THE HOUSE OF ASSEMBLY GOVERNMENT ADMINISTRATION COMMITTEE B MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART ON FRIDAY, 8 NOVEMBER 2024

INQUIRY INTO THE ASSESSMENT AND TREATMENT OF ADHD AND SUPPORT SERVICES

The committee met at 9.15 a.m.

CHAIR (Mr Behrakis) - Welcome. We have in front of us for the Inquiry into Assessment and Treatment of ADHD and Support Services hearing Professor Nitin Kapur, Dr Theresa Naidoo and Associate Professor Heinrich Weber from the Royal Australian College of Physicians. I might just ask the three of you, as you're appearing via video, to introduce yourselves individually and then I'll get you to read out a declaration.

Dr NAIDOO - My name is Dr Theresa Naidoo. I'm a paediatrician based in Hobart, and Heinrich and I are here together at the RACP, representing the Royal Australasian College of Physicians (RACP) and the interest of paediatricians and paediatric patients.

Associate Prof WEBER - I'm Heinrich Weber. I'm based in north-west Tasmania and we cover the north-west region including west coast. And I'm also here on behalf of the RACP.

Prof KAPUR - Hi all, my name is Nitin Kapur. I'm a respiratory and sleep paediatrician based in Queensland, Brisbane and the current president of the Paediatric and Child Health Division of the RACP.

PROFESSOR NITIN KAPUR, RACP PAEDIATRIC AND CHILD HEALTH DIVISION PRESIDENT, AND PAEDIATRIC RESPIRATORY AND SLEEP PHYSICIAN, **Dr THERESA NAIDOO**, RACP TASMANIAN COMMITTEE CHAIR, AND COMMUNITY AND CHILD HEALTH PAEDIATRICIAN, AND **ASSOCIATE PROFESSOR HEINRICH WEBER**, RACP TASMANIAN COMMITTEE MEMBER, AND PAEDIATRIC RESPIRATORY PHYSICIAN, ROYAL AUSTRALASIAN COLLEGE OF PHYSICIANS (RACP), WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - We have until 10.00 a.m. in this session. Do you guys want to give an opening statement and then we'll go to questions?

Dr NAIDOO - Firstly, thank you for this opportunity to be a part of this important discussion regarding the assessment and treatment of ADHD and support services in Tasmania. As paediatric representatives of the RACP, who are responsible for training all paediatricians across Australia and New Zealand, we hold the overwhelming responsibility for diagnosing, initiating treatment and managing ADHD in the paediatric population. Our specialist training, that encompasses at least six extra years of specialist training in neurodevelopment, ensures that we have evidence-based expertise and a holistic understanding of the complexities within this space for our patients and their families, as well as our colleagues.

Our response to the inquiry is focused on services for children and young people from the point of view of experts who diagnose ADHD and neurodevelopmental conditions in childhood [inaudible] mental health conditions, neurodevelopmental conditions and behavioural problems, including ADHD, are increasingly the major cause of health problems in young people. The leading causes of the burden of disease in children between the ages of five and 14 years are mental health conditions, namely ADHD, autism spectrum disorder, anxiety disorder, conduct disorder and depressive disorders. The only physical illness to be listed in the top five conditions is asthma. That information is from the Australian Institute of Health and Welfare Report 2024.

Children with ADHD commonly have higher rates of specific learning difficulties and oppositional defiant disorder, reflecting the true neurodevelopmental nature of this disorder. What we do know as paediatricians is that mental health conditions are multifactorial in nature and the behavioural presentation can reflect a number of possible underlying diagnoses. Neurodevelopmental trauma, parenting stressors, learning difficulties and other mental health conditions may present with ADHD-like symptoms, and many children will suffer from more than one condition. This is why a detailed medical assessment by someone with appropriate paediatric child health training of children presenting with these behavioural problems such as ADHD is essential to diagnose conditions which can mimic ADHD and the comorbidities of ADHD. And that is one of the key messages that we would like to share with you today, as well as addressing the access barriers for our patients, the workplace shortages and the fact that Tasmania is the only state without a dedicated neurodevelopmental service.

In closing, our key recommendations are - and we hope to impart that, obviously, this is a space that we are very passionate about and could talk about for a long time, but we only have a small amount of time today. So, hopefully this is the start of a conversation. That Tasmania needs a dedicated neurodevelopmental service to improve the current challenges in this area that encompass access barriers for our patients and workforce shortages for our colleagues. And that we need this service to provide multidisciplinary care, which is essential in the neurodevelopmental space that spans not only health, but also education. That provides education to all stakeholders, which includes our general practice colleagues and allied health colleagues, as well as our colleagues within the Education department. But also have an important intersection with our patients to ensure the best care of our patients, and encourage shared-care arrangements to improve efficiency and access of services where possible.

Another part of our recommendations is to address and improve the efficiency and safety of S8 medication prescribing, which contributes to some of the barriers that we face. Thank you very much.

CHAIR - Great. I apologise. There was something I should have read out earlier. Before we go into questions, can I confirm that you have received and read the guide sent to you by the committee secretary? Key points being that parliamentary privilege covers this hearing, allowing witnesses to speak without fear of being sued or questioned in any court or place outside of parliament, and that this protection is not provided to any statements that may be defamatory being repeated or referred by you outside the parliamentary proceedings. And that this hearing is public and media may be present. If you would like parts of your evidence to be heard in private, you may request to the committee at the time.

Associate Prof WEBER - Yes, thanks.

Prof KAPUR - Yes, thank you.

CHAIR - Great. Any questions?

Ms JOHNSTON - Thank you very much for your presentation and your appearance here today, and also your submission. I'm keen to understand a bit more about the experience of wait times, particularly in regional Tasmania, in accessing services. In your submission you talk about significant delays, in the vicinity of two years. I'm particularly interested to know a bit more about the wait times in regional Tasmania.

Associate Prof WEBER - I'll take on notice the exact waiting times, but that is correct that waiting times are excessive and we obviously know the morbidity associated with late diagnosis of ADHD. It's advisable that diagnosis is made early. That is a significant challenge, accessing service, and, more so, accessing supportive services. Because the diagnosis is one part but, in terms of management, you need the support of services such as allied health, and that is significantly lacking and almost absent along the more rural areas such as west coast.

Ms JOHNSTON - Thank you. You made a good point, I think, that the delay in the diagnosis, or having the waitlist for the diagnosis, but then also for accessing support and treatment compounds the wait. What's the kind of length, in your experience, that people are waiting for to go from recognising that they need to see a specialist, to diagnosis and then to actually accessing services in Tasmania? Do you have a rough average of what that might look like in terms of years for a young person?

Associate Prof WEBER - Previously, it could take easily up to two years, but we've introduced a project locally that is now adopted statewide where we ensured a more comprehensive intake process to ensure we have all assessment, all documentation. Because what happened previously was the patient came to the clinic, often with the idea to get medication, but then they had no school reports, no psychometric testing, no psychology or OT assessments, and we had to initiate all those processes and play a coordinating role. And that process took many months. Just to get an appointment with a psychologist or OT is a major stumbling block. We've introduced a process where we coordinate the intake process, which will then assist us in making a diagnosis faster.

Ms JOHNSTON - Does that assist particularly those families, for instance, where English is not their first language? I'm thinking about First Nations families as well. I think you highlighted that in your submission, where navigating all the various services and supports that are available or assessments they need to get done, that coordination process speeds that up for them? Does it make it easier?

Associate Prof WEBER - That's right. I mean, that is a challenge that needs to be addressed as well as to be researched. People's voices need to be heard. I also do clinics at the Aboriginal centres and over there we have people assisting with coordination. Similarly, in the Aboriginal services we also have the issue of accessing supportive services.

Ms HADDAD - My name is Ella Haddad. I'm one of the three members for Clark on this committee. Nice to meet you all. I'm interested in some of the workforce challenges that you've touched on in your introductory statement and in your answers to Kristie's questions. I'd like to know your views on multidisciplinary care and the role that could be played by specialist GPs, or by GPs in general, in being part of a care team. One of the things that the committee has been hearing is the extra pressure on your profession, and on psychiatrists as well, of people who are stably managing their ADHD still having to come back for regular consultations with specialists. This is putting added pressure on the other patients you need to see and on yourselves as clinicians.

Could you talk generally, and you've touched on it in some of your written statements, about multidisciplinary care teams? What the committee might benefit from hearing is how those are working elsewhere and how that might be of benefit to Tasmanians seeking assessment and ongoing treatment for ADHD.

Dr NAIDOO - In other states, there are current models that are of multidisciplinary care that are showing promise of relieving some of these access barriers. That is definitely something that paediatricians on a whole are supportive of. I guess it's within this understanding of, at the moment - I can only speak to the numbers in the south, but we've got about 1500 children under the age of 18 that have been referred to our service and we receive about 200 to 250 new referrals each month. That's just to the public service in the THS in the south.

In private, they're looking at servicing about 450 private referrals because, as this demand has exponentially increased, the process has been that generally it's initiated by the school to say, 'We think this child needs to be put forward for a diagnosis of ADHD'. Then that person goes to their GP and the referral is sent.

One of the really important things that we want to share with the inquiry is that there are many mimickers of ADHD. Having a dedicated neurodevelopmental service may help us to triage and consider the other things that aren't ADHD that equally need to be addressed so that we are providing the appropriate support for these patients and their families.

With the ADHD lens, if we had multidisciplinary care that enabled children to access school-based cognitive assessments, we can then be able to extract the children who need more support with their learning that then may not appear as distracted or hyperactive, because we've actually addressed what's driving those potential mimickers of ADHD. We need clinics that give us access to allied health professionals that can help us collect that information and do those - these are really time-consuming assessments.

I think a really key thing for everyone to understand is that the process of assessment to make a diagnosis of ADHD, it's not a tick box exercise. This is a very nuanced area of medicine. It generally takes about three to six appointments to be able to do justice to that, for that child and their family, and take into consideration all of those other potential diagnosis and the social context, and collect all of that information. The diagnosis itself cannot just be made on a one-off tick box kind of approach. It's really important for us to understand that.

Currently in the south, our general paediatric clinics is where these children are being seen because we don't have a dedicated service. In the future, we hope that there will be a clinic that's jointly run between paediatrics and the child and adolescent mental health service. It should be that paediatricians and psychiatrists share this burden of diagnosis. In Tasmania, because of the long-standing issues with our cam service, this responsibility and burden has been fully shouldered by paediatricians in the paediatric space.

Working together, we see that this is the way forward to access allied health staff and, basically, get to a place where we can weed out the patients that are sorted out and stable that then can be transitioned to their specialist GPs.

Part of that is also needing to provide education to our colleagues so they have a good understanding of what we do as paediatricians and how we view ADHD with a more neuro-affirming lens. I think there's a lot of education that needs to happen in this space for the betterment of our patients.

Ella, your question was fantastic and I feel like I've probably gone off track because there's so much to say in this.

Ms HADDAD - It is. It's been very helpful. Thank you.

Associate Prof WEBER - Perhaps I can just add one sentence. There are number of pilot projects and I think in medicine we aim to provide evidence-based care. I think we should - we are awaiting the results of those pilot studies which could help inform futures strategies.

Ms HADDAD - Theresa, you touched on training. We're hearing that a lot as well on the Committee from other submitters as well, the need for training. You used the term neuro-affirming, which I think is a really positive one.

I'd like to know if you could expand a little bit on who would be best placed to provide that training. Either to specialist GPs or GPs that have an interest in being part of a multidisciplinary team like that. But also, for schools, how we're best placed to support schools better. Who would be best placed to provide that training for them too, in your view?

Dr NAIDOO - Absolutely. I think, as paediatricians, we are very used to collaborating. One of the reasons that this work takes up so much time and one of the other issues in providing this care and attracting people to this workforce is that the current MBS system doesn't really support the intensity of this work. I think you're all getting an understanding that the work I do as a neurodevelopmental paediatrician is vastly different to a paediatrician that, you know, might be working in a different area because there's so much to consider and so much time required for these patients.

In Tasmania, there's less than 100 paediatricians to service. 20 per cent of our population is under the age of 17. We see ourselves as having a key role in rising the tide of understanding amongst our allied health and GP colleagues about the work that we do in the space of neurodevelopment and in particular with ADHD, because we really want people to look at it from the lens it is not just a tick box, black or white, you have ADHD or not. We really need to share our understanding that we've gained through all this extra training and our interactions with our patients that everything that looks like ADHD may not be ADHD. If we truly want to help people and cause no harm, we need to make sure that when we're approaching diagnosis and treatment that we are considering all of those things to be able to support our patients. I think that's why we feel quite strongly that the creation of ADHD-specific services to act as a front door - it won't actually address the complex reasons why the children are actually presenting for assessment.

I think something that we recognise is that, you know, the stress on the education system for teachers to be able to support children in busy classrooms is pushing, it's adding to this demand for a diagnosis. Then, you know, the other systems in place where having a diagnosis attracts funding that is actually taking us away from the core issue and that's how a child functions. So there are children, and adults for that matter, with ADHD who can do amazing things and function very well in society. So we need to make sure that when we're, you know, especially in the diagnostic space, that we're really considered about the other things that might be coming into play.

Where we've got room to move and to shift some of this burden of care is by drawing in our GP and allied health colleagues when we've actually been able to make a diagnosis and support the young person - is then transition those people out of the system to those, you know, more accessible care providers. So that that clears up space for paediatricians to be seeing more children. But at the end of the day, we need more paediatricians and a dedicated neurodevelopmental service to be able to provide that care and that is very complex because it draws in, you know, issues around prescribing and the barriers that it presents.

For example, one thing that's a real sticking point from many of our colleagues is that in Tasmania, the *Poisons Act*, as it is at the moment, only allows one person to be the prescriber and, you know, for example, I might make a diagnosis, get the child started on medication, they might be doing really well and I transitioned their care to their GP, who then applies for an authority to prescribe. But that then removes my authority. So should that child ever need to come back to me because, you know, something happens in their care and it becomes too complex for the GP to manage because they don't have the experience with these medications, I then have to go through the lengthy process and thereby pass that on to my patient an additional weight to reapply for their authority. So there are inefficiencies in the system that we need to consider and that we need to address, you know, when you're considering what legislation might help to improve this.

I know in the submissions that have been put forward people have named up, you know, not only issues with the efficiency of S8 prescribing as it stands with the Pharmaceutical Services Branch, but also, you know, newer things like TasScript and the additional time and barriers that it puts forward because that translates to children having to wait longer for the management and the care that they require.

Ms HADDAD - Thank you. I don't want to hog all the questions. I've got questions about PSB too, but I won't ask those now. We'll see if we get time to come back. But just when you're applying, I wanted to quickly ask, when you're applying for that authority to prescribe, roughly how long does that process alone take?

Dr NAIDOO - So it has gotten better. You know, five years ago, sometimes it was three to four weeks and obviously that is also an additional burden on our pharmacy colleagues who have to go through all of those applications and cross reference things and balance safety. Now, I think, in the best-case scenario, it's around two weeks if I need to access something urgently. I think we've learned how to be really good advocates for our patients and if there's an urgent situation, I will pick up the phone and advocate for my patient. But that takes time and I think if we take anything out of today, it's really that the complexity of the space that we work in neurodevelopment, this is time consuming work. So whatever we can do to make sure that we've got people as part of our team to collect that information to remove barriers leaves paediatricians more time to do their jobs and that's seeing children and making sure that we're considering things in a really holistic way.

CHAIR - Just going off the back of one of Ella's questions, we've just heard from you about the need for more training and more resources and that there's designated neurodevelopmental unit. Pulling back and Ella did touch on this in her questions about training for teachers and people in the education side of things.

Yes, we need to focus and I appreciate the point that there's a lot of things like you said that mimic ADHD and those that's probably more for your colleagues to obviously determine what's what and making sure that people are getting appropriate assessments and appropriate treatments but under the status quo, do you think that the education system teaches and parents are equipped to even identify when kids need to be referred to a paediatrician for an assessment in the first place before it gets to the point where the kid is at crisis point and we need to - there's something quote unquote, something wrong with him and we need to fix a serious problem?

One of the things that a lot of people with ADHD are, and kids with ADHD are good at, is masking the symptoms of ADHD. Like, are teachers appropriately equipped today, in being able to identify these things to get looked at before they become a serious problem?

Dr NAIDOO - Teachers are a great resource. Apart from parents, they spend a significant amount of time with our children. I think where the area becomes difficult is they're not experts in neurodevelopment from a paediatric understanding, per se, but they do have other skills that I think that we can definitely draw on and a collaborative approach to supporting children is really important because I think everyone's got something really useful to bring to the table, be it the child's GP and be it the school teacher, the learning support staff at the school.

So it's really about making the most of those people. But part of that is making sure that they have a good understanding of what ADHD is and I think we're in a space at the moment where ADHD has a better awareness these days than it has in the past, but there's still a lot of stigma attached to it. So I think paediatricians have a really important role in being able to reset some of that understanding and hopefully disassemble some of those old ideas that are really negative and I think we've got a really big role to play in making sure that what we move forward to is a more neuro affirming approach.

I know that my colleagues who are working in the Kids Care clinics, which are really focused on particularly vulnerable children in out-of-home care, they're actually going into schools with psychology colleagues because they have been able to get funding for a multidisciplinary team but it is only focused on children in out-of-home care, so excluding all the other children that still might have neurodevelopmental concerns but don't meet the cut for being in out-of-home care and they're actually helping our teachers and support staff understand what some of the behaviours that we're seeing in children who are having challenging behaviours may be driven by, and I think that can only be a good thing. I hope that we reach a point in Tasmania where we have the paediatric workforce to be able to, you know, not be super-saturated with having 1500 kids to see and barely any time to do it, but actually be able to help our colleagues and not be so siloed.

I'll pass on to Heinrich, because he has a wealth of experience to share, as well, in that space - working together across institutions, across our different medical and allied health colleagues - that can only be a good thing. If we can change one person's mind about what ADHD means, or the other things they need to be considering and looking out for, then we're helping the children who not only have ADHD but one of several other possible diagnoses that before might've not even been considered.

CHAIR - In a perfect world, if you had the adequate resources - you know, I remember when I was in school, a team came around to the schools and gave everybody seeing tests, optical tests, and that's how I discovered that I needed glasses in grade 6. Is that something where, in a perfect world, you'd go through a school and talk to students and say, 'Look, maybe these kids need to come and see us'? Having some sort of early capture of people, before they reach that point where they're seen as the lazy kid, or the disruptive kid, or the kid that - not to use that truism - but, you know, the 'really bright, if only he applied himself'. Then years down the track, it's a moral issue of that person just not being motivated enough.

With adequate resourcing, is this something that could be done through a proactive mechanism, rather than waiting for kids to present to you guys with an issue?

Dr NAIDOO - Absolutely.

Associate Prof WEBER - The Australian National ADHD evidence-based guidelines actively discourage routine screening, and they actually suggest screening in high-risk groups - kids with other learning problems, kids with epilepsy, kids with other neurodevelopmental problems. They are actually not in favour of just the routine screening.

Dr NAIDOO - Yes. I think one thing that would be helpful is better access to school-based cognitive assessments for children. That enables us to collect that information that, when you do get your spot with a paediatrician, if you come with an assessment that's been completed by a school psychologist that gives us a good understanding of where your cognition's at, where your challenges lie, where you're functioning compared to what you're capable of. That's really powerful information for educators, for medical practitioners.

It's also really important for us being able to empower our patients and their families. So many of the patients who we see come to us with anxiety and depression around the fact that their self-esteem is so poor because they've been made to feel like they're the problem their whole life. They cause problems for their family, they cause problems for their school. The reason why we're so passionate about this area is that we really have the chance to change the trajectory for many children by giving them the tools to understand that there are parts of their ADHD that are amazing strengths. It's just that everything is so deficit-based at the moment; it's a really negative mindset for children.

Associate Prof WEBER - One thing to add to that is, I think, one of the fears is also that you may attach a label to a child who may meet all the diagnostic criteria, but may be functioning quite fine.

Dr NAIDOO - Absolutely.

CHAIR - I know parents who have that. Like, I'll worry that my kid's got similar things to what you've spoken about, talking to me, but I don't want them to be somebody with ADHD and have that. There is a bit of a fear around that. What you've just said is a really important thing - I think there is a lot of that deficit mentality. I don't want to take up too much time, because we only have a little bit left and I could ask an hour's worth of questions, on my own, about this. Just before, then I'll pass back over.

One of the things that I've heard - in some of the submissions, and I've heard it a lot from people talking to me personally - are people that have had their children diagnosed with ADHD, then they've had either the kid's school tell them 'we're not equipped to look after your kid anymore' or they have a hard time getting their kids into schools. Is that an issue, or are these minor circumstances? Is that something that you guys see, where once the kid's diagnosed, the education system is sort of telling them they're not equipped to look after them?

Dr NAIDOO - In my experience, I have not found that in particular. I will preface that by letting you know that in my role as a neurodevelopment paediatrician, a huge part of what I do every day is speak to schools and liaise with schools, conduct complex care meetings for my patients, so that I can provide that one-to-one individual education about that child, advocate for that child.

For the most part, I have found learning support staff and teachers to be supportive and wanting to do the best for the child. The thing that they are lacking in is resources to be able to provide that. Not every school has access to a school psychologist. Pretty much all of the schools - and I can only really speak to the south because that's where I work - share one psychologist between many schools.

As you can see, as the demand has exponentially increased, the lack of other support resources in school means that there's this push to go to your GP, get a referral to a paediatrician, and people think that the diagnosis of ADHD is going to be the magical cure because of the medicine. The reality is, medication is only one part of the solution, and it's not for everyone. I could probably speak for another hour about medication itself.

This is a complex problem that requires behavioural strategies and supports that are non-pharmacological as well. It involves us recognising that there's many pieces to this puzzle if we want to do this well and we want to do the best for our patients. We have to really think about drawing in on all the strengths of people that can contribute to children's wellbeing, and make sure that we can streamline and make this process more efficient for everyone involved.

CHAIR - Great. Did Ms Rosol or Mr Wood have any questions?

Ms ROSOL - I have a question. Hello, I'm Cecily Rosol, member for Bass. Just a question around the PBS, where you say in your submission there's a comment around the transparency of the PBS and decisions that are made there around permissions being given, or approval being given. How often do you find that approvals aren't given, and what kind of access are you given to information about the decision-making processes there? Can you comment on that, please?

Dr NAIDOO - In my experience, I'm given very little information about why conditions might be applied to an authority that I am granted for a patient.

For example, I recently had a family where the older child had been diagnosed with ADHD a year ago, and I was granted an unconditional authority to prescribe. In the time between seeing the oldest child and the two years for the parents and the school to recognise that similar traits were being seen in the younger child, the father of the child had also been diagnosed with ADHD. This meant that the Pharmaceutical Services branch then had access to his information, which showed that he had a driving under the influence condition placed on him. When it came to accessing medication for the younger child, what came back to me was an authority that was conditional based on the facts of the father having access to that child's medication. I was only privileged to that information because the father was able to share that with me. It wasn't something that was provided to me.

I guess, for a number of families, paediatricians are very - we want to do the best for our patients. I feel like, often, I have to do things that go above and beyond. Sometimes I will ring a school and say, 'This child really needs this medication. What can we do to make sure that they get their medication at school every day?'. But that involves phone calls and emails and other safety measures to make sure that we can get the medication delivered from the pharmacy to the school so the school can administer it. It doesn't take into account what happens during the holidays.

I think more thought and more discussion needs to be had around the complexities around prescribing in the current rules. Probably, one thing that we can do to really move forward in that pharmacological space is go back and have a look at section 59E of the *Poisons Act* and our Schedule 8 psychostimulants in Tasmania so that we can come up with a set of guidelines that - once someone's been appropriately diagnosed by a qualified specialist and, at the moment, that only is paediatrician, psychiatrists, sleep physicians, and neurologists, in the more adult space - that we can simplify our prescribing rules so that the paediatrician and the general practitioner can hold concurrent authority.

Using the systems that we've got in place, like, for example, TasScript, we've been advised that the pharmacist can't actually see what conditions have been imposed by the PSB. I think we can - we don't need to reinvent the wheel. We just need to use what we've got in a smarter way to give the people who need access to information the information, and, at the core of it, not cut children out of the treatments that they may require. Bearing in mind that not all children need to be on medication for ADHD for the rest of their lives. Often, medication is used as a circuit breaker so that they can engage with the non-pharmacological behavioural strategies. That's equally as important.

Uknown speaker - You had other questions about the PSB, Ella.

Ms HADDAD - I think you've covered it pretty succinctly. There are only a few minutes to go, but I had similar questions to Cecily. Happy to move on to other questions.

CHAIR - I had one. Another thing that's been raised with me has been paediatric patients, especially in the public system. Once they hit age, a lot of people feel that they're kind of just left for dead. If they don't have private insurance then they do almost feel like they're left for dead.

Even if they don't, it's cool, you're an adult now, figure it out. There isn't a supported sort of transition from being a kid treated under a paediatrician to being an adult. It's kind of just, 'The paediatric system doesn't treat you anymore. Off you go, figure it out.' Is that something that needs to be looked at as well?

Associate Prof WEBER - That scenario is unfortunately true. That is a huge, huge problem. Once they've reached the age of 18, we can't continue with treatment. The only other specialist then that could become involved is a psychiatrist who, often, are not keen to get involved. Patients struggle to get appointments. The GP is essentially stuck with this patient. Especially trying to access the stimulant medication, it is a significant problem.

Dr NAIDOO - Absolutely. I think one of the things on our wish lists would be for there to be transition clinics or plans for transition because we've invested our time and our care into these patients and, knowing that there isn't somewhere for them to transition to is really, really hard. So, a lot of work needs to be done in the transition space to support young adults and GPs who are now having to assume those responsibilities for prescribing, despite the fact that they don't have the dedicated training that paediatricians and psychiatrists do. It's essentially evolved to that space because psychiatrists have not wanted to touch the remit of ADHD in the child space and that flows on to then adults, at psychiatrists, not wanting to continue that on, but we as paediatricians are limited to the under-18 space. So we hope to provide advocacy for those of our patients who are transitioning to adulthood.

Associate Prof WEBER - This is compounded by a shortage of psychiatrists, too.

Mr BEHRAKIS - What would those transition programs look like? Because we're looking at people who, just by definition of the condition, without ongoing support, are the people who have a hard time, then, it's like, 'Go figure it out'. It's like, 'Well, you need to figure out who's the GP or the right specialist to contact.' Actually taking the time and not procrastinating on doing all those things and figuring it out on their own, when up until that point, they've been a kid who's probably had their parents and paediatricians and all that doing all that administration for them because they've been kids. 'Now you're an adult, figure it out - book your appointments, figure it all out on your own'. It's sort of specifically difficult for those people without, when they find themselves in a position where they're not receiving support anymore.

Associate Prof WEBER - So in the north-west we thought about the issue. We had discussions with the GP liaison officer and one of the things that the GPs complain about, they get a patient arriving on their doorstep at the age of 18 who they have not seen for a decade, and they're just supposed to take over management. So, what we've started doing for patients who are stable, we start transitioning much earlier and also throughout the process we try to co-manage with GPs, so they remain involved with the care of the patient.

Mr BEHRAKIS - So, sort of a soft transition before that?

Associate Prof WEBER - That is right.

Mr BEHRAKIS - Did anyone else have any pressing questions because we are at time now? Look, in that case, thank you for your contribution. I could ask another couple of hours' worth of questions on my own about this. But look, thank you for your appearance. Your evidence today is protected by a parliamentary privilege, once you leave I remind you that privilege does not attach to comments you make to anyone, including the media, even if you are just repeating what you said here today. Do you guys understand that?

Dr NAIDOO - We do.

Mr BEHRAKIS - Thanks again. That's been really informative, really helpful, and thanks for all your work.

Dr NADIOO - Thank you for your time and hearing us.

THE WITNESSES WITHDREW.

The committee suspended at 10.04 a.m.

The committee resumed at 10.15 a.m.

CHAIR - The time being 10.15, we have the Australian Psychological Society. Can you please state your name and the capacity in which you're appearing before the committee?

Mr DAVERN - Sure. My full name is Timothy James Davern. The capacity in which I appear is as a senior policy adviser with the Australian Psychological Society, or the APS as I'll refer to it.

It might also be worth noting that I am actually also a registered psychologist. As well as working at the APS part time, I also do work in a clinical practice.

CHAIR - Can I confirm that you have received and read the guide sent to you by the committee secretary? The key points being parliamentary privilege covers this hearing allowing witnesses to speak without fear of being sued or questioned in any court or place out of parliament. This protection is not provided to any statements that may be defamatory being repeated or referred to by you outside the parliamentary proceedings. This hearing is public and media may be present. If you would like your evidence to be heard in private, you must make a request to the committee at the time. Have you been provided with that information?

Mr DAVERN - Yes, I have.

Mr TIMOTHY DAVERN, SENIOR POLICY ADVISER, AUSTRALIAN PSYCHOLOGICAL SOCIETY, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED via TEAMS

CHAIR - Did you want to give an opening statement before we go into questions?

Mr DAVERN - Yes. To start with, I'd like to just thank the committee for inviting the APS to provide further information at this hearing. We very much welcome the opportunity to do so.

I also want to note that I am dialling in from Victoria, which is where I'm located. A lot of the Tasmanian-specific information provided by the APS in the submission is actually from APS members who either reside in or have past experience practising in Tasmania.

The APS submission did highlight several key issues, so I won't go through them, but to touch on the ones that we see as important very briefly. There are obviously multiple avenues to which individuals can access an ADHD assessment: your paediatrician, psychiatrist, psychologist - all able to provide assessment and diagnosis. Each profession and professional may go about the assessment process slightly differently.

I want to highlight the importance of ADHD being assessed and diagnosed accurately. It's critical because more than two-thirds of individuals with ADHD have and do experience some sort of comorbid mental health or learning condition, so it really is important that the diagnosis and assessment process can accurately disentangle the presenting issues.

A major challenge and key theme in ADHD assessment is the significant time and financial costs involved for clients. They're often required to attend multiple appointments for the assessment alone. Then, if a diagnosis is made, they may need to attend additional appointments, you know, either with a psychologist, psychiatrist or paediatrician for treatment.

The key issue with the process and access, as it relates to the profession of psychology, is the shortage of psychologists available to actually conduct ADHD assessments and then provide ongoing support. It leads to lengthy wait times to access assessments. That shortage is evident not just in Tasmania - it's an issue across the entire country.

Also, just quickly, because ADHD assessments are not specifically funded by Medicare, it does appear to create a bit of a gap - or a significant gap I should say - in the connection between assessment and treatment under the Medicare Benefits Schedule, the MBS.

Our submission, as you've read, also highlighted a variety of other issues within schools, educational systems, your workplace and the justice system. We see opportunities for addressing many of the challenges are through improved access, coordinated care, and enhanced workforce development. They're the areas we see as essential to improve to ensure that individuals with ADHD can receive the support that they need. I'll stop there, and obviously happy to take any questions from the committee about the APS submission and the terms of reference more broadly.

Ms HADDAD - Hi Tim, my name is Ella Haddad. I'm a member for Clark. In your written submission, and thank you for a very comprehensive submission, you touch on the collaboration between psychologists, psychiatrists and paediatricians, and that your members are - I'm reading into it now, but potentially feeling frustration around people not accepting the reports and the work done by psychologists when it comes to diagnosis. Could you expand on that a little bit and provide the committee with any advice you deem useful on how we might make recommendations around improving that situation for psychologists making those initial assessments?

Mr DAVERN - Yes, certainly. That's an issue that we find not only in Tasmania but nationwide as well. Just as way of background, a psychologist can undertake an assessment and the diagnosis process. However, the client, if diagnosed with ADHD, will often then be required to go back to a GP for a referral to a psychiatrist or paediatrician for the prescription of medication and ongoing management of the condition, with psychostimulant medication usually being the first-line treatment to address the symptoms. So, what seems to be happening here - and this can happen, obviously, for children and adults as well - feedback from APS members are reporting a shift in the relationship between paediatricians and psychiatrists; it appears to be around increased caution around ADHD diagnosis, perhaps due to concerns over overdiagnosis or misdiagnosis. I certainly have heard stories myself of psychologists providing an assessment and a diagnosis but then the paediatrician disagreeing with that. So, then, for example, wanting to redo that assessment to try to ensure that the diagnosis is accurate. Even when clients present with detailed assessment reports from psychologists, often psychiatrists and whatnot do require their own lengthy assessments.

On that as well, one of the key issues around that is it just increases the cost and delaying the treatment, and that person then requiring and having to deal with ongoing functional difficulties in whatever setting that is, whether that be in schools or the workplace. Delays up to six to 12 months.

So, I think in some way, shape or form, collaboration needs to be improved between the psychiatrists, paediatricians and the psychologists to help reduce these barriers. I probably don't have all the answers about what that could potentially look like, but yes, it definitely, the issue, and I think what needs to be addressed is the collaboration somehow needs to be improved. Not just with the professions as a whole, but also within the professions and between them, and the individuals as well.

Ms HADDAD - Would you say it's in the majority of cases that the initial assessment by a psychologist is dismissed or pushed back on by the other professions? Is it a frequent thing or is it a bit less frequent depending on the complexity of a diagnosis?

Mr DAVERN - I don't have any data to really support one way or another how frequently this is occurring. What I can say is that I do hear it happening quite a lot, not just through members I deal with in the APS but also in my own clinical practice as well. It does appear to be happening with increasing frequency that we're starting to see it, to the point that what I hear as well is, again, through both members and at my own clinical practice, is that some psychologists are actually not even bothering to then actually undertake an assessment themselves with a client, but just kind of saying 'just go straight to the paediatrician or the psychiatrist for the assessment' because of those issues that I raise in terms of, they could go through and spend thousands of dollars with the psychologist and then have to go through the exact same thing. I just don't think that's very efficient. It's almost unethical to some extent.

That is an issue, but then the issues get even deeper there because we do also think and I do actually believe it really is important for a psychologist to be involved in the assessment process. Psychologists are very experienced with the ability to accurately assess, formulate, determine the appropriateness of a diagnosis, develop a treatment plan and take in all the things that need to be taken into when providing an ADHD assessment within that client's or individual's broader content environment, again, whether that be school, family or cultural factors, all the different things that really need to be considered. I think it's definitely an issue.

Ms JOHNSTON - Touching on some of those financial barriers that you talked about there, in your submission, you refer to some limitations with the medical benefits schedule in terms of accessing appointments where the carer or the parents might want to be participating in learning about better supports for the young person, but those two sessions are included in the 10 sessions. In your experience, is that meaning that families aren't accessing those two appointments because they prefer the 10 full to be used for the child or that they're simply not providing those important critical support appointments? As a financial barrier, are they having to pay for that in addition to it?

Mr DAVERN - Yes. I think it's probably more an issue around having an appropriate pathway for referral, assessment and intervention around the assessment for ADHD. Currently, there doesn't appear to be any specific items that can be accessed through the MBS for ADHD assessment. ADHD intervention may be accessed and partly funded under the 10 sessions of psychological services that are available, but as I said, it's our understanding that the assessment of ADHD isn't specifically recognised or funded, so it's probably tapping more into this issue that there appears to be a significant gap and disconnect between assessment and intervention for ADHD within the MBS.

I do believe that perhaps some psychologists may bill for assessment under the existing MBS items with the justification that providing the assessment for ADHD, identifying reasons for presenting problems and whatnot is a part of providing psychological services and treatment. It becomes an issue because following an evidence-based and best-practice assessment process for ADHD is likely to be about maybe three to four sessions for a standard assessment, depending on the complexities, and that sort of eats into those sessions. Ideally there would be separate MBS items for ADHD assessments for psychologists, psychiatrists and paediatricians to access as well, which would enable the assessments to be directly undertaken with a subsidy to the client under one sort of banner and area where then, if a diagnosis is provided and non-pharmacological treatment is considered appropriate, then a referral could be made under their mental health treatment plan to access the 10 sessions.

I think that would probably be an ideal state from that perspective. But the issue with the carer and the parent MBS items is again, sometimes those items can get chewed up and used when the client might be able to use them for something else.

Ms JOHNSTON - Thank you.

Mr DAVERN - I don't know if that answers your question, sorry.

Ms JOHNSTON - That does. Thank you very much.

CHAIR - Some of what you said a moment ago pretty much exactly describes my experience going through the system to the point where as you were speaking, I pulled up a letter that I'd received from my psychologist and I only raise this because going off Kristie's question and you made some comments about the need for the pathways of assessment and support, is there enough education or material available to the everyday person that might be wanting to seek assessment and treatment? It seems everyone, from my own experience, talking to other people, everyone's got a completely different experience in navigating. Some have had very good, some have had more difficulties than me. They've gone through different channels. People have just sort of had to figure it out.

I called up a clinic and was told we can't see you without a referral from a GP. I went to the GP and the GP told me that they thought that I might have an iron deficiency and then eventually referred me to a clinic who told me, 'We're psychologists, we can assess you, but you need to go to a psychiatrist as well'. So rather than go through this whole process, like you said, and cost thousands dollars, you know, they wrote a letter where they said rather than doubling up on assessments and consults, he needs to go see a psychiatrist, and then going back to a GP and then waiting. That doesn't even include all the months of waiting for those appointments. Is there a need for some sort of material or education or something that someone can say, 'Look, I think I might have ADHD. This is what you need to do.' Even as far as me going to a psychologist and them asking 'where's your mental healthcare plan' and me going 'well, no-one told me I needed one of those', there is no 'the first step is talk to these people and then these are the places you need to go there'. It's almost like everyone's got different experiences based on how they approach things.

Mr DAVERN - Your experience there does happen quite a lot in these sort of situations and, again, this is one of the issues raised from the outset in terms of the different pathways, because different professions and different individuals within those professions have different ways of recommendations and things like that in terms of how to go about it. It would be useful to have some sort of best-practice pathway to access.

The issue is what does that look like because, again, all the different professions may have different ideas about what that would particularly look like and the best pathway around that. I certainly hear it through some clients where the GP might have said 'come to a psychologist for the assessment' or some clients come in and say, 'oh, you know, I'm already booked into the psychiatrist for an assessment'. So, well, we could do that here, and you have that discussion with them.

I think one of the issues at the moment is that there is seemingly a vast amount of information resources that's available online at the moment; there's probably almost too much. Particularly with ADHD being such a growing area, there's a lot of misinformation that appears to be floating around the social media channels, TikTok, and this and that, and people get influenced by this as well and then might go off on a separate pathway based on what they hear through those avenues.

To briefly answer your question, I think ideally, yes, if there was a one particular way to say this is how it should look in terms of if you think you need an assessment, follow this pathway, that would be great. Where that information would sit, who would develop it, obviously if that was to happen, APS would love to be involved. But then implementing it as well, I think, is a separate conversation around that as well. So it is an interesting area.

CHAIR - Is that something where, you know, perhaps government - I don't know if we'll be talking state or federal here - the entity that is government. But is that something where you say the psychologist, paediatricians, GPs and psychiatrists might all have different views on how that process should work? Is that where a government body should be the ones to take all these things on board, consult with all the relevant groups and then work out, 'okay, this is the cheat-sheet' or 'this is the sort of government-encouraged pathway'?

At the end of the day, we're talking about people who, without the support that they're currently in the process of looking for, have a hard time navigating the bureaucracies and organisations, you know, and administrations and, you know, all that sort of stuff is the stuff, you know. It's kind of half the reason why we're looking for help in the first place.

So, navigating these systems without, you know, at the very least, you know, do this, do this, do this, is particularly difficult. Would it be best that someone can just go on Google and the first thing that pops up is Tasmanian Health Service? - 'Do you think you have ADHD? Call this number' or 'call your GP and ask about X, Y or Z', you know, like they're having some sort of FAQ sheet provided by government. Then that way you can kind of balance and manage all the different stakeholder opinions on what that should look like.

Mr DAVERN - Absolutely. I think that's a good idea to go through that process. And obviously, as you say, there would need to be someone to coordinate all the incoming information around that sort of consultation. I think that definitely could have some usefulness.

To extend on that, there could also be other opportunities there as well to try to improve the efficiency of the process.

So, just thinking out loud, like are there opportunities there to rather than, for example, you know, again just sort of think it out loud, a psychologist referring back to a GP, who needs to refer onto a psychiatrist or a paediatrician, could the psychologist refer directly to a paediatrician or a psychiatrist? Does the psychiatrist, knowing how hard it is and a paediatrician to get into them, do they need to be the ones to prescribe? Can that be prescribed through the GP in the first instance if that diagnosis is provided? So, I think there are opportunities that could be explored which could actually then potentially improve the efficiency of the process as well as explain the process. Obviously, that would take all those professions to be on board with what that looks like as well. So, I think that could be an interesting piece of work but a useful one.

CHAIR - Last question before I try to avoid hogging it too much because I could ask hours' worth of questions on my own. You did touch on the question I was going to ask. So, does it need to be that psychiatrists are the only ones who can prescribe? But, even if we look at it under the current paradigm, the status quo, where psychiatrists are, we've heard through submissions and through witnesses and I've heard myself that the best practice isn't just pharmacological support. It's that as well as therapy and psychological support as a package of support. However, currently there is the perception that the be-all and end-all is getting those Schedule 8 drugs, stimulants; that's sort of what the perception is at the very least. It's all about getting to a psychiatrist and getting the prescriptions. Yes, that is a big part of it, it's not the entire package of support that people need. But, speaking from my own experience and of others, my psychologist said, 'Yes, you've got ADHD, but I can't prescribe you. So, we're going to refer you back through to get a consult with a psychiatrist'. That can take, like as has been said, six to 12 months just to get that first appointment.

In between that, when people are in that limbo stage, like psychologically, is there any risk of without having interim support? And maybe that's through psychologists, in the meantime, before they get that prescription that they're waiting for, that they fall in - people have - is there a risk of psychological harm, say, of people having that 'I'm in limbo now, I know I've got a problem, and I can't fix it until I get this appointment that might be six months away, it might be a year away, so I'm just going to tread water for a year, and everything that's going wrong, I can't do anything about'.

It was a difficult time for myself, but I'm sure there are things that can be done - best practice - in the meantime, while people are waiting for that. Because, I almost felt worse off in that year than I did before I'd started the process of looking into ADHD, because before that, that's just how it was. But then you had this - you've got this problem and you can't do anything about it until you get that appointment. Is there a better way of going about that, even under the status quo of the psychiatrist being the only one who can prescribe?

Apologies for the long-winded sort of rant of a question.

Mr DAVERN - You don't need to apologise to me; that's perfectly fine.

I think that the issue that you raised is one that occurs in reality, and again, we sort of see this quite a lot - a diagnosis of any kind can have a major impact on a person, and without being able to attain the proper treatment for whatever that particular condition is, they're likely to experience ongoing issues in important areas of functioning, whether that be academic work, social, whatever that issue is. So, you're correct in that - the best practice guidelines - and I'll just sort of pull up something here - I just want to read out of the guidelines. I think it's page 94.

This is a quick paragraph here that talks about best practice treatment considering both pharmacological and non-pharmacological interventions. This states:

> Pharmacological treatment was more effective than non-pharmacological treatment in reducing core ADHD symptoms. Combined pharmacological and non-pharmacological treatment was better than either alone. Each mode was more effective than the other in targeting specific aspects of ADHD. Pharmacological treatment was more effective for reducing core ADHD symptoms, and non-pharmacological treatments were more effective in improving functional outcomes for people with ADHD.

The point of that is that combined treatment would be best practice, not just medication alone. So, absolutely, if someone is linked into a psychologist, undertaken that assessment, is able to get ongoing treatment and appointments whilst waiting for access to a psychiatrist to actually get the medication and the pharmacological treatment side of things, undertaking ongoing psychological intervention would also be quite useful and aligns with best practice.

Ms HADDAD - Thanks, Tim. In your written submission, you also - well, it's come up a lot in this committee so far, workforce shortages and challenges generally. I know there are a number of psychologists who don't necessarily practise in this field, and you've mentioned that there's some federal government funding to try to grow that workforce, but I just wondered what the barriers are to psychologists wanting to specialise or to work specifically with ADHD diagnoses, and what we might be able to learn around those barriers to try to help break them down and encourage and increase in psychologists working in this area? Existing psychologists, I guess.

Mr DAVERN - Existing psychologists? Yes. In terms of existing psychologists, I wouldn't be too sure exactly why the psychologist would not want to be undertaking this work. I think a lot that I'm familiar with are undertaken - it does require specific competence in terms of actually being able to assess and diagnose and to have undertaken, I guess, specific training to know and be confident and competent in doing it.

For us, in terms of the workforce shortage, one of the biggest issues that we actually do seem to be experiencing, and our information shows that the current psychology workforce is only meeting about 35 per cent of the national demand for psychologists broadly and generally. Yes, there has been some recent funding to improve that and to look at that. It does look like it'll be more of a long-term option. But that is where we see the opportunities to actually improve this area because the current university policy and funding structures really do fail to actually adequately recognise the importance of training future cohorts of psychologists to meet the growing demand. The current funding levels are insufficient to really cover the costs of psychology training.

And due to these funding constraints, what we've actually seen is the closure of quite a lot of psychology courses in Australian universities, particularly over the last five years. Postgraduate programs in what we in 'Psychology Land' refer to as areas of practice endorsement, so they're your more specialised areas of psychology where there might be forensic psychologists, educational development psychologists, counselling psychologists. There are a lot of different, eight specific areas of practice endorsement. Where they were once offered at 15 universities, they're no longer available, really, aside from the clinical psychology programs. Clinical psychology is still a thing. These eight other areas of practice endorsement are now offered at fewer than five universities around Australia. That's really significantly reduced the number of future psychologists trained in these particular areas, including being capable of undertaking these assessments. As a result, these universities can only actually accept a limited number of students, which really narrows the training pipeline.

This is quite interesting, given the high demand for psychologists in the community. And not only that: there's such a strong interest from people wanting to be psychologists. So many people want to be a psychologist and want to go through this process. They can get into the undergrad and do their degree, but then the pipeline and this bottleneck starts occurring when we get into the fourth year and then the master's programs, where very, very few people can get into it. That really does create an issue there.

Another issue relating to what you're talking about as well is the lack of supervision and lack of supervisors. Supervision is one of the essential components of a psychologist's training. And, again, there's a situation where the demand for supervisors is exceeding the supply of supervisors. That's another area that the APS was able to recently secure some funding, to train a couple of hundred supervisors to improve this area.

It's sort of around those areas that we see are the main areas that need to be addressed in terms of the workforce shortages. There needs to be more opportunities for people to train, more supervisors to oversee the training and more funding through the university system.

Ms HADDAD - Thank you. That's really useful information for us to hear. As far as those master's programs - and you described it well as a bottleneck - it's easy to get into undergrad, but then the master's specialty programs, you said a lot of universities aren't offering that any more. Why is that when there's such a high demand? Are there barriers in the higher education sector as to why universities have pulled out of providing enough places for those master's-level programs?

Mr DAVERN - As I said, it's the funding which is the issue here. Each university can only accept a limited number of students annually as a result of the funding constraints which leads to that narrow training pipeline. And it appears - how do I explain it? - the universities after a while need - it actually starts costing them money to take on students. So, the more students that they take on, then that actually starts costing the university. They need to pay for that. That is sort of where the issue becomes at a loggerhead and they need to draw a line and say, 'Well, we can only accept this amount of students per year', before they start losing out on the on money themselves. So that's, I think, where the issue is. It comes back to the funding, yes. And the different bands of funding. I'm not fully across the different bands of funding and how it works. I could probably provide further information about that, if the committee would find that useful - more specific information about what those different bands look like.

Ms HADDAD - All right, thank you.

Ms ROSOL - I've got a question around the non-pharmacological support, so, the ongoing psychological treatment for people with ADHD. You've talked about mental health plans, how sometimes it can be managed so that assessments can be conducted in mental health plan-funded sessions, the Medicare-funded sessions. How many people would meet the criteria for the psychological treatments for ADHD under a mental health plan? And how many sessions might they need for an adequate level of support to have been given for them? Just trying to get a handle on the mental health plan, how it operates at the moment and where ADHD treatment fits within that; whether it's sufficient, whether it covers it at all. Do you have an idea of how many people access ADHD support and treatment under a mental health plan and how many are not able to, and have to fund it themselves?

Mr DAVERN - I probably can't really put figures or numbers on that off the top of my head. I don't know if that sort of data would even exist anywhere. To talk more broadly, all I can say is that, and probably as everyone around the table already knows, it's a growing area and a lot of people are starting to access that.

How long does someone need in therapy to address the issues? Again, I'll probably have to do a bit of a review of the literature in order to actually answer that from an evidence-based perspective. Again, it's a bit of a 'How long is a piece of string' issue because I think that one of the issues that really needs to be highlighted within this is, again, about two-thirds of people with ADHD have some other mental health condition, whether that's a depressive or anxiety disorder, conduct disorder in children. Fairly, I wouldn't say common, but it's one of those sorts of common comorbidities. It's that sort of thing where things can get quite disentangled in terms of the treatment. So, it might not necessarily be just dealing with the ADHD symptoms and presentations, but also disentangling how that relates to some of the other issues that a person might be experiencing.

I probably can't answer your question directly in terms of how many people are accessing it and how many sessions are needed specifically, other than to say that the 10 sessions that are currently available isn't adequate, really, for anyone. I think that's probably well established as well or well thought as well, that 10 is just generally not enough. It was good when, throughout COVID, that increased to 20. And the APS wasn't exactly impressed when that was reduced back to 10 more recently. It's an area of need, to increase the sessions available for all areas.

Ms JOHNSTON - Just going back to the issue around training, I think I understood that you said that there are only five universities currently offering the full suite of the eight endorsed areas of practice. Is that correct?

Mr DAVERN - Yes, that's my understanding.

Ms JOHNSTON - Do you know if UTAS is one of those five universities? Obviously, you recognise in your submission that there's a chronic shortage right across the country, but particularly in Tasmania. It would be nice to have our own home-grown psychologists here. What's the situation with UTAS?

Mr DAVERN - I actually don't know off the top of my head. I should have looked that up. It would be easy enough to find out. I can have a look at that, again, if that's something you want me to provide information about after. I can take that question on notice and provide you further information. Just let me know.

Ms JOHNSTON - That would be lovely, thank you. We hear it right across a whole range of professions in terms of the limitations of home-growing our profession body here, so really keen if you could take that one on notice to let us know.

Mr DAVERN - Absolutely, and I don't have the stats off the top of my head - that might be in the submission, because I did look at this when we were putting the submission together - there isn't a lot of psychologists in Tasmania. There isn't a lot. Even some of the Australian Psychological Society members I consulted with when putting the submission together were from Tasmania originally, but were now residing in other states. Yes, I think it's an issue and it's definitely an area of need in Tasmania.

CHAIR - One of my questions, I've asked this a few times with other people. Are there ways and mechanisms - and I suppose it'd be harder for adults as well - for an early identification or early capture of just people going, 'Maybe I have something that needs looking at' and going to a psychologist or other mental health professional for assessment, before it becomes a problem?

Once you're in that position where you need help - you know, there are problems that need fixing - those delays in wait times, the six to 12 months that people might be waiting, are a serious issue. If it's something that you're looking at proactively, you have that lead-in time where you can address these things and you have enough time to address these things, so having to wait six or 12 months for an appointment isn't quite the end of the world.

Are there ways, or things that can be done, to help people identify things in their own behavioural patterns that maybe should be looked at before you end up in that crisis point where you desperately need help and can't get it for months or what have you? Whether it's set in at the paediatric level or at the adult level?

Mr DAVERN - Yes, obviously, prevention and early intervention are best, if people can somehow, you know, screen for that. I think, just based on my own experience, people are getting better at doing that - accessing some of that information online that we were referring to before. There's a lot of stuff online. Google ADHD symptoms and, you know, questionnaires and all sorts of different things pop up. A lot of them aren't evidence-based, but it starts getting people thinking about what they're actually experiencing. I think the more information that is out there at the moment, it is starting to get people to actually think about their own behaviour. You want to be careful about self-diagnosis, obviously, in that regard.

One area, I think, that is important in terms of tapping into this sort of thing early, as early as possible, is via the schools and the educational system. To speak to the members in Tasmania, I'm aware in Tasmanian public schools that children can get access to evidence-based diagnostic assessment through the school psychology service, and that the psychologists who work in those schools do receive extensive and ongoing training in this area. Again, it comes back to that months of waiting before they can actually access that assessment. I think that could be a potential area to try to capture people early.

Those psychologists and the other people working in the schools as well are getting really good at starting to recognise some of the key characteristics of ADHD. It can present differently in different people. There's not necessarily one presentation. As you probably know yourself, there's the hyperactive, impulsive type, there's the inattentive type, there's the combined presentation. Each one has different symptoms.

CHAIR - Also the fact it presents differently with girls and boys as well. Even if you're looking in that paediatric space, the boys are probably easier to identify because they're the disruptive kid that's bouncing off the walls. Ideally, it would be great if there was a mechanism or a better way to identify these kids - girls or boys - before they get that label of being the problematic, disruptive kid. I think once you get that, it kind of hangs around for a while. How do you identify that in girls that present differently to, you know, the kid that's throwing paper clips at students from across the classroom?

Mr DAVERN - Yes, and again, it probably comes down to education and having the right people there to observe the behaviour and to understand the behaviour and what it actually looks like as well.

The gender thing's an interesting one. The research I looked at a while ago suggested that the male to female ratio of diagnosis was sort of 3:1 when diagnosed in childhood, but in adulthood, male to female ratio of diagnosis was about 1:1. The reasons for that, I guess, are really unclear. It could be a combination of factors, females being either under-diagnosed, misdiagnosed, maybe ADHD symptoms are persisting less into adolescence and adulthood. Maybe more females are being diagnosed as adults. Further research into that would really be interesting to try to understand that a bit better. I think, again, misdiagnosed. I think, traditionally, some females may be diagnosed with anxiety disorders, then later on in adulthood it turns out that it was actually ADHD, not an anxiety disorder, or it could be both - that comorbid presentation.

I think it's always important to do some screening. There's some evidence-based questionnaires that can be used and that are recommended in the best practice guidelines as the key questionnaires to use to initially screen for ADHD. Anyone can do these, obviously, if they have access to them, but for me, that's the first thing. If there's ever any sort of inkling that someone may have ADHD, it's 'do this questionnaire'. It takes 20 minutes. It's a screening questionnaire, it's evidence-based, it's reliable, it's valid. That could just give us some indication about some of the symptoms that they're experiencing. From there, it gives you a little bit of information and evidence and data to work off about whether further investigation may be required.

Coming back to that question, I think some of that screening being undertaken through the school system would probably be a good way of picking up potential individuals with ADHD earlier in the piece.

CHAIR - Yes. Then, like you said, a few people have raised the social media and the glut of information that's come out of that. Not all of it's medically accurate or correct or whatnot, but the role that it could serve - not so far as giving people self-diagnosis and doing treatments outside of what's proper practice - but something might pop up on one of your reels or feeds and you might think, 'Oh, I experience all those things - maybe I should look at that, before it becomes a problem'. It potentially serves that function in just bringing it to people's front of mind, to even consider it; then serving an educational role, in that sense.

Mr DAVERN - Exactly. It can't hurt, if people suspect that there might be something going on with them, it certainly can't hurt to make that appointment and just do the initial screening, at the very least, and to have that conversation. There could be something going on, there could be not what they think going on - but it certainly can't hurt to ask the question.

CHAIR - We are pretty much out of time. Did anyone have any pressing questions? In that case ,thank you so much. It's been very, very informative. I could ask you hours more of questioning, if I had the time, but unfortunately, we don't.

I'll just read this quickly. Thank you for your appearance. Your evidence today is protected by parliamentary privilege. Once you leave the table, I remind you that privilege does not attach to comments you may make to anyone, including the media, even if you are just repeating what you said here today. Do you understand that?

Mr DAVERN - I do.

CHAIR - Thank you, and thank you so much for speaking to us. It's been really helpful and it's much appreciated.

Mr DAVERN - No worries. Good luck to the committee for the rest of the inquiry. I certainly look forward to reviewing the outcomes and the report.

CHAIR - Thanks a lot.

The witness withdrew.

The committee suspended at 11.05 a.m.

The committee resumed at 11.15 a.m.

CHAIR - We have in front of us the Advanced Pharmacy Australia. Welcome. Thanks for coming. Thanks for joining us. Can you please state your name and capacity in which you are appearing before the committee?

Ms PAINE - Hi, this is Michelle Paine and I'm representing Advanced Pharmacy Australia.

Mr YIK - My name is Jerry Yik. I'm the Head of Policy and Advocacy at Advanced Pharmacy Australia.

CHAIR - Great. Can I confirm that you have received and read the guide sent to you by the Committee Secretary? Key points being parliamentary privilege covers this hearing allowing witnesses to speak without fear of being sued or questioned in any court or place out of parliament. This protection is not provided to any statements that may be defamatory being repeated or referred to by you outside the parliamentary proceedings. This hearing is public and media may be present. If you would like parts of your evidence to be heard in private, you must make a request to the committee at the time.

Have you been provided with that information?

WITNESSES - Yes.

CHAIR - Can each of you make the statutory declaration?

Ms MICHELLE PAINE, MEMBER OF PAEDIATRICS AND NEONATOLOGY SPECIALTY PRACTICE GROUP AND **Mr JERRY YIK**, HEAD OF POLICY AND ADVOCACY, ADVANCED PHARMACY AUSTRALIA, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED

CHAIR - Great. Do you want to make an opening statement, then we'll ask some questions of you?

Ms PAINE - Good morning, Chair, Deputy Chair, and members of the standing committee. As stated, I'm Michelle Paine and I'm representing Advanced Pharmacy Australia or AdPha.

AdPha is the progressive voice of Australian pharmacists and technicians. We have over 80 years of hospital innovation that puts people and patients first. AdPha supports all practitioners across hospitals, transition of care, and general practice clinics to realise their full potential. They are the peak body committed to forging stronger connections in healthcare by extending advanced pharmacy expertise from hospitals to everywhere medicines are used. The core aims of our organisation and its members are supporting medicine safety, quality use of medicines, access to medicines, and high-quality pharmacy services.

As stated, Mr Jerry Yik is seated beside me and is Head of Policy and Advocacy for AdPha. Here, I'm a Tasmanian member of the AdPha state branch and also a member of the practice streams of medication safety and also paediatric neonatal. Across those practice streams that represents pharmacists who are involved in medication safety, strategy, and systems changes, particularly in hospitals around medicine safety, but everywhere medicines are used, members of the paediatric and neonatal stream work wherever children are treated. That may include neonatal intensive care, ICU, outpatient clinics, and so forth. These members and members of our mental-health specialty practice stream see the day-to-day support services for children and adults with ADHD and provide specialist advice.

Medicines play a key role in maintaining the healthy lives of many Australians. In Australia, children aged 6-12 years old account for over 40 per cent of the PBS ADHD medicine supplied. Additionally, in the 2022-23 financial year, Tasmania had the highest rate of prescribing ADHD medicines in the same age group. Tasmania, alongside Queensland, also has one of the highest rates of treatment in children over six years old.

It's well known that there's a lot of medication-related hospital admissions each year. The estimate is 250,000, and it costs about 1.4 billion a year, as well as another 400,000 medicine-related emergency department presentations. Hospital pharmacists see patients that their most unwell. Patients with ADHD, just like everybody else, end up in hospital, so hospital pharmacists are very well placed to provide care, check for interactions, and make sure these medicines are chartered and available in a timely fashion.

Data shows that there is an increasing rate of ADHD medicines being prescribed and dispensed to patients. Over 60 per cent of young people with ADHD believe that there should be an increased focus on information around ADHD medicines, including the risks and benefits of treatment.

Pharmacists are key in any healthcare team providing care to people with ADHD. They are the medication experts and support patients to make evidence-based care, decisions about their care and also advise doctors and nurses in the hospital setting on appropriate prescribing, treatment, and management of any adverse effects. Pharmacists do have the key role in determining appropriate treatment and including assessing capability of the person and their family for compliance and taking the medicines effectively can also provide education on storage of medicines, which is really important in the home with some of the medicines used for ADHD.

Education by pharmacists can help carers and people with ADHD to better understand their management, particularly in terms of side effects, how they work and any special instructions on administration. Some health services employ specialist mental health and paediatric pharmacists who review medicines in public outpatient or private clinics, adjusting medicines and liaison. Generally, it's always a collegial, multidisciplinary approach to managing medicines. The hospital pharmacy departments also determine which medicines might be available via individual patient-use schemes when medicines are unavailable on the PBS. This is something Tasmania does really well because, unlike other states, we have a statewide formulary, so, there's equity of access regardless of which public hospital you're accessing.

To conclude our opening remarks, pharmacists need to be present in all healthcare settings where patients receive healthcare relating to ADHD, to support safe and quality use of medicines. On behalf of the hospital pharmacy sector, AdPha is grateful for the opportunity to give evidence today and welcome any questions from the committee.

Ms HADDAD - Thank you. Nice to meet you both. My name's Ella Haddad. I'm a Labor member for Clark. Thanks for the comprehensive written submission that you've provided as well. One of the things that you've touched on is the single prescriber rule. We've heard that in some other evidence that the committee has been provided as well, with the challenges not only of the time it takes to be authorised as a prescriber, but also when transfer of care happens between, say, a paediatrician or a psychiatrist to a GP, but then that patient might need to go back to the paediatrician or psychiatrist down the track. That transfer of care requires the other practitioner to reapply, if you like, to be the prescriber, cancelling out the other. Can you expand a little bit on the challenges of that from a pharmacy perspective, if there are any, and what might make it easier from a patient and clinician perspective?

Ms PAINE - We're talking about the prescriptions where they are presented and you can only keep it at the one pharmacy, or just the one prescriber specifically?

Ms HADDAD - The one prescriber. For example, we heard from a paediatrician who explained that if she transfers care of her patient to a GP, who becomes the prescriber, that obviously takes time. There's an administrative process for the GP to become the prescriber. That cancels out her ability to be the prescriber for that patient. But that patient may need to revisit her down the track for another reason or if the situation becomes more complex and they need the services of a specialist. She's no longer the prescriber, the GP is, so she has to reapply to become the prescriber. That takes time, two to five weeks apparently, and then that cancels out the GP's right to prescribe to that patient. It just feels like it's a barrier to multidisciplinary care.

Ms PAINE - The patient is not at the centre.

Ms HADDAD - Correct, yes.

Ms PAINE- Okay. From a pharmacy perspective, that would be challenging because if the patients run out of their medicines and you're trying to maintain supply, which is one of our key roles, that would make it very challenging because there is no way around that.

I think with services like mandatory real-time prescription monitoring, it seems like double handling, in a way. If you've got access to real-time prescription monitoring, you can check for trends and make sure that people aren't doubling up or doctor shopping or pharmacy shopping.

Mr YIK - And I just also want to add to that, that burden of checking that patients can get their medicine often falls on pharmacists. That issue you describe there does occur and often the pharmacist, before they supply that medication to the patient, of course, they have to do their due diligence and make sure that the prescriber has the right permit or is a recognised prescriber for that patient. And if that hasn't been done, or that script is not valid, it's often the pharmacist that has to then tell the patient, 'Sorry, I can't fill this prescription for you', and you can imagine the frustration that causes carers, patients and parents when you can't supply that medication where they only have one more day's supply.

Ms HADDAD - And the pharmacists bear the brunt.

Mr YIK - Yeah, pharmacists bear the brunt of that. I really want to acknowledge all the work that pharmacists do. And so, I think that is a really important issue for us to address. Yes, there needs to be really strong regulation and governance to prevent any diversion and inappropriate prescribing. I think, as Michelle said, having a real-time prescription monitoring system that is mandatory really does help the situation. I'm happy for that to be reviewed.

Ms HADDAD - Thank you. Touching on that, all your comments have drawn me into the issue of dispensing of interstate prescriptions. We know that's a big problem for people travelling or for people who seek medical care interstate because they can't get in to see somebody in Tasmania. Do you have a perspective from a pharmacy point of view around how that might be better managed? I know there has to be protections around potential diversion of medications and so on, but I know that is a real problem for people who might be stably managing their medications but can't get into a professional here, or they're travelling and a local pharmacy can't dispense schedule 8 prescriptions.

Ms PAINE - I think in this modern world, where we've got access to telehealth and so forth, that perhaps that needs to be reviewed. I understand that there was an announcement by the government in October that that would be looked at. We would certainly be supportive of that. To go hand-in-hand, I think looking at national real-time prescription monitoring would help with looking at trends and ensuring that medicines aren't diverted. Do you have anything to add, Jerry?

Mr YIK - Nothing else to add, thank you.

CHAIR - On reducing the risk of diversion and whatnot, quite a few submissions, you guys as well, have commented on some of the - whether it's the legislation itself around the *Poisons Act* or the administration of the act itself that's restrictive. I'd be curious to know which of the two is more of the issue, acknowledging, as you said, that there's a reason why these rules exist. And the reason why the PSB (Pharmaceutical Services Branch) operates in the first place is to minimise the risk of diversion, or the risk of misuse or harm. But can you speak more to whether that is adequately allowing people to access the help they need? We tend to a risk of zero, but that also means that we're not getting any of the benefits of people being able to access, or reducing the ability for people to access medications that they need.

Ms PAINE - I think it's a balance.

CHAIR - Where are we on that balance, I suppose, is the core question.

Ms PAINE - Can we answer that?

Mr YIK - I think we've got good experience.

Ms PAINE - Yeah. Look, we have to have patient-centred care. It's really important. We can't, I don't personally agree with locking down things so tight that people can't access the medicines they need. We do need to consider the risk to the community. I think that's a responsibility for all health professionals, not just PSB alone.

Having real-time prescription monitoring that we mandatorily have to check before we look really gives you a pretty good indication of where the medicines are being diverted. If someone's on one tablet a day and they're coming back every week, well, clearly something's going on. PSB will already know about that, you know. It can be tricky because people do struggle to manage their medicine and lose it, and so forth, but people have to be able to access the medicines they need.

CHAIR - I know when this is raised and questions are asked, the response is there's a very small number that are refused. When you talk to people, whether it's people that have made submissions or talking to people directly, a lot of the frustrations and difficulties aren't from refusals. It's from approvals with some really onerous conditions. You have to go in weekly and get your weekly allocation, or sometimes more or you have to do urine tests just to be able to get your dispensation. What does that do for appropriate care for people that have ADHD?

Ms PAINE - I'm not aware of the numbers. Is that a large number of patients where those onerous conditions are? I don't actually know.

Mr YIK - Yeah, I think what you are talking about, and, certainly, I agree and understand that patients, when they are unable to receive their care, whether it be access to diagnosis services or access to medicines, that is felt in a really personal way.

Looking more broadly around health, addressing how people understand and engage with the healthcare system, there may be sometimes really legitimate, or technical, or regulatory reasons why they can't access something that might be explained to them. Maybe not in the way that they understand, but there would have been, I assume, hopefully, an attempt by the pharmacist or doctor to explain why they couldn't receive that medicine. The way that's interpreted is, well, the conclusion is that, 'Well, as a patient, I only get the medicine that helps me function, that helps me survive, helps me live', and we really understand that.

I think there are some instances, going to what you've talked about there, where there might be reasons where the prescriber has placed some additional restrictions on the supply of that medicine. If a patient has other risk factors, they might stipulate to the pharmacist, please only supply one week at a time, or two weeks at a time, or come in every three days. We see that with other high-risk medicines that are used in patient cohorts that have other risk factors, that might have a history of medicines misuse or abuse, and/or diversion. There are ways or other regulatory controls or practices that pharmacists and prescribers can use to ensure, to minimise diversion even further.

I think I also want to say that, because we do have a real-time prescription monitoring system, that really has helped a lot. That has prevented people from doctor-shopping. It is just there's no point. You can't really doctor-shop any more. That has really, really reduced a lot of that diversion.

CHAIR - Obviously, we have to acknowledge that there is a level of risk in these schedule 8 drugs, otherwise they wouldn't be schedule 8 drugs in the first place. Is there the tendency from regulators in comparing the risk of making that drug available to a patient, comparing that to the risk of zero being like the not, rather than comparing it to the risk of this patient not having access to that support. A lot of the things that do trigger these considerations and these conditions are previous drug-taking behaviour, drink-driving or other things like that. But untreated ADHD has a lot of those things as symptoms. Perhaps, providing this pharmacological support that they need is reducing the risk of those things reoccurring.

You're not comparing the risk of providing a drug that does - once again, appreciating there is a level of risk above zero in providing these drugs, but you're comparing it to another risk rather than comparing it to zero. I'm not sure if I'm articulating that point.

Mr YIK - Absolutely, yeah. Absolutely, because we talk about holistic care and nothing, health care is not a binary issue. Michelle, I'll let you talk about that.

Ms PAINE - I was just going to say it's a difficult question for us to answer because it's really the Pharmaceutical Services Branch that need to answer that. However, we're certainly in support of making sure patients get the care they need. As hospital pharmacists, we experience that benefit versus risk every day, and there's risk in everything we do. But you've got to have that balance. For us, if you've got a patient who's previously had a history of abusing medicines, part of that may be because they've got ADHD, and untreated.

CHAIR - Yes, and trying to self-medicate and do things like that because they can't access.

Ms PAINE - Yes, we need to find a way to make sure that they can access treatment.

CHAIR - Last question before I pass on, I promise I won't hog it for much longer. Does that then speak to, as well - we've heard it just today from, I think, every person who's come before us, including you guys - the need for a less siloed and more multidisciplinary - not to use the buzzword of 'holistic' - but a more multidisciplinary approach, where we don't have the silos of, you know, the pharmacies, the psychiatrists, the psychologists, the GPs, and the schools - Is mitigating these risks done more effectively through models like that?

Ms PAINE - Absolutely, and, I guess that's why - I'm going to speak personally again - that's why I love hospital pharmacy because it is so much a team effort. You work in the ICU, you're there with the doctors, nurses, dieticians, physios, and you're making decisions together. You all think differently; you all see different risks and different benefits. Absolutely, a collaborative approach is the best way to go.

CHAIR - Yes, great. Ms Johnston and Ms Rosol?

Ms JOHNSTON - Thank you. I'm Kristie Johnston, independent member for Clark.

You spoke, Michelle, in your opening statements, about the really important educative function that pharmacists have. I'm really interested in exploring how that can be expanded in the situation that Simon was talking about in terms of minimising the risk. When those patients do have conditions put on them, perhaps for reasons of prior history and things like that, the role of pharmacists in that instance in educating that person to get them into a position where those conditions can be removed, through better understanding the use of their medications and the side effects of their medications, and how to manage that in the home - particularly for caregivers and parents, for instance, with their children. What's the role you see there for pharmacists in trying to reduce those conditions, or those restrictions over time?

Ms PAINE - In a multidisciplinary way, pharmacists every day are educating patients about how to take their medicines, assessing how much capacity they have to take their medicines appropriately, and providing them with resources to assist. That might be as simple as the medicines list, suggesting that the medicines are pre-packed, offering suggestions. or doing the teach-back method to make sure that patients understand.

Also, something I was particularly passionate about in paediatrics, is how medicines are stored in the home. Clonidine, for example, which is often used in ADHD, is particularly a risk for small children. We often have 'keep out of reach of children' on the labels and one of my bugbears is, every time I was giving Clonidine to a parent who had a child with ADHD is that, 'This is really beneficial for your child and this is how you take it, but you must be aware that you need to not just keep it out of reach; it needs to be locked up' because quite often children climb. We have a few children in ICU where that had indeed happened.

I think pharmacists play a key role in knowing the risks of medicines, and just partnering with patients and carers and parents in finding out their capacity for taking things correctly, but providing them with resources as well.

Ms JOHNSTON - That's understanding the person's health literacy levels to know where that message needs to be pitched at. A generic label on the bottle that says, 'keep out of reach of children' might not be sufficient for particular family circumstances, where you need to say, 'we've got a climber; that needs to be locked up'.

Ms PAINE - Yes, exactly right.

Ms ROSOL - Hello, I'm Cecily Rosol. I have a question around some of the interactions that you might have with the PSB, coming partly from my experience as a counsellor and hearing from people who had pretty terrible experiences. I understand that, in an ideal situation, you would be part of a multidisciplinary team and included in the process of prescription and education and the things we've been talking about, but that doesn't always happen. In the situations where it does happen and you are able to contribute, what opportunities do you have to inform the PSB and provide information to them, and how well do you think that clinicians with personal knowledge are included and listened to through the PSB assessment process?

Ms PAINE - I can't- I'm just trying to think of my interactions with PSB - my current role is very much in a policy guideline type of role, and so my interactions are saying, 'can we do this and we want to do this, tell us how we can manage it'. We have fairly good rapport, but I have no experience of advocating for a patient that hasn't been able to access medicines - but I certainly would.

Mr YIK - I think Michelle's approaching it from, you know, she has inside access working at Tasmania Health. I think PSB, generally, whenever there are any changes to regulation or policy or legislation, there usually is a consultation process. I believe the government has flagged, with the upcoming changes that will allow the prescriptions from interstate to be dispensed, we would presume that there is a public consultation to support that. I believe that's part of our government's usual processes. That is an opportunity for us to talk about or raise other issues that can also support increasing access to medicines.

In terms of the second part of your question around mobilising clinicians or gathering views from clinicians who might have lived experience, I think that relies on clinicians to identify themselves and put themselves forward. They are public consultations. We have a lot of members in our organisation - over 6000 - and we will ask their views on consultations and policy proposals, to inform our organisational submission. We'll do that for this process as well, but it relies on them to self-identify if they also have lived experience of ADHD.

Ms ROSOL - On that large, systemic level you definitely have the opportunity to advocate and speak, but on an individual level you could, but you haven't done it personally, and a pharmacist could do that?

Ms PAINE - That's right. You definitely can ring and ask for advice and provide their experience, yes.

Mr YIK - Yes, pharmacists would engage with PSB in a variety of matters and can give that experience of well yes, this happened at my local pharmacy, what should I do? Hey, here's how you can make it better because this keeps happening. Absolutely, those channels are open. I would think that pharmacists are also very, very busy at this point in time and have been for a very long time - so even making that phone call, doing that e-mail, can also just be another job on that never ending to-do list.

Ms ROSOL - I was thinking that as well - if you have to do the daily dispensing and the weekly dispensing, that would be burdensome, I imagine, on a pharmacy.

Mr YIK - Yes, it can be burdensome, but it is also part of protecting the public and making sure that patients receive medicines in the most appropriate way. The benefits, again, around providing multidisciplinary care is that you can actually see that patient every few days or every week - 'Hey, how you going?'

I think what we are seeing in the last few years is that there are more and more options for treating ADHD, there are more medicines. There are some medicines, like Clonidine, that are being used off label, they're not on the PBS. So that's good to have more treatment options, given that we have had some shortages as well. That also then requires patients - whenever they are changing their medicines, for whatever reason, and/or changing their dosage - that relationship with the pharmacist is really important. They know what their correct dosage is, how to take it properly and how it might impact the other medicines that they're taking.

I think that's a really big part of our submission is that we don't treat ADHD in silo, as you've talked about. ADHD is just a part of anyone, like them being left-handed. It's just a part of them. They might have other health issues, they may not have other health issues, but we have to look at that as a patient, as a whole. I think that's really important.

Ms HADDAD - Thank you. While we're on this topic of kind of multidisciplinary care, you have touched on, in your written submission, an example of health services employing specialist ADHD pharmacists who are part of that care team. You've identified that that improves not only patient adherence to treatment, but also probably patient outcomes as well. Can you expand a little bit on examples of where that's working well, and where specialty pharmacy staff are being included well in a multidisciplinary team treating ADHD?

Mr YIK - I really don't think there's that many specialist ADHD pharmacists out there at all. I would say that these pharmacists tend to specialise in paediatrics and neonatology. They do absolutely have a role in providing care advice, medication reviews to patients. That can absolutely work in any outpatient clinics that might exist. If you are, say, complex ADHD or ADHD with a lot of other comorbidities that require specialist care in a clinic, then it's possible that the medicines you'd be prescribed - your ADHD medicines and your non-ADHD medicines - can be a complex picture. Or you might have had multiple attempts on starting different types of ADHD medicines as well.

I think having a pharmacist there can provide all the information to the prescriber, as well as the patient and/or carer, on what medicines you're taking, how to take them safely, how to adjust or taper any doses as required - especially if you are a bit more complex - for patients that even require more-than-once daily dosing as well. I think, in that context where you are embedding the pharmacists into those clinics, then you would, hopefully, have pharmacists who are specialists in paediatrics or mental health, who have done the training and know more than the average pharmacist about ADHD.

Ms PAINE - I think most paediatric pharmacists would know more than the average pharmacist about ADHD, but the processes are similar across the board: doing best possible medication history to make sure that you've captured everything, that there's several different formulations, making sure that the patient's getting the right formulation - be that when they're admitted to hospital or not - making sure it's stored correctly on the ward, making sure - if you've got a really unwell patient, for example - that there's no interacting medicines. So, an important role.

Ms HADDAD - Yes, absolutely. Thank you very much.

CHAIR - Whether it's through the multidisciplinary style, which, from all accounts, would be the best way forward or from changes to the existing dynamic, is there a benefit or scope, in your view, in expanding the people that can prescribe - like, appropriately trained, from just psychiatrists? One of the issues we've heard is that there's an undersupply of psychiatrists in Tasmania and there's an even greater undersupply of psychiatrists that are working in this space. Is there a benefit in expanding to other medical practitioners that do specialise in ADHD to be able to prescribe - taking into consideration all the different risk factors? Would that make it more accessible?

Ms PAINE - Absolutely. Tasmania's a very small state, but also a lot of pockets of isolated, disadvantaged communities as well. Getting to Hobart to see a psychiatrist, or Launceston, is a really big deal for a lot of people. I think there are GPs with special interests, and I think, with appropriate training, that would be absolutely appropriate that prescribing should be opened up to them.

CHAIR - We heard from you about the issue of the 'single prescriber at a time' issue. We've heard from a few people around that. For patients that are in - I don't know what you call it - they're stable, they're in a maintenance phase, getting them off the books of the limited number of psychiatrists under the current system, I would think, would be a goal that we'd want to achieve, to free them up to do what they're the only ones that can do, which is diagnose and provide the initial prescription and titration and all of that.

Is the one prescriber limiting the ability to move people off, not necessarily move them off the books, but free those consult times up for psychiatrists to do the assessments that only they can do?

I know I'm in that phase at the moment. I've been taking the same dosage of the same medication for the last, almost, two years, but I still need to do those regular catch-ups with the psychiatrist. Me going off the books - is that the biggest limiting factor in freeing up or are there other ways to free up the ability, in that system? We do really need to expand the resources and the capacity, but at the same time, how do we get the current capacity working less inefficiently?

Ms PAINE - A shortage of specialists is pretty much across the board, and we're using allied health members, for example, for surgical clinics as well. It makes perfect sense to have the psychiatrist doing what they are specialist at, and having other trained people to follow up patients that are more stable. That makes perfect sense, and increases accessibility for many more people to get appropriate treatment.

Mr YIK - Yes. As healthcare has become more multidisciplinary, as we've talked about, possibly they could consider having more than one prescriber being attached to that patient's approval. I mean, in a hospital, we often have multiple prescribers prescribing the same patient on the same day, because that's how hospital care is. That actually -

Ms HADDAD - And for other medications too - including some that you might consider high risk, you can have multiple prescribers. It seems like it's a special barrier for neurodivergence. It feels really unfair.

Mr YIK - Yes. Look, I'm sure that the system was designed when healthcare was much more siloed than what it is -

Ms PAINE - In the 1970s.

Mr YIK - Yes, much more siloed than what it is today. Yes, we would welcome a review into that. And I think, yes, to your point, it probably would make - given that there is a shortage of specialists, we do want to see the specialists doing the diagnoses, because that probably is the rate limiting step for accessing treatment.

CHAIR - Yes. That's what they should be focused- and I suppose that comes down to, like, a general view I have on process-heavy regulations - not necessarily in this space, but across the board - is sometimes these process-driven systems are needed by virtue of the area that we're operating in, and the processes are there to ensure the outcomes that we want or prevent outcomes that we don't want, which is, in this case, the risk of misuse or what have you.

Are we potentially in a space where we are kind of more focused on the process being what the process is, and the outcomes are just sort of at the mercy of whatever- like, we've lost- do we need to refocus on the outcomes that we're trying to get, rather than the process itself, if that makes sense?

Ms PAINE - Yes, it does. Look, I think the regulations are well-intentioned to protect the public -

CHAIR - Of course, yes. 100 per cent.

Ms PAINE - But, I think, perhaps they need to be contemporised, because they are from a long time ago. With real-time prescription monitoring and the ability for national real-time prescription monitoring, I think it's not contemporary anymore - a bit old-fashioned.

And I think in the past, in healthcare, it was very much, 'We know what we're doing and we'll just do it to you', but these days, that's not how it is. It's absolutely a partnership with patients and carers and other health professionals, and it definitely is time for a review.

Mr YIK - I think, with the intention for allowing pharmacists in Tasmania to dispense prescriptions from interstate, at some point in the future, and then also allowing referrals to GPs with interest or specialists interested in ADHD, I think that has to be looked at, because you can't make all those changes from a policy and access perspective without making sure that the regulatory settings also allow you to do that. We would expect that to be reviewed.

CHAIR - Last question from me. There's a lot that - people talk about, 'Tasmania doesn't allow this, when other states do', like the single prescriber thing. Even the Senate inquiry into the same issue acknowledged that pretty much across the board, nationally, we're sort of behind where we should be, as far as - as you said, it's our understanding of ADHD has changed, not just - it's like, even over the last 10 years it's changed. It's a very rapidly moving space.

With that said, are there any states that have either gotten it right or a closer- you know, are there any states that we should be looking at, saying, 'Look, we should be doing something similar to what these guys are doing?'

Mr YIK - I'm actually not aware of that, to be honest. I'm happy to take that on notice. I think the developments that we've been seeing from Tasmania have been fairly progressive. I understand they're probably some of the most progressive, actually, in terms of allowing -

CHAIR - Are these the new announced -

Mr YIK - Yes. I do believe so, yes, and even exploring whether GPs with a special interest in ADHD can have a greater role as well is a really important step forward, given that there is not enough specialists in Tasmania.

I think with the e-referral system as well- I was talking to someone at Tasmania Health about the e-referral system, whether that could also be congruent or tack onto prescribers from the mainland and I think theoretically that is possible if they have all conformance software. That could also hopefully expand access to specialists from the mainland if that's what's needed.

CHAIR - I was planning on that being my last one but reading your - I think it's page 8 - where one of the restrictions are that the medical practitioner must be physically present and practicing medicine. Does that limit things like Telehealth from being a bit of a circuit breaker in the capacity issue that we have? A, the physically present, and also the inability for interstate -

Ms PAINE - Or even that prescriptions have to be kept at one pharmacy if there's repeats. With real time prescription monitoring, is that really necessary?

CHAIR - Yeah, it's almost like that's a solution for a -

Ms PAINE - For a paper-based system. That's right.

CHAIR - Yes, it's a solution for a former time not for a contemporary Tasmania because with Telehealth obviously there's a great potential for that to be really useful - and I think it's a symptom, potentially, nationally of the fact that we're behind where we are in the capacity to assess and provide support for ADHD and that's not in Tasmania, it's across the board.

There's a lot of really legitimate Telehealth services in this space, but there's also ones that have popped up that have the, you know, 'Pay us two grand or three grand and you won't have to worry about the wait times', and, 'We'll diagnose this for three grand', which kind of transactionalises healthcare because you would think if you're paying somebody three grand for a diagnosis, you're expecting a diagnosis when that may or may not be what the appropriate care you need is. Can you speak to that? Because obviously, like I said, from the perspective of, I suppose, the people that are paying three grand for a diagnosis, they want three grand for a prescription, effectively, at the end of the day.

Mr YIK - I'm happy to speak about that generally and I think part of that aspect, part of that issue from what we've been hearing is NDIS providers as well. For some providers they seem to be - they believe there is some incentive in some of these practises that you've been talking about and I think that is quite concerning if it is true.

I think, also, another issue that we haven't touched on is that actually really increases the gap in access for lower SES cohorts as well. I think $3000 is a lot of money to access a diagnosis and that's even before you consider the waiting time as well.

I think that is an issue that we should look at, say, if we are expanding access to diagnosis from mainland specialists for Tasmanians, I would hope that there is a healthcare regulator that would clamp down on any predatory practises.

Ms PAINE - They would still need to be a psychiatrist, a paediatrician or a GP that's credentialed and maybe that would help to limit that.

CHAIR - Because I know they exist, and, I suppose, would they exist otherwise or do they, only because, like I said, there are very legitimate Telehealth set of services and, I suppose, the issue is differentiating the two. But those predatory ones call - let's call it what it is, I think it should be criminal, right? - they only exist because there's people that are in a position of desperation because they're having to wait months or 12 months so they're willing to pull out their life savings to get a diagnosis without having to wait that 12 months or longer. Would that market exist if there wasn't that gap in the first place because of the need for the health system to catch up?

Ms PAINE - It may still exist.

CHAIR - I'm asking some speculative question, I understand.

Ms PAINE - You are.

CHAIR - I understand that. I appreciate that.

Ms PAINE - It may still exist because if you don't get a diagnosis and people do abuse the system, like they're very few and far between.

Mr YIK - It happens.

Ms PAINE - But I guess it happens and it could still exist if you're willing to pay but -

Mr YIK - Look, I think there are people out there who really want treatment and they believe they have ADHD, and they haven't had diagnosis yet. I'm sure there are instances where people go through an assessment and the outcome of the assessment is not what they believe they have. Potentially, that is where they may be channelled into these types of services. As Michelle said, at the end of that service you would think is a registered psychiatrist who has that authority.

CHAIR - Yes, we've heard from quite a few people that ADHD is one of those things where simultaneously it's one of the most under-diagnosed, but then also one of the most over-diagnosed. Like, it's better to call it 'misdiagnosed', because there's a lot of people that haven't gotten diagnosis that they need and there's a lot of people that have gone on social media and read all these things - 'Oh, I must have that'.

The question is, are people getting the care and the support they need and the right the right treatment? Not are they getting a diagnosis they think that they need? I think when you transactionalise it is when people are getting -

Mr YIK - I think, and again, it goes back to Michelle's comments around striking the right balance. I think when we have talked about and promoted telehealth services to really resolve these access barriers, we still absolutely support that. I think that it can also create some other challenges. If you have a completely online prescribing model then, as a pharmacist, if you want to call up the prescriber because you have an issue around the prescription, whether it be the wrong medicine or the wrong dose, or just to query the prescription or make sure they've got the right permit, then that can be sometimes a bit more difficult to find that prescriber if they're a complete online service.

Ms PAINE - That's a very good point because as pharmacists to do our job, many times a day you will have a prescription that has an issue with it. You do need access to be able to check.

CHAIR - Having the telehealth has a lot of potential to increase people's access to get that assessment and then the prescriptions. But there is the risk if it's not managed properly, how do you enter that into that multidisciplinary care model? How do you have continuity of care if somebody has just gone, 'The shortest wait time is someone in northern Queensland'. Nothing wrong with that, but you live in Hobart. How do you have that continuity of care and how do you have that multidisciplinary approach if it's sort of like a bulk product?

Ms PAINE - Maybe that needs to be explored because maybe even it's just opened up to a referral from the GP to an interstate psychiatrist, rather than just the patient being able to self-refer. That certainly needs exploring further.

Mr YIK - I think one of the issues that we have, that a lot of organisations and clinicians have talked to the federal government about, is having a secure messaging service for clinicians. I think when we have the My Health record, a lot of clinicians wanted that record to also be a platform where doctors and pharmacists could communicate with one another, provide referrals and discuss patients online through a secure messaging service, so that you wouldn't have to have that really destructive phone call or using a third-party email server.

I think to your question, I think that is potentially something that could be explored. I have a feeling the federal government has made some remarks around secure messaging. I'm not sure. I'm happy to take this on notice and provide you what I may have heard in the past. I think that could be one way to mitigate some of those risks, is you do actually provide a platform for prescribers and pharmacists and other team members of the multidisciplinary care team to communicate. That would potentially resolve some of these issues. Because I think it goes to your point around we can't not do anything. We can't just assess any new proposals or any new ideas against zero because that's not appropriate.

CHAIR - Any other pressing questions? No? If not, thank you guys so much for your appearance. Your evidence today is protected by parliamentary privilege. Once you leave the table, I remind you that privilege does not attach to comments you may make to anyone, including the media, even if you were just repeating what you said here today. Do you understand that?

Mr YIK - Yes.

Ms PAINE - Yes.

CHAIR - Thank you so much for your time. It has been really informative and really helpful, and great to meet you.

The witnesses withdrew.

The committee suspended at 12.05 p.m.

The committee resumed at 12.15 p.m.

CHAIR - We've got the Alcohol, Tobacco and Other Drugs Council of Tasmania. Welcome. Thanks for coming. Can both of you please state your name and the capacity in which you are appearing before the committee?

Dr HALLAM - I am Dr Jackie Hallam and I'm the CEO of the Alcohol, Tobacco and Other Drugs Council Tasmania.

Mr VAUTIN - I'm Daniel Vautin. I'm the 2IC, director of Policy and Impact at the Alcohol, Tobacco and Other Drugs Council of Tasmania.

CHAIR - Can I confirm that you have received and read the guide sent to you by the committee secretary? The key points of which include that parliamentary privilege covers this hearing, allowing witnesses to speak without fear of being sued or questioned in any court or place out of parliament. This protection is not provided to any statements that may be defamatory being repeated or referred to by you outside the parliamentary proceedings. This hearing is public and media may be present. If you would like parts of your evidence to be heard in private, you must make a request to the committee at the time.

Dr HALLAM - Yes.

Mr VAUTIN -Yes.

Dr JACQUELINE HALLAM, CHIEF EXECUTIVE OFFICER AND **Mr DANIEL VAUTIN,** DIRECTOR OF POLICY AND IMPACT, ALCOHOL TOBACCO AND OTHER DRUGS COUNCIL TASMANIA WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED

CHAIR - Did you guys want to make an opening statement? Then we'll jump into questions.

Dr HALLAM - If that's okay, I'll kick off and then throw to Dan for the second part of it. Our opening statement, we'd just like to clarify, I guess, where we're coming from and just provide the context on which we make our claims and evidence. We're talking about alcohol and other drugs services that are in the community sector that go across the state of Tasmania. We're going to give a view from what the issue looks like from those who are on the ground in these organisations and the clients that they see every day. We do wish to note that there is a high demand for these services across the state, and that, currently, their capacity is shrinking to provide those services. We will note that there are aspects across the things that we will say which will manifest different in the regions. And we'll be noting quite a lot of service system impacts and issues.

The other part of the opening statement I'd like to provide is a very quick overview of the clients that our community sector organisations see. Three-quarters of the clients are male. The main drugs that our services see in the clients that present are alcohol, cannabis and methamphetamine use. There's a high level of social disadvantage in the client group and that manifests in what we call complex presentations. There's lots of other aspects to that but I'm sure, as we go through, they'll get teased out in the things that we say.

One of the biggest things which is of relevance to this is that the reports of, it's very, very hard to access, from the point of view of the community sector, mental health professionals. And that's particularly hard in the regions, for example, the north-west coast. The thing that I will end with, and I'll speak in a general sense, is that stigma towards people who use alcohol and other drug use is an extremely material and live issue for our clients. It manifests in many, many ways. When we think about this issue, people have a right to access health care and that stigma plays a historical role and it's extremely live right at the moment in a broad sense in terms of how people interact with the health system. As we go through, and the comments that my colleague will provide, will no doubt show how much of a problem that stigma towards people who use alcohol and other drug use presents to us.

Mr VAUTIN - Thanks, Jackie. To add to that, I think we're bringing a different aspect of this conversation around a marginalised community of people and a very vulnerable community. There's varying different bits of research out there, but lots of studies: somewhere around 30 per cent of people in treatment for alcohol and other drug, for a substance use disorder or alcohol use disorder, have ADHD. That can vary from 20 to 40 per cent. Similarly, in correctional facilities, they think somewhere around that same amount. It's quite a big number of people in those cohorts.

When we talk about substance-use disorders, treatment for alcohol and other drugs, there are risk and protective factors that influence the uptake and use of alcohol and other drugs, of which mental-health conditions including cognitive impairment disorders, such as ADHD, are a big part of that. It's a very complex space to work in. We hear words like trauma, social disadvantage. I want to acknowledge that this conversation is in and amongst this milieu of factors that influence why people use alcohol and drugs and find themselves experiencing dependency.

We know that 30 per cent of people have co-occurring conditions. I think it's more than that. I think it's diagnosed co-occurring conditions. If we think that 30 per cent of people have ADHD, ADHD as you know, you're likely to see conditions such as depression and anxiety and a variety of other mental-health concerns.

What we do know, and I want to stress this from the start, is that the treatment works. We know that the longer a person is in treatment and the earlier they get treatment, the better the outcomes. It's in that context that I'd really like to talk about ADHD today.

Ms HADDAD - Thank you, both. I am Ella Haddad, member for Clark.

I want to start where both of you finished which is around stigma and discrimination experienced by people who use alcohol and other drugs, particularly when it comes to that high proportion of people who might be considered to be misusing drugs, actually potentially having ADHD or other neurodivergent conditions.

One of the things that the committee's been hearing about is a bit of a feeling of stigma and discrimination when people go to seek treatment for ADHD because it's usually treated with a stimulant-based medication, whereas the evidence from what the committee's heard certainly shows that once somebody is treated successfully through their ADHD, then potential other misuse, in fact, decreases significantly. The misuse may actually have been caused by untreated and undiagnosed ADHD.

I just wonder if you're willing to expand a little bit on your experiences with, or your members' experiences with, working with clients who are seeking to be treated for their ADHD and the barriers that they might find in the medical profession because of a potentially wrong assumption around the use of stimulant-based medications.

Mr VAUTIN - Absolutely.

Ms HADDAD - I don't know if I expressed that quite right.

Mr VAUTIN - That's a great start to the conversation. To start with, people who use alcohol and other drugs and find themselves in dependency, experience intersectional stigma. We're not just talking about stigma for their drug use, we're talking about stigma because they may have ADHD or another cognitive impairment. Their stigma may also include the fact that if you have ADHD or you're neurodiverse, you're more likely to be LGBTIQA+, or the fact that, you know, you might experience stigma because of your race, the colour of your skin, where you live, et cetera. All of this stigma put together for people who use drugs can create a very hostile environment to operate in.

They experience stigma when they seek health treatment in lots of different ways. Beyond ADHD, people seeking medication for pain medication. If you have a history of drug use, when you present in an emergency department, you may be denied or you may be given less medication because you're on pharmacotherapy when, in fact, most likely you need more. This is where ideology intersects with evidence and treating the person for the condition they're presenting with at the time they're presenting with it. That's where that stigma can sit.

In terms of stigma and its effects on people when they have ADHD and they're looking to get medication, often what happens in our cohort is that by the time you get to treatment and you're at one of our member organisations, you've lost contact with your GP. You've lost contact with your psychiatrist, if you had a diagnosis from childhood. You've been treated by the system in a certain way and you know you have ADHD, but you know that there's very few opportunities out there for you to have that diagnosis confirmed again and treatment provided.

Many, many people within the system don't want to work with you. Many surgeries don't want to see people who use alcohol and other drugs in their surgeries. Many pharmacists don't want them coming into the pharmacy to get pharmacotherapy, for example. Even though ADHD may be one of the critical factors in the reason you use alcohol and other drugs in the first place, you know that you're not going be prioritised. If anything, you're going to be deprioritised. You know that if you go into a public health system, psychiatrists are dealing with some of the most chronic mental health concerns that we have in Tasmania. If you're someone who uses drugs, who has a co-occurring ADHD, you're not likely to get an appointment soon. So, stigma, I think, is an enormous barrier.

Dr HALLAM - I read this morning the account of somebody with a lived experience, who you spoke to quite recently. It really showed in a practical sense what it looks like on the ground, so please help me bring the story forward.

The person had recently gone back on pharmacotherapy, so opioid replacement medication. They had gone to their pharmacy and they were going to pick up their meds for ADHD.

Mr VAUTIN - Vyvanse. Their regular medication.

Dr HALLAM - Because they had, prior to that, been diagnosed for ADHD, then they recently went back on the pharmacotherapy program. Person enters the pharmacy, they pick up their dose for their opioid replacement side of things, go to pick up their ADHD meds, and were told that their prescription has been cancelled. They were not notified of this. This is the first time that they had heard of this, and this happened in a pharmacy. So, they were left wondering why and, obviously, felt shame and stigma, and things like that.

The choice to cancel those meds - that was not communicated to the care team.

Ms HADDAD - It was made by the PSB - not by the person's treating practitioner?

Dr HALLAM - Not by the treating practitioner, but by the PSB, we think it must have been the PSB.

Mr VAUTIN - It was the PSB.

Dr HALLAM - Then, it took an enormous amount of time to work through all of that. Can you provide any more details story-wise?

Mr VAUTIN - I can. In this case, the client contacted her GP, who then contacted PSB and found out the first reason was that they wanted confirmation from her treating psychiatrist that they were aware she was back on pharmacotherapy. There were scrambling and emails and the client's leading and advocating for themselves in this space. The email's sent back and they go 'Yes, the psychiatrist was aware'. Then another reason comes out, and the other reason was some other immaterial things to do around the dosage, I think. So, there were more emails back and forth. Then, the last one, then decided that you needed to provide a urine test. She'd not needed to provide a urine test before, so all of a sudden - and she felt like they were just coming up with reasons. And after, in her case, she was lucky, it was only three weeks between her getting the prescription cancelled and her practitioners, who are really good, backing her up and working through the system.

To go from having 60 mg of Vyvanse to nothing is in itself, for someone who has a substance use disorder and who's trying to do the right thing on their treatment journey, is dangerous. It's really dangerous. The outcome, fortunately, was good for the client. It ended up being daily dosing. They go and get their pharmacotherapy and a daily dose of Vyvanse and that satisfied the board.

This leads to a much bigger question, which I think we'll get to, around the tension between the TGA and the guidelines within the PSB, and the guidelines provided by the Matilda Centre and organisations that specialise in the treatment of addiction. There is a big tension between the two.

Ms HADDAD - That's a really compelling story. I'm glad it had a good outcome for that woman, but it obviously came at, well, it was a good outcome because she was able to really successfully self-advocate and she had clinicians ready to advocate on her behalf. I imagine there would be many other patients in a similar situation, in terms of their prescribing, who might not have those things working in their favour.

I want to see if you can expand a little bit on the interactions between the PSB and people's treating care teams? We asked similar questions of the health department when they appeared - it wasn't the PSB, but it was representatives from the Department of Health - because, from a patient's perspective what the committee's heard is that it can feel like the PSB is making a decision around your prescription, but they've not met you and they might not have spoken to the people who are treating you. Is there information that the committee would benefit from hearing about how those interactions could be better managed between the PSB and treating care teams, because they're the people who actually know that patient and know what their needs are?

Mr VAUTIN - I can speak a little bit to that. One of the issues with me answering that question well is that it is opaque, and it's not clear how it is managed. There is an invisible curtain where the client or the patient just isn't aware of what's being done behind the scenes and the process at all.

In one case, one young man, who does not have a substance use disorder - this is another example - got accepted into university for his engineering degree, has ADHD and disclosed in one of his appointments that he had been to a festival and had used drugs at a festival, which is not uncommon for young people, adolescents and people in the emerging adult phases, this is well-researched and evidenced. His honesty saw his prescription cancelled. Cancelled.

Again, without any communication. He found out when he went to fill a prescription. So, that has to stop. The client needs to be made aware and the treating doctors need to be made aware, so they can be either titrated down, or dosage can change, but the summary cancellation of prescriptions can be quite traumatising and problematic for people who may have co-occurring other mental health conditions. In this young person's case, four months. And the constant refrain was, 'It's been referred back to the committee,' and he didn't know what the committee was, right? 'The committee,' whatever that is. Until, finally it was resolved and his prescription was reinstated. But, four months. And for him and one of the AOD workers from a residential treatment facility - and I can talk about it in that context, some time - likened the medication to having your reading glasses. You know, that's what it's like in the education setting. He had his glasses taken away.

Ms HADDAD - That's a great example.

Mr VAUTIN - While someone, somewhere, in some office, dealt with something that was really personal to him.

Ms HADDAD - Thanks. That's a really compelling story.

CHAIR - I've heard quite a few stories personally myself and there are Facebook groups of people with ADHD, and a lot of people share those stories, and when the Health Department was here and we were told 'Oh, a very small number of people get rejected,' but it's not so much the rejections, it's the approvals with conditions and situations like that. People say you get made to feel like a criminal sometimes, if you go into the pharmacist and you're being asked to give urine tests, just to be able to get the medicine that you need. I know it's probably not a huge number on the daily, because I've heard weekly and fortnightly and three-day prescription refills, but the ones that are on daily, it's -

Ms HADDAD - It's very disruptive.

CHAIR - And it's a condition that if you're not treated, bad organisation is a big part of it. You can't function on a day-to-day basis until you get your meds, so you have to factor that into your day before you go to school or before you go to work. I don't understand how that's even feasible. In your submission, you've got the 20 to 30 per cent, and you mentioned that as well, how much of that 20 to 30 per cent are people that have ADHD and aren't getting treated, versus the ones who are?

Mr VAUTIN - I don't know, and that's where we land with the data issues. If we look at cognitive impairment in general, in residential treatment, over 40 per cent of people have some form of cognitive impairment - which can include ADHD, but it can include things like autism, acquired brain injuries, et cetera. It's probably more than that.

What we struggle with at the moment within Tasmania is data around exactly how many people are likely to have ADHD in treatment, and would benefit from further assessment, both in treatment organisations, but also we do need to talk about correctional facilities. Similar numbers, if not more, exist in correctional facilities, and if we were able to assess and understand how many people, and then provide diagnosis and treatment, we could really radically change the trajectory in the lives of a lot of these people.

I mean, can you imagine if you were put in a position - and this includes remand - where you're in remand, you have ADHD, you have a known diagnosis, you will not be prescribed or provided stimulant medication in prison. You will not. No-one will be able to make a referral to the prison psychiatrist for that. That's not going to happen.

So you have a condition that affects your executive dysfunction, your impulse control, in a highly conformed environment where you have to comply. In remand you're dealing with lawyers, the change to your life, family issues, relationship issues, loneliness, isolation, all of the new social rules and you don't have the medication that you need for your health condition, that is so impactful on your functioning.

From my perspective and just from a human perspective, we are really failing people in that space and it's something that we need to shine a light on because we have extended release formulations of medication that have been shown to be very safe and effective. Why are we doing it? We provide pharmacotherapy in prisons, but we can't provide daily dosing of Vyvanse, for example.

CHAIR - That's the one place you think daily dosing is actually practical because you can sort of take it in front of them.

Mr VAUTIN - Obviously, there are issues around ensuring that diagnosis and assessments are adequate but I think that's a problem for us to work out rather than just deny people access to medication.

CHAIR - Once again, we are talking about medications that do have a level of risk, we have to acknowledge that, a level of risk above zero, but under the current regulatory system - because this is where a lot of people are having their pressure points - are we avoiding the risk rather than managing the risks?

Yes, there is a level of risk, but are we comparing that to zero and saying, look, if we tend to zero risk, then that's better? But zero risk also means zero access to medication. When you have, as you have said, a condition that when untreated presents with things like increased risk of drug or alcohol abuse, impulse control issues, whether people are at high risk of drug use because they're self-medicating or if it's just a reflection of impulse control or if that distinction doesn't even matter, one of the most proven ways to reduce that risk is providing the medication that people need. Are we, rather than managing the risk of those medications, avoiding it rather than comparing the risk of providing the medication in a manageable way against reducing the risk of all these risks that occur with untreated ADHD, as opposed to comparing it to zero? Is that what's currently happening? Is that the system that we're in at the moment?

Mr VAUTIN - I would say you could flip it and say, well, driving a car is a risk to use another analogy, so we can ban cars. But the reality is, I would say we are introducing much greater risk, community harm and risk to the individual by not treating the conditions in a number of different ways. We know that the functioning of the individual, whether that's employment, relationships, complying with community orders, making appointments, even the simple things, just managing those relationships is vastly improved if you have your ADHD treated.

My concern is that for a lot of people who use drugs or alcohol, the easy path to getting treatment for some of the things that are informing your drug use, go and see a doctor and you can get treatment for depression or anxiety. But that's not the underlying condition a lot of the time. So we're actually providing medication for people that they don't need in place of medication and support where they do need it.

CHAIR - Yes, they've got anxiety or depression because they've been living with untreated ADHD -

Mr VAUTIN - That's right.

CHAIR - and if the people that are vulnerable in this, that we're talking about here, are people that have a history or a risk of drug misuse; those people are the ones that would benefit from the medication reducing that risk, but because they've got that risk, we're preventing them from accessing that medication that will help them.

Mr VAUTIN - Which is undermining their treatment and their journey, entirely.

Dr HALLAM - I think we need to call out the elephant in the room, which is a notion that is called drug-seeking behaviour, which is something which is thrown about quite regularly but there's not a lot of evidence that sits underneath it in terms of the clinical guidelines and so on. So the Matilda Centre Comorbidity Guidelines has a section on ADHD and really does seek to counter that particular idea - that concept is something which says that we shouldn't exert extra risk around prescribing meds. It's not actually founded in evidence these days when we think about the new long-acting formulations. It's simply not the case that they have what they like to call the abuse potential of other meds. So I don't know if you'd like to go into those guidelines.

Mr VAUTIN - The Matilda - these guidelines are developed by the Matilda Centre funded by the Department of Health. These are regularly updated. AOD workers are trained using this all the time for co-occurring conditions and these cover things like eating disorders and a whole bunch of other stuff as well. You can keep this copy by the way. This is to the committee.

ADHD is in there and what they've found is there is no evidence for misuse or diversion of these medications, certainly not wholesale misuse. So it's a very, very low risk. There is a very low abuse potential for extended release medications. Vyvanse is a good example. There are lots of different ways that you could even give it to people to reduce that further. Dissolve in water, drink it in a glass. It's very hard for someone to walk away in a prison environment in a daily dosing regime.

The other points that they make in that is that it does reduce use. We work in a harm-reduction framework. At the moment the TGA Guidelines and Pharmaceutical Services Branch is expecting that anyone who has used drugs or uses drugs is going for abstinence, and abstinence is the only condition under which you should be provided medication for your ADHD. That is unrealistic. It's also not contemporary with the evidence and science around treatment for drug and alcohol use disorder. It's way, way behind. It's a dinosaur view.

The other things in that piece, that folder there from the Matilda Centre, is that they also acknowledge that pharmaceuticals medication is one aspect. There are other things that really support ADHD treatment, something that we - I have ADHD myself and I haven't received this and most people that I talk to haven't got this and that includes psychosocial support. So education around ADHD, CBT, DBT if it's required, and other forms of therapies plus social supports. We put all of those things together and ADHD can be treated very effectively. We also know that if we - there have been some studies from the United States that show that if you assess and diagnose and treat a young person at the age of nine, in terms of substance use, their trajectory, they are exactly like the neurotypical peers in terms of the probability that they will develop substance use disorder. So early identification and treatment from a prevention perspective, you're going to take a lot of the steam out of what we're seeing, which is the treatment and in the justice system, we just got to get it right.

CHAIR - So as far as managing the risks of psychostimulants medication, we're not comparing it to the risk of doing nothing and that's just across the board, the social, the health, the risk of ending up in hospital or ending up going through the justice system, like all those things, we're not comparing the cost of doing nothing to the risks of providing a medication. On the point of drug-seeking behaviour and diversion, I'm no pharmacist and I can only speak for like I'm on Vyvanse myself, I can't conceive of how anybody could get their hands on some Vyvanse pills and get their rocks off for recreational purposes. I don't think it's possible. Like, I don't, you know, it's the idea that, you know, it's a risky drug, people might develop addictions to them - you know, and the joke amongst the community of people with ADHD talking about this online is everyone's, you know, the regulators are telling us that they're really concerned that we might become addicted to these substances. Meanwhile, I'm struggling to remember if I remembered to take them this morning. Yes, that's the irony of it. Are we adequately comparing the risks of not doing anything?

Dr HALLAM - Yes, I think there's a really good opportunity to look at what we could do to improve the safety of the community. I mean, just the fact that people can be suddenly pulled off meds that are really important to their executive functioning and they've got a whole heap of other things going on in their lives would be a good trigger for somebody to go and have an episode and cause harm in family, community and so on. I think you are right. We do need to weigh up the risks of the current system and then the flow-on effects to hospitals and prisons and budgets and things like that.

Ms ROSOL - Thank you so much for what you're sharing today. I really appreciate this perspective. I'm going back to something you said earlier, because when the minister for Health and some people from the Department of Health were here, we asked them about access to stimulant medication in correctional facilities. Can I just clarify what you said before? Are you aware of anyone who is allowed to stay on their stimulant medication in correctional facilities? You said then that they're all taken off it.

Mr VAUTIN - My understanding is they will provide the non-stimulant medication, but you will not be - I've had a conversation with medical staff, I won't say who, at the prison - you will not be provided stimulant medication, full stop. You certainly won't be referred to a psychiatrist or be able to get a diagnosis or assessment whilst incarcerated.

Dr HALLAM - I think that's part of a broader issue of lack of treatment opportunities in prison in general. That's the landscape anyway. Access to health support.

Ms JOHNSTON - I'm keen to explore how PSB gets its information to start with. This morning, I was deeply impacted by a story we heard from a paediatrician who said that a patient of hers, the eldest child had an ADHD diagnosis, was able to access medication no problem. By the time the second child came to be diagnosed, the parent had a drink driving, I think it was from memory, conviction-

Ms HADDAD - And an ADHD diagnosis himself.

Ms JOHNSTON - That's right, an ADHD diagnosis himself, so the second child was restricted from accessing medication based on a parent's prior drug use history.

There's a number of things that I'm really keen to get your thoughts on. One, about the appropriateness of that in terms of what does that do to the parent in terms of stigmatising them and their prior drug and alcohol use history, in terms of their recognising that parenting and families are a protective factor against use, and the negative impact on that. Also, on how PSB gets its information to make these decisions and to suddenly switch off people's medication or to decline new prescriptions and things like that. I'm really keen to explore that.

Mr VAUTIN - I'd be keen to explore that too. It's opaque. It sits behind this curtain. That's not the first time I've heard of that. I've heard of families where multiple children have ADHD and they're on medication. One child is on a different dosing regime and has to go to the pharmacy where the other children aren't because they're from a different family.

I am aware that PSB accesses records of parents and looks beyond the individual client and prescription. I've been made aware of that with a few conversations, and that is concerning, because PSB is making some very big decisions that really are the purview of social workers or other people within the health sector. I don't think that really sits with PSB.

Ms JOHNSTON - So are they accessing criminal records?

Mr VAUTIN - I don't think they're accessing. Well, I don't know, but they are accessing health records of other family members. I'm not sure that that shouldn't be referred back out to community where it can be assessed if there is a real concern.

Ms JOHNSTON - Obviously, if they're accessing criminal records, they're using that without the health perspective lens in which they should be. They are a health service provider, not a criminal justice authority. Then also the privacy issues, I would assume, in terms of where they're getting information from and if there are other patients records, to inform our patients' and other patients' access to medication that's a serious - how broad do you extend that knowledge base or that information base? Do you extend it to extended families? When does the parent give consent for their medical records to be looked at by PSB for their child's prescription? It seems very opaque like you called it.

Dr HALLAM - That's right. I think we do need to know that. I think your line of questioning is you're answering your own questions.

Ms JOHNSTON - Sorry, could be a leading Dorothy Dixer.

Dr HALLAM - No, but I just want to say that the way that you're framing them shows that there is a definite concern there. And I think one of the chief concerns is that we just don't know. And, more to the point, the actual client doesn't know. There is a charter of access to health care in terms of - when does the right of the Tasmanian to access health care and be given appropriate information around data that's being shared, how clinical decisions are being made? That's a really important part of this because, as we know, the voices of people who are actually in the system, who are the clients of the system, they are the ones that can provide that unique and valuable information that the rest of us just don't know. So, I think we just need the voices and experiences of clients.

But the other thing we obviously need to note is that it's not an easy job that PSB has. There are risks, going back to the complexity of presentations. The risks, however, might not be related to ADHD meds, but they're related to other aspects. So, we do need to acknowledge that. But there are so many opportunities for improvement to the client experience because we want people to be active in their own health care. We don't want people to be afraid to access health care. We want people to be educated -

CHAIR - Or afraid to be honest to their medical practitioners.

Dr HALLAM - Afraid to be honest and things like this. So, currently as it stands, it does act as a huge barrier for Tasmanians who have ADHD to be a participant in their own health care.

Ms JOHNSTON - These are probably my words and you might agree with them or not. It seems that the PSB is being more punitive in their assessments, particularly around prior drug and alcohol use, than they are with the healthcare lens. So, it's more of a punishment, if you like, for their prior use and a value judgment, a moral judgment being put around that, as opposed to a healthcare assessment. Is that a fair, accurate assessment?

Mr VAUTIN - I think that's a reasonable statement to make and I think the people who should be making clinical decisions for clients accessing medication are the clinicians themselves who are working with the clients, who have a much greater understanding of their global experience.

Ms JOHNSTON - And context.

Mr VAUTIN - And context. Not, with all due respect, faceless bureaucrats in committees that we have no access to and the patient doesn't even know exists.

Dr HALLAM - I think that's a good example of where those comorbidity guidelines bump up against the regulations. So, then the question becomes, should we be listening to the evidence base from a clinical point of view with all those things considered? Or do the regulations sit above that? Where's the authority? And the answer's probably both. But right now, it feels like there's one that's got the upper hand in decision making. Can we strike a better balance?

CHAIR - What we're hearing and what Kristie was just talking about, it's not just how did they get this information, then they made a decision. It's not, 'Okay, we've raised a concern. Let's flag it with their medical practitioner'. Maybe they have questions to ask. Maybe there is something that needs to be looked at. Maybe it does result in them having their prescriptions, or maybe other options. But it's not doing that. It's just, 'Oh, we've heard this', bang, done. That's almost as big of an issue on its own. They've accessed information or been provided information that flags a concern. It would be appropriate for them to look into that, but they've just gone up, and that's what we're hearing in a lot of cases. Is that something that -

Mr VAUTIN - I would say that's a really good characterisation. I think justice is served when you don't presume that the individual is doing the wrong thing or that there is some other concern. I think the correct path would be: ask the question and interrogate the prescription if you need to, and the clinical decision. But certainly you need to consider the individual at the time - their safety, their wellbeing, especially when you're talking about extended release, for example, where the implications of just stopping use has led to suicidality, suicides, not to mention other things across jurisdictions. So, it's unsafe to do that.

Dr HALLAM - I do wonder to an extent, though, are we simplifying the issue? And, potentially, is there more to it with regard to resourcing? I'm wondering if GPs and mental health clinicians, as well as the people from the regulation side of things, maybe they just don't have the resources to enable the conversations to happen. I really just want to be a little bit cautious to assume that there could be - and I don't think anyone's saying here that there's negative intentions on the part of anybody. Sometimes the most simplest answer is the fact that people don't have the time or the capacity sometimes.

CHAIR - And everyone's doing the best in the system that they're in. Perhaps we need to ask the PSB some questions directly.

Ms HADDAD - I want to return to the prison environment. I'll tell you a very quick story of a person I advocated on behalf of because I've heard the same as you have, Dan, that when someone's going through the intake process at Risdon it's routine that they're taking off any stimulant-based medications or any other schedule 8 medications basically, or others of that type. He had only a two-month sentence. Two months. I didn't even think that happened any more, but this bloke got a two-month sentence for a two-year-old conviction. In the two years between the conviction and incarceration, he had got his life together, bought a house, had a baby, his family was going well, really well-managed ADHD and anxiety on the outside. And also had an acquired brain injury as well. They were all really well managed. Then he was in a prison environment, suddenly taken off all of those medications for that short period of time, which is really dangerous clinically. It was his partner who contacted me and said, 'Look, he knows he's going to get in trouble because he doesn't have any of his self-regulation tools or medication available to him that was managing those three conditions on the outside'.

My question is, do you know whether or not that decision to take people off any medication - and they are usually told that they will see the prison psych, but there's a wait. It might be weeks or months before they see someone from Correctional Primary Health. Is that a Department of Justice policy to take people off medications on intake or is it a Correctional Primary Health policy to take people off medications on intake? I'm interested in what the committee could learn about what recommendations we might be able to make about use of medications inside the prison.

Mr VAUTIN - I don't know the answer to that question, to be honest. I don't know who makes that decision. All I do know is that my understanding is the general practitioners at the prison know not to make referrals. They are well aware that similar medication isn't prescribed and that the psychiatrists currently working in that environment do not work with ADHD. It is definitely a policy decision.

Ms HADDAD - Whether it's a Department of Justice TPS decision or a Correctional Primary Health decision, I'd love to find that out. We might ask the department next time they're at the committee, if they come back. Thank you.

CHAIR - Did anyone else have any questions? If not, we're pretty much bang on at 1 p.m. Thank you, guys for taking the time. It's been really helpful and informative. I do have something to read out to you.

Thank you for your appearance. Your evidence today is protected by parliamentary privilege. Once you leave the table, I remind you, that privilege does not attach to comments you may make to anyone, including the media, even if you are just repeating what you said here today. Do you understand that?

WITNESSES - Yes.

CHAIR - Thank you so much for coming. Thanks for taking the time.

THE WITNESSES WITHDREW.

The Committee suspended at 1.00 p.m.

The committee resumed at 2.18 p.m.

CHAIR - The time being 2.18 p.m., we have the AMA Tasmania Branch. We have some people in person and online. If those present could please state your name and the capacity in which you're appearing before the committee. Just introduce yourself and then-

Dr SMITH - I'm Dr Clare Smith. I've worked in general practice in Kingston for over 30 years, but recently retired. I've great interest in this topic due to my personal experience, my work experience, and my volunteering in primary schools.

Ms GIDDINGS - I'm Lara Giddings, the CEO of the Tasmanian branch of AMA, but here as a support person, not to provide any evidence today.

Dr LAIDLER - My name is Dr Natasha-Ann Laidler. I'm a paediatrician in Burnie, Tasmania and I work with a lot of young people with neurodevelopmental diagnoses and also vulnerable children and out-of-home care as well.

CHAIR - Great, and can I confirm that you all received and have read the guide sent to you by the committee secretary? Key points being parliamentary privilege covers this hearing allowing witnesses to speak without fear of being sued or questioned to any court or place outside of parliament. This protection is not provided to any statements that may be defamatory being repeated or referred to by you outside parliamentary proceedings. This hearing is public and media may be present. If you would like part of your evidence to be heard in private, you must make a request to the committee at the time. Have you all received that information?

WITNESSES - Yes.

Dr CLARE ELIZABETH SMITH, AND **Dr NATASHA-ANN LAIDLER,** AMA TASMANIA, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Given that Ms Giddings isn't providing evidence, we won't need to swear her in. Did you want to make a statement before we get into questions?

Dr SMITH - Yes, I'm assuming that all of you are pretty well across some of the needs in this area and how acute they are, how big they are, and the struggles that we're facing. I would perhaps like to particularly talk about general practice and the load for general practice. Because this neurodiversity issue is so very common - and it could well be 10 or more per cent of the population and it is a lifelong disability - clearly we're seeing a lot of these children. Some of them are in the very complex difficult end but lots of them also aren't. They're in families that are quite functional, they're well supported, but they're still having a lot of difficulty at school.

In general practice, we already deal with a great deal of complexity. We have a lot of very complex patients. We handle their care, we manage without perhaps the special support we'd love to have in many areas. We're very used to doing that and used to working out when we really do need specialist support. When it comes to paediatrics, we can get to that point, but bad luck. There isn't the specialist support available because there just aren't the specialists available and the appointments available.

One of the things that I would really hope that we can get to is a better collaborative system where we use the workforce that we have, both the specialists, the psychiatry specialists, the child and adolescent psychiatrist, psychologists who are trained, paediatricians and GPs to work just much better, so we can get better, more effective treatment to far more children and adults.

One of the other things that you may not really be across is that one of the consequences of our lack of treatment options for ADHD flows on to every other childhood difficulty. GPs are now also holding many very sick children that they would love to get a specialist opinion on, but they can't because the specialists are busy seeing children who are just growing up and need another set of scripts. So, whilst there are definitely children who should remain in their care of paediatricians, I believe there are many children who could remain in the care of general practice. Like any other illness, like severe asthma or less severe asthma, they could be managed until things aren't going so well, and then call out for a specialist opinion with the chance of being able to get one. That's children.

Adults, we have a terrible problem due to our very longstanding lack of transfer of care to adult care. So, we have a huge number of people, many of who have other comorbidities and they're already being seen in the system, but they're not having their ADHD recognised and treated. Because we've had such a long period where it's not been recognised, we don't have a kind of education of all our medics of any kind on how to manage ADHD. We have a lot of work to catch up, but I think there's such a growing recognition of the size of the problem that there's a lot of willingness.

If we could fix some of the barriers, we could really improve outcomes. Because there's so much evidence for harm reduction, if you get really good treatment in place, we'll be decreasing some of the terrible consequences of untreated - or untreated ADHD contributes to, I'm not saying it's necessarily causative. That would have to be a win for Tasmania.

One other comment, I don't know if you all got to the very end of all these very long documents, but in my document I did point out that it's possible that Tasmania has an extra high load of ADHD. That's because of its links with incarceration. Fifty per cent of Tasmanians have at least one convict forebear and it's quite possible that that cohort of people who were transported had a higher rate of impulsive, stupid crimes, just like our jails do. It's also - there's not good research on it, but it's a plausible theory - that migrants, free migrants who just choose to up sticks and go to the other side of the world, may be more likely to have ADHD. We have a very high immigrant population. Also, people who are closer to an indigenous past and close to a hunter-gatherer past, also have a higher load.

So, we probably really have a higher motivation because we've got a bigger baseload of this issue. Personally, I'm sure it contributes to our 50 per cent functional illiteracy rate that I know schools are working really hard on, but this would be a great support. If you could learn to read before grade 2, when so often you have to wait to get treatment, then you would be far better off.

That's the main comments. There are many other things like pick-up requirements - many other issues that I'm more than happy to take questions on, but that would be my opening remarks. I'm sure Dr Laidler has something to add to that.

Dr LAIDLER - Yes. I guess if you're ready for me. We see a lot of young people come through clinic. One of the things that we've discussed locally is that there is a high number of young children being referred for ADHD diagnoses who haven't had the other services available to them prior to being referred to us and supporting GPs to provide a holistic care for young people in that setting and through the department of Education, and child health and family nurses should be a priority for us to consider.

Our waiting lists are incredibly long. We often have children who, by the time they get to us, have already suffered significant blows to their self-esteem and educational trajectories. Particularly in the north-west, there are obviously, as you would be aware, high rates of family violence and other socio-economic impacts. These are often disadvantaged children who are being further disadvantaged by not accessing care.

We support the increasing - the recommendations made in the document, particularly around reducing the number of visits that children require to paediatricians and putting their period of review time between appointments. That's been discussed at a statewide level as well. In terms of support, that's also really important because often it's not straightforward and these children and families need extra support to manage the behaviour of their children in the community as well.

Ms HADDAD - Hi, thank you, all of you, and thanks for a very comprehensive written submission as well that has provided the committee with substantial information addressing all our terms of reference.

I'm really interested to explore more the barriers to multidisciplinary practice. One of the examples that's been given to us by a paediatrician is the single prescriber rule as being a barrier to practice. Even when care can be handed to a GP, when you do need to get to the point of seeking specialist input again, you have to go through the administrative process of the paediatrician reapplying for prescriber access and then it drops off the GPs prescribing rights.

Are you able to inform the committee a little bit more about those challenges? I note we have a GP and a paediatrician here so it might be ideal to hear that experience. Also I have some questions about your experiences with the Pharmaceutical Services Branch as well, but let's talk about those barriers.

Dr SMITH - As I finished speaking, I thought I forgot to mention the single prescriber - one of the things that I think is the most important barrier. I'm delighted that you've asked me that question, thank you. The single prescriber rules are really adverse to the best outcomes. It's my very clear view about this. Whilst it's true that GPs can prescribe, there are really significant procedural barriers to doing that. You have to fill out a form to apply to be the new prescriber and often there's no time or even knowledge about how to do that and the prescriptions due. This is always the case because we have this problem, which you may also be aware of, that the script runs from six months from the day it's actually written, not from when you picked it up. But you can't pick it up early, so inevitably the last script may be invalid.

So then they rush in and then somehow the GP, if it was a GP, has to apply for that authorisation and then get the authorisation and then provide that prescription and then six months later they have to go back to the specialist. So they may have to come back and get another referral to the specialist and then they have to go back to the specialist and the specialist writes the script, but he has also got to fill in the form to allow him to prescribe the script.

Only one person can prescribe so it is incredibly an unnecessarily clunky system -

Ms HADDAD - Can I ask, sorry, I didn't mean to cut you off, but does that apply to any other type of medication? Does it apply to opioid medication, to benzos, to any other? It's just stimulant medication?

Dr SMITH - Just stimulant medication. Bewildering, isn't it? We've got a history of a very punitive approach to stimulants and it's not been helped by the arrival of ice on our shores. Ice is methamphetamine, people mix it up, they think it's the same thing. Ice and cocaine both have a much higher legacy of harm than the stimulants that are used for treating ADHD. But they've all got lumped in together even in the deaths and the coroner's reports. So it's very hard to really sort out how dangerous this drug really is. Personally, I think the evidence is quite strong that if someone has ADHD, and they're treated, they are protected from many of those very harms to do with drug addiction and so on. So I think the single prescriber problem is the simplest one to just fix.

My only provisory with that is I believe there's some consideration of allowing interstate specialists to prescribe. We really in the AMA in Tasmania would not like to see interstate GPs prescribe because we really like the idea of somebody on the ground actually meeting and seeing those children, in particular, but adults as well and to avoid the niche marketing, which is an increasing problem of fragmentation of care in Australia where you just sign up and you pay your money and you get your diagnosis and you get your script. That's definitely not best practice.

Even if specialists were allowed to prescribe, we would want dual prescribing to be with the Tasmanian-based GP that they actually had to meet apart from, maybe, when their remote requirements for telehealth.

In general, we tend to know our families and our people pretty well. We can also spot when things are going wrong, we can spot the comorbidities, we can spot, hopefully, some of the other complexities. We can also see the ones where it's going very smoothly as well.

Ms HADDAD - One of the things the committee's heard around that dispensing rule is around access to specialist care. So people going more for psychiatry and paediatrician appointments interstate rather than GP appointments. I could be wrong about that. Do you have a view around specialist prescribers being able to have their prescriptions dispensed locally? That's what we've heard definitely from consumers, that's where the big wait time is, getting a psychiatrist or a paediatrician appointment, and that's what they're seeking interstate. Then of course they can't fill their scripts here because of that rule.

Dr SMITH - Yes, I was not necessarily expecting to hear that from - who was the Health minister then. Mr Guy Barnett? I don't quite know exactly who he's referring to or how that would be set up. I guess there would be a place, because of our huge work workforce shortage, to have a specialist providing some prescriptions, but I feel some hesitation.

I'd be interested in Dr Laidler's view of having only offshore provision of care with nobody on the ground ever actually meeting or seeing that person. Whilst it's a lot better than nothing, telehealth is not as good as having somebody in your room, especially with some of these difficulties, I feel. There's a lot of other non-verbal and - just the general family stuff.

Often, certainly in my practice, I've had four generations of the same family in my care and I've tiptoed very carefully around all that. But it's also been a great benefit and richness. It adds an awful lot to my capacity to care for those families. Certainly up in the north-west, I think Dr Laidler would see that as a very valuable thing to have: all that information at your disposal. Not just, you know, a telehealth consult on its own. We'd be really keen to base the prescribing here but if it meant that on your review appointment your specialist could prescribe interstate, I think that would be okay.

The problem with GPs prescribing, as I said, is about that little niche opportunity that will be taken up because of the size of the problem. But on the other hand, I think they're looking at provisions for people who live interstate to have their prescriptions prescribed here when they're travelling, which seems to be perfectly sensible.

Dr LAIDLER - Yes, I would agree with what Dr Smith said around having local prescribers. The reality is that most of the people who go interstate have to pay quite high amounts of money to access those services, which swings in favour towards a kind of inequitable approach anyway. It's not what we would ideally want. We would like people to be able to get into a GP, to be able to access specialists in Tasmania as a preference, understanding that desperate people do seek other avenues.

I would agree with Dr Smith's concerns about some of the risks of relying on interstate prescribing, particularly for the mass marketed clinics that could end up - and particularly for children, not provide the kind of holistic care that they require.

CHAIR - I suppose when we talk about interstate, almost like - if people are moving from interstate to Tasmania or they're here for a temporary amount of time or whatever - we wouldn't want to prevent them from being able to fill scripts here, but we need to differentiate from that market that's popped up in the gaps that exist. We've heard about it, publicly and here, where people are desperate. They're looking for what they see as a need for a diagnosis. But when people are getting charged as much as $3000 for a diagnosis, not for assessment and treatment, that's three grand for a diagnosis and transactionalising. It's called price gouging, effectively. It's taking advantage of vulnerable people. We'd want to make sure that any changes we make have protections regarding that. Is that a fair assessment of what you're saying?

Dr LAIDLER - Absolutely. I think that it's a very exploitative practice and it's able to be. Personally, I know there's some concerns by some of my specialist colleagues about the capacity of GPs to diagnose ADHD, but I'd rather have a GP that knew the family make that diagnosis and someone who was paid for the diagnosis, and how often do they get their $3000 and say, 'No, we don't think that is your diagnosis'. Whereas in general practice, I've been presented with exactly that. I think it's ADHD. It's like, 'Actually, I don't really think it is. I think it's more likely to be explained by this other thing'. You know, try some other avenues. But if you've paid $3000, you're probably going to get your diagnosis in all -

CHAIR - You're expecting one, aren't you?

Dr LAIDLER - Exactly, and it doesn't go with the business model to not be given it.

On the other hand, given that we just don't have the workforce here, I wouldn't want to close down the option of interstate access because then there's a whole lot more people who won't be treated. What we really want is more treatment for more people however we can get it.

CHAIR - Back to the single prescriber issue. Effectively, what you were saying, and my my take on what you were saying, when you have the need to keep continuously going back to your psychiatrist. I think most people that we've heard from haven't had any issues in the psychiatrist perhaps being the first prescriber and the one doing the titration and then working out which is the best medication, go on a dosage and whatnot. But, like myself, once you're in a maintenance phase, or stable phase, or whatever the terminology is, it would be preferential for me to be off the books of the psychiatrist so he or she can focus and spend more time on assessing new patients that are on that huge waiting list.

The way the rules are at the moment, effectively I can't get off having my psychiatrist as my prescriber. I can't transfer it to the GP, because then I'll continuously have to transfer back and forward. Is that - ?

Dr SMITH - Not for an adult. Well, the prescribing could go back to the GP. The problem there is the review interval. In paediatrics it's been understood to be one year. Actually, some of these regulations have just quietly changed but no one knows, so they're operating as if it's still one year - and I think it's gone to three years - and it doesn't seem to have an age range for it - but it's the same for adults.

I've looked after people with really nasty chronic schizophrenia, which is a really nasty disease, for years and years without a specialist, but someone who's ADHD who might be a GP or a parliamentarian, for example - there's plenty of them - I have to refer them every three years, as you say, to take up a valuable resource that they actually don't need. It's a real waste. It's a real misallocation of resources, in my view.

CHAIR - Yes, because at the end of the day, I think everyone we've heard from, there's an agreement that there's a need to build our existing capacity of GPs and psychiatrists and people in this space. There's also a need to make sure that our existing capacity is being used in an efficient way and currently that's not the case.

You mentioned some about the attitude towards psychostimulant medication and this was punitive - I'm not sure if you or a previous person used that terminology. Just for clarity, and the difference between and the confusion between methamphetamines and cocaine and ice, and dexamphetamines and lisdexamfetamines like Vyvanse and whatnot - I'm currently on the highest dose of Vyvanse. If someone got their hands on those, there's no way they're going to be able to have a recreational experience with those. It's not the same drug, it's not the same thing.

Dr SMITH - It's not the same drug, and it's not nearly as desirable. Back in the day when there wasn't any ice on the street, Ritalin had more street value. I understand - and I'm a few years out of having much contact with my patients who could fill me in on these things - that Ritalin is a poor substitute and not anything particularly valued. I'm sure it still probably has some street value, but we have to balance that against the harms of not treating and all of that. I can't think of any other useful drug that's being treated in quite such a harsh way.

In particular, in the prison environment - because that's an area that I didn't mention, but I'm really concerned about, because they have a very high rate of ADHD. Treating their ADHD decreases recidivism, allows people to concentrate and learn some things and decreases their impulsiveness, and yet, they're almost completely barred from treatment. Speaking to the local clinical supervisor at the prison, he's just told me in the last couple of weeks that he has tried to find a psychiatrist who would even consider assessing and diagnosing ADHD in the prison, and he says that no one interested. No one will do it. They've all got plenty of work, 'it's a difficult world', they don't want to, 'it's just too hard.' And so, we just have this extra vulnerable cohort, and all their dependents and families and all the rest of it. We're wasting an opportunity when we could be turning them around.

CHAIR - On that, what is the obstacle or hurdle there? We need more psychiatrists in Tasmania, but the number of psychiatrists in Tasmania and the number of psychiatrists that are willing to look at and treat ADHD is much smaller. Maybe this is a question more for the next witnesses, but what's the hurdle that's making people resistant to wanting to treat that, given how prevalent it is?

Dr SMITH - Partly prejudice and because there's no history of it being treated, because it just has not been treated, we've got more than one generation of psychiatrists who did training here, who have worked here, who've had no exposure to people being assessed and treated for ADHD. So, it's unfamiliar. It's got this association in their minds with crime and, not surprisingly, with people who do finish up in jail because of the impulsive, stupid things they do and because they probably come from a background with more trauma and more multi-generational disability. It's all just very difficult.

Because there are so few psychiatrists, they can pick and choose. There's no real incentive to do it. I mean, personally, if there's going to be GPs with special interests employed by the hospital system, I'd love to see that as an avenue maybe of special consideration where they could actually take over the assessment, treatment and management of people in prison and then support them as they leave prison.

With our TasScript surveillance systems, it's going to be so much harder to rort the system in terms of diversion of those drugs anyway, and we've got regular treatment pickups and all of that stuff. We can do all that already, so I feel like a really effective harm reduction strategy would be to treat people in prison, not to stop and block their treatment in prison, which is what is happening now.

Ms HADDAD - We've heard from witnesses earlier today that there's no stimulant medication available in the prison. Yet we all know that opioid replacement therapies operate quite effectively in the prison and stimulate medication could be managed safely in the prison population, but it isn't because of historical practice and policy really.

Dr SMITH - Can I just make one more comment? My experience and people that I know well and my work experience is that it doesn't seem that if you have ADHD, that being on a stimulant is anything like as addictive as being on a narcotic. People don't crave their medication. People crave coffee more than they crave their Vyvanse or Ritalin.

CHAIR - And mostly you wonder if you remembered to take it.

Dr SMITH - People have to set alarms and put things on their dashboard like, 'Did you take your pills?' It just doesn't behave like narcotics do. It's like ticking down the time, 'Oh, I'm going to have my next dose at four o'clock'.

CHAIR - There's no rush.

Dr SMITH - There's no rush and so, in fact, I think a lot of this is built on fear rather than the actual real experience of people.

CHAIR - Before I go to Ms Rosol, Dr Laidler, you've got your hand up.

Dr LAIDLER - Going back to the single prescriber thing, I've been working whilst that change happened and I think one of the reasons that it happened was that there was concern that people were going to their GP and their specialist and getting scripts done. But with TasScript now in place and very easy to access, I don't see that as being a barrier to going back to co-prescribing. The barriers for patients are often cost of getting to the GP or getting into a GP to get their scripts. They don't have to pay anything to come to our clinic, but if we could have co-prescription then all the extra appointments that they require might not be necessary with a GP. So, yes, I definitely support co-prescribing to be put back in place and hopefully then the transition for patients will be easier.

The prison side of things, there are non-stimulant options but for prisoners to not even be able to get a diagnosis is a huge shame. And, yes, in prisons there is currency for certain medications, that's known, but they could be managed safely. So that's something and it will actually have an impact on children for their parents to come out to actually have been treated. I think it would make a big difference to those children.

Ms ROSOL - I had a question following up from a witness this morning. The Australian Psychological Society was here earlier. They talked about how people get a psychologist assessment and often they then have to get another assessment done with a paediatrician or a psychiatrist for the diagnosis to receive a script and get medication. What are the differences in the assessment process between the two? What's your experience and insight into what's happening there with that double diagnosis?

Dr SMITH -Yes, it's incredibly frustrating, as I'm sure you've heard, for parents, where teachers have identified it, the parents are on board, they pay the money, they see a psychologist, they do lots of tests, they talk to the school, they do all this work. They say, 'Yes, we're pretty sure it's ADHD', and now you have to start back at the beginning and wait for a paediatrician appointment, which could, if you're in the public system, take two or even more years.

There's a funny kind of thing here where if you're not as badly affected, you'll actually wait longer. So, these children are missing such a valuable opportunity of being able to learn to read and settle down in school and not be told that they're useless all the time. They're not directly told that, but they clearly can't concentrate. They're just struggling all the way. It is just really tragic. I feel we should be using everyone to their scope of practice and we should have a way of incorporating the fact that they've had that bit of assessment by a psychologist who's trained to do that as something that is beneficial instead of something that just adds to your frustration as a parent or as a person.

Personally, I would like to see GPs being able to assess those reports, have a look at them, see that they add up, they didn't just pay for it, here's all the different kinds of questionnaires and the report from the school where they usually have a pretty good idea about what's going on, and then proceed. Even if they still needed to see a specialist, maybe at least start some treatment beforehand.

Ms ROSOL - Are the assessments different? Why don't they count?

Dr SMITH - Yes, actually, Dr Laidler might have more of a view on that.

Dr LAIDLER - It will depend on a psychologist. There's a few assessments which are really thorough and most of those are what the psychologists are doing. Sometimes we get reports back that don't have every aspect that we would normally expect.

In terms of the diagnosis, we'd have to, in terms of training, that would need to be with GPs with special interest. I've had a couple working with us which have been very helpful. They have become more comfortable with making sure that they've gone through the whole diagnostic process for children.

One of the issues is, provided, we really do have to have the two settings to have been assessed - school and home. Not often but occasionally we'll have assessments that will only maybe have a parent's report, which might not always reflect what's going on for the child if their difficulties are only at home and not at school.

I think as long as, whoever it is, GP or paediatrician, is comfortable with reading those assessments and interpreting them and doing their own assessments, that's going to be adequate for a child through a diagnosis of ADHD. I don't know if I could explain that very well. The assessments are pretty standard.

It is hard for families because if they have to pay for it privately, that's expensive. Obviously, that restricts certain people from being able to access that avenue and the school psychologists are quite overwhelmed with assessments. So, they have a lot of children on their wait lists that they haven't been able to get to yet to do assessments for.

There's a lot of complexity around things which we have issues sometimes is the taking into account the impact of family violence on children's behalf behaviour, for example, and other diagnosis. That's really important that those are taken into account before we decide just on ADHD as the only thing that needs to be corrected, because often that's not the case.

Dr SMITH - If I could add to that as well. I think that's where, if you are a GP with a bit of extra training or an interest or something, and you saw a child who had that assessment that said they had ADHD, but you're with the family and the child and you maybe knew them, you'd be in a good position to say 'This is not uncomplicated ADHD. This needs more assessment and more opinion. Just because you've ticked off these things, that's not the whole picture' which we do with plenty of other things.

I think that if there was some system where we could, I'd like to see those easy ones have a kind of fast track into treatment and general practice management to clear the deck for the ones that really need that extra layer of expertise.

Ms ROSOL - Can I clarify, are you saying that, yes, psychologists do assessments and they can show ADHD, but the medical assessment is broader than what they're doing? Is that what I'm hearing?

Dr SMITH - It's not hugely broader in terms of those particular parameters, but the GP and the paediatrician are trained to look much more holistically and see much more of the picture. Hopefully, often certainly general practice would know more of the whole family setting. It'd be more able perhaps to think about domestic violence and trauma and multigenerational issues and all of that other complex stuff that we often do know already.

The problem is having that diagnosis from a psychologist, it does enable the family or the person, individual, to put in place the non-medication strategies, which there's an increasingly good amount of evidence on. Although, most of it like these very good books, *ADHD 2.0* and *The Year I Met My Brain*, require a level of literacy that's reasonably high. So, once again, the cohort that most need it are sort of self-selected out of some of these strategies and need that extra support.

Ms JOHNSTON - Thank you very much for your evidence here today and your frankness. It's really refreshing, I think, your opening statement maybe wrote a bit of our report.

I'm really interested to understand your interactions with the PSB and we've heard a lot of evidence around patients experiencing extreme frustration and health practitioners, too, from the secrecy around PSB decision making and where it's getting its information from. Are you able to speak to that from your experience, about what you find the situation to be?

Dr SMITH - Extremely frustrating, extremely opaque. For example, whilst I was practicing, which I retired in 21 so it's getting to be less current, there used to be age 70 restriction, an upper limit for prescribing. And I think it was when I first started my preparation for this, but when I went back to look at all the rules, it's just not there. It's just quietly gone and I've spoken to other older people and they've said, 'Yes, no, it is, it's 70, but you can get around it, you can have an exemption'. It's like, 'Well, you don't need one anymore because that's just quietly disappeared, like the quiet extension of the review period.' There's no real explanation and it's very, very hard to find out what those rules actually are, having spent many hours doing it.

There are really frustrating things like you can be asked to get a patient to do a random blood screen test. So, they do a random test and if, for example, it comes up clear, no drug is there. It's assumed that they're diverting their pills onto the black market.

Whereas what actually happened was they don't really like the feeling sometimes, but they're doing their tax return or something complex. They'll take their pills and quite a lot of people do this and they actually don't pick their pills up very often. They just have some for when they want them. Lots of children don't take them on the weekend because they don't eat enough. There are lots of reasons people don't take their pills that are quite legitimate. Then they're penalised by the PBS, which says they didn't have any drug in their system, so they must be diverting it, so they can't have another script. Of course, they presented because they want another script.

Things like that; then you waste so much time ringing up, trying to find the right person, arguing with them and saying, 'Yes, but I authorised this gap in treatment or there was a reason for it. You didn't even tell me, like suddenly I've got a problem.' It's just so frustrating and unnecessary. I really can't see where the evidence base for this is.

Ms JOHNSTON - How much of that frustration be avoided if rather than the PSB, instead of making hard and fast rules without any understanding of the context, if they were actually proactive in engaging with the GP, for instance, and saying what's the reason behind this - we've noted that this is a concern why is this and can you provide some context?

And how much information do they ask for? And we've heard concerns about, you know, criminal records or other patients' medical records being accessed to determine whether the patient should be getting prescription or things like that. Can you elaborate on that, please?

Dr SMITH - I'm sure you've had plenty of stories like this. For example, a child in shared care, which like between two different parents very common. One parent has been put on daily pickup for who knows why? They haven't got any personal record with drugs, they haven't got any criminal record; it's just been deemed for some reason that they have to go on daily pickup and it's just, and they're just like, 'Oh, well, these are people who are used to having things drop on them from on high. So they just do it.'

Daily pickup is so onerous, the pickup requirements are so onerous. To pick up something and it's not even every 28 days. I think if you read my earlier letter, I tried to work out a calendar of when every 30 days was and had to do it four times and I'm not sure it's right in the end, because even just working it out on a calendar, sitting there was actually really challenging.

And what's the point of that? Seriously, what's the point?

Ms HADDAD - So two parents of the same child, sorry to butt in, so it’s the child's prescription where one parent has to pick up daily and the other parent doesn't have to pick up daily?

Dr SMITH - Yes, because this is a very common problem. Who holds the script? So, one parent lives in New Norfolk, one parent lives in Kingston. So these children are swapping backwards and forwards all the time, sometimes more than once a week, and sometimes they can bring their pills with them.

But sometimes, for reasons unclear, some script is held at one pharmacy and some's at another, but this one's got to do daily pickup and that one doesn't, and it is just a nightmare and these are people, the ones I'm particularly thinking of, with low general social functionality, like to actually get to the chemist every day just a huge impost.

CHAIR - One of the other things -

Dr LAIDLER - But I just - sorry -

CHAIR - You go.

Dr LAIDLER - I also just want to be very clear that there are - out of many children I see on stimulants, there are a few where drugs have been diverted to the disadvantage of the child. If we have a holistic system in place where schools, if they know that the child's not acting as if they've been medicated, we have an open system around communication, then those problems can usually be recognised and dealt with early.

And, there are many patients who have tried to advocate to not be on daily pickups, and sometimes it's not anything to do with what the carer has done, it's because someone's misplaced something, or stolen something off them. So, the system is overly punitive to patients, but I do understand there has to be some way of monitoring it. There just has to be a balance, I guess, and maybe a bit more clarity for patients, because they just feel like they're not really being listened to.

CHAIR - Just to round it off because I think we do have to be mindful of time for the last segment - and maybe it's good to ask this of a retired GP, because it might be safer. A number of people wanting lived experience, but also some medical professionals had contacted me either asking for clarity around confidentiality of submissions, and some just didn't make submissions, because they had things that they wanted to say about the PSB, but they felt that there was a risk in them even speaking their mind about it, in fear of it impacting them professionally or impacting on someone whose reliant on those medications. Have you heard - do you have anything to say in regards to that?

Dr SMITH - I have worried that the PSB sometimes takes a position about a doctor's prescribing - and that particularly happens to doctors who have special interests, which actually a lot of us do develop. You know, we have got 3000 to 5000 conditions we could treat. We tend to choose some that we're going to be better at and there will be some that we aren't as good at or aren't as interested in. And, if you do have a special interest, your pattern of prescribing will be different. Then you get flagged by the PSB because you're not 'standard'. Then, there'll be questions asked, and then, before you know what, you'll be having your scripts questioned or rejected, and have to justify it, and then be asked for a specialist's opinion and it's like, 'if you can think of a specialist or go and see this person in the nursing home, you tell me who they are, then, maybe, they can have their whatever-it-is,' because their requirements sometimes are just unfeasible.

I hope, and I think that might have changed a little bit in recent times, with a bit more leniency, but I think it's just been really arcane; it's just really hard to know exactly. And then, we're also busy - suddenly you get this, and then it's not always timely. So, you think you've done everything right and you send it off, and then suddenly you get this letter in your inbox that says, 'We've rejected this'. Well, that's going to put them in a pickle and that's going to put me in a pickle, because they're suddenly going to run out of their whatever-it-is. This is not necessarily just for stimulant medication - it may be narcotics, say.

I think just having a much more open view, a more collaborative view, a more pro-treatment view - I can't really see why we're stopping - we want to stop people having treatment? As a general practitioner, I'd say, overall, patients are more likely to stop treatments if they aren't perceived as really useful, than keep going. Even treatments we really want them to keep going, where they can't really tell the difference, like antihypertensives - getting people to keep taking tablets is actually quite difficult. So, there seems to be an unnecessary fear that people are going to keep on taking something that's giving them no benefit.

My experience is that doesn't happen; it's more the opposite. For people with ADHD, it gives them great benefit, but they forget, then they get out of habit, and they just don't do it. So, it's really trying to get people to take tablets that is much harder, but now it's made harder because you can't get the tablets for them to be able to take - if they are remembering to take them.

CHAIR - We could go on for another hour, but look, we'll have to end it there so we can get the next one underway. I think they're already waiting in the online lobby.

Thank you for your attendance and your contributions. It has been really helpful and really informative.

Your evidence today is protected by parliamentary privilege. Once you leave the table, I remind you, that the privilege does not attach to comments you may make to anyone, including the media, even if you are just repeating what you said here today. Do you understand that?

Dr SMITH - Yes.

CHAIR - Great. Thank you so much; it's been really helpful. Thanks for joining us.

Dr LAIDLER - Thank you for having me.

THE WITNESSES WITHDREW

The committee suspended at 3.03 p.m.

The committee resumed at 3.05 p.m.

CHAIR - Welcome, the time being 3.05 p.m. we have the Royal Australian and New Zealand College of Psychiatrists both appearing on online. Can you please state your name and capacity in which you are appearing before the Committee?

Dr PENNINGTON - Dr Honor Pennington. I'm an adult psychiatrist. I work full time within the public mental health system in Tasmania. I also hold the position of the Chairperson of the Branch Training Committee so that I oversee doctors in training within Tasmania who will go on to become psychiatrists - around 40 trainees at the moment. Holding those roles, I'm a member of the College Branch Committee of the Royal [Australian and New Zealand] College of Psychiatrists within Tasmania.

I'm here to present evidence along with Dr Reddy to support the recommendations that have been made by the college in the submission.

Dr REDDY - Good afternoon, I am Dr Anil Reddy. I'm a general adult psychiatrist. I'm working both public, at the Royal Hobart Hospital and in private, Archer Street Health. I'm also a member of the Tasmanian Branch Committee and thereby representing the branch of the Royal College of Psychiatrists. I'm here to support Honor in giving evidence for the assessment and treatment of ADHD.

CHAIR - In the interests of disclosure and openness, Dr Reddy is actually my psychiatrist as well.

Can I confirm that you two have both received and read the guide sent to you by the committee secretary? The key points of which being, parliamentary privilege covers this hearing allowing witnesses to speak without fear of being sued or questioned in any court or place out of parliament. This protection is not provided to any statements that may be defamatory being repeated or referred to by you outside parliamentary proceedings. This hearing is public and media may be present. If you would like parts of your evidence to be heard in private, you must make a request to the committee at the time. Have you been provided with that information?

WITNESSES - Yes.

Dr HONOR PENNINGTON and **Dr ANIL REDDY**, ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS, TASMANIAN BRANCH MEMBERS, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED

CHAIR - Do either or both of you would like to make a statement before we get into questions?

Dr PENNINGTON - We considered that I might start and then Dr Reddy, who has much more experience of the day-to-day practicalities of caring for those with ADHD on a day-to-day basis, might continue and answer further questions.

From a college perspective, we want to assert that we committed to supporting the Tasmanian government to ensure that all of us in Tasmania have equitable access to high quality healthcare. The college recognises in regard to ADHD, that there are some measures that if they were taken would improve the health of large numbers of Tasmanians.

I'm sure that you've already heard ADHD is the most prevalent neurodevelopmental disorder that we have, affecting 8.2 per cent of young people and about 11 per cent of young men, so more prevalent in men.

What's also interesting is that it's a diagnosis that's associated with significant comorbidities. Up to 60 per cent of those who are identified as having a diagnosis of ADHD will also experience other mental health conditions which leads to some degree of complexity in both diagnosis and management.

An individual who has ADHD is potentially at significant risk of adverse health outcomes, an impacted quality of life and increased associated healthcare costs. That is across the lifespan. What we do know is that early diagnosis, intervention and consistent treatment throughout life will mitigate these risks.

We also know that a multimodal approach is needed and that will require integration of services. We need to think about an integrated approach so that primary and specialist mental health services are collaborating within care. The age specific services also can collaborate and there can be transition of care from a child to a young person to an adult.

We also need to consider that there are medical and psychosocial aspects to this condition and that those need to be integrated as well. I think, with that background, the college has some key recommendations they would like to put forward. They are that:

- we would very much support the delivery of specialised public ADHD mental health services;
- we want to ensure that there's public training pathways for specialised education to all and that's in line with the AADPA guidelines;
- we would very much like to ensure that we collaborate with the federal government to make sure that there's equitable access for disadvantaged populations;
- we would also encourage a review of the ADHD psychostimulant regulations, to make sure that we have the most efficient and accessible pathways for those who require medication treatment for their ADHD.

That summarises an overview of the college recommendations and perspective.

CHAIR - Great. Did you have anything to add, Dr Reddy, or go into questions?

Dr REDDY - Happy to go into the questions.

CHAIR - One of the things we've heard, are two big factors: obviously, the need to build the capacity of psychiatry and of other medical professionals in this space, and psychiatry generally in Tasmania. However, the number of psychiatrists in Tasmania is still a lot higher than the psychiatrists that assess and look at ADHD. I think it's only a very small number. From the perspective of the college, what is the impediment to more psychiatrists working in this space? Why is there, at least the perception, of a resistance by some to treat and assess ADHD?

Dr REDDY - First of all, I want to thank you, Mr Behrakis, for taking us up to this level, and passionately, so thank you for giving me time to talk.

First of all, I think there's a general shortage of psychiatrists all over Australia. Especially when it comes to ADHD, I think there are very few psychiatrists who are actually willing and able to do assessments and prescribe. It may go back to the training. I have learnt, over the last five to seven years, how to improve my practice in this area. But generally, there's a lack of training in the RANZCP degree curriculum and in general training with the GPs and everywhere. I think now there's more awareness, but generally, one is a shortage of psychiatrists, but I'm sure also there's a shortage in the training program itself, in how to recognise ADHD and treat it. So there are two parts to it.

Then there is also an impediment between public and private psychiatry where, generally in the public system, people have a more conservative approach; a sense of reluctance to take on and treat.

Then, I suppose, it ties in with more funding and resources, in terms of getting more people – specialists – and expertise from interstate and overseas to improve our knowledge systems.

That's my take in terms of the kind of barrier, the shortage itself. I'm happy to go to the next question you have.

Dr PENNINGTON - If I could just add, from a public psychiatrist perspective as well, that we have a public mental health system which is already struggling to meet demand, and increasingly, public mental health services are really only able to manage those with most complex comorbidities and needs. While this is a really important diagnosis, I think those who are missing out are those who perhaps we could identify early on and we could manage effectively early on. When you get to adulthood, at the moment I don't think the public mental health services would have the capacity to both assess and treat individuals who have a diagnosis of ADHD without other comorbidities. That's a definite barrier to the identification and treatment for an individual whose primary diagnosis is ADHD, if that makes sense.

CHAIR - I'll ask a last one and then I'll pass on. Regarding the existing capacity and the status quo of what we have at the moment in Tasmania, how do we get that working more efficiently? What are the hurdles? What are the pressure points? Given that psychiatrists at the moment are the only professionals that can prescribe, how do we ensure that the limited number of psychiatrists are seeing as many people waiting for assessments, or waiting for that initial prescription, as possible - rather than the existing people who are on a maintenance phase? What would allow you and your colleagues to take on more new people and reduce those waiting lists, as it stands?

I know the PSB comes up a lot when this question gets asked, and one of the things that does come up a lot is the single prescriber limitation. I am wondering if you had some thoughts on that or any of the other pressure points?

Dr PENNINGTON - There are a number of strategies that should be considered. As I say, the consideration of a streamlined approach, with some specific resources around identification of ADHD as a condition which is cared for under public mental health, and a strategy for streamlining that care, would certainly be helpful.

Collaboration with our primary health colleagues so that you hold back the specialist psychiatry resources for those where there is complexity, so that those where we have a straightforward diagnosis and treatment path and stability post-treatment, I think taking that away from psychiatrists, and perhaps supporting primary health colleagues to be able to manage that, would be really effective.

Those would be two thoughts that I had. Anil, perhaps you've got more?

Dr REDDY - I could give examples of my challenges in my daily practice, I suppose.

One is children and adolescents who have already been, for example, diagnosed with ADHD. As soon as they turn 18, they can no longer, unfortunately, see the paediatrician to continue the script. Then they have to transition to seeing your general adult psychiatrist, which may take time, not available, or may have a long wait list. GPs generally would hesitate to continue the same prescriptions unless supported by adult psychiatrists. I see that itself as a barrier, because if ADHD usual diagnosis happens, it's a neurodevelopmental disorder. Mostly onset is in childhood. Once they've been diagnosed, I would like to see a system where if a paediatrician or a child psychiatrist has already made a diagnosis, there's no need for a duplication to see your adult psychiatrist.

For consistency and continuity, they could see the GP and the GP could continue the same kind of prescriptions. Of course, if there are complications and if they need more support from the psychiatrist, you ask for a referral and get support.

In the meantime, you see a lot of kids who fall into the gaps because they just can't get access to a general adult psychiatrist who can diagnose and treat. So that's one.

The second is I think there should be more support for the GPs. GPs should be the primary prescribers with support from psychiatrists. I think, again, it goes back to GPs. A lot of GPs are quite reluctant to take on, first of all, to diagnose ADHD and to treat. Again, it goes back to good education and support because it is a very complex condition, especially when it's occurring with a lot of comorbidities, which are very confusing. On that same point, I'm digressing, but patients with anxiety, depression, trauma can also present with ADHD symptoms. It becomes very difficult for GPs to make the primary diagnosis.

I think to answer the question, support for our paediatrician, support for our GPs and make a pathway for consistency and continuity of care between these three faculties.

CHAIR - Is the ideal way of addressing that having perhaps psychiatry as the specialists doing that initial prescription, the titration, working out what works and doesn't work. I know we did that and tried just about every different combination. Once you get into the stable maintenance phase it's just repeating scripts. If that person has a complex case, then maybe that's one for specialists to remain focused on. But if someone's just in that stable maintenance phase, pass them back to the GP and then it's just if anything changes, raise it but then leave your books open to handle (a) more complex cases, and (b) more new assessments.

Dr REDDY - Absolutely. I think that is already happening. But once the GP colleagues get more support from psychiatrists, even if it means kind of a liaison role in the public system. For example, a psychiatrist who has an interest with ADHD, is in the public system liaising between private psychiatrists and GPs.

It's all about just making sure that we get the correct prescriptions. There's reducing the risk of deviance and misuse. The core issues with the stimulant medication is risk of misuse and deviance. So, I suppose if those can be managed through a good pathway, that would reduce the kind of help with the barriers for assessment and treatment.

CHAIR - Mindful about not taking up the whole session myself, did anyone else have questions?

Ms HADDAD - Thank you both for attending. My name is Ella Haddad. I'm a Labor member for Clark. We've heard a lot of evidence around prescribing rules, not just the single prescriber, which you've talked about a little, but the approval of prescriptions by the Pharmaceutical Services Branch. I wondered if you would be happy to share your experience with that. We've heard from parents, particularly parents of young people with ADHD and from consumers, themselves, that there's often a very long wait time between a psychiatrist issuing a prescription and the PSB approving that prescription. That's certainly been my own experience in my daughter's experience.

What I'm wondering is if you can expand a little bit on what that means for a treatment pathway. Particularly, Simon's been very open in his experience. He said that you've tried lots of different things. I had one parent describing it to me like tuning a radio, you know, it might be the right prescription, but not the right amount or a different medication needs to be tried until you land on the right thing for that patient.

So, I wondered how the impact for potential delays of the PSB approving your prescriptions are in terms of actually landing on the right medication pathway for a particular patient?

Dr PENNINGTON - I might just make a general comment and then hand over to Anil. I would say, generally the clunkiness of the pathways and the restrictiveness of the pathways are initially off-putting to a general practitioner or even a psychiatrist to be able to understand how to navigate the system. That is something that is impacting on accessibility. Even before you get onto the pathway, I think you'll find that a number of medical practitioners are wary of prescribing ADHD medicine because they know that they're going to have to navigate a system which they don't fully understand and which is quite clunky. Then you hand on to those who do prescribe.

I might hand over to Anil because he knows more fully than I do.

Dr REDDY - Yes. Just giving an example first of all of the inconsistencies and ambiguity in our different state levels. For example, in Queensland I don't think there's so much of regulation in terms of applying to the pharmaceutical board and getting approvals to prescribe as compared to Tasmania.

I think there's good things about the Pharmaceutical Services Branch having the regulation because of that deviance and risk of misuse of Schedule 8 medication, but we need to look at streamlining and making it easy.

For example, if I have to prescribe a stimulant, it's not too bad, it doesn't take too long, but I have to put in an application called 59E application, which I can show you. That's the piece of paper, it's two pages. You have to put that application in, whether it's me or the GP. It's not too much, but it still requires me putting that information, all the information and putting in the application and waiting for the approval from the Pharmaceutical Services Branch. They will send me a letter authorising me to prescribe and then only I can prescribe.

The complications here are that of, if for example, there's a history of substance misuse, then that would lead to the pharmaceutical branch asking us to do a urine drug screen and confirming that the patient is not misusing it. There may be delays. Then I have to do a urine drug screen, all for good reasons. For example, if it becomes positive, either that's the end of the road or later we will have to do a series of more urine drug screens to make sure and then referral to getting the patient to see the alcohol and drug services. So, complications like that.

There may also be a time delay because everybody's flooded with referrals with ADHD, so I suppose the pharmaceutical branch is also flooded with applications for a stimulant with the 59E application. There may be a time between me applying to the Pharmaceutical Service Branch and approving my application.

Then, of course, there may be time limitation in terms of when I could see the patient and prescribe and do the re-prescription. There's is a bit paperwork and a bit of time restrictions, which may delay the process. Sorry if I've have gone off track.

Ms HADDAD - No, not at all. It's very useful. Can I just clarify the 59E: is that the application for you to be authorised as the prescriber, or is that the application for the prescription to your patient, if those things are different? Because I've heard stories -

Dr REDDY - Sorry?

Ms HADDAD - I just wondered, the 59E, is that your application as a clinician to be authorised to be the prescriber associated with that patient, or is that the application for the prescription itself? We've heard of the psychiatrist will issue a prescription to the patient, but the patient may be waiting 3, 4, 5 weeks or longer for the prescription to be approved for them to go and dispense.

Dr REDDY - Yes, so the application is made by me and the letter is addressed to me, so you are authorising me to prescribe. For example, if I am in the clinic and I get the approval, I do immediately and within a week's time, we do an e-script or a prescription which goes to the patient. But say suppose I have the authority but I'm on leave so the patient has to wait for me to come back to do the prescriptions unless I endorse the GP, general practitioner too, authorising them to be the prescriber and then the GP can prescribe.

Ms HADDAD - It also takes time to transfer the prescribing rights to the GP rather than you as a psychiatrist?

Dr REDDY - Yes.

Ms HADDAD - So, the delay is being felt by the patient, is that right?

Dr PENNINGTON - Yes, and I think you are right that the approval endorses a specific prescriber for a specific patient, so both need to be endorsed.

Ms HADDAD - Thank you, and I do not want to hog the questions either, like Simon said, but that 59E application, does that apply to prescribing other types of medications like opioids or narcotics or benzodiazepine medication, or is it just for stimulant medication?

Dr PENNINGTON - It is not for benzodiazepines, and I believe it may be the only medication that requires the authority at point of initiation of prescription. Anil, is there anything else?

Dr REDDY - It is for Schedule 8 medications.

Ms HADDAD - All Schedule 8, okay. Thank you.

Ms ROSOL - Hi, Cecily Rosol, the Greens MP for Bass. You've talked a little bit about collaboration and the importance of care pathways. We have heard from psychologists and we've also heard stories of people who get an assessment of an ADHD diagnosis by their psychologist but have to follow that up with another assessment with a psychiatrist. I am wondering if you could give some insight, or your thoughts, around where psychology fits in with this and that broadening of collaboration beyond GPs and psychiatrists to some of the other members of the multidisciplinary team.

Dr PENNINGTON - Certainly. Anil, do you want to go?

Dr REDDY - I think the thing with clinical psychologists is, unfortunately, they cannot prescribe, they’re psychologists who do assessments and the assessments can, again, show inconsistencies depending on what screening tool they use or how valid the tool is. For example, a psychologist may do a screening tool and make a diagnosis, but unfortunately, they cannot prescribe. The patient then has to seek a psychiatrist to prescribe. Then I see the patient and, for example, if the patient had schizophrenia or psychosis and then the psychologist has 'diagnosed with ADHD,' I will be reluctant to prescribe stimulant medication to this particular patient because the psychosis can get worse or the bipolar can get worse. So I have to make a clinical decision whether it is appropriate for me to, again, confirm diagnosis and secondly, what is the right treatment here.

I suppose that would be the differences, for example, between the psychologist's assessment and us and the treatment. A lot of psychologists are doing the assessments, but the patient is then not able to find psychiatrists or psychiatrists in time to prescribe and there is a delay - and I am being a devil's advocate - there may be a psychiatrist who may not agree with my diagnosis and may not concur with the treatment.

So, there are all these complexities.

Dr PENNINGTON - I think that would speak to the benefit of a multidisciplinary clinic where you had various disciplines and an opportunity to have a case discussion. In that situation - because I concur with what Anil is saying - it's very difficult for a prescriber to accept a diagnosis that's been made by another colleague without doing the assessment themselves, just to be reassured that they're comfortable with that diagnosis and comfortable to prescribe. That becomes quite difficult.

Even if you're really respectful of your colleagues and generally concur with their opinions, you would really need to have an assessment yourself. Where you could streamline that is, if you had a multidisciplinary setting where you had access to psychologists, occupational therapists, psychiatrists, that could be a considered approach around the table after a clinical review. That would be a way of streamlining that stop-start approach that you're describing, which is really difficult for the person to go to a psychologist, when she says, 'Yes, you've got ADHD', but you need to go to psychiatrist to get a diagnosis. Then you have to wait. It's a really difficult journey for an individual, whereas if they could go to an ADHD clinic and know that they had their needs met there and they had all the aspects of their condition considered and the team came back to them and said, 'Yes, we believe you've got ADHD and we believe that you would benefit from medication.' Or 'yes, we believe you've got ADHD, however, we think there may be other approaches before medication,' that would be a really high quality of way of managing this.

CHAIR - Anyone else before I jump back in?

In the circumstance that Ms Rosol talks about where the interplay between psychologists and psychiatrists, and the experience that Ms Rosol outlined was exactly my experience where I went to a went to a psychologist and then was told, 'I can assess you, but I can't prescribe you and you're probably better off just doing it at the at the psychiatry stage,' and then there being the wait time for an appointment to open up.

In that period of knowing that I've been told that I've got ADHD to when I'm actually in front of a psychiatrist that can properly assess and prescribe me, that limbo of knowing, but knowing you can't do anything until you see that psychiatrist, is that a space where that more multidisciplinary approach could perhaps, instead of nothing and leaving a patient in limbo, having the psychologist providing psychotherapy as not just part of the package of support? I think it's been pretty well agreed on that the best treatment is a combination of medication and psychotherapy providing that as an interim until they're able to get in and be prescribed.

Dr PENNINGTON - Yes. That's a very considered and sensible pathway really, but that does speak again to the recommendation for needing to have high level training, education, specialised understanding across our workforce, whatever discipline you're in, about how we manage it and care for those who've got ADHD, so, yes, absolutely. As you point out, while medication is a really effective strategy and tool, it's not the only one. We want to make sure that people are getting the right care, but all the bits of the right care that they need.

CHAIR - There was talk, I think it was Anil, about the better training and some clarity in the process and pathway from start to finish for assessment and treatment from the perspective of other medical professionals. But then also, is there a need for some guidance and clarity to be accessible for the patient or the potential patient that's in that, 'okay, I think I might have ADHD, how do I even go about this?'

Anil would be familiar with my experience. I went to a clinic. I was told, 'You can't see us without a referral,' so I went to a GP. The GP didn't believe that I had it, suggested I had an iron deficiency, and then on some arm twisting referred me to a psychologist who then said, 'Well, I can assess you, but I can't prescribe you,' then referred me back to a GP to refer me to a psychiatrist. That whole process is like getting bounced around like a ping-pong and waiting for every single one of those appointments. Just providing, whether it's the THS or whether it's somewhere else, some centrally trusted place where someone can go, 'Okay, I think I've got ADHD, this is what the process should be', and then by the same token for GPs to go, 'Okay, someone's come to me with the potential that they might need to be assessed for ADHD, this is where I should send them,' rather than different people having very different experiences when they're trying to go through that process.

Dr PENNINGTON - Yes, absolutely. I think a centralised understanding, both physically and in terms of education, would be really helpful and that co-design would be an exceptionally useful thing as well. That collaboration with those with lived experience would add strength to any model that was considered.

Dr REDDY - I agree. I think there should be the same like a specialist, for example, an eating disorder unit or early psychosis unit or things that we should have a speciality clinic, part of the THS, which can include the multidisciplinary team approach, including a psychiatrist and psychologists who are interested in this area who can provide that expertise. And then similar stuff in private, which we are doing here at my clinic. I think we definitely need collaboration between all these systems which will improve the clarity or rather the misdiagnosis of ADHD and leading to other wrong treatment.

So, I think we need more funding to get this kind of specialist area improved in both public and private.

CHAIR - Just in the last couple minutes, it's been mentioned a few times from other witnesses and through submissions that the issue of awareness around ADHD and stigma both amongst the public and then some medical professionals, where some people may have an old, outdated view of ADHD and there may be some cynicism, perhaps to be diplomatic, around ADHD from everyone from GPs to some psychologists and psychiatrists. What's the solution to address that, other than wait for the generational change once like the new sort of generation of psychiatrists have a bit more of a modern understanding. What is the answer to that?

Dr PENNINGTON - Education, education, and more education, I think. It is a generational thing. It's also, I guess psychiatrists - it is our role to make sure that individuals are accurately diagnosed. We do need to make sure that it is those who do have a diagnosis of ADHD who are diagnosed and treated for that and to make sure that we identify and properly exclude and screen those who don't. So, that is one thing I would say.

I also think that in a system where we are already under-resourced and creaking at the seams, at the moment, this is something that is poorly understood and is relatively straightforwardly excluded from service. So, I think it's about education, understanding, training, certainly teaching our new psychiatrists, and trying to teach us old dogs new tricks as well so that we get a better understanding of what is actually going on.

I think that, with knowledge and resources, those barriers would be reduced and you would find that people could better access appropriate services. It's a combination of factors at the moment.

There's no doubt that there is a level of stigmatisation and a level of reservation of psychiatrists to wholeheartedly embrace everyone who presents with a diagnosis of ADHD, because we do see ourselves as an important part of making sure that people get the right diagnosis.

Dr REDDY - Just to add, you'll be surprised, with all due respect to all my colleagues and everybody, I think lot of medical profession, a lot of other people, don't believe it exists. They don't believe there's something called ADHD which exists. So, again, back to our education awareness to help the general population and also the medical professional to become aware of this diagnosis because it is only when it's very severe, that people believe that, yes, that is ADHD. But unfortunately most disorders happen on a spectrum. So when it's just attention deficit without hyperactivity or just ADHD which is mild, the question will come - 'How come they did a PhD or they became doctors and professionals and they're able to manage their ADHD this far but can't do it now? Why does it need medication now?' There are a lot of questions to be answered in that sense. But I think it goes back to improving the awareness and psychological about this condition.

CHAIR - We could ask another hour's worth of questions, I definitely could, but we're already a couple minutes over, so we might have to cut it short there. Thank you both for your time. It's been really helpful and informative.

Thank you for your appearance. Your evidence today is protected by parliamentary privilege. Once you leave, I remind you that privilege is not attached to comments you may make to anyone, including the media, even if you're just repeating what you said here today. Do you both understand that?

WITNESSES - Yes. Thank you.

THE WITNESSES WITHDREW.

The committee adjourned at 3.48 p.m.