



The Royal  
Australian &  
New Zealand  
College of  
Psychiatrists



Tasmanian Parliament

**Inquiry into the assessment and treatment of ADHD and Support Services**

August 2024

# Improve the mental health of communities

# Royal Australian and New Zealand College of Psychiatrists submission

## Committee Inquiry into ADHD Barriers in Tasmania

### About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is responsible for training, educating, and representing psychiatrists in Australia and New Zealand. The RANZCP has more than 8,400 members, including around 5,900 qualified psychiatrists and over 2,400 members who are training to qualify as psychiatrists (referred to as Associate members or trainees).

The Tasmanian Branch currently has 107 qualified psychiatrists and 41 members in training to qualify as psychiatrists.

Psychiatrists are clinical leaders in the provision of mental healthcare in the community and use a range of evidence-based treatments to support a person in their journey of recovery.

### Introduction

The RANZCP Tasmania Branch welcomes the opportunity to contribute to the House of Assembly Standing Committee on Government Administration B inquiry into the availability and efficiency of the assessment and treatment of Attention Deficit Hyperactivity Disorder (ADHD) and support services for adults and children with ADHD in Tasmania (the Committee Inquiry).

The RANZCP acknowledges ADHD as a major mental disorder and welcomes efforts to develop a more appropriate, accessible, equitable health system that caters for the needs of people with ADHD across their lifespan. This includes necessary improvements to the provision of services for the assessment, diagnosis, treatment, and management of people with ADHD throughout their lives.

Informed by a range of the RANZCP's expert Committees, including our Tasmania Branch Committee and the ADHD Network Committee, this submission provides the RANZCP response to all of the [terms of reference](#).

The Tasmanian Branch Committee supports the recommendations in the [RANZCP submission](#) to the Australian Federal Inquiry into Assessment and support services for people with ADHD.

For further information on the RANZCP's position on the assessment and treatment of people with ADHD, please see Position Statement 55: [ADHD Across the Lifespan](#) and the RANZCP endorsed [Australian ADHD Professionals Association \(AADPA\) Evidence-Based Clinical Practice Guideline for ADHD](#).

### Background

ADHD is a clinical syndrome of pervasive inattention and/or hyperactivity and impulsivity, which is in excess of that typical for one's developmental age. It adversely affects learning, interpersonal relationships, and occupational and overall functioning, and has a mortality rate above that in the general population.[1] ADHD's complex presentation and persisting impairments, including significant emotional dysregulation, from childhood into adult life arise from its heterogenous genetic, epigenetic, and environmental aetiology. [1-16]

ADHD is the most common neurodevelopmental disorder in Australia. Estimates of ADHD prevalence vary: the [Australian Institute of Health and Welfare](#) has estimated prevalence among children at 8.2%, while the Deloitte Access Economics report: The [social and economic costs of ADHD in Australia](#), estimated the prevalence in children (aged zero to 14 years) to be 4.1%, and 3.0% for adults (aged 15 years and over).[17]

ADHD is underdiagnosed and undertreated in public sector mental health services. This affects people who are unable to afford psychiatric care through the private sector and is compounded by a lack of public sector capacity to meet the need for assessment and treatment, particularly as they transition into adult services.

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### Key recommendations

The Tasmanian Branch of the RANZCP recommends that the Tasmanian Government;

- Support the delivery of specialised public ADHD mental health services to improve access to assessment and treatment.
- Ensure public training pathways for further specialised education and training are offered to all medical professionals involved in the care of patients with ADHD (in line with the [AADPA Guidelines](#)).
- Collaborate with the Federal government to develop and implement effective measures to improve access to care for those experiencing financial disadvantage.
- Review ADHD psychostimulant regulations and administrative processes to improve efficiencies while managing risk.

### Terms of Reference

#### a. adequacy of access to ADHD diagnosis.

When assessing for ADHD clinicians should perform a comprehensive assessment so that ADHD and other, possibly comorbid, psychiatric disorders (e.g. anxiety, bipolar affective disorder, depression etc.) can be diagnosed. For children and adolescents this is normally done within the Tasmanian Health Service by paediatricians and Child Youth Mental Health Services psychiatrists where a patient has been referred to the relevant services.

Access to ADHD assessment and treatment is far more restricted for adults in Tasmania. There are only 3 psychiatrists in Tasmania currently who actively assess and treat ADHD. All are in private practice, and one operates solely through telehealth. There is infrequent diagnosis of ADHD within the Adult Mental Health Services setting, as most patients do not meet the admission criteria.

Presently, there is limited capacity for adult public mental health services to provide assessment and treatment for ADHD. A similar situation exists in child and adolescent mental health services. Given that ADHD is the most common neurodevelopmental disorder, is more treatable than other neurodevelopmental disorders and often co-exists with many high prevalence psychiatric disorders (such as depressive, anxiety, substance use, psychotic, trauma spectrum and personality disorders), public mental health services should be supported with additional funding to train mental health clinicians and to integrate assessment and treatment of ADHD in the core business model. The Branch urges the Tasmanian Government to support public mental health services to deliver this important activity through funding, resourcing and education.

#### b. adequacy of access to supports after an ADHD assessment.

The RANZCP acknowledges that people with ADHD can reach high levels of achievement academically or professionally; however, the cognitive, socioeconomic, and cultural effects of ADHD mean they require adequate access to supports after their diagnosis. Across educational and professional settings, people with ADHD encounter significant barriers and challenges across their lifespan.

- Primary health

Psychiatrists should not be the only providers of continuing management of ADHD as this would reduce new patient assessment and treatment. At present, there is a significant gap in the knowledge and skills between primary and specialist sectors in relation to ADHD assessment and treatment, despite general

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practitioners (GPs) being the first contact for patients. There should be training initiatives at the state level to upskill GPs.

A recent improvement in Tasmania has been for GPs to continue prescribing after assessment and recommendation by a local psychiatrist under the Tasmanian Government [GP Guarantee](#). However, any change in dosing still necessitates a return to the psychiatrist for review.

- Specialist Mental Health Services

A subgroup of patients with ADHD have other associated psychiatric disorders, (e.g. substance use disorders, major mental illness, trauma spectrum disorders, personality disorders) adding to the complexity of management in primary care. Child and adolescent and adult public mental health services would benefit from enhanced training, to negotiate the complexity. Funding for public ADHD clinics would improve access for assessment and treatment given the unmet community need.

- c. the availability, training, and attitudes of treating practitioners, including workforce development options for increasing access to ADHD assessment and support services.**

- Training

The limited number of health professionals trained in the assessment and support of those with ADHD results in bottlenecks in diagnosis and care, which directly impacts patient's everyday lives. The training of and bolstering of the existing workforce is critical to rapidly increase the accessibility of ADHD diagnosis, treatment, and support. Training, however, is currently highly variable with limited availability.

Medical professionals engaged in provision of ADHD treatment, including all psychiatrists, should receive education and training in the aetiology, assessment, treatment, and ongoing care of ADHD across the lifespan to a breadth and depth appropriate to their professional care. Given that patients with ADHD require a multimodal and multi-disciplined approach to treatment and support, this training should extend across curriculums for a range of disciplines. The Tasmania Branch supports the recommendations within the [AADPA Guideline](#) (Section 7.4 – Professional Training).

- Attitudes

ADHD remains poorly understood by healthcare services, governments, the general public and many medical professionals. It is often dismissed as a behavioural problem or personality disorder. This can have a damaging effect on consumers' health and ongoing treatment. As detailed in our strategic plan (2022-25), the RANZCP is committed to the development of contemporary evidence-informed clinical and practice resources to support the delivery of ADHD assessment and treatment.

- d. regulations regarding access to ADHD medications, including the Tasmanian Poisons Act 1971 and related regulations, and administration by the Pharmaceuticals Services Branch (PSB), including options to improve access to ADHD medications.**

The Tasmanian Poisons Act 1971 is more than 50 years old and needing review. The current regulations under the Act, through the Pharmaceutical Services Branch (PSB), are seen by clinicians as overly restrictive, creating a tension between safety regulations and patient access to treatment. Concerns about drug diversion are valid but may be overly weighted in the regulations and their applications.

Current processes are seen by clinicians as restrictive resulting in a slow authorisation process in complex cases likely due to a significant under resourcing of the pharmaceutical services branch. A separate legislative sub framework for stimulants that focuses on treatment and has a therapeutic focus for an illness with lifelong consequences, has both economic and health benefits for the state and individual.[17]

Schedule 8 psychostimulants are listed under Regulation 24 which requires an authority at the point of initiation. Patients with complex comorbidities are processed differently creating a significant administrative

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load for psychiatrists. The administrative burden also increases when a patient's dosage of medication is changed above the authorised range as a new authority must be lodged.

The requirement for an authority at the point of initiation is only replicated for high-risk opioids such as a pethidine and fentanyl, where deaths are much more likely (there is no other known non-life sustaining medicine that is responsible for so many preventable deaths). This is opposed to prescriptions of opioids for persistent pain where the vast majority only require authority when prescribed beyond 60 days. We urge the Tasmanian Government to support reformed and fit for purpose prescribing regulations of S8 psychostimulants.

### **e. the adequacy of, and interaction between the State Government and Commonwealth services to meet the needs of people with ADHD at all life stages.**

The RANZCP emphasises that cooperation between Commonwealth, state and local government services is critical to meet the needs of people with ADHD at all life stages. Consumers are mobile between jurisdictions, and ADHD is a life-long mental health condition. Cooperation and administrative-legislative congruence between regulatory and governmental bodies at all levels is a crucial requirement for patients to be able to receive high quality treatment and assistance with ADHD throughout their life.

An inhibiting factor for residents of Tasmania in receiving effective and equitable support for ADHD is the regulations surrounding psychostimulants. Currently there are differences between states and territories in the conditions of how stimulants can be prescribed and the maximum doses of the medicines. In addition, some states/territories, including Tasmania do not honour prescriptions from other jurisdictions, and therefore require a local assessment, including patients that are stably maintained. This adds unnecessary burden and pressure on the limited number of psychiatrists that treat ADHD in the state and patients who may suffer discontinuities of care.

The cost of services is another barrier to adults in Tasmania receiving adequate ADHD services. Due to the workforce shortages and inability of the public system to service the (ADHD) requirements of Tasmanians, most are forced to rely on private psychiatry for assessment and treatment. For those experiencing financial hardships this can be a prohibitive burden.

The Branch urges the Tasmanian Government to work with the Federal Government to;

- Develop bulk-billing incentives for psychiatry consultations for patients experiencing financial disadvantage.
- Means-tested bulk billing incentives must be prioritised to ensure those experiencing financial disadvantage obtain affordable access to ADHD diagnosis.

Such reforms must be supported by continual review of effective measures of financial disadvantage to ensure the long-term efficacy of funding reform and the provision of services to those in need. This reflects Recommendation 11 of the [Evaluation of the Better Access Initiative](#).

### **f. the social and economic cost of failing to provide adequate and appropriate ADHD services.**

ADHD is the most common neurodevelopmental disorder in Australia. Although there has been a significant increase in the recognition and diagnosis of ADHD over the last twenty years, it remains under-diagnosed and under-treated. For people living with ADHD the cognitive, socioeconomic, and cultural effects of ADHD mean they are likely to encounter significant barriers and challenges across their lifespan. Patients with ADHD are likely to have higher healthcare costs than their peers, both as children and adults.[18] The financial cost to families of raising a child with ADHD over the course of the child's life has been estimated as being up to five times higher.[18]

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In Australia, untreated ADHD has enormous economic costs to society with estimates of overall cost amounting to \$20 billion per year. [19-21] The unique features of untreated ADHD often lead to significant personal and social costs, with higher mortality rates in individuals with ADHD than those without across both Australia. The Deloitte Access Economics report: [The social and economic costs of ADHD in Australia](#) details costs across multiple domains, including costs to the health, education and crime and justice systems, as well as costs to productivity, taxation revenue costs and the deadweight loss of taxation payments.

### **g. any other related matters**

Community and carer involvement as best practice to equitably provide ADHD assessment and treatment, alongside the provision of culturally appropriate social support, services should be co-produced and governed by experts in mental health, with patients, family carers and clinicians working in equal partnership. As noted in the [RANZCP's position statement on partnering with carers in mental healthcare](#), shared care arrangements with carers, community and family support structures supports ADHD treatment by broadening the understanding of the patient's personal, educational, occupational, and social functioning at key interventions across their lifespan.

- **Addiction Perspective**

Noting that stimulant medications are subject to abuse and diversion, the role of the psychiatrist also involves ensuring that universal precautions are routinely applied when prescribing stimulants.[22] In particular, a patient background of addictive behaviour requires extra prescribing caution e.g., a more prolonged assessment phase, a preference for long-acting formulations, staged supply, urine drug screens and close follow-up supervision. In this scenario, the use of third-party informants and collateral information becomes even more useful.

- **Justice and Custodial Systems**

Although it is well recognised that the prevalence of ADHD in custodial settings is substantially higher than in the community (20-45% in youth justice populations,[23,24] and 20.5% in adult prison populations,[25]), multiple barriers exist that result in substantial under-treatment of ADHD amongst this population.[26] Young people with ADHD are more than twice as likely to be convicted of a crime and three times more likely to be incarcerated,[27] with substantially higher rates of recurrent offending with earlier re-entry to justice systems than young people without ADHD.[28]

Incarceration rates in Tasmania have increased significantly (from 630 prisoners in June 2022 to 751 prisoners in June 2023). [29] ADHD is likely to be overrepresented in this increasing prison population, however, Tasmania is the only Australian jurisdiction which does not have an integrated prison mental health service. In addition, while prison mental health services require 11 full-time equivalent mental health staff for every 550 prisoners, in Tasmania, there are approximately 2 mental health staff per 550 prisoners.[30]

Further to this, the fragmentation of care between state funded custodial health services and community-based health services, both public and private, presents a significant barrier to successfully implementing evidence-based treatment in a custodial setting. Even if treatment is initiated, it is often discontinued upon a person's release from custody because they are unable to access the necessary treatment providers for both pharmacological and non-pharmacological interventions.

The Branch highlights the critical need for a state-run and integrated prison forensic mental health service. We urge the Tasmanian Government urgently review workforce requirements to service Tasmania's current and future needs, in line with accepted benchmarks.

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### References

1. Kooij JJS et al. Updated European Consensus Statement on diagnosis and treatment of adult ADHD. *Eur Psychiatry*. 2019 Feb; 56:14-34.
2. Katzman MA et al. Adult ADHD and Comorbid Disorders: Clinical Implications of Dimensional Approach. *BMC Psychiatry*. 2017 Aug;17(302).
3. Brikell I et al. Insights into attention-deficit/hyperactivity disorder from recent genetic studies. *Psychological Medicine*. 2021; 51(13):2274-2286.
4. Demontis D et al. Discovery of the first genome-wide significant risk loci for attention deficit/hyperactivity disorder. *Nat Genet*. 2019 Jan;51(1):63-75.
5. Yadav SK et al. Genetic variations influence brain changes in patients with attention-deficit hyperactivity disorder. *Transl Psychiatry*. 2021 Jun;11(1):349.
6. Nussbaum NL. ADHD and female specific concerns: a review of the literature and clinical implications. *J Atten Disord*. 2012 Feb;16(2):87-100.
7. Ostojic D & Miller C. Association Between Pubertal Onset and Symptoms of ADHD in Female University Students. *Journal of Attention Disorders*. 2016 Sep; 20(9): 782–91.
8. Faraone SV et al. The World Federation of ADHD International Consensus Statement: 208 Evidence-based conclusions about the disorder. *Neuroscience & Biobehavioral Reviews*. 2021;128: 89-818.
9. Beheshti A, Chavanon ML & Christiansen H. Emotion dysregulation in adults with attention deficit hyperactivity disorder: a meta-analysis. *BMC Psychiatry*. 2020 Mar;20(1):120.
10. Faraone SV & Larsson H. Genetics of attention deficit hyperactivity disorder. *Molecular psychiatry*. 2019 Apr;24(4):562-75.
11. Shaw P et al. Emotion dysregulation in attention deficit hyperactivity disorder. *Am J Psychiatry*. 2014 Mar;171(3):276-93.
12. Villemonteix T et al. Grey matter volume differences associated with gender in children with attention-deficit/hyperactivity disorder: A voxel-based morphometry study. *Dev Cogn Neurosci*. 2015 Aug;14:32-7.
13. Van Stralen J. Emotional dysregulation in children with attention-deficit/hyperactivity disorder. *Atten Defic Hyperact Disord*. 2016 Dec;8(4):175-187.
14. Wender PH. Attention-deficit hyperactivity disorder in adults. *Psychiatr Clin North Am*. 1998 Dec;21(4):761-74.
15. Reimherr FW et al. ADHD and Anxiety: Clinical Significance and Treatment Implications. *Curr Psychiatry Rep*. 2017 Nov 20;19(12):109.
16. Tannock R. ADHD with anxiety disorders. In Brown TE (Ed.). *ADHD comorbidities: Handbook for ADHD complications in children and adults*. American Psychiatric Publishing. 2009;131–155
17. Australia's Children. Australian Government: Institute of Health and Welfare; 2020.
18. Solanto MV. Child vs adult onset of attention-deficit/hyperactivity disorder. *JAMA Psychiatry*. 2017; 74(4):421.
19. Sciberras E et al. Social and economic costs of attention-deficit/hyperactivity disorder across the lifespan. *Journal of Attention Disorders*. 2020 Oct. *Eur Psychiatry*. 2019 Feb;56:14-34.
20. Katzman MA et al. Adult ADHD and Comorbid Disorders: Clinical Implications of Dimensional Approach. *BMC Psychiatry*. 2017 Aug;17(302).
21. Kooij JJS et al. Updated European Consensus Statement on diagnosis and treatment of adult ADHD.

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22. Gourlay D & Heit H. Universal Precautions Revisited: Managing the Inherited Pain Patient. *Pain Medicine*. 2009 Jul;10(2):S115–S123
23. Justice Health & Forensic Mental Health Network and Juvenile Justice NSW. 2015 Young People in Custody Survey: Full Report Justice Health & Forensic Mental Health Network 2015.
24. Harpin V & Young S J The Challenge of ADHD and Youth Offending Cutting Edge Psychiatry in Practice 2012 January: 138-143.
25. Young S et al. A meta-analysis of the prevalence of attention deficit hyperactivity disorder in incarcerated populations. *Psychol Med*. 2015 Jan;45(2):247-58.
26. Baggio et al. Attention deficit hyperactivity disorder as a neglected psychiatric disease in prison: call for identification and treatment. *Forensic Science International: Mind and Law*. 2022 3;100071.
27. Mohr-Jensen C et al. Attention-Deficit/Hyperactivity Disorder in Childhood and Adolescence and the Risk of Crime in Young Adulthood in a Danish Nationwide Study. *J Am Acad Child Adolesc Psychiatry*. 2019 Apr;58(4):443-452.
28. Philipp-Wiegmann F et al. ADHD modulates the course of delinquency: a 15-year follow-up study of young incarcerated man. *European Archives of Psychiatry and Clinical Neuroscience* 2018 268: 391-399.
29. Prisoners in Australia. Australian Bureau of Statistics; 2023.
30. Tasmania's Prison Mental Health Care Taskforce reveals system failing inmates, advocates say. ABC News; 2020.

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