assessed as low. Where it is a high risk there are a number of steps PSB staff will go through to gather the evidence before they issue the authority and that's a very small number.

As you appreciate, 59 E is also around opioids and things like that, not just psychostimulants. Having said that, under our current regime, for instance, psychostimulants are treated the same as opioids in respect of interstate prescriptions. As the minister said, we're already moving to say we believe psychostimulants are different from opioids in that respect and we can actually have a different regime.

The review of the Poisons Act the minister just mentioned, we need to modernise our legislation and we need to consider where other states have moved and what's happened and what's the evidence of the impact of that, and feed that into our risk assessment of what the Poisons Act really needs to govern. We've done this on the individual matters as we've gone, but it's now time to do a full review.

A provision like 59E treats all Schedule 8s as one category, when clearly they need to be split out, and is it part of it? One of the issues of changing 59E quickly is the unintended consequences. At the moment it is a catchall section for all Schedule 8s. We don't want to have to go through a situation where we actually open it up for opioids when we see the evidence there that we need tighter controls. At the moment we're not seeing the same evidence for psychostimulants. We are moving forward with some changes, but we will do a full review of the act, because it's old, it's out of date, and it doesn't reflect contemporary practice.

Mr BEHRAKIS - I'm really glad to hear that, because a lot of the feedback - through submissions, through talking to people, and even some of the hearings we've heard today, which have been more from medical professionals - have been about difficulties with the authorisation at the PSB stage. A lot of people in submissions, and from me talking to people, have been individuals having problems at the PSB stage, at the authorisation stage. There are people saying that it's causing delays. Then there are also people who aren't getting approved, or are having difficulties in that sense.

I appreciate in the submission on page 24 you have the graph on the statistics regarding approvals and refusals. You have 95 per cent were issued, and 5 per cent were refused. I suppose the other cohort that I'd like to ask about is the ones that are issued, but then have varying levels of sometimes onerous requirements and conditions put on them. One of the symptoms of undiagnosed or untreated ADHD is a higher risk or higher proclivity for drug-taking behaviour. One of the core treatments is appropriate psychostimulants. If the Poisons Act is effectively saying that the people that are experiencing one of the very typical symptoms of a condition, we're going to restrict their access to one of the most evidence-proven treatments for that - it seems counterintuitive to me.

I appreciate the PSB's role is in mitigating drug-based harm or drug abuse or whatever the catchall term is there. I suppose my question would be when we're assessing that risk, is that risk compared to zero - I apologise for my rambling question, but I appreciate that there is a level of risk inherent in psychostimulants, but is that risk equal, or greater or lower than the reduced risk in providing treatment to people? If they're not able to access drugs like Vyvanse or Ritalin or those clinical prescriptions, will they consciously or subconsciously seek self-medication in other ways, or continue to experience symptoms that impact or injure them in other ways as well? What are the statistics around those ones that are issued, but are then given pretty onerous restrictions?

I've heard from some people, 'I have to go to the pharmacy every single day and take the pill in front of the pharmacist, which (a), makes me feel like I'm a criminal, and (b), this is a condition where one of the main symptoms is terrible organisation' - I can attest to that personally. Having to organise your day such that you get to the pharmacist in the morning before you do anything that day, because you won't be able to do it without the medication, is just borderline impossible for a lot of people. I know that is on the higher end of the level of conditions, but that's a really important part of this conversation as well. I apologise for my very long question, but I was wondering if you could speak to that?

Mr WEBSTER - I probably won't address specific things that you said through there, because I think that then identifies clients and things like that. What I do want to say is that when we look at heightened risk, we don't just have one member of PSB or the chief pharmacist making the decision. So, on the level one or the straightforward ones, then it basically is somewhere within PSB, when we get to a heightened level of risk and that may be past behaviours around other Schedule 8s. Then we would consult a medical officer and a senior medical officer consultant to have input to the decision making.

Where it is a very complex case, because you just outlined the different types of behaviours and those sorts of things, we actually gather an advisory panel. So, it's pharmacists and clinicians in a room actually discussing the particular one which adds to the delays. We accept that adds to the delays, which is why, at the moment, we treat all Schedule 8s and put them through the same risk assessment-style of process. That's why I'm saying we have to separate the different types of Schedule 8s and ask, 'Are there different levels of risk that we need to assess those sorts of things?'.

CHAIR - Are those decisions reviewable once they are made?

Mr WEBSTER - Yes, they are. There are review processes through that and that's on page 25 of the submission, the flow chart. But just to look at some of the stage supply conditions, which is what happens, we may start with the need to attend a pharmacy daily, but we would try it based on continued risk assessment to move away from that over time. So, it's not that's going to be the circumstance forever, so I do need to say that. But where there has been harmful behaviours in the past, then that is taken into account. We would make a decision based on that harm. I don't want to go into -

Mr BEHRAKIS - I appreciate that. I suppose to focus the question a bit on that exact point, when you have someone who does have either, not just a risk of that behaviour, but a history of that behaviour per se, and when that is actually clean and clear, you're obviously assessing the risk that they're going to misuse or divert or do something with a psychostimulant. I appreciate that.

When you're taking these things into consideration and these panels are taking these things into consideration, are you also considering the potential probability of providing that psychostimulant in reducing some of those other behaviours? We might have someone who might have taken cocaine or whatever other drugs, methamphetamines from the street, is there a possibility that if you provide them appropriate psychostimulant medication that there's a lower risk that they're going to be taking or buying drugs off the street? Does that factor into these decisions?

Mr WEBSTER - Yes, it does. It's important to emphasise that the idea of this is not to stop the prescription, but to do it in a way that is safe and then to withdraw as quickly as possible, but as safely as possible into the standard circumstance. There's not just the risk from other substance they may take, there is the risk of overdose and things like that. So, all those things come into it.

I should emphasise the panel - and I talked about the panel - they involve adult psychiatrists. If it's a child, they involve both paediatricians and psychiatrists. So, it's clinicians from pharmacists through to specialists that come into that panel that inform the assessment of risk and therefore the management of risk that applied in a particular circumstance.

The other thing is that we try to have the risk-benefit sort of analysis but also try to go to a normalised circumstance. So, it's not a case of putting in the restriction and that's there forever. It's about how we can move this person through from daily to twice weekly to long-term sort of circumstances, all of that informed by clinicians.

Mr BEHRAKIS - Can we get some of those statistics around where, as far as percentage wise, I don't want to identify anybody but some of that stuff. Can we get that on notice? I appreciate you might not have that with you.

CHAIR - I think consistent with the flow chart you provided, where you've got refused approval condition support pending additional information and approved. If that's possible to break it down like that, for instance?

Mr BARNETT - We should be able to do that. We should be fine with that, Dale?

Mr WEBSTER - Yes.

Ms HADDAD - My questions are specifically around the work of the PSB as well. You've described it really clearly, but I want to drill down on it a bit further. I've got a few questions.

The first one is when someone is identified as high risk when assessing a prescription and you put together those panels, do they consult with that patient's own clinical team, their own psychologist, psychiatrist or GP when making those decisions? That's my first question, but I have more.

Mr WEBSTER - The initial contact is usually from a GP. Usually at the point of prescribing there is actually a specialist who has created a treatment plan. That informs part of the risk assessment. It's important that, if you like, the prescription of the drug is always seen as part of a treatment plan rather than a visit to the GP, here's an antibiotic. It's a visit to a specialist. A specialist then develops a treatment plan, which is then shared with the GP. The GP then usually becomes the prescribing doctor beyond that original visit with the specialist. That's an important part of the panel.

Ms HADDAD - Are they involved in the PSB's work? The treatment plan comes to the PSB?

Mr WEBSTER - Yes. The plan comes to the PSB. It helps them with their risk assessment to say which level is this at. Then the team tells me the applying prescriber who is responsible for coordinating care. I think that's a quick way of saying if it's a psych who prescribes, then it's the psych. If it's the GP, the GP.

Ms HADDAD - They do get consulted?

Mr WEBSTER - That's what I'm seeing from Sam on the feed.

Ms HADDAD - That's relieving to hear because we do hear about long delays. People are often confused about why those delays occur and whether it's possible that there's specialists within the PSB who are called upon who are making a decision about a prescription who've never met the patient. People do have that belief in the community.

My next question is about how the PSB gathers that information to make that risk assessment. Do they gather that directly from that patient's treating team? I've also heard from patients and people in the community, constituents and so on that it's come as a surprise to them to know that people in a department who they've never met could have actually really quite unfettered access to their long-term medical records. They haven't provided consent for their medical records to be accessed in that way by people who are not their treating clinicians.

Mr WEBSTER - To comment on that, the first thing is that Tasmania has had real time prescription monitoring now for a number of years and that's now rolled out Australia-wide. I think all states and territories are switched on. There is a prescribing history that is available to PSB that's been available in Tasmania for a number of years.

Ms HADDAD - Sorry to interrupt you, but a prescribing history wouldn't show a history of drug abuse, for example. How would the PSB get that?

Mr WEBSTER - I wanted to make it clear that we have access to that information through the PSB.

In relation to the gathering of it, the second part of it is the treatment plan. The treatment plan is going to be a very detailed assessment of things like, in the past they've used these stimulants, and those sorts of things. It needs to have that before you start prescribing, and then levels et cetera.

The other inputs are in fact that the specialist input - they're not within the PSB, that might actually be within the broader THS or indeed, depending on who is required, beyond the the THS. There is also the access to the digital medical record that's held by the department, which is the THS record.

Ms HADDAD - Is there something in that process that loops back to the patient providing consent to the PSB, or the PSB plus THS employees who are called upon to make that risk assessment, for their medical records to be accessed to make those assessments?

Mr WEBSTER - My understanding would be that the Poisons Act is actually the regulatory authority that allows for that. It sets up the framework from which you do it. I don't believe you would need consent in those circumstances or direct consent because the Poisons Act says there has to be an approval attached to that. I'm certainly happy to check to see whether we're saying that. It is built into the pathway that there is an informing of the patient of the process, but I guess, it is answering the question, which I think I failed to answer from Mr Behrakis earlier, is part of what we need to do.

We are discovering quite regularly is that we need to better inform GPs of the pathway; that's part of the issue. There is a lack of knowledge of how you actually get through this pathway. You have specialists referring to the GP with a treatment plan and then the GP not being exactly sure what their role is within that. We have started work with Primary Health Tasmania (PHT) to better inform, generally, GPs on what the pathway is within Tasmania.

Mr BEHRAKIS - And the consumer and the patient.

Mr WEBSTER - Yes, a part of the pathway management is informing consumers.

Ms ROSOL - I have a couple of branches of questions. The first few are following up on some of those PSB questions. In relation to the reviews that happen, how are the reviews conducted? How independent are they from the initial people who would have made the decision, whether it was a panel or any individual making the decision?

Mr WEBSTER - In the first instance, it may be a quick review by the chief psychiatrist or a senior person within PSB so that it doesn't slow down the process of going through to make sure there are no basic errors and things like that. Secondly, if it was a decision made by using only a consultant, then it may be one that then gets referred off to a panel and of course the panel is different. In the instance where it is a panel, then it is reviewed by a separate group to make sure that it is there. Ultimately under the act, I guess that the referral is up to the secretary, but I want to assure people I don't get involved at all in these reviews.

Ms ROSOL - Just on that, how many reviews result in a change to the decision? Do you keep statistics on that? Is it possible to get that information?

Mr WEBSTER - Through you, minister, I'm certain we keep statistics on that, but I don't have them with me.

Ms ROSOL - Would it be possible to get that as a question on notice, please? Thank you.

CHAIR - Take that, minister?

Mr BARNETT - Yes, no problem. Thank you.

Ms ROSOL - I'm keen to change topic now, I don't know if anyone else has other questions still on this, but I have some questions relating to the social and economic costs of ADHD.

We've heard through submissions, and through some of the witnesses that we've heard from this morning, that ADHD contributes to economic and social disadvantage, and then that economic and social disadvantage contributes to people not being able to access the assessments and the treatment that they need. Following that kind of trajectory and pathway, we know that there is a significant proportion of people in our prisons who have ADHD. I wonder what services are available for people in prison knowing that a large percentage of them are likely to have ADHD. What health services and mental health services are available for them? Are they able to access assessment, treatment and medications in that place?

Mr BARNETT - That might be best for yourself, acting secretary or George, perhaps?

Mr WEBSTER - Specifically within the prison, we have a team within our state-wide mental health services called the Forensic Mental Health Service. That particular team - little bit misnamed - provides both the primary health service to the prison service and to youth detention as well as providing the mental health services to those who are found not guilty by reason of insanity or, indeed, not fit to plead-type categories.

Forensic Mental Health Services, for a number of years, provided services to the prison and youth detention, as well as having their focus on their primary role of forensic. From this year's State Budget, we have separated prisoner mental health from forensic mental health. We are establishing a Prisoner Mental Health Service, so that we can have better diagnosis and support within the prison services for, not just ADHD, but a range of mental illness and psychosocial support. The model of care development is underway to establish that. In fact, we have just started to advertise the roles to go into that service.

Ms ROSOL - I am following up on my question, which was around access to medication, how does that work in that circumstance?

Mr WEBSTER - The Forensic Mental Health is the specialist part of the current service and that will be replaced by Prisoner Mental Health and then the Correctional Primary Health is the GP part of that service. Prescriptions done in the same way as in the public, but then delivery of that is from congressional Primary Health to medication rounds within the Prison Service, although in some of our outlying like Launceston there are things like Webster packs used to achieve that. It is done very much as in the community except for - because the control of the Schedule 8 - it is then done through nurses actually going around and doing delivery of medication across the service.

Ms ROSOL - I am curious because I imagine we have been talking about how difficult it can be to be approved sometimes for stimulant medication because of certain criteria. I imagine that people who are in prison tick a lot of the boxes for those criteria. Is it possible for them to access stimulant medication while they are in prison?

Mr WEBSTER - Yes, it is, because in the community, what we have just discussed, the high-level restrictions are an automatic in the prison service. Prisoners do not have medications in their cells. They are actually taken to them, around the prison, on regular medication rounds. It is possible because, in effect, the restrictive practice is an automatic practice with how medications are delivered within the prison service.

Ms JOHNSTON - When the prisoners are within the prison system it sounds like they do have access to public health diagnosis and treatment plans which is different from the wider population from what we're hearing. When they exit, what's the support and the continued treatment plan for them in the public health system that does not provide for the greater population? From what you are saying, they have the possibility to be assessed and they have a treatment plan for them whilst they are in prison, which is unique to the broader population, but when they leave that public health support is not there anymore. How do they continue without being able to afford private services?

Mr WEBSTER - Through you, minister, the Correctional Primary Health would do the treatment plan; they're the GP service in this category. It'll be transfer of that treatment plan to another GP within the community. Once the treatment plan is established that can be an up to three-year plan so it is highly likely they have continued service initially, but may need review down the track as any other citizen.

Ms JOHNSTON - So access to psychologists and psychiatrists, though, in terms of ongoing care and support, that would have to be through a private system rather than public?

Mr WEBSTER - Through the Medicare system. A mental health plan can be developed in the Medicare system. You'll have to excuse me - I can't remember if it's back to 10 - it went up to 20 - I think it's back to 10 sessions now. Their initial treatment plan is established, it can be monitored by their GP, but they have the same access as everyone else through Medicare.

CHAIR - I have some questions about paediatric services, noting the long delays and some of the data that you've provided illustrates the size of the challenge. You've said that the THS paediatric service currently receives 305 to 380 new referrals each month for behavioural and neuro-developmental concerns. You've broken that down by region.

Then you've said that due to current workforce capacity constraints, children and families awaiting ADHD assessment in the public health system can face prolonged wait times and parents report waiting up to 18 months to access public paediatric services and many paediatricians in the private sector have stopped accepting new patients. You, in the submission, say that in response, the Tasmanian government is committed to establishing a new GP specialist service for children with ADHD to boost services available to Tasmanian families. I'm assuming that's the Kids Clinic that you referenced in your opening remarks, minister. I'm very keen to understand the details of this because there are many stories we hear from people who are waiting very long times to access paediatric services and, clearly, it's a massive gap.

Mr BARNETT - I did make those remarks in my opening statement, but it's best if the acting secretary could add to those remarks and that question.

Mr WEBSTER - Through you, minister, the Kids Care Clinic, I think that's what it's called, is in fact a service we established last year where, effectively, we have a statewide team and a presence statewide and they deliver clinics in non-clinical spaces. That might be a Child and Family Learning Centre. At Kingston, I know it's the Neighbourhood House for instance. That's now established and the minister referred to the 12-month anniversary event he went to recently at Bridgewater. That's separate to what the minister was talking about with the new GP ADHD clinics.

We're currently developing a model of care where we will either attract or train GPs to become special interests GPs in ADHD speciality, which will supplement our paediatric workforce and psychiatry workforce for children so that we can increase the number of appointments available, particularly through Outpatients. That's funded for the next four years to attract and we have a model of care where we've got GPs with special interest adding to the number of people that can see children and diagnose.

In addition to that, the paediatric part of our women's and children's service is working with our child youth mental health service to design a statewide specific ADHD treatment service. There are some children for whom the prescription of psychostimulants might be counterintuitive to their treatment or might not be sufficient treatment. We want to make sure that they are treated in a multidisciplinary sense between paediatrics and mental health to make sure they have that additional support. They're the extras, if you like, that we're adding to the suite of services over the next period.

The reality is that nationally, we have a shortage of paediatricians and psychiatrists both of which are the people we need involved directly in the development treatment plans. The GPSI as we call it - the GPs with Special Interests - idea is one that we're keen to progress while we are still working through how we increase the number of paediatricians and psychiatrists.

CHAIR - Do other states have GPs with Special Interests providing similar services? Is this new for Tasmania?

Mr WEBSTER - I'm aware of only one other state that's done it, but all states are looking at GPs with Special Interests in a number of areas. We're also looking in ear, nose and throat, for instance, it's an area where we're trying to grow the workforce in different ways across Australia.

CHAIR - This committee's heard evidence today already about the benefits of multidisciplinary teams and the role that nurses can play, for instance, and an example was shared with us about the role they're playing in some of the clinics in New South Wales. Have you considered utilisation of the nursing profession to bolster access to services in Tasmania for adolescents or children seeking a diagnosis?

Mr WEBSTER - Yes, we have. In fact, through nurse practitioner roles and again in a number of spaces we're now pursuing, what we call nurse practitioner candidates and we've advertised for those. Those nurse practitioner candidates come in and go through the training program and are guaranteed a role with the Tasmania Health Service at the end of their training, but again, we need to grow that workforce because they're not automatically available to us. At the moment they are advertising more for nurse practitioner candidates than nurse practitioners, because we haven't been able to attract the nurse practitioners.

CHAIR - With the changes to the Poisons Act, would that also change prescribing rights so that nurse practitioners can prescribe certain medications?

Mr WEBSTER - Through you, minister, the short answer is yes, but we're pursuing scope of practice issues for all our health professionals so that they are all performing at the highest level of scope. We've made a number of changes for pharmacists. Through COVID we made a number of changes for enrolled nurses and RNs. We continue to pursue that to maximise the scope of practice of all our workforce because we see that as a way of achieving a more diverse multidisciplinary workforce.

CHAIR - Minister, can I draw to your attention to the evidence we received in the first hearing today from Professor David Coghill who spoke about the multidisciplinary team which included nurses, not necessarily nurse practitioners, but nurses who provide essentially diagnostic services supported then through a referral to a psychiatrist who could make a final assessment and determination. It helped them see far more patients and it seems to me there's an opportunity for us in Tasmania to do something similar. You've spoken about nurse practitioners and he spoke about that too being more costly and timely pursuit, given there aren't any and you have to train them, but there are lots of nurses who could potentially help build the capacity of the service to meet the demand.

Mr WEBSTER - Through you, minister, I started with the nurse practitioners and then I changed to scope of practice of RNs, so I do apologise. Nurse practitioners is one part of what we're doing. Scope of practice is not just for nurse practitioners, it's actually for RNs, ENs, pharmacists, allied health, et cetera. We need to pursue scope of practice. In fact, nationally, Professor Mark Cormack from ANU is, on behalf of all jurisdictions, undertaking a major piece of work on scope of practice of all health professionals, as part of the outcomes of the Strengthening Medicare Taskforce and Tasmania represents the small states on the Strengthening Medicare implementation team, working with people like Mark Cormack to implement that part of the taskforce.

Mr BEHRAKIS - On the comment you made a moment ago about there being a shortage of psychiatrists, there's also a shortage of psychiatrists that take ADHD patients - and I'm not sure what the difference is. I think it's four, maybe five psychiatrists that I know of in Tasmania, who will even open the door for ADHD. I don't know what the total number that's out of. To what extent do you think the capacity will increase through the things like the GPSI and the nurse practitioners? I suppose what would be the appetite for people to take part in those programs?

One of the things that we heard in evidence earlier today was about some of the risks that GPs and psychiatrists have when prescribing because of the nature of it. You are prescribing a stimulant and then people fear, or are under fear of being audited or those sorts of things. Is that an issue that's limiting people's willingness to enter into that space? Are there things that can be done to - I don't know if it's some sort of panel or something - try to provide some protection or some sort of surety or absorb some of that liability from GPs and psychiatrists and other people so they don't feel like fearful of entering into space and taking on risk by trying to treat people?

Mr WEBSTER - We talked about needing the education for GPs around ADHD and pathways. I think this applies to all health professions and we need to make it sure. I have had discussions with, for instance, the psychiatry college around how each individual practitioner will be doing their own risk assessment. We need to make sure that risk assessment is informed by knowledge of the process and those sorts of things, that can be achieved through Continuing Professional Development (CPD). We continue to work with colleges, PHT and all the players to actually increase the knowledge base. Through that knowledge we get informed risk assessment and, hopefully, we get individual practitioners comfortable with taking the broader range of patients. This is a long-term, plugging away with education, et cetera, to do that because we don't have the ability to tell individual practitioners which patients they see and don't see. So we need to -

CHAIR - Unless you establish a service in the public system, for instance

Mr WEBSTER - For instance, yes.

Ms HADDAD - Coming back to the PSB, when that branch, either within the existing staff or when you draw in those other experts, when they're making a decision about a prescription for a child, do they have access to information about that child's parents in making that risk assessment and how much information about the parents do they have access to?

Mr WEBSTER - I don't know the answer to that one. It's an incredibly good question, but I'm not sure and I don't want to take a punt at it. Through you, minister, we can find out what level we involve the parents or information about the parents.

Ms HADDAD - Are you happy to take that on notice, minister?

Mr BARNETT - It would be good to take it on notice and we'll get back to you.

Ms HADDAD - Thank you.

Mr WEBSTER - Certainly if it's indicated in the treatment plan, we have that knowledge, but that's all I know, I'd have to ask.

CHAIR - Any further questions from committee members? Thank you very much. That is our allocated time. We appreciate you joining us online and I'm sure we will invite you back at a future date to talk with the committee again. Thank you for coming today.

Mr BARNETT - Thank you, members.

The committee suspended at 12.02 p.m.

The committee resumed at 12.17 p.m.

CHAIR - Thank you for joining the committee today. Thank you very much for your submission. Before we proceed, I'll ask you to state your name and the capacity in which you're appearing before the committee today.

Ms RYALL - No problem. My name is Vikki Ryall and I'm appearing as Chief Clinical Officer for headspace National.

CHAIR - Thank you. Can I confirm that you've received and read the guide sent to you by the committee secretary?

Ms RYALL - I have. Thank you.

Ms VIKKI RYALL, CHIEF CLINICAL OFFICER, hEADSPACE, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED VIA WEBEX

CHAIR - My name is Rebecca White and I'm the chair of the committee. We've also got other members of the committee, Deputy Chair Simon Behrakis - it is very hard for you, probably, to see where everyone is sitting on the screen.

Ms RYALL - I can see you quite well actually and nice to see you all. One of my colleagues has kindly put your photos next to your names in a document, which makes it a bit easier.

CHAIR - We have Ella Haddad, Cecily Rosol and Kristie Johnston. Thank you very much for your submission. It is excellent. Would you like to make an opening statement before we begin?

Ms RYALL - I will, while Natasha's joining.

Good morning, Chair, and committee members, I'm very grateful to be here. I'll start by acknowledging I'm joining you from the lands of the Wurundjeri people of the Kulin nation in Melbourne, and pay my deepest respects to the elders in this part of the world, but also to the elders in the land that you're coming from and acknowledge the palawa people. Thank you to the committee for holding the inquiry and providing the opportunity for headspace to give evidence.

CHAIR - I will quickly stop you because I can see Natasha has joined and I will quickly welcome her and also just go through the same process I went through with you, if that's alright.

Ms RYALL - Sure.

CHAIR - Natasha, can I ask you to state your name and the capacity in which you're appearing before the committee?

Ms MARSTON - I'm Natasha Marston. I'm here as the Manager of Practice Development in the clinical practice team at headspace.

CHAIR - Thank you very much. Can I confirm you've received and read the guides sent to you by the committee secretary?

Ms MARSTON - I have received and read them.

CHAIR - I'll just need to swear you in as a witness. I can read that to you.

Ms NATASHA MARSTON, MANAGER OF PRACTICE DEVELOPMENT, hEADSPACE, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED VIA WEBEX

CHAIR - Sorry to interrupt you, Vikki. I thought we would do that so that you can both speak now and we can have a free ranging conversation.

Ms RYALL - Natasha and I are both here representing headspace, the National Youth Major Health Foundation. We are guided by the voices of young people and families in everything we do. We also have the voices of staff from centres and lead agencies in contributing to all submissions that we make, including the one that you have. As the committee is probably already aware, we support young people between the ages of 12 and 25 and their families, and lots of the young people who we've seen have a whole range of mental health and psychosocial difficulties and might have experienced bullying or discrimination.

I'm here with Dr Natasha Marston. Natasha is the manager of clinical practice but also currently acting as the head of that area. Our work across the country gives us a national perspective. We work in primary and secondary schools and obviously the physical centres, 163, are open around the country. We also have a national online telephone service.

As you're aware, and I'm sure the origins of this inquiry, more and more young people have been diagnosed with ADHD. Attention Deficit Hyperactivity Disorder has a lifelong impact, but treatment and support can make a huge difference to the lives of those young people and their families.

As you're well aware and is well documented, the access to assessment and commencement of treatment is increasingly a challenge but there are some some steps that governments and communities can take. We support the idea that young people and families can access good assessment and medication where that's clinically indicated and the psychosocial supports that are recommended by this practice for young people diagnosed with ADHD.

As is indicated in our submission, all clinicians, medical, non-allied health and peer workers need to have a better understanding of ADHD in order that that discrimination is minimised and also that people can access the care they need. I guess we're all well aware, but just to state, the fact is that we know that we need more specialist clinicians who are able to assess and diagnose and commence treatment.

That's my opening statement, we're happy to take questions from here.

CHAIR - Thank you very much. That's very consistent with the evidence the committee's received from other submitters. Are you able to provide any Tasmanian-specific data about the number of young people you see who are either waiting for an ADHD diagnosis or have received one?

Ms RYALL - I'm checking the data that we've been given for this. I can take that question on notice about whether or not we can provide you something in writing afterwards. From the centre minimum data set, we don't have that exact information.

CHAIR - I see the global data you've provided, which is that in 2023-24, 2586 young people accessing your services had a diagnosis of ADHD. That's 14 per cent of all young people had a diagnosis recorded of the young people that you supported that year, which is higher than the number in the general population but, I presume, given the types of presentations you receive, that could be expected. What sort of support can you provide to a young person who has a diagnosis of ADHD?

Ms RYALL - We've got four centres operating in Tasmania. I'll state, firstly, we think headspace centres are a good place for people to access care for ADHD. Many of the centres may not currently have the specialist workers who would be able to assess and commence treatment, but some of them may. Some of them are supported by our national telepsychiatry service which is operated by headspace National, where psychiatrists, in collaboration with their local GP, can assess and commence treatment for ADHD. Where the jurisdictional prescribing and treatment laws allow, they can collaborate on the care for young people.

There's a funding review for headspace centres currently in process and what we're hoping is that with a slightly bigger funding base for headspace centres, they'd be better equipped to provide more holistic care. Currently, most of the centres would be able to support a lot of the other needs that young people with ADHD might have. For a lot of headspace centres, it's a four-core stream model: mental health, physical health, alcohol and other drugs, and work and study. Some of the other needs across those four core streams could well be met by staff at a headspace centre. Often many of the centres have peer work models, so I guess engagement and destigmatising support that can safely be provided by - I'm sorry there's something very noisy in the background.

The psychosocial peer support, allied health support, that is very clearly coming through as recommended treatment that young people may or may not be indicated to receive their medication. Regardless they need to have the support for all of themselves so they can continue to stay in school and work, if that's what they want to do, and their families get good information. We think headspace centres are a good place to provide some of the care, even if not all of the care.

Mr BEHRAKIS - Thank you for speaking to us. You mentioned things that can be done to improve access. We've heard a lot about the need to build capacity and get more specialists and obviously accepted. Is there anything in your experience as far as things that can be done to make the existing capacity stretch further or accomplish more, as far as inefficient things that can be made more efficient. Things that get those existing psychiatrists and paediatricians being able to see more people to provide that level of care with what we've got today?

Ms RYALL - Yes, it's a good question. We've not got any comments on and sort of productivity or that kind of efficiency, but certainly there's efficiencies to be made across the country. If we're able to, one of the recommendations you read on ADHD policy is a national approach. As you are probably aware, there's jurisdictional differences in assessment, commencement of treatment and ongoing prescribing in ADHD. We think you would get some economies of scale if we were able to have a national approach to that. We know areas like Tasmania and lots of other regional areas in other parts of the country also miss out on specialist treatment, but if we were able to have psychiatrist paediatricians in other parts of the country able to assess people in your area and work with local providers.

We've had incredible success of that under the headspace telepsychiatry program. We're comfortable to send a video. One of the psychiatrists, John Callary speaks quite a lot about it. It's not just he sees the young person and that's it - he actually works with the team in the headspace centres. It is matching that multi-disciplinary team-based care that evidence talks about. We think there's models like that could be made much more efficient nationally.

One of our colleagues, Natasha, is a mental health occupational therapist based in Launceston. I have a feeling I slightly mispronounced that, but I hope you forgive me as a non-Tasmanian. My understanding is you just are commencing OT course for the first time in Tasmania, but things like that as an addition to support and OTs play a critical role in psychosocial recovery for problems like ADHD. I think next year you're actually about to start growing your own OTs. There's lots of things like that can also really help.

Mr BEHRAKIS - In your submission, you've a quote there from one of the reference group members:

> So after diagnosis, I mostly relied on internet resources to understand and work through the supports required.

I myself, and I've heard from a lot of people who have had that same experience, not just after diagnosis, but even in the lead-up to and through that whole process. How many of the young people who have come through headspace - you said that was 17 per cent with ADHD - needed help in navigating the systems and the health bureaucracy - for a lack of a better term - do I go to a GP, a paediatrician, psychologist or a psychiatrist - just to get to where they need to go for assessment and treatment? How many young Tasmanians are needing help with that?

Ms RYALL - I don't have an actual number. I would say a lot/most. We hear again and again that young people and families really struggle to get most of their mental health needs met and, in particular, in navigating the service system. One of the original goals of headspace was to create and build a brand that young people recognise as being for them about mental health. To literally help improve that navigation so that the logo and the green and whatever you think of that colour means that hopefully young people understand that is a service that is safe for them. That is one of the reasons that I still believe that for supporting young people with ADHD, headspace is a good option because it does remove that navigation problem.

It should, that is one of the goals that we really want. That any young person can go there and whether that centre itself is in a position to provide the assessment of a treatment, they should be able to help and walk young people and families to the right connection. That is part of their job. Certainly, we hear that again and again.

I am sure, like us, you have been very closely following the social media conversations and what you are talking about, that phenomena, comes through very strongly there. We know that many young people are finding information about whatever difficulty, including ADHD, through social media. We certainly feel very strongly we need - headspace and like organisations, with good reputations and evidence-based information - to make sure we are putting information out there that young people can trust.

The other thing we are hearing from the sector and from young people is there is some place for the sort of self-assessment. That is not sort of a pop-psychology quiz, but actual evidence-based self-assessment in order to determine whether or not a formal assessment is needed. We would support, if there was a very clear evidence-based self-assessment, that could then help people know when to receive professional help. Right now, I am not sure that -

Mr BEHRAKIS - If for no reason other than to give them some direction.

Ms RYALL - Correct. Yes, exactly. Obviously, I say that with a degree of hesitation because we do not want people diagnosing themselves. We are very much about getting help and help being a useful thing to do and assessment being a specialist area. However, if there was an evidence-based tool that would suggest, and these things when they are available on the internet are fairly cautious and would direct people to care with a low threshold as they should, things like that could also create some efficiencies.

Mr BEHRAKIS - I have more on other things, Chair, so we can bounce around if you want.

Ms JOHNSTON - Hi, it is Kristie Johnston here. headspace sees young people aged from 12 to 25 and we have heard in this committee, particularly this morning, about the difference in Tasmania and accessing services for children compared to adults. You are in a unique position that you are dealing with young adults. Can you comment on the difficulties of young adults trying to seek a diagnosis and treatment compared to children? Obviously recognising, there is a significant issue with children, but particularly for adults in Tasmania not being able to access public health services.

Ms RYALL - Yes, it is a good question. I may not be able to exactly answer your question to a higher degree of depth. One of the other things I am sure you have heard is there are gender differences in the presentation for ADHD. One of the things we know is for young women, it may be picked up quite a bit later. What you would hope in an ideal world is that ADHD was assessed and management and treatment commenced before they reach headspace age, even. But, that is not what we are seeing.

Certainly, there is a better public conversation now about ADHD. We are grateful for that. We think that is a good thing, but it does create the problem we are now in, where there are now more people looking for assessment and care than not. I am going to have a look to see if this may contribute to your answer: the age at first service is slightly higher in - I will give you the breakdown. The national average for age at first service is 24 per cent between 12 and 14. In Tasmania about 12 to 14 is 18 per cent. Nationally, the average for 15 to 17 age at first service is 32 per cent and in Tasmania, that's 27. Generally speaking, it looks like they're help seeking a little bit older for the first time overall. I can give you those actual numbers in writing if that's of interest.

Ms JOHNSTON - Is that for seeking ADHD services or?

Ms RYALL - No, that's age at first service. Correct.

Ms JOHNSTON - Okay. Yes, that'd be useful if we can get that information.

Ms RYALL - I won't try to explain a graph to you in words. It's probably not an idea.

Ms JOHNSTON - Thank you.

CHAIR - I have some questions about your telepsychiatry services. I assume that quite a lot of young people access them. I'd be keen to know if you've got any data around that and whether you also break that down by state.

Ms RYALL - I can take that on notice. We don't have it with us in front of us today, but certainly we can. I can get that absolutely. We do have it by state broken down and by age, and we probably also have the reason for the referral. I know they are inundated with referrals for ADHD assessments.

CHAIR - That would be really useful if you're able to do that, thank you so much. Can you explain to us what that service looks like? I'm assuming you've got psychiatrists based in your organisation and they are available what hours, what days and people can just self-refer. What's the process?

Ms RYALL - No, it's set up because the telepsychiatry Medicare item numbers, you may know, have restrictions on the area. I'm pretty confident that most of the Tasmanian services are qualified. We actually have a team in headspace National that employs, through contract, a range of psychiatrists and then we set up an agreement with the headspace centre about what it is that they're looking for so that the local GPs that either are employed at that centre or proximal to the centre can refer to telepsychiatry. Often the young person may receive a happy appointment sitting in the headspace centre via video conference so that we can put the rest of the supports around it. Again, as per the example I was saying earlier, the psychiatrist is providing primary consultation but also secondary consultation to the clinicians in the headspace centre. They are all over the country, their psychiatrists, although we don't have any in Tasmania because they're all busy doing other things.

CHAIR - I read here that they can conduct ADHD assessment and prepare management plans.

Ms RYALL - Correct.

CHAIR - But they don't provide prescriptions? That has to be provided by the GP, is that right?

Ms RYALL - Again, it's a very complicated thing that I won't try to speak to. Essentially, there are different laws in different areas about the assessments and then commencement of treatment. What can happen? In Victoria, for example, psychiatrists or paediatricians make a diagnosis and commence the prescription of stimulants or medication. A GP can continue to prescribe that for, I think, two years, but then another assessment has to occur by the psychiatrist to continue that. That varies by state and territory, which is what I was saying before. We think that simplifying those rules would make a big difference in access to care.

CHAIR - The Minister for Health presented to this committee earlier today and has informed us that the state government will be making changes to our Poisons Act so that prescriptions written interstate can be filled here in Tasmania, which might provide greater revenues for people to use your service and have those scripts filled here. I imagine that's a barrier at the moment.

Ms RYALL - Yes, absolutely. There's a few developments that we heard of in preparation for the submission and the conversation today, and that's one of them. Yes, there's a few movements to some of the laws being changed that we think will improve things. I'm speaking really generally because they are very new ones and I don't want to get them wrong.

CHAIR - That's fine, thank you. We're only interested in the Tasmanian context anyway. Do any other members have a question?

Mrs BESWICK - Obviously one of the big things that's coming out is the shortages in the workforce. I know some of your centres, and I don't know if that's consistent across all of them, but that they do utilise some uni staff and things like that. What can you tell us about the training area?

Ms RYALL - There is a big workforce challenge. We've set up a few programs to try to address that. We've got an early career program for allied health professionals, for psychology, mental health, social work, where we're working with universities to have students and graduates in health-based centres. The Tasmanian centres are in the early career program. What that means is we give them money to employ a clinical educator and that person's job is simply to support the graduates and students. We create relationships with local universities and these centres then are equipped to have students from those three disciplines. We have two graduates in Tasmania in the most recent cohort and we're in the middle of recruiting 44 new graduates who will start at the beginning of next year. They spend one year in one centre and then they move to another centre.

In fact, the two graduates that I can think of who were in Tasmanian centres were not Tasmanian, but one of them stayed there for the whole two years rather than moving because they enjoyed it so much. That has happened a few times.

We've also done a GP registrar program. Again, I think headspace Hobart was part of the GP registrar program to try to support and train general practitioners. We are in the middle of writing a proposal to the Commonwealth to look at a psychiatry registrar program because where centres are accredited to have a psychiatry registrar and that's a huge increase in the capacity for that centre. We've also had some success in more flexible models where supervision has been provided by a local hospital psychiatrist or something. If we're successful in that, I think certainly Tasmania would be a good place to trial that.

You may not be aware that the College of Psychiatrists has just started a youth specialty so we think that a registrar rotation would only attract senior registrars, in the youth specialty as well. headspace centres would be really good and they would pick up what one of you were asking of the question before around the older presentations of ADHD. We're trying to do as much as we possibly can to grow the workforce and particularly grow it with knowledge of our age cohorts. We know not all those GP, psychiatrists, allied health officials will stay in headspace centres but we think if they've trained with us they'll go out and have better skills and knowledge to support young people outside headspace.

Mr BEHRAKIS - You mentioned in your submission about early intervention. Do you have any views or opinions on ways that we can identify young people with ADHD before they've gotten to a point where their quality of life and the symptoms have gotten so bad that they're in crisis and they have to seek help? Are there any mechanisms or models that you know of that can help identify it early and pre-emptively rather than reactively after someone's fallen off the wagon?

Ms RYALL - It's an incredibly complex question but a good one. We've been trying to do community education around early intervention for a whole range of mental health difficulties for 18 years now. Difficulties like ADHD is slightly more difficult to do public education about, but not impossible, because it may not necessarily be a change in the young person's behaviour, whereas a lot of the other difficulties we do public education about you can give more generic information to families such as 'you know your young person, look for marked changes in how they relate to the world, their sleep and their appetite,' those sorts of things, whereas in someone who has neurodiversity it's less likely to be a significant shift.

That's not to say that we can't do good parent education about what to look out for. There are some really good parent tools that you can look through. We probably need to take some of those actions ourselves to make sure we've got good accessible evidence-based information on our website about ADHD for families to have a look through. There's some parent assessment that you can go through yourself to rate, and it will suggest whether or not you should seek a professional diagnosis.

I think it's possible. I don't know of any particular models that have shown success, but we would happily add it to the suite of things that we try and communicate to families and young people about.

Mr BEHRAKIS - In the experience of the young people who have come through headspace, how many are dealing with, or have had to experience, that lack of awareness, misunderstanding and stigma from the broader community, but then also as they're trying to navigate the healthcare system from medical professionals?

Ms RYALL - In relation to ADHD specifically? I don't have data on that question. What we hear anecdotally is that there are many young people, particularly in the older cohort as you were asking about earlier, who have seen information through social media and are then wondering if this is a relevant thing for them to consider and seek assessment, often wait for a long time, often at great cost to them, and feel some level of judgment about asking about that, which I think is a real shame. If someone, as you're all suggesting, they will have taken time and gone through several steps to reach that point, what we really want is someone to then explore that with them openly and curiously and non-judgmentally. Definitely that is occurring.

We also know, in the subtext of your previous question, there are people living with these difficulties and not identifying them and not reaching out for help. We still have stigma in both ways, if you see what I mean. Stigma of not just the discrimination, but also the lack of understanding about when to seek help.

Mr BEHRAKIS - On the first page of the submission, you quote a study that said people with ADHD have increased risks of low-quality life, substance use disorders, accidental injuries, education, underachievement, unemployment, gambling, teenage pregnancy, difficulty socialising, delinquency, suicide and premature death. I know there was a Deloitte report that quantified the economic cost nationally at $20 billion, which included things like increased burden on the health system and issues such as people getting arrested and going through the court system and lower earning potential because of having untreated ADHD.

For the benefit of people who aren't read up on this issue, and for people who might be watching this inquiry or reading the reports that are produced out of it, those people who have gone through headspace and gotten the assistance of your organisation with ADHD, how has accessing that treatment affected them and their quality of life in the context of those facts around having untreated ADHD?

Ms RYALL - I don't have data on those with a diagnosis of ADHD and their outcomes relative to young people without ADHD and their outcomes. In some ways that's not even what you're asking. What we know from headspace outcomes, broadly speaking, that mostly young people have a really good experience. There are a couple of measures that we've created ourselves, 'MyLifeTracker' and 'My headspace Experience'.

'MyLifeTracker' is around all the things that you're talking about. Days out of role, that they're able to continue with all the other aspects of their life. We think that's a really important outcome. Generally speaking, they're really positive. If you want, we can send those through out of session. 'My Headspace Experience' is about feeling listened to and understood. We know that's a key part of any therapeutic change process and an important outcome in and of itself so that people feel less stigmatised. They feel heard for who they are.

We have good outcomes on both of those measures by and large. I can certainly send you the more specific data if we have enough to make it meaningful for ADHD specifically, but if not just on the general outcomes.

Mr BEHRAKIS - That'd be great. Thank you.

CHAIR - There are no further questions. Thank you very much. We've asked if there's some further information you can provide on a couple of matters discussed today. Hopefully, we can receive that from you when you're able to compile it. If we have any further questions we'll also ask, or if there's anything further you think of later you'd like to share with the committee, please don't hesitate. We'll wrap it up there. Thank you very much for your time today.

Ms RYALL - Thank you so much for having us. Thank you for the doing the inquiry. It's really good that these conversations are happening. I look forward to seeing the outcomes of it.

THE WITNESSES WITHDREW.

The Committee suspended at 12.55 p.m.

The Committee resumed at 2.18 p.m.

CHAIR - Thank you very much for coming and joining us today. I will first ask you if you can state your name and the capacity in which you're presenting to the committee today?

Dr JONES - Dr Timothy Simon Jones. I'm the current Chair of Child and Young Person's Health for the RACGP representing RACGP Tasmania.

CHAIR - Can I confirm you've received and read the guide sent to you by the committee secretary?

Dr JONES - Yes, I can confirm that.

Dr TIMOTHY JONES, GENERAL PRACTITIONER, ROYAL AUSTRALIAN COLLEGE OF GENERAL PRACTITIONERS TASMANIA, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED

CHAIR - We've received your submission. Thank you very much for providing that level of detail to us. For your information, my name is Rebecca White. I'm the Chair of the committee. Simon Behrakis is the Deputy Chair. Miriam Beswick, Ella Haddad, Kristie Johnston and Cecily Rosol are also members of this committee. We're very keen to hear from you and ask if you have an opening statement you would like to make.

Dr JONES - Yes, we really value that the parliament is taking such attention to this issue. It is a critical one for many in our community. While we'd acknowledge that ADHD is, to an extent, a national and a global challenge at the moment, it certainly seems to be disproportionately affecting Tasmania. We value the opportunity to contribute to finding solutions to meet the needs of our community.

CHAIR - Would it be possible perhaps to start with an overview question about what demand you're seeing and what GPs are telling you about the difficulty they're having meeting that demand?

Dr JONES - Yes, if it's okay, I'll share a story. As a GP, it does depend whether I'm seeing a child or an adult as to what happens here, and it depends whether the family has access to means or not. The inequity is one of the challenges that I think will keep coming up in our discussions.

If I see a child as a GP and concerns have been raised about possible ADHD, I can work with that family on supporting the health fundamentals - their sleep, screen usage, exercise habits, all of those things - but if they need assessment and access to supports, it's extremely challenging right now. There's been no private paediatric access largely in Tasmania for more than two years now; those books are closed. Assessment is largely happening through our public service; the wait time is normally over two years. The whole time that's happening, the child is struggling more and more.

If I'm seeing an adult, if they don't have access to means, there is nothing I can offer them beyond those health fundamentals. There is no public service that can provide adequate assessment and recommendations for their support. If they have access to means, then largely they are asking to access interstate telepsychiatry services for the purposes of assessment. My experience as a GP and representing my colleagues here today is that those services are of variable quality and there is an absolute lack of continuity of care and ongoing support. Hence the patients we're seeing just report a feeling of utter abandonment and frustration with the current situation.

CHAIR - You've spoken in your submission about the guidelines. How well communicated do you think the guidelines are to general practitioners to enhance their understanding and potentially their attitude toward ADHD?

Dr JONES - We are seeing increased interest within the general practitioners of the RACGP of Tasmania. We have to reflect the needs of our communities that we live and work in and the Australasian ADHD Professionals Association (AADPA) prescribing guidelines and assessment guidelines are increasingly being utilised as a standard of care by GPs here in Tasmania.

CHAIR - What sort of professional development or opportunities for that exist so that GPs can familiarise themselves with that?

Dr JONES - Within our college, we have the specific interest group on ADHD, ASD and Neurodiversity. It contains approximately 1400 members nationwide at last review and they offer regular professional development, networking and educational opportunities which are being increasingly taken up by GP fellows within Tasmania and our training GPs as well.

CHAIR - That is good to understand, thank you. I will open up to other members of the committee to ask questions.

Mr BEHRAKIS - One of the things we heard today, and you're locked on the topic of it in your submission, you've spoken to expanding the role of GPs in this space from a prescription and also assessment and ongoing treatment. One of the things we did hear was sometimes the reluctance that some medical professionals have, including psychiatrists, under the current model, is the risk around the prescription of the psychostimulants and fear of audits or fear of things happening and then being held liable or responsible and that sort of stuff. Obviously, the number of psychiatrists that treat ADHD is much smaller than the number of psychiatrists in Tasmania and possibly for that reason. What changes could be made to make - obviously in this context - GPs more comfortable to engage in that? Even if we did expand the role of GPs in there, that's only the GPs that feel comfortable entering into that space who are going to take up those programs.

Dr JONES - The key message for me regarding that issue would be around the availability of a steady long-term GP to support that patient and their family if they're a child. One of the challenges we see due to some of the challenges in our community care is access to both general practitioners for cost or community reasons and that is a detriment to the care that people receive. We believe firmly that in terms of achieving safe and appropriate use of stimulant medications, the person best equipped to ensure that safety would be a GP, with that generous knowledge and awareness of the entire situation and that ability to provide a longitudinal and individualised care.

We're working on our end to make sure that the GPs who we train here in Tasmania have increasing confidence and competency to provide that care. We're very grateful that our training numbers, after dwindling for many years, are now increasing again and hopefully into the future we're going to be able to meet more and more of that need.

Mr BEHRAKIS - In your submission, you speak about, in regards to the PSB, some of the onerous regulations and restrictive nature of that space. Can you speak to that from the perspective of the GPs more specifically and how that can be improved without throwing the baby out with the bath water, I suppose, in risk mitigation and those considerations?

Dr JONES - One of the factors that's really playing a role is that variability of the initial assessment and recommendations. I think talking to my PSB colleagues, they feel compelled to put extra governance steps in place at that point of assessment to ensure community safety. What is challenging as general practitioners is once we have a patient with stable ADHD, who has an effective treatment plan and it's clearly working for them, the current legislation does tie us to regular specialist paediatrician or psychiatry review normally every one to two years. Due to the massive challenges around that access to assessment, one of the wisest investments we could see to optimise continuity of care and flow of care is to empower general practitioners who are appropriately credentialed, who do have that long-term relationship, to be able to provide that ongoing continuity of care. This includes changes of medication, not necessarily to different classes, but certainly doses or different formulations of the same class of medications. Talking to my colleagues, that would be comfortably within their scope to provide that care safely with discussion with PSB.

Mr BEHRAKIS - Great, because I know there's been a lot of conversation around the need to expand the numbers of psychiatrist numbers and GPs and that capacity and obviously I agree with that as well. But also, like you said, not having a system where the limited people that we have treating and supporting people in that space are being - so there's blockages that are occurring in that existing system - how would we make sure that the psychiatrists are spending more time assessing, diagnosing people who are in that waiting list, then people like me who I am in a maintenance phase or whatever you want to call it. I still need to go, however often, to my psych and that's how many appointments that are being used for that, which could be assessing and helping new people.

Dr JONES - If I can speak more to that, I think that collaboration between our psychiatrists, paediatricians and GPs on agreed discharge criteria, what I mean by that is what is a stable patient that would then be appropriate to receive community-based care. Talking to my colleagues in those professions, the number of additional appointments that would then become available for assessment of people on our waitlists, even with no additional resources going into that space, would create a significant improvement in our current situation.

Mr BEHRAKIS - Is the lack of co-prescribing making that difficult? I think I was told we're the only state that doesn't allow co-prescribing with the GPs.

Mr JONES - No, my understanding is there is only one other state that truly provides a co-prescribing arrangement, but there are other states that allow GPs to register with the pharmaceutical branch in their state as essentially a credentialed or accredited prescriber for the purposes of either assessment, ongoing treatment or both. They provide a workforce need that's just expanding the scope and they are particularly relevant if we're exploring areas of rural and remote Tasmania where we just know that access becomes even more inequitable.

Ms HADDAD - PSB as well? In your experience at the stage when there's a new prescription for either a child or an adult patient in your care, and the PSB is making a risk-based assessment on whether to approve that prescription or not, do you find that they reach out to you as that patient's treating GP to liaise with you about their treatment plan?

Dr JONES - In my personal practice, I occupy a slightly different space because of my ongoing links to ADHD assessment through other services. Generally, PSB don't often contact me. We have a good working relationship but they would always contact me if there was an extra concern raised or a flag that might affect our treatment plan. In talking to my colleagues, generally, it's to do with how the information is communicated to PSB as to what the PSB response is like. If all the information is provided to PSB and is provided in an electronic format, my colleagues are reporting satisfaction. If the information is haphazard or it's communicated in a fax-based format, then things are slipping through the cracks.

Ms HADDAD - I suppose if they're heading towards a refusal or conditions on that prescription, do you know whether routinely they do reach out to either the GP or other people involved in that patient's care, a psychiatrist or paediatrician?

Dr JONES - What I'm aware of from my colleagues is that largely that only happens in written form to the GP. It doesn't necessarily happen in a more conversational or proactive way at the moment.

Ms ROSOL - Following up on the PSB, if you applied for a review or a patient applied for a review of the decision, what opportunity is there for you to provide feedback in that and what kind of a hearing do you get in that review process?

Dr JONES - I personally haven't had to go through it. Maybe I am not the best person to provide that information. Colleagues who have say that they have received calls from the clinical component of PSB, the pharmacist and the doctors assigned to that service seeking clarification, offering options, but that the hearing about the review is generally conducted behind closed doors and the decision is reached without necessarily the ability to provide a lot more representation to those situations.

Ms ROSOL - Is there any opportunity to appeal that or is it just the review?

Dr JONES - Appeals are done and sometimes the decision is upheld and sometimes the decision is modified.

CHAIR - Do you think that process could be improved?

Dr JONES - Yes, I think that there is an opportunity for closer collaboration. One of the reasons the first point in our submission to the committee is multidisciplinary care being so critical is that there is a siloification of healthcare about ADHD. As much as there are many interested people trying to contribute in a positive way, we don't talk, we don't have easy lines of communication and that includes to the regulatory body as well. We don't have a lot of liaison into that place.

CHAIR - I am keen to get your opinion on that, if we can talk about the shared care models you've referenced the NSW and then the WA examples. We've heard a little bit about the NSW model but the WA model is newer to me. Can you explain to the committee the benefits in having something like that and what you would like to see in the Tasmanian context? What do you think would work here because we are still different to both of those states?

Dr JONES - I'll speak to the WA prescribing pilot first, which is really an opportunity for a future model of care that would have two positive impacts. The first is that would improve access to assessment and support, but the second is that it would contribute to that accelerated upscaling of our general practice workforce in terms of providing care needed for ADHD. In that proposed pilot, what essentially would happen is a multidisciplinary approach where GPs are performing the assessment for ADHD in consultation with paediatrician or psychiatry colleagues and allied health colleagues and then liaising directly with that patient's treating general practitioner to individualise the management plan and make sure appropriate supports in that community are in place. We feel that that instantly deals with the siloification problem. You've got people with similar backgrounds, similar levels of training, providing that care.

The New South Wales pilot is already happening, but it's smaller scale and it's in one regional area and we are seeing significantly improved access in that area, but it hasn't been running long enough to see long-term outcomes in a way I can report to the committee.

CHAIR - In the Tasmanian context, do you have a view about the different professions who would work as a part of a shared care team?

Dr JONES - Yes, my expertise is in child health and so I will always speak to that first. I think that if we look at our communities of great need, and in the south they are largely communities around the Bridgewater area, communities around the Rokeby/Clarendon Vale area, and communities in Kingborough and south. We know that the majority of our ADHD referrals for children happen from those catchments. We also know that those are the areas with the most limited support, so partnering with appropriately trained and credentialed GPs into that area in a way that is affordable for families to access, we feel that would lift the whole community's ability to understand and support this condition. Certainly talking to my colleagues in the north and north-west, they expressed similar opinions. That's what they would love to see happen for the communities they live and work in.

CHAIR - So having a place-based approach in areas where we know there are pockets of need is one part of the solution you're proposing and then in terms of the different professions, who might make up that team? Obviously GPs, but then there could be a cohort of other health professionals. What would you advise the committee on the best model?

Dr JONES - The best model of care would be to have a liaison point to either paediatrics or psychiatry, depending on whether it's a child or adult patient. A representation from PSB to ensure that we've got that wraparound communication and discussion, a liaison point into education systems if it's a child, or workplace support systems if it's an adult, and potentially representation of a psychologist as well to individualise some of the support strategies that may be relevant to that specific individual.

CHAIR - We obviously have a lot of workforce challenges.

Dr JONES - We do.

CHAIR - They're not unique to our state. One of the discussions we had earlier today was about the utilisation of nurses to help with some of the workload. Do you have a view about that?

Dr JONES - I think it's a great untapped workforce that we could look into. There is an amazing role of our nurses in providing that, again, individualised care, but also that long-term follow-up.

We use nurses routinely once we institute a treatment plan to touch base with people about how it's going and to report earlier if there are any concerns, side-effects, any issues along the way. I think there's amazing scope to use our existing workforce better there.

Similarly, I think, teachers, as much as that is a stressed workforce at the moment, they really care about the kids they're seeing and having that direct liaison point to just bridge a divide that normally doesn't get crossed, would deliver better outcomes tomorrow if we have it.

CHAIR - We've got school nurses in many of our schools, do you see that as an avenue to improve that linkage?

Dr JONES - Definitely. When we are conducting medication trials in children, I'm often part of that process as a GP, having that direct observational evidence of what is working and any side-effects that are happening enables better and faster care. If we don't have that and remember that these are often the families where access to support may be very limited, we don't always get that information back and we need it. When I talk to school nurses they're keen to help and we trust their expertise.

CHAIR - Are you able to draw on their expertise at the moment or is that one of the challenges that you have about those points of liaisons?

Dr JONES - As an individual GP, I love to make an effort to connect those dots at a grassroots level wherever I can. That's not a current standard of care because there aren't frameworks to support it.

Mr BEHRAKIS - Just on the great segue, because one of the things we did hear earlier, it's two different questions. One of the things that we've heard and my experience as well is, there's an inconsistency in the experience that people get. I'm saying this from the adult perspective; you might go to a GP that's very well versed such as yourself who's got an interest in it, they'll have a great experience as far as navigating that system. Other people - you might go to a GP - I went to a GP and they tried to argue with me and told me I probably had an iron deficiency and maybe you do not need to, even though I was previously diagnosed as a child. Then I was referred to the wrong place and then had to go through that rigmarole, with all the procrastination and organisation that comes with untreated ADHD.

There is not a standardised experience and I get that things cannot be completely uniform, but that lack of knowing what to expect and especially for someone who is probably doing it tough - otherwise wouldn't be looking for help - have the symptoms of someone with ADHD. They are having to put together their own - I went to a psychologist not long ago and they have said: okay, where's your mental health care plan? I am like, no-one told me I needed that and so I went and got one. You might go to one GP and you get one experience; you get a different

GP and you have a completely different experience. Is there a need to put in some sort of standardisation, so there is some sort of uniformity?

Dr JONES - There are already efforts being made in that area. There has been a lot of liaison with Primary Health Tasmania to establish the HealthPathways suite of guidelines for general practitioners and other primary care providers. That really does standardise what a GP needs to be doing if a patient presents with concerns in this area and what sort of investigation, supports, pathways exist to facilitate that assessment and ongoing care.

Can I draw an analogy? In that, there will always be diversity of practice and that will be a challenge. But, if we look at something like autism and children, we have a Tasmanian autism diagnostic service provided publicly. It is multidisciplinary, it works statewide, it has a large workload, but it will always fill that need in a timely fashion to provide that assessment. In a way, one of the areas that is important to consider is what sort of standard backstop public care can we provide to ensure that no-one goes without.

Mr BEHRAKIS - And at the same time, the information the individual gets can consistently differ as well. I used the analogy earlier today, that last year, I had an accident. I fell over and hit my head and went to get checked up at the ER for a concussion - I am fine.

UNKNOWN - Are you?

Mr BEHRAKIS - I suppose that's debatable. It would explain a lot. On the way out, they gave me a pamphlet, it had all the post-care and what to expect and what you should do and if this happens do not worry that is normal and if this happens, call somebody. That was more information than I got the entire process that I was through seeking and figuring out the way forward post and during the ADHD assessment and treatment. That is where you hear about people getting their information from social media. Sometimes, that is great; sometimes it is not.

Is there a need for some sort of standardised information that somebody can go to a GP - I think I have got this or the GP thinks that you have got this - here's some information for you as we go through that process?

Dr JONES - The challenge in providing that level of care is that ADHD remains a spectrum and we need to individualise our approach to a degree. Having a baseline level of information is really important, but individualising it to those specific circumstances is important for good outcomes. I saw you had Professor David Coghill speaking to the committee at the start of this day. I do not know whether he would have raised the idea that in some of his past areas of practice they have really looked at supporting lived-experience organisations to take on the mantle of a lot of that community education, support and mentoring to essentially guide people through what is currently a difficult and fragmented process.

In a way, I think some of the challenges you are referring to, they are reactive to the situation we are in. We are still recovering from COVID and the adult space has evolved faster than services have established to meet it. I do get the feeling that with increasing attention, some of the chaos is going to organise itself. However, the responsibility to provide oversight to it and ensure that it is what it needs to be is, I think, one of the reasons why we are here today.

Mr BEHRAKIS - I am happy to share the love. I have a million questions, I could take the whole hour.

Ms JOHNSTON - Thank you, Dr Jones, for your frankness in your opening statements. It was refreshing to hear you be quite blunt about the kind of different pathways that Tasmanians will receive care. I am deeply troubled from the evidence you have given and evidence of others and submissions on access for adults who have no means. That seems to me to be a tragic dead-end for them in terms of accessing health care. Could you perhaps elaborate? And I appreciate you work in the child space, but perhaps elaborate on what are the consequences, their health and wellbeing consequences for a patient coming to see a GP with no means who needs to have an assessment for ADHD in terms of their other situations? I'm not sure if you heard Dr Derrick's evidence earlier today about ADHD is sort of the overarching umbrella that needs to be treated first before you can actually deal adequately with other conditions and issues. Can you perhaps elaborate on that a bit?

Dr JONES - I meant what I said with my frankness that it feels so disheartening as a clinician to be there with nothing else I can offer beyond supporting them as a good GP. We really need to clarify that the consequences start to snowball and the earlier we are intervening, not just even in assessment, but early supports and access to individualised care. We need that for good outcomes and in terms of engagement and community engagement and family engagement and workforce. That's what we're seeing as GPs, people are suffering and they do feel like they're in a world where there's no doors in front of them that are open to them. And again, I draw that parallel with the autism diagnosis service in that is an opportunity in children where we ensure anyone with that concern as a child does have a public pathway to access appropriate assessment and then links into all other services. We don't have anything like that in the adult area publicly.

Ms JOHNSTON - You talk about that snowballing effect and obviously there's a snowballing effect in terms of people's family relationships and employment relationships or education. But in terms of health specifically, we know the health system is overwhelmed and that GP access is really critical. It's hard to get GP appointments. If you're seeing adults who aren't getting that treatment or that assessment of ADHD, the other health needs would be snowballing at the same time.

Dr JONES - Correct.

Ms JOHNSTON - You're seeing people over and over again for something that could perhaps be managed much better if they're ADHD had been managed.

Dr JONES - I'm sure every time we're talking about health, we're talking about the ambulances at the bottom of the cliff analogy. We're getting really good at that. We're not front loading supports and so we will wait till they develop major drug and alcohol issues or until they end up in a public mental health institution before we then reactively try to apply care and even there it's still fragmented. The question of ADHD is still working with no place it can attach to for ongoing support.

CHAIR - Do you have a view about how the state might meet that need? We heard from the minister earlier today who argued that primary health care is the responsibility of the federal government, but doesn't resolve the problem we have where adults can't access these services in the state. Is there an example you can share with us from another jurisdiction perhaps, or just more broadly, what you would like to see as a holistic approach to health care we could apply in Tasmania?

Dr JONES - As GPs, we firmly believe in addressing inequity first. What would be lovely to see is a state government-backed initiative to look at where the areas of greatest need around our state are and to establish a pilot model of care - using appropriately credentialed GPs to provide that more rapid and more wraparound assessment, because they can liaise with all the other services.

CHAIR - That would be for adults as well as children?

Dr JONES - I believe so, yes. I think we need to be dealing with both issues simultaneously now, although we do have a belief that better support in childhood will lead to less adults who are in this current situation, because we know that early intervention matters and we know that the vast majority of children with ADHD, if they're provided with adequate supports, will no longer require treatment as an adult. They will be able to self-manage. But we can't currently offer that to enough people to make it stick.

CHAIR - And do you think those place-based approaches - you talked about, the areas you identified in the south with us already - could be delivered from existing GP facilities.

Dr JONES - That's a really good question. I don't think so in the current situation because of the liaison points not existing within community-based general practices. But I do think there are the opportunities to look at in the children's area, our child and family learning centres, and in the adult space to look at our existing mental health footprint and look at whether we can have community-based clinics operating within those services, again using as much of our existing workforce who's already passionate about this area, to deliver that care.

CHAIR - Would that involve looking at facilities like community health centres?

Dr JONES - Yes, definitely. I think my lived experience work going on this journey with patients is that they feel much safer and much more likely to engage and feel safe to open up about their experience and look at goal-setting when it's in a community-based care facility.

CHAIR - Can I ask you about our education system?

Dr JONES - Yes.

CHAIR - We've heard some evidence already today about the role teachers play in the lives of children, but how overwhelmed they can be and how difficult it is for them to know how to respond if the child is showing behaviour in the classroom that's showing up as destructive but possibly is undiagnosed ADHD or something like that. How do we support our teaching workforce and what liaison points would you like to see so they can do that well?

Dr JONES - When we talk to our teachers there is, similar to healthcare workers, a very large diversity of perspectives and approaches to supporting children with hyperactive or inattentive behaviours within the classroom and it's very telling for me that just like with GPs, we see far less referrals coming to us as GPs from certain schools than we do compared to others, not because of any other demographic than the certain teachers who are attached to those classrooms and the fine work they're doing.

There is a situation where we would love to see a model explored for Tasmania which is referred to in our submission, which is both parent-child interaction therapy and its variant teacher-child interaction therapy and the reason why I'm mentioning this is because of the early intervention mindset. We know that a large number of children are being referred at a very young age, four, five and six. We know many of them may not actually go on to reach a diagnostic label of ADHD, but currently we do have a situation where the only support we can provide is the hammer of the diagnosis and the treatment.

If we had the availability to offer low-cost but personalised intervention services to those early groups of children, we know from experience in other states where those services are offered that we get excellent outcomes out of it. In the submission we put that we see roughly double the impact of putting these children on stimulants, we also see that their long-term engagement with health care essentially dries up.

If the concerns are addressed early enough, very few then follow on through to needing more formal assessment and ongoing treatment. So we're huge believers, GPs, in preventative care and these are low-cost models that are being rolled out using telehealth, group consulting and the support of mental health care plans from the federal government to deliver that family based-care and we'd love to bring that to the committee's attention.

CHAIR - Thank you, I was going to ask, can you give some practical examples of the types of intervention that you speak of, but you just gave us three. Are there any other further examples?

Dr JONES - Yes. Looking at what's offered in NSW for example, this is where children where there is that significant concern about their emotional learning development, those families are grouped into similar cohorts, they are paired to a trained psychologist, the families are all receiving support through mental health care plan through their GP and the state government has contributed a little bit of funding to top that up and they receive either six or 12 weekly one-hour sessions to talk about what's going on with the child, to explore the behaviours with the trained professional and to then implement strategies. It's those pathways that are seeing those fantastic response rates because they're individualised and because they're empowering either the teacher, the parent or both, to meet the needs of the child.

CHAIR - And in those examples, you don't require a diagnosis?

Dr JONES - Correct.

CHAIR - This is about providing solutions to some of the challenging behaviours.

Dr JONES - You may still be activating an assessment pathway knowing that you can de-escalate it, but it's front-loading supports in a way that is essentially telling the family, 'You're not alone. We're going to help you.' It's very hard to speak in data about how much hope that gives people, but the lived experience of us working in the community is, it's tremendous.

CHAIR - Thank you for explaining that; it is really helpful.

Mrs BESWICK - Right back at the beginning, we've been hearing a lot about the fact that Tasmania seems to have quite a higher proportion of ADHD genomes, et cetera. We also have a few other health issues that are more common here. What kind of training or how do you communicate those sorts of things within your organisation to really encourage and understand?

Dr JONES - The root causes of ADHD are complex and are still not agreed on at a medical level and the Tasmanian experience is unique. We have a situation now where again, if we speak about childhood numbers, 9 per cent of our school-age children are diagnosed and medicated for ADHD currently. Another 9 per cent are wait-listed for assessment. The highest number globally I could find is 8 per cent of school-age children achieving an ADHD label. I think again that speaks to that inadequacy of supports unfortunately, because if we continue to tie any available support, particularly unfortunately at a school-based level, to whether you have enough symptoms to reach a diagnostic threshold, then funnily enough everyone is going to ascend to that diagnostic threshold and receive that label.

My experience working as a GP with those children, with their families, is that there are a significant number of children at that very high acuity level who really deserve that label and deserve all the supports we can give them. There are also a significant majority of children who are really expressing mild symptoms at best and it's quite hard for us as GPs when we know that school-based supports are really reliant on that diagnosis to achieve. That's why it's also in our submission to consider a decoupling of educational supports for children as they're currently funded from whether the diagnostic label applies, and instead look at some objective measure of how much that child is either thriving or not thriving within the educational environment.

CHAIR - It speaks to the environment and we heard that from other submitters today too. Would you share that view that sometimes it's the class environment, school environment, that's contributing to these diagnoses?

Dr JONES - Definitely. In a way, one of the challenges is because of ADHD being heritable to a degree, we've got a generation of parents who are really struggling and it's very hard to expect their child to thrive if the home situation doesn't support that, hence the consistent push from RACGP to consider what supports we can offer because that's just as important as anything we're doing in the assessment or treatment space, if not more.

Mr BEHRAKIS - You mentioned the hopelessness that some people can feel. Not so much on the ongoing level, but in between and at the moment we've got long wait times to go through that process and that's for people like myself who are lucky enough for the financial aspects not to be an obstacle or a barrier. The feeling of hopelessness that someone can get where you go from the GP and then you hopefully get referred to the right place and then it could be a 10-month wait to get an appointment. It's almost worse knowing but not being able to do anything about it for 10 months than it was not knowing in the first place. You have that feeling of 'I'm just going to live my life in limbo and not be able to do anything for the next 10 months'. It can be psychologically difficult. Is there anything that could be provided in an interim sense? Obviously, we want to reduce those times but in the status quo that we have today, are there supports that can be provided on an interim basis before somebody's able to find that point of actual formal assessment and prescription and whatnot?

Dr JONES - There are certainly opportunities within primary care and general practice within it to provide some of those supports. One of the areas we're exploring as the Royal College of General Practitioners is this idea of recognition of extended skills in that it's not always clear when you access a GP what specific background, interest, skills and training they have. We do recognise that there are significant numbers of GPs who are not currently providing care to ADHD. There are significant numbers who are but we'd really like to formalise credentialing GPs as having evidence that they have that extended skill and that's a process that we hope to complete within the next year or two nationally. That in a way will be a stamp on the door to say if you go and see this person and they are your GP, you'll be able to receive not just access to people who are aware of the condition and what it means, but potentially some of those other support strategies. Biting off as much of the piece as you can. I think that's a good opportunity that we continue to explore and we'll be pushing pretty hard towards.

Mr BEHRAKIS - That would allow someone to say hypothetically, look up like I'm in Hobart. We did hear about some misinformation or misunderstandings or lack of awareness and stigma in the general community around ADHD, but that also exists in the medical professions as well, where some GPs are either cynical, you know, there are multiple different views and people could go to a GP and have a really negative experience or have -

Dr JONES - Which is even more crushing, contributing to that hopelessness.

Mr BEHRAKIS - Correct, that was going to be my question. How do we address that and what do we do about making sure that experience doesn't happen for people? Is that a solution to that?

Dr JONES - In a way that's where the Lived Experience organisation becomes so important. If I can again draw a parallel, if we look at eating disorder support, a lot of GPs do provide eating disorder care, not all do. The Butterfly Foundation is the local organisation to support those families when they're accessing that care. It maintains a list of GPs with specific interest in managing eating disorders and provides that front loaded to people accessing them.

I think in terms of a lived experience organisation for people with concerns about ADHD, there's a tremendous opportunity to maintain that close relationship and make sure they know in their area, there are these psychologists, GPs, social workers, whatever services needed, that are aware, trained and appropriately sensitive to provide the care you need.

CHAIR - Do we have that in Tasmania?

Dr JONES - Not yet, no. There are certainly within healthcare organisations, there are ADHD working groups, there are ADHD professional organisations, you'll be hearing from some of them. We don't have a lived experience body in Australia in the sense that other countries provide.

CHAIR - We note the time. Any further questions?

Ms HADDAD - In terms of that variability of attitudes, I really like what you said about GP's special interest. What's provided at the university level or through continual professional education opportunities for practising GPs to update their knowledge around ADHD?

Dr JONES - As a GP here in Tasmania, we've had at least four, that I can think of, opportunities to attend local or Zoom-based events to upskill in ADHD awareness, support and assessment this year, so there is increasing professional development happening. It's also a little bit hamstrung by that challenge of 'we can provide the support, but the assessment is what a lot of people -

Ms HADDAD - At the university level, is there very much in the undergraduate degree?

Dr JONES - That I'm not aware of. I'm getting too old.

CHAIR - Thank you for the information you shared with us today. We'll finish up there.

Dr JONES - Thank you for your time.

THE WITNESS WITHDREW

The Committee suspended at 3.02 p.m.

The Committee resumed at 3.03 p.m.

CHAIR - Thank you very much for joining the committee today and thank you for the submission that you've made. Before we commence our inquiry, I'd like to ask you each to state your name and the capacity in which you're appearing before the committee.

Mr TICE - Matthew Tice, Chairman, ADHD Australia.

Ms ENDACOTT - Jane Endacott, Vice Chair ADHD Australia.

Ms WEBSTER - Melissa Webster, Chief Executive Officer, ADHD Australia and a person with an ADHD diagnosis.

CHAIR - Thank you. Can I confirm that you've each received and read the guides sent to you by the committee secretary?

Mr MATTHEW TICE, CHAIR, **Ms JANE ENDACOTT**, VICE CHAIR, AND **Ms MELISSA WEBSTER**, CHIEF EXECUTIVE OFFICER, ADHD AUSTRALIA, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED VIA WEBEX

CHAIR - Thank you for joining us. My name is Rebecca White, I'm the Chair of this committee, at the table you should hopefully be able to see the Deputy Chair, Simon Behrakis; and Miriam Beswick, Ella Haddad, Kristie Johnston and Cecily Rosol. We are very pleased to hear from you. Thank you so much for sharing your submission in writing with us too. Before we ask you questions, I'd like to ask if you'd like to make an opening statement at all.

Mr TICE - On behalf of ADHD Australia, I'd like to very much welcome this process on behalf of our community. It's great to see this level of focus on these issues. We're all very pleased to be part of this process, and we're grateful for the support of the committee here and all the people who've submitted. There are a lot of major, important issues that we're going to discuss today as part of our constituency, individuals living with ADHD, their parents, their carers and communities, so we're very open and welcome to working with you to bring these issues to light in this process and to continue the dialogue. Melissa, Jane, is there anything you want to add?

Ms ENDACOTT - No, just to echo that we're really pleased to be able to present ADHD Australia's findings today on behalf of the individuals who have fed back to us that we have reached out to, that they're facing both within Tasmania but also as well nationally. Can you hear me?

CHAIR - Yes, it just cut out very briefly, but it's perfectly fine now.

Ms ENDACOTT - I do apologise. I was just explaining that we in Melbourne have very bad thunderstorms today. I don't know if you've heard of the weather and if I do cut out, I do apologise. I will keep connecting back in, but it is quite significant outside at the moment.

CHAIR - Thank you for explaining that. We appreciate your submission. It's very comprehensive and it's useful to understand from a lived experience perspective some of the specific challenges people are facing trying to access services. I'll open up to the committee to ask questions, and I imagine that the Deputy Chair might have some.

Mr BEHRAKIS - To kick off, we had the Senate inquiry that looked at the issue from a national perspective. They did identify that there were state by state things that need to be done. By your understanding what are the pressure points in Tasmania? Specifically, what can you see as the ways forward out of this, apart from the obvious which is getting more psychiatrists and building that capacity. What do you think needs to change or be improved?

Ms ENDACOTT - You can see from the information, there are many similarities nationally around diagnosis through to challenges through education system in the employment and just access more broadly within the community to a range of different services.

We can clearly see within Tasmania there are distinct differences, particularly around an increased challenge in getting access to services, probably because there's more limitation in those services in Tasmania in comparison to some of the other states like Sydney, for example, or Melbourne, where there are still challenges, but maybe not to the same extent within the school system and also continued through to education.

Yes, there's an obvious getting of a quick fix, I suppose, which is never going to happen, to getting more allied health practitioners, more psychologists and other. That is something that is a long term battle. But, from our perspective, having a national framework, being able to link in nationally to problem solve some of these challenges more broadly is something that will be beneficial, being able to collaborate together to come up with solutions and not doing things in isolation is going to be the way forward. There are some pockets of fantastic things done across different states, really being able to share our ideas and to look more collaboratively at what that could look like to be able to look at the utilisation of shared resources in the best way possible with limited resources that we have.

Mr BEHRAKIS - Thank you. One of the things that we've heard over the course of today is the need for some guidelines for GPs and for psychiatrists. In my experience in talking to people, one person could go to a GP or a psychiatrist who has a particular interest in ADHD and have a really good experience with a lot of wraparound support, or you could go to someone who doesn't, or they have a negative sort of interaction with it. Because you might have a GP or psychiatrist who has some cynicism, to use that word. Different people can have wildly different experiences. Without any sort of guideline about what, where to go and what to expect, people can have a condition where, when untreated, you get poor organisation procrastination, all those things that come with untreated ADHD, and you're leaving them at the moment to figure out the process themselves. If they go to a medical professional who isn't helpful that could be the end of that journey and that could be a really crushing thing for them.

What could be done to try to give that educational or some sort of standardisation or some sort of guideline (a) to the person going through that process, and (b) to people who work in that space?

Ms ENDACOTT - Definitely, there has been some attempts to bring some guidelines together, approve actually specifically looked at guidelines and bringing some information together so people have more of a standardised approach to looking at some of the challenges that individuals face. Obviously, there's still many gaps and continuing to be able to build on and develop more of a standardised approach that people can access as a resource for guidelines is going to be the way forward. Definitely at this moment in time, a lot of the feedback from our community members is that the struggling of knowing where to go, getting accurate information, is really tricky for individuals. Even though there are some standardised guidelines that have been produced more recently and are out there, it's obviously isn't necessarily giving all the the answers that people are wanting and there are still gaps.

Mr TICE - Can I add to that, please?

Ms ENDACOTT - Matt, if you want to add to that.

Mr TICE - I'm sure you're aware that our colleagues at ADPAA have done a lot of work in creating the prescribing guide for healthcare professionals, which goes a long way towards starting that process from a clinical point of view. So that's very welcome. I think ongoing harmonisation of the clinical guidelines are important that do address the different facets of the healthcare system. So that's really important and welcome.

Simon, you mentioned the need also for the flip of that, which is 'how do I, as an individual with ADHD or a parent or a carer or partner, navigate that system?'. That is the other half of that, so that there is some work being done. We are waiting a little bit collectively as an ecosystem to do the work that will bring together the consumer side of that in the context of the ADHD national framework, which is inevitably going to be precipitated out of the national inquiry process, we hope. Okay, so there is that work, but I think that we're really largely focused in this part of the conversation on access to medication and diagnosis.

Access, as Mel pointed out, to standards or guidelines around education are really important in the justice setting. Our vision in the long-term is to be able to extend those guidelines also to support individuals and employment and so forth.

So I think that this really is a multimodal problem that requires a 360 degree approach and the industry, and we're part of that industry, I suppose needs more guidance from government about how best to fund these activities. We have a lot of resources to help build education materials and to develop these guidelines that are sort of queued up to do the work but we are a sector chronically underfunded to achieve these goals.

Mr BEHRAKIS - On the access to medication, we've heard from a few people that Tasmania's prescribing regulations and system is quite onerous or restrictive. We did hear that whilst the majority of prescriptions are authorised by the Pharmaceutical Services Board, there are many cases where they're authorised but with sometimes onerous restrictions: people having to get no more than a week's allowance of medication, or sometimes even having to take the medication on a daily basis in front of the pharmacist.

What impact does that have on people, acknowledging the need to mitigate the risk that does exist with psychostimulant medication but also trying to get the benefit out of them and reducing the risks of other of other factors? Are there better ways to manage those risks rather than putting patients under conditions like that?

Ms ENDACOTT - I could give you an example that has happened recently of an individual who has recently caught up with - I'm going to say a live example of where wanting some guidance. They were going on holiday for a couple of weeks and were only able to get medication which would be prescribed for a week. That individual didn't know how to source a medication because they were going out of the country and their prescribing doctor wouldn't prescribe them with medication and didn't know what to do.

That individual was very concerned with and obviously recommended various different people they could talk to, to try to get additional supports to put forward their case around why they needed their regular medication. What it actually led to is this particular individual felt they had no other alternative but to actually halve their medication so that it lasted them the whole time of their holiday. Basically there was advice by us that was not to happen and that they go back and get some support.

After advocating for them for a significant period of time that support was put in place but it was a huge amount of work through coming to us to seek that support and knowing where to go and directing them to actually get that medication. The outcome of that actually means that people are making poor decisions or decisions that could have significant impact on their health because they're feeling that there is no other option and that's just one example that's recently somebody had come to us to seek some advice on.

So I think in terms of the activities that people do, if they actually can't receive the medication in the way that they need, it places them at risk in some occasions. Also as well, if somebody can't get an appointment immediately with their prescribing doctor that could mean that there's delays in them taking their medication and obviously that has adverse effects on individuals.

We hear of cases where people can't get in with their prescribing doctor in the timeframe that they need to, therefore the impact of that means that they are missed by a couple of days.

In terms of thinking of alternative ways around how to manage this and giving people taking the medication the correct education and the correct tools to be able to have the skill set and have what they need to be able to take it safely. That focus on education, the real focus on giving them the right advice to the individuals to be able to make the right decisions so that medication can be given. People can actually feel that they can take their medication safely and are not making decisions such as these two that I've just given.

Mr TICE - I would like to add to that but that's all right, if you're satisfied with that, we can leave it.

CHAIR - By all means, add to the answer.

Mr TICE - I was going to make the point that these issues that Simon is bringing up are particularly acute for the less advantaged members of our communities. I think that we have to be really wary and understand that not everyone experiences these challenges the same way. Our Aboriginal and Torres Strait Islander communities, remote, rural, lower socioeconomic parts of our community, I think there is a big gap in terms of how our constituents understand this problem and experience it. Certainly, we need to put more resources into this part of the ADHD community.

Ms HADDAD - My name is Ella and I want to thank you as well for your written submission, but also for the trouble that you went to, to survey individual community members. It was interesting to read those individual responses and the key themes that came out from that work. There are a few that I wanted to ask if you could elaborate on a little bit more and one of those is what you identified as a gender bias around diagnosis between either adult men and women or boys and girls in childhood. Is there anything additional to what's in your written submission that you'd like to share with the committee around the differences in diagnosis that you've seen across genders?

Ms WEBSTER - I would not probably say additional. Maybe one comment is that there are now more females as we know being diagnosed with ADHD. The education for the gender differences around females and males is being more known now to psychologists or psychiatrists that are diagnosing. Historically, and a couple of years ago, the information wasn't there. More recently, there is a lot more information coming out, and a lot more research being done in this space. That obviously is making awareness being out there. It is less of a risk as time goes on around females being diagnosed later because there is more awareness now around those gender differences.

Ms HADDAD - Some other evidence that the committee's heard, and you've touched on in your submission, around comorbidities or other conditions that might be more prevalent in those with ADHD. We've heard from a psychologist that often people are being treated for those co-diagnosed conditions like OCD or anxiety or other things without recognising or treating the root because which might be ADHD, and you have touch on that as well. You have identified a misdiagnosis or missed diagnosis while seeking assessment for coexisting conditions.

I wondered if you had any advice for the committee about how we might be able to identify that is happening in Tasmania and advice that we can give for recommendations that we might be able to lead towards. This could be in terms of expanding understanding amongst practitioners around looking to that initial ADHD diagnosis when they're treating people with other conditions that might be present because of the ADHD, but untreated or undiagnosed? Sorry, that's a bit of a rambling question.

Mr TICE - That's fine, we understand the question. I think the first thing the committee should understand is that the majority of ADHD cases have at least one comorbid condition. The default is that there are likely other conditions that need to be diagnosed, it's not unheard of, but it's not unusual for individuals with an ADHD, as you pointed out, to have ASD, ODD or other comorbid conditions. I would say that the advice that we would give is that you should treat this in a way that the default is that people who present with ADHD, in the majority of cases, would have other conditions that need diagnosis and to proceed with that assumption. Because that's essentially what the data tells us that those individuals are experiencing. It's generally a complex, as I said before, multimodal challenge.

Ms WEBSTER - To add to that as well, often what happens when individuals are going for diagnosis and they talk about some of the challenges that may be faced with, the individual themselves, whether it will be psychologists or psychiatrists or whatever, is basically specifically doing an assessment on, for example, ADHD. The advice would actually be to keep it more broad and actually to have a look at doing a range of assessments to see if they could pull out as well any other diagnosis whilst doing that, as opposed to looking particularly into one.

Ms HADDAD - Are you seeing a prevalence of people being treated for those comorbidities but not having their right ADHD recognised? In other words, not necessarily mistreated for anxiety, but perhaps they do have anxiety as well as ADHD, but they're being treated for anxiety or treated for OCD, for example, but their ADHD diagnosis hasn't been recognised or made?

Mr TICE - To understand the question and to answer that, we don't have these statistics in front of us. We can only speak anecdotally that both sides of your question are true for certain members of the community. That is not unusual in terms of the consumer feedback that we get in the research and the work that we do every day with individuals with ADHD. We hear those stories all the time. For the purposes of today's discussion, we don't have the statistics at hand, but we'd be happy to circle back if that's something you'd be interested to explore further.

CHAIR - That would be wonderful if you can do that, please. Thank you so much.

Mr BEHRAKIS - We did hear there was a lot of misconceptions, lack of awareness or stigma in the broader community around ADHD and what it is, how it presents and a lot of that. We also did hear that in some cases there is also a fair amount of that stigma in elements of the medical community. Is that something that you see? Is there a way to navigate through that to ensure that people are getting good outcomes when they're engaging with the health system?

Mr TICE - Simon, stigma is always going to be a challenge and that exists across our society, unfortunately. I will say that compared to a decade ago, or even five years ago, in the pre-COVID world, we are getting a lot more awareness in terms of the mainstreaming of mental health. The autism community has done a tremendous job ploughing the ground ahead of our efforts in ADHD, to build that awareness and overcome some of that stigma. You can see it every day in the schools and other places, but it's patchy. Simon, it is certainly in different parts of the community.

To my earlier point about disadvantaged communities or in different parts of the system, for example, justice is way behind, clinicians is way behind, teachers, employers are even further behind. It really depends where we are but, fundamentally, we have seen a significant shift in awareness. To give you an example, it was two weeks ago, we had our international conference where last year we had some 6000 people join the conference. This year we had 30,000 people join the conference plus or minus. The interests -

Mr BEHRAKIS - There were some great speakers at that conference as well.

Mr TICE - There were some great speakers and thank you for your support on that.

Ms WEBSTER - Actually it was 56,000 in the end, Matt. We got the updated statistics, which I haven't actually let you know yet, but we got that this week.

Mr TICE - It is a great lead indicator that the community is starting to coalesce and organise. When we look at it, there's still a tonne of work to do in terms of overcoming stigma at all levels, but we are making significant progress on a whole number of fronts and there are, tens, hundreds and thousands of people working on this. We are probably 20 per cent of the way where we need to be but five years ago, we were 5 per cent, I think we made a lot of progress and but we need to provide education. We need to enable people on the front lines who are working with individuals in our community to understand what ADHD is all about, train them how to work with individuals with ADHD and help individuals navigate those life journeys in a way that they can be equipped to bring what they have to offer forward in a positive way. A lot of work to be done there and it really is an education challenge.

Ms WEBSTER - To add to that, some of the things that are common themes that often come out and some of the things that were within the conference as well, is that it is a real challenge for many individuals to be able to get a diagnosis now and some may never get one and others may take years. For those individuals who feel that they have got challenges that are impacting their everyday life, there are proactive, positive strategies that individuals can put in place now even if they have or haven't got a diagnosis of ADHD.

Awareness can support that ability to put proactive strategies in place for individuals and it's looking at what are those proactive strategies that individuals can put in place to help them prior to getting a diagnosis. Even if they were to go to try to get a diagnosis later on in life and they don't have an ADHD diagnosis, proactive strategies can still help you to be able to support you with any challenges you may be faced with. They're not going to be a disadvantage. They would only be an advantage for people who are having challenges there and then.

What it could do for those people that are seeking a diagnosis and can't get one straight away, is that it can help them to put some early intervention strategies in place. I think it's looking at what can be put in place as early intervention strategies that could be educated to the wider community to help people to be able to think of some things that can help them prior to getting to that next stage.

Mr BEHRAKIS - I think that segues into a question that I asked the previous presenter. Obviously, we want to focus on reducing the time for when somebody starts seeking assessment and treatment to when they actually receive it. In many cases, it could be many months and the psychological impact of knowing and the waiting is almost worse than before you start that process because you feel like you're in limbo and there's a lot going on there and dwelling on it and whatnot. You talked about those early intervention and other strategies that people can do in that meantime, is there a space - I don't know if you want to say interim supports or stuff - that could be provided while people are in that sort of treading water, waiting in limbo stage? Are there other supports that could be provided for them while they're waiting to see that end goal of a psychiatrist who can assess, prescribe and provide those other supports?

Mr TICE - Can I take this one, Melissa?

Ms WEBSTER - Yes, go for it.

Mr TICE - Simon, that's such a great question, I love that question and let me tell you why. There are two facets to this: one, for most people, navigating the system is opaque to them, so they don't know what to expect. Even just the waiting, there's an assumption that when you enter this process, it's going to be streamlined but because everyone experiences it differently, you never know where you are at in the system. I think there's work to be done there just to help people understand what to expect. It's sort of like if you go into an emergency room, you're waiting and you're very tense and it's very uncomfortable. It's identical for an individual with ADHD, and probably even more so, going through a system that we don't often understand.

That is one side of it. The other side of it is for most people going, that's the beginning of their journey. What I've just described is what to expect from the health system in the medication journey, but I think the education of what to expect in your life journey with ADHD, at that point of interaction is incredibly important. For many people it takes a very long time to start to absorb what this all means and how it's going to help them interact with society and we're just not doing a good enough job at that point where people become aware of their need for diagnosis, so we really have to work that issue.

Mr BEHRAKIS - I think a lot of people have that conception once they start trying to engage in looking for support, the end goal is finding a psychiatrist, getting assessed and getting your meds and then happy days, the sun will shine through the clouds and everything's going to be okay.

Mr TICE - It's just the beginning.

Mr BEHRAKIS - Correct and I suppose the education work that needs to be done so that the individual knows what they could be doing and what they need to seek out and what needs to happen from there and the strategies that they need to build for themselves and all that sort of stuff. I did have another one, but I've lost my train of thought ironically given the topic of the inquiry.

Ms WEBSTER - I think just to add to that as well, some individuals will get the diagnosis and opt for medication, some individuals will choose not to opt for medication, some individuals will have medication and implement some strategies that they might put in place as well to help them to be able to manage their thinking, their processing, help them to be able to manage levels of anxiety and those proactive strategies can be done in advance of any diagnosis. Whilst people go through those processes, it's really thinking about those strategies.

This morning I did a podcast and was talking quite a lot around individuals, particularly females with ADHD, and the benefits of actually walking and being outside and sports. There's a lot of work being done there in research and the positive outcomes, looking at what could be done to support individuals to start thinking about how they can manage some of the challenges they may be faced with if they have an ADHD diagnosis or should they later on be getting an ADHD diagnosis.

Now that doesn't mean that they won't later down the line get the diagnosis and choose medication, but for those people, if they've got to wait a year or two years, it will just be an interim measure to support people in the best way that we can through that education.

CHAIR - Thank you all very much for your time and for the submission that you provided to us too. If we have any further questions, I hope you're happy for us to just reach out and ask.

Ms WEBSTER - Absolutely.

Mr TICE - Certainly. Thank you.

CHAIR - Well, thank you very much. We'll finish up there. I appreciate your time.

Mr TICE - All the best. Good luck with the inquiry and we look forward to hearing how it all turns out. Thanks so much.

THE WITNESSES WITHDREW.

The committee adjourned at 3.36 p.m.