



The Royal
Australian &
New Zealand
College of
Psychiatrists



Senate Standing Committee on Community Affairs
Inquiry into Assessment and support services for people with ADHD
June 2023

Improve the mental health of communities

Royal Australian and New Zealand College of Psychiatrists Submission

Inquiry into Assessment and support services for people with ADHD

About the Royal Australian and New Zealand College of Psychiatrists (RANZCP)

The RANZCP is a membership organisation that prepares doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness and advises governments on mental health care. The RANZCP is the peak body representing psychiatrists in Australia and New Zealand and as a bi-national college has strong ties with associations in the Asia-Pacific region.

The RANZCP has more than 7900 members including more than 5600 qualified psychiatrists. Psychiatrists are clinical leaders in the provision of mental health care in the community and use a range of evidence-based treatments to support a person in their journey of recovery.

Introduction

The RANZCP welcomes the opportunity to provide a submission to the Senate Standing Committee on Community Affairs' [Inquiry into the Barriers to consistent, timely and best practice assessment of attention deficit hyperactivity disorder \(ADHD\) and support services for people with ADHD](#).

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 ADHD Network Committee, this submission provides the RANZCP's response to all the [terms of reference](#).

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]

Untreated and un-diagnosed ADHD has significant personal, family and community costs, associated with higher rates of behavioural and conduct problems, accidents, injuries and death, school and learning difficulties, workplace difficulties, substance use disorders, family and interpersonal conflict, gambling and financial difficulties, law enforcement and incarceration costs.

Despite this prevalence the RANZCP is aware of significant service gaps, with a fragmented care system that contrasts with the urgent need for a multimodal, multi-professional and multi-agency approach to ADHD care. Such fragmentation increases the significant barriers to equitable access. 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

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capacity to meet the need for assessment and treatment, particularly as they transition into adult services. Public services are also often difficult to access due to long waiting lists and out-of-pocket costs for both assessment and treatment.

Terms of Reference

a. Adequacy of access to ADHD diagnosis.

Psychiatrists' unique and comprehensive understanding of the bio-psycho-social assessment and treatment of ADHD puts them at the centre of ADHD diagnosis. All patients must undergo a psychiatrist led comprehensive assessment so that ADHD and other, possibly comorbid, psychiatric disorders (e.g. anxiety, bipolar affective disorder, depression etc.) can be diagnosed. This comprehensive psychiatric assessment may lead to a diagnosis of ADHD or alternate or comorbid conditions. Within ADHD services, the RANZCP advocates for psychiatrists being in a position of clinical leadership within a multidisciplinary team.

Psychiatrists' ability to offer access to a diagnosis of ADHD is however limited by psychiatric workforce shortages, and the current cost of accessing psychiatric treatment through the private sector.

- Workforce Shortages

The [Productivity Commission](#) and the National Skills Commission's [Skills Priority List](#) have both identified a national shortage of psychiatrists. Without an adequate number of clinicians to meet the needs of the community, patients can be left under treated or without access to services entirely. The needs of patients for greater access to affordable services is a key priority for the RANZCP. Raising demands on the existing mental health workforce also contributes to burnout, high rates of leave and staff exiting the workforce.

To improve the access for patients to psychiatrist services in a timely and equitable fashion and enable access to an ADHD diagnosis, the RANZCP advocates that the Inquiry recommend the Commonwealth Government further commit to psychiatry workforce initiatives including the [Specialist Training Program](#), [Psychiatry Workforce Program](#) and the [Rural Psychiatry Roadmap](#).

Owing to the early onset of ADHD, the RANZCP recommends the funding of additional child and adolescent psychiatry positions. Of the approximately 80,000 children with a severe disorder, only 22,000 had seen a psychiatrist (27%) over a 12-month period.[18] Calls for increased access to child and adolescent psychiatry echo those of the [Productivity Commission report](#), the [National Mental Health Service Planning Framework](#) and [RANZCP's Child and Adolescent Psychiatrist Workforce Discussion Paper](#).

- Cost

Noting the lack of public sector capacity to diagnose and treat ADHD, many patients seek services via the private sector. For those experiencing financial disadvantage, this is a significant financial burden. The RANZCP advocates that the Inquiry recommend the following actions to allow psychiatrists to assess those experiencing financial disadvantage for ADHD:

- Increase the MBS rebate for psychiatry services to 100% of the schedule fee from the current 85% and increase the MBS billing provision for psychiatry trainees, so that they can bill at 60% of the consultant psychiatrist rate.

The affordability of services for patients of all socio-economic levels is paramount to providing equitable access to mental health care services. Many RANZCP members have raised that MBS rebates for psychiatry services are too low to meet the costs associated with delivering these services, causing the costs to be absorbed by the consumer. For Australians experiencing financial disadvantage, the cost of seeing a psychiatrist can mean delaying a diagnosis for ADHD. Increasing the bulk-billing incentive to 100% (that of general practice) will improve the affordability of psychiatry services by increasing the number of bulk-billed patients. The RANZCP's advocacy reflects Recommendation 9 of the [Evaluation of the Better Access Initiative](#), to determine appropriate levels for MBS fees.

- Develop bulk-billing incentives for psychiatry consultations for patients experiencing financial disadvantage.

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Means-tested bulk billing incentives must be prioritised to ensure those experiencing financial disadvantage obtain affordable access to ADHD diagnosis. Such reform 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](#).

- Funding for public mental health services

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.

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

- Specialist mental health services

A subgroup of patients with ADHD have other associated psychiatric disorders, which carry the risk of falling between gaps (e.g. substance use disorders, trauma spectrum disorders, personality disorders) as these patients cannot be adequately treated in primary care. Child and adolescent and adult public mental health services should be supported through funding, training and mentoring so that this subgroup of patients can be case managed for a sufficient period to allow recovery and improved functioning. Funding for public ADHD clinics would improve access for assessment and treatment.

- Educational settings

Symptoms of ADHD can result in unsupported or untreated students falling behind academically in comparison to their peers and experiencing adverse social treatment by both peers and teachers.[19] There is evidence that many schools do not provide management plans or adequate support for students with ADHD. These gaps are compounded by punitive and exclusionary punishment practices.[20] The RANZCP endorses the Australian ADHD Professionals Association (AADPA) [guideline](#), which includes the following recommendations:

- 7.2.2 Students with ADHD of all ages require reasonable adjustments to be made to maximise their inclusion and learning opportunities. Co-occurring neurodevelopmental disorders including specific learning disorders should be identified and supported. The types and number of adjustments should be decided as part of an individual learning support plan developed with the person with ADHD, their carers, education staff and other relevant clinicians.

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- 7.2.3 Education settings should be supported to implement learning support plans, host inter-agency meetings, and possibly host visiting clinicians to consult and provide intervention recommendations.

We also note that school education systems often require a formal diagnosis before a child can receive supports. Given the challenges in accessing appointments, and the cost barrier facing many families, this requirement excludes many students from appropriate supports, and further marginalises children and young people who come from lower socio-economic backgrounds. The resultant impact on learning may translate into lessened options for further study and work, and a lifetime of lower income.

- Professional settings

The RANZCP highlights work as a challenge due to ADHD, including difficulty with listening and recalling instructions, speaking and listening at meetings, time management, psychological distress and managing workplace burnout.[21] Individuals with ADHD are more likely to face difficulty gaining and maintaining employment compared to neurotypical adults, especially if they received no treatment in childhood.[22-23] In the United States, college graduates with ADHD earn much less per year than their peers.[24] Individuals with ADHD need improved services across healthcare and community settings to remedy this issue.

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

- Availability

As discussed previously, access to ADHD assessment and subsequent support is severely impacted by the supply of psychiatrists to diagnose. Without diagnosis, patients are unable to receive mental health care treatment, or the accommodations and support often required for them to thrive in academic, employment and social settings. However, the RANZCP notes that such inaccessibility is compounded by the ineffectiveness of current shared-care mechanisms. This in turn serves to reduce access to care, silo services, and deprive professionals of autonomy.

The RANZCP notes the existence of one such mechanism, which exemplifies how the current design of shared care mechanisms serves to contradict best practice for the assessment of ADHD. Medicare Benefits Schedule Item 291 allows a GP to refer a patient to a psychiatrist for either an 'opinion and report' – for the GP to then manage as the primary health-care provider. This includes the authorisation to prescribe stimulant medications. However, as the patient is only eligible for one Medicare rebate under this site, this does not support follow up assessments as often two or more assessment sessions (depending on the clinical complexity) are needed to clarify and confirm the diagnosis of ADHD and associated conditions. The RANZCP recommends that there be an allowance of three instances of the 291 item code within a six-month period in order to provide accurate assessment, confirmation of diagnosis, and/or review of prescribed medications.

Systemic change is required to facilitate the collaborative development of a comprehensive assessment and management plan between a psychiatrist, other relevant clinician, the individual with ADHD and/or their carer engaged in information sharing – see the RANZCP [Professional Practice Guideline 20: Information sharing with families/ whanau/ carers](#). This is the basis of good clinical care. It ensures continuity of care as patients move between age groups, health services and community services, whilst proactively recognising and adjusting to new psycho-social/environmental factors that may emerge throughout the patient's lifespan.

Of particular importance is the forging of connections between child health services, child and adolescent mental health services, and adult mental health services. Multidisciplinary ADHD teams including paediatricians, child and adolescent psychiatrists, and adult psychiatrists can ensure that psychiatric services

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are age appropriate across one's lifespan. To support such change the RANZCP recommends the following action, as outlined in our 2023-2024 Pre-budget submission:

- Investment in MBS Item numbers to support psychiatrists engaging in multidisciplinary cooperation, and forge connections between mental health, physical health, and other social services. Items should include case discussions, case conferences and phone advice with paediatricians, psychologists, GPs, nurse practitioners and ADHD coaches. Such multidisciplinary co-management would enable psychiatrists to collaborate in the best practice management of many more people with ADHD, allowing prompt assessment of new patients.

- 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 the existing workforce is critical to rapidly increase the accessibility of ADHD diagnosis, treatment and support. Training, however, is currently highly variable.

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.

Whilst ADHD is typically on the curriculum for the training of psychiatrists, paediatricians, and psychologists, it is often a neglected area in clinical education and supervision and is not a mandatory training requirement. Later stage clinicians and psychiatrists are also unlikely to have practical training in diagnosis and treatment. Developing the capacity of care providers to recognise and treat ADHD, outside of medical professions such as psychiatrists and paediatricians, would also widen access to ADHD assessment and treatment, which would have a marked impact on patient's quality of life.

In keeping with the recommendations within the [AADPA Guideline](#) (Section 7.4 – Professional Training) the RANZCP recommends that:

- Information about ADHD and its treatment and support options throughout the lifespan is included in the curriculums of mental health/developmental disorder training for educators, medical, nursing, pharmacy, and allied health professionals and other relevant professions such as social work, justice system, and child protection.
- Organisations providing services to people with ADHD, including all public health services (child, adolescent, adult), should ensure staff receive appropriate ADHD training including, where appropriate, skills to identify, diagnose, treat and provide ongoing monitoring and support. This includes training and resources for those involved in transitioning people with ADHD from adolescent to adult services.
- GPs and other specialist medical practitioners, paediatricians, psychiatrists, and geriatricians are supported to increase their skills in identifying, diagnosing, and treating people with ADHD, including prescribing stimulants.
- Ongoing professional development for ADHD treatment and care options (both interdisciplinary and discipline-specific) is made readily available.

- 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. In order to support the health and

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treatment of patients, the RANZCP advocates for the development, dissemination and maintenance of contemporary evidence-informed clinical and practice resources to break down misconceptions surrounding ADHD. The RANZCP also recommends the provision of 'consumer-friendly' resources to challenge similar negative attitudes towards ADHD within the community.

d. Impact of gender bias in ADHD assessment, support services and research.

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 in females. In childhood, approximately three males are diagnosed with ADHD for every female (rising to six in clinical settings). This evens out in adulthood, reflecting a combination of under-recognition and later onset in females, or remission in males.[25-29] Masking and internalisation of symptoms and behaviours is common in females and social perceptions of, for example, the "chatty girl", leads to the under-recognition of the disorder.[25-26]

Girls with ADHD have been shown to be more easily distinguished from their peers without ADHD by reference to their comorbidities than by classical ADHD symptoms.[37] Comorbidities, especially anxiety, depression, eating disorders, substance use disorders and deliberate self-harm are common. All clinicians who work with people with these disorders should be trained to screen for ADHD and refer or treat as necessary. Federal funding to promote research into gender bias is also urgently needed.

e. Access to and cost of ADHD medication, including Medicare and Pharmaceutical Benefits Scheme coverage and options to improve access to ADHD medications.

The RANZCP contends that current scheduling within the Pharmaceutical Benefits Scheme (PBS) inhibits the delivery of best practice treatment for ADHD, including pharmacological. In Australia, the PBS subsidises ADHD medications but has limitations based on both age and dosage:

- For children diagnosed between ages 6-18 inclusive, and for the rest of their lives, the PBS subsidises methylphenidate, dexamfetamine, lisdexamfetamine, long-acting methylphenidate, guanfacine and atomoxetine
- For adults diagnosed after the age of 18 years (Retrospective diagnosis), the PBS only subsidises methylphenidate, dexamfetamine, lisdexamfetamine and one type of long-acting methylphenidate (LA version).

The [AADPA guideline](#) states that for people with co-morbid substance use disorder, non-psychostimulant medications should be first line pharmacotherapy, with modified release psychostimulants as second line, and immediate release psychostimulants as third line agents in this patient group. The current PBS scheduling makes it difficult to provide affordable access to best practice treatment for people with co-morbid ADHD and who were not diagnosed in childhood. The known association between ADHD and substance use disorder means that this is not a rare co-morbidity, and that these limitations impact accessibility for a substantial number of patients.

The RANZCP recommended in our 2023-2024 Pre-budget submission that the PBS list long-acting methylphenidate for those over 18, alongside the subsidy of additional medications including Bupropion, Modafinil, Atomoxetine, agomelatine and vortioxetine and the revision maximum doses of medications permitted under the PBS.

f. The role of the National Disability Insurance Scheme (NDIS) in supporting people with ADHD, with particular emphasis on the scheme's responsibility to recognise ADHD as a primary disability.

The RANZCP recommends that, because of its complex presentation, persisting impairments from childhood into adult life, and prevalent comorbidities with other psychosocial conditions, ADHD is included

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within the NDIS as an eligible psychosocial disability. The RANZCP supports the recommendations of the AADPA guideline:

- 7.1.3 People with ADHD should have the same rights of access to NDIS as those with a disability who do not have ADHD. To ensure optimisation of necessary and reasonable NDIS interventions and supports for people with ADHD, a shared understanding of the following is needed:
 - appropriate accommodations
 - value of suitably qualified ADHD coaches
 - the importance of a specialist in ADHD as a lead member of the care team.
- 7.1.4 Eligibility and access to support from the NDIS should be decided based on the functional needs of the person with ADHD, and not based solely on diagnosis.

g. The adequacy of, and interaction between, Commonwealth, state and local government services to meet the needs of people with ADHD at all life stages.

The RANZCP emphasises that interaction between Commonwealth, state and local government services is critical to meet the needs of people with ADHD at all life stages. Consumers are not immobile, and ADHD is a life-long mental health condition. Interaction 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. A lack of effective communication and interaction between Commonwealth, state and local services causes unnecessary harm to patient's health and ability to access necessary treatments and accommodations and hinders recovery and lifestyle.

This is pertinent considering the varying jurisdictional regulations for the prescription of stimulant medications. State and territory-based regulations surrounding the management of controlled substances ('Schedule 8' - dangerous drugs/poisons) determine the prescription of stimulants through various mechanisms:

- [Australian Capital Territory](#) (Canberra script)
- [New South Wales](#) (SafeScript NSW)
- [Northern Territory](#) (NTScript)
- [Queensland](#) (QScript)
- [South Australia](#) (ScriptCheckSA)
- [Tasmania](#) (TasScript; previously DORA)
- [Victoria](#) (SafeScript)
- [Western Australia](#) (ScriptCheckWA)

This variation poses a great difficulty for patients moving between jurisdictions and for clinicians engaging in telehealth across jurisdictions. Currently, there are significant differences between different states and territories in the conditions of how stimulants can be prescribed and the maximum doses of the medicines. In addition, some states/territories do not honour prescriptions from other jurisdictions. The regulations on State and territory Health Department websites range from well laid out, specific instructions and ready access to application forms, to vague information to contact the local S8/Drugs of Dependence Units with all enquiries.

To reduce these complications and subsequent barriers to access, the RANZCP recommends that in keeping with [AADPA Guideline](#) Recommendation 7.1.2:

- Laws and regulations for stimulant prescribing and shared care should be uniform between the states and territories in Australia and allow for cross-border dispensing.

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In the current absence of this, the RANZCP stresses the need for all states and territories to provide clear guidelines for stimulant prescribing in both routine and non-routine situations (e.g. high dose, comorbidity/substance abuse disorders) so that clinicians can efficiently provide appropriate treatment to patients with ADHD.

The RANZCP does note the existence of the [Real-Time Prescription Monitoring \(RTPM\)](#), a nationally implemented system designed to monitor the prescribing and dispensing of controlled medicines to reduce their misuse across all states and territories. However, RTPM is only mandatory in Victoria and Queensland, limiting the efficacy of the program.

h. The adequacy of Commonwealth funding allocated to ADHD research.

As detailed in our [strategic plan](#) (2022-25), the RANZCP is committed to developing contemporary evidence-informed clinical and practice resources to support the profession deliver psychiatric care. The RANZCP supports the development of greater research on the best practice for diagnosis and treatment of ADHD. The RANZCP recognises the numerous research gaps and subsequent priorities, highlighted within the RANZCP endorsed [AADPA guideline](#) (page 178 – 180).

Research must include people with a lived experience of, or caring for something with ADHD, and follow established participatory research methods. This process will support the greatest relevance and benefit of the research to the ADHD community. Please see RANZCP Position Statement 62: [Partnering with people with a lived experience](#) (September 2021) for further information.

The RANZCP also notes that, owing to the varying jurisdictional regulation of controlled substances (Schedule 8), research on the prescription and impact of stimulant medications must occur across Australian jurisdictions at a state and territory level.

i. The social and economic cost of failing to provide adequate and appropriate ADHD services.

ADHD is the most common neurodevelopmental disorder in Australia. Estimates of ADHD prevalence vary: the [Australian Institute of Health and Welfare](#) has estimated the 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] 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.[32] 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.[32]

In Australia, untreated ADHD has enormous economic costs to society with estimates of overall cost amounting to \$20 billion per year.[30-32] 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.

j. The viability of recommendations from the Australian ADHD Professionals Association's Australian evidence-based clinical practice guideline for ADHD.

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The RANZCP officially endorses the [AADPA's Australian evidence-based clinical practice guideline for ADHD](#) and recommendations. Following significant consultation with RANZCP members, including a selection of our members' presence on the Guideline Development Group, the RANZCP recognises the [guideline](#) as a considered and high-quality evidence-based resource that covers significant aspects of caring and managing ADHD patients. It provides pragmatic advice on the effective care for patients with ADHD in Australia.

k. International best practice for ADHD diagnosis, support services, practitioner education and cost.

The RANZCP presents the following resources, which detail best practice ADHD diagnosis, support services and practitioner education, within various jurisdictions worldwide:

- Canadian ADHD Resource Alliance (CADDRA) – [Canadian ADHD Practice Guidelines](#) (2018)
- National Institute of Clinical Excellence (NICE) – [Diagnosis and management of ADHD in children, young people and adults \(Clinical Guideline 72\)](#) (2018)
- British Association for Psychopharmacology (BAP) – Update on the [Evidence-based guidelines for the pharmacological management of attention deficit hyperactivity disorder](#) (2014)

l. 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.

- Regulatory Bodies

The RANZCP states in Position Statement 55: [ADHD Across the Lifespan](#) that common misunderstandings and stigma related to ADHD and its treatment cause those who assess and treat individuals with ADHD to be exposed to a risk of review by regulatory bodies. As a matter of integrity and competence, reviews should be informed by expertise in ADHD across the lifespan and its various settings. The RANZCP advocates that regulatory bodies utilise professional opinions from experts in ADHD when a review of a psychiatric practice related to ADHD is considered.

- Addiction Perspective

The RANZCP supports efforts to improve equitable access to ADHD treatment, but notes that access to pharmacological treatment requires necessary precautions. Stimulant medications are controlled substances and consideration must be paid to those with active or suspected substance abuse disorders. The RANZCP draws the attention of the Inquiry to section 6.3 within the [AADPA guideline](#) to ensure that proposed service design adheres to the best practice outlined regarding ADHD and comorbid substance abuse disorders. The widening of access to treatment must recognise that:

- only *general practitioners* with appropriate authorisation can initiate psychostimulant medication
- *psychologists'* role in a multidisciplinary team does not include involvement in the diagnosing and prescribing process

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- *psychiatrists* (with child psychiatrists for persons under 18 years of age) are primarily authorised to prescribe psychostimulants.

The RANZCP believes that for patients to receive the best quality treatment and support, service design should also strive to improve linkages between addiction specialists and clinicians engaged in the treatment of ADHD, including support for addiction screening for patients seeking stimulants.

Within services, the psychiatrist has a key role in coordinating the appropriate prescription of medications such as stimulants. These play a key part (supported by psychological and educational treatments) in providing patients with effective treatment for ADHD and minimizing the social and lifestyle effects of the condition. In the presence or suspected presence of active substance abuse disorders, the expertise of an addiction specialist is required to determine the efficacy of pharmacological treatments and to inform safety considerations and risk mitigating strategies.

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.[33] In particular, a patient background of addictive behaviour suggests extra prescribing caution e.g., a more prolonged assessment phase, a preference for long-acting formulations, staged supply 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,[38,39] and 20.5% in adult prison populations,[36]), multiple barriers exist that result in substantial under-treatment of ADHD amongst this population.[34] Young people with ADHD are more than twice as likely to be convicted of a crime and three times more likely to be incarcerated,[35] with substantially higher rates of recurrent offending with earlier re-entry to justice systems than young people without ADHD.[40] 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.

- Subgroups

The RANZCP recognises inequitable access to ADHD diagnosis and treatment between specific groups. Females are a largely under-diagnosed and under-treated cohort (discussed in section 'd' of the terms of reference). Culturally and linguistically diverse populations also have complex needs and barriers to receiving a diagnosis and subsequent treatment, including a lack of general and health literacy, and cultural relevance regarding treatment programs. For Aboriginal and Torres Strait Islander peoples and Māori, system-wide recognition of the role of culture and community in the ADHD treatment process is required.

Summary

The RANZCP wishes to again thank the Standing Committee for the opportunity to provide a submission and offers our services to discuss the submission in further detail via a public hearing. If you have any queries regarding this submission and/or this offer, please contact Nicola Wright, Executive Manager, Policy, Practice and Research Department via nicola.wright@ranzcp.org or on (03) 9236 9103.

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. Australian Government: Institute of Health and Welfare. *Australia's Children*. 2020.
18. Northwood K, Siskind D, Suetani S, McArdle P. An assessment of psychological distress and professional burnout in mental health professionals in Australia during the COVID-19 pandemic. *Australasian Psychiatry*;29(6):628-34.
19. Goodsell B et al. *Child and Adolescent Mental Health and Educational Outcomes: An analysis of educational outcomes from Young Minds Matter: the second Australian Child and Adolescent Survey of Mental Health and Wellbeing*. The University of Western Australia. 2017 Dec.
20. Parents for ADHD Advocacy Australia. *Parent & carer experiences of ADHD in Australian schools: Critical gaps*. 2019 Apr.
21. Fuermaier ABM et al. ADHD at the workplace: ADHD symptoms, diagnostic status, and work-related functioning. *Journal of Neural Transmission*. 2021 Feb;128:1021–1031.
22. Küpper T et al. The negative impact of attention-deficit/hyperactivity disorder on occupational health in adults and adolescents. *Int Arch Occup Environ Health*. 2012 Nov;85(8):837-47.

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23. Halmøy A et al. Occupational outcome in adult ADHD: impact of symptom profile, comorbid psychiatric problems, and treatment: a cross-sectional study of 414 clinically diagnosed adult ADHD patients. *J Atten Disord.* 2009 Sep;13(2):175-87.
24. Adamou M et al. Occupational issues of adults with ADHD. *BMC Psychiatry.* 2013 Feb; 13(59).
25. Carbonneau M et al. Meta-Analysis of Sex Differences in ADHD Symptoms and Associated Cognitive Deficits. *J Atten Disord.* 2021 Oct;25(12):1640-1656.
26. Quinn PO & Madhoo M. A review of attention-deficit/hyperactivity disorder in women and girls: uncovering this hidden diagnosis. *Prim Care Companion CNS Disord.* 2014;16(3).
27. Young S et al. Females with ADHD: An expert consensus statement taking a lifespan approach providing guidance for the identification and treatment of attention-deficit/ hyperactivity disorder in girls and women. *BMC Psychiatry.* 2020 Aug;20(1):404.
28. Skogli EW et al. ADHD in girls and boys--gender differences in co-existing symptoms and executive function measures. *BMC Psychiatry.* 2013 Nov;13:298.
29. Solanto MV. Child vs adult onset of attention-deficit/hyperactivity disorder. *JAMA Psychiatry.* 2017; 74(4):421.
30. Kooij JJS et al. Updated European Consensus Statement on diagnosis and treatment of adult ADHD. *Eur Psychiatry.* 2019 Feb;56:14-34.
31. Katzman MA et al. Adult ADHD and Comorbid Disorders: Clinical Implications of Dimensional Approach. *BMC Psychiatry.* 2017 Aug;17(302).
32. Sciberras E et al. Social and economic costs of attention-deficit/hyperactivity disorder across the lifespan. *Journal of Attention Disorders.* 2020 Oct.
33. Gourlay D & Heit H. Universal Precautions Revisited: Managing the Inherited Pain Patient. *Pain Medicine.* 2009 Jul;10(2):S115–S123.
34. 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.
35. 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.
36. 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.
37. Littman et al ADHD in Females Across the Lifespan and the Role of Oestrogen. *The ADHD Report* 2021 August 29(5): 1-8.
38. 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.
39. Harpin V & Young S J The Challenge of ADHD and Youth Offending *Cutting Edge Psychiatry in Practice* 2012 January: 138-143.
40. 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.