Question 2 on notice: Do you have any insights as to how we could actually make it simpler in terms of the red tapes that people need to go through to access services?

The development and implementation of education that facilitates early recognition of ADHD

Education on ADHD should be provided to teachers, general practitioners, child and family health nurses, psychologists and other people at the coal face, in order to facilitate early recognition, diagnosis and treatment of ADHD. These education programs should be freely available or financially accessible to all, and provided to both participants undertaking undergraduate training programs and people already practicing in healthcare and teaching roles. They should be developed with lived-experience input, based on converging research findings, facilitate an accurate and unified understanding of ADHD, and promote early referral and multimodal, multidisciplinary care provision.

Clinical care pathways

Clinical care pathways could be developed for pre-schoolers, children, adolescents and adults with ADHD that provide clinicians with guidance on appropriate, holistic and streamlined diagnosis, treatment, and care interventions. The aim of multidisciplinary clinical pathways is to translate clinical practice guideline recommendations for a well-defined group of patients into patient-centred clinical processes of care and standardise practices, thereby maximising safety and clinical efficiency. To prevent overservicing, clinicians could be guided to consider further investigations only if a person with ADHD presents with a number of associated traits i.e., symptoms of a learning disorder.

Clinical pathways, however, can be problematic depending upon whether the guidance they contain, i.e., whether they:

- Outline a set multidisciplinary diagnostic, treatment and support route that all children and adults presenting to a clinic need to follow.
- Promote referral to different multidisciplinary team members based on the person's individual presentation, needs and wants.

I personally witnessed overservicing when attending a government funded, public hospital-based, ADHD specialist clinic, on referral from my son's paediatrician. Despite the fact my son already had an ADHD diagnosis, was solely referred to the clinic for a second opinion on his medication regime, and was not having any issues at home or at school, before his medication regime could be reviewed by the child and adolescent psychiatrist, in line with their clinical pathway:

1. I was expected to complete copious assessment tools and attend two interviews with a nurse without my son being present.
2. My son was then expected to attend an appointment with the nurse, followed by an appointment with an allied health care provider regarding school.

I attended two appointments with the nurse, and then cancelled all of our other appointments as they were totally unnecessary and equated to overservicing. The whole experience left me feeling like my son and I were statistics with no prior knowledge, understanding or agency. (The nurse knew I had an excellent knowledge base, ran workshops for teachers on ADHD, and worked and studied in the ADHD arena).

Diagnosis

- Cost can preclude people from seeking assessment for ADHD, with some diagnostic routes being more costly than others. People with ADHD and their families should be provided with information related to their assessment options (i.e., via paediatrician, psychiatrist or psychologist) and the costs involved, so that they can make an informed decision regarding the diagnostic route they take.

- When assessing people for ADHD, questionnaires and assessments are useful, but not exact. The clinical constellation of symptoms and impact they may have on individual's life needs to be synthesised by a professional with training and experience in ADHD and how it may present across the life course. Thus, education programs needs to be in place to ensure practitioners working in paediatric, psychiatry and psychology roles receive the education, training and support required to appropriately diagnosis and treat/support people with ADHD.
- If a psychologist has completed appropriate cognitive and behavioural assessments to the required standard, rather than reassessment occurring, these reports should be used by paediatricians and psychiatrists to guide diagnosis.

Care provision

The outcomes of people with ADHD are likely to improve, decreasing the burden on healthcare resources, if they receive multimodal, multidisciplinary care that is:

- evidence-based
- holistic
- protective
- collaborative
- person-centred
- recovery-orientated
- trauma informed
- adaption focused.

Care that fosters:

- self-awareness of both strengths and limitations
- acceptance of disability
- self-compassion
- informed decision-making
- co-production of a persons individualised treatment plan
- personal empowerment, independence and self-determination.

This care paradigm should to start in childhood, as symptom control and behaviour management are not the end goal. The end goal is for children with ADHD to grow into self-aware, well-adjusted individuals who understand their condition and accept themselves fully—individuals who have learned to harness their strengths and scaffold their challenges to the best of their ability so they can competently navigate societal expectations and the challenges they will inevitably face, and live full and rewarding lives.

Holistic care provision can be defined as care that:

- takes in account a person's individual biological, psychological, educational, social, spiritual and cultural background, and needs and wants
- includes all aspects of a person's functioning, activities, participation, abilities and disabilities and the context in which they occur.

Recovery in the mental health arena, is viewed as being:

- a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles (Anthony, 1993, p. 527)
- important for living a life where one feels hopeful, satisfied and able to contribute to society irrespective of any limitations resulting from illness or disability (Anthony, 1993; Green, 2004; Leamy, Bird, Le Boutillier, Williams, & Slade, 2011).

Conceptualised as an alternative to the medical model, recovery-focused care fosters hope, self-understanding of one's abilities and limitations, empowered self-determination, independence, and

self-advocacy skills. It also emphasises the right to a life that is inclusive, meaningful, of one's own choosing, and free of discrimination (Anthony, 1993; Green, 2004). More information on Recovery Focused Care can be found here

Trauma-informed care is based on the understanding that:

- a significant number of people living with mental health conditions have experienced trauma in their lives (including people with ADHD)
- trauma may be a factor for people in distress
- the impact of trauma may be lifelong
- trauma can impact the person, their emotions and relationships with others.

Trauma informed care providers' view trauma survivors as 'unique individuals who have experienced extremely abnormal situations and have managed the best they could' (Dr Cathy Kezelm). They avoid re-traumatising or blaming victims for their efforts to manage their traumatic reactions and instead promotes healing and fosters hope, optimism and the belief that recovery is possible.

The core principles underlying trauma informed care include:

- Safety (both emotional and physical)
- Trust
- Choice
- Collaboration
- Empowerment
- Respect for Diversity (Fallot and Harris, 2001).

More information about trauma informed care can be found here.

Acceptance of disability acknowledges that a person's health and well-being are not exclusively determined by the characteristics of their disability or illness and that people can be happy and healthy despite their disability (Schultz et al., 2002). Positive acceptance of disability enables people with a disability to accept their reality, recognise their own values and strengths, and to move towards adaption and recovery.

Co-production refers to clinicians and people with ADHD working together to develop a individualised treatment and support plan with people with ADHD and their families being at the centre of all decision-making.

Address the lack of ADHD diagnosis and treatment in public hospital mental health facilities

At present, the majority (if not all) psychiatrists working in public mental health services do not assess patients admitted to these facilities for ADHD. This is hugely problematic as it is highly likely a large number of people presenting to these facilities have undiagnosed ADHD, and will remain undiagnosed as a result.

Standardise stimulant prescribing laws across Australia and improve interstate/territory access to stimulant dispensing

- Unifying the regulations on who can prescribe stimulant medications across Australia would minimise confusion across state lines and equalise access to pharmacological treatment interventions. Currently people with ADHD tend to experience difficulty when trying to have their scripts filled when traveling to other states/territories, or when their script was written by a medical practitioner residing in different state to them, due to the different regulations currently in place. This not only precludes people with ADHD from travelling, it also hampers their ability to access healthcare practitioners in other states if access to care is limited in their area.

- Currently, some states do not allow prescribing of the upper therapeutic doses of stimulant medication. This needs to be addressed. Access to appropriate doses of stimulant medication improves outcomes and productivity of individuals with ADHD
- Improving access to stimulant medication across Australia, could be facilitated implementing Safescript. Safescipt would assist prescribers and pharmacists to identify when and where a person with ADHD was last given a script for stimulant medication as well as facilitate the tracking of scripts.

Reduce misconceptions around the use of stimulant medication

The current misunderstanding and misplaced fear mongering surrounding the use of stimulant medications to treat ADHD needs to be address via education, due to the impact it has on a person with ADHD's ability to access effective treatment interventions. Rather than causing harm, there is evidence to indicate that taking stimulant medication when you have ADHD, may be protective.

The below research papers address many of the frequently raised concerns regarding stimulant medication, and provide evidence that these concerns appear unfounded:

- Medication for Attention-Deficit/Hyperactivity Disorder and Risk for Suicide Attempts
- Associations Between Attention-Deficit/Hyperactivity Disorder (ADHD), ADHD Medication, and Shorter Height: A Quasi-experimental and Family-Based Study
- Stimulant ADHD medication and risk for substance abuse
- Brain development in ADHD (Stimulant drug treatment 'normalizes' anatomic and functional measures in ADHD)
- Gray Matter Volume Abnormalities in ADHD: Voxel-Based Meta-Analysis Exploring the Effects of Age and Stimulant Medication

Please note: that while ADHD medication effectively reduces ADHD symptoms and is invaluable and often lifesaving, it does not take all your ADHD symptoms away. Nor does it rectify a lag in brain and cognitive development or make a person with ADHD neurotypical. Therefore, we need to ensure that care and support provided to people with ADHD is holistic, protective and adaption focused. Medication should only form one part of a person's treatment plan that aims to foster acceptance of disability, hope, self-determination and personal empowerment.

Furthermore, while some children with ADHD may appear to not need medication because they are well behaved, looks can be deceiving. These children may still be struggling to:

- focus and concentrate
- absorb, process information and learn
- stay on track and complete tasks
- develop self- and social awareness.

I have met many adults with ADHD, mostly women, whose parents chose not to give them medication because they were well behaved. The majority of these adults wish their parents had made a different decision. They feel that their ability to learn and function was compromised, and that they are still trying to deal with the consequences now.

Please note: research indicates that stimulant medication increases motivation but decrease the quality of cognitive effort in healthy individuals. That is, they compromising performance and problem-solving ability.

Other ideas

- Enable GP's to participate in providing care to people with ADHD, post diagnosis, in partnership with specialist clinicians. This could be facilitated by providing appropriate

education, training and support to GPs and by standardising the way information is handed over.
- Provide General practitioners in regional and remote areas of Australia, with the education and training they required to diagnosis and treat people with ADHD.
- Consider facilitating the development of multidisciplinary neurodevelopmental clinics (rather than ADHD clinics) that could provide interdisciplinary care to people with ADHD and other co-occurring conditions, utilising pharmacists, GPs, specialist clinicians, nurse practitioners, and psychologists to help support individuals living with ADHD. These clinics may, however, come with the risk of overservicing without the implementation of a clinical pathway that promotes referral to different multidisciplinary team members based on the person's individual presentation, needs and wants, (rather than a multidisciplinary diagnostic, treatment and support route that all children and adults presenting to a clinic need to follow).

From Professor Dave Coghill

True collaborative interdisciplinary practice should be a major goal for ADHD. In addition to the overall shortfall in healthcare professionals who have sufficient training to assess, diagnose and treat ADHD, professional siloing is one of the biggest obstacles to multidisciplinary working in Australia. This is particularly the case for private healthcare professionals but is also true for many public health settings. This often results in people being asked to undertake multiple assessments through different professionals to first get a diagnosis and then access treatment. The duplication of effort is costly and risks overservicing.

On one level the solution is simple. We need interdisciplinary teams working together in a truly collaborative way to avoid duplication and ensure that the work done by one professional does not have to be replicated by another. However, currently this is challenging. For example, we often hear that a medical practitioner insists that they reassess someone who has already received a diagnosis from a psychologist. While this is unfortunate, it is to a degree inevitable within current models of care. If a medical practitioner does not know or have a relationship with the psychologist they may feel unable to accept the diagnosis as valid, or be unwilling to initiate prescribing based on their report.

This obstacle, however, is not insurmountable. I work within a private neuropsychology clinic where initial ADHD assessments are usually conducted by the neuropsychs. Because we worked together, and they understand the standards of assessment I require, I do not feel the need to repeat their assessments before confirming diagnosis and planning treatment. There are times when they may triage a new referral, and determine that it would be better for me to complete an assessment for ADHD prior to them completing a neuropsych assessment. Sometimes this averts the need for a neuropsych assessment, sometimes it confirms one would be helpful.

I also work with a similar clinical pathway, albeit with different crafty groups, in public care. The major challenge here is funding that allows people in publicly funded services to provide care for people with ADHD.

Another approach would be within primary care where the multidisciplinary team that can also include nurses and allied health can work with GPs to conduct assessments and plan treatment.

These models need two essential ingredients that are currently difficult to attain.
1. Trusting relationships between different craft groups that are built over time.
2. Appropriate funding models that allow these professionals to work together and allocate enough time to conduct the required assessments etc.