2026 (No. 43)

PARLIAMENT OF TASMANIA

House of Assembly Standing Committee on Government Administration B

Inquiry into the assessment and treatment of Attention Deficit Hyperactivity Disorder (ADHD) and support services

MEMBERS OF THE COMMITTEE

Ms *Brown*
Mr *Fairs*
Mr *George*
Ms *Haddad* (Chair)
Ms *Johnston* (Deputy Chair)
Ms *Rosol*
Mr *Vermey* (Proxy for Mr *Jaensch*)

CONTENTS

CHAIR'S FOREWORD

On behalf of the Committee, I am pleased to present this Report into the assessment and treatment of ADHD and support services in Tasmania.

The House of Assembly established this Inquiry following former Member for Clark Mr Simon *Behrakis* successfully moving a motion for its establishment. Mr *Behrakis* served as the Inquiry's Deputy Chair until his departure from Parliament after the 2025 State Election.

I want to especially recognise Mr *Behrakis'* own lived experience with ADHD diagnosis and treatment. This work was a passion for him, and he also shared his own experiences generously with Members. While he was unable to remain involved until this Report's completion, we hope he finds some satisfaction in the final Report.

Committee Members were pleased that evidence heard by the Inquiry led to tangible policy commitments from both major parties during the 2025 State Election, some of which have now been implemented, including the ability for General Practitioners (GPs) to diagnose ADHD in some circumstances.

The Committee heard evidence about significant difficulties for people accessing assessment, diagnosis, treatment and care for ADHD. These included workforce shortages, long wait times, complexity of the service system, attitudes to and stigma around ADHD and around pharmacological treatment options, structural barriers in our legislative framework, and funding challenges both State and Commonwealth.

Workforce shortages across both the public and private sectors impact the ability of both children and adults to access assessment, diagnosis and treatment for ADHD in Tasmania. While these workforce challenges are faced in other jurisdictions around the country and the world, these are more pronounced in Tasmania and more deeply felt here, due to our highly regionally dispersed population, our prescribing rules and the increasing level of need.

A high level of health literacy is required to navigate the complexity of diagnostic pathways for ADHD in Tasmania. This prevents some people from accessing services for themselves and for their children. Current service options are often very siloed, resulting in duplicative processes and inconsistent access and outcomes.

Early intervention is widely recognised as crucial in someone's ADHD journey, yet Tasmanian services are so stretched that often young children suspected of having

ADHD miss out on assessment in the early years and can start school without having received the support they needed prior.

Once in school, accessing services is inconsistent and dependent on workforce, location and availability. The Committee is hopeful that some recent initiatives including Kids Care Clinics, increasing access to specialist General Practitioners with Special Interests (GPSIs) and expanding the scope of practice of GPs, may increase access to services.

The economic and social impacts on people with ADHD not receiving assessment, diagnosis and treatment are profound. These social and economic costs of inadequate treatment also place increased demand and cost on Tasmania's health, education and justice systems.

Despite recent societal developments in the understanding and acceptance of neurodivergence, there sadly remains a great deal of stigma associated with ADHD and other neurodiverse conditions. These stigmas exist in the general community, as well as in the medical profession and the education sector. Although there are also many incredible professionals working across all fields in this area.

Much of the stigma surrounding ADHD stems from the fact it can be, and often is, treated with psychostimulant medications, and the stigma of drug dependence that is often associated with these medications. The Committee heard evidence of the stigma relating to the use of stimulant-based medications being greater than the stigma experienced with the use of other medications often associated with dependence, such as opioids and benzodiazepines.

The Committee welcomes the current review of the *Poisons Act 1971* (Tas) and is hopeful that it will lead to a more seamless process for people to access the prescribed stimulant-based medications they need to manage their ADHD.

While the Committee accepts that strong safeguards should exist for the dispensing of any drugs considered to have a risk of dependence, the current system of regulation of psychostimulant medications in Tasmania often works in direct contradiction to contemporary medical advice, including medical advice given by medical professionals treating people in Tasmania.

The single prescriber model, required by the *Poisons Act 1971* (Tas) is particularly burdensome and the Committee has recommended that dual prescribing of psychostimulant medications be implemented in Tasmania (Recommendation 13). The Committee has also recommended that the review of the *Poisons Act 1971* (Tas) include modernisation of the Pharmaceutical Services Branch operations; the publication of clear and visible assessment criteria for the approval of applications for authorisations

to prescribe under section 59E of the Act; and increasing flexibility to the current 28-day medication collection schedule (Recommendations 14, 15 and 19).

Overall, clearer communication between the regulatory authority and the treating practitioners of people with ADHD who are prescribed psychostimulant medication would improve outcomes for patients, as well as reduce complexity in the system.

Treatment of many medical conditions in custodial settings can be complex. The Committee heard evidence that people incarcerated in Tasmanian prisons are generally not provided with the types of medications typically prescribed for ADHD due to the risk of diversion. While the Committee fully appreciates the complexity of managing medications in a prison environment, we also heard evidence of the complexities of managing behaviour of unmedicated prisoners (especially when removed from medication suddenly as is often the case when imprisoned) and that this presents challenges, not only for inmates managing their neurodiversity unmedicated in a custodial setting, but also presents added challenges for prison staff as behavioural changes can be compounded in these circumstances. The Committee has recommended work be undertaken by Government to address this (Recommendations 27 to 30) and recognises the research suggests that ADHD is overrepresented in custodial settings.

On behalf of Members of this Inquiry, I would like to give heartfelt thanks to the many individuals who shared their experience with us. The generosity of spirit of so many individuals, parents, carers, advocacy organisations, as well as health professionals working in this field, has been crucial in the work of the Inquiry and the 118 findings and 31 recommendations we have made in this final Report.

It is our sincere hope that this Report will be endorsed by the Tasmanian Government, and that our recommendations will be accepted and progressed swiftly.

The Committee heard much evidence about the difficulties experienced by people with ADHD. We also want to highlight the positive impacts people with ADHD have in our community. Neurodiversity can, and does, make life more difficult for people, but it can also be a superpower. People with ADHD are frequently highly motivated, creative and innovative and bring many positive gifts to our community. With good access to diagnosis and ongoing treatment, people with ADHD will be better able to share their strengths and abilities with those around them.

I would like to thank all of the Members who served on the Inquiry throughout its life: Mr Simon *Behrakis*, Mrs Miriam *Beswick*, Mrs Rebekah *Pentland*, the Honourable Rebecca *White* MP, and Mr Simon *Wood* – and especially recognise those who formed the final membership presenting this Report: Ms Meg *Brown* MP, Mr Rob *Fairs* MP, Mr

Peter *George* MP, Ms Kristie *Johnston* MP, Ms Cecily *Rosol* MP and Mr Marcus *Vermey* MP.

Ms Ella *Haddad* MP
CHAIR

24 June 2026

SENSITIVE CONTENT DISCLAIMER AND SUPPORT SERVICES

The Committee recognises that this Report discusses highly sensitive matters and themes that have deeply impacted the lives of Tasmanians. This may be a trigger or distressing for individuals who have participated in the Inquiry or who choose to read this Report.

The Committee encourages anyone impacted by the content of this Report to contact services and supports such as:

- Lifeline Tasmania on 1800 98 44 34 for mental health support;
- Lifeline's helpline on 13 11 14 or via text at 0477 13 11 14 for 24/7 mental health support;
- ADHD Foundation Helpline on 1300 39 39 19; and
- Kids Helpline on 1800 551 800 or kidshelpline.com.au.

FINDINGS

Chapter 2 - Adequacy of access to ADHD diagnosis in Tasmania

1. **A general practitioner referral to a specialist is the most common pathway for children and adults to receive an ADHD assessment in Tasmania**
2. **For children, ADHD assessments are conducted by both private and public sector paediatricians, public school psychologists, and less commonly by child psychiatrists.**
3. **For adults, there is limited capacity to receive an ADHD assessment through the public health system and assessments will most often be accessed through a private psychiatrist.**
4. **The diagnostic pathway for ADHD is difficult to navigate, with a lack of accessible information, leading to significant variations in assessment experiences.**
5. **Duplication of ADHD assessments is a significant issue. Initial assessments made by psychologists are not routinely recognised by psychiatrists or paediatricians, who require their own assessment to make a diagnosis and provide pharmacological support.**
6. **Since public hearings concluded, general practitioners in Tasmania have been authorised to diagnose ADHD, which should improve access to diagnosis, treatment and support.**
7. **Tasmanians seeking ADHD assessment and diagnosis wait too long. This negatively impacts all aspects of their lives.**
8. **The financial costs associated with ADHD assessment and diagnosis in the private health system are high.**
9. **The wait times and costs associated with seeking ADHD assessment and diagnosis are significant barriers for people pursuing a suspected diagnosis.**
10. **The requirement for an ADHD diagnosis to be made by a psychiatrist or a paediatrician means those who have already been assessed by a psychologist will experience a second waiting period and incur additional costs.**
11. **A high level of health literacy is required to navigate the complexity of diagnostic pathways for ADHD. This prevents some people from accessing assessment and diagnosis, and compounds costs and wait times.**
12. **Workforce shortages and service availability exacerbate wait times for ADHD assessment and diagnosis, especially in rural and regional areas of Tasmania.**
13. **People with ADHD who live in rural and regional areas may experience increased difficulty and cost in accessing an assessment and diagnosis.**

14. **The high rate of comorbidities associated with ADHD can lead to complexities during diagnosis, reinforcing the importance of high-quality and accessible specialist assessment services.**
15. **Aboriginal and Torres Strait Islander people face additional barriers to accessing ADHD assessments and diagnoses, which have not generally been developed to be culturally safe and appropriate.**
16. **Due to significant barriers to accessing ADHD assessment and diagnosis in Tasmania, many Tasmanians use telehealth and interstate services.**
17. **Use of telehealth and interstate services for ADHD assessment and diagnosis result in issues around variable service quality, continuity of care, and significant costs.**
18. **Early intervention is key as undiagnosed ADHD can lead to lower self-esteem, anxiety and depression.**
19. **Increased access to school-based assessments would help children displaying symptoms of ADHD access earlier support.**
20. **The implementation of the Statewide Referral Criteria should improve the referral process.**
21. **There is currently minimal capacity for ADHD assessment and diagnosis of adults in the Tasmanian public health system.**
22. **Adult assessment and diagnosis for ADHD are more often provided in the private sector.**

Chapter 3 - Adequacy of access to supports after an ADHD assessment

23. **There are several effective treatments and supports for ADHD. These include medication, psychological therapy, occupational therapy, speech pathology, support groups, behavioural strategies, lifestyle changes and structure, and ADHD coaching.**
24. **Barriers associated with accessing ADHD assessment services, such as cost and wait times, are also experienced by people accessing support services following an ADHD diagnosis.**
25. **The supports available to Tasmanians with ADHD are impacted by their location, personal financial resources and the ability to access private services.**
26. **The high level of comorbidity experienced by people with ADHD creates complexities in accessing appropriate individualised support.**
27. **A combination of pharmacological and non-pharmacological support is best practice for the effective treatment of ADHD.**
28. **A multidisciplinary approach to supporting people with ADHD and other comorbidities is important.**

29. **The ten subsidised Medicare sessions per year are insufficient for people with ADHD who access a Mental Health Care Plan.**
30. **Early intervention for children displaying symptoms of ADHD can decrease the need for interventions later in life.**
31. **Child and Family Learning Centres and the Early Childhood Inclusion Service offer opportunities to identify children who may require additional supports prior to and after commencing school.**
32. **Diagnostic services for ADHD are not available in Child and Family Learning Centres.**
33. **There is scope to increase the supports available through Child and Family Learning Centres.**
34. **There are a lack of publicly-funded supports for children with ADHD, including psychologists and occupational therapists.**
35. **Some children begin school without having had adequate access to ADHD diagnosis and support in their pre-education years.**
36. **Appropriate, consistent, and readily available school-based supports are critical for the wellbeing and development of children with ADHD.**
37. **The Tasmanian Government states that Tasmania's public education system is aiming to increase integrated supports for neurodiverse children, such as multidisciplinary School Support and Wellbeing Teams where matters can be escalated and appropriate referrals to speech and language pathologists, social workers, and school psychologists can be made.**
38. **The roles and expertise of teachers and teachers' assistants are crucial to the support and development of children with ADHD in the school environment.**
39. **Where available, the Educational Adjustments Disability Funding Model for Tasmanian public schools has achieved positive results, with a needs-based, strengths-focussed approach that does not require a formal diagnosis to access funding for learning supports for students at all year levels.**
40. **Teachers and support staff in the education system are motivated to provide as much support as possible to students with ADHD and other neurodiverse presentations.**
41. **The transition from a paediatrician to psychiatrist for young people with ADHD when they turn 18, is a critical juncture. It requires a rediagnosis in the adult system that leads many to miss out on continuing care.**
42. **There is a critical need for transitional care planning for young people with ADHD with responsibility best shared across all relevant healthcare providers, paediatricians, general practitioners, psychologists, and psychiatrists.**

43. **Since public hearings concluded, general practitioners in Tasmania have been authorised to diagnose ADHD, which may help to address issues for young people transitioning from paediatric care.**

44. **There is a severe lack of support for adults with ADHD in both the public and private systems in Tasmania. This results in long wait times and people missing out on treatment. This is particularly pronounced for people on low incomes.**

45. **Lack of treatment options and support for adults with ADHD, particularly after adult diagnosis, may lead to feelings of disempowerment and increases comorbid mental health conditions and related substance abuse issues.**

46. **Workplace understanding and support are important for adults with ADHD to be able to continue in employment.**

Chapter 4 - Availability, training and attitudes of practitioners, and workforce development options

47. **There is a critical shortage of paediatricians, psychiatrists, and psychologists in both the public and private health systems in Tasmania. These workforce challenges are being felt across the country and world.**

48. **Tasmania's unique workforce challenge is the relatively small number of ADHD practitioners, leaving it vulnerable should even a few treating practitioners leave the profession.**

49. **Across Tasmania's public and private health sectors, there are fewer paediatricians, psychiatrists, and psychologists employed per 100,000 population compared to the national average.**

50. **In north and north-west Tasmania, there are fewer general practitioners per 100,000 population compared to the national average.**

51. **The Tasmanian Government recognises that the increased demand for medical professionals who diagnose and treat ADHD outstrips the availability of these professionals and is undertaking recruitment across health and education sectors.**

52. **There is a 'gap' in training focussed on ADHD at undergraduate, postgraduate, and professional levels across psychiatry, psychology, and primary healthcare.**

53. **There is a recognised need for more structured and consistent ADHD training and development across the Tasmanian health workforce.**

54. **Some universities are reducing the areas of practice endorsement for psychologists seeking to specialise in areas other than clinical psychology.**

55. **Teachers play a key role in managing behavioural symptoms of ADHD and other neurodiverse presentations in educational settings.**

56. **Teachers are crucial contributors to a multidisciplinary approach to treatment and support of children and young people with ADHD.**

57. **Learners would benefit from teachers and other educational staff receiving further undergraduate and ongoing professional training and development in best practice management of neurodiverse behaviours.**

58. **Providing a learning environment that meets the needs of children and young people with ADHD, and other neurodiversity, benefits all students and their teachers.**

59. **Stigma, negative stereotypes, and discrimination are still pervasive within the health system despite the existence of some excellent practitioners treating people with ADHD in Tasmania.**

60. **Stigma arising from comorbidities and alcohol and drug use add further significant barriers to ADHD treatment.**

61. **There are widespread misunderstandings and negative stereotypes of people with ADHD in the Tasmanian community, however societal awareness and acceptance are increasing.**

62. **Multidisciplinary teams including general practitioners, specialists, and allied health professionals represent the best practice model of care for ADHD treatment.**

63. **Currently Tasmanian ADHD services are relatively siloed, resulting in duplicative processes, inconsistent access, and poor health outcomes.**

64. **Tasmania is taking early steps towards developing a multidisciplinary response to the assessment, diagnosis, treatment, and support of people with ADHD.**

65. **The Tasmanian Government is implementing policies to improve access to ADHD services, including Kids Care Clinics, an ADHD clinic pilot program, and increasing access to General Practitioners with Special Interests.**

66. **There is opportunity for nurses and nurse practitioners to take a greater role in the multidisciplinary assessment and ongoing treatment of people with ADHD in Tasmania.**

Chapter 5 - ADHD medications, Poisons Act 1971 (Tas) and the Tasmanian Health Service's Pharmaceutical Services Branch

67. **There are many barriers to accessing ADHD medication in Tasmania, including the high cost and varying availability of medications, and the costs of ongoing medical appointments.**

68. **Tasmania has lower prescribing rates than other Australian jurisdictions of psychostimulants for adults. This is indicative of the lack of access to diagnosis and treatment for adults with ADHD.**

69. **Commonly prescribed ADHD medications are Schedule 8 psychostimulants. The *Poisons Act 1971* (Tas) strictly govern and restrict access to them.**

70. **In 2025, the Tasmanian Parliament passed legislation allowing Tasmanian pharmacists to dispense prescriptions issued by interstate practitioners.**

71. **In 2022, the Department of Health made administrative changes that allowed general practitioners to seek authorisation to prescribe Schedule 8 medications under section 59E of the *Poisons Act 1971* (Tas). However, the Act still has a limit of one prescribing authorisation per patient, which is a barrier to access.**

72. **A review of Tasmania's Poisons Act legislative framework is currently underway, with an aim to modernise, streamline, and simplify the regulation of medications, including Schedule 8 medications.**

73. **The *Poisons Act 1971* (Tas) and its subordinate legislation dictate the rules for prescribing and accessing psychostimulant medication in Tasmania. The Pharmaceutical Services Branch in the Department of Health is responsible for administering this legislative framework.**

74. **The aim of the Pharmaceutical Services Branch is to help prevent harm to the public, patients and the community by applying a risk-based approach to authorisation to prescribe, and the prescription of, psychostimulant medications.**

75. **The single prescriber model, required by the *Poisons Act 1971* (Tas), is burdensome and leads to complications for the Pharmaceutical Services Branch, prescribers, patients and caregivers.**

76. **Tasmanian prescription requirements for psychostimulants are stricter and more complex than for other medications that carry a potential for misuse, such as opioids and benzodiazepines.**

77. **Communication between the Pharmaceutical Services Branch, prescribers and patients, during the *Poisons Act 1971* (Tas) section 59E approvals process, can be lacking and not in the patient's best interests.**

78. **Prescribers and patients are not always directly informed when the Pharmaceutical Services Branch cancel a prescription. Patients may only be advised of a cancellation when attending a pharmacy to fill their prescription. This is an unreasonable imposition on both patients and pharmacists, often occurs in public, and results in delays in medication access.**

79. **Conditions placed on accessing psychostimulants by the Pharmaceutical Services Branch are sometimes inconsistent and confusing, for example different access conditions applied to members of the same family household.**

80. **There is a lack of understanding in the community and parts of the medical profession about the role and function of the Pharmaceutical Services Branch.**

81. **There is stigma attached to the use of stimulant medication in the community and medical profession.**

82. Conditions applied by the Pharmaceutical Services Branch (PSB) for the use of psychostimulants can conflict with the advice of patients' treating practitioners. People who follow medical advice, for example taking regular pauses in their medication, risk being penalised by the PSB, potentially impacting future access to medication.

83. Inflexible medication collection schedules and staged-supply conditions are barriers to people with ADHD accessing prescribed psychostimulants.

84. The Pharmaceutical Services Branch lacks transparency, making it difficult to seek a review or appeal a decision or condition.

Chapter 6 - Interaction of Tasmanian Government and Commonwealth services to meet the needs of people with ADHD at all life stages

85. Collaborative funding between State and Commonwealth Governments is needed to streamline ADHD assessment and support services.

86. There is consensus that addressing barriers to assessment and service provision for people with ADHD requires a nationally consistent approach.

87. A national approach to the diagnosis and treatment of ADHD has been endorsed by Health Ministers from all Australian jurisdictions and will be progressed as a priority.

88. The Australasian ADHD Professionals Association's Australian Evidence-Based Clinical Practice Guideline for ADHD provides a framework for governments to improve the assessment, care and support for people with ADHD.

89. The Australasian ADHD Professionals Association's Australian Evidence-Based Clinical Practice Guideline for ADHD has been endorsed by all major Australian medical and allied health colleges and associations, as well as the ADHD New Zealand and the World Federation of ADHD.

90. The Australasian ADHD Professionals Association's Australian Evidence-Based Clinical Practice Guideline for ADHD is not consistently implemented or followed across Australian jurisdictions, including in Tasmania.

91. Individuals with a primary or sole diagnosis of ADHD are not eligible for funding under the National Disability Insurance Scheme.

92. Foundational Supports provide an emerging opportunity to deliver services and support for people with ADHD.

93. The applicable Medicare Benefits Scheme billing items available to practitioners for ADHD assessments are unclear. This results in an ad hoc application of fees and charges to patients.

94. The expansion of specific billing items through the Medicare Benefits Scheme to fund ADHD assessments would increase affordability for patients.

Chapter 7 - Social and economic cost of failing to provide adequate and appropriate ADHD services

95. There are many social and economic costs of inadequate treatment of ADHD. These can include decreased productivity, academic failure, social isolation, chronic mental health issues, substance misuse, and unemployment.

96. The social and economic costs of inadequate treatment of ADHD place increased demand on health, education and justice systems.

97. ADHD frequently presents alongside other conditions or comorbidities. This can lead to misdiagnosis or misunderstanding of ADHD symptoms and impacts.

98. Misdiagnosis or missed diagnoses have significant negative impacts on the mental and physical health of people with ADHD and can lead to suicidal ideation, suicide attempts, and completion.

99. Successful diagnosis and treatment of ADHD can be lifesaving.

100. For adults, the social and economic costs of not receiving adequate assessment, treatment or support services for ADHD can include impacts on employment, study and participation in community life, family breakdown, impulsive decision-making, incarceration, and substance use disorders.

101. Anxiety and/or depression are common among adults with undiagnosed, untreated, or poorly managed ADHD. It is also common for people with unrecognised ADHD to be misdiagnosed with these conditions.

102. Adults with ADHD have better lived experience and outcomes when their ADHD is recognised and supported in their workplace.

103. Children with undiagnosed or untreated ADHD face challenges in their schooling, which impacts on future study and employment opportunities.

104. Children with undiagnosed or untreated ADHD may also experience bullying, low self-esteem, anxiety, and social isolation which can lead to mental health issues continuing into adulthood.

105. Early diagnosis and intervention for children with ADHD leads to better educational and life outcomes.

106. Families and caregivers of people with undiagnosed or poorly treated ADHD experience challenges in day-to-day life, including managing behaviours and responding to crises. This can lead to poor mental health.

107. Caring for someone with undiagnosed or poorly treated ADHD can affect employment and earning capacity.

Chapter 8 - Related matters raised with the Committee

108. ADHD is underdiagnosed and undertreated in correctional settings.

109. There is likely to be an overrepresentation of people with ADHD in the Tasmanian correctional system. This is due to the affects of ADHD on behaviour and the increased exposure to circumstances that may result in crime and interaction with the criminal justice system.

110. Assessment of ADHD in the Tasmania Prison Service only occurs incidental to other health or behavioural assessments.

111. Stimulant medication is not prescribed or dispensed in the Tasmanian prison system.

112. Some other Australian jurisdictions are trialling the use of stimulant medications in correctional settings.

113. Correctional settings can exacerbate the ADHD symptoms and behaviours of people whose ADHD is undiagnosed, untreated, or their medication is withheld.

114. The lack of diagnosis and treatment of ADHD in correctional settings makes the environment more challenging to manage and live in.

115. Correctional settings provide a unique opportunity to address and provide intensive treatment for many health conditions, including ADHD.

116. Accurate diagnosis and treatment of ADHD in correctional settings may reduce recidivism and crime.

117. Further research and funding are required to improve knowledge, assessment, treatment, and support for people with ADHD.

118. Specific research into ADHD presentations in women, girls, gender-diverse people, culturally and linguistically diverse and Aboriginal and Torres Strait Islander communities is required to reduce knowledge 'gaps' in diagnostic and support services.

RECOMMENDATIONS

Chapter 2 - Adequacy of access to ADHD diagnosis in Tasmania

1. **The Tasmanian Government acknowledge and address the impact of inadequate and inaccessible ADHD assessment and diagnosis.**

Chapter 3 - Adequacy of access to supports after an ADHD assessment

2. **The Tasmanian Government increase investment in treatment and support in Tasmania's public health system for people with ADHD.**
3. **The Tasmanian Government investigate options to provide access to ADHD diagnostic services in Child and Family Learning Centres.**
4. **The Tasmanian Government increase ongoing supports through Child and Family Learning Centres for children with ADHD.**
5. **The Tasmanian Government develop educational materials and information for employers to support employees with ADHD in the workplace.**
6. **The Tasmanian Government advocate to the Australian Government for an increase in Medicare subsidised sessions under Mental Health Care Plans.**

Chapter 4 - Availability, training and attitudes of practitioners, and workforce development options

7. **The Tasmanian Government continue to prioritise the recruitment of psychologists, psychiatrists, and paediatricians, and work with industry representative bodies to increase the attraction of professionals to Tasmania.**
8. **The Tasmanian Government increase ADHD professional development opportunities for people working in the Tasmanian health and education systems.**
9. **The Tasmanian Government call on the Australian Government to fund general practitioner training in ADHD diagnosis and management.**
10. **The Tasmanian Government call on the University of Tasmania to increase ADHD training in existing relevant undergraduate courses, and provide a broad range of practice endorsements for its master's level psychology.**
11. **The Tasmanian Government undertake work to reduce misunderstanding, stigma, and discrimination relating to ADHD in the community.**
12. **The Tasmanian Government support and enable multidisciplinary teams as the model of care for ADHD diagnosis and treatment in Tasmania. This would require cooperation and collaboration across Tasmania's public health and education systems and the primary health care system.**

Chapter 5 - ADHD medications, Poisons Act 1971 (Tas) and the Tasmanian Health Service's Pharmaceutical Services Branch

13. **Dual prescribing of psychostimulant medication be implemented as part of the review of the *Poisons Act 1971* (Tas) legislative framework.**
14. **Modernisation of the Pharmaceutical Services Branch's operations, and increased transparency of its decision-making processes, be implemented as part of the review of the *Poisons Act 1971* (Tas) legislative framework.**
15. **The Pharmaceutical Services Branch publish clear and visible assessment criteria for the approval of applications for authorisation to prescribe under section 59E of the *Poisons Act 1971* (Tas).**
16. **Development and implementation of formal communication processes between the Pharmaceutical Services Branch and a patient's prescriber when considering section 59E applications be included in the review of the *Poisons Act 1971* (Tas) legislative framework.**
17. **Development and implementation of formal communication processes between the Pharmaceutical Services Branch, the patient's prescriber and the patient when cancelling a prescription be included in the review of the *Poisons Act 1971* (Tas) legislative framework.**
18. **Development of enhanced appeal mechanisms, including external review, relating to Pharmaceutical Services Branch decisions be included in the review of the *Poisons Act 1971* (Tas) legislative framework.**
19. **Increasing flexibility to the current 28-day medication collection schedule for all psychostimulant prescriptions be included in the review of the *Poisons Act 1971* (Tas) legislative framework.**
20. **Reasonable alternatives to the additional restrictive supply conditions currently placed on some prescriptions, such as weekly or daily collection, be included in the review of the *Poisons Act 1971* (Tas) legislative framework.**

Chapter 6 - Interaction of Tasmanian Government and Commonwealth services to meet the needs of people with ADHD at all life stages

21. **The Tasmanian Government continues to work with the Australian Government to promote collaborative funding opportunities and a nationally consistent approach to ADHD assessment and treatment.**
22. **The Tasmanian Government implement the use of the Australasian ADHD Professionals Association's Australian Evidence-Based Clinical Practice Guideline for ADHD in the Tasmanian Health Service and encourages its consistent use in the private sector.**
23. **The Tasmanian Government fund sufficient Foundational Supports for people with ADHD.**

24. **The Tasmanian Government call on the Australian Government to provide clearer guidance to practitioners about the use of current Medicare Benefits Scheme billing items for ADHD assessment and treatment.**

25. **The Tasmanian Government call on the Australian Government to introduce separate Medicare Benefits Scheme billing items for the assessment of ADHD.**

Chapter 7 - Social and economic cost of failing to provide adequate and appropriate ADHD services

26. **The Tasmanian Government acknowledge and address the social and economic costs of failing to provide adequate and appropriate ADHD services.**

Chapter 8 - Related matters raised with the Committee

27. **The Tasmanian Government acknowledge and address the social and economic impact of undiagnosed and untreated ADHD on the prison population, management of prisons, and recidivism.**

28. **The Tasmania Prison Service include screening for preexisting ADHD diagnoses and prescriptions in standard prison intake processes.**

29. **The Tasmania Prison Service facilitate the assessment of inmates displaying ADHD symptoms where they do not have a preexisting diagnosis.**

30. **The Tasmania Prison Service trial the provision of stimulant medication for inmates diagnosed with ADHD.**

31. **The Tasmanian Government advocate for increased and ongoing research into ADHD.**

1 INQUIRY PROCESS

Appointment and Terms of Reference

1.1 On 19 June 2024, Mr Simon *Behrakis* MP, then Liberal Member for Clark, moved a motion in the House of Assembly about Attention Deficit Hyperactivity Disorder (ADHD) Support in Tasmania.

1.2 The House of Assembly referred the following reference to the Standing Committee on Government Administration B (the Committee) with the following Terms of Reference:

(2) …to inquire into and report upon 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, with the following Terms of Reference:—

(a) adequacy of access to ADHD diagnosis;

(b) adequacy of access to supports after an ADHD assessment;

(c) the availability, training and attitudes of treating practitioners, including workforce development options for increasing access to ADHD assessment and support services;

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

(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;

(f) the social and economic cost of failing to provide adequate and appropriate ADHD services;

(g) any other related matters; and

(h) that the Committee report by 31 March 2025.

1.3 The Committee's first meeting for the Inquiry into the assessment and treatment of ADHD and support services (the Inquiry) was held on 25 June 2024 with the following membership: Mr Simon *Behrakis* MP (Deputy Chair), Ms Ella *Haddad* MP (proxy for then Opposition Leader, the Honourable Mr Dean *Winter* MP), Ms Kristie *Johnston* MP, Mrs Rebekah *Pentland* MP, Ms Cecily *Rosol* MP, Ms Rebecca *White* MP (Chair), and Mr Simon *Wood* MP. On 16 September 2024, Mrs Miriam *Beswick* MP joined the Committee's membership as proxy for Mrs *Pentland* MP for the Inquiry.

1.4 On 19 November 2024, the Chair moved a motion in the House of Assembly that the reporting date for the Inquiry be extended until 13 May 2025. The motion was agreed to by the House.

1.5 On 12 February 2025, the Chair resigned as a Member of Parliament. In accordance with the Resolution establishing the Committee, the Hon. Mr *Winter* MP, advised the Clerk of the House that he nominated Ms *Haddad* MP to serve as a substantive Member of the Committee to fill the resulting vacancy.

1.6 On 17 February 2025, Ms *Haddad* MP was elected as Chair of the Committee. On 18 February 2025, the Hon. Mr *Winter* MP advised the Chair in writing that Ms Meg *Brown* MP was nominated to serve as his proxy for the Inquiry.

1.7 On 6 May 2025, the Chair moved a motion in the House of Assembly that the reporting date for the Inquiry be extended until 26 August 2025. The motion was agreed to by the House.

1.8 The Committee had not yet reported when the House of Assembly was dissolved, and the Parliament of Tasmania prorogued, on 11 June 2025.

1.9 On 9 September 2025, the House established the Committee in the Fifty-Second Parliament. The new Committee was authorised to receive all evidence and papers of the former Committee.

1.10 On 24 September 2025, the Committee resolved that all evidence and papers received by the Inquiry of the Fifty-First Parliament, be received by the Committee for its consideration.

1.11 The Committee's first meeting for the Inquiry for the Fifty-Second Parliament was on 10 October 2025 with the following membership: Ms *Brown* MP, Mr Rob *Fairs* MP, Mr Peter *George* MP, Ms *Haddad* MP (Chair), Ms *Johnston* MP (Deputy Chair), Ms *Rosol* MP, and Mr Marcus *Vermey* MP (as proxy for Mr Roger *Jaensch* MP).

1.12 During the Fifty-First Parliament, the role of Minister for Health was held by two Members of Parliament. For clarity, it is noted that the Hon. Guy *Barnett* MP held the position from the commencement of the Parliament on 11 April 2024 to 23 October 2024. During this time, Minister *Barnett* appeared at a public hearing on 18 October 2024. This was the only interaction Minister *Barnett* had with the Committee in this role. From 23 October 2024 until the appointment of the new Cabinet after the 2025 General Election, the Hon. Jacquie *Petrusma* MP held the position of Minister for Health. Minister *Petrusma* appeared at the 16 May 2025 public hearing.

1.13 The portfolio of Mental Health and Wellbeing was also held by two Members of Parliament throughout the Fifty-First Parliament. The Hon. Guy *Barnett* MP was the responsible Minister from 11 April 2024 until 23 October 2024 and appeared at the 18 October 2024 hearing. Minister Roger *Jaensch* MP then held the role

from 23 October 2024 until the appointment of the new Cabinet after the 2025 General Election. Minister *Jaensch* appeared at the 11 April 2025 public hearing.

1.14 At the time of the establishment of the Committee in the Fifty-Second Parliament, the Hon. Bridget *Archer* MP held the position of Minister for Health, Mental Health and Wellbeing. Minister *Archer* remained in this portfolio until the conclusion of the Inquiry, and provided the Committee with a written update on 26 November 2025.[1]

Conduct of the Inquiry

1.15 The Committee resolved to invite interested persons and organisations to make a submission to the Committee in relation to the Terms of Reference. This was done by advertisement on the Parliament of Tasmania website and in the three major Tasmanian newspapers.

1.16 The Committee also directly invited a number of persons and organisations to provide the Committee with any information they deemed to be relevant to the Inquiry.

1.17 In addition to general and direct invitations to make submissions, the Committee resolved to expand the opportunity for people with lived experience of ADHD to provide submissions to the Committee via video message, private informal roundtable, or informal email, as well as attending a formal hearing if they wished.

1.18 The Committee received 60 submissions and held six public hearings at Parliament House, Hobart. A list of submissions can be found in Appendix A, and a list of hearing witnesses can be found in Appendix B.

1.19 The Committee held a private, informal roundtable on 15 November 2024 where participants confidentially shared their experiences with ADHD. Deidentified dot points summarising the matters heard can be found in Appendix C.

1.20 The minutes of the Committee for this Inquiry are attached in Appendix D, a Glossary of Abbreviations can be found in Appendix E, and the Transcripts of Evidence are at Appendix F.

Structure of this Report

1.21 This Report consists of the following Chapters:

- Chapter 1 provides a brief overview of the Inquiry.
- Chapter 2 considers the adequacy of access to ADHD assessment and diagnosis in Tasmania.

[1] Letter from Hon. Bridget Archer MP, Minister for Health, Mental Health and Wellbeing, dated 26 November 2025.

- Chapter 3 examines the adequacy of supports after an ADHD assessment.
- Chapter 4 looks at the availability, training and attitudes of treating practitioners, and includes workforce development options for increasing access to ADHD assessment and support services.
- Chapter 5 considers current regulations regarding access to ADHD medications, including the *Poisons Act 1971* (Tas) and related regulations, the administration by the Pharmaceutical Services Branch, and how to improve access to ADHD medications.
- Chapter 6 assesses the interaction between the Tasmanian Government and Commonwealth services to meet the needs of people with ADHD at all life stages.
- Chapter 7 considers the social and economic cost of failing to provide adequate and appropriate ADHD services.
- Chapter 8 presents related matters raised with the Committee in this Inquiry, including the diagnosis and treatment of ADHD in the Tasmania Prison Service and the need for further research into ADHD.

2 ADEQUACY OF ACCESS TO ADHD DIAGNOSIS IN TASMANIA

2.1 ADHD is a neurodevelopmental condition that is "defined by excessive levels of inattention and/or hyperactivity-impulsivity that are inappropriate for developmental stage."[2]

2.2 The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (5th Ed.) (the DSM-5) is the primary tool used by healthcare practitioners for the assessment and diagnosis of ADHD in Australia. The World Health Organisation's International Classification of Disease (the ICD-11) is another commonly used resource for diagnosis.[3]

2.3 There are three presentations of ADHD:

- The predominantly inattentive presentation;
- The predominantly hyperactive–impulsive presentation; and
- The combined presentation (symptoms of both inattentive and hyperactive-impulsive subtypes).[4]

2.4 ADHD is the most common neurodevelopmental disorder in Australia.[5] It adversely affects learning, interpersonal relationships, and occupational and overall functioning, and has a mortality rate above that in the general population.[6]

2.5 In this Report, the acronym 'ADHD' will be used to include these three presentations unless identified otherwise.

2.6 This Chapter considers the adequacy of access to ADHD diagnosis in Tasmania.

Current process for receiving an ADHD diagnosis

2.7 The Committee heard a range of evidence that outlined the current processes for receiving an ADHD diagnosis, and the barriers of accessing assessment services in Tasmania.

[2] Submission No. 44, Australasian ADHD Professionals Association, p. 3.
[3] Submission No. 44, Australasian ADHD Professionals Association, p. 3.
[4] Submission No. 44, Australasian ADHD Professionals Association, p. 3; Submission No. 51, Australian Medical Association Tasmanian Branch, p. 1.
[5] Submission No. 46, Royal Australian and New Zealand College of Psychiatrists, p. 2.
[6] Submission No. 46, Royal Australian and New Zealand College of Psychiatrists, p. 2.

2.8 Currently, healthcare professionals qualified to diagnose ADHD consist primarily of paediatricians, psychiatrists and psychologists.[7] The Tasmanian Government's submission outlined the current process for ADHD assessments and diagnoses available to children and adults:

> *In Tasmania, paediatricians, or, to a lesser extent, child psychiatrists provide ADHD assessment and diagnosis for children. The most common pathway is through GP* [General Practitioner] *referral to a paediatrician for assessment and diagnosis, either in the public or private sector. Often, difficulties identified in school learning environments trigger referrals through GPs. While there are no costs for assessment and treatment for ADHD provided to a child in the public system, there are generally costs in the private sector.*
>
> *In Tasmania's public health system, referrals to Tasmanian Health Service (THS) paediatric clinics are categorised by urgency. Most referrals for ADHD assessment are classified as non-urgent (category three). However, certain factors, such as a child being in out-of-home care or disengaged from school, may warrant a higher priority ranking (categories two or one). The diagnostic process in the public sector generally requires three to six appointments, depending largely on the availability of information at the initial appointment.*
>
> *…*
>
> *In Tasmanian public schools, children and adolescents have access to thorough, evidence-based diagnostic assessments through the school psychology service. However, the high demand for these school psychology services results in waiting times that can extend over a year. School psychologists have a limited allocation per school and are often addressing significant mental health needs and critical incidents, potentially delaying ADHD assessments.*
>
> *…*
>
> *Assessment, diagnosis, treatment, and support of ADHD in adults typically occurs in the private sector, with a GP referral to a private psychiatrist. As priority is given to more acute cases within the Adult Mental Health Services of Tasmania's public health system, there is limited capacity to support less critical cases.*
>
> *Adults, particularly parents of children with ADHD or young adults in years 11 and 12, face significant difficulties in accessing assessment and treatment. The shift to telehealth services, with few adult psychiatrists in Tasmania specialising in ADHD, has created challenges. Better collaboration between healthcare professionals and services may alleviate barriers for adults seeking diagnosis and treatment, such as out-of-pocket expenses and delays.*[8]

[7] Submission No. 44, Australasian ADHD Professionals Association, p. 6.

[8] Submission No. 60, Tasmanian Government, pp. 7-9.

2.9 As part of their submissions to the Inquiry, both the Regional Autistic Engagement Network (RAEN) and Women's Health Tasmania conducted surveys to gather evidence based on lived experience. RAEN's findings stated:

> *Over 60% of respondents reported that obtaining a diagnosis was 'very difficult' (33%) or 'difficult' (32%) and less than 10% indicated that accessing their diagnosis was 'Easy' (9%) or 'Very Easy' (2%).*[9]

2.10 Women's Health Tasmania's survey found similarly:

> *… almost half (44%) of the survey respondents indicated that it is 'very difficult'.*[10]

2.11 The Committee received evidence describing the challenges Tasmanians face with the current process for receiving an ADHD diagnosis. In their submission, the Tasmanian Adult ADHD Support Group stated:

> *The process of having an assessment, followed by a diagnosis and then a treatment plan, which may then move to a GP for management is extremely complicated, expensive and time consuming and could involve four different health professionals in four different practices.*[11]

2.12 Similarly, a respondent to the Women's Health Tasmania survey stated that there is a:

> *…Lack of accessible information about the diagnostic process. The process to diagnosis is convoluted; it is not designed for ADHD people who have difficulties with executive function, remembering appointments and steps, having the motivation to follow up and wait out the years-long ordeal.*[12]

2.13 At the 18 October 2024 public hearing, Dr Timothy Jones, a General Practitioner (GP), and representative of the Royal Australian College of General Practitioners (RACGP), provided his perspective on ADHD assessments and diagnoses to the Committee:

> ***CHAIR*** [Ms White] - *Would it be possible perhaps to start with an overview question about what demand you're seeing and what GPs are telling you…*
>
> ***Dr JONES*** *- Yes, if it's okay, I'll share a story. As a GP, it does depend whether I'm seeing a child or an adult as to what happens here, and it depends whether the family has access to means or not. The inequity is one of the challenges that I think will keep coming up in our discussions.*

[9] Submission No. 25, Regional Autistic Engagement Network, p. 5.
[10] Submission No. 20, Women's Health Tasmania, p. 4.
[11] Submission No. 21, Tasmanian Adult ADHD Support Group, p. 2.
[12] Submission No. 20, Women's Health Tasmania, p. 7.

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

If I'm seeing an adult, if they don't have access to means, there is nothing I can offer them beyond those health fundamentals. There is no public service that can provide adequate assessment and recommendations for their support. If they have access to means, then largely they are asking to access interstate telepsychiatry services for the purposes of assessment. My experience as a GP and representing my colleagues here today is that those services are of variable quality and there is an absolute lack of continuity of care and ongoing support. Hence the patients we're seeing just report a feeling of utter abandonment and frustration with the current situation.[13]

2.14 At the 8 November 2024 public hearing, Mr Timothy Davern, Senior Policy Advisor for the Australian Psychological Society (APS), expanded on the difficulties some encounter when navigating assessment services:

CHAIR [Mr Behrakis] - *... 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.*

...

Mr DAVERN - *... 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.

[13] Dr. Timothy Jones, General Practitioner, Royal Australian College of General Practitioners, Transcript of Evidence, 18 October 2024, pp. 44-45.

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.[14]

2.15 The Committee heard evidence from Mr Nicholas Spohn, a witness with lived experience of ADHD, who discussed his experience in navigating the assessment process:

***Mr BEHRAKIS** - From when you decided that you wanted to look into whether or not you had ADHD to when you got to the point of being formally diagnosed and treated - you would say it was a number of months - how easy or difficult was it for you to figure out the steps: you need to go to the GP, need to go here, and navigating that on your own? How much support did you get in doing that, and how easy or hard of a time did you have in navigating that?*

***Mr SPOHN** - That's a good question. For me, there were a lot of steps, it felt. It was mostly informed by talking to my friend who had been diagnosed himself, and he outlined the steps to get there. As far as support was concerned, it was basically: I make the appointments, I show up to the appointments, I take the actionable steps, all of that. There wasn't really a framework to follow so much as just the advice of a friend who'd gone before me.*

...

***Mr BEHRAKIS** - Were you getting any other support while you were waiting to see the psychiatrist? What was it like when you were in that period of waiting to sit down with the person who was going to formally diagnose you? You kind of know what's going on inside your head - but what was that like?*

***Mr SPOHN** - Oh it's basically like being on hold for all eternity. You're dealing with a few feelings. You're feeling excited - you know, finally I'm getting to the bottom of this. You're feeling like terrified: like, what if I'm wrong? This has been an awful lot of effort and an awful lot of money if I'm wrong.*

[14] Mr. Timothy Davern, Senior Policy Advisor, Australian Psychological Society, Transcript of Evidence, 8 November 2024, pp. 15-16.

Yes, it's a bit of a tangle, again, around that period. I'm trying to remember it in a linear sense, but I do think I had a mental health plan in place at the time as well. I was seeing a psychologist at the time to sort of 'therapy me back' out of the pits of bad anxiety that I'd been having. There was definitely, like, mental health help going on, but not specifically to help an ADHD brain with anxiety and depression so much as just like, 'This is the anxiety and depression medication we - ' - well, not medication, but the therapy we give to everyone.[15]

2.16 Ms Vikki Ryall, Chief Clinical Officer at headspace, provided the Committee with evidence on the challenges young people experience in navigating the pathways to diagnosis:

Mr BEHRAKIS *- …How many of the young people who have come through headspace - you said that was 17 per cent with ADHD - needed help in navigating the systems and the health bureaucracy…*

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

…

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

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

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

Ms RYALL *- Correct. Yes, exactly. Obviously, I say that with a degree of hesitation because we do not want people diagnosing themselves. We are very much about*

[15] Mr. Nicholas Spohn, Transcript of Evidence, 21 February 2025, pp. 42-43.

getting help and help being a useful thing to do and assessment being a specialist area. However, if there was an evidence-based tool that would suggest, and these things when they are available on the internet are fairly cautious and would direct people to care with a low threshold as they should, things like that could also create some efficiencies.[16]

2.17 A similar point on the access to information prior to a diagnosis was raised by Mr Davern:

> ***CHAIR*** [Mr Behrakis] - *…Are there…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…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.*[17]

2.18 Mr Davern also reflected on ways to improve assessment pathways and making them easier to navigate:

> ***CHAIR*** [Mr Behrakis] - *…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'?*
>
> *…*
>
> ***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.*[18]

[16] Ms. Vikki Ryall, Chief Clinical Officer, headspace, Transcript of Evidence, 18 October 2024, pp. 38-39.
[17] Mr. Timothy Davern, Senior Policy Advisor, Australian Psychological Society, Transcript of Evidence, 8 November 2024, p. 21.
[18] Mr. Timothy Davern, Senior Policy Advisor, Australian Psychological Society, Transcript of Evidence, 8 November 2024, p. 16.

2.19 At the 18 October 2024 public hearing, further evidence on this issue was received from Ms Jane Endacott, Vice Chair of ADHD Australia:

> ***Mr BEHRAKIS*** *- … What could be done to try to give that educational or some sort of standardisation or some sort of guideline (a) to the person going through that process, and (b) to people who work in that space?*
>
> ***Ms ENDACOTT*** *– … there has been some attempts to bring some … information together so people have more of a standardised approach to looking at some of the challenges that individuals face. Obviously, there's still many gaps and continuing to be able to build on and develop more of a standardised approach that people can access as a resource for guidelines is going to be the way forward. Definitely at this moment in time, a lot of the feedback from our community members is that the struggling of knowing where to go, getting accurate information, is really tricky for individuals. Even though there are some standardised guidelines that have been produced more recently and are out there, it… obviously isn't necessarily giving all the… answers that people are wanting and there are still gaps.*[19]

2.20 During the same hearing, the Committee heard evidence from GP, Dr Jones, regarding the potential to standardise the diagnostic pathway:

> ***Mr BEHRAKIS*** *- … There is not a standardised experience and I get that things cannot be completely uniform, but that lack of knowing what to expect and especially for someone who is probably doing it tough - otherwise wouldn't be looking for help - have the symptoms of someone with ADHD… Is there a need to put in some sort of standardisation, so there is some sort of uniformity?*
>
> ***Dr JONES*** *- There are already efforts being made in that area. There has been a lot of liaison with Primary Health Tasmania to establish the HealthPathways suite of guidelines for general practitioners and other primary care providers. That really does standardise what a GP needs to be doing if a patient presents with concerns in this area and what sort of investigation, supports, pathways exist to facilitate that assessment and ongoing care.*
>
> *Can I draw an analogy? In that, there will always be diversity of practice and that will be a challenge. But, if we look at something like autism and children, we have a Tasmanian autism diagnostic service provided publicly. It is multidisciplinary, it works statewide, it has a large workload, but it will always fill that need in a timely fashion to provide that assessment. In a way, one of the areas that is important to consider is what sort of standard backstop public care can we provide to ensure that no-one goes without.*
>
> …

[19] Ms. Jane Endacott, Vice Chair, ADHD Australia, Transcript of Evidence, 18 October 2024, pp. 58-59.

The challenge in providing that level of care is that ADHD remains a spectrum and we need to individualise our approach to a degree. Having a baseline level of information is really important, but individualising it to those specific circumstances is important for good outcomes...[20]

2.21 The Committee heard evidence that duplication of assessments by different health practitioners is another concern with the current process:

> ***Ms HADDAD*** *- …In your written submission… you touch on the collaboration between psychologists, psychiatrists and paediatricians, and that your members are… 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…?*
>
> ***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...*
>
> ***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?*

[20] Dr. Timothy Jones, General Practitioner, Royal Australian College of General Practitioners, Transcript of Evidence, 18 October 2024, pp. 48-50.

***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.[21]

2.22 At the 8 November 2024 public hearing, the Committee heard evidence from Australian Medical Association (AMA) Tasmania Branch members, Dr Natasha-Ann Laidler, a paediatrician, and Dr Clare Smith, a recently retired GP, on the issue of duplicating a diagnosis:

***Ms ROSOL** - ... What are the differences in the assessment process between the two* [psychologist and paediatrician or psychiatrist]*? 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

[21] Mr. Timothy Davern, Senior Policy Advisor, Australian Psychological Society, Transcript of Evidence, 8 November 2024, pp. 13-14.

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.

…

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

…

***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.*

…

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…

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… [where] *we have issues sometimes is the taking into account the impact of family violence on children's… 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.*[22]

2.23 Dr Anil Reddy, adult psychiatrist and member of the Royal Australian and New Zealand College of Psychiatrists (RANZCP), provided the Committee with a psychiatrist's perspective:

***Ms ROSOL** - … 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.*

…

[22] Dr. Natasha-Ann Laidler, Paediatrician, and Dr. Clare Smith, retired General Practitioner, Australian Medical Association Tasmania Branch, Transcript of Evidence, 8 November 2024, pp. 57-58.

> ***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 difference, 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.*[23]

2.24 The Committee also heard evidence regarding the adequacy of support for those awaiting an ADHD assessment. At the 18 October 2024 public hearing, Dr Jones discussed work currently being undertaken by the RACGP to address this:

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

[23] Dr. Anil Reddy, Psychiatrist, Royal Australian and New Zealand College of Psychiatrists, Transcript of Evidence, 8 November 2024, p. 69.

opportunity that we continue to explore and we'll be pushing pretty hard towards.[24]

2.25 At a public hearing on 21 February 2025, Mr Scott Wynands provided evidence on his lived experience with ADHD diagnosis and treatment:

> ***Ms JOHNSTON*** *- You talked about that… psychologist with the lived experience being so supportive during that time. What kind of practical things were they able to put in place for you until you received your official diagnosis? Were they able to give you some tools to help manage daily life? What kind of things were useful for you?*
>
> ***Mr WYNANDS*** *- I had a couple of books that she recommended I read. One of them was* ADHD 2.0*, and that was a really amazing book. That really helped me. And, because I was interested in what was wrong with me, I read it. Otherwise, I probably wouldn't have. Also cognitive behavioural therapy, CBT, and lots of other life experiences, because it was relatable, things that may have helped her, she thought, 'I'll see if they will help you.' Everyone presents differently, so you can never really tell, but with a bit of an idea, you can work around it and then branch off and go in different ways, 'Okay, that seems to be working and more focused on this, so we'll go this way, or we'll go the other way.' Lots of different methods. Also, I have rejection sensitivity dysphoria. I have a hard time task switching, and she was helping me learn how to task switch without making myself anxious or uncomfortable.*[25]

2.26 On 29 May 2026, Minister *Archer* announced that GPs will be trained "to expand their scope of practice to assess, diagnose, and initiate the prescription of medication for children and adults with ADHD", with 50 GPs undertaking to complete the training.[26]

Findings

The Committee finds:

1. A general practitioner referral to a specialist is the most common pathway for children and adults to receive an ADHD assessment in Tasmania.
2. For children, ADHD assessments are conducted by both private and public sector paediatricians, public school psychologists, and less commonly by child psychiatrists.

---

[24] Dr. Timothy Jones, General Practitioner, Royal Australian College of General Practitioners, Transcript of Evidence, 18 October 2024, pp. 54-55.
[25] Mr. Scott Wynands, Transcript of Evidence, 21 February 2025, pp. 27-28.
[26] Hon. Bridget Archer MP, *Media Release: Delivering high-quality ADHD care through general practice*, dated 29 May 2026. Accessed at: https://www.premier.tas.gov.au/latest-news/2026/may/delivering-high-quality-adhd-care-through-general-practice.

3. For adults, there is limited capacity to receive an ADHD assessment through the public health system and assessments will most often be accessed through a private psychiatrist.
4. The diagnostic pathway for ADHD is difficult to navigate, with a lack of accessible information, leading to significant variations in assessment experiences.
5. Duplication of ADHD assessments is a significant issue. Initial assessments made by psychologists are not routinely recognised by psychiatrists or paediatricians, who require their own assessment to make a diagnosis and provide pharmacological support.
6. Since public hearings concluded, general practitioners in Tasmania have been authorised to diagnose ADHD, which should improve access to diagnosis, treatment and support.

Barriers to receiving an ADHD diagnosis

2.27 The evidence heard by the Committee highlighted that the cost and wait times associated with assessment services can be significant barriers to receiving an ADHD diagnosis and support.

2.28 In its submission to the Inquiry, the Australasian ADHD Professionals Association (AADPA) gave evidence on the cost of an ADHD assessment:

> *There are also reports from our members in Tasmania, as well as in other states, that increased demand for assessments against a backdrop of poor availability of services has led to some clinics increasing prices further, making access even more difficult. Full ADHD assessments can cost between $500 to $3000…* [27]

2.29 The RACGP's submission acknowledged the impact of the financial barriers associated with receiving an ADHD diagnosis:

> *There are financial barriers to receiving a diagnosis, with patients often paying significant out-of-pocket costs, and many patients needing to travel long distances, sometimes interstate, to see a specialist with availability. This cost barrier means that people on low incomes are unable to access care and are disproportionately affected by poor access to care.* [28]

2.30 Evidence was provided to the Committee by the Royal Australasian College of Physicians (RACP) on the wait times for children in the north-west Tasmania in its correspondence dated 24 January 2025:

[27] Submission No. 44, Australasian ADHD Professionals Association, p. 7.
[28] Submission No. 40, Royal Australian College of General Practitioners, p. 2.

> *The average waiting times are as follows for children with development assessment/ADHD/Autism Spectrum Disorder (ASD) (category 3) assessments:*
>
> *Mersey Community Hospital (MCH) – 201.5 days*
>
> *North West Regional Hospital (NWRH) – 268.2 days*
>
> *Waiting times for patients with ADHD in the northwest of Tasmania are likely to increase due to recent staffing changes at NWRH and MCH.*[29]

2.31 At the 16 May 2025 public hearing, then Minister for Health, Hon. Jacquie *Petrusma* MP, provided the Committee with the average wait times for children to access a public paediatrician:

> ***Mrs PETRUSMA*** *- … The average wait time for Category 2 in the south is 329 days, for Category 3, it is 390 days. In the north, for Category 2 it is 278 days, for Category 3 it is 358 days. In the north-west, it is 185 days for Category 2, and for Category 3 it is 301 days.*[30]

2.32 The Minister took a question on notice regarding the number of children currently awaiting ADHD assessment services, broken down by region, sex and age. The current Minister for Health, Mental Health and Wellbeing, Hon. Bridget *Archer* MP, responded to this question on notice on 29 January 2026 and advised that as at 5 January 2026, 2,994 children are currently on the waitlist, comprising 1,219 females and 1,775 males.[31]

2.33 For adults, AADPA's submission stated that wait lists for assessment can exceed two years.[32]

2.34 At the 8 November 2024 public hearing, Mr Davern expanded on the cost and wait times associated with ADHD assessments:

> ***Mr DAVERN*** *- … 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*

[29] Additional Information in Response to Questions on Notice, Royal Australasian College of Physicians, dated 24 January 2025, p. 1.
[30] Hon. Jacquie *Petrusma* MP, former Minister for Health, Transcript of Evidence, 16 May 2025, p. 15.
[31] Additional Information in Response to Questions on Notice, Hon. Bridget Archer MP, Minister for Health, Mental Health and Wellbeing, dated 29 January 2026, p. 2.
[32] Submission No. 44, Australasian ADHD Professionals Association, p. 7.

access assessments. That shortage is evident not just in Tasmania - it's an issue across the entire country.[33]

2.35 Associate Professor Heinrich Weber, a Paediatric Respiratory Physician and member of the RACP, also provided evidence regarding the challenges of extended wait times, as well as work undertaken to decrease these wait times:

> ***Ms JOHNSTON*** *- … I'm keen to understand a bit more about the experience of wait times, particularly in regional Tasmania, in accessing services…*
>
> ***Associate Prof WEBER*** *- … 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 -*** *… 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* [Occupational Therapy] *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.*[34]

2.36 At the 21 February 2025 public hearing, Ms Ellen MacDonald, Chief Executive Officer of Health Consumers Tasmania, provided the Committee with evidence on the impact of wait times on children and their families:

> ***Ms JOHNSTON*** *- … We are hearing a lot, particularly from families trying to access assessment for children, the long wait list for accessing a paediatrician in Tasmania. You highlighted that with a quote from one of the consumers from*

[33] Mr. Timothy Davern, Senior Policy Advisor, Australian Psychological Society, Transcript of Evidence, 8 November 2024, pp. 12-13.

[34] Associate Professor Heinrich Weber, Paediatric Respiratory Physician, Royal Australasian College of Physicians, Transcript of Evidence, 8 November 2024, p. 3.

Hobart of a three-year wait to access a paediatrician. Can you talk to us a bit more about what that means for parents who might not have the same level of privilege or health literacy or access to services? What it means for them and their child, particularly in their early years where early diagnosis is so important to have the best chance of success at school and entry into school, and what you're hearing from consumers about their frustrations? Are people giving up?

***Ms MacDONALD** - People are incredibly resilient in a lot of ways, but it is understandable when some will. It has wide-ranging impacts on families. I probably can't speak to it as well as some others might be able to, but from our knowledge, access to diagnosis for kids is the most difficult for people. I have heard that, for some, access has been a little bit easier more recently than what it has been in the past, but I don't know if that's a certain situation with certain families. A lot of the time, I guess, some people can be quite anti-diagnosis, but I think having a diagnosis is just so important for kids and families to be able to access the support that they actually need, because often you can't get it unless you have the piece of paper. I believe it's incredibly problematic.*

The other thing is, more broadly if we're looking at diagnosis and what's happening for me, it's ADHD, but it's also, more broadly, that child might not have ADHD. There could be something completely different going on, but I guess that child and that family's whole wellbeing and health, the fact that kids aren't able to obtain an assessment from a specialist around whatever that could be is really concerning.[35]

2.37 Paediatrician, Dr Laidler, provided evidence on the wait lists and the potential impact on vulnerable children in regional Tasmania:

***Dr LAIDLER** - … 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.*[36]

2.38 Mr Spohn, a witness with lived experience of ADHD, shared his story at the 21 February 2025 public hearing, and outlined his experience in accessing an ADHD diagnosis:

***Mr SPOHN** - … Then came getting a psychiatrist appointment that, at the time, was something north of $600 for the appointment, and it was a six-month wait. Again, I get it - it was kind of a tough time. There was a spike in people having a similar realisation to me. I guess the pathway is kind of obstructive in and of itself*

[35] Ms. Ellen MacDonald, Chief Executive Officer, Health Consumers Tasmania, Transcript of Evidence, 21 February 2025, pp. 6-7.

[36] Dr. Natasha-Ann Laidler, Paediatrician, Australian Medical Association Tasmania Branch, Transcript of Evidence, 8 November 2024, p. 52.

because you really need to drive yourself, you need to be fixated to actually see it through. That will automatically cancel out people who just can't be bothered, but again, that can be more of a problem. I had to wait on a list for six months, just hanging on, thinking, 'I just want to sort this out.' I was able to get in in three months in the end because he had a cancellation.[37]

2.39 Mr Wynands provided lived experience evidence on his concerns with the costs of ongoing appointments:

> ***Mr WYNANDS*** *- It was about $1200 for the initial assessment and it would be lower with follow-up appointments, but I can't actually afford the follow-up appointments. I am concerned in the next, well, year now, when I need to reapply for my medication, will I be able to access it because I cannot afford to see a psychiatrist?*
>
> *...*
>
> *I was actually quite lucky I had a six-month turnaround from managing to find a psychiatrist to be able to organise an appointment. I was looking at over a year and a half and I was seen within six months.*[38]

2.40 The Committee received evidence that ADHD is a condition associated with high rates of comorbidities, which leads to complexities in diagnosis. RACP's submission stated:

> *...ADHD is a common diagnosis with other psychiatric disorders including depression, anxiety, trauma, and bipolar affective disorder. ADHD is often associated with, or substantially shares symptoms with trauma, Autism Spectrum Disorder and Fetal Alcohol Spectrum Disorder. ADHD has also been associated with substance use disorder, obesity, asthma, diabetes, epilepsy, and sleep disorders. Insufficient understanding of these comorbidities and contributing factors can lead to poor quality assessments, relevant assessments not being undertaken, no assessment of learning ability, or alternative issues not being considered in referrals...*[39]

2.41 During the public hearing on 8 November 2024, Dr Honor Pennington, an adult psychiatrist and representative of RANZCP, expanded on this:

> ***Dr PENNINGTON*** *- ...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*

[37] Mr. Nicholas Spohn, Transcript of Evidence, 21 February 2025, p. 40.
[38] Mr. Scott Wynands, Transcript of Evidence, 21 February 2025, p. 27.
[39] Submission No. 54, Royal Australasian College of Physicians, p. 6.

of ADHD will also experience other mental health conditions which leads to some degree of complexity in both diagnosis and management.[40]

2.42 Mr Davern also gave evidence on the prevalence of comorbidities during the same hearing:

> ***Mr DAVERN*** *- …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.*[41]

2.43 Dr Theresa Naidoo, Community and Child Health Paediatrician and RACP Tasmania Committee Chair, discussed the challenges faced by children in particular:

> ***Dr NAIDOO*** *- …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.*[42]

2.44 Representatives from ADHD Australia, Mr Matthew Tice and Ms Melissa Webster, provided evidence on the prevalence of comorbidities:

> ***Mr TICE*** *- …I think the first thing the committee should understand is that the majority of ADHD cases have at least one comorbid condition. The default is that there are likely other conditions that need to be diagnosed, it's not unheard of, but it's not unusual for individuals with an ADHD, as you pointed out, to have ASD* [Autism Spectrum Disorder], *ODD* [Oppositional Defiant Disorder] *or other comorbid conditions. I would say that the advice that we would give is that you should treat this in a way that the default is that people who present with ADHD, in the majority of cases, would have other conditions that need diagnosis and to proceed with that assumption. Because that's essentially what the data tells us*

[40] Dr. Honor Pennington, Psychiatrist, Royal Australian and New Zealand College of Psychiatrists, Transcript of Evidence, 8 November 2024, p. 64.
[41] Mr. Timothy Davern, Senior Policy Advisor, Australian Psychological Society, Transcript of Evidence, 8 November 2024, p. 12.
[42] Dr. Theresa Naidoo, Paediatrician, Royal Australasian College of Physicians, Transcript of Evidence, 8 November 2024, p. 2.

that those individuals are experiencing. It's generally a complex, as I said before, multimodal challenge.

***Ms WEBSTER** - To add to that as well, often what happens when individuals are going for diagnosis and they talk about some of the challenges that may be faced with, the individual themselves, whether it will be psychologists or psychiatrists or whatever, is basically specifically doing an assessment on, for example, ADHD. The advice would actually be to keep it more broad and actually to have a look at doing a range of assessments to see if they could pull out as well any other diagnosis whilst doing that, as opposed to looking particularly into one.*[43]

2.45 At the 16 May 2025 public hearing, the then Minister for Health, Hon. Jacquie *Petrusma* MP, and representatives from the Department of Health, Dr Sean Beggs, Mr Dale Webster, and Dr Dinesh Arya, gave evidence on the complexities of assessing ADHD when other conditions are present:

***Ms BROWN** - …if a patient was to present to the hospital with one of these illnesses or disorders, how likely is that to be picked up that that's actually ADHD that's the underlying factor, in the hospital setting?...*

***Mrs PETRUSMA** - These are comorbidities associated with ADHD, so it depends on if the comorbidity is high-risk at that time when you present to an accident and emergency department, you'd be treating the initial outcome, but what they're presenting with before, then you could go into ADHD…*

***Dr BEGGS** - This is more talking about the benefits of treating people with ADHD because of the significant comorbidities they have, rather than necessarily knowing that we'll pick up a diagnosis of someone with ADHD because they presented with one of them, if you understand what I mean. It's a bit different. Certainly, in the acute setting, someone presenting with a problem - as in, presenting to the hospital acutely - maybe not, but if they were referred for one of those problems to the out-patients and they were being assessed, yes, there is a likelihood that the ADHD would be detected as the underlying problem or one of the diagnoses associated with it. A child might be referred in for aggressive behaviour, and then worked through and work out whether it was a trauma history, ADHD, a conduct problem, and work out which one of it was contributing, anxiety, which one of those things were contributing, and the primary problem.*

***Mr WEBSTER** - Because the list is acute, it will vary about the amount of time. Are you focused on treating someone with a brain injury or are you treating the underlying of the acute phase in the ED? We're very much at the, 'We've got to treat the life-threatening element of it initially', so time is the thing that varies there. For instance, eating disorders are on the list. Perhaps Professor Arya can talk to this one, but if you're treating an eating disorder, then you are spending*

[43] Mr. Matthew Tice, Chair, and Ms. Melissa Webster, Chief Executive Officer, ADHD Australia, Transcript of Evidence, 18 October 2024, p. 61.

time with the client, the patient, so you're probably going to look at an underlying diagnosis as well.

***Dr ARYA** - …I think whenever anyone comes to our hospital or to our community services, they obviously have a very comprehensive specialist assessment. Even though they may be coming with one issue or one condition, the assessment that we do also looks for comorbidities. If ADHD or any other neurodivergent issue is there, then it will get picked up as part of our comprehensive assessment. As we were discussing before, our teams are multidisciplinary. There are doctors, allied health professionals, there are nurses who will pick up the very specific conditions that are very specific to their expertise.*[44]

2.46 Further barriers to accessing services are experienced by those living in rural and regional areas of the state. As stated by Advanced Pharmacy Australia (AdPha) in their submission:

> *…People in rural and remote areas in Tasmania have limited access to qualified specialists who can diagnose and manage ADHD, leaving people no alternative other than extended wait times and travelling extensive distances to receive an appropriate diagnosis and ongoing care.*[45]

2.47 This concern was echoed by lived experience witness Mr Chris Anderson, from the north-west coast, during his appearance before the Committee on 21 February 2025:

> ***Mr BEHRAKIS** - And how much harder is it being in a regional area?*
>
> ***Mr ANDERSON** - It kind of is a lot of the time for all sorts of things, like, you get used to 'Oh, I've got appointments,' so you go to Launceston or Hobart and things. I mean, Devonport or Burnie aren't too bad for things, but I can imagine that for people down the west coast - Queenstown, those sort of areas - things will be hard. And then, when you do have to go to the mainland for different things, we don't have the cheap airfares that Hobart gets and the big sales and things like that. So, you do have to pay a premium at times.*[46]

2.48 AdPha also submitted that Aboriginal and Torres Strait Islander people face additional barriers in accessing services:

---

[44] Hon. Jacquie Petrusma MP, former Minister for Health, and Mr. Dale Webster, Secretary, Dr. Sean Beggs, Clinical Director, Women's and Children's Services, Dr Dinesh Arya, Deputy Secretary, Clinical Quality, Regulation and Accreditation, Chief Medical Officer and Chief Psychiatrist, Department of Health, Transcript of Evidence, 16 May 2025, p. 16.

[45] Submission No. 58, Advanced Pharmacy Australia, p. 5.

[46] Mr. Chris Anderson, Transcript of Evidence, 21 February 2025, p. 20.

Unfortunately, these complexities are heightened amongst Aboriginal and Torres Strait Islander people as they do not receive culturally safe and appropriate assessment and treatment for ADHD...[47]

Findings

The Committee finds:

7. Tasmanians seeking ADHD assessment and diagnosis wait too long. This negatively impacts all aspects of their lives.
8. The financial costs associated with ADHD assessment and diagnosis in the private health system are high.
9. The wait times and costs associated with seeking ADHD assessment and diagnosis are significant barriers for people pursuing a suspected diagnosis.
10. The requirement for an ADHD diagnosis to be made by a psychiatrist or a paediatrician means those who have already been assessed by a psychologist will experience a second waiting period and incur additional costs.
11. A high level of health literacy is required to navigate the complexity of diagnostic pathways for ADHD. This prevents some people from accessing assessment and diagnosis, and compounds costs and wait times.
12. Workforce shortages and service availability exacerbate wait times for ADHD assessment and diagnosis, especially in rural and regional areas of Tasmania.
13. People with ADHD who live in rural and regional areas may experience increased difficulty and cost in accessing an assessment and diagnosis.
14. The high rate of comorbidities associated with ADHD can lead to complexities during diagnosis, reinforcing the importance of high-quality and accessible specialist assessment services.
15. Aboriginal and Torres Strait Islander people face additional barriers to accessing ADHD assessments and diagnoses, which have not generally been developed to be culturally safe and appropriate.

Telehealth and interstate assessments

2.49 Given the barriers to access assessment services, some Tasmanians are seeking an ADHD diagnosis through telehealth and interstate services. Lived experience witness Ms Madeleine O'Keeffe's submission stated:

[47] Submission No. 58, Advanced Pharmacy Australia, p. 5.

> *…*[there are] *no avenues for assessment for adults whatsoever in the public system in Tasmania. My only options were all telehealth assessments costing over $1000, to be paid in advance, and waitlists were over 6 months long.*[48]

2.50 The Tasmanian Adult ADHD Support Group's submission also highlighted this:

> *…To fill the void, a considerable number of telehealth providers have begun to operate in this space in Tasmania and for most adults seeking a diagnosis this is the only option currently available. Prices are often very high, and the quality of care varies, according to feedback from our members.*[49]

2.51 AADPA's submission further discussed the increase in telehealth services:

> *Unfortunately, there are also reports that the assessments being offered by some new clinics, many of which operate via telehealth, do not meet the quality standards set out in the ADHD Clinical Practice Guideline. AADPA does not support increased access that comes at the cost of reduced quality.*[50]

2.52 At the 18 October 2024 public hearing, AADPA President, Professor David Coghill, provided further evidence highlighting his concern with the quality of telehealth services:

> ***Prof COGHILL*** *- … we hear - and I'm sure you've heard - in the press about services popping up that offer a kind of quick route to ADHD assessment and online assessment that's usually not followed up by proper treatment plans. It's: see, assess, do a very quick assessment, and then refer to the GP for prescribing. My concern is that because the waits in all other aspects of - probably very good-quality - care, when you get to it, in Tasmania are so long, that Tasmanian families are at risk of using those quick fix services more often. That may mean that you've got people who are what I call 'misdiagnosed', as well as a lot of people who have missed - m-i-s for the misdiagnosed and m-i-s-s-e-d for the 'missed-diagnosed'. I think that language is much more helpful than talking about under- and over-diagnosing. You can have both missed and misdiagnosis at the same time.*[51]

2.53 Lived experience witness Mr Anderson, who was diagnosed with 'AuDHD' (co-occurrence of Autism Spectrum Disorder (ASD) and ADHD) as an adult, detailed his experience as a parent seeking an ADHD assessment for his child:

> **Mr *ANDERSON*** *- …it's our daughter who's been the biggest challenge. We've been looking for about 18 months now for a diagnosis for her. We've been suspecting things for years, but it's been tough. We've looked around Tasmania several times, and we've had to go to Sydney. Last year, we went to Sydney in*

[48] Submission No. 3, Maddie O'Keeffe, p. 1.
[49] Submission No. 21, Tasmanian Adult ADHD Support Group, p. 2.
[50] Submission No. 44, Australasian ADHD Professionals Association, p. 8.
[51] Professor David Coghill, President, Australasian ADHD Professionals Association, Transcript of Evidence, 18 October 2024, p. 2.

April and did some testing and obtained a provisional diagnosis of ADHD. That came through about June, from memory. We thought, great, that's the hard work done. Then we went looking for paediatricians here in Tasmania, and we haven't been able to find them. We've looked publicly and we've searched privately several times and no-one's taking on new people at the moment. That's been hard because the behaviour keeps getting worse and worse as the days go on.

We had an appointment late last year with a guy in Brisbane and, unfortunately, that one set us back even further. We had an appointment with him and it was really frustrating. It was Telehealth. I went in, my wife was nervous about it.... Unfortunately, I was wrong and she was right. The doctor dismissed a lot of the things that I said and my experiences. He didn't believe it about her and, of course, she was really well behaved for the appointment. That would be great normally, but really tough with that one. He just spent the time yawning through the appointment and, in the end, he just suggested melatonin to help her sleep and we should do parenting classes.

CHAIR [Ms Haddad] - *Was that a paediatrician, Chris?*

Mr ANDERSON - *Yes, I believe it was. That was just really hard. We stuck with it for a bit, and then we were due to have an appointment just after Christmas last year and he stuffed us around with appointments there.*

We just had to make the decision that it was not working out. We begged our GP, and our daughter's been seeing a child psychologist here in Devonport as well. We have an appointment with the place where we had the testing done. It's a paediatrician appointment in Sydney at the beginning of March, so about a week away. We will be heading up to Sydney for that one, where hopefully we'll be able to get some answers. They prefer not to do it that way, because of the restrictions across the state borders with all the different medications and everything, but they understand that we're struggling and how hard things are.

Cost wise, that's another $1500 that it's costing us. While we are in a position that my wife is really good with money, we're not rich. We are stable, which is good, so we can afford to do these sorts of things…

…

CHAIR - *That's coming up for two years that you've been trying to access that treatment for your daughter?*

Mr ANDERSON - *Yes, it would be coming close to two years.*[52]

[52] Mr. Chris Anderson, Transcript of Evidence, 21 February 2025, pp. 17-18.

Findings

The Committee finds:

16. Due to significant barriers to accessing ADHD assessment and diagnosis in Tasmania, many Tasmanians use telehealth and interstate services.

17. Use of telehealth and interstate services for ADHD assessment and diagnosis result in issues around variable service quality, continuity of care, and significant costs.

Child assessments

2.54 As the process of assessment for children and adults is different, the Committee heard specific evidence regarding the adequacy of assessment services for children.

2.55 Waitlists for paediatricians have been cited as a barrier in accessing an ADHD diagnosis. In their submission to the Inquiry, Hobart ADHD Consultants noted the increased demand on private paediatricians:

> *…most, if not all, private practice paediatricians in Tasmania have had their books closed for much of the last 18 months. There is a repeated cycle of paediatricians closing and re-opening their books because of their own need to manage demand on services.*[53]

2.56 In another submission, a Tasmanian GP, currently employed as a GP with Special Interest (GPSI), who wished to remain anonymous, explained the impact of the limited availability within the private sector:

> *…In the paediatric space the loss of our private sector has exacerbated the equity gap as families who could previously afford to access the private sector paediatricians for assessment and support of ADHD are now largely having to access public paediatric services which are not equipped to handle that demand. It is my experience working in a GPSI role that referrals to paediatrics are dominated by requests for consideration of ADHD.*[54]

2.57 This private witness also submitted evidence on the outcome of the referrals they have received in their current role:

> *…However of the greater than 150 children I have seen where this was the reason for referral only two have met diagnostic criteria for this condition. The remainder do not and there are instead complexities affecting their presentation. We see screen dependence, limited physical activity, poor diet, lack of parenting resources and limited classroom supports all playing a role. Children referred have been as young as 18 months when the generally accepted minimum age of*

[53] Submission No. 30, Hobart ADHD Consultants, p. 4.

[54] Submission No. 15, Private Witness, p. 1.

diagnosis for ADHD would be 6. It is my opinion the vast majority of behavioural or emotional referrals for younger children would be better and more efficiently supported through more proactive community and early school based support programs and would thus free up diagnostic services in paediatrics to more adequately handle community demand...[55]

2.58 At the 8 November 2024 public hearing, the Committee heard from Dr Naidoo, a paediatrician based in Hobart, about the utilisation of school-based supports and assessments:

> ***Dr NAIDOO*** *- ... 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.*[56]

2.59 During the same hearing, Mr Davern also provided evidence on school-based assessments:

> ***Mr DAVERN*** *- ... 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*

[55] Submission No. 15, Private Witness, pp. 1-2.
[56] Dr. Theresa Naidoo, Paediatrician, Royal Australasian College of Physicians, Transcript of Evidence, 8 November 2024, p. 8.

type, there's the inattentive type, there's the combined presentation. Each one has different symptoms.[57]

2.60 In raising school-based assessment, Mr Davern also discussed challenges associated with the different presentations of ADHD for females and males:

> ***Mr DAVERN*** *- …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…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.*[58]

2.61 At the 16 May 2025 public hearing, the then Minister for Health gave evidence regarding recent reform to the Statewide Referral Criteria to improve assessment referrals for children:

> ***Mrs PETRUSMA - …*** *we want to ensure children are referred with comprehensive supportive documentation to minimise the time between their initial appointment and full assessment. This will enable general practitioners to specifically refer a patient for neurodevelopmental concerns as opposed to general paediatric concerns. The Statewide Referral Criteria is due to be implemented in the first quarter of 2025-26, so from July, because once implemented, this new criteria will be linked to the existing HealthPathways*

[57] Mr. Timothy Davern, Senior Policy Advisor, Australian Psychological Society, Transcript of Evidence, 8 November 2024, p. 21.
[58] Mr. Timothy Davern, Senior Policy Advisor, Australian Psychological Society, Transcript of Evidence, 8 November 2024, pp. 21-22.

portal to support GPs to ensure that as much assessment as possible can occur while awaiting the paediatric appointment.

We know that behavioural presentations in children can reflect several possible underlying diagnoses. Therefore, we believe it is crucial that healthcare professionals with specialised paediatric training conduct thorough medical assessments of children presenting with neurodevelopmental or behavioural issues like ADHD, so that we can accurately diagnose conditions that also may mimic ADHD, and we also want to identify any comorbidities. As part of this program, developmental and behavioural training will be a core component of training for all the general paediatricians. It's about improving the whole scope.[59]

Findings

The Committee finds:

18. Early intervention is key as undiagnosed ADHD can lead to lower self-esteem, anxiety and depression.
19. Increased access to school-based assessments would help children displaying symptoms of ADHD access earlier support.
20. The implementation of the Statewide Referral Criteria should improve the referral process.

Adult assessments

2.62 The Committee heard evidence regarding the adequacy of diagnostic services for adults.

2.63 Then Acting Secretary of the Department of Health, Mr Dale Webster, provided the Committee with evidence about the services provided by the public health system:

> ***Mr WEBSTER*** *- The mental health services model that we deliver in the public health system is an acute mental health service and diagnosis, early diagnosis, et cetera, actually sits in the primary health sector. It sits with the federal government part of the equation with mental health. Certainly, those with ADHD who are having acute episodes or chronic episodes would come to mental health services. But, generally, it is done through GPs and psychiatrists in the private sector as per the model which splits primary funding to the Australian Government through Medicare and the acute sector through the state government.*
>
> ***CHAIR*** [Ms White] *- What avenue is there for someone in Tasmania who doesn't have the resources to go to a private practitioner, as an adult, to access diagnostic and treatment services for ADHD in the public health system?*

[59] Hon. Jacquie Petrusma MP, former Minister for Health, Transcript of Evidence, 16 May 2025, pp. 6-7.

***Mr WEBSTER** - They are limited through the public health system…*

…

In the ADHD space, if they're not exhibiting chronic or acute, then the treatment they're getting is limited in that they may be referred back to their GP or to the private sector. Again, because if they don't require acute services, then they fall outside of our core group of patients or consumers.[60]

2.64 At the 8 November 2024 public hearing, Dr Pennington provided her perspective as a public adult psychiatrist:

> ***Dr PENNINGTON** – …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…*[61]

Findings

The Committee finds:

21. There is currently minimal capacity for ADHD assessment and diagnosis of adults in the Tasmanian public health system.
22. Adult assessment and diagnosis for ADHD are more often provided in the private sector.

Recommendations

The Committee recommends:

1. **The Tasmanian Government acknowledge and address the impact of inadequate and inaccessible ADHD assessment and diagnosis.**

[60] Mr. Dale Webster, Acting Secretary, Department of Health, Transcript of Evidence, 18 October 2024, pp. 22-23.

[61] Dr. Honor Pennington, Psychiatrist, Royal Australian and New Zealand College of Psychiatrists, Transcript of Evidence, 8 November 2024, p. 65.

3 ADEQUACY OF ACCESS TO SUPPORTS AFTER AN ADHD ASSESSMENT

3.1 This Chapter discusses the adequacy of access to supports after an ADHD diagnosis is received in Tasmania.

3.2 Evidence heard by the Committee outlined specific areas of support that are beneficial for those with ADHD, as well as barriers that Tasmanians face in accessing supports after an assessment.

3.3 ADHD Australia's submission included survey results from Australians who identified treatments and supports that they found most useful in managing ADHD, including:

- *Medication*
- *Therapy / counselling*
- *Occupational therapy*
- *Support groups / online forums / peer support and talking with friends who have ADHD*
- *Behavioural strategies*
- *Habits + structure – e.g. routines, calendars, to-do lists*
- *Lifestyle changes – e.g. exercise, nutrition, goals*
- *Resources – e.g. books, ADHD magazine, YouTube, social media, podcasts, TikTok*
- *Speech pathology*
- *Coaching, and*
- *Supports at school or work – e.g. note-takers, flexibility.*[62]

3.4 The use of medication for treatment and support for children and adults with ADHD will be discussed further in Chapter 5.

Barriers to access

3.5 Evidence received by the Committee indicated that similar barriers associated with accessing an ADHD assessment and diagnosis are experienced when patients seek support after their diagnosis.

3.6 In their contribution to the Inquiry, National Disability Services submitted:

[62] Submission No. 49, ADHD Australia, p. 11.

> *Barriers to accessing support after an ADHD assessment were similar to those encountered when seeking an assessment. The main obstacles included cost, long waiting lists, and a lack of access to appropriately trained professionals...*[63]

3.7 This point was echoed in the Hobart ADHD Consultants' submission:

> *Access to intervention and support services faces the same critical shortages as those for assessment and diagnosis. Access is inadequate for those who choose private health care, and nearly impossible for most who rely on the public health system.*[64]

3.8 The prevalence of comorbidities associated with ADHD can lead to complexities in diagnosis and treatment. The Royal Australian College of General Practitioners (RACGP) submission discussed this further:

> *People living with ADHD require lifelong, individualised support. The support they need will depend on factors including any co-existing conditions and their external environment.*
>
> *...*
>
> *More than two thirds of individuals with ADHD have at least one other co-existing condition. Common co-existing conditions include autism spectrum disorder, anxiety, behaviour disorders, Tourette Syndrome, sleep disorders, and depression. People living with ADHD require individualised care which also diagnoses and treats these conditions alongside the ADHD.*[65]

3.9 The Australian Medical Association (AMA) Tasmania Branch's submission discussed additional vulnerabilities affecting Tasmanians with ADHD:

> *In Tasmania, almost half of the population is functionally illiterate and most likely includes the highest percentage of ADHD patients. Support for this large vulnerable group, also more likely to be rural, poor, disabled, and have less work, housing and food security, and have experienced multigenerational disadvantage and domestic and other violence, needs to be targeted with these factors in mind...*[66]

3.10 At the 18 October 2024 public hearing, Dr Madelyn Derrick, clinical psychologist and Director of Hobart ADHD Consultants, provided evidence on the adequacy of support services for those with ADHD and co-existing mental health conditions:

[63] Submission No. 48, National Disability Services, p. 5.
[64] Submission No. 30, Hobart ADHD Consultants, p. 5.
[65] Submission No. 40, Royal Australian College of General Practitioners, p. 3.
[66] Submission No. 51, Australian Medical Association Tasmania Branch, p. 7.

> ***Dr DERRICK*** *- You look at how someone rebuilds their life from that point when, in their whole life, they haven't had the experience of being able to be organised, engage with services in a way that's positive and reinforcing for them. It's not only difficult for them, but they're starting as an adult with the skills that others would develop much earlier. Trajectories can be very much switched at that point. This is from the very severe end of difficulties that are very costly for the state purse.*
>
> *I suppose we also have a wasted opportunity that creates a revolving door where we're treating part of what is happening for someone. We're maybe treating pharmacologically. They're bipolar, they're OCD* [Obsessive-Compulsive Disorder]*, they're anxiety, all these things that someone with ADHD has a higher risk of having, but we're not treating the ADHD. Then because of the impacts on cognitive functioning, the capacity to make the most of the benefits of any other treatment for any other conditions, it's just wiped away. You need your self regulation. That's the set of cognitive functions of ADHD. You need those to remember to take medication, to show up to appointments, to organise supports for yourself to get help getting a job.*[67]

3.11 Dr Derrick highlighted the importance of appropriate support services for vulnerable Tasmanians:

> ***Dr DERRICK*** *- … I'm not sure if it's written policy amongst public mental health to not treat ADHD or it's just practice, but when ADHD is a genetic condition and there's going to be intergenerational patterns of disadvantage, we are going to have a skew of ADHD in lower socioeconomic groups. Arguably there are more things to have to fight against. It's a harder climb up to a level of functionality from there. It doesn't make sense that assessment and intervention is more accessible to those who have more resources and less levels of challenge. That's in a very – taking averages – generalised sense.*
>
> *Again, it's the same thing of you can't treat the OCD or schizophrenia effectively if you're not actually treating the ADHD. You're creating a revolving door through the public health system. Much like in the drug and alcohol sector, if we don't get in and treat the mental health, then we've just got that revolving door. When I was in the drug and alcohol area, there was all the comorbidity funding that was actually running the comorbidity project at the Bridge there. That was really key. Once we've got them here, we've got them thinking… sober and straight, let's do all the mental health work while we can cause otherwise we're just sending them back out with a 'see you soon'.*
>
> *…*

[67] Dr. Madelyn Derrick, Clinical Psychologist, Hobart ADHD Consultants, Transcript of Evidence, 18 October 2024, p. 18.

We can make the same case for ADHD, with more complex mental health co-occurring.[68]

3.12 Mr Daniel Vautin, Director of Policy and Impact, from the Alcohol Tobacco and Other Drugs Council Tasmania, gave evidence on the prevalence of substance use disorders among people with ADHD:

> ***Mr VAUTIN*** *- … 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* [with ADHD] *have co-occurring 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.*[69]

Findings

The Committee finds:

23. There are several effective treatments and supports for ADHD. These include medication, psychological therapy, occupational therapy, speech pathology, support groups, behavioural strategies, lifestyle changes and structure, and ADHD coaching.

24. Barriers associated with accessing ADHD assessment services, such as cost and wait times, are also experienced by people accessing support services following an ADHD diagnosis.

---

[68] Dr. Madelyn Derrick, Clinical Psychologist, Hobart ADHD Consultants, Transcript of Evidence, 18 October 2024, p. 19.

[69] Mr. Daniel Vautin, Director of Policy and Impact, Alcohol Tobacco and Other Drugs Council Tasmania, Transcript of Evidence, 8 November 2024, p. 39.

25. The supports available to Tasmanians with ADHD are impacted by their location, personal financial resources and the ability to access private services.

26. The high level of comorbidity experienced by people with ADHD creates complexities in accessing appropriate individualised support.

Non-Pharmacological Support

3.13 The Committee received evidence on the importance of non-pharmacological support to treat ADHD. RACGP's submission stated:

> *ADHD is a complex condition that requires multi-faceted supports. Most commonly a combination of medication, lifestyle changes and psychological support is required for best outcomes*[xiii]*. Due to the current demand on services in Tasmania access to supports beyond medication has been deprioritised which is negatively impacting a patient's ability to move towards effective self-management of their condition.*
>
> *Given these factors it is essential that people living with ADHD have a comprehensive care plan with input from a GP led multidisciplinary team that is regularly reviewed. It is also important to recognise that once effective treatment for ADHD is deployed it is frequently a stable chronic condition that is well suited to primary care management and support...*[70]

3.14 The Royal Australian College of Physicians (RACP) submission also highlighted the need for non-pharmacological, multimodal support, and noted the difficulties in accessing these kinds of supports:

> *Our RACP members have previously noted complex cases of ADHD often have several contributing factors and require multimodal care with allied health input. This can be difficult to access in the public sector and involves additional expenses to patients and their families to access privately. Once ADHD is diagnosed, whilst a key treatment is often medication, however there are often minimal supports and/or programs available to provide additional assistance. Medicare provides a limited number of allied health therapy sessions, which is generally insufficient and can involve a substantial gap payment. ADHD coaches are also not supported by Medicare, despite offering strategies to help people with ADHD to function more efficiently. Increasing demand for occupational therapists and speech*

[70] Submission No. 40, Royal Australian College of General Practitioners, p. 3, including reference to Footnote xiii - Catalá-López F, Hutton B, Núñez-Beltrán A, Page MJ, Ridao M, Macías Saint-Gerons D, Catalá MA, Tabarés-Seisdedos R, Moher D. The pharmacological and non-pharmacological treatment of attention deficit hyperactivity disorder in children and adolescents: A systematic review with network meta-analyses of randomised trials. PLoS One. 2017 Jul 12; 12(7):e0180355. doi 10.1371/journal.pone. 0180355 PMID: 28700715; PMCID: PMC5507500.

pathologists is also extending allied health waitlists and becoming another barrier to accessing support after diagnosis[11]*.*[71]

3.15 At the 8 November 2024 public hearing, Mr Timothy Davern of the Australian Psychological Society (APS) gave evidence on the effectiveness of non-pharmacological support:

> ***Mr DAVERN*** *- … 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… I just want to read out of the* [AADPA] *guidelines:…*
>
> > *… 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.*[72]

3.16 Mr Davern expanded on the adequacy of non-pharmacological supports and treatments provided under a Mental Health Care Plan:

> ***Ms ROSOL*** *- … 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?… 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*** *- … 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… in terms of how many people are accessing it and how many sessions are needed specifically… the 10 sessions that*

[71] Submission No. 54, Royal Australasian College of Physicians, p. 6, including reference to the submission's Footnote 11 - Marozzi, M. (2022). *Speech pathologist and OT demand soars with waitlists blowing out, job ads going unanswered*, ABC News. https://www.abc.net.au/news/2022-05-11/job-ads-go-unanswered-as-demand-for-speech-pathologists-otssoar/101041504

[72] Mr. Timothy Davern, Senior Policy Advisor, Australian Psychological Society, Transcript of Evidence, 8 November 2024, pp. 17-18.

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.[73]

3.17 At the same public hearing, Mr Vautin discussed the effectiveness of non-pharmacological support for people with ADHD and substance use disorders:

> ***Mr VAUTIN*** *- …There are other things that really support ADHD treatment… education around ADHD, CBT* [Cognitive Behavioural Therapy], *DBT* [Dialectical Behavioural Therapy] *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… there have been some studies from the United States that show that if you assess and diagnose and treat a young person* [with ADHD] *at the age of nine, … 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...*[74]

Findings

The Committee finds:

27. A combination of pharmacological and non-pharmacological support is best practice for the effective treatment of ADHD.
28. A multidisciplinary approach to supporting people with ADHD and other comorbidities is important.
29. The ten subsidised Medicare sessions per year are insufficient for people with ADHD who access a Mental Health Care Plan.

Early intervention

3.18 The importance of early intervention for children experiencing symptoms of ADHD was raised by several witnesses to the Inquiry. At the public hearing on 18 October 2024, Dr Timothy Jones, GP and representative of RACGP, stated:

> ***Dr JONES*** *- … we do have a belief that better support in childhood will lead to less adults who are in this current situation, because we know that early intervention*

[73] Mr. Timothy Davern, Senior Policy Advisor, Australian Psychological Society, Transcript of Evidence, 8 November 2024, pp. 19-20.

[74] Mr. Daniel Vautin, Director of Policy and Impact, Alcohol Tobacco and Other Drugs Council Tasmania, Transcript of Evidence, 8 November 2024, p. 45.

matters and we know that the vast majority of children with ADHD, if they're provided with adequate supports, will no longer require treatment as an adult.[75]

3.19 Dr Jones provided examples of effective early intervention strategies:

> ***Dr JONES*** *- … There is a situation where we would love to see a model explored for Tasmania which is referred to in our submission, which is both parent-child interaction therapy and its variant teacher-child interaction therapy and the reason why I'm mentioning this is because of the early intervention mindset. We know that a large number of children are being referred at a very young age, four, five and six. We know many of them may not actually go on to reach a diagnostic label of ADHD, but currently we do have a situation where the only support we can provide is the hammer of the diagnosis and the treatment.*
>
> *If we had the availability to offer low-cost but personalised intervention services to those early groups of children, we know from experience in other states where those services are offered that we get excellent outcomes out of it. In the submission we put that we see roughly double the impact of putting these children on stimulants, we also see that their long-term engagement with health care essentially dries up.*
>
> *If the concerns are addressed early enough, very few then follow on through to needing more formal assessment and ongoing treatment. So we're huge believers, GPs, in preventative care and these are low-cost models that are being rolled out using telehealth, group consulting and the support of mental health care plans from the federal government to deliver that family based-care…*
>
> *…*
>
> *Looking at what's offered in NSW for example, this is where children where there is that significant concern about their emotional learning development, those families are grouped into similar cohorts, they are paired to a trained psychologist, the families are all receiving support through mental health care plan through their GP and the state government has contributed a little bit of funding to top that up and they receive either six or 12 weekly one-hour sessions to talk about what's going on with the child, to explore the behaviours with the trained professional and to then implement strategies. It's those pathways that are seeing those fantastic response rates because they're individualised and because they're empowering either the teacher, the parent or both, to meet the needs of the child.*
>
> ***CHAIR*** [Ms White] *- And in those examples, you don't require a diagnosis?*
>
> ***Dr JONES*** *- Correct.*

[75] Dr. Timothy Jones, General Practitioner, Royal Australian College of General Practitioners, Transcript of Evidence, 18 October 2024, p. 52.

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

Dr JONES *- You may still be activating an assessment pathway knowing that you can de-escalate it, but it's front-loading supports in a way that is essentially telling the family, 'You're not alone. We're going to help you.' It's very hard to speak in data about how much hope that gives people, but the lived experience of us working in the community is, it's tremendous.*[76]

3.20 Ms Vikki Ryall, Chief Clinical Officer at headspace, gave evidence that parent education could help with early identification and intervention for children with ADHD:

Ms RYALL *- … There are some really good parent tools that you can look through. … There's some parent assessment that you can go through yourself to rate, and it will suggest whether or not you should seek a professional diagnosis…*[77]

3.21 The Minister for Education, Hon. Jo *Palmer* MLC, and representatives from the Department for Education, Children and Young People (DECYP), appeared before the Committee at the 11 April 2025 public hearing.

3.22 The Minister and Ms Jodee Wilson, Deputy Secretary Development and Support, gave evidence on the pathways for children to receive support before they begin school:

CHAIR [Ms Haddad] *- … I would really love to hear reflections from you and your Department on… the challenge… that presents when a young person starts kindergarten, or perhaps Launch into Learning, but they come to you with quite often known neurodiversity that that child hasn't been able to access treatment for in an early intervention pre-school-age environment, and what kind of challenges that provides for teachers and others working in schools to support those children…*

Ms PALMER *- … ideally, we are hoping that by the time children are getting to kindergarten that, where they have had an interaction, whether that be through the Early Childhood Inclusion Service (ECIS) or particularly Child and Family Learning Centres, early learning for three-year-olds, that, if there is any indication, that there might need to be further investigation or supports put in, that we can actually have the opportunity to do that prior to them getting to kindergarten. But we absolutely acknowledge that, for a cohort of families, sometimes for a student, their very first start on their educational journey is when they step into a kindergarten class.*

…

[76] Dr. Timothy Jones, General Practitioner, Royal Australian College of General Practitioners, Transcript of Evidence, 18 October 2024, p. 53.
[77] Ms. Vikki Ryall, Chief Clinical Officer, headspace, Transcript of Evidence, 18 October 2024, p. 42.

Ms WILSON *- … Launching into Learning is another… program where there are early insights gained by the teachers and by the professionals in those spaces in order that the learning needs can be determined. The early identification isn't dependent on a diagnosis; teachers are really skilled at being able to identify the behaviours of a young person and a little person to be able to really see what their strengths might be, where there might be challenges by way of gaps in their learning or gaps in their ability to regulate their behaviour, and are supported not only through their own expertise, but through connecting with other adults in the school setting to be able to meet their needs.*[78]

3.23 Ms Alison Brooks, Director Student Support, provided further evidence on the support staff available at Child and Family Learning Centres (CFLCs), as well as evidence on the Head to Health Program:

Ms ROSOL *- …I am curious to know, because I know that CFLCs have psychologists and allied health in there, what's the FTE* [Full Time Equivalent] *allocation in CFLCs for the different roles, and what kind of wait times are you seeing for referrals?...*

…

Ms BROOKS *- …First of all, the allocation for professional support staff to CFLCs is not the same as it is to schools, so it's slightly different. They each have access to speech and language pathology, but not to psychology. We don't have a diagnostic service within CFLCs. That's important to note. I guess, in saying that, we also acknowledge that the little people in those spaces may not always be ready for a diagnosis at that point in time. I guess it's the beginning of the journey. Once they hit school, so once they come into contact with school through the kindergarten, that's when they would have direct access to a psychologist, for example, for diagnostic purposes.*

One thing I wanted to note is our partnership with health through the Head to Health Program. Currently, there are three new Head to Health for kids clinics that are co-located in three spots across the state: one at Brighton, one at East Tamar here in Launceston and one in Burnie. The purpose of that program is to work with other professionals and other agencies, in particular, Education, to be able to work in that early identification space. That effectively is a multidisciplinary team working with the resources that are available within the CFLCs to look at diagnosis and early intervention for children and families.[79]

3.24 Ms Brooks expanded on the support provided through the Early Childhood Inclusion Service (ECIS):

---

[78] Hon. Jo Palmer MLC, Minister for Education, and Ms. Jodee Wilson, Deputy Secretary Development and Support, Department for Education, Children and Young People, Transcript of Evidence, 11 April 2025, pp. 31-32.

[79] Ms. Alison Brooks, Director Student Support, Department for Education, Children and Young People, Transcript of Evidence, 11 April 2025, pp. 33-34.

> ***Ms BROOKS*** *- … I just wanted to pick up on ECIS intervention because we do have professional support staff that are allocated through our ECIS programs and in many cases an assessment would be done at that level, and whilst sometimes diagnosis doesn't result from that assessment, what comes from that is a really comprehensive learning and transition plan that identifies some of the supports and adjustments that need to be made as the young person transitions into formal school. I think that's a very important step that we need to be reminded of. Then as that young person comes into school and those behaviours are identified, that's when we have the learning plan mechanism that is a way of capturing the adjustments that are needed.*[80]

Findings

The Committee finds:

30. Early intervention for children displaying symptoms of ADHD can decrease the need for interventions later in life.

31. Child and Family Learning Centres and the Early Childhood Inclusion Service offer opportunities to identify children who may require additional supports prior to and after commencing school.

32. Diagnostic services for ADHD are not available in Child and Family Learning Centres.

33. There is scope to increase the supports available through Child and Family Learning Centres.

Support for children

3.25 The AMA Tasmania Branch provided evidence on effective support for children with ADHD in its submission:

> *Evidence-based behavioural interventions (interventions proven to be effective) are foundational for the treatment of complex ADHD. Examples of these interventions include parent training on behavioural management, teacher training on classroom behaviour management, peer interventions and organisational skills training (for older children). Interventions that have not been scientifically proven to be effective (such as play therapy, cognitive training, neurofeedback, sensory integration therapies, and eye tracking training) should not take the place of those that have*[15]*.*[81]

[80] Ms. Alison Brooks, Director Student Support, Department for Education, Children and Young People, Transcript of Evidence, 11 April 2025, p. 36.

[81] Submission No. 51, Australian Medical Association Tasmania Branch, pp. 6-7, including reference to the submission's Footnote 15 - Luo Y, Weibman D, Halperin JM, Li X. A Review of Heterogeneity in Attention Deficit/Hyperactivity Disorder (ADHD). Front Hum Neurosci. 2019 Feb 11; 13:42. doi: 10.3389/fnhum.2019.00042. PMID: 30804772; PMCID: PMC6378275.

3.26 Evidence heard by the Committee reflected on the adequacy of support currently available to children diagnosed with ADHD. A GPSI who wished to remain anonymous provided their perspective:

> *Currently we do not provide adequate supports to children and families with a diagnosis of ADHD. I frequently receive requests from families regarding availability of psychologists, educational advisors and occupational therapy support related to children with ADHD. I usually have to comment that these resources are not available at present. Even liaising with schools I find that attitudes and classroom support of ADHD can be extremely variable, even within the same school. I think a prudent approach would be to educate and empower an organisation to provide direct family support, coaching and school liaison roles in ADHD similar to how the MS Society supports and advocates for those with multiple sclerosis. This would again free up our highly stretched health and educational resources to perform more assessment and management of complex cases rather than having to provide individual case management to large numbers of patients/students.*[82]

3.27 In its submission, Hobart ADHD Consultants stated:

> *For individuals with ADHD of school age, there is not only a lack of adequate support, but for many, their experience at school is detrimental to their development and wellbeing. The way schools respond to ADHD-related challenges can lead to making the ADHD-related challenges even greater. For some, it can lead to severe, detrimental, longer-term impacts.*[83]

3.28 Carers Tasmania also provided evidence on school-based supports:

> *Within the context of Tasmanian schools, Carers Tasmania often hears from parents of children with ADHD who are not able to obtain the support that they need at school. We hear stories of children who have ADHD who are sent home because they are said to be disruptive to others, or disobeying rules. These experiences occur across public, private and independent schools, and sometimes result in home-schooling, taking parents out of the workforce.*
>
> *Often within school settings, children with ADHD are made to try and conform to rules that may not be fully achievable, such as being quiet, staying still, and keeping on task, but for many this is simply not possible. There are physiological reasons that can inhibit children with ADHD to 'conforming' to the same expectations for children without ADHD. Schools must be resourced effectively to support these children to engage and complete their schoolwork, in ways that suit their specific needs, rather than sending them home or punishing them. Carers Tasmania sometimes hears of children who have ADHD who do not have an individual learning plan in place, scenarios where the plan is not followed or monitored, or the plan includes ableist goals that are not realistic. Many parents*

[82] Submission No. 15, Private Witness, p. 3.
[83] Submission No. 30, Hobart ADHD Consultants, p. 7.

caring for school-aged children with ADHD are referred to individual advocacy services such as The Association for Children with Disability.[84]

3.29 At the 8 November 2024 public hearing, Dr Theresa Naidoo, paediatrician and representative of RACP, gave evidence on her experience interacting with school-based support services:

> ***Dr NAIDOO*** *- …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… 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…*
>
> *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.*[85]

3.30 The Committee heard from Mr Chris Anderson regarding his experience with school-based supports as a parent:

> ***Mr ANDERSON*** *- …One thing that is really good these days is the schools. I feel like the schools have really improved with things. With the school that my children go to, I've got a teacher there who's a wellbeing teacher and she is absolutely brilliant. I would not be able to talk her up higher. She loves the kids, she looks after them, she pushes them, she works with their anxieties, and she just really gets the best out of them and understands them, and that's so good to see.*
>
> *I remember back when I was at school, I remember about grade four or grade five, I was sick every morning. I was feeling really sick every morning, and it was just seen as me wanting to get out of school, it was me faking it and things like that. I remember getting laughed at because it was called 'Chris's morning sickness' sort of thing. It was really hard because I didn't want to miss school, but*

[84] Submission No. 19, Carers Tasmania, pp. 11-12.

[85] Dr. Theresa Naidoo, Paediatrician, Royal Australasian College of Physicians, Transcript of Evidence, 8 November 2024, p. 9.

also I felt really sick. If I said that to anybody today, it would be simple to say, 'Oh, that was just anxiety'. But even 30 years ago, that wasn't really known about back then. There was nothing that could really be done. It was, 'Have some of this Rescue Remedy stuff,' or something like that. Now, there's a recognition of all those sorts of things. I know with my kids' school, my son was showing me the other day that there's a special chair in his classroom that kids can sit in if they need to and it blocks out a lot of the sound and sensory stuff in there. So, if you need a moment to realign yourselves and calm down. That's great.

People are understanding what sensory overwhelm is now. A lot of the schools have a special room where kids can go to now if they do need a bit of time out, if they need a bit of a chill space. They're not just getting sent to the principal because they're naughty and disruptive. That's good. Now working at a secondary school, working with learning enhancement, learning support teams there, I've seen the different learning plans that kids get these days. It's really great seeing all that stuff now that is being done for people. I think awareness would be a really great thing to get out there in the community for people.[86]

3.31 The Minister for Education and DECYP representatives provided the Committee with evidence on the support available in Tasmanian public schools at the 11 April 2025 public hearing.

3.32 The Committee heard evidence from the Minister on the Educational Adjustments Disability Funding Model:

> ***Ms PALMER*** *- …In 2020, we introduced the Educational Adjustments Disability Funding Model. Now, this is a needs-based model and it allows schools to plan and then apply support based on a student's individual need. Funding and adjustments are provided based on what students require in their classrooms and this includes many students with ADHD and other forms of neurodivergence, which would not have received funding support under previous approaches prior to 2020.*
>
> *So, each year we do see this model continue to grow. In 2019, under the previous disability funding model, we had 2600 students who received funding support and now, in 2024, that number was 7200 students. Alongside that, annual funding to schools through the Educational Adjustments Model has more than doubled from under $60 million in 2019. We now see a funding commitment of over $125 million last year. Much of this growth is supporting students with ADHD and with other forms of neurodivergence.*[87]

3.33 The Minister also discussed the outcomes from the Independent Review of the Educational Adjustments Model, conducted by KPMG in 2023:

[86] Mr. Chris Anderson, Transcript of Evidence, 21 February 2025, pp. 22-23.
[87] Hon. Jo Palmer MLC, Minister for Education, Transcript of Evidence, 11 April 2025, p. 29.

***Ms PALMER** - … The independent Review of the Educational Adjustments Model, which was conducted by KPMG in 2023, certainly confirmed the positive outcomes that we are seeing in our schools, and the review found that more students with disability are now receiving supports - and it was good that we were also able to identify that our teaching staff and our school staff also felt that their confidence was increasing and that the support was being delivered earlier. It also highlighted opportunities of how we can improve our model and we are certainly looking at improvement across how the adjustments are planned, how they are documented and then how they are reviewed in particular.*

So, there were 12 recommendations that came out of the KPMG report and we accepted all of those and are working through all of those and acting on them now. This includes delivering new professional learning, clearer guidance for school, practical tools to help educators make and monitor adjustments with confidence, a new learning plan platform is now in place to support more consistent and effective planning across schools, and we're also strengthening our school-based teams, with every government school now supported by a School Support and Wellbeing Team to coordinate planning and support for students.

Then, as part of our Lifting Literacy Strategy, we're rolling out the multi-tiered system of supports. This is a framework that gives schools that consistent structure for identifying and responding to students' needs. It includes universal screening for learning and wellbeing, targeted intervention when needed, and coordinated planning for students with more complex needs. At the same time, we are building greater understanding across our schools and our school communities about disability. This year, we're delivering an awareness campaign on the Disability Standards for Education, supported by new resources distributed to all schools. They'll also be distributed to our Child and Family Learning Centres [CFLCs] *and also our Early Childhood Intervention Services* [ECIS]. *These actions all form part of our commitment under the Strategic Plan to make sure every child and young person is known, safe, well and learning.*[88]

3.34 The Committee heard further evidence on the support provided under the Educational Adjustments Disability Funding Model:

***Ms WILSON** - …In each of our schools, there are a number of people, professionals, who have a level of skill and expertise that can augment what the classroom teacher is able to provide, whether it is the support teacher who is able to supplement the skills that the classroom teacher might have in being able to recognise what the student needs and plan for their next steps; or whether it is a focus for the Student Support and Wellbeing Team by being able to triage the information they are getting and prioritise that that young person may need to be prioritised for further assessments, potentially, in the first instance through the professional support staff…*

[88] Hon. Jo Palmer MLC, Minister for Education, Transcript of Evidence, 11 April 2025, p. 30.

Ms BROOKS *- …*[it is] *a strength-based approach for teachers. So, rather than looking at it as a deficit, they're treating every child as an individual and looking at their strengths, their behaviours and intervening with their skillset, and I think that is something to consider, that it is not all doom and gloom for these little people when they come in. Because teachers are very skilled in looking for the strengths and developing the behaviours and working with the behaviours they are presented with, but to pick up on what Jodee* [Wilson] *had said, all of those teachers have access to professional support staff, inclusive practice coaches, school health nurses - in those spaces to get support, to build their toolbox of skills to be able to work with these young people. So it's not as if - I guess the best way to describe it is that we come from an educational perspective of intervention rather than a health perspective. So, things don't stop or stall until an intervention or a diagnosis has happened, we continue to work.*

Ms PALMER *- I think that's a really important point, even from a funding perspective, that, no, we don't have to have a diagnosis of a young person to get that resourcing. That's been a change in the model, which means we're seeing a lot more young people who we are supporting because we accept that, across health and education, we have an issue with waiting lists to get in to see some of our allied health professionals. We don't want to wait for that before we are able to support a young person. So it's a very proactive model.*[89]

3.35 Mr Adam Potito, Director Inclusion and Diversity Services, gave evidence on the wait times for students to be identified as requiring additional supports under this Model:

Ms ROSOL *- …With the…Educational Adjustment Funding Model, what kind of lag time, or how long does it take for a child or a student to be identified as needing extra supports and that being provided within the school?*

…

Mr POTITO *- …There are some levels to this or some different approaches depending on the circumstances. For new students to a government school, within the first 12 weeks of their enrolment, a process can be undertaken at any point throughout the school year, whenever they arrive, for that funding to be backdated to the date of enrolment.*

The point that you've raised is still true though for students that have been identified for the first time, who have been an existing enrolment, they've been at the school for maybe a longer time than 12 weeks, maybe years even, and there's a new point of need that's arisen. It wasn't there last year; it's there this year. Our process for educational adjustments, moderation, determination of the adjustment levels, et cetera, is in line with the NCCD (Nationally Consistent

[89] Hon. Jo Palmer MLC, Minister for Education, and Ms. Jodee Wilson, Deputy Secretary Development and Support, and Ms. Alison Brooks, Director Student Support, Department for Education, Children and Young People, Transcript of Evidence, 11 April 2025, pp. 32-33.

Collection of Data). We've aligned that for efficiency. That gets completed by mid-year, and then the funding, at this point in time, for those students arrives in the next year. That's similar to what you've described. There are some students that will get funded straight away if they're new to our system, but if there is a new need or a change level for an existing student, there is a delay at this stage.

***Ms ROSOL** - Is there any way of that being reduced? What's the reason for there needing to be that delay?*

***Mr POTITO** - Yeah, we're definitely actively looking at that, and the KPMG review recommendations 10, 11 and 12 went to that, and that's currently being explored about how we do that.*[90]

3.36 Ms Brooks gave further evidence on the wait times for students to access supports once identified as requiring them:

***Ms ROSOL** - … What's happened with wait times over this period where you have increased the funding and changed the model?*

***Ms BROOKS** - We've probably not seen a huge change in wait times, and I think that speaks to Adam's point that we are identifying needs and we are making sure that those young people are referred. So, I think early identification of need, increasing the number of support staff, but we're still seeing wait times, I have to say, but I think our sophistication in working in that multitiered system of support and working more holistically across schools to build the capability of staff means that we are getting support to children when they need it.*[91]

3.37 Mr Potito confirmed for the Committee that students of all grade levels have access to this funding:

***Mr POTITO** - … It's obviously most pertinent at kindergarten… Many of our young people come through our ECIS centres. However, not all do. Those that are coming through the ECIS centres, the educational adjustment team work with the ECIS staff to put in a funding moderation for them, so they can be supported with additional funding in their school from the commencement of kindergarten. If a new need is identified in kindergarten within the first 12 weeks, then that can be funded, as we've just described.*

What we've talked about is if that emerges later in the year because we haven't known that student particularly well or for whatever reason it just hasn't been

[90] Mr. Adam Potito, Director Inclusion and Diversity Services, Department for Education, Children and Young People, Transcript of Evidence, 11 April 2025, pp. 34-35.
[91] Ms. Alison Brooks, Director Student Support, Department for Education, Children and Young People, Transcript of Evidence, 11 April 2025, p. 40.

identified, that's where the delay comes in. The first 12 weeks would be true for a student arriving at any year level, right through to year 12.[92]

3.38 The Committee heard evidence on how the decision-making on types of supports and adjustments provided to students is undertaken:

> ***Mrs BESWICK*** *- When the funding is allocated how much control is with the school and the principal versus, 'This is what you do with it' from a departmental point of view?*
>
> ***Mr POTITO*** *- … It's an area that there is some confusion, particularly for those families that are also engaging with the NDIS* [National Disability Insurance Scheme] *because the process is different. It comes in two parts, as I said earlier: every school in Tasmania gets a minimum of 0.2 of a full-time equivalent of a support teacher, and that scales proportionally based upon the number of students within the school with disability.*
>
> *No school has less than 0.2, but many schools have way more than 0.2 in terms of an allocation…*
>
> *The funding that goes to the school is for the school to make the adjustments as they see fit, and a really key consideration there… is ensuring families have a voice. That happens through the development of the learning plan. So the process is that a school identifies need or a family identifies need, have a conversation about what that may be, the parents might come to the school with evidence of disability, and they have the conversation, and a learning plan gets developed early, they agree upon adjustments and goals for that young person. Our educational adjustment moderator's process comes in, and that gets funded.*
>
> *It's around the funding for those adjustments and goals that are agreed at the learning plan development stage. So it is very flexible for a school to determine how they use it. Most schools use it largely for employment of teacher assistants, but that's not prescriptive; they can use it as they see fit in that space.*
>
> *And so it could be, and we're talking there about universal inclusive education practices, if they wanted to create modifications to a room to decrease its sensory profile, to make it quieter, they could use that money for that if that's how they think it's best going to be used.*[93]

3.39 Mr Potito discussed the work of the DECYP School Support and Wellbeing Team:

> ***Mr POTITO*** *- … The School Support and Wellbeing Team was a team that's been in many schools for a long time, but it's been formalised through COVID to make*

[92] Mr. Adam Potito, Director Inclusion and Diversity Services, Department for Education, Children and Young People, Transcript of Evidence, 11 April 2025, p. 35.

[93] Mr. Adam Potito, Director Inclusion and Diversity Services, Department for Education, Children and Young People, Transcript of Evidence, 11 April 2025, p. 41.

sure that all students were known. It has now become a procedure. It's a must. It's been a subtle shift. I wouldn't say it's a high degree of compliance, because schools were largely doing it anyway, but it gives some formality around a multidisciplinary team within the school for matters to be escalated to for consideration. That includes… diagnosis, about then ensuring that referrals through to professional support staff, whether it's speech and language, social work, or school psychology, can be considered by that team and then put forward, and that's a team that meets - in the procedure, I think it's at least a couple times per term, but I'd need to check on that. It's a minimum standard that we have. It often meets weekly or fortnightly within a school to bring that forward and then, based upon the need, whether that diagnosis happens really soon or is pushed out further, their diagnosis… is triaged. It's not based upon the point of when the information has gone, you haven't gone to the back of the list. It's with, obviously, an early intervention focus as well.[94]

3.40 Ms Brooks gave evidence on the support provided by teachers and teachers assistants:

> ***Ms BROOKS*** *- … I think the easiest way to talk about them is what the individual teacher does and that's based on the teacher's understanding and skill level. They would be things like making those adjustments around visual schedules, understanding how the young person communicates, putting in supports for communication by making things more visual, making things more tactile for example, whether or not an alternative communication device or mechanism needed to be used. Sometimes, that might be through assisted technology - through an iPad - sometimes it might be through visual schedules or just normal everyday activities. The way that the classroom is structured, being able to have movement breaks, making sure that there's support through a teacher assistant (TA) in that classroom.*
>
> *I want to make it very clear that I'm not saying that support is provided by the TA for a student with a disability, but the TA provides support to the teacher within the classroom to be able to meet the needs of all the children in that class, freeing up the teacher to be able to do more in depth work around what's needed for that young person.*
>
> *Teachers have amazing skills… someone with ADHD might present with some dysregulated behaviours and an inability to manage their emotions. That would be the first step that the teacher would take, is to build those skills and help that young person to manage their emotions. That might be through sensory play, it might be through breaks, it might be managing the climate of the classroom, for example.*
>
> *Then we'd look at what are the school wide supports and that taps into… the School Support and Wellbeing Team, the multidisciplinary approach. Those*

[94] Mr. Adam Potito, Director Inclusion and Diversity Services, Department for Education, Children and Young People, Transcript of Evidence, 11 April 2025, pp.35-36.

young people would be talked about at those meetings which generally happen twice a term or could happen more frequently as the need arises. Then we would be tapping into the expertise sitting around that table, whether it be the speech and language pathologist, the psychologist, social worker, school health nurse, and they would talk about what else we can offer in this space - do we need to provide professional learning to the school, to the cohort of teachers?

The other layer of support we have is through student support, which is the team that I lead and that, again, includes the professional support staff, but also accessibility services and the inclusive practice team. Our inclusive practice coaches provide that at-the-shoulder coaching around interventions and adjustments for young people with disability or significant complex behaviours.[95]

3.41 Ms Wilson expanded on the support provided to children and their families:

***Mr BEHRAKIS** - When students, children, are identified as neurodiverse or specifically, in this context, with ADHD, is there support given to the parents to help them navigate that?...*

***Ms WILSON** - Each child who requires educational adjustments has a learning plan and the learning plan is co-constructed with the family. As the family work with the school to identify the child's strengths and their assets and the goals for their learning, the family has input into the plan and, as a consequence of that, has a better idea about what the school can do and then flow-on is that that would then follow through to the family.*

Our work, certainly, is around supporting the educational adjustments in order for the young person to be able to thrive in their learning trajectory but, through those conversations, reviewed at least twice yearly with the families, are a really important part to ensure that the school, the teacher, and the family are working in partnership, in the best interest of the child, accessing their learning needs and being sure that they are known, in a way that supports the information to be clear for what occurs at home but also at school.[96]

Findings

The Committee finds:

34. There are a lack of publicly-funded supports for children with ADHD, including psychologists and occupational therapists.

35. Some children begin school without having had adequate access to ADHD diagnosis and support in their pre-education years.

[95] Ms. Alison Brooks, Director Student Support, Department for Education, Children and Young People, Transcript of Evidence, 11 April 2025, p. 36-37.

[96] Ms. Jodee Wilson, Deputy Secretary Development and Support, Department for Education, Children and Young People, Transcript of Evidence, 11 April 2025, p. 45.

36. Appropriate, consistent, and readily available school-based supports are critical for the wellbeing and development of children with ADHD.

37. The Tasmanian Government states that Tasmania's public education system is aiming to increase integrated supports for neurodiverse children, such as multidisciplinary School Support and Wellbeing Teams where matters can be escalated and appropriate referrals to speech and language pathologists, social workers, and school psychologists can be made.

38. The roles and expertise of teachers and teachers' assistants are crucial to the support and development of children with ADHD in the school environment.

39. Where available, the Educational Adjustments Disability Funding Model for Tasmanian public schools has achieved positive results, with a needs-based, strengths-focussed approach that does not require a formal diagnosis to access funding for learning supports for students at all year levels.

40. Teachers and support staff in the education system are motivated to provide as much support as possible to students with ADHD and other neurodiverse presentations.

Support for young people

3.42 The Committee heard evidence regarding the adequacy of support provided to young people as they transition out of paediatric care.

3.43 At the 16 May 2025 public hearing, Dr Sean Beggs, Clinical Director of Women's and Children's Services with the Department of Health, gave evidence on the challenges of this transition:

> ***Dr BEGGS*** *- A key part of any paediatric long-term management is transition. The difficulty is when there's not a lot of places to transition to. I think, as we know, the acceptance of the importance of continuing to manage ADHD into adult life is something that's evolved over the last 10-plus years. Those services haven't necessarily kept up with that space to transition. I think the difficulty has been that whilst it would be standard for most paediatricians to be thinking about transition from 15 on, it's about where to and finding those places. Historically, having to primarily find a psychiatrist to continue to prescribe has been one of those limiting factors.*
>
> *There are processes, we have whole frameworks around transition in general for kids who have conditions that will transition into adult life. Historically, a lot of the default has been back to your GP in this space, which, as we're saying, those pathways need to evolve.*[97]

[97] Dr. Sean Beggs, Clinical Director of the Women's and Children's Services, Department of Health, Transcript of Evidence, 16 May 2025, p. 19.

3.44 Dr Anil Reddy provided the Committee with evidence from his perspective as an adult psychiatrist:

> ***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.*[98]

3.45 Representatives from RACP, Dr Naidoo and Associate Professor Heinrich Weber, discussed their experience with patients transitioning out of paediatric care:

> ***CHAIR*** [Mr Behrakis] *- …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…*
>
> *…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*

[98] Dr. Anil Reddy, Psychiatrist, Royal Australian and New Zealand College of Psychiatrists, Transcript of Evidence, 8 November 2024, p. 66.

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 adult 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.*[99]

3.46 The Committee heard further evidence on possible transition processes from Associate Professor Weber:

CHAIR [Mr Behrakis] - *What would those transition programs look like?…*

***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.*[100]

3.47 The Committee heard evidence on the targeted support provided by headspace to young people with ADHD:

CHAIR [Ms White] - *I see the global data you've provided, which is that in 2023-24, 2586 young people accessing your services had a diagnosis of ADHD. That's 14 per cent of all young people…that you supported that year…What sort of support can you provide to a young person who has a diagnosis of ADHD?*

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

There's a funding review for headspace centres currently in process and what we're hoping is that with a slightly bigger funding base for headspace centres,

[99] Dr. Theresa Naidoo, Paediatrician, and Associate Professor Henrich Weber, Paediatric Respiratory Physician, Royal Australasian College of Physicians, Transcript of Evidence, 8 November 2024, pp. 10-11.
[100] Associate Professor Henrich Weber, Paediatric Respiratory Physician, Royal Australasian College of Physicians, Transcript of Evidence, 8 November 2024, p. 11.

they'd be better equipped to provide more holistic care. Currently, most of the centres would be able to support a lot of the other needs that young people with ADHD might have. For a lot of headspace centres, it's a four-core stream model: mental health, physical health, alcohol and other drugs, and work and study. Some of the other needs across those four core streams could well be met by staff at a headspace centre. Often many of the centres have peer work models, so I guess engagement and destigmatising support that can safely be provided…

The psychosocial peer support, allied health support, that is very clearly coming through as recommended treatment that young people may or may not be indicated to receive their medication. Regardless they need to have the support for all of themselves so they can continue to stay in school and work, if that's what they want to do, and their families get good information. We think headspace centres are a good place to provide some of the care, even if not all of the care.[101]

Findings

The Committee finds:

41. The transition from a paediatrician to psychiatrist for young people with ADHD when they turn 18, is a critical juncture. It requires a rediagnosis in the adult system that leads many to miss out on continuing care.

42. There is a critical need for transitional care planning for young people with ADHD with responsibility best shared across all relevant healthcare providers, paediatricians, general practitioners, psychologists, and psychiatrists.

43. Since public hearings concluded, general practitioners in Tasmania have been authorised to diagnose ADHD, which may help to address issues for young people transitioning from paediatric care.

Support for adults

3.48 The Committee received evidence from individuals with lived experience, medical professionals and organisations regarding the adequacy of supports available to adults with ADHD.

3.49 The Tasmanian Adult ADHD Support Group's submission stated:

… There is a lack of consistency and integration of services and the complete lack of public health provisions for adults. Some people are unable to access treatment at all and these are often the most in need.

…

[101] Ms. Vikki Ryall, Chief Clinical Officer, headspace, Transcript of Evidence, 18 October 2024, p. 37.

> *Many have challenges with employment and income due to their ADHD or rely completely on government benefits and with no provision in the public system, they have little prospect of treatment for their condition and options for support are very few. Many adults with ADHD, especially if it is untreated or inadequately treated, have comorbid mental health conditions and sometimes related substance abuse issues. The long wait times to access treatment and the high costs exacerbate these issues, leaving some in great emotional distress and without support for extended periods of time, with all the attendant risks this brings.*[102]

3.50 A private witness to the Inquiry shared their experience in a submission:

> *…I went through the relief and joy of being assessed and diagnosed and felt enlightened to have answers to something that had plagued me for so many years, to then finding myself with no continuity of supports and the inability to do anything other than wait. It is a form of psychological torture to know what you need and/or can do to improve your quality of life, but not have the resources, support or information to do so.*[103]

3.51 The inadequacy of supports in the workplace was identified by the AMA Tasmania Branch in their submission:

> *Resources for employers and workplaces need development to recognise and support people in the workplace with ADHD. Without better understanding of ADHD and how best to manage a person with it, an employment relationship is more likely to fail.*[104]

3.52 In another submission, a private witness provided evidence on the impact of not receiving adequate support in their workplace:

> *…my workplace had become so accustomed to my work ethic that was unsustainable and verging on burnt-out (this being an attempt to mask how significantly I was struggling) that they didn't change anything after I disclosed my diagnosis because they thought I was still competent at my job. When I did experience burn-out, and became less competent in my job, inconsequential effort, or no effort at all was made to support me and/or resolve the issues I was experiencing, instead choosing to steer me away from new work and actively push for me to resign under the guise of 'helping me to find the right job' or 'looking after my wellbeing', not considering the mental harm that unemployment and subsequent financial hardship can cause. The trauma associated with these workplace experiences resulted in me remaining unemployed for four months in one instance, as I experienced depression in a more severe way than I had to that point…*[105]

[102] Submission No. 21, Tasmanian Adult ADHD Support Group, pp. 2-3.
[103] Submission No. 28, Private Witness, p. 5.
[104] Submission No. 51, Australian Medical Association Tasmania Branch, p. 7.
[105] Submission No. 28, Private Witness, p. 8.

3.53 The Committee also received evidence from Tasmanian practitioners currently supporting adults diagnosed with ADHD.

3.54 Dr Kate Bendall, a Specialist GP, outlined the supports provided to her patients:

> *I have built a collection of resources to recommend, such as books, youtube videos and websites, which I tailor to the individual. I recommend patients consider coaching, or psychological support. I encourage patients to have a mental health plan, to support this self-education and understanding with some goal setting, with or without psychology referrals associated.*
>
> *In reality, within my clinical work, time intended to provide structured support can be interrupted by acute health issues, the processes involved in medication approval, and differing agendas. Subsequent access to ideal supports can be limited – by all the factors of workforce and financial capacity, or the capacity to put the steps in place to make and attend appointments or seek further information.*[106]

3.55 Hobart ADHD Consultants, a private practice in Bellerive, shared their approach to supporting their adult patients:

> *We are currently developing a group program for adults. These groups will be capped at 10 participants, to allow for Medicare rebates to be applied. Additional online content will be provided to assist individuals to make the most of the 10-per-year Medicare group session allowance. The rebates are small, and necessary gap fees will unfortunately mean that this option will not be an affordable option for many.*[107]

Findings

The Committee finds:

44. There is a severe lack of support for adults with ADHD in both the public and private systems in Tasmania. This results in long wait times and people missing out on treatment. This is particularly pronounced for people on low incomes.

45. Lack of treatment options and support for adults with ADHD, particularly after adult diagnosis, may lead to feelings of disempowerment and increases comorbid mental health conditions and related substance abuse issues.

46. Workplace understanding and support are important for adults with ADHD to be able to continue in employment.

[106] Submission No. 39, Dr Kate Bendall, p. 5.

[107] Submission No. 30, Hobart ADHD Consultants, p. 7.

Recommendations

The Committee recommends:

2. **The Tasmanian Government increase investment in treatment and support in Tasmania's public health system for people with ADHD.**
3. **The Tasmanian Government investigate options to provide access to ADHD diagnostic services in Child and Family Learning Centres.**
4. **The Tasmanian Government increase ongoing supports through Child and Family Learning Centres for children with ADHD.**
5. **The Tasmanian Government develop educational materials and information for employers to support employees with ADHD in the workplace.**
6. **The Tasmanian Government advocate to the Australian Government for an increase in Medicare subsidised sessions under Mental Health Care Plans.**

4 AVAILABILITY, TRAINING AND ATTITUDES OF PRACTITIONERS, AND WORKFORCE DEVELOPMENT OPTIONS

4.1 Limited availability of treating practitioners, such as GPs, psychiatrists, psychologists, and paediatricians, has been identified as a barrier to accessing ADHD assessments and supports referred to in previous chapters.

4.2 This Chapter will discuss this issue, workforce shortages, attitudes of practitioners towards ADHD, and then consider workforce development options.

Service availability and workforce shortages

4.3 The Tasmanian Government's submission provided evidence on the current workforce availability in Tasmania's public and private sectors:

> *In 2022, the total number of paediatricians working in the public and private sectors in Tasmania was 51 (49.0 FTE), equating to 8.6 FTE per 100,000 population, which is below the national rate of 10.1 FTE per 100,000 population.*
>
> *In response to the significant growing demand for paediatric outpatient services in Tasmania, in the five years to 2022, the Tasmanian Government has increased the number of paediatricians employed within the THS by 45 per cent, to a total number of 46 (30.2 FTE).*
>
> *Adult diagnosis is usually via a psychiatrist, with psychologists also playing a key role in non-medical treatments and support for both adults and children with ADHD. Both professions are in shortage in Tasmania and nationally as demand for mental health care continues to grow.*
>
> *In 2022, 86 psychiatrists (75.3 FTE) worked across Tasmania's public and private sectors (with total clinical hours worked being 39 per cent private and 61 per cent public). This equates to 13.2 FTE psychiatrists per 100,000 population (below the national rate of 14.9 FTE per 100,000).*
>
> *In 2022, there were 573 psychologists (471.4 FTE) across Tasmania's public and private sectors (total clinical hours worked being 64 per cent private and 36 per cent public). This equates to 82.6 FTE psychologists per 100,000 population (well below the national rate of 107.5 FTE per 100,000 population).*
>
> *The Department for Education, Children and Young People (DECY)* [sic] *is the largest employer of psychologists in the state, and national research shows that school psychologists are often the first healthcare contact for students and families seeking professional support for difficulties and concerns, followed by general practitioners.*

School psychologists in public schools have been provided with extensive training and ongoing professional learning in assessment, diagnosis, and support for students with ADHD. The demand for school psychology services far outstrips the number of available professionals. Steps to increase recruitment and retention of school psychologists will enable a greater level of service.

While our state allows various health professionals to diagnose ADHD, national guidelines suggest that only doctors and psychologists with specialised knowledge should do so. The Tasmanian school psychology team contains several psychologists with an endorsed area of practice. DECYP is currently investigating the processes and resourcing required to support endorsement for eligible staff.

GPs are also a key workforce in the referral, treatment and ongoing management and support of people with ADHD. Tasmania's GP workforce numbers in 2022 of 118 FTE per 100,000 population were above the national rate of 111.3 FTE due to higher rates in the South of 130.9 FTE compared with 103.0 in the North and 105.5 in the North West. GP workforce shortages in Tasmania, as with all other Australian states and territories, continue to be a major issue, with poor access to timely primary care leading to deferral of care and worsening of health conditions, which in turn leads to higher and more complex care needs and increased demand pressure on public health systems.

Health workforce distribution has proven to be a key challenge [in] *Tasmania and other states and territories face, particularly in rural and remote areas. In North West Tasmania in 2022, there were only 6.3 FTE psychiatrists per 100,000 population and 51.8 FTE psychologists per 100,000 population. Similarly, paediatrician numbers per 100,000 population were lowest in the North West at 4.7 FTE (compared with 11.3 FTE in the South and 6.5 FTE in the North).*[108]

4.4 At the 18 October 2024 public hearing, then Minister for Health, Mental Health and Wellbeing, Hon. Guy *Barnett* MP, provided further evidence on the paediatric workforce in Tasmania:

> ***Mr BARNETT*** *- … In recognition of this growing demand, we have taken action and I can advise that the department has increased the number of paediatricians employed by 45 per cent in the five years to 2022, which is positive and has made a real difference to many people and families across the state. Further to this and building on this increased resourcing, the Tasmanian government is developing a statewide paediatric strategy under the Long-Term Plan for Healthcare in Tasmania 2040. This is an implementation plan to improve access to healthcare services in the community and hospital for children and young people.*[109]

[108] Submission No. 60, Tasmanian Government, pp. 14-15.

[109] Hon. Guy Barnett MP, former Minister for Health, Mental Health and Wellbeing, Transcript of Evidence, 18 October 2024, pp. 21-22.

4.5 At a subsequent public hearing on 16 May 2025, then Minister for Health, Hon. Jacquie *Petrusma* MP, provided the Committee with updated data on the workforce in Tasmania:

> ***Mrs PETRUSMA*** *- …In 2023 there were 53 paediatricians working across Tasmania's public and private sector, including 49 paediatricians employed in Tasmania's public sector, and I'm delighted to confirm that an additional 3 paediatricians have been employed by the THS in the past 12 months. As well, since our submission to the Committee, which was based on 2022 data, the number of psychiatrists working across Tasmania's public and private sector has increased by 13 from 86 in 2022 to 99 in 2023, and the number of psychologists by 43 from 573 to 616.*[110]

4.6 Professor David Coghill, President of the Australasian ADHD Professionals Association (AADPA), reflected on the unique workforce shortages in Tasmania at the 18 October 2024 public hearing:

> ***Prof COGHILL*** *- …Many of the things that we'll talk about today are not unique to Tasmania. There are many problems in accessing and delivering care for people with ADHD. Many of those are across Australia, and many of them are across the world. I think that Tasmania has its own particular issues. Part of that is due to size and scale. With the workforce shortages I understand are there, combined with insufficient training of the workforce that is there, I think makes your services in Tasmania very vulnerable. Very small changes in the number of people who are providing can have a very big impact on the care that's available to people. That goes across the whole of the age range, and between public and private services.*[111]

4.7 In response to the workforce shortages in regional Tasmania, Regional Autistic Engagement Network's (RAEN) submission included a proposed recommendation:

> *…Increase the availability of diagnostic services in Tasmania by investing in at least one additional publicly funded diagnostic service in each major region of Tasmania with additional travelling and telehealth options to ensure regional and rural access. Ensure that these services are multidisciplinary and include diagnosticians who can offer ADHD assessments for both adults and children as well as dual diagnostic assessments for people with both Autism and ADHD.*[112]

4.8 At the 11 April 2025 public hearing, the Department of Education, Children and Young People (DECYP) representatives provided the Committee with evidence on the availability of support staff in public schools:

---

[110] Hon. Jacquie Petrusma MP, former Minister for Health, Transcript of Evidence, 16 May 2025, p. 3.
[111] Professor David Coghill, President, Australasian ADHD Professionals Association, Transcript of Evidence, 18 October 2024, p. 1.
[112] Submission No. 25, Regional Autistic Engagement Network, p. 16.

> ***Ms BROOKS*** *- … in bare figures, we've seen a 60 per cent increase in approved establishment for professional support staff, including psychologists, since March 2014. So, that's an enormous growth. I guess there are a couple of points to make in terms of the multidisciplinary approach of those professional support staff. So, we are not just relying on psychologists or speech and language pathologists. From a student support perspective, we work together as a multidisciplinary team so that we are making sure that there are no gaps in that service.*
>
> *…*
>
> *… in 2022, there were 117 support teachers in schools, and in 2024, there are now 286 - 2020 sorry.*
>
> *… So, from 2020 to 2024, we have seen that double, more than double.*[113]

4.9 The Minister for Education also outlined for the Committee the strategies implemented to recruit additional school psychologists:

> ***Ms PALMER*** *- … We're offering scholarships and recruiting far and wide across Australia, which is difficult because every state and territory across Australia is experiencing issues in getting speech and language pathologists and psychologists.*
>
> *We have gone out internationally in our search and offered scholarships to graduate psychologists. We had five, I believe, come on board under that program. We have five new psychologists and five new speech and language pathologists who are now in our schools. I had the opportunity to meet a couple of them the other day, one from Western Australia, one from Victoria. We still have another 10 of those scholarships that we've gone out again across Australia and internationally to encourage new graduates to come to Tasmania and to work in our schools environment.*[114]

Findings

The Committee finds:

47. There is a critical shortage of paediatricians, psychiatrists, and psychologists in both the public and private health systems in Tasmania. These workforce challenges are being felt across the country and world.

48. Tasmania's unique workforce challenge is the relatively small number of ADHD practitioners, leaving it vulnerable should even a few treating practitioners leave the profession.

49. Across Tasmania's public and private health sectors, there are fewer paediatricians, psychiatrists, and psychologists employed per 100,000 population compared to the national average.

[113] Ms. Alison Brooks, Director Student Support, Department for Education, Children and Young People, Transcript of Evidence, 11 April 2025, p. 40.
[114] Hon. Jo Palmer MLC, Minister for Education, Transcript of Evidence, 11 April 2025, pp. 40-41.

50. In north and north-west Tasmania, there are fewer general practitioners per 100,000 population compared to the national average.

51. The Tasmanian Government recognises that the increased demand for medical professionals who diagnose and treat ADHD outstrips the availability of these professionals and is undertaking recruitment across health and education sectors.

Training for Health Practitioners

4.10 Limited training opportunities for health practitioners to gain the skills needed to assess and support patients with ADHD were cited by witnesses as another factor limiting accessibility to services.

4.11 In its submission to the Inquiry, Royal Australian and New Zealand College of Psychiatrists (RANZCP) stated:

> *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 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.*[115]

4.12 At the 18 October 2024 public hearing, Professor Coghill provided evidence on the current ADHD-specific training available for health practitioners:

> ***CHAIR*** [Ms White] - *…I am keen to understand what you know of the Tasmanian context and what workforce development or training options currently exist for health professionals looking to better understand how to support patients with ADHD?*
>
> ***Prof COGHILL*** - *…I know that the primary care network has done a lot of work in developing a kind of prototypical pathway for primary care. I came myself and did a day training with psychiatrists in training. Also your colleague…was at a meeting I did in the evening which was really well attended by general practitioners for talking about ADHD…*
>
> *…Apart from that, I am not aware that there is any practical and official plan to training. Training for ADHD is very poor at medical school, in psychology basic training, but also then for psychologists, psychiatrists and paediatricians, as well as those in primary care and nurses. My assumption would be, because I don't*

[115] Submission No. 46, Royal Australian and New Zealand College of Psychiatrists, p. 4.

know any different, is that in Tasmania, as in much of the rest of Australia, it's ad hoc. It's not really done in a structured way...[116]

4.13 Dr Timothy Jones, appearing on behalf of Royal Australian College of General Practitioners (RACGP), provided the Committee with evidence on the professional development opportunities available for GPs, as well as training provided at university:

> ***Ms HADDAD*** *- ...What's provided at the university level or through continual professional education opportunities for practising GPs to update their knowledge around ADHD?*
>
> ***Dr JONES*** *- As a GP here in Tasmania, we've had at least four, that I can think of, opportunities to attend local or Zoom-based events to upskill in ADHD awareness, support and assessment this year, so there is increasing professional development happening. It's also a little bit hamstrung by that challenge of 'we can provide the support, but the assessment is what a lot of people* [need] –
>
> ***Ms HADDAD*** *- At the university level, is there very much in the undergraduate degree?*
>
> ***Dr JONES*** *– That, I'm not aware of...* [117]

4.14 Representing the Australian Psychological Society (APS), Mr Timothy Davern gave evidence about the current availability and training for psychologists in Australia:

> ***Ms HADDAD*** *- ...what* [are] *the barriers... 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* [existing] *psychologists working in this area?*
>
> ***Mr DAVERN*** *- ...In terms of existing psychologists, I wouldn't be too sure exactly why the psychologist would not want to be undertaking this work... 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*

[116] Professor David Coghill, President, Australasian ADHD Professionals Association, Transcript of Evidence, 18 October 2024, p. 8.

[117] Dr. Timothy Jones, General Practitioner, Royal Australian College of General Practitioners, Transcript of Evidence, 18 October 2024, pp. 55-56.

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.

…

***Ms HADDAD** - …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…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 money themselves. So that's, I think, where the issue is. It comes back to the funding, yes… [118]

4.15 At the 8 November 2024 public hearing, Dr Anil Reddy, appearing on behalf of the RANZCP, discussed the link between workforce shortages and limited training options:

> ***Dr REDDY - …*** *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.* [119]

4.16 Ms Vikki Ryall provided evidence on training programs provided by headspace to address workforce shortages:

> ***Mrs BESWICK*** *- Obviously one of the big things that's coming out is the shortages in the workforce. I know some of your centres, and I don't know if that's consistent across all of them, but that they do utilise some uni staff and things like that. What can you tell us about the training area?*
>
> ***Ms RYALL*** *- There is a big workforce challenge. We've set up a few programs to try to address that. We've got an early career program for allied health professionals, for psychology, mental health, social work, where we're working with universities to have students and graduates in health-based centres. The Tasmanian centres are in the early career program. What that means is we give them money to employ a clinical educator and that person's job is simply to support the graduates and students. We create relationships with local universities and these centres then are equipped to have students from those three disciplines. We have two graduates in Tasmania in the most recent cohort and we're in the middle of recruiting 44 new graduates who will start at the beginning of next year. They spend one year in one centre and then they move to another centre.*

[118] Mr. Timothy Davern, Senior Policy Advisor, Australian Psychological Society, Transcript of Evidence, 8 November 2024, pp. 18-19.
[119] Dr. Anil Reddy, Psychiatrist, Royal Australian and New Zealand College of Psychiatrists, Transcript of Evidence, 8 November 2024, p. 65.

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

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

You may not be aware that the College of Psychiatrists has just started a youth specialty so we think that a registrar rotation would only attract senior registrars, in the youth specialty as well. headspace centres would be really good and they would pick up what one of you were asking of the question before around the older presentations of ADHD. We're trying to do as much as we possibly can to grow the workforce and particularly grow it with knowledge of our age cohorts. We know not all those GPs, psychiatrists, allied health professionals will stay in headspace centres but we think if they've trained with us they'll go out and have better skills and knowledge to support young people outside headspace.[120]

4.17 At the 8 November 2024 public hearing, the Committee heard from Dr Theresa Naidoo, paediatrician, representing the Royal Australasian College of Physicians (RACP), on the potential of utilising paediatricians to train other health practitioners:

***Ms HADDAD** - …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* [Medicare Benefits Scheme] *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,

[120] Ms. Vikki Ryall, Chief Clinical Officer, headspace, Transcript of Evidence, 18 October 2024, p. 41.

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.[121]

4.18 Then Minister for Health, Hon. Jacquie *Petrusma* MP, presented a view that RACGP be funded by the federal government to increase training of GPs.

> ***Mrs PETRUSMA*** *- … because GPs are the responsibility of the federal government, I'd welcome a recommendation saying that the state government actually lobbies the federal government for funding towards the RACGP (Royal Australian College of General Practitioners) to actually do training in regards to ADHD so that the GPs feel more familiar with diagnosis and treatment. I think it does come down to that training that they have during their… degrees but also when they're a resident and registrar and doing their GP training. This is an issue Australia-wide, it's not just in Tasmania. I think if the federal government provided funding to RACGP to do this - we're trying to do what we can at our end, but fundamentally, GP training is the federal government.*
>
> *…*
>
> ***CHAIR*** [Ms Haddad] - *…I wonder whether if there's still, and I say this with respect, a cohort who are still a little cynical around the increase - I don't think it's an increase in prevalence - of neurodiverse conditions, I think it's an increase in understanding and an increase in options for people to be diagnosed and treated. I wonder if there's still maybe a cohort of GPs who are just generally a little cynical about –*
>
> ***Mrs PETRUSMA*** *- This is where the college can again provide training, because every GP is required to do CPD (Continuing Professional Development) points, so this can be another module that can be offered for all GPs. You can have it during their training, but also, once they are a GP, just so that they understand. Ideally, it would be for PHT* [Primary Health Tasmania] *to actually come through and do some training and show them also how HealthPathways works and everything else, so that it makes it easier for the GP to assess, to understand, and to actually work out who to refer and to get that familiarity, as we've discussed, with Schedule 8 medications as well. I think it does really come down to training. We're trying to equip the GPs on our end, but it also requires the other side as well…*[122]

[121] Dr. Theresa Naidoo, Paediatrician, Royal Australasian College of Physicians, Transcript of Evidence, 8 November 2024, p. 5.

[122] Hon. Jacquie Petrusma MP, former Minister for Health, Transcript of Evidence, 16 May 2025, pp. 14-15.

Findings

The Committee finds:

52. There is a 'gap' in training focussed on ADHD at undergraduate, postgraduate, and professional levels across psychiatry, psychology, and primary healthcare.

53. There is a recognised need for more structured and consistent ADHD training and development across the Tasmanian health workforce.

54. Some universities are reducing the areas of practice endorsement for psychologists seeking to specialise in areas other than clinical psychology.

Training for Teachers

4.19 Training for teachers and other education support staff to support students with ADHD was also raised by witnesses to the Inquiry.

4.20 At the 18 October 2024 public hearing, Professor Coghill discussed the current training available to teachers, as well as work undertaken by AADPA to provide training resources:

> ***Ms HADDAD*** *- … I wondered if you're aware of any other jurisdictions where there might be training available, or better understanding within schools and other education settings around young people and students with ADHD.*
>
> ***Prof COGHILL*** *- There are some variations. There are some states where there seems to be better understanding. I would actually highlight the New South Wales education site and their resources for teachers around ADHD. We are just about to look for funding. We actually think it's a big problem. One of my research group colleagues… is doing her training as an educational developmental psychologist. She said, 'Wow, the training we get in ADHD in Victoria on that course, which should actually be one of the courses where it's heaviest, is still really rather rudimentary'.*
>
> *One of the other research opportunities that we're looking at, very practical, is actually to develop virtual reality training for teachers to be able to better recognise and understand what is and what isn't ADHD in the classroom. That would be on the recognition side. A second module in that, we hope, would be to look at then how do you manage ADHD behaviours in the classroom and how do you monitor outcomes...*
>
> *We think that will be a huge opportunity because there is a huge gap. Teachers don't get training. The training they get is rather cursory. We know from talking with teachers that they feel pretty much at sea when it comes to, 'How do I recognise what's ADHD and what's anxiety, and when I've got someone with ADHD, how do I manage them without disadvantaging the rest of the class', et*

cetera. It's a big gap. That's something we thought - we have an excellent VR group who are really interested in doing that work.[123]

4.21 Dr Madelyn Derrick, clinical psychologist and Director of Hobart ADHD Consultants, highlighted the current pressure on teachers to manage students with support needs:

> ***Dr DERRICK*** *- In education, we have this a lot when we consult with schools through either an individual student or more broadly the concern is from teachers, who are understandably very pressured. The concern is, 'I don't have time and headspace to do more'. What we try to communicate to them is that this is not about doing more. This is about doing different. Then you'll find you're doing less. It takes up a lot more of their resources to respond to when things have gone wrong than it does to put the right environment in place to support teachers. I know there are a lot of teachers out there who do have the knowledge and the capacity to do a great job, but they're impeded by what's above them, the lack of TA assistance or LSO* [Learning Support Officer] *assistance in the classroom, and just simple things, like - well, it's not simple - but being overloaded in the teaching profession. I come from a family of teachers; most of our friends are teachers. They do not get paid anywhere near enough, thank you, for what they do. They are very much all hanging on the edge of burnout. I think the sorts of things that we would be wanting to get in place to improve the situation for kids with ADHD would improve the situation for all kids. We know from research that if you put appropriate adjustments in place for the kids with learning needs, all students benefit.*
>
> ***CHAIR*** [Ms White] *- Can you elaborate on that and help us understand what you mean in a practical sense?*
>
> ***Dr DERRICK*** *- … Say we have an impulsive student with ADHD in grade 2. They're very excited by the question the teacher is asking and they're calling out the answers. The teacher has two of the kids that are calling out, plus another child with sensory needs in the corner in their tent who they're worried about. They know they have to call mum in a moment, and mum gets upset when she gets called, and they know they will have a meeting to explain why this other parent has complained. They have all this load about them. Then they've got this child who's calling out over and over again. Of course, they are going to hit their own limit and go to the headspace of, 'I need this child out.' Then it's threatened relocation - 'You go off to the grade 6 classroom'. The child experiences humiliation in that. They come back to the classroom, and then the next time they get that feeling, 'The teacher's looking at me that way, now I'm going to be humiliated again'. Stress drains their resources, reduces their self-regulation neurochemically, and then they're more likely to not be able to stop themselves. This time what they're not stopping themselves saying is 'I effing won't' or*

[123] Professor David Coghill, President, Australasian ADHD Professionals Association, Transcript of Evidence, 18 October 2024, pp. 8-9.

something, or picking up a chair and throwing it. That seems dramatic - in reality, it builds up over more time than that.

However, if the teacher had been given just a little bit more room and a bit more support to manage the multiple things in the classroom, the teacher might have had the space to be able to say to the student, 'I can see you've got a great answer coming. I can't wait to hear it so you don't lose it, can you write it down for me? And then I'm coming to you first'. Simple as that. The ADHD student: 'Yes, excellent, she likes what I'm going to say'. It's so simple. It helps in that moment, but it helps in every other moment, across the school and in all other classrooms. Realistically, at the moment, for a teacher to have that level of emotion regulation and headspace themselves to come up with that, it's not fair to expect that.[124]

4.22 Dr Derrick continued by discussing the current training available for teachers to develop the skills required to support children with ADHD:

CHAIR [Ms White] - *... What kind of education are you aware of that occurs in our education system so that teachers have those tools?*

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

It doesn't achieve anything except perhaps create stress and defensiveness. Naturally, humans will want to start blocking things out that are adding stress. We really need at least one full day of training to sit and do this sort of thing. I put something together for a school recently, I haven't heard back yet, but ongoing and actually having case examples from students, and teachers working in teams, like a year group. The grade 3 teachers will get together and work on solutions, apply the principles, so they're actually developing their skills as they go, and can see and check back in later to see how that's panned out. They can actually see and feel the difference that makes. Then there's going to be a lot more motivation and hope.[125]

4.23 Dr Derrick gave further evidence on the education available to teachers while undertaking their university studies:

CHAIR [Ms White] - *... You are talking about once teachers are in the classroom and they're already practising their craft - what happens at university? How are*

[124] Dr. Madelyn Derrick, Clinical Psychologist, Hobart ADHD Consultants, Transcript of Evidence, 18 October 2024, pp. 11-12.

[125] Dr. Madelyn Derrick, Clinical Psychologist, Hobart ADHD Consultants, Transcript of Evidence, 18 October 2024, p. 12.

we able to support them so they have the skills before they head into the classroom?

***Dr DERRICK** - I can't say for certain what happens in education courses at the moment for any teachers I speak to. Even for new grads it wasn't a lot. It certainly seems to be more than there is in health though. I think probably we absolutely need that education for people coming through university, but it's kind of pointless if they get into a school and the school isn't resourced or doesn't have the right priorities and attitudes to allow them to put those things in place.*[126]

4.24 At the 18 October 2024 public hearing, the Committee heard evidence from GP, Dr Jones, regarding ADHD-specific training for teachers:

CHAIR [Ms White] *- We've heard some evidence already today about the role teachers play in the lives of children… How do we* [better] *support our teaching workforce and what liaison points would you like to see so they can do that well?*

***Dr JONES** - When we talk to our teachers there is, similar to healthcare workers, a very large diversity of perspectives and approaches to supporting children with hyperactive or inattentive behaviours within the classroom and it's very telling for me that just like with GPs, we see far less referrals coming to us as GPs from certain schools than we do compared to others, not because of any other demographic than the certain teachers who are attached to those classrooms and the fine work they're doing.*[127]

4.25 Paediatrician, Dr Naidoo, provided her perspective on working with teachers to provide collaborative support to children with ADHD:

***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

[126] Dr. Madelyn Derrick, Clinical Psychologist, Hobart ADHD Consultants, Transcript of Evidence, 18 October 2024, p. 12.
[127] Dr. Timothy Jones, General Practitioner, Royal Australian College of General Practitioners, Transcript of Evidence, 18 October 2024, p. 52.

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.[128]

4.26 At the 11 April 2025 public hearing, the Minister for Education and DECYP representatives provided evidence on the professional development available for teachers in Tasmanian public schools:

***Ms ROSOL** - I have some questions around professional learning… I'm curious about what's available at the moment and how do teachers access that? Is it a school responsibility for teachers to access that, or is that something that is being planned at a department level?*

…

***Ms WILSON** - Teachers develop the skills that they need, in order to become more confident with their inclusive practical strategies that are needed to support all our learners. They access training at multiple levels. Our improvement practice coaches provide mentoring and at-the-shoulder support to build the skills in a practical way, as I say, at the shoulder. There's also professional learning that is undertaken by the support teacher allocated to each school.*

… every school has a resource that covers an allocation of a support teacher, allocations of access to professional support staff, to the in-practice coach team, to the School Support and Wellbeing Team. There is a lot of human resource that exists in the school and there is also resource outside the school, through the Student Support Team, through the team that works with Adam [Potito] *in relation to supporting students with diverse learners that all go to providing levels of support and training and professional learning bespoke to the areas of need. There would be direct professional learning related to supporting students with ADHD and other neurodivergent conditions, equally to those that are also available for supporting students with other disabilities.*

[128] Dr. Theresa Naidoo, Paediatrician, Royal Australasian College of Physicians, Transcript of Evidence, 8 November 2024, p. 7.

***Ms PALMER** - Another point that's probably good to mention with regard to first-year teachers who are starting out and beginning their career, they actually attend a specialised learning program with the Inclusive Practice Team at the beginning of their teaching careers. We try to get that support in there straight up.*

***Ms ROSOL** - How often would external education be provided or accessible for staff? I think a lot of what you talked about there was internal within the Education Department, but say if there was an expert education day that was available, are staff able to access that? Are they supported to access that with relief teachers?*

...

***Ms WILSON** - Definitely, schools have the ability to access a variety of external providers to deliver professional learning to their staff. Generally speaking, as a Department, we try to be really responsive to the needs that we identify from the ground. The people resources that exist within the school and those that exist within the Department more broadly are really skilled at being able to galvanise the interests and needs of the people that are working directly with the children to determine what additional professional learning and supports they might need. On occasion, we would outsource and broker people to come in and deliver that professional learning. We've done so in relation to the modules around the disability standards in education. Generally speaking, we would be wanting to be sure that the guidance that the schools access is well curated to be sure that it lines up with the evidence that exists more broadly and not necessarily delivered by a provider that doesn't meet the threshold of quality.*[129]

4.27 Ms Alison Brooks, Director Student Support for DECYP, provided further evidence on the expertise of staff and building capacity within the Department:

***Ms ROSOL** - ... you've talked about the improvement practice coaches and that team having the skills to provide the information and the education to teachers on the ground. What education are they accessing? If they're the specialists within the Department, where do they get their training and expertise from?*

...

***Ms BROOKS** - I'll just clarify. We're talking about the Inclusive Practice Team, which includes a team of 16 inclusive practice coaches. Each of those coaches is allocated to a school across the state, so every school has access to a coach; then there are two leads who offer an extra level of support and expertise as needed. That team is very proactive in its professional learning. The manager of that team is very proactive in accessing evidence-based, up-to-date professional learning for the team.*

[129] Hon. Jo Palmer MLC, Minister for Education, and Ms. Jodee Wilson, Deputy Secretary Development and Support, Department for Education, Children and Young People, Transcript of Evidence, 11 April 2025, pp. 43-44.

> *They learn on two levels. One is about pedagogical practices, which is led by the manager. The other is around expert input. Of particular note is that last year, four members of that team participated in a Hardie Fellowship and visited the United States of America to look at best practice in inclusive practice. They are very active in that space. They are also highly connected with other professional organisations across the nation, looking at best practice. They're also very discerning in their collection or advocacy for particular people…So the answer is yes, very proactive in building their capacity and professional learning.*[130]

Findings

The Committee finds:

55. Teachers play a key role in managing behavioural symptoms of ADHD and other neurodiverse presentations in educational settings.

56. Teachers are crucial contributors to a multidisciplinary approach to treatment and support of children and young people with ADHD.

57. Learners would benefit from teachers and other educational staff receiving further undergraduate and ongoing professional training and development in best practice management of neurodiverse behaviours.

58. Providing a learning environment that meets the needs of children and young people with ADHD, and other neurodiversity, benefits all students and their teachers.

Attitudes

4.28 The Committee heard that inadequate training of professionals and a misunderstanding of ADHD leads to negative attitudes and stigma towards people with ADHD.

4.29 Witnesses to the Inquiry shared their experience encountering negative attitudes while seeking support for their mental health. Mr Matthew McDonagh's submission stated:

> *… the nonchalant attitude of the GP about my query of ADHD may have seem*[ed] *trivial to them. This attitude of the medical system needs to change. For someone who was in 'extreme' psychological distress it didn't seem like there was much urgency to provide a solution.*[131]

4.30 ADHD Australia's submission included a direct quote from an individual with lived experience:

[130] Ms. Alison Brooks, Director Student Support, Department for Education, Children and Young People, Transcript of Evidence, 11 April 2025, p. 44.
[131] Submission No. 9, Matthew McDonagh, p. 3.

My GP was reluctant to refer as she felt it was being overdiagnosed and not worth pursuing. I asked 3 separate times before she referred...[132]

4.31 The Hobart ADHD Consultants expanded on this issue in their submission:

> *There remains an unacceptable amount of stigma and misinformation about ADHD amongst health practitioners. This includes beliefs that people seeking help with ADHD are "drug seekers", and beliefs that ADHD is not a valid condition (or not as prevalent as it actually is). These beliefs have no valid basis and are indicative of being uninformed about ADHD. They also contribute to the bottleneck in the system as many practices/practitioners with these beliefs will not see people for ADHD. This is compounded by consumers not always being informed of this when first contacting the service.*[133]

4.32 Dr Derrick, of Hobart ADHD Consultants, further discussed this issue at the 18 October 2024 public hearing:

> ***Mr BEHRAKIS*** *- ...just on the awareness and understanding and misinformation and stigma. There's a lot of talk about that in the broader community, but in your submission, you talk about the misinformation and stigma that exists within the medical profession.*
>
> *...*
>
> *For a profession where we talk about people who are well educated in matters of medicine and psychology and psychiatry, what are those stigmas and misunderstandings and how do we address that?*
>
> ***Dr DERRICK*** *- Yes, well-educated, lots of skills, but also not time and incentive to put their waitlist on further hold and make time in their day for training to update their knowledge based on what we currently know. The knowledge space around ADHD has changed dramatically since neuroimaging studies in the 2010s started coming out showing clear differences. Then it was like, 'Ah, now it's not a debate anymore. We can see this.' When you're looking at however many weeks it takes to get into your regular GP at the moment, let alone find a new one, when that's how much our health professionals are pushed, what's the likelihood of them taking their time out for training?*
>
> *... I'm aware of a particular case, probably about 10 years now, of a psychiatrist in Hobart. That was probably the event that put the fear in a lot of psychiatrists, and, 'Why would I bother doing that when I've got more than enough patients here? I don't want to have to go through that risk'. We do have stigma around drug-seeking, which to me is ridiculous because if it's much easier to find stimulants on the streets, on the black market, than it is to put yourself through this whole process. Why would you do it?*

[132] Submission No. 49, ADHD Australia, p. 24.
[133] Submission No. 30, Hobart ADHD Consultants, p. 10.

…

There's still a lot of talk within professionals in the ADHD space about exposing themselves to risk of being investigated, and there not being a committee that reviews their prescribing practices that is ADHD-equipped. I'm not sure of involvement of state versus federal level there, but I think that would be something that would assist. I think at university-level we need to be careful of what we are training as well and make sure that we have an up-to-date attitude and culture coming through.[134]

4.33 During the same hearing, Mr Matthew Tice and Ms Melissa Webster, representatives of ADHD Australia, provided their perspective on the stigma associated with ADHD:

> ***Mr TICE*** *- … stigma is always going to be a challenge and that exists across our society, unfortunately. I will say that compared to a decade ago, or even five years ago, in the pre-COVID world, we are getting a lot more awareness in terms of the mainstreaming of mental health. The autism community has done a tremendous job ploughing the ground ahead of our efforts in ADHD, to build that awareness and overcome some of that stigma. You can see it every day in the schools and other places, but it's patchy…*
>
> *To my earlier point about disadvantaged communities or in different parts of the system, for example, justice is way behind, clinicians is way behind, teachers, employers are even further behind. It really depends where we are but, fundamentally, we have seen a significant shift in awareness. To give you an example, it was two weeks ago, we had our international conference where last year we had some 6000 people join the conference. This year we had 30,000 people join the conference plus or minus.*
>
> *…*
>
> ***Ms WEBSTER -*** *Actually it was 56,000 in the end, Matt…*
>
> ***Mr TICE*** *- It is a great lead indicator that the community is starting to coalesce and organise. When we look at it, there's still a tonne of work to do in terms of overcoming stigma at all levels, but we are making significant progress on a whole number of fronts and there are, tens, hundreds and thousands of people working on this. We are probably 20 per cent of the way where we need to be but five years ago, we were 5 per cent, I think we made a lot of progress but we need to provide education. We need to enable people on the front lines who are working with individuals in our community to understand what ADHD is all about, train them how to work with individuals with ADHD and help individuals navigate those life journeys in a way that they can be equipped to bring what they have to*

[134] Dr. Madelyn Derrick, Clinical Psychologist, Hobart ADHD Consultants, Transcript of Evidence, 18 October 2024, pp. 14-15.

offer forward in a positive way. A lot of work to be done there and it really is an education challenge.[135]

4.34 Mr Daniel Vautin, as Director of Policy and Impact for the Alcohol Tobacco and Other Drugs Council Tasmania, gave evidence on the stigma experienced by those with ADHD who are interacting with treatment services:

> ***Ms HADDAD*** *- …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*** *- … 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.*
>
> *…*
>
> *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.*[136]

[135] Mr. Matthew Tice, Chair, and Ms. Melissa Webster, Chief Executive Officer, ADHD Australia, Transcript of Evidence, 18 October 2024, pp. 62-63.

[136] Mr. Daniel Vautin, Director of Policy and Impact, Alcohol Tobacco and Other Drugs Council Tasmania, Transcript of Evidence, 8 November 2024, pp. 39-40.

4.35 The Committee heard evidence on the attitudes held by those within the medical profession.

4.36 Dr Jones gave evidence on his experience, as well as ways to address negative attitudes among GPs:

> ***Mr BEHRAKIS*** *- … We did hear about some misinformation or misunderstandings or lack of awareness and stigma in the general community around ADHD, but that also exists in the medical professions as well, where some GPs are either cynical, you know, there are multiple different views and people could go to a GP and have a really negative experience…*
>
> ***Dr JONES*** *- Which is even more crushing, contributing to that hopelessness.*
>
> ***Mr BEHRAKIS*** *- Correct, that was going to be my question. How do we address that and what do we do about making sure that experience doesn't happen for people? Is that a solution to that?*
>
> ***Dr JONES*** *- In a way that's where the Lived Experience organisation becomes so important. If I can again draw a parallel, if we look at eating disorder support, a lot of GPs do provide eating disorder care, not all do. The Butterfly Foundation is the local organisation to support those families when they're accessing that care. It maintains a list of GPs with specific interest in managing eating disorders and provides that front loaded to people accessing them.*
>
> *I think in terms of a lived experience organisation for people with concerns about ADHD, there's a tremendous opportunity to maintain that close relationship and make sure they know in their area, there are these psychologists, GPs, social workers, whatever services needed, that are aware, trained and appropriately sensitive to provide the care you need.*
>
> ***CHAIR*** [Ms White] *- Do we have that in Tasmania?*
>
> ***Dr JONES*** *- Not yet, no. There are certainly within healthcare organisations, there are ADHD working groups, there are ADHD professional organisations, you'll be hearing from some of them. We don't have a lived experience body in Australia in the sense that other countries provide.*[137]

4.37 Representatives from RANZCP, Dr Honor Pennington and Dr Reddy, provided their perspectives on addressing stigma held by psychiatrists:

> ***CHAIR*** [Mr Behrakis] *- … 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*

[137] Dr. Timothy Jones, General Practitioner, Royal Australian College of General Practitioners, Transcript of Evidence, 18 October 2024, p. 55.

psychologists and psychiatrists. What's the solution to address that, other than wait for the generational change...?

***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.

...

***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 psychoeducation about this condition.*[138]

Findings

The Committee finds:

59. Stigma, negative stereotypes, and discrimination are still pervasive within the health system despite the existence of some excellent practitioners treating people with ADHD in Tasmania.

60. Stigma arising from comorbidities and alcohol and drug use add further significant barriers to ADHD treatment.

[138]Dr. Honor Pennington and Dr. Anil Reddy, Psychiatrists, Royal Australian and New Zealand College of Psychiatrists, Transcript of Evidence, 8 November 2024, pp. 71-72.

61. There are widespread misunderstandings and negative stereotypes of people with ADHD in the Tasmanian community, however societal awareness and acceptance are increasing.

Workforce Development Options to Increase Service Access

4.38 The Committee heard evidence from a range of witnesses regarding options to improve workforce shortages and improve access to suitably trained healthcare professionals.

4.39 At the 18 October 2024 public hearing, the then Minister for Health, Mental Health and Wellbeing, Hon. Guy *Barnett* MP, provided evidence on the work undertaken by the Tasmanian Government to increase capacity for ADHD assessment and support services:

> ***Mr BARNETT*** *- … In line with our election commitment, this will see the delivery of new GP specialist service for children with ADHD to ensure families can access a GP with a specialist interest sooner, with $2.5 million committed in the recent Budget to progress this important service. We have also increased the time frame that GPs with a special interest and other specialists can prescribe medications from two to three years, reducing the number of specialist appointments that families are required to attend.*[139]

4.40 At the same public hearing, then Acting Secretary for the Department of Health, Mr Dale Webster, continued to discuss the Government's recent initiatives:

> ***Mr WEBSTER*** *- … the Kids Care Clinic, I think that's what it's called, is in fact a service we established last year where, effectively, we have a statewide team and a presence statewide and they deliver clinics in non-clinical spaces. That might be a Child and Family Learning Centre. At Kingston, I know it's the Neighbourhood House for instance. That's now established…*
>
> *We're currently developing a model of care where we will either attract or train GPs to become special interests GPs in ADHD speciality, which will supplement our paediatric workforce and psychiatry workforce for children so that we can increase the number of appointments available, particularly through Outpatients. That's funded for the next four years to attract* [GPs] *and we have a model of care where we've got GPs with special interest adding to the number of people that can see children and diagnose.*
>
> *In addition to that, the paediatric part of our women's and children's service is working with our child youth mental health service to design a statewide specific ADHD treatment service. There are some children for whom the prescription of psychostimulants might be counterintuitive to their treatment or might not be sufficient treatment. We want to make sure that they are treated in a*

[139] Hon. Guy Barnett MP, former Minister for Health, Mental Health and Wellbeing, Transcript of Evidence, 18 October 2024, p. 22.

multidisciplinary sense between paediatrics and mental health to make sure they have that additional support. They're the extras, if you like, that we're adding to the suite of services over the next period.

The reality is that nationally, we have a shortage of paediatricians and psychiatrists both of which are the people we need involved directly in the development treatment plans. The GPSI as we call it - the GPs with Special Interests - idea is one that we're keen to progress while we are still working through how we increase the number of paediatricians and psychiatrists.[140]

4.41 During the public hearing on 16 May 2025, the then Minister for Health, Hon. Jacquie *Petrusma* MP, provided the Committee with an update on the ADHD-specific service, previously cited by Mr Webster:

> ***Mrs PETRUSMA*** *- …I'm also pleased to share that we have also established a specific service for neurodevelopmental assessment and management with a new joint model of care between paediatrics and Child and Youth Mental Health Services now being established in April. We expect that this ADHD clinic pilot will deliver multiple benefits, including reducing the significant paediatric waitlist for specialist neurodevelopmental assessment, enhancing care coordination and improving timely access to care that meets the needs of Tasmanian children and their families.*
>
> *This initiative will also support our government's commitment of $2.5 million, plus we are now providing another $500,000 to make a total of $3 million over three years to establish a new GP specialist service for children with ADHD so their families can access support sooner statewide.*
>
> *The new joint model of care initiative that was launched in April follows a successful launch of Kids Care Clinics in 2023, which provides targeted healthcare and support to Tasmania's most vulnerable children and their families. Kids Care Clinics have a focus on early identification of health and wellbeing concerns, including ADHD, and through the Kids Care Clinics we're also trialling parent and school education sessions on ADHD.*[141]

4.42 The then Minister provided further evidence on the clinic pilot:

> ***Mrs PETRUSMA*** *- …we have established a specific service with a joint model of care between paediatrics and Child and Youth Mental Health Services (CYMHS) for neurodevelopmental assessment and management. This model will be delivered through the paediatric outpatient department and is being designed to address the paediatric waitlist for ADHD assessments. This will, from 1 July, also include the $3 million of Tasmanian government funding that we've now committed over three years. We believe that this is a unique opportunity to pilot a joint Child and Youth Mental Health Service and Women's and Children's*

[140] Mr. Dale Webster, Acting Secretary, Department of Health, Transcript of Evidence, 18 October 2024, p. 32.

[141] Hon. Jacquie Petrusma MP, former Minister for Health, Transcript of Evidence, 16 May 2025, p. 3.

Services ADHD Clinic with multidisciplinary staff, including a paediatrician, clinical nurse consultant, a psychiatrist, a psychiatric registrar and a range of allied health professionals.

Eligible children and young people with suspected ADHD will be drawn from the current paediatric waitlist for neurodevelopmental assessments and treatments as appropriate. We expect that this initiative will deliver multiple benefits, including reducing the significant paediatric waitlist for specialist neurodevelopmental assessment, it will enhance care coordination, and it will improve timely access to care that meets the needs of Tasmanian children and their families.

Stage 1 of this new model, focused on children, not adults, with suspected ADHD, commenced in April this year and is staffed by paediatricians, child psychiatrists and nursing staff. To further bolster staffing, this service will expand in the first quarter of the 2025-26 financial year under stage 2 and will employ GPs and more paediatricians to support the model of care and to expand capacity to see more children.

Initially, this model will be trialled in the south, while planning for statewide implementation is also now underway, with the model to be rolled out to all three regions to support ADHD assessments and treatment.[142]

4.43 Mr Webster and Dr Sean Beggs, Clinical Director of the Women's and Children's Services of the Department of Health, provided evidence on the age limit for this service:

***Mr WEBSTER** - …these particular initiatives we're talking about today are focused on paediatrics, but the CYMHS model actually floats these days. The reason why we changed from Child and Adolescent to Child and Youth was that if there is someone who is reaching adulthood, who the clinicians within CYMHS believe would benefit from staying within the CYMHS service, then they actually do stay there. Every client doesn't automatically move from CYMHS to adult at 18. There is a floating* [cohort] –

CHAIR [Ms Haddad] - *Is there an age limit for that floating cohort?*

***Mr WEBSTER** - Yes, it's 24. It's up to six years of that floating. That acknowledges that levels of maturity are actually what may affect the types of treatments that are required rather than a fixed birthday as such. Not many of our clients would float through that, but if there is a need, they do. That's important, it wasn't just a name change, it was a model of care change when we moved from CAMHS to CYMHS.*

…

[142] Hon. Jacquie Petrusma MP, former Minister for Health, Transcript of Evidence, 16 May 2025, pp. 4-5.

> ***Dr BEGGS*** *- …As was key, knowing that the waitlist - there was a number of children who had been sitting on that waitlist for a number of years and were about to hit the age where they would no longer qualify for paediatric services, they were emphasised as being the ones to be seen. They were a bit more time consuming and maybe not getting through as many volumes as we would have ideally liked, but they were the priority to get done.*
>
> *The service model has started and it is running and is established outside of the actual hospital setting, at the moment it's running out of Glenorchy, so that it's in a community setting, so it's more appropriate.*[143]

4.44 Dr Beggs provided further evidence on the interaction between the clinic and the Child Health and Parenting Service (CHaPS):

> ***Ms ROSOL*** *- …I just had a couple of questions actually, but one is about CHaPS (Child Health and Parenting Service) and how CHaPS fits in with this, because we know that's often the first place that parents go to and where things are picked up. Will there be a formal relationship between CHaPS and this clinic? How will they work together?*
>
> ***Dr BEGGS*** *- At this point, there's not a formal relationship with CHaPS for this clinic per se, but we do work with CHaPS. CHaPS is part of our WaCS* [Women and Children's Service] *network in terms of interacting to put systems in place. CHaPS pathways at the moment, generally, if they have a concern of this sort of nature would be primarily to GPs who would then refer to the service. In terms of systems in place, we would certainly have lots of dialogues with CHaPS in terms of our formal network that we have with them.*
>
> ***Ms ROSOL*** *- …Is there space there do you think for CHaPS formally being included in those pathways because that could take a step out of it couldn't it? If CHaPS can refer in to you, then it could take the GP referral out of it and make a smoother pathway.*
>
> ***Dr BEGGS*** *- Yeah, and to be clear we do take referrals directly from CHaPS if there's a time nature of it that we think - it's always important to have the primary care physician involved as well, so we would still, if they refer directly to the paediatric clinics, they would also expect them to be corresponding with the GPs to say that that's happened. If there's a time nature of it where we think that that extra step is going to be detrimental, then CHaPS can refer directly into the paediatric clinics.*[144]

4.45 The Committee heard further evidence on the role of allied health professionals at the clinic:

---

[143] Mr. Dale Webster, Secretary, and Dr. Sean Beggs, Clinical Director, Women's and Children's Services, Department of Health, Transcript of Evidence, 16 May 2025, pp. 5-6.

[144] Dr. Sean Beggs, Clinical Director, Women's and Children's Services, Department of Health, Transcript of Evidence, 16 May 2025, p. 11.

Ms ROSOL *- … I'm interested about allied health's involvement in it, maybe not so much in the diagnosis, but if it's a clinic for treatment as well, will there be space for allied health? How do you envisage that developing?*

Mrs PETRUSMA *- Yes, there's going to be - it includes a paediatrician, clinical nurse consultant, psychiatrist, psychiatric registrar and a range of allied health professionals are involved in the model of care…*

Dr BEGGS *- … The ultimate aim would be, yes, particularly psychologists and maybe speech pathologists would be the two main ones that we would think that could be of value going forward. That's the aim, to bring those into it as well, to make it truly multidisciplinary.*[145]

4.46 Dr Beggs discussed the multidisciplinary aspect of the model of care used at the clinic:

Dr BEGGS *- The model will probably evolve a bit, but the idea is that there will be a whole lot of pre-work done probably by a combination of the allied health team, the GPs, registrars if involved. Not all of those, but one of those doing a whole lot of the pre-information gathering work-up. By the time they get to see the psychiatrist or the paediatrician, who at the moment are the ones who primarily can make the diagnosis and prescribe, if that's what it is, have got all that information. Instead of having to be seen multiple times by those people, they only need to be seen maybe once or twice to confirm the diagnosis.*

If there's confusion or ambiguity about the diagnosis, then there would be a time for that team to meet together to discuss those things. I think the GP component outside of that clinic would be very much about the ongoing management once returned to primary care, whereas the GPs in the service would be very much about supporting the initial diagnosis and the formulation about what the most appropriate management going forward would be and they would come together.[146]

4.47 The current Minister for Health, Mental Health and Wellbeing, Hon. Bridget *Archer* MP, provided an update to the Committee of the Fifty-Second Parliament:

Department of Health Service Updates

Our 2025 election commitment to enable Tasmanian GPs to diagnose, treat and manage ADHD for both children and adults builds on other initiatives already underway, including our newly established ADHD Clinic for children. This clinic was established to provide a specific service for neurodevelopmental assessment and management, with a joint model of care between Paediatrics and Child and

[145] Hon. Jacquie Petrusma MP, former Minister for Health, and Dr. Sean Beggs, Clinical Director, Women's and Children's Services, Department of Health, Transcript of Evidence, 16 May 2025, p. 11.
[146] Dr. Sean Beggs, Clinical Director, Women's and Children's Services, Department of Health, Transcript of Evidence, 16 May 2025, p. 21.

Youth Mental Health Services (CYMHS). This pilot model is delivered through the Paediatric Outpatient Department and has been designed to address the paediatric waitlist for ADHD assessments and is part of our Government's commitment of $3 million over three years to establish a new GP specialist service for children with ADHD.

This service provides a unique opportunity to pilot a statewide joint CYMHS and Women's and Children's Services ADHD Clinic with multidisciplinary staff, including a Paediatrician, Clinical Nurse Consultant, Psychiatrist, and Psychiatric Registrar. Eligible children and young people with suspected ADHD are drawn from the current Paediatric waitlist for neurodevelopmental assessments and treated as appropriate.

We expect this initiative to deliver multiple benefits, including reducing the significant paediatric waitlist for specialist neurodevelopmental assessment, enhancing care coordination, and improving timely access to care that meets the needs of Tasmanian children and their families.

This initiative follows the launch of Kids Care Clinics in 2023 to provide targeted healthcare and support to Tasmania's most vulnerable children and their families, with a focus on early identification of health and wellbeing concerns, including ADHD. Through Kids Care Clinics, we are also trialling parent and school education sessions on ADHD. The first of these two sessions has been trialled in rural communities and if successful, will be further developed and rolled out more widely...[147]

4.48 The importance of multidisciplinary care was raised by several witnesses to the Inquiry.

4.49 At the 18 October 2024 public hearing, Professor Coghill provided an example of effective multidisciplinary care:

> ***Prof COGHILL** - ... I worked in Scotland before coming to Australia and we ran our service in actually a part of Scotland that's not too unlike Tasmania in that it was outside of the main centres. We had difficulty recruiting. We ran our service very much with nurses - not prescribing nurses, but regular nurses who we've taken time to train providing a lot of the face-to-face care with the medical staff, who we didn't have many of, providing support and backup to that. That service demonstrated better clinical outcomes than any other publicly funded service in the world has ever demonstrated. There are real opportunities, to think laterally, to think broader about how you fund and design services for ADHD. Unfortunately, it has not been possible yet to get that into Australia.*[148]

[147] Letter from Hon. Bridget Archer MP, Minister for Health, Mental Health and Wellbeing, dated 26 November 2025, p. 3.

[148] Professor David Coghill, President, Australasian ADHD Professionals Association, Transcript of Evidence, 18 October 2024, p. 2.

4.50 Professor Coghill provided further evidence on nurse-led clinics:

> ***CHAIR*** [Ms White] - *… Seeing the opportunity, you've outlined a relation to nurse-led clinics or the role they might play. You talked about non-prescribing nurses. Have you seen any examples where nurse practitioners have played a role in those multidisciplinary teams, and could you comment on that?*
>
> ***Prof COGHILL*** *- Yes, they have. We didn't have the luxury of having a lot of nurse prescribers in our service. We did have two just before we finished. They make a fantastic contribution. I think that they are often as - if not more - diligent than some of the medical staff who we work with, because they've taken very specific training. I think that is an opportunity. I think my - not concern, I have no concern about nurse practitioners and nurse prescribers - but my concern over the practicality is they're very expensive to train and there aren't that many of them. When you're looking at services that need to be high volume, it's similar to relying just on psychiatrists or paediatricians. I think that you hit a barrier with numbers that you'll get. From a theoretical perspective, if you're able to find enough well-trained, well-motivated nurse practitioners, then that's a great part of a solution.*
>
> *…*
>
> ***Mr BEHRAKIS*** *- …On the topic of the multimodal model for approaching this… Can you explain how that multimodal, including nurses, including GPs more in that process would benefit when you still have that need for specialists?*
>
> ***Prof COGHILL*** *- I don't question the need for specialists, but I would question the need for specialists in every case, or them having a core central role in every case. Per ADHD guidelines, when we were thinking about who can do an assessment for ADHD, our line was very much that there are many types of health professionals who can do an assessment as long as they're well enough trained and well enough supported.*
>
> *Doing an assessment for ADHD is not just about saying - does this person have ADHD, yes or no? It's also about taking the person holistically into consideration, thinking about any other coexisting problems they have. These may be other mental health conditions or other physical and developmental conditions. It's not an easy job, but I don't think that there's a reason other people can't be trained to play a big role in that.*
>
> *I gave the example of our nurse-led service. In our nurse-led service, all of the assessment information was gathered by the nurses. Then a psychiatrist came in at the end of that process, reviewed that information and had a relatively brief meeting to fill in any gaps that were there, to discuss the diagnosis, do the psychoeducation and do the treatment planning. When we came to delivering the treatment, the nurses were much better placed to deliver the non-medication treatment. They were also extremely good at monitoring the medication treatments. That's just one example. Psychologists, occupational therapists, other allied health professionals, as well as general practitioners, nurses,*

psychiatrists, paediatricians, all can play complementary roles. The key is them working together. Often what we have in Australia is people working in relative isolation. If they want someone else to be involved they have to make another referral. There's a dislocation, a siloing of care…I think those roles shouldn't be fixed by discipline; they should be fixed by skills and training. There are many complementary works.[149]

4.51 During the same hearing, Dr Jones provided examples of shared care arrangements used for the assessment and treatment of ADHD in other Australian jurisdictions:

> ***CHAIR*** [Ms White] - *…if we can talk about the shared care models you've referenced the NSW and then the WA examples. We've heard a little bit about the NSW model but the WA model is newer to me. Can you explain to the committee the benefits in having something like that and what you would like to see in the Tasmanian context? What do you think would work here because we are still different to both of those states?*
>
> ***Dr JONES*** - *I'll speak to the WA prescribing pilot first, which is really an opportunity for a future model of care that would have two positive impacts. The first is that would improve access to assessment and support, but the second is that it would contribute to that accelerated upscaling of our general practice workforce in terms of providing care needed for ADHD. In that proposed pilot, what essentially would happen is a multidisciplinary approach where GPs are performing the assessment for ADHD in consultation with paediatrician or psychiatry colleagues and allied health colleagues and then liaising directly with that patient's treating general practitioner to individualise the management plan and make sure appropriate supports in that community are in place. We feel that that instantly deals with the siloification problem. You've got people with similar backgrounds, similar levels of training, providing that care.*
>
> *The New South Wales pilot is already happening, but it's smaller scale and it's in one regional area and we are seeing significantly improved access in that area, but it hasn't been running long enough to see long-term outcomes in a way I can report to the committee.*
>
> ***CHAIR*** - *In the Tasmanian context, do you have a view about the different professions who would work as a part of a shared care team?*
>
> ***Dr JONES*** - *Yes, my expertise is in child health and so I will always speak to that first. I think that if we look at our communities of great need, and in the south they are largely communities around the Bridgewater area, communities around the Rokeby/Clarendon Vale area, and communities in Kingborough and south. We know that the majority of our ADHD referrals for children happen from those catchments. We also know that those are the areas with the most limited*

[149] Professor David Coghill, President, Australasian ADHD Professionals Association, Transcript of Evidence, 18 October 2024, pp. 3-4.

support, so partnering with appropriately trained and credentialed GPs into that area in a way that is affordable for families to access, we feel that would lift the whole community's ability to understand and support this condition. Certainly talking to my colleagues in the north and north-west, they expressed similar opinions. That's what they would love to see happen for the communities they live and work in.

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

***Dr JONES** - The best model of care would be to have a liaison point to either paediatrics or psychiatry, depending on whether it's a child or adult patient. A representation from PSB* [Pharmaceutical Services Branch] *to ensure that we've got that wraparound communication and discussion, a liaison point into education systems if it's a child, or workplace support systems if it's an adult, and potentially representation of a psychologist as well to individualise some of the support strategies that may be relevant to that specific individual.*[150]

4.52 Dr Jones also discussed the use of nurses as part of multidisciplinary care:

CHAIR [Ms White] *- ... One of the discussions we had earlier today was about the utilisation of nurses to help with some of the workload. Do you have a view about that?*

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

We use nurses routinely once we institute a treatment plan to touch base with people about how it's going and to report earlier if there are any concerns, side-effects, any issues along the way. I think there's amazing scope to use our existing workforce better there. Similarly, I think, teachers, as much as that is a stressed workforce at the moment, they really care about the kids they're seeing and having that direct liaison point to just bridge a divide that normally doesn't get crossed, would deliver better outcomes tomorrow if we have it.

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

***Dr JONES** - Definitely. When we are conducting medication trials in children, I'm often part of that process as a GP, having that direct observational evidence of what is working and any side-effects that are happening enables better and faster care. If we don't have that and remember that these are often the families where*

[150] Dr. Timothy Jones, General Practitioner, Royal Australian College of General Practitioners, Transcript of Evidence, 18 October 2024, pp. 47-48.

access to support may be very limited, we don't always get that information back and we need it. When I talk to school nurses they're keen to help and we trust their expertise.

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

***Dr JONES** - As an individual GP, I love to make an effort to connect those dots at a grassroots level wherever I can. That's not a current standard of care because there aren't frameworks to support it.*[151]

4.53 The then Acting Secretary of the Department of Health responded to the evidence heard by the Committee regarding the use of nurses in a multidisciplinary service at the same hearing:

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

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

...

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

***Mr WEBSTER** - ...Nurse practitioners is one part of what we're doing. Scope of practice is not just for nurse practitioners, it's actually for RNs* [Registered

[151] Dr. Timothy Jones, General Practitioner, Royal Australian College of General Practitioners, Transcript of Evidence, 18 October 2024, p. 49.

> Nurses], *ENs* [Enrolled Nurses], *pharmacists, allied health, et cetera. We need to pursue scope of practice. In fact, nationally, Professor Mark Cormack from ANU* [Australian National University] *is, on behalf of all jurisdictions, undertaking a major piece of work on scope of practice of all health professionals, as part of the outcomes of the Strengthening Medicare Taskforce and Tasmania represents the small states on the Strengthening Medicare implementation team, working with people like Mark Cormack to implement that part of the taskforce.*[152]

4.54 Further evidence was received from health practitioners regarding the opportunity for increased collaboration between specialists and GPs.

4.55 At the public hearing on 8 November 2024, Dr Clare Smith, recently retired GP and representative of the Australian Medical Association (AMA) Tasmania Branch, stated:

> ***Dr SMITH*** *- … 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.*[153]

4.56 Dr Pennington provided evidence about the effectiveness of collaboration between health practitioners:

> ***CHAIR*** [Mr Behrakis] **-** *… 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?*
>
> *…*
>
> ***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.*

[152] Mr. Dale Webster, Acting Secretary, Department of Health, Transcript of Evidence, 18 October 2024, pp. 32-33.
[153] Dr. Clare Smith, retired General Practitioner, Australian Medical Association Tasmania Branch, Transcript of Evidence, 8 November 2024, p. 51.

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.[154]

4.57 Dr Pennington also discussed options to address the duplication of ADHD assessments, as cited in Chapter 2:

> ***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* [Reddy] *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.*[155]

4.58 At the same public hearing, the Committee received evidence from Dr Naidoo, representing RACP, about the potential to increase the collaboration between specialists and GPs:

> ***Ms HADDAD*** *- … 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*

[154] Dr. Honor Pennington, Psychiatrist, Royal Australian and New Zealand College of Psychiatrists, Transcript of Evidence, 8 November 2024, pp. 65-66.
[155] Dr. Honor Pennington, Psychiatrist, Royal Australian and New Zealand College of Psychiatrists, Transcript of Evidence, 8 November 2024, pp. 69-70.

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 CAMHS 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.[156]

4.59 Mr Jerry Yik, Head of Policy and Advocacy for Advanced Pharmacy Australia (AdPha), discussed the role pharmacists could play in multidisciplinary care:

Ms HADDAD *- ...You've identified that* [specialist ADHD pharmacists]*... 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.[157]

[156] Dr. Theresa Naidoo, Paediatrician, Royal Australasian College of Physicians, Transcript of Evidence, 8 November 2024, pp. 3-5.

[157] Mr. Jerry Yik, Head of Policy and Advocacy, Advanced Pharmacy Australia, Transcript of Evidence, 8 November 2024, pp. 31-32.

Findings

The Committee finds:

62. Multidisciplinary teams including general practitioners, specialists, and allied health professionals represent the best practice model of care for ADHD treatment.

63. Currently Tasmanian ADHD services are relatively siloed, resulting in duplicative processes, inconsistent access, and poor health outcomes.

64. Tasmania is taking early steps towards developing a multidisciplinary response to the assessment, diagnosis, treatment, and support of people with ADHD.

65. The Tasmanian Government is implementing policies to improve access to ADHD services, including Kids Care Clinics, an ADHD clinic pilot program, and increasing access to General Practitioners with Special Interests.

66. There is opportunity for nurses and nurse practitioners to take a greater role in the multidisciplinary assessment and ongoing treatment of people with ADHD in Tasmania.

Recommendations

The Committee recommends:

7. **The Tasmanian Government continue to prioritise the recruitment of psychologists, psychiatrists, and paediatricians, and work with industry representative bodies to increase the attraction of professionals to Tasmania.**

8. **The Tasmanian Government increase ADHD professional development opportunities for people working in the Tasmanian health and education systems.**

9. **The Tasmanian Government call on the Australian Government to fund general practitioner training in ADHD diagnosis and management.**

10. **The Tasmanian Government call on the University of Tasmania to increase ADHD training in existing relevant undergraduate courses, and provide a broad range of practice endorsements for its master's level psychology.**

11. **The Tasmanian Government undertake work to reduce misunderstanding, stigma, and discrimination relating to ADHD in the community.**

12. **The Tasmanian Government support and enable multidisciplinary teams as the model of care for ADHD diagnosis and treatment in Tasmania. This would require cooperation and collaboration across Tasmania's public health and education systems and the primary health care system.**

5 ADHD MEDICATIONS, *POISONS ACT 1971* (TAS) AND THE TASMANIAN HEALTH SERVICE'S PHARMACEUTICAL SERVICES BRANCH

5.1 Medication has been briefly discussed as an effective treatment for children and adults with ADHD in Chapter 2.

5.2 This Chapter further considers the access to ADHD medications, the *Poisons Act 1971* (Tas) and associated regulations, and the Pharmaceutical Services Branch (PSB).

Prescribing rates and access to ADHD medication in Tasmania

5.3 At the 18 October 2024 public hearing, Professor David Coghill, President of Australasian ADHD Professionals Association (AADPA), provided evidence on the prescribing rates of ADHD medications in Tasmania:

> ***Prof COGHILL*** *- … One thing we noticed… was rates of prescribing for ADHD in Tasmania. They were really quite interesting to look at. When you look at the under six-year-olds - actually, we don't think many under-sixes at all should be receiving medication - Tasmania was the highest prescriber in Australia, when you look by state. Similarly, for the six to 12-year-olds, the rate of prescribing for ADHD medications in Tasmania was the highest in Australia. They were about average for adolescents, for 13 to 18-year-olds. They were much lower for adults. I think it really highlights the very different levels of access to care that people are getting.*[158]

5.4 The Committee heard evidence of the multiple barriers faced by Tasmanians seeking access to medication to treat ADHD, including the cost of medication, medication availability and shortages, issues with prescribers, and the limitations of current arrangements.

5.5 Women's Health Tasmania raised the cost barriers faced by patients accessing medication, where appointments to receive a prescription and the medication cost itself, can be inaccessible:

> *Despite medication being cited as one of the only supports available to people diagnosed with ADHD, barriers to accessing medication were a common concern among survey respondents. Many individuals reported difficulties in obtaining prescriptions due to restrictive regulations and the need for frequent specialist appointments, which are expensive and often challenging to secure given the long waitlists and limited availability of professionals. The cost of medication*

[158] Professor David Coghill, President, Australasian ADHD Professionals Association, Transcript of Evidence, 18 October 2024, pp. 1-2.

itself was also cited as a barrier to access, particularly among those who were not eligible for the PBS rate.[159]

5.6 Women's Health Tasmania also provided views of their respondents on the cost of ADHD medication:

> *As a migrant, I pay full price for all my medications. My Vyvanse is 92 dollars a month – most folks with ADHD, especially late diagnosed women have other mental and physical health issued* [sic] *they are managing. The cost burden is unbelievable.*
>
> *…*
>
> *Having a later diagnosis does not make me eligible for the reduced fee for my medication. My script is currently $22 for a 30 day supply. It is a cost of $1.10 a day for the remainder of my life to be well in our community. That will eventually add up over time, and likely continue to be affected by inflation…* [160]

5.7 The Association for Children with Disability Tasmania discussed the financial strain of accessing ADHD medication:

> *…Some ADHD medications, even with listing on the Pharmaceutical Benefits Scheme (PBS), are around $30 per month, which is a significant cost during a 'cost of living crisis'. While these medications are cheaper for those with a health care card ($6-7), this is significant and recurring additional cost to a family, especially where multiple family members require daily medication.*[161]

5.8 Tinkers Farm raised the issue of medications not being covered by the Pharmaceutical Benefits Scheme (PBS) in its submission:

> *Certain ADHD medications are not covered by the Pharmaceutical Benefits Scheme (PBS), or are only covered if diagnosed before the age of 18. This limits treatment options and imposes additional financial burdens on those seeking care.*[162]

5.9 Health Consumers Tasmania provided a direct quote from a Tasmanian who explained that, as a result of the cost of a doctors' appointment and their prescription, they had gone without medication:

> *Even simple things, like getting medication, getting a script refilled, it's like, well, do I have the ninety dollars to pay up front to get the pills, is my doctor going to*

[159] Submission No. 20, Women's Health Tasmania, p. 12.
[160] Submission No. 20, Women's Health Tasmania, p. 12.
[161] Submission No. 56, The Association for Children with Disability (Tas), p. 13.
[162] Submission No. 37, Tinkers Farm, pp. 2-3.

write me a prescription again? I've gone without medication, because I just don't have the money, until I can get an appointment again. It's bad.[163]

5.10 Tasmanians have also faced challenges in accessing their medication due to stock shortages. One witness reflected on their experience:

> *The next hurdle came in finding a pharmacy with Lisdexamfetamine stock available. Having access to several pharmacies in close proximity was another benefit that I am again very aware of and grateful for. On my third attempt, I received my medication but was advised that they were likely to be out of stock when I next came to fill the script as there was a 'national shortage'. The fear of starting on a medication that would potentially provide significant improvements to my wellbeing to then have it no longer available was profound.*[164]

5.11 At the 21 February 2025 public hearing, Mr Scott Wynands highlighted difficulties he experienced accessing prescriptions for ADHD medication:

> ***Ms ROSOL*** *- …I'm just wondering if you could talk about what your experience has been like around medication and accessing a prescription, and obtaining it.*
>
> ***Mr WYNANDS*** *- It's been a nightmare. I had to wait two years for my medication…Because my doctor - I don't know whether he didn't put the paperwork in, or he didn't follow it up, it took him ages to even get in contact with my psychiatrist, even though she had emailed him. I found that out from the staff there. He then sent off, apparently, I don't know what the form's called, but –*
>
> ***Mr BEHRAKIS*** *- The authorisation, yes.*
>
> *…*
>
> ***Mr WYNANDS*** *- The authorisation, thank you. I heard nothing back. He said, 'Call back in two weeks,' I did, another two weeks passed, I did, another two weeks, 'Oh, they may have lost it, I'm not sure, I'll give them a call, call me back in two weeks,' and I got that for a year. Then I was getting really sick of it, and I booked an appointment and said, 'What is going on?' and he says, 'You've been rejected.'*
>
> ***CHAIR*** [Ms Haddad] *- But they hadn't told you that?*
>
> ***Mr WYNANDS*** *- I went, 'Right,' I said, 'Can I see this rejection letter, or the reason why, can I get some input into it?' And, 'No, no you can't see it. But, we can give you alternative methods.' So I changed my doctor…That took a little bit of a time because the people who overlook the thing lost my paperwork twice. Then he*

[163] Submission No. 55, Health Consumers Tasmania, p. 6.
[164] Submission No. 28, Private Witness, pp. 6-7.

followed it up, and I finally got medicated. I wasn't rejected at all. There was no reason why I shouldn't have had my medication.[165]

Findings

The Committee finds:

67. There are many barriers to accessing ADHD medication in Tasmania, including the high cost and varying availability of medications, and the costs of ongoing medical appointments.

68. Tasmania has lower prescribing rates than other Australian jurisdictions of psychostimulants for adults. This is indicative of the lack of access to diagnosis and treatment for adults with ADHD.

Poisons Act 1971 (Tas)

5.12 Medications used to treat ADHD include both psychostimulants and non-stimulants.

5.13 Commonly prescribed psychostimulant medications include dexamfetamine, methylphenidate, and lisdexamfetamine, which are all classified as *Schedule 8 Controlled Drugs* (Schedule 8) by the Therapeutic Goods Administration (TGA). Non-stimulant medications, including atomoxetine, are classified as *Schedule 4 Prescription Only* (Schedule 4). Unlike Schedule 4 substances, Schedule 8s require additional oversight and regulation to mitigate risk and maintain safe administration.[166]

5.14 The Tasmanian Government's submission explained the classification of Schedule 8 medications:

> *Substances are included under Schedule 8 where:*
>
> *• the substance is included in Schedule I or II of the United Nations Single Convention on Narcotic Drugs 1961 or in Schedule II or III of the United Nations Convention on Psychotropic Substances 1971, and/or*
>
> *• the substance has an established therapeutic value but its use, at established therapeutic dosage levels, is recognised to produce dependency and has a high propensity for misuse, abuse or illicit use.*[167]

5.15 The Government's submission also outlined the state's responsibility in regulating Schedule 8 substances:

[165] Mr. Scott Wynands, Transcript of Evidence, 21 February 2025, pp. 28-29.
[166] Submission No. 60, Tasmanian Government, p. 17.
[167] Submission No. 60, Tasmanian Government, p. 18.

Australia is a signatory to the United Nations Single Convention on Narcotic Drugs 1961, the 1971 Convention on Psychotropic Substances and the 1988 United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.

These treaties require signatory nations to provide strict oversight of the supply chain (production, distribution, and use) of narcotic drugs, which include Schedule 8 psychostimulants.[168]

5.16 The Tasmanian Government's submission outlined the legislative and regulatory framework in place for Schedule 8 medications:

In Tasmania, the Poisons Act 1971 *governs regulation, control, and prohibition of the importation, making, refining, preparation, sale, supply, use, possession, and prescription of certain substances and plants.*

DoH's Pharmaceutical Services Branch (PSB) administers the Poisons Act 1971 *and subordinate legislation on behalf of the Tasmanian Minister for Health, Mental Health and Wellbeing.*

Section 59E of the Poisons Act 1971 *provides a framework for the DoH Secretary to authorise health practitioners in specified circumstances to prescribe Schedule 8 medicines to patients. The DoH Secretary has delegated authority to PSB to administer s59E. Schedule 8 medicines do not only include psychostimulants used in the treatment of ADHD, but also include a range of other medicines used in treatment of various health conditions (such as opioids, benzodiazepine, and cannabis).*

For medicines included in Regulation 24 of the Poisons Regulations 2018 *(Tas), such as the ADHD medications dexamfetamine, lisdexamfetamine and methylphenidate, a prescriber is required to seek and obtain a s59E authority prior to issuing a prescription for a patient. Medicines are included in Regulation 24 either due to the higher risk nature of the medicine based on chemical properties and clinical patterns of use, where the use of the medicine or diagnosis of a condition relevant to the use of that medicine should occur with relevant specialist involvement, or for consistency with other regulatory requirements (such as the TGA Act).*[169]

5.17 The submission also outlined recent changes to the administration of Section 59E of the *Poisons Act 1971* (the Act):

In April 2022, the DoH made a technical change to the administration of the s59E authorisation process to enable GP 'co-prescribers'. Previously, s59E applications for psychostimulants for the treatment of ADHD were exclusively accepted from

[168] Submission No. 60, Tasmanian Government, p. 17.
[169] Submission No. 60, Tasmanian Government, p. 18.

specialist medical practitioners in psychiatry and pediatrics who could choose to indicate a collaborating prescribing GP.

From April 2022, GPs have been allowed to seek authorisation for the prescribing of Schedule 8 psychostimulants where an assessment and diagnosis of the patient was conducted by a relevant medical specialist in the condition being treated. This administrative change allowed for greater flexibility in who could seek authorisation and better accommodated the increasing prevalence of interstate telehealth psychiatry services which routinely entrust prescribing functions to a patient's GP.

As of 30 June 2024, approximately 83 per cent of prescribers authorised to prescribe Schedule 8 psychostimulants for ADHD are GPs.[170]

5.18 At the 18 October 2024 public hearing, then Minister for Health, Mental Health and Wellbeing, Hon. Guy *Barnett* MP, announced the Tasmanian Government's intention to amend the Act to allow interstate prescriptions for psychostimulant medication to be dispensed in Tasmanian pharmacies:

> ***Mr BARNETT -*** *… I am pleased to announce to the committee that we are taking action to improve access to medication for Tasmanians with the* Poisons Act 1971 *to be amended to allow prescriptions issued interstate to be filled in Tasmania. Currently, the Act restricts interstate prescriptions of certain medicines, including the psychostimulants commonly used to treat ADHD. We've heard feedback loud and clear from those frustrated with the current situation; I've heard that directly on many occasions over a period of time. We're taking action to rectify it to ensure Tasmanians can access the medications they need.*
>
> *With appropriate safeguards, the proposed changes will mean that Tasmanians can access medicines that have been legitimately prescribed by an appropriately qualified health professional interstate. Consultations on these changes will commence shortly, with legislation expected to be considered by parliament early in the new year. In the meantime, Tasmanian GPs can continue to work with interstate specialists to apply for an authority to prescribe those medicines and have them dispensed by Tasmanian community pharmacies.*[171]

5.19 The then Acting Secretary of the Department of Health, Mr Dale Webster, advised that the amendments would change the prescribing rights of nurse practitioners:

> ***CHAIR*** [Ms White] *- With the changes to the Poisons Act, would that also change prescribing rights so that nurse practitioners can prescribe certain medications?*
>
> ***Mr WEBSTER*** *- … the short answer is yes, but we're pursuing scope of practice issues for all our health professionals so that they are all performing at the*

[170] Submission No. 60, Tasmanian Government, pp. 19-20.

[171] Hon. Guy Barnett MP, former Minister for Health, Mental Health and Wellbeing, Transcript of Evidence, 18 October 2024, p. 22.

highest level of scope. We've made a number of changes for pharmacists. Through COVID we made a number of changes for enrolled nurses and RNs. We continue to pursue that to maximise the scope of practice of all our workforce because we see that as a way of achieving a more diverse multidisciplinary workforce.[172]

5.20 At a subsequent public hearing on 11 April 2025, the then Minister for Mental Health and Wellbeing, the Hon. Roger *Jaensch* MP, and Mr Webster gave evidence on a further review of the Act:

> ***Mr JAENSCH*** *- …I'll just also foreshadow that a more fulsome review of the Poisons Act has begun and will continue, with consultation kicking off later this year. I am hopeful that that means that if there are further matters identified through this inquiry process, that we will have a live legislation review for them to feed into as well. So again, for those who have their needs and hopes for change linked to this inquiry, there is a vehicle there for your findings to be fed into another process of legislative change later this year.*
>
> ***CHAIR*** [Ms Haddad] *- …Will members of the public be able to provide input into that review of the Poisons Act? Or will it be more of a targeted consultation with practitioners?*
>
> ***Mr JAENSCH*** *- I would expect we would be receiving advice and input from wherever we can get it…*
>
> ***Mr WEBSTER*** *- …we have actually been underway for some months now doing that background research, comparing to interstate legislation, all those sorts of steps that we take in that process. But there are two public consults that will happen. One is generally about comments, but secondly, the legislation will be released for a period of time so that people can have a look at it.*[173]

5.21 Ms Ellen MacDonald of Health Consumers Tasmania noted the importance of including consumers' perspectives in the review of the Act:

> ***Ms MacDONALD*** *- …I think there's the review of the Poisons Act this year. I think that having consumer voices in there will be essential because we can listen to people, we can consult, and come away with what we think the solutions are. Sometimes they're quite different from what we've sort of assumed and, even if we have a fair idea, having consumers involved at every point means that it's collaborative and that it's going to hit the mark. Because, sometimes it's quite easy to get stuck in very clinical places, which don't recognise, I guess, that the*

[172] Mr. Dale Webster, Acting Secretary, Department of Health, Transcript of Evidence, 18 October 2024, p. 33.

[173] Hon. Roger Jaensch MP, former Minister for Mental Health and Wellbeing, and Mr. Dale Webster, Secretary, Department of Health, Transcript of Evidence, 11 April 2025, pp. 2-3.

consumer perspective might be quite different and doing that together means that you have both perspectives working together to get the best outcome.[174]

5.22 As a part of the proposed recommendations for the Inquiry from Royal Australian and New Zealand College of Psychiatrists (RANZCP), psychiatrist, Dr Honor Pennington shared the organisation's position was to 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 in the review of the Act".[175]

5.23 In her letter to the Committee dated 26 November 2025, the current Minister for Health, Mental Health and Wellbeing, Hon. Bridget *Archer* MP, provided an update on the review of the Poisons Act legislative framework:

> *In line with our commitment, we introduced the Poisons Amendment (Interstate Prescriptions) Bill 2025 to Parliament within the first 100 days of Government. I am pleased that this has now passed both Houses (subject to the third reading in the Legislative Council). This legislative reform will enable Tasmanian pharmacists to dispense prescriptions written interstate for medicines, including the psychostimulants commonly used to treat ADHD, increasing access to these medicines.*
>
> *I am advised the Department of Health has also commenced a comprehensive review and rewrite of the* Poisons Act 1971 *and Regulations. The overarching intention of this review is to modernise, streamline and simplify the regulation of medicines and poisons, resulting in an overall reduction of red tape and administrative burden, while ensuring safe access by maintaining appropriate controls where necessary. This full review will provide a timely opportunity to consider any legislative and regulatory recommendations made by the Inquiry in relation to the Poisons Act. Extensive public consultation will be undertaken during 2026 to inform the review.*[176]

Findings

The Committee finds:

69. Commonly prescribed ADHD medications are Schedule 8 psychostimulants. The *Poisons Act 1971* (Tas) strictly govern and restrict access to them.

70. In 2025, the Tasmanian Parliament passed legislation allowing Tasmanian pharmacists to dispense prescriptions issued by interstate practitioners.

---

[174] Ms. Ellen MacDonald, Chief Executive Officer, Health Consumers Tasmania, Transcript of Evidence, 21 February 2025, p. 8.

[175] Dr. Honor Pennington, Psychiatrist, Royal Australian and New Zealand College of Psychiatrists, Transcript of Evidence, 8 November 2024, p. 64.

[176] Letter from Hon. Bridget Archer MP, Minister for Health, Mental Health and Wellbeing, dated 26 November 2025, pp. 1-2. The Committee notes that *Poisons Amendment (Interstate Prescriptions) Bill 2025* gained Royal Assent on 23 December 2025.

71. In 2022, the Department of Health made administrative changes that allowed general practitioners to seek authorisation to prescribe Schedule 8 medications under section 59E of the *Poisons Act 1971* (Tas). However, the Act still has a limit of one prescribing authorisation per patient, which is a barrier to access.

72. A review of Tasmania's Poisons Act legislative framework is currently underway, with an aim to modernise, streamline, and simplify the regulation of medications, including Schedule 8 medications.

Pharmaceutical Services Branch

5.24 As stated in the Tasmanian Government's submission, the Pharmaceutical Services Branch (PSB) is responsible for administering the Act and subordinate legislation. This includes administering Section 59E of the Act. The Government's submission provided evidence on the work of the PSB:

> *PSB applies an evidence-informed and risk-based approach to the assessment of s59E applications consistent with the Australian Commission on Safety and Quality in Health Care's Quality Use of Medicines principles, current profession-endorsed clinical guidelines, and scientific literature on the benefits and harms of Schedule 8 medicines.*
>
> *DoH policies, processes, procedures and approaches to authorising prescribers to prescribe Schedule 8 medicines have also been informed by other key sources, including:*
>
> • *Tasmanian Coroner recommendations.*
> • *The National Alcohol and Drug Research Centre's 'A Review of Opioid Prescribing in Tasmania; a Blueprint for the Future' conducted in 2012.*
> • *The Ombudsman's 'Investigation into the administration of s59E of the* Poisons Act 1971 *by the Pharmaceutical Services Branch of the Department of Health and Human Services' conducted in 2013.*
>
> *The Ombudsman acknowledged that PSB operate in a difficult environment in administering s59E and found there are no serious shortcomings in the way that s59E is administered by PSB. The Ombudsman also congratulated PSB for the introduction of DORA, Australia's first real-time prescription monitoring (RTPM), an innovation which pioneered the introduction of RTPM across the country.*[177]

5.25 The Government's submission expanded on the process of assessing Section 59E applications:

> *Section s59E* [sic] *applications are assessed by a pharmacist as delegate of the DoH Secretary, who undertakes an initial risk-benefit assessment based on available objective information (including available clinical, criminal and real-time*

[177] Submission No. 60, Tasmanian Government, p. 19.

prescription monitoring system records) and considers the requested medicine regimen alongside current published evidence-based clinical guidelines. Further information may be requested from an applicant where there is insufficient detail, or where other information could inform the assessment (for example, pathology results or medical specialist reports) consistent with evidence-based and clinically informed precautions regarding the use of Schedule 8 medicines.

In most cases, it is expected s59E applications for Schedule 8 psychostimulants will be consistent with maximum doses and within patient age parameters described in the TGA-approved Product Information and profession endorsed clinical guidelines. Applications for regimens outside the TGA-approved Product Information should be accompanied by a detailed clinical rationale.

The s59E application assessment process includes consideration of Risk Evaluation and Mitigation Strategies to identify patients at increased risk of preventable harm, minimise preventable harms from illicit diversion of Schedule 8 psychostimulants into the community, and ensure children receiving these medicines are supported (for example, where there may be risks in respect of safekeeping of medicines).

For applications where complex documented clinical issues are involved that are likely to increase the risk of harm to the patient or public from a Schedule 8 medicine, a delegate may seek advice from a Consultant Medical Officer (CMO) or a panel of two or more relevant specialist medical practitioners. This may occur in situations where, for example, there is an application for a regimen outside TGA-approved Product Information, a significant and recent history of unsafe or illicit substance use, or where the individual has demonstrated an inability to safely manage such medicines.[178]

5.26 At the 18 October 2024 public hearing, the then Acting Secretary of the Department of Health provided further evidence on the delegated authority of administering Section 59E:

> ***Mr WEBSTER*** *- … Under the Tasmanian Poisons Act there is a number of regions that the secretary of the department is given authority to actually make decisions. Given that I'm not a clinician, I have delegated all of those powers to a position in our Pharmaceutical Services Branch and the role is called the chief pharmacist. The chief pharmacist has developed, adopted those guidelines, but then said okay in respect of 59E applications, the majority go through fairly quickly; he says to me 99 per cent - don't accept that it's exactly 99 per cent - but a vast majority go through very quickly because the risk is assessed as low. Where it is a high risk there are a number of steps PSB staff will go through to gather the evidence before they issue the authority and that's a very small number.*
>
> *As you appreciate, 59E is also around opioids and things like that, not just psychostimulants. Having said that, under our current regime, for instance,*

[178] Submission No. 60, Tasmanian Government, p. 20.

psychostimulants are treated the same as opioids in respect of interstate prescriptions. As the minister said, we're already moving to say we believe psychostimulants are different from opioids in that respect and we can actually have a different regime.

…

A provision like 59E treats all Schedule 8s as one category, when clearly they need to be split out, and is it part of it? One of the issues of changing 59E quickly is the unintended consequences. At the moment it is a catchall section for all Schedule 8s. We don't want to have to go through a situation where we actually open it up for opioids when we see the evidence there that we need tighter controls. At the moment we're not seeing the same evidence for psychostimulants. We are moving forward with some changes, but we will do a full review of the Act, because it's old, it's out of date, and it doesn't reflect contemporary practice.[179]

5.27 Mr Webster then discussed the process of balancing the risks associated with Schedule 8 medications with the benefit of patients receiving adequate treatment:

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

***Mr WEBSTER** - …when we look at heightened risk, we don't just have one member of PSB or the chief pharmacist making the decision. So, on the level one or the straightforward ones, then it basically is somewhere within PSB, when we get to a heightened level of risk and that may be past behaviours around other Schedule 8s. Then we would consult a medical officer and a senior medical officer consultant to have input to the decision making.*

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

[179] Mr. Dale Webster, Acting Secretary, Department of Health, Transcript of Evidence, 18 October 2024, p. 25.

CHAIR [Ms White] - *Are those decisions reviewable once they are made?*

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

...

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

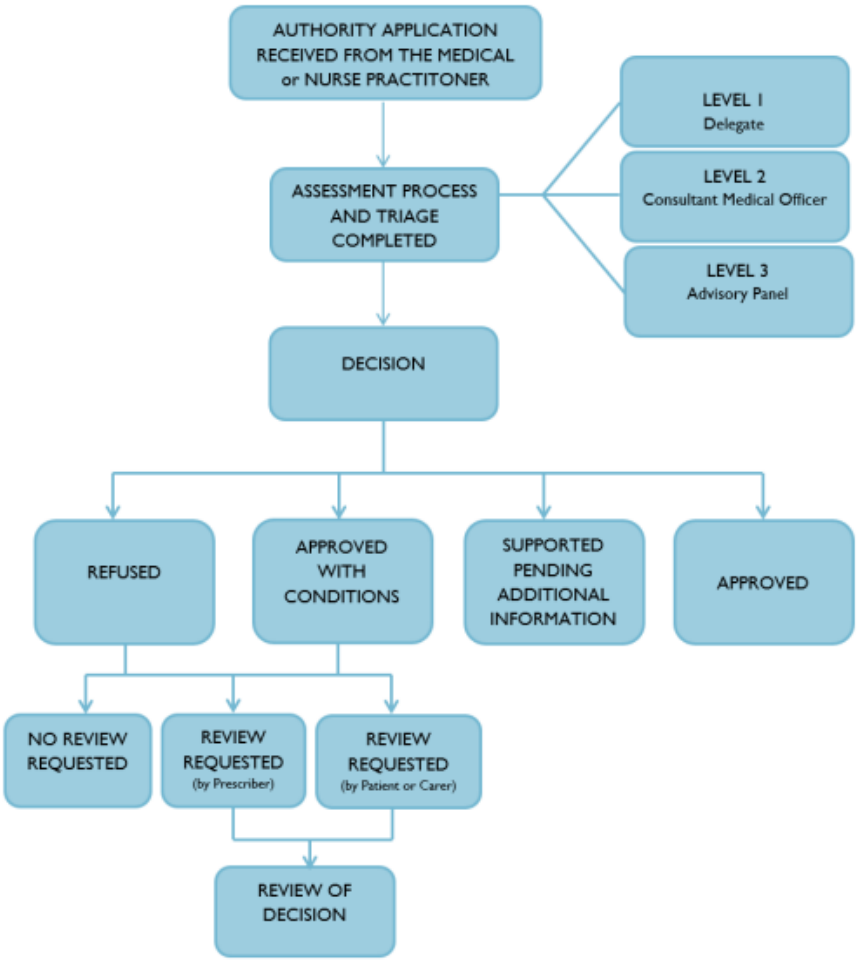
I should emphasise the panel - and I talked about the panel - they involve adult psychiatrists. If it's a child, they involve both paediatricians and psychiatrists. So, it's clinicians from pharmacists through to specialists that come into that panel that inform the assessment of risk and therefore the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

The other thing is that we try to have the risk-benefit sort of analysis but also try to go to a normalised circumstance. So, it's not a case of putting in the restriction and that's there forever. It's about how we can move this person through from daily, to twice weekly, to long-term sort of circumstances, all of that informed by clinicians.[180]

5.28 The Tasmanian Government included a flow chart of the assessment process section 59E of the Poisons Act at Table 1 of its submission:[181]

[180] Mr. Dale Webster, Acting Secretary, Department of Health, Transcript of Evidence, 18 October 2024, pp. 26-27.
[181] Submission No. 60, Tasmanian Government, p. 25.

Table 1: Flow chart of s59E assessment process



5.29 Mr Webster further discussed the review process involved in the risk-benefit assessment:

> ***Ms ROSOL*** *- …In relation to the reviews that happen, how are the reviews conducted? How independent are they from the initial people who would have made the decision, whether it was a panel or any individual making the decision?*
>
> ***Mr WEBSTER*** *- In the first instance, it may be a quick review by the chief psychiatrist or a senior person within PSB so that it doesn't slow down the process of going through to make sure there are no basic errors and things like that. Secondly, if it was a decision made by using only a consultant, then it may be one that then gets referred off to a panel and of course the panel is different.*

In the instance where it is a panel, then it is reviewed by a separate group to make sure that it is there. Ultimately under the Act, I guess that the referral is up to the secretary, but I want to assure people I don't get involved at all in these reviews.[182]

5.30 The Committee heard of the consultation undertaken as part of the assessment:

> ***Ms HADDAD*** *- …when someone is identified as high risk when assessing a prescription and you put together those panels, do they consult with that patient's own clinical team, their own psychologist, psychiatrist or GP when making those decisions? …*
>
> ***Mr WEBSTER*** *- The initial contact is usually from a GP. Usually at the point of prescribing there is actually a specialist who has created a treatment plan. That informs part of the risk assessment. It's important that, if you like, the prescription of the drug is always seen as part of a treatment plan rather than a visit to the GP, here's an antibiotic. It's a visit to a specialist. A specialist then develops a treatment plan, which is then shared with the GP. The GP then usually becomes the prescribing doctor beyond that original visit with the specialist. That's an important part of the panel.*
>
> ***Ms HADDAD*** *- Are they involved in the PSB's work? The treatment plan comes to the PSB?*
>
> ***Mr WEBSTER*** *- Yes. The plan comes to the PSB. It helps them with their risk assessment to say which level is this at. Then the team tells me the applying prescriber who is responsible for coordinating care. I think that's a quick way of saying if it's a psych who prescribes, then it's the psych. If it's the GP, the GP.*
>
> ***Ms HADDAD*** *- They do get consulted?*
>
> ***Mr WEBSTER*** *- That's what I'm seeing from Sam* [Samuel Halliday, Chief Pharmacist] *on the feed.*[183]

5.31 Mr Webster also provided evidence on the information used to inform the PSB's decision-making:

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

[182] Mr. Dale Webster, Acting Secretary, Department of Health, Transcript of Evidence, 18 October 2024, pp. 29-30.

[183] Mr. Dale Webster, Acting Secretary, Department of Health, Transcript of Evidence, 18 October 2024, p. 28.

consent for their medical records to be accessed in that way by people who are not their treating clinicians.

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

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

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

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

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

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

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

We are discovering quite regularly is that we need to better inform GPs of the pathway; that's part of the issue. There is a lack of knowledge of how you actually get through this pathway. You have specialists referring to the GP with a treatment plan and then the GP not being exactly sure what their role is within that. We have started work with Primary Health Tasmania (PHT) to better inform, generally, GPs on what the pathway is within Tasmania.[184]

[184] Mr. Dale Webster, Acting Secretary, Department of Health, Transcript of Evidence, 18 October 2024, pp. 28-29.

5.32 At the 11 April 2025 public hearing, Mr Samuel Halliday, Chief Pharmacist for the PSB, provided the Committee with evidence regarding the information accessed by the PSB when assessing child applications:

> ***Mr HALLIDAY*** *- … usually what would happen with child applications is that there's an application form completed by the prescriber, and that application form currently includes fields for providing either parent or carer details. Part of the Good Medical Practice: Code of Conduct for Doctors in Australia includes… this discussion between the treating physician and the family, in the case of a child patient, to talk about how information is going to be shared with the department. In the case of most prescribers, we understand that they talk about the safe custodianship of these medicines in the home, but we are aware there are circumstances where those conversations may not be happening.*
>
> *So, the application would come in with the details of parents and carers on there. Our pharmacists assess the patient scenario, which in the case of most children is reasonably straightforward, and then for the parents, most of the information that we would refer to is the records that we hold within the real-time prescription monitoring database that we administer the authorities from. That includes information such as declarations of drug seeking, notifications of drug seeking, past authorities for treatment for parents around certain Schedule 8 medicines, so that could be Schedule 8 opioids, stimulants, cannabis, benzodiazepines, and a small number of other types of Schedule 8s. Within that database, that is most of the information that we hold and would refer to in terms of saying, 'Okay, are there any custodianship issues here that mean that the child might not be getting their medicine?' That is, fundamentally, the focus of that check.*
>
> ***CHAIR*** [Ms Haddad] *- And that is based on information that's already held by the Department or the Tasmanian Health Service?*
>
> ***Mr HALLIDAY*** *- Correct, yes.*
>
> ***CHAIR*** *- Do you have a need to seek information from other departments like from police or courts or anything like that?*
>
> ***Mr HALLIDAY*** *- No. In the past we have, where there has been published information about events happening - that information may or may not have been held in our previous database, for example, if a person was convicted. We don't go out of our way to go, 'Dear police, are there any concerns here?' because the focus of the application is about a patient getting clinical care and access to a medicine and treatment overall for their condition and that is the same for any other patient, not just children as well.*[185]

[185] Mr. Samuel Halliday, Chief Pharmacist, Pharmaceutical Services Branch, Department of Health, Transcript of Evidence, 11 April 2025, pp. 4-5.

5.33 Mr Halliday also provided the Committee with evidence on the risk assessment criteria for Section 59E applications:

> ***Ms ROSOL*** *- …I have a question about the risk assessment criteria that you use when you're making decisions…I'd be interested in looking at what the criteria are and seeing that…how often is that criteria reviewed? When was it most recently reviewed? Is there a regular review process of the assessment criteria?*
>
> ***Mr HALLIDAY*** *- Good question. Fundamentally, it's looking for, on an application or in the recent history provided, around risk factors in the Diagnostic and Statistical Manual around certain substance-use disorders or certain types of behaviours; they're sort of categorised in there. In terms of adjusting or considering the particular thresholds, if you like, there isn't anything like that in the risk assessment. It's clinically informed.*
>
> *Our medical specialists that we seek advice from, in the case of ADHD medicines, are psychiatrists, child and adolescent psychiatrists, paediatricians, and addiction medicine specialists. We take the case, the pharmacist will prepare on the concerns that are visibly evident from the application, and here's what the requested regimen is from the prescriber, and these are questions for you about if is this okay to be provided for three to six months, no conditions or are there concerns here that you think need to be clinically managed?*
>
> ***Ms ROSOL*** *- Would you say there's an element of subjectivity to it?…*
>
> ***Mr HALLIDAY*** *- I think it is experience-based, regarding their clinical experience for sure. I suppose…the small number of cases - and most applications that we receive will be done within a day or two, it's not a three-week process - but, for this smaller cohort of patients, they do take longer because in a lot of cases we will have information in our system about previous authorities that the prescriber who's applying might not have any idea about.*[186]

5.34 Mr Halliday also explained the review process for the criteria used to inform the PSB's assessments:

> ***Ms ROSOL -*** *What I'm hearing from my original question is that there is no protocol for regular review, or there's no kind of time frame for regular review of the criteria. There's flexibility within the criteria based on clinical expertise.*
>
> ***Mr HALLIDAY*** *- Yes, they keep up with emerging clinical practice standards, clinical guidelines, for example. I think there's also been evidence provided by Australasian ADHD Professionals Association (AADPA) around the release of their prescribing guidelines and a prescribing manual.*

[186] Mr. Samuel Halliday, Chief Pharmacist, Pharmaceutical Services Branch, Department of Health, Transcript of Evidence, 11 April 2025, p. 11.

Ms ROSOL *- That's informally incorporated through individual clinicians keeping up with the research and the guidelines that are coming out?*

Mr HALLIDAY *- Yes, correct. Yes, it's absolutely - like any other area of medicine, I suppose, when new evidence becomes available it either gets incorporated into best practice guidance or clinical guidelines. Sonny* [Atherton…] *could probably talk better to this than I can. Or if there's large-scale evidence that gets published that hasn't yet been incorporated into studies, they'd be considering those sorts of things as well.*

Ms ROSOL *- Do you think there's room for a review of the criteria now, or are you happy with the way it's working and the use of current evidence in decision-making?*

Mr HALLIDAY *- I think what we are getting is absolutely as best as we can get, in terms of the clinical advice. I have great confidence in the clinicians that we have. It's sort of a rotating pool of clinicians. I suppose the AADPA guidelines or prescribing manual is great because that's provided something quite detailed around what previously didn't exist. For general practitioners who have been prescribing these medicines, they haven't had very much to turn to in terms of clinical guidance and things there. So, yes, that helps.*[187]

5.35 The Committee heard from Ms Michelle Paine, representing Advanced Pharmacy Australia (AdPha), on the PSB's approach to balancing the risk and benefit of Schedule 8 medications used to treat ADHD:

CHAIR [Mr Behrakis] *- On reducing the risk of diversion… quite a few submissions,… have commented on… 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 … 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 *- 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*

[187] Mr. Samuel Halliday, Chief Pharmacist, Pharmaceutical Services Branch, Department of Health, Transcript of Evidence, 11 April 2025, p. 12.

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.[188]

5.36 At the 8 November 2024 public hearing, Dr Jackie Hallam and Mr Daniel Vautin, representing the Alcohol Tobacco and Other Drugs Council of Tasmania, discussed the risks associated with Schedule 8 medications:

> ***CHAIR*** [Mr Behrakis] - *…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;* [and] *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…*
>
> ***Mr VAUTIN*** *- The Matilda - these guidelines are developed by the Matilda Centre funded by the* [Commonwealth] *Department of Health. These are regularly updated. AOD* [Alcohol and Other Drugs] *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…*
>
> *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*

[188] Ms. Michelle Paine, Member of the Paediatrics and Neonatology Specialty Practice Group, Advanced Pharmacy Australia, Transcript of Evidence, 8 November 2024, pp. 27-28.

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.[189]

5.37 Evidence was received by the Committee on conditions imposed on some Section 59E applications. The Tasmanian Government's submission outlined the potential conditions that can be applied:

> *The DoH Secretary can include conditions on a s59E authority under which the authorised Schedule 8 medicines may be made available.*
>
> *These measures reflect relevant medical specialist advice and recommendations, and evidence-informed 'universal precautions' recommended by the Australasian Chapter of Addiction Medicine aimed at protecting the public from documented harmful side effects of Schedule 8 medicines both in the short and long term.*
>
> *Conditions may include clinical monitoring or provision of further relevant information either during the period of the authority or to be provided with any subsequent application to prescribe. This can include the provision of a report from a relevant medical specialist involved in the care of a patient and/or the requirement for pathology testing for the period of the authority.*
>
> *…*
>
> *Staged supply conditions are included on s59E authorities where objective, documented evidence exists that a patient has demonstrated an inability to manage larger quantities of these medicines or has increased risk of harm from possession of Schedule 8 medicines (for example, where a patient presents frequently to prescribers and pharmacists seeking early supplies or extra medicine supplies or presents concurrently to multiple medical practices seeking these medicines).*
>
> *Prescribers may themselves choose to implement staged supply conditions independent of a s59E authority condition.*[190]

5.38 Chief Pharmacist, Mr Halliday, provided further evidence on these conditions at the 11 April 2025 public hearing:

---

[189] Dr. Jackie Hallam, Chief Executive Officer, and Mr. Daniel Vautin, Director Policy and Impact, Alcohol Tobacco and Other Drugs Council Tasmania, Transcript of Evidence, 8 November 2024, pp. 44-45.
[190] Submission No. 60, Tasmanian Government, p. 26.

> **Mr *HALLIDAY*** *- …There are clinically informed decisions. So our pharmacist delegates don't unilaterally make a decision in circumstances where that information becomes available, we will refer to a specialist medical practitioner to assess the risks and benefits because that's very much the focus of it, is to sort of look at this is saying there might have been a risk factor that was quite apparent in the past, but the benefit of treatment based on the psychiatric review or the circumstances that are happening now outweighs that. When that risk benefit profile starts to become a little bit more close, that's where the clinical expertise is really relied upon in terms of saying, 'Okay, this person needs to have access', they've been diagnosed, but this certain staged supply condition, for example of weekly collection, allows for a pharmacist to say 'g'day' to the patient a little bit more frequently just to check that things are going okay.*
>
> *The authorities that are issued can vary in time frame and usually in cases where there are staged supply conditions, they may be a bit shorter than, for example, for kids, they're usually issued until the age of 18. And then for adults where there aren't any of those past or current substance use issues, they'll probably be issued for 36 months, so three years.*
>
> *…*
>
> *…in the cases where there are some clinical risk factors, they're mostly issued a bit shorter so that there is a point in time when the next application can say, look, we've had a demonstrated period of great stability here. The medicine is working, their behaviours are actually, as you pointed to, improved and this might be a time to have a look at that to say, 'Do we relax the restriction?' That's generally how the trajectory works in those cases where the substance use disorder that might have happened in some of these cases isn't persisting and there're still risky behaviours that are in play. That's sort of the picture about how that happens.*[191]

5.39 Mr Halliday also addressed the requirement for patients to keep repeat prescriptions at the same pharmacy:

> ***CHAIR*** [Ms Haddad]- *We have heard that from people who are on a regular pick-up at the same chemist every 28 days who are well-treated… But if they're away travelling, they can't get to that pharmacist on that day, then they do have a lag and a period of time where they're unmedicated…*
>
> ***Mr HALLIDAY*** *- There's a more general control around Schedule 8 medicines and a subclass of prescription Schedule 4 medicines, in terms of intervals for repeats that exists in our legislation in Tasmania and in the other jurisdictions. The intention there is oversight with those medicines. That's a degree above what would be, for example, a normal blood pressure medicine.*[192]

[191] Mr. Samuel Halliday, Chief Pharmacist, Pharmaceutical Services Branch, Department of Health, Transcript of Evidence, 11 April 2025, pp. 6-7.
[192] Mr. Samuel Halliday, Chief Pharmacist, Pharmaceutical Services Branch, Department of Health, Transcript of Evidence, 11 April 2025, p. 8.

5.40 The then Minister for Mental Health and Wellbeing, Hon. Roger *Jaensch* MP, and the Secretary of the Department of Health, Mr Webster, also gave evidence on the application of conditions:

> ***Mr WEBSTER*** *- … it's an assessment of risk. So for someone where the risk factors are incredibly low and the benefits are high, there aren't these steps. We're describing a very small number that actually have conditions applied to them, but it is this assessment of risk. These are Schedule 8 drugs; worldwide, these are seen as the drugs that could do the most harm to an individual and most harm to society if they were freely released into society. We have to consider that risk.*
>
> *…*
>
> ***Mr JAENSCH*** *- I think one of the scenarios that also needs to be in our mind is that sometimes we'll have a situation arise where, because we didn't get this right, we end up with two victims and possibly more, someone who's not getting their medication, someone else who is getting that medication on top of a range of other things in a very complex cocktail, and possibly because of either or both of those, behaviours manifesting in the community that do other people harm as well. It can be a very complex web of interactions that we're trying to guard against that trace back to the provision of a substance that can do great good, but also harm in the wrong circumstances. I know that you understand that; it's just one of the things that there is a liability associated with administering these chemicals.*[193]

5.41 In response to a question on notice, then Minister *Jaensch* provided the Committee with data on Section 59E applications for Schedule 8 psychostimulants, broken down by decision outcome, in number and percentage, from 14 May 2024 to 14 November 2024:[194]

Decision outcome	***Count***	***Percentage***
Approved without staged supply conditions	*5909*	*91.87%*
Approved with staged supply conditions	*500*	*7.77%*
Supported pending additional information	*0*	*0.00%*
Total approved	***6409***	***99.64%***
Refused due to clinical safety concerns	*23*	*0.36%*
Total applications	***6432***	***100.0%***

[193] Hon. Roger Jaensch MP, former Minster for Mental Health and Wellbeing, and Mr. Dale Webster, Secretary, Department of Health, Transcript of Evidence, 11 April 2025, p.10.

[194] Additional information in response to Questions on Notice, Hon. Roger Jaensch MP, former Minister for Mental Health and Wellbeing, dated 22 November 2024, p. 1.

5.42 The Committee received evidence from individuals with lived experience, as well as professional and advocacy organisations, on the conditions imposed on Schedule 8 medications.

5.43 Ms Gracie Patten cited that it took more than four weeks to get her first ADHD prescription.[195] One Tasmanian required five approvals for changes to their medication to identify the correct dosage, each taking between three to eight weeks.[196]

5.44 Mr Matthew McDonagh reflected on how the wait time impacted him:

> *…I had been waiting for months after receiving an ADHD diagnosis to receive approval from Pharmaceutical Services Branch to access stimulant medication as had been recommended by my treating Psychiatrist*
>
> *The anxiety and depression were overwhelming. I couldn't see a positive future and felt that the challenges were insurmountable.*[197]

5.45 Another Tasmanian, who wished to remain anonymous, described their experience:

> *…Its* [sic] *taken since April 2023 to work my way through medication changes outlined. Each change requires a new approval by Pharmacy* [sic] *Services Branch despite being on my care plan that has been developed and authorised by my Psychiatrist (who is a member of AADPA). I'd love to try the other drug family – dexamphetamine to see if the* [sic] *work better for my brain but I cant* [sic] *bring myself to go through the approvals process again. I'd also like to try nonstimulant medication. But if they don't work as well I have to go through. the approvals process again to get back onto stimulant treatment, so I feel a little trapped and reluctant to change medications. I am also concerned that if I change medications too frequently I'll get a bad reputation with PSB Tasmania and they will impose a restriction on my supply like weekly or daily pick up...*[198]

5.46 The Tasmanian ADHD Support Group reflected on the experience of one of their members:

> *…It took seven months to get this approval finalised, and then he was restricted to accessing only two or three tablets at a time, having to attend the pharmacy three times a week, for a year...*[199]

5.47 In his submission, Mr Richard Hill discussed the challenges of this inflexibility, including missing medication doses:

---

[195] Submission No. 34, Gracie Patten, p. 2.
[196] Submission No. 17, Private Witness, p. 3.
[197] Submission No. 9, Matthew McDonagh, p. 1.
[198] Submission No. 17, Private Witness, p. 3.
[199] Submission No. 21, Tasmanian ADHD Support Group, pp. 1-2.

The first problem I have is with inflexibility in the timing that I can pick up my medication. There is a date on my medication box stating the earliest date that I can pick up my next repeat. The problem I have is that as an exploration geologist, I am often away for extended periods of time on a quite variable work roster. A scenario that has happened to me is that I was about to head off to work for two weeks and knew that I would not be able to get to a pharmacy during that time (due to constraints around my work hours and distance from a pharmacy). I'd known that I would run out of my script after one week at work, however my pharmacy could not provide me with my script 7 days early due to Tasmanian rules. I therefore ran out of my script while at work and had to go without for half of that time. I work in a high pressure environment with a lot of responsibility, part of which relates to the safety of myself and others. Due to the lack of medication I know I did not perform at my peak.

…

This is a more extreme example of what I have experienced. Every 2-3 months I am faced with a similar scenario where the date I am able to pick up my script is a few days before the end of my rostered swing. My workaround for this scenario is to not take my medication sometimes on my days off work and always try and pick up my medication at the earliest opportunity. This means I can build up a buffer (i.e., horde a small amount of medication) so that I have some spare for this sort of scenario.[200]

5.48 Ms Ellen MacDonald described her experience with the strict pick-up requirements for ADHD medication:

***Ms MacDONALD** - …I also think that the very restrictive way in which you can get the medication dispensed is really problematic. Particularly if you have a patient - there's so many different circumstances that we could use as an example, but yes, the daily prescribing, there's all sorts of problems, but even in the regular schedule, like for myself, going every 29 days, I'm not always there, and my prescription has to stay with the same pharmacy. To be able to actually be in Launceston at that pharmacy –*

CHAIR [Ms Haddad] *- You're in a busy job, too, that requires travel, like a lot of people would be…*

***Ms MacDONALD** - …Even if there was flexibility around not picking up too many prescriptions in your time period, you have your scripts for six months, but to be able to go five days before… you have to try to talk to the same pharmacist. There's a lot of nervousness even in that space, when you say, I need to come two days earlier because I'll be somewhere else.*[201]

[200] Submission No. 45, Richard Hill, pp. 1-2.

[201] Ms. Ellen MacDonald, Chief Executive Officer, Health Consumers Tasmania, Transcript of Evidence, 21 February 2025, pp. 6-7.

5.49 At the 18 October 2024 public hearing, representatives of ADHD Australia gave evidence on the conditions imposed on Section 59E applications:

> ***Mr BEHRAKIS*** *- On the access to medication, we've heard from a few people that Tasmania's prescribing regulations and system is quite onerous or restrictive. We did hear that whilst the majority of prescriptions are authorised by the Pharmaceutical Services Board, there are many cases where they're authorised but with sometimes onerous restrictions: people having to get no more than a week's allowance of medication, or sometimes even having to take the medication on a daily basis in front of the pharmacist.*
>
> *What impact does that have on people, acknowledging the need to mitigate the risk that does exist with psychostimulant medication but also trying to get the benefit out of them and reducing the risks of other factors? Are there better ways to manage those risks rather than putting patients under conditions like that?*
>
> ***Ms ENDACOTT*** *- I could give you an example that has happened recently of an individual… They were going on holiday for a couple of weeks and were only able to get medication which would be prescribed for a week. That individual didn't know how to source a medication because they were going out of the country and their prescribing doctor wouldn't prescribe them with medication and didn't know what to do.*
>
> *That individual was very concerned with and* [we] *obviously recommended various different people they could talk to, to try to get additional supports to put forward their case around why they needed their regular medication. What it actually led to is this particular individual felt they had no other alternative but to actually halve their medication so that it lasted them the whole time of their holiday…*
>
> *After advocating for them for a significant period of time that support was put in place but it was a huge amount of work through coming to us to seek that support and knowing where to go and directing them to actually get that medication. The outcome of that actually means that people are making poor decisions or decisions that could have significant impact on their health because they're feeling that there is no other option and that's just one example that's recently somebody had come to us to seek some advice on.*
>
> *So I think in terms of the activities that people do, if they actually can't receive the medication in the way that they need, it places them at risk in some occasions. Also as well, if somebody can't get an appointment immediately with their prescribing doctor that could mean that there's delays in them taking their medication and obviously that has adverse effects on individuals.*
>
> *We hear of cases where people can't get in with their prescribing doctor in the time frame that they need to, therefore the impact of that means that they are missed by a couple of days.*

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

***Mr TICE** - …these issues that Simon* [Behrakis] *is bringing up are particularly acute for the less advantaged members of our communities. I think that we have to be really wary and understand that not everyone experiences these challenges the same way. Our Aboriginal and Torres Strait Islander communities, remote, rural, lower socioeconomic parts of our community, I think there is a big gap in terms of how our constituents understand this problem and experience it. Certainly, we need to put more resources into this part of the ADHD community.*[202]

5.50 At the 8 November 2024 public hearing, representatives from the Alcohol and Other Drugs Council Tasmania gave evidence on experiences of individuals accessing ADHD medications:

***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?*

…

***Mr VAUTIN** - It was the PSB.*

…

…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

[202] Mr. Matthew Tice, Chair, and Ms. Jane Endacott, Vice Chair, ADHD Australia, Transcript of Evidence, 18 October 2024, pp. 59-60.

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.[203]

5.51 Dr Hallam and Mr Vautin provided further evidence on the balance of risk and benefit in decision-making:

> ***Mr VAUTIN** - …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.*
>
> *…*
>
> ***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?*[204]

5.52 At the same public hearing, retired GP, Dr Clare Smith, provided the Committee with an example of conditions imposed on a child's prescription, and the impact on the child's parents:

> ***Dr SMITH** - I'm sure you've had plenty of stories like this. For example, a child in shared care… 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*

[203] Dr. Jackie Hallam, Chief Executive Officer, and Mr. Daniel Vautin, Director Policy and Impact, Alcohol Tobacco and Other Drugs Council Tasmania, Transcript of Evidence, 8 November 2024, pp. 40-41.
[204] Dr. Jackie Hallam, Chief Executive Officer, and Mr. Daniel Vautin, Director Policy and Impact, Alcohol Tobacco and Other Drugs Council Tasmania, Transcript of Evidence, 8 November 2024, pp. 47-48.

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 … 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 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 [is] *just a huge impost.*[205]

5.53 Dr Smith also raised concern over the PSB making adverse assumptions about patients who temporarily pause their medication, for example on weekends, as recommended by their treating practitioners:

> ***Ms JOHNSTON** - …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** - …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*

[205] Dr. Clare Smith, retired General Practitioner, Australian Medical Association Tasmania Branch, Transcript of Evidence, 8 November 2024, p. 60.

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.[206]

5.54 The Committee heard evidence from witnesses regarding the transparency of decision-making between the PSB, patients, and prescribers. At the 18 October 2024 public hearing, Dr Timothy Jones provided evidence on his experience with the PSB as a GP:

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

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

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

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

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

***Dr JONES** - I personally haven't had to go through it… Colleagues who have say that they have received calls from the clinical component of PSB, the pharmacist and the doctors assigned to that service seeking clarification, offering options,*

[206] Dr. Clare Smith, retired General Practitioner, Australian Medical Association Tasmania Branch, Transcript of Evidence, 8 November 2024, p. 60.

but that the hearing about the review is generally conducted behind closed doors and the decision is reached without necessarily the ability to provide a lot more representation to those situations.

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

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

CHAIR [Ms White] *- Do you think that process could be improved?*

***Dr JONES** - Yes, I think that there is an opportunity for closer collaboration. One of the reasons the first point in our submission to the committee is multidisciplinary care being so critical is that there is a siloification of healthcare about ADHD. As much as there are many interested people trying to contribute in a positive way, we don't talk, we don't have easy lines of communication and that includes to the regulatory body as well. We don't have a lot of liaison into that place.*[207]

5.55 Psychiatrists, Dr Pennington and Dr Anil Reddy, provided the Committee with evidence on their experience as prescribers:

***Dr PENNINGTON** - …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.*

…

***Dr REDDY** - …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

[207] Dr. Timothy Jones, General Practitioner, Royal Australian College of General Practitioners, Transcript of Evidence, 18 October 2024, p. 47.

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… 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 is a bit of paperwork and a bit of time restrictions, which may delay the process...

…

***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… 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.*[208]

5.56 At the 8 November 2024 public hearing, Dr Theresa Naidoo reflected on her experience as a paediatrician:

***Ms ROSOL** - … 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?...*

[208] Dr. Honor Pennington, Psychiatrist, and Dr. Anil Reddy, Psychiatrist, Royal Australian and New Zealand College of Psychiatrists, Transcript of Evidence, 8 November 2024, pp. 67-68.

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 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.[209]

[209] Dr. Theresa Naidoo, Paediatrician, Royal Australasian College of Physicians, Transcript of Evidence, 8 November 2024, pp. 9-10.

5.57 Mr Vautin provided further evidence on the communication between the PSB, patients, and their care teams, when conditions on their prescriptions are imposed:

> ***Ms HADDAD*** *- … 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… 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* [Alcohol and Other Drugs] *workers from a residential treatment facility… 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.*[210]

5.58 Dr Hallam and Mr Vautin also provided evidence on the information accessible to the PSB:

> ***Ms JOHNSTON*** *- I'm keen to explore 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…*

[210] Mr. Daniel Vautin, Director Policy and Impact, Alcohol Tobacco and Other Drugs Council Tasmania, Transcript of Evidence, 8 November 2024, p. 41.

Mr VAUTIN *- ...It's opaque. It sits behind this curtain...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...*

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 *- ... 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...When does the parent give consent for their medical records to be looked at by PSB for their child's prescription?...*

Dr HALLAM *- ...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...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 –

...

…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.[211]

5.59 At the 11 April 2025 public hearing, Chief Pharmacist, Mr Halliday, gave evidence on the communication between the PSB, patients, and prescribers:

> ***Mr HALLIDAY*** *- …we have a very open dialogue with the prescribers who are applying because that's who we directly - and strictly speaking, that's what the Act regulates. We're very open to receive calls from patients, but we're really limited in terms of how we can actually interact with their cases, regarding confidentiality and things like that. In the case of staged supply conditions, we have a standard operating procedure that if advice is given and the decision is then made by a pharmacist that that would be on the authority with the staged supply condition. We ring the prescriber, we have a verbal conversation with them. If they're not available, we leave a message. We then follow up a week later if we haven't heard back from them, and that type of thing - they're busy people, we totally get it, but that's the sort of thing that we try to do because we understand that, also for the prescriber, these aren't easy conversations to have. We then will provide a written record of that decision to them.*[212]

5.60 The Committee received evidence regarding the regulation of prescribers of ADHD medications in Tasmania, and particularly the restriction of nominating a single prescriber:

> ***CHAIR*** [Ms Haddad] **-** *Can there be dual prescribers?*
>
> ***Mr HALLIDAY*** **-** *Legally, no. Not at the moment.*
>
> ***CHAIR*** **-** *Is that Tasmanian law preventing that or something national?*
>
> ***Mr HALLIDAY*** **-** *Yes, section 59E nominates a prescriber. The idea is that it triangulates. Effectively, there is a person who's looking after that person's care with Schedule 8 medicine or medicines...*
>
> ***Mr BEHRAKIS*** **-** *Why was that changed?*
>
> ***Mr HALLIDAY*** **-** *I'll get there. Section 59E allows, though, for a prescriber in the same medical practice because obviously they're going to have access to the medical records to treat. The framework was built, as I understand it, very much with the GP setting in mind, because you're going to have, maybe in 1971, you might have had a couple of doctors at a particular clinic and one goes away and then they can actually look after the patient.*

[211] Dr. Jackie Hallam, Chief Executive Officer, and Mr. Daniel Vautin, Director Policy and Impact, Alcohol Tobacco and Other Drugs Council Tasmania, Transcript of Evidence, 8 November 2024, pp. 46-47.
[212] Mr. Samuel Halliday, Chief Pharmacist, Pharmaceutical Services Branch, Department of Health, Transcript of Evidence, 11 April 2025, p. 11.

CHAIR - *You've said in the written submission that 83 per cent of prescribers are GPs.*

Mr HALLIDAY - *Yes, correct. The Department actually realised in 2022 that there wasn't a facility legally to enable co-prescribing, and that was communicated quite a lot with the prescribing community to understand that and work through that. I think that would be something of interest down the track in terms of any modernisation of the Poisons Act and to look at other models in other jurisdictions around how that works.*[213]

5.61 Dr Naidoo, representing Royal Australasian College of Physicians (RACP), provided the Committee with her perspective on Tasmania's prescriber framework:

Dr NAIDOO - *… 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…*

…

Ms HADDAD - *… 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*

[213] Mr. Samuel Halliday, Chief Pharmacist, Pharmaceutical Services Branch, Department of Health, Transcript of Evidence, 11 April 2025, p. 25.

their jobs and that's seeing children and making sure that we're considering things in a really holistic way.[214]

5.62 AdPha representatives gave a pharmacy perspective on the implications of the single prescriber rule:

> ***Ms HADDAD -*** *… One of the things that you've touched on is the single prescriber rule…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*** *- The patient is not at the centre.*
>
> *…*
>
> *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.*[215]

5.63 In their evidence, Mr Jerry Yik and Ms Michelle Paine of AdPha stated that allowing more than one prescriber at a time would be more reflective of multidisciplinary healthcare:

---

[214] Dr. Theresa Naidoo, Paediatrician, Royal Australasian College of Physicians, Transcript of Evidence, 8 November 2024, p. 6.

[215] Mr. Jerry Yik, Head of Policy and Advocacy, and Ms. Michelle Paine, Member of the Paediatrics and Neonatology Specialty Practice Group, Advanced Pharmacy Australia, Transcript of Evidence, 8 November 2024, p. 26.

CHAIR [Mr Behrakis] ***-*** *…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?*

…

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…*

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…*

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.*[216]

5.64 Recently retired GP, Dr Smith, explained how the single prescriber model is a barrier to care and peculiar to stimulant medication:

Ms HADDAD - *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…

Dr SMITH - *…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*

[216] Mr. Jerry Yik, Head of Policy and Advocacy, and Ms. Michelle Paine, Member of the Paediatrics and Neonatology Specialty Practice Group, Advanced Pharmacy Australia, Transcript of Evidence, 8 November 2024, pp. 32-33.

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 [an] *incredibly… unnecessarily clunky system –*

***Ms HADDAD** - …does that apply to any other type of medication? Does it apply to opioid medication, to benzos, to any other? Is it 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.*[217]

5.65 The Committee also heard evidence about the role of GPs in the prescribing of ADHD medication. The Chief Pharmacist gave evidence on the role of GPs in the current prescribing framework:

***Mr HALLIDAY - …** The framework that we've got at the moment is a psychiatrist can absolutely provide that diagnosis, after an assessment, to the GP and we authorise the GP to prescribe. Any changes to that can be done by the GP according to the instructions of the psychiatrist.*

For example, if the authority is for Vyvanse 20mg and the dose needs to go up based on the advice of the psychiatrist to 50mg, the GP would then need to re-apply. However, if the GP originally applied at a higher dose, but they were prescribing at a lower dose, that would be okay. Then they'd have the facility. There's nuance in there about how the application will be made and how the psychiatrist determines what a starting dose would be, up to a maximum dose,

[217] Dr. Clare Smith, retired General Practitioner, Australian Medical Association Tasmania Branch, Transcript of Evidence, 8 November 2024, pp. 52-53.

for example. If that's not communicated, then we don't actually have any visibility on 'Right, you want to go up to 70mg potentially at another point in time'…

CHAIR [Ms Haddad] **-** *Can I ask a question on that too?… you might switch to your GP as your sole prescriber for that maintenance phase, but you need to have your checkup with the psychiatrist or paediatrician every two years… Could another solution be that you have your checkup with the psychiatrist, but the GP remains your prescriber and the psychiatrist speaks to the GP about changes?*

Mr HALLIDAY **-** *That is what happens now.*[218]

5.66 General practitioner, Dr Jones, expanded on the greater role his profession could have in treating ADHD, and the benefit of having greater flexibility when prescribing ADHD medications:

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

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

…

I think that collaboration between our psychiatrists, paediatricians and GPs on agreed discharge criteria, what I mean by that is what is a stable patient that would then be appropriate to receive community-based care. Talking to my colleagues in those professions, the number of additional appointments that would then become available for assessment of people on our waitlists, even with

[218] Mr. Samuel Halliday, Chief Pharmacist, Pharmaceutical Services Branch, Department of Health, Transcript of Evidence, 11 April 2025, pp. 25-26.

no additional resources going into that space, would create a significant improvement in our current situation.

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

Dr JONES *- No, my understanding is there is only one other state that truly provides a co-prescribing arrangement, but there are other states that allow GPs to register with the pharmaceutical branch in their state as essentially a credentialed or accredited prescriber for the purposes of either assessment, ongoing treatment or both. They provide a workforce need that's just expanding the scope and they are particularly relevant if we're exploring areas of rural and remote Tasmania where we just know that access becomes even more inequitable.*[219]

5.67 Psychiatrist, Dr Reddy, provided his perspective of developing a system where GPs are primary prescribers:

Dr REDDY *- … 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.*

…

CHAIR [Mr Behrakis] *- 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… 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

[219] Dr. Timothy Jones, General Practitioner, Royal Australian College of General Practitioners, Transcript of Evidence, 18 October 2024, p. 46.

through a good pathway, that would reduce the kind of help with the barriers for assessment and treatment.[220]

5.68 In her letter of 26 November 2025 updating the Committee, the current Minister for Health, Mental Health and Wellbeing, Hon. Bridget *Archer* MP advised of the steps the Tasmanian Government is taking to resolve access and treatment issues, emphasising a multidisciplinary approach and faster access to medication:

> *…we made a…policy commitment to enable Tasmanian general practitioners (GPs) to diagnose, treat and manage ADHD for children and adults. This will mean faster access to medication, reduced costs for patients, and better continuity of care.*
>
> *Through this initiative, paediatricians, psychiatrists, GPs and pharmacists will work together to enable a system that supports increased GP involvement in the diagnosis and initial management of ADHD. We have commenced work with GPS* [sic] *and the Royal Australian College of General Practitioners to ensure GPs having the training and supervision they need to support Tasmanians living with ADHD from 2026, freeing up wait lists for paediatricians and psychiatrists.*[221]

Findings

The Committee finds:

73. The *Poisons Act 1971* (Tas) and its subordinate legislation dictate the rules for prescribing and accessing psychostimulant medication in Tasmania. The Pharmaceutical Services Branch in the Department of Health is responsible for administering this legislative framework.

74. The aim of the Pharmaceutical Services Branch is to help prevent harm to the public, patients and the community by applying a risk-based approach to authorisation to prescribe, and the prescription of, psychostimulant medications.

75. The single prescriber model, required by the *Poisons Act 1971* (Tas), is burdensome and leads to complications for the Pharmaceutical Services Branch, prescribers, patients and caregivers.

76. Tasmanian prescription requirements for psychostimulants are stricter and more complex than for other medications that carry a potential for misuse, such as opioids and benzodiazepines.

77. Communication between the Pharmaceutical Services Branch, prescribers and patients, during the *Poisons Act 1971* (Tas) section 59E approvals process, can be lacking and not in the patient's best interests.

[220] Dr. Anil Reddy, Psychiatrist, Royal Australian and New Zealand College of Psychiatrists, Transcript of Evidence, 8 November 2024, pp. 66-67.
[221] Letter from Hon. Bridget Archer MP, Minister for Health, Mental Health and Wellbeing, dated 26 November 2025, p. 1.

78. Prescribers and patients are not always directly informed when the Pharmaceutical Services Branch cancel a prescription. Patients may only be advised of a cancellation when attending a pharmacy to fill their prescription. This is an unreasonable imposition on both patients and pharmacists, often occurs in public, and results in delays in medication access.

79. Conditions placed on accessing psychostimulants by the Pharmaceutical Services Branch are sometimes inconsistent and confusing, for example different access conditions applied to members of the same family household.

80. There is a lack of understanding in the community and parts of the medical profession about the role and function of the Pharmaceutical Services Branch.

81. There is stigma attached to the use of stimulant medication in the community and medical profession.

82. Conditions applied by the Pharmaceutical Services Branch (PSB) for the use of psychostimulants can conflict with the advice of patients' treating practitioners. People who follow medical advice, for example taking regular pauses in their medication, risk being penalised by the PSB, potentially impacting future access to medication.

83. Inflexible medication collection schedules and staged-supply conditions are barriers to people with ADHD accessing prescribed psychostimulants.

84. The Pharmaceutical Services Branch lacks transparency, making it difficult to seek a review or appeal a decision or condition.

Recommendations

The Committee recommends:

13. **Dual prescribing of psychostimulant medication be implemented as part of the review of the *Poisons Act 1971* (Tas) legislative framework.**

14. **Modernisation of the Pharmaceutical Services Branch's operations, and increased transparency of its decision-making processes, be implemented as part of the review of the *Poisons Act 1971* (Tas) legislative framework.**

15. **The Pharmaceutical Services Branch publish clear and visible assessment criteria for the approval of applications for authorisation to prescribe under section 59E of the *Poisons Act 1971* (Tas).**

16. **Development and implementation of formal communication processes between the Pharmaceutical Services Branch and a patient's prescriber when considering section 59E applications be included in the review of the *Poisons Act 1971* (Tas) legislative framework.**

17. **Development and implementation of formal communication processes between the Pharmaceutical Services Branch, the patient's prescriber and the patient when cancelling a prescription be included in the review of the *Poisons Act 1971* (Tas) legislative framework.**
18. **Development of enhanced appeal mechanisms, including external review, relating to Pharmaceutical Services Branch decisions be included in the review of the *Poisons Act 1971* (Tas) legislative framework.**
19. **Increasing flexibility to the current 28-day medication collection schedule for all psychostimulant prescriptions be included in the review of the *Poisons Act 1971* (Tas) legislative framework.**
20. **Reasonable alternatives to the additional restrictive supply conditions currently placed on some prescriptions, such as weekly or daily collection, be included in the review of the *Poisons Act 1971* (Tas) legislative framework.**

6 INTERACTION OF TASMANIAN GOVERNMENT AND COMMONWEALTH SERVICES TO MEET THE NEEDS OF PEOPLE WITH ADHD AT ALL LIFE STAGES

6.1 The Tasmanian and Commonwealth Governments share responsibility for providing services to meet the needs of people with ADHD at all life stages.

6.2 At the 18 October 2024 public hearing, then Acting Secretary of the Department of Health, Mr Dale Webster, outlined cross-jurisdictional healthcare responsibilities for ADHD:

> ***Mr WEBSTER*** *- … The mental health services model that we deliver in the public health system is an acute mental health service and diagnosis, early diagnosis, et cetera, actually sits in the primary health sector. It sits with the federal government part of the equation with mental health. Certainly, those with ADHD who are having acute episodes or chronic episodes would come to mental health services. But, generally, it is done through GPs and psychiatrists in the private sector as per the model which splits primary funding to the Australian Government through Medicare and the acute sector through the state government.*[222]

6.3 Evidence received by the Committee discussed the adequacy of the interaction between the Tasmanian and Commonwealth Governments, often describing the services as 'fragmented' or 'disjointed':

> *… Services for people with ADHD are often fragmented across different levels of government. This lack of coordination leads to gaps in service provision and inconsistencies in the quality of care available to individuals with ADHD. There are inconsistencies in policies, eligibility criteria, and funding across government services. This results in varied access to services depending on geographic location, leading to inequities in care. Government services at all levels are often underfunded, which limits the availability of ADHD-specific programs and services. This results in long wait times for assessment and support services, particularly in public health systems. Many government services are not adequately designed to address the full spectrum of ADHD needs across different life stages, from childhood through to adulthood. This can result in individuals "aging out" of services or facing significant barriers when transitioning between different stages of care (e.g., from child to adult services)…*[223]

6.4 Australasian ADHD Professionals Association (AADPA) discussed the consequences of inconsistent services in its submission:

[222] Mr. Dale Webster, Acting Secretary, Department of Health, Transcript of Evidence, 18 October 2024, p. 23.

[223] Submission No. 14, Private Witness, p. 3.

There is little consistency or coordination between Commonwealth, state, and local government services in supporting individuals with ADHD. This can lead to confusion and frustration for individuals and their families, as well as gaps in service provision which means that those with ADHD often feel as if they are falling between the gaps between services.

The impact of ADHD is broad and touches many aspects of society. So, the responsibility for providing access to adequate support for people with ADHD does not just rest with one or two government departments.[224]

6.5 AADPA emphasised the importance of collaboration between state and federal governments in ensuring people with ADHD are provided with accessible assessment and support services:

We strongly support the need for policy makers at all levels of government to work together to support those with ADHD. This will mean active cooperation between the departments responsible for health, disability, education, justice, welfare and employment to develop funding plans to optimally support those with ADHD to thrive and contribute to the wellbeing of the country.[225]

6.6 In its submission to the Inquiry, Royal Australian and New Zealand College of Psychiatrists (RANZCP) also highlighted its support for collaboration:

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.[226]

Collaborative funding

6.7 Evidence received highlighted the need for collaborative approaches to funding for health services in Tasmania. Royal Australian College of General Practitioners (RACGP) stated:

Tasmania's strategic plan for mental health (Rethink 2020) identifies 10 key reform priorities to improve mental health outcomes for Tasmanians, all of which are relevant to improving the management of ADHD[xix]*. Future iterations of state mental health plans should specifically consider ADHD as a condition which requires a coordinated approach between state and commonwealth mental health services. ADHD inclusive mental health policy is a key enabler of*

[224] Submission No. 44, Australasian ADHD Professional Association, p. 21.
[225] Submission No. 44, Australasian ADHD Professional Association, p. 21.
[226] Submission No. 46, Royal Australian and New Zealand College of Psychiatrists, p. 5.

coordinated funding for shared models of care and clear health pathways for patients.

RACGP Tasmania supports coordination between Commonwealth, state and local governments in funding models of care which support shared care models and clear health pathways for patients.[227]

6.8 Dr Kate Bendall highlighted the need for coordinated funding to bolster the support provided by GPs:

> *…The interplay between funding of State Government and Commonwealth services complicates the health system and may shift costs between systems without benefitting the patient. Essentially the current system is inadequate to meet the needs of many Australians with ADHD. They would be better served with a well-funded model of General Practice. The Tasmanian State Government would do well to advocate for adequate funding of general practice to encourage more trainees to consider a career in general practice, and to improve access for patients.*[228]

6.9 AADPA discussed the need for collaboration between a range of stakeholders:

> *…Support for people with ADHD needs to come from various sources, including health professionals, coaches, educators, and those working in justice, welfare, drug and alcohol, disability, and employment sectors.*
>
> *AADPA believes that the issues currently limiting access to treatment for those with ADHD can be addressed. However, this will require funding and support from both the Federal and Tasmanian governments, the medical, psychology and nursing colleges, allied health peak bodies and universities who provide education to our current and future health needs, and for professionals to work closely with people with lived experience to develop and implement services that work together across traditional boundaries.*[229]

Findings

The Committee finds:

85. Collaborative funding between State and Commonwealth Governments is needed to streamline ADHD assessment and support services.

---

[227] Submission No. 40, Royal Australian College of General Practitioners, p. 5, including reference to the submission's Footnote xix - Tasmanian Department of Health Pharmaceutical Services Branch. Fact Sheet: Seeking Authorisation to Prescribe Schedule 8 Psychostimulants in Tasmania. July 2024. Available at www.health.tas.gov.au [Accessed 30 August 2024].

[228] Submission No. 39, Dr. Kate Bendall, p. 9.

[229] Submission No. 44, Australasian ADHD Professionals Association, pp. 11-12.

National framework

6.10 In November 2023, the Australian Senate's Community Affairs References Committee tabled its Final Report for its Inquiry into the assessment and support services for people with ADHD.[230]

6.11 The Senate Inquiry received 701 submissions, heard from 79 witnesses and held three public hearings.[231] The Senate Inquiry gathered evidence from individuals and organisations across Australia.

6.12 The 15 recommendations from the Senate Inquiry centred around a more coordinated approach, better quality of care, affordable and accessible services, improved awareness, and reduced stigma.[232]

6.13 The Australian Government responded to the Senate Inquiry Report and recommendations in December 2024. The Australian Government's response acknowledged the complex healthcare needs associated with ADHD, as well as the fragmented system that can be difficult to navigate.[233] Of the 15 recommendations, one was supported, nine were supported-in-principle, and five were noted.[234]

6.14 The Australian Government supported-in-principle the recommendations to review the Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS), and noted the recommendation to improve accessibility and quality of information around the eligibility as a condition under the National Disability Insurance Scheme (NDIS). The Australian Government supported-in-

[230] Parliament of Australia, Senate Community Affairs References Committee, *Inquiry into Assessment and support services for people with ADHD*, November 2023. Accessed at: https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/ADHD/Report.
[231] Parliament of Australia, Senate Community Affairs References Committee, *Inquiry into Assessment and support services for people with ADHD Report*, November 2023, p. ix. Accessed at: https://parlinfo.aph.gov.au/parlInfo/download/committees/reportsen/RB000138/toc_pdf/AssessmentandsupportservicesforpeoplewithADHD.pdf.
[232] Parliament of Australia, Senate Community Affairs References Committee, *Inquiry into Assessment and support services for people with ADHD Report*, November 2023 p. x. Accessed at: https://parlinfo.aph.gov.au/parlInfo/download/committees/reportsen/RB000138/toc_pdf/AssessmentandsupportservicesforpeoplewithADHD.pdf.
[233] Parliament of Australia, Senate Community Affairs References Committee, *Australian Government response to the Senate Community Affairs References Committee report: Assessment and support services for people with ADHD*, tabled 12 December 2024, p. 3. Accessed at: https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/ADHD/Government_Response.
[234] Parliament of Australia, Senate Community Affairs References Committee, *Australian Government response to the Senate Community Affairs References Committee report: Assessment and support services for people with ADHD*, tabled 12 December 2024, p. 5-6. Accessed at: https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/ADHD/Government_Response.

principle the recommendation that the Australian Government consider funding and co-designing a National Framework for ADHD.[235]

6.15 Witnesses to this Inquiry have strongly recommended that the Tasmanian Government adopt a nationally consistent framework that addresses the need for adequate assessment and support services available to people with ADHD.

6.16 AADPA submitted the following:

> *We believe that the most effective way to deliver an integrated and effective approach to ADHD is through the development of a National ADHD Strategy that generates a clear set of priorities and actions for improving support and services for individuals with ADHD. This would require close communication and cooperation between the Commonwealth, state and local government services to ensure that services are delivered effectively and efficiently to stop people with ADHD from falling through the gaps.*
>
> *We believe the recommendations in AADPA's Clinical Practice Guideline provides a blueprint to develop a strategy that is relevant and deliverable. With the support and engagement of many of our colleagues in the colleges and associations around the country we have already started this work by beginning to tackle legislative and policy barriers such* [as] *workforce capacity, education resources and national prescribing standards but this work requires investment to be fully realised.*[236]

6.17 AADPA recommended:

> *Development of a National ADHD Strategy that complements and builds on current initiatives and framework such as the National Disability Strategy, the National Child Mental Health and Wellbeing Strategy and Vision 2030.*[237]

6.18 At the 18 October 2024 public hearing, Ms Jane Endacott, Vice Chair of ADHD Australia, advocated for a collaborative, national approach:

> ***Ms ENDACOTT -*** *… from our perspective, having a national framework, being able to link in nationally to problem solve some of these challenges more broadly is something that will be beneficial, being able to collaborate together to come up with solutions and not doing things in isolation is going to be the way forward. There are some pockets of fantastic things done across different states, really being able to share our ideas and to look more collaboratively at what that could*

[235] Parliament of Australia, Senate Community Affairs References Committee, *Australian Government response to the Senate Community Affairs References Committee report: Assessment and support services for people with ADHD,* tabled 12 December 2024, p. 5. Accessed at: https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/ADHD/Government_Response.

[236] Submission No. 44, Australasian ADHD Professionals Association, p. 21.

[237] Submission No. 44, Australasian ADHD Professionals Association, p. 22.

look like to be able to look at the utilisation of shared resources in the best way possible with limited resources that we have.[238]

6.19 The Committee received recommendations advocating collaboration with the Commonwealth to bolster training and incentives for practitioners to specialise in ADHD. Regional Autistic Engagement Network (RAEN) suggested that the Tasmanian Government:

> *…Collaborate with the Federal Government and registered training providers as well as community representative organisations to create incentive programs encouraging healthcare professionals to specialise in ADHD. Offer scholarships and grants to neurodiversity-affirming, evidence based programs for those willing to work in rural, regional and remote areas.*[239]

6.20 In its submission to the Inquiry, Mental Health Families and Friends Tasmania (MHFFTas) recommended state and federal cooperation to improve training for teachers:

> *State and National integration to review the content of teaching degrees to ensure teachers have some knowledge and skills on how to work with neurodivergent children.*[240]

6.21 The Minister for Health, Mental Health and Wellbeing, the Hon. Bridget *Archer* MP, provided the Committee with an update on the progress of national reforms that will positively impact on the assessment and treatment of ADHD in Tasmania:

> *Like other states and territories, Tasmania is experiencing increasing demand for specialist assessment of children with behavioural and developmental management issues, including ADHD. As a result, there have been announcements across many jurisdictions in Australia regarding improving access to ADHD diagnosis and prescribing. All Australian Health Ministers, through the Health Ministers' Meeting (HMM), have endorsed the need for national harmonisation of ADHD diagnosis and prescribing practices and work is being progressed on this as a priority.*
>
> *Together as Health Ministers we have acknowledged that a uniform approach that includes professionals who are appropriately qualified, and with the right safeguards, can improve access and affordability for Australians in need. Health Ministers have also commissioned work, in consultation with relevant stakeholders, to develop nationally consistent prescribing rules for ADHD medications.*

[238] Ms. Jane Endacott, Vice Chair, ADHD Australia, Transcript of Evidence, 18 October 2024, p. 58.
[239] Submission No. 25, Regional Autistic Engagement Network, p. 17.
[240] Submission No. 29, Mental Health Families and Friends Tasmania, p. 5.

> *Our Government welcomes the progression of a national approach and will actively contribute to its design through national working groups. Tasmania looks forward to helping shape this work and to considering how it can further improve access to assessment and treatment for Tasmanians living with ADHD…* [241]

Findings

The Committee finds:

86. There is consensus that addressing barriers to assessment and service provision for people with ADHD requires a nationally consistent approach.

87. A national approach to the diagnosis and treatment of ADHD has been endorsed by Health Ministers from all Australian jurisdictions and will be progressed as a priority.

AADPA Guideline

6.22 In discussing the development of a National ADHD Framework, AADPA's submission raised the opportunity to implement the recommendations in its Australian Evidence-Based Clinical Practice Guideline for ADHD (the Guideline). Its submission stated:

> *The Guideline provides an evidence-based framework for the diagnosis and management of ADHD in Australia. It is a roadmap for policy makers to improve the assessment, care and support for people with ADHD and that the Tasmania* [sic] *Government can draw upon.*
>
> *Building on the well-respected NICE* [National Institute for Health and Care Excellence] *ADHD Guidelines (2018)*[16] *developed in the UK it represents the most up to date evidence-based guideline for ADHD internationally.*
>
> *The Guideline was developed with funding received by AADPA from Australian Government Department of Health in 2018. The Guideline Development Group (GDG) followed the National Health Medical Research Council (NHMRC) Principles for Guidelines, adhered to a strict approach to avoid conflicts of interest and included representatives from a broad range of professional organisations, consumers, and First Nations peoples.*
>
> *Following development of the draft guideline there was a public consultation and peer review with 51 submissions accepted, containing 755 items of feedback. These were addressed by the GDG and the final Guideline was launched by Minister Butler in October 2022.*

[241] Letter from Hon. Bridget Archer MP, Minister for Health, Mental Health and Wellbeing, dated 26 November 2025, p. 2.

The process of developing recommendations includes an explicit consideration of how feasible it is to implement a recommendation within the Australian context with priority given to the following:

1. *Upskilling the existing clinical workforce.*
2. *Optimising Care Pathways.*
3. *Reducing Policy and regulatory barriers.*
4. *Prioritising and increasing Research Opportunities (Women & Girls, First Nations presentations).*
5. *Giving a meaningful voice to Lived Experience.*
6. *Better understanding of how ADHD impacts Indigenous and CALD communities.*
7. *Providing better resources for indigenous and CALD communities that align with the Guideline.*

Implementation of clinical guidelines takes time to effectively execute. Although AADPA was required to submit an implementation plan to the NHMRC for their endorsement, the Guideline's full implementation was not funded in the development grant. There is scope for State Governments to invest in the development of specific services as required.[242]

6.23 AADPA's submission further stated that the Guideline has been:

> *Endorsed by all major Australian medical and allied health colleges and associations, as well as the World Federation of ADHD and ADHD New Zealand.*[243]

6.24 At the 18 October 2024 public hearing, AADPA President, Professor David Coghill, gave further evidence on the Guideline, and discussed the opportunity to implement its recommendations in Tasmania:

> ***Prof COGHILL** - The reason for having evidence-based guidelines is to improve consistency and reduce variability. It's not to make everything uniform so that every person has to go through exactly the same process. That wouldn't actually be doable or suitable. It is designed so that there are a certain set of hurdles. Maybe I shouldn't call them hurdles because that makes it hard, but a certain set of processes that everybody should go through. I think the guideline does that very well in a theoretical sense.*
>
> *We've been back to the federal Minister for Health on many occasions. I wrote very recently to him, I think, for me, a strong letter to a government minister, saying, 'You've had the Senate inquiry report on your desk, you've had a Department of Health set of recommendations from that on your desk, and we've heard absolutely nothing'. I've still to get a reply. We've been trying at AADPA.*

[242] Submission No. 44, Australasian ADHD Professionals Association, pp. 23-24, including reference to the submission's Footnote 16 - https://www.nice.org.uk/guidance/ng87.
[243] Submission No. 44, Australasian ADHD Professionals Association, p. 4.

Writing guidelines is the first step. The next step is actually to implement them. Implementing them takes money.[244]

6.25 Professor Coghill also provided evidence to the Committee on the Guideline's Consumer Companion Guide, a tool to help Tasmanians understand national best practice contained in the Guideline:

> ***Ms JOHNSTON*** *- …what should parents or caregivers, particularly for those young children - we are talking in primary school - what should they be looking for? In terms of trying to figure out whether the health care, the assessment that they are getting, is quality at the moment? We understand that there are long waiting lists and people obviously are trying to find ways of getting help quicker.*
>
> ***Prof COGHILL*** *- The simple answer to that is we actually published a consumer guide to the guidelines that is freely available to download from the AADPA website. It really puts the evidence-based guidelines - the hundreds and thousands of pages if you go all the way in - into a usable package. One of the things that we've applied to the Federal government for, and one of the things that I am trying to develop, is what we call QPLs - or question problem lists. That's a set of questions that you give to consumers and say, 'These are the things that you should or could be asking your practitioner. These are the kind of things you should expect and these are the kind of questions that you ask'…* [245]

6.26 In its submission, RACGP endorsed the implementation of the Guideline's recommendations to improve research:

> *A detailed summary of areas for future research is included in the ADHD Clinical Guideline and the RACGP encourages Tasmanian decision makers to implement policy changes that align with the guideline.*[246]

6.27 Dr Timothy Jones, representing RACGP, provided the Committee with evidence on GPs utilising the Guideline:

> ***CHAIR*** [Ms White] *- …How well communicated do you think the guidelines are to general practitioners to enhance their understanding and potentially their attitude toward ADHD?*
>
> ***Dr JONES*** *- We are seeing increased interest within the general practitioners of the RACGP of Tasmania. We have to reflect the needs of our communities that we live and work in and the Australasian ADHD Professionals Association (AADPA) prescribing guidelines and assessment guidelines are increasingly being utilised as a standard of care by GPs here in Tasmania.*[247]

---

[244] Professor David Coghill, President, Australasian ADHD Professionals Association, Transcript of Evidence, 18 October 2024, pp. 5-6.
[245] Professor David Coghill, President, Australasian ADHD Professionals Association, Transcript of Evidence, 18 October 2024, pp. 6-7.
[246] Submission No. 40, Royal Australian College of General Practitioners, p. 6.
[247] Dr Timothy Jones, General Practitioner, Royal Australian College of General Practitioners, Transcript of Evidence, 18 October 2024, p. 45.

6.28 Having endorsed the Guideline, RANCZP's submission included the key recommendation:

> *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).*[248]

6.29 Mr Matthew Tice of ADHD Australia also raised the Guideline in his evidence at the 18 October 2024 public hearing:

> ***Mr TICE** - I'm sure you're aware that our colleagues at AADPA have done a lot of work in creating the prescribing guide for healthcare professionals, which goes a long way towards starting that process from a clinical point of view. So that's very welcome. I think ongoing harmonisation of the clinical guidelines are important that do address the different facets of the healthcare system. So that's really important and welcome.*
>
> *Simon* [Behrakis], *you mentioned the need also for the flip of that, which is 'how do I, as an individual with ADHD or a parent or a carer or partner, navigate that system?'. That is the other half of that, so that there is some work being done. We are waiting a little bit collectively as an ecosystem to do the work that will bring together the consumer side of that in the context of the ADHD national framework, which is inevitably going to be precipitated out of the national inquiry process, we hope. Okay, so there is that work, but I think that we're really largely focused in this part of the conversation on access to medication and diagnosis.*
>
> *Access… to standards or guidelines around education are really important in the justice setting. Our vision in the long-term is to be able to extend those guidelines also to support individuals and employment and so forth.*
>
> *So I think that this really is a multimodal problem that requires a 360 degree approach and the industry, and we're part of that industry, I suppose needs more guidance from government about how best to fund these activities. We have a lot of resources to help build education materials and to develop these guidelines that are sort of queued up to do the work but we are a sector chronically underfunded to achieve these goals.*[249]

6.30 The Tasmanian Government's submission provided evidence on how the PSB currently utilises the Guideline in its decision-making process:

> *In October 2022 the inaugural 'Australian Evidence-Based Clinical Practice Guideline for ADHD' was published by the Australasian ADHD Professionals Association (AADPA). This clinical practice guideline has further informed the approach taken to s59E authorisation, along with feedback from stakeholder groups, and advice provided by DoH specialist medical practitioners.*[250]

[248] Submission No. 46, Royal Australian and New Zealand College of Psychiatrists, p. 3.
[249] Mr. Matthew Tice, Chair, ADHD Australia, Transcript of Evidence, 18 October 2024, p. 59.
[250] Submission No. 60, Tasmanian Government, p. 21.

Findings

The Committee finds:

88. The Australasian ADHD Professionals Association's Australian Evidence-Based Clinical Practice Guideline for ADHD provides a framework for governments to improve the assessment, care and support for people with ADHD.

89. The Australasian ADHD Professionals Association's Australian Evidence-Based Clinical Practice Guideline for ADHD has been endorsed by all major Australian medical and allied health colleges and associations, as well as the ADHD New Zealand and the World Federation of ADHD.

90. The Australasian ADHD Professionals Association's Australian Evidence-Based Clinical Practice Guideline for ADHD is not consistently implemented or followed across Australian jurisdictions, including in Tasmania.

National Disability Insurance Scheme

6.31 An additional barrier to accessing assessment and support services for people with ADHD is their ineligibility to receive funding from the National Disability Insurance Scheme (NDIS).

6.32 Evidence received indicated that because of the lack of support from the NDIS, individuals and their families are not receiving adequate support. Royal Australasian College of Physicians (RACP) stated in its submission:

> *One RACP member reported that many early development support groups, which provided supports for families of children with ADHD, have ceased operating. In many cases, this leaves the NDIS as the key mechanism for families of children with ADHD to access support. However, the NDIS faces long waitlists – for assessment processes and services – and not all children and families can access NDIS support, even if the child's functional impact is severe. This leaves some children and families falling through the cracks, with some also facing concurrent challenges in accessing mental health supports in Tasmania as well.*[251]

6.33 Carers Tasmania explained further:

> *Because people who have ADHD as their primary or only diagnosis are not eligible for support such as the NDIS, there is usually a higher responsibility burden felt by carers, because they can't access the additional layers of support that NDIS may be able to provide. Care2Serve is the Tasmanian Carer Gateway provider and is able to broker some forms of support to assist carers in their caring role. However, this support is short term. The Tasmanian Community Care Referral Service (TCCRS) exists to support people aged 65 and under who need additional support at home. However, TCCRS will usually decline referrals for supports such*

[251] Submission No. 54, Royal Australasian College of Physicians, p. 7.

as domestic assistance if there is a carer living in the household who is 'able bodied'. This places the responsibility back onto the carer, who will often have their own competing responsibilities and needs to look after.[252]

6.34 Another Tasmanian discussed the potential of increasing early intervention services provided by the NDIS:

> *There is an opportunity to look at how Early Intervention services provided by NDIS services intersect with our state-based education system. Currently we do not see any significant collaboration hence the transition to school for children who are developmentally outside the neurotypical range is poorly handled and frequently disruptive. Our state provides a Early Childhood Intervention Service that has been progressively de-scaled since the NDIS was established but in my professional opinion did a significantly superior job of performing this critical role.*[253]

6.35 In order to improve access to support services, the Committee received recommendations that ADHD become a recognised condition, and thus eligible for funding, under the NDIS. The Australian Medical Association (AMA) Tasmania Branch stated:

> *ADHD is not a recognised NDIS condition; there are now fewer services for those whose needs are real, such as for ADHD, but who are not covered by the NDIS. There needs to be an expansion of funding for these important supports, particularly in areas of need.*[254]

6.36 AADPA made a similar recommendation:

> *The Guideline recommends that ADHD be part of the NDIS. However, AADPA believes that inclusion should not be based solely on a diagnosis but on how ADHD impacts the ability of a person to function and thrive.*[255]

6.37 Acknowledging that oversight of the NDIS does not fall within the Tasmanian Government's jurisdiction, RAEN and National Disability Services provided more specific examples of how the Tasmanian Government could contribute. In its submission to the Inquiry, RAEN stated:

> *While it is understood that oversight of NDIS individual support plans is not within the jurisdiction of the Tasmanian Government conducting this inquiry, RAEN emphasises that the roll out of NDIS Foundational Supports, planned via the states and territories, is a key opportunity for the Tasmanian Government to prioritise the provision of community based supports for neurodivergent*

[252] Submission No. 19, Carers Tasmania, p. 13.
[253] Submission No. 15, Private Witness, p. 4.
[254] Submission No. 51, Australian Medical Association Tasmania Branch, p. 11.
[255] Submission No. 44, Australasian ADHD Professionals Association, p. 19.

individuals; including support groups and educational programs, as recommended by RAEN survey respondents.[256]

6.38 National Disability Services also discussed the Foundational Support Strategy:

> *With the shift towards a Foundational Support Strategy which is co funded by State and Commonwealth and codesigned with people with disability, the Tasmanian government has the opportunity to holistically design and implement services that could meet the needs of individuals with ADHD, regardless of age, functional ability or eligibility for the NDIS. This should occur alongside recommendation 8 (9.59) from the Senate inquiry, which was for the National Disability Insurance Agency (NDIA) to improve the accessibility and quality of information around the eligibility of ADHD as a condition under the NDIS.*[257]

6.39 Women's Health Tasmania also provided examples of advocacy the Tasmanian Government could embark on to improve the NDIS:

> *…Advocate for the amendment of the NDIS A and B Access Lists to explicitly include ADHD. This will help clarify eligibility and reduce confusion among potential applicants, ensuring that ADHD is recognised as a valid and primary disability for NDIS support.*
>
> *…*
>
> *Advocate for increased inclusion of and support for individuals with ADHD under the NDIS as part of the implementation of the NDIS Review and the recently passed NDIS Amendment Bill.*[258]

6.40 At the 16 May 2025 public hearing, Hon. Jacquie *Petrusma* MP, then Minister for Health, outlined her commitment to collaborate with her federal counterparts to secure appropriate funding for treatment of ADHD, and noted that it is not included within the NDIS:

> ***Mrs PETRUSMA*** *- …We are determined to also work together with our federal colleagues, especially in regard to GPs, because that is a federal government responsibility. The fact that ADHD isn't on the NDIS - we do need federal government assistance to step up in this space, because, as we heard, we have too many children being referred for neurodevelopmental disorders. Australia-wide this is an issue. I'm very happy to advocate for what we need through Health Minister's meetings as well, with the federal government.*[259]

[256] Submission No. 25, Regional Autistic Engagement Network, p. 10.
[257] Submission No. 48, National Disability Services, p. 8.
[258] Submission No. 20, Women's Health Tasmania, p. 17.
[259] Hon. Jacquie Petrusma MP, former Minister for Health, Transcript of Evidence, 16 May 2025, p. 25.

6.41 Since the Committee concluded evidence gathering, substantial changes to the NDIS have been announced by the Australian Government.[260]

Findings

The Committee finds:

91. Individuals with a primary or sole diagnosis of ADHD are not eligible for funding under the National Disability Insurance Scheme.

92. Foundational Supports provide an emerging opportunity to deliver services and support for people with ADHD.

Medicare

6.42 Limited or absent Medicare rebates available for ADHD assessment and support services is another barrier cited by witnesses to the Inquiry.

6.43 Mr Timothy Davern, representing the Australian Psychological Society (APS), presented this issue to the Committee:

> ***Mr DAVERN*** *- … 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.*[261]

[260] Note the introduction of National Disability Insurance Scheme Amendment (Securing the NDIS for Future Generations) Bill 2026 on 14 May 2026. Accessed at: https://www.aph.gov.au/Parliamentary_Business/Bills_Legislation/Bills_Search_Results/Result?bId=r7487

[261] Mr. Timothy Davern, Senior Policy Advisor, Australian Psychological Society, Transcript of Evidence, 8 November 2024, pp. 14-15.

6.44 The APS submission proposed the following recommendation:

> *…We therefore recommend developing separate MBS item numbers for ADHD assessments by psychologists, psychiatrists and paediatricians.*[262]

6.45 Dr Kate Bendall, a GP in southern Tasmania, provided the Committee with a similar recommendation that could be based on existing models:

> *…There could be a role for specific item numbers to facilitate ADHD support and referrals such as there are with eating disorders.*[263]

6.46 Hobart ADHD Consultants provided evidence that stated that although support services can be partly funded through Medicare, for example through Mental Health Care Plans (MHCPs), practitioners do not always have a clear understanding on its application:

> *There appears to be a lack of clarity around the applicability of MHCPs to ADHD assessment as part of treatment delivery.*
>
> *For example, some clients report having been advised by their GP that Medicare rebates do not apply to sessions where ADHD assessment is conducted; and some psychologists advertise ADHD assessment services as only being able to be conducted privately (with no Medicare rebate).*
>
> *The confusion may in part stem from some providers including cognitive testing as part of an ADHD assessment. The clinical guidelines do not recommend this approach[4]. The recommended approach is not excluded under a MHCP, and is not dissimilar to the approach that would be used for assessing other mental health conditions (i.e. via clinical interview with the potential addition of standardised questionnaires)…*
>
> *The confusion is also likely to be contributed to by Medicare's definition of 'Focussed psychological strategies' in MHCP item number descriptions. Whilst 'assessment' is not specifically noted as part of the definition, assessment is an inherent and necessary part of any treatment provision. It would be unethical to commence psychological treatment without having conducted an appropriate assessment of presenting concerns. If ADHD is suspected, it must be assessed, as the presence of ADHD is likely to change how treatment would be approached.*
>
> *…*
>
> *There appears to be a lack of clarity around the processes and requirements relating to Mental Health Care Plans (MHCPs) and associated Medicare item numbers. This contributes to additional appointments being required, additional out-of-session administrative work for providers, additional administrative*

[262] Submission No. 52, Australian Psychological Society, p. 2.
[263] Submission No. 39, Dr. Kate Bendall, p. 9.

demands on consumers, delays in accessing services, and applicable Medicare rebates not being accessed...[264]

6.47 The AMA Tasmania Branch concluded with the recommendation:

AMA Tasmania urges the State Government to advocate to the Commonwealth for better renumeration for the diagnosis and management of ADHD and for service provision outside of the NDIS.[265]

6.48 The Tasmanian Government recognised the need for improved Medicare rebates for Tasmanians requiring ADHD assessment and support services:

Current funding models, including the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS), present barriers to equitable access to ADHD services. There is a need for the Australian Government to review these to reduce out-of-pocket costs and improve access to assessment, diagnosis, and treatment.[266]

6.49 At the 18 October 2024 public hearing, the then Minister for Health, Mental Health and Wellbeing, Hon. Guy *Barnett* MP, and Mr Dale Webster, discussed the State's ongoing work in contributing to these improvements:

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

...

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

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

[264] Submission No. 30, Hobart ADHD Consultants, p. 16, including reference to the submission's Footnote 4 - ADHD Guideline Development Group. (2022). Australian evidence-based clinical practice guideline for ADHD. Melbourne: Australian ADHD Professionals Association.

[265] Submission No. 51, Australian Medical Association Tasmania Branch, p. 11.

[266] Submission No. 60, Tasmanian Government, p. 5-6.

commissioned by the ministers, through the chief executives, to say how can we change the system so we don't have a gap in the middle.

…

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

We have agreed to meet twice a year as mental health ministers with the health ministers. There has been that gap and now we're coming together twice a year to flesh out and work together as health ministers and mental health ministers on these important matters. We've already received a needs analysis… [267]

Findings

The Committee finds:

93. The applicable Medicare Benefits Scheme billing items available to practitioners for ADHD assessments are unclear. This results in an ad hoc application of fees and charges to patients.

94. The expansion of specific billing items through the Medicare Benefits Scheme to fund ADHD assessments would increase affordability for patients.

Recommendations

The Committee recommends:

21. The Tasmanian Government continues to work with the Australian Government to promote collaborative funding opportunities and a nationally consistent approach to ADHD assessment and treatment.

22. The Tasmanian Government implement the use of the Australasian ADHD Professionals Association's Australian Evidence-Based Clinical Practice Guideline for ADHD in the Tasmanian Health Service and encourages its consistent use in the private sector.

23. The Tasmanian Government fund sufficient Foundational Supports for people with ADHD.

24. The Tasmanian Government call on the Australian Government to provide clearer guidance to practitioners about the use of current Medicare Benefits Scheme billing items for ADHD assessment and treatment.

[267] Hon. Guy Barnett MP, former Minister for Health, Mental Health and Wellbeing, and Mr. Dale Webster, Acting Secretary, Department of Health, Transcript of Evidence, 18 October 2024, pp. 23-25.

25. **The Tasmanian Government call on the Australian Government to introduce separate Medicare Benefits Scheme billing items for the assessment of ADHD.**

7 SOCIAL AND ECONOMIC COST OF FAILING TO PROVIDE ADEQUATE AND APPROPRIATE ADHD SERVICES

7.1 The Committee received evidence about the significant social and economic costs as a result of the failure to provide adequate assessment and support services for people with ADHD.

Deloitte Report

7.2 Australasian ADHD Professionals Association's (AADPA) submission to the Inquiry referenced evidence found in its 2019 report, titled the *Deloitte Access Economic Report into the Social and Economic Costs of ADHD in Australia.* AADPA explained:

> *In 2019 we partnered with Deloitte to study the social and economic cost of ADHD. The subsequent Report found that the cost of ADHD to the economy is estimated at over $20 billion a year[10]. It highlights the very real costs we will continue to accrue if we fail to provide adequate and appropriate support and services for individuals with ADHD.*
>
> *These costs arise because individuals with ADHD are at increased risk of academic failure, social isolation, and unemployment, all of which can have lifelong knock-on effects on mental health and wellbeing. For those of us on the Board involved in the economic analysis, the biggest shock and the biggest lesson was that lost productivity accounted for 81% of the total financial costs.*
>
> *There were also significant costs associated with health, education, justice, and wellbeing, but they were outstripped by the impact on the nation's productivity. This brings into sharp focus the issues around identifying and treating adults with ADHD, how we support the parents of children with ADHD, and the need to take a systemic approach when we develop our strategies for addressing ADHD.*[268]

7.3 Dr Kate Bendall, a Tasmanian GP, expanded on the findings of the Deloitte Report:

> *The Deloitte report found that the cost to Australia annually is $20 billion. This is a cost that is both material and in lost productivity.*

[268] Submission No. 44, Australasian ADHD Professionals Association, p. 23, including reference to Footnote 10, Sciberras, E., Streatfeild, J., Ceccato, T., Pezzullo, L., Scott, J. G., Middeldorp, C. M., Hutchins, P., Paterson, R., Bellgrove, M. A. & Coghill, D. 2022b. Social and Economic Costs of Attention-Deficit/Hyperactivity Disorder Across the Lifespan. J Atten Disord, 26, 72-87.

From my personal and professional experience, this looks like real people (with an ADHD diagnosis or who are highly suspected to have ADHD but not able to access diagnosis) experiencing:

- *Recurrent injuries with associated medical costs and time off work*
- *Drug and alcohol use because of a mind that feels like it will never turn off,*
- *Missed appointments, missed deadlines, ADHD 'tax' from associated costs,*
- *Gifted students not reaching their potential due to under recognised and under supported 'twice exceptionality' (ie giftedness and another diagnosis which includes but is not limited to ADHD),*
- *Students struggling with attention, concentration, regulation, and flow on effects on friendships, self-esteem, learning.*
- *Dying by suicide after a life of chronic mental health issues, impulsivity, inability to relax, lots of mental health input but in hindsight, not addressing clear features of ADHD.*
- *Reduced ability to follow through with health advice, investigations, making and keeping appointments, treatment, and subsequently poor outcomes.*
- *Very capable people becoming burnt out and requiring time off work.*[269]

7.4 Dr Madelyn Derrick, a clinical psychologist, stated that there is a level of public knowledge and understanding of the social and economic costs of untreated ADHD:

> ***Dr DERRICK*** *- … We're at a point now where we have enough understanding and enough of a sense of intervention needs for ADHD to mean that it would be nonsensical to not make strategic and significant change now. We have more than enough evidence of the cost of ADHD. This is a cost to individuals and others in their lives, as well as to society more broadly economically. This is a cost that comes about when ADHD is not recognised and not appropriately supported right across the lifespan. It's about early intervention, but also about recognition for people who have been missed and jumping straight in from there.*
>
> *So much of the cost to quality of life and the economic costs is really preventable. It really is. We don't have the firm evidence, we don't have randomised control trials to specifically say how these things work, but that from the collective clinical knowledge in the space it's very clear and evidence-based from all the various disciplines, and general principles of practice and what works in public health. There's no debate there on the general things that are going to work.*[270]

[269] Submission No. 39, Dr Kate Bendall, p. 9.

[270] Dr Madelyn Derrick, Clinical Psychologist, Hobart ADHD Consultants, Transcript of Evidence, 18 October 2024, p. 10.

Findings

The Committee finds:

95. There are many social and economic costs of inadequate treatment of ADHD. These can include decreased productivity, academic failure, social isolation, chronic mental health issues, substance misuse, and unemployment.

96. The social and economic costs of inadequate treatment of ADHD place increased demand on health, education and justice systems.

Risks of undiagnosed and untreated ADHD

7.5 The Committee received considerable evidence about the risks associated with undiagnosed and untreated ADHD.

7.6 AADPA's submission listed some of these risks:

- *relationship problems*
- *family breakdown*
- *poor academic achievement*
- *increased unemployment*
- *teenage pregnancy*
- *abuse*
- *anxiety*
- *depression*
- *eating disorders*
- *substance misuse*
- *suicide ideation and completion*
- *accident and injury*
- *criminality and incarceration*
- *physical health problems*
- *decreased life expectancy* [271]

7.7 Women's Health Tasmania's submission stated:

> *The costs to individuals can be high. People with untreated or poorly managed ADHD can struggle to continue their education, maintain employment and reach their full potential – with 'long-term economic consequences for both individuals and society'. Particularly for those with coexisting conditions, unsupported ADHD can result in lower wellbeing, higher healthcare costs and decreased quality of life. ADHD can also significantly impact families and relationships, leading to increased stress, conflict and negative wellbeing, resulting in adverse outcomes for all family members...* [272]

7.8 The Tasmanian Government provided evidence of the increased risk to an individual without access to adequate support:

> *The outcomes of undiagnosed and/or unsupported ADHD are well evidenced in the research literature. They include an increased likelihood of poor health such as:*

[271] Submission No. 44, Australasian ADHD Professionals Association, p. 5.

[272] Submission No. 20, Women's Health Tasmania, p. 17.

- *risk of brain injuries and accidental injuries, including motor vehicle accidents*
- *increased likelihood of violence as both perpetrator and victim*
- *high risk for earlier childbearing and contracting Sexually Transmitted Diseases*
- *less healthy diet and associated consequences*
- *significantly increased risk of obesity (three times) by adolescence and up to three times the risk rate for type II diabetes*
- *increases in the risk for eating disorders in females (3.5 times)*
- *significantly increased use of tobacco, marijuana and alcohol, as well as increased difficulty quitting, resulting in a greater risk of cancer*
- *greater risk of cardiovascular disease*
- *much greater likelihood of depression and anxiety*
- *greater risk of dementia (particularly if unmedicated)*

They also include greater risk of mortality:

- *increased risk of suicidal ideation, attempts and completion (nearly five times)*
- *link between externalising behaviour in ADHD to greater mortality in later life*
- *missed appointments for physical and mental health, linked to up to eight times greater mortality*
- *many studies have found increased risk of mortality in ADHD, up to five times the neurotypical population rate – these include comorbid disorders, suicide, and accident.*[273]

7.9 In its submission, Hobart ADHD Consultants referred to the sobering impacts on life expectancy attributable to lack of access to ADHD intervention:

> *A lack of adequately funded and located public health services for children and adults leads to lost opportunities to intervene early in the individual's treatment. This increases the likelihood of further difficulties and complications as the individual's quality of life is compromised. These negative impacts on quality of life are captured in the 12.7-year reduction in estimated life expectancy reported for young adults who have not been able to access ADHD intervention in their developmental years*[2]*.*[274]

[273] Submission No. 60, Tasmanian Government, p. 32.

[274] Submission No. 30, Hobart ADHD Consultants, p. 15, including reference to Footnote 2, Barkley RA, Fischer M. *Hyperactive Child Syndrome and Estimated Life Expectancy at Young Adult Follow-Up: The Role of ADHD Persistence and Other Potential Predictors*. J Atten Disord. 2019 Jul;23(9):907-923. doi: 10.1177/1087054718816164.

7.10 Evidence received from Tasmanians with lived experience also discussed the costs and risks associated with ADHD. One private Tasmanian witness explained:

> *…Some ADHD folks experience symptoms so debilitating that they struggle to maintain employment, attend school and engage in social activities. When the supports and services available in society fail to be accessible to them, this not only fails to ease these issues, but further exacerbates the shame and isolation that accompanies them. It becomes a vicious cycle – over time, some ADHDers give up on both maintaining employment and attempting to access treatment and supports that could make this easier. This, accompanied with the costly process of accessing diagnosis and treatment, is a huge economic cost. The social cost then increases too – not having a stable income often affects ability to participate in certain social activities, and the low self-esteem that often accompanies unemployment and ADHD symptoms also further pushes folks into isolation.*[275]

7.11 Mr Chris Anderson provided another example of the effect ADHD has had on his health and financial stability:

> *Health wise I have found that my obesity can be attributed to my AuDHD. This comes from comfort eating, binge eating, inability to get started for weight loss, hyperfocus for losing weight but then putting it all back on afterwards as happened to me over recent years and never being able to start again.*
>
> *Splurge spending and poor impulse control which can lead to poor financial decisions and outcomes which in a world like we have today can bring about terrible outcomes including leading to poverty or homelessness.*
>
> *Addictions whether they be drug, alcohol, gambling, pornography or a myriad* [of] *things are also quite common for those suffering from ADHD and can come about from searching for those quick dopamine hits to keep the brain happy or from those who have been shunned and cast out by society for being different or being unable to integrate effectively and so they have sought attention from elsewhere.*[276]

7.12 Misdiagnosis and comorbidities can disrupt appropriate assessment and support for patients with ADHD. These factors also contribute to the ongoing social and economic cost of the condition. One Tasmanian reflected on their experience:

> *…For years, I was misdiagnosed with treatment-resistant depression and prescribed up to 11 different medications in an attempt to manage my symptoms. Despite these efforts, I continued to struggle with severe depression that left me bedridden for an extended period. The level of pain and despair I was feeling*

[275] Submission No. 14, Private Witness, pp. 3-4.
[276] Submission No. 35, Chris Anderson, p. 4.

during this time was completely unbearable, and I am extremely grateful that I survived it.[277]

7.13 Mr Niall Harden also shared the impact of being misdiagnosed:

Being misdiagnosed for years with depression when I actually had ADHD has nearly cost me my life, and still might.[278]

7.14 Another Tasmanian discussed their feelings of inadequacy before receiving an ADHD diagnosis:

I have spent more than half of my young life feeling lesser than, broken and so painfully confused about what I couldn't explain. I have been diagnosed with Generalised Anxiety Disorder, panic attacks, depression, Post-Traumatic-Stress-Disorder and broadly just 'being a teenager/young woman growing up' along the road to the ADHD diagnosis...[279]

7.15 The risk of suicidal ideation, attempts and completion is increased by nearly five times for those with undiagnosed and untreated ADHD.[280] The Committee heard evidence from those who have contemplated or attempted suicide. One Tasmanian stated:

…As a young teen I half-heartedly attempted suicide 3 times. I also had an eating disorder during my 20s, post-natal depression (twice) in my 30s and have had persistent depression and anxiety since I was a teenager.[281]

7.16 Another witness shared their experience:

In the time it took me to find a Psychiatrist in Tasmania I attempted to commit death by suicide once by overdose and contemplated it many times.[282]

7.17 Evidence was received from parents with children who were unable to access adequate assessment and support services, and as a result, attempted suicide. ADHD Australia provided the following quote:

…My son who is 7 has suicidal ideation due to his impulsivity and has attempted 3 times. Due to his age, we cannot access the mental health services for free and paid services are long waits and outside of the amount we can pay… [283]

7.18 In discussing their daughter's condition, another Tasmanian parent stated:

---

[277] Submission No. 13, Private Witness, p. 1.
[278] Submission No. 33, Niall Harden, p. 2.
[279] Submission No. 28, Private Witness, p. 12.
[280] Submission No. 60, Tasmanian Government, p. 32.
[281] Submission No. 17, Private Witness, p. 1.
[282] Submission No. 31, Private Witness, p. 2.
[283] Submission No. 49, ADHD Australia, p. 8.

She had characteristics of separation anxiety from 18 months old, flagged by paediatricians as obese, suffered… bullying, depression, sleep deprivation, social anxiety, self harm building to 2 attempted suicides.[284]

7.19 The Committee heard that a considerable proportion of people in treatment for alcohol or other drug dependence have ADHD:

> ***Mr VAUTIN*** *- …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.*[285]

7.20 Dr Timothy Jones, a GP, explained that the prevalence of substance use disorders among those with ADHD is a result of not providing proactive treatment for the condition:

> ***Dr JONES*** *- …We're not front loading supports and so we will wait till they develop major drug and alcohol issues or until they end up in a public mental health institution before we then reactively try to apply care and even there it's still fragmented. The question of ADHD is still working with no place it can attach to for ongoing support.*[286]

7.21 Ms Kelly Warburton provided her perspective from her interactions with young people engaged in the use of alcohol and drugs:

> *I have also listened as teenagers work through their experiences of addiction and/or trauma and wondered if it was symptoms of undiagnosed ADHD that contributed to their use of alcohol and other drugs and/or their involvement in a traumatic event. I wonder if they could have avoided these experiences if they had adequate access to assessment, diagnosis and support services for ADHD.*[287]

7.22 Another Tasmanian shared their experience in self-medicating to relieve their ADHD symptoms:

> *Throughout the rest on my teens/20's I was diagnosed with depression and anxiety… was medicated and took to self medicating with marijuana. I used this for years to help quiet my world and feel a sense of calmness. I stopped smoking*

[284] Submission No. 16, Private Witness, p. 2.
[285] Mr. Daniel Vautin, Director of Policy and Impact, Alcohol Tobacco and Other Drugs Council Tasmania, Transcript of Evidence, 8 November 2024, p. 39.
[286] Dr. Timothy Jones, General Practitioner, Royal Australian College of General Practitioners, Transcript of Evidence, 18 October 2024, p. 51.
[287] Submission No. 11, Kelly Warburton, p. 2.

this in my late 20's and noticed I transitioned to using alcohol as a coping mechanism.[288]

7.23 ADHD Australia's submission provided a direct quote from a person with lived experience which shared their perspective on the causes of engaging in high-risk behaviour:

> *From a very young age, you learn you are wrong. Until you are diagnosed you cannot know how deep it runs. Dopamine seeking behaviour like drugs to help you, also can put you in jail and also give you shame. People say quit but they don't get why it's difficult for us, it's because we need more dopamine, and the drugs actually help us function. I have no self-esteem from the shame of trying to be normal but failing.*[289]

Findings

The Committee finds:

97. ADHD frequently presents alongside other conditions or comorbidities. This can lead to misdiagnosis or misunderstanding of ADHD symptoms and impacts.

98. Misdiagnosis or missed diagnoses have significant negative impacts on the mental and physical health of people with ADHD and can lead to suicidal ideation, suicide attempts, and completion.

99. Successful diagnosis and treatment of ADHD can be lifesaving.

Cost to adults

7.24 Adults with undiagnosed, untreated, or poorly managed ADHD experience workplace challenges, and difficulties pursuing further education, managing day-to-day tasks, and maintaining relationships.

7.25 General Practitioner, Dr Kate Bendall provided evidence on the social and economic costs of this:

> *For adults, unable to afford to be assessed privately, this can look like patients with a childhood diagnosis of ADHD now untreated, living a chaotic life, having difficulty with planning around life skills, making poor and impulsive decisions that may lead to going to prison, and for some, using drugs and alcohol and struggling to make changes. Or it might look like someone with suspected ADHD and co-existing borderline personality disorder having repeated situational crises, quitting jobs, putting themselves in unsafe situations, having abusive*

[288] Submission No. 32, Private Witness, p. 1.
[289] Submission No. 49, ADHD Australia, p. 8.

relationships, not sleeping, having insecure housing, and being given advice to keep trying many of the same things.[290]

7.26 Tasmanian Adult ADHD Support Group also raised the risks for adults with untreated ADHD in its submission:

> *Many have challenges with employment and income due to their ADHD or rely completely on government benefits and with no provision in the public system, they have little prospect of treatment for their condition and options for support are very few. Many adults with ADHD, especially if it is untreated or inadequately treated, have comorbid mental health conditions and sometimes related substance abuse issues...*[291]

7.27 Mental Health Families and Friends Tasmania (MHFFTas) gave evidence from the perspective of families and friends of those affected:

> *…families and friends stress the impacts on their adult loved ones…living with undiagnosed, untreated, and unsupported ADHD. Families and friends and their loved one's* [sic] *share lifelong feelings of inadequacy and shame, and damaging comparisons to people their age due to the education, career, and social disadvantages they have faced. Families and friends describe the turmoil their loved ones have experienced, including severe mental ill health, suicidality, unhealthy and abusive relationships, and drug and alcohol dependency, and the subsequent impacts that has on themselves as support people.*[292]

7.28 Mr Anderson reflected on his experience before receiving a diagnosis:

> *…I would waste entire weekends where I wanted to do things but simply couldn't muster any energy to do things and then I would beat myself up for being a terrible person, husband and father. Learning about executive dysfunction and autistic burnout made so much sense for me.*
>
> *The way I would describe to people the way I was living would be by every day trying to give 100% to work, 100% to my wife, 100% to my kids and 100% to myself and I would still always feel like I was drowning or not doing enough and beating myself up constantly for my failings and trying to work out why my life was feeling like a mess despite me trying to put in 400% and why it was unsustainable.*[293]

7.29 At the 21 February 2025 public hearing, Mr Nicholas Spohn shared his experience of ADHD and being undiagnosed until his early-30s:

> ***Mr SPOHN** - …I was undiagnosed until 33. What that looked like was from about year 11 and onwards I had various bouts of bad anxiety and depressive episodes.*

[290] Submission No. 39, Dr. Kate Bendall, p. 2.
[291] Submission No. 21, Tasmanian Adult ADHD Support Group, p. 3.
[292] Submission No. 29, Mental Health Families and Friends Tasmania, p. 10.
[293] Submission No. 35, Chris Anderson, p. 2.

They, obviously, negatively impacted my life, in some small ways, but other times in more significant ways. I have struggled to find a job I could stick to. My pattern usually went: get hired, do my best, enjoy some time actually excelling at the job, begin to falter, completely flame out, quit, and repeat. That was the cycle. I just assumed, 'Okay, I've just got a chemical imbalance in my brain. I just have anxiety and depressive issues…'… so I would medicate for those.[294]

7.30 Another Tasmanian shared their lived experience via a written submission:

ADHD affects all aspects of my life.

Financially it makes it very hard as the learning of tools to regulate my symptoms has only happened in the last year and that has unlocked huge progress at work, but it's hard to express how impaired (and how little I understood the degree of impairment) I was prior to diagnosis and medication.

ADHD has caused me significant and lifelong issues with Anxiety, turning to major depression due to dysregulation and chronic stress.

…

There are [a] *lot of day to day tasks that are insignificant for most people – paying the power bill, doing your taxes, getting sheets in off the clothesline. Small daily tasks like these that are not intrinsically interesting to the ADHD mind require a lot of effort to manage. Post diagnosis I have found many tools to help me (beside medication) but to most people it can look like laziness or incompetence when we miss these tasks. That can be really hard on our self confidence.*

…

While I knew "something was wrong" I didn't know what it was. I feel it's key to understand that any people with undiagnosed (or suspected but not confirmed) ADHD have no idea of how much it is impacting their lives.[295]

7.31 The Committee received evidence on the impact of employment challenges and financial strain experienced by those with ADHD who are unsupported in the workplace. The Tasmanian Adult ADHD Support Group submitted:

…For many the requirements needed to function independently as an adult and find consistent employment become more difficult as they grow older, and as their peers mature and gain independence, these differences become starker and co morbid [sic] *conditions such as anxiety and depression start to appear. Many with ADHD find it hard to maintain steady employment and although there are*

[294] Mr. Nicholas Spohn, Transcript of Evidence, 21 February 2025, p. 38.
[295] Submission No. 41, Private Witness, pp. 3-4.

> *now workplaces that are prepared to offer support and accommodations for those with the condition, this would still be far from the norm...*[296]

7.32 As a result of insufficient support for her condition, Ms Madeleine O'Keeffe experienced unemployment:

> *I believe my health deteriorated enough to require a 2 month admission as a direct result of the lack of support and care for neurodiverse adults in Tasmania. As a result I have lost my job, I was a clinical nurse specialist in our public system earning over $100k a year, now I am living with my parents, on job seeker with a medical exemption for at least 6 months. I am attempting to get on DSP* [Disability Support Pension] *but again, am struggling to get the support from medical services and evidence for my application. Instead of paying something in the range of $40k a year in taxes, I am now costing the taxpayer this much just to survive.*[297]

7.33 Another Tasmanian shared that they had lost multiple jobs, and pointed out that additional support from job agencies is not provided to those with ADHD:

> *As an ADHD'er it is difficult to identify let alone voice my own limitations, and has cost me multiple jobs because I couldn't function in various environments, sometimes ending up bullied for my differences, eg. The way I learn is slower. I'm expected to perform like any other person, and treated dreadfully when I can't do things the same as others even though I get similar if not better results.*
>
> *There are job agencies that handle disabilities, yet ADHD isn't one of them. They advertise they can find jobs for those with ADHD, but won't help because I'm not on Job Seeker (don't qualify) or NDIS...*[298]

7.34 Without the necessary supports implemented in their workplace, one witness shared that they experienced suicidal ideation:

> *In my previous job here in Tasmania I was in a toxic workplace, I was unsure of this and thought it was me but having spoken extensively to my Psychologist and GP I now realise it was the workplace. As my attention span and ability to concentrate was so low I found it really difficult to employ coping mechanisms to deal with the situation. I got to such a state that I was contemplating suicide again...*[299]

7.35 MHFFTas submitted that for those with poorly managed ADHD who are unable to work, their financial burden is exacerbated and access to supports are further limited:

---

[296] Submission No. 21, Tasmanian Adult ADHD Support Group, p. 6.
[297] Submission No. 3, Maddie O'Keeffe, p. 2.
[298] Submission No. 26, Private Witness, p. 4.
[299] Submission No. 31, Private Witness, p. 4.

…many adults who have gone undiagnosed or untreated for their ADHD have disclosed that their ability to participate in further education or in employment has been significantly impaired for a range of reasons. Subsequently, adults have had to rely on the disability pension, often requiring their families and friends to support them financially, also. Families tell us that they often fund their adult family member's treatment because the disability pension is inadequate to fund the cost of living as well as the cost of much needed care and treatment.[300]

7.36 Another submission discussed the consequences of reducing work hours in an attempt to manage ADHD:

…for those that choose to take fewer hours of work to protect their psychological wellbeing, it is a financial sacrifice. This can result in people with ADHD, like myself, finding themselves between a rock and a hard place, choosing to either take on a psychological or financial burden in order to exist. You can work 40 hours and be able to afford additional things above the bare necessities, like more frequent psychological support and other protective supports (e.g. noise-reducing/cancelling devices, services like exercise and nutrition coaching) but find yourself experiencing burnout and/or breakdown and being unable to maintain your employment. Or, you can take a job with fewer hours, resulting in less income, and whilst you've got more space and time to decompress, access formal and informal supports and reduce the likelihood of and/or delay burnout/breakdown, you've got to sacrifice the things that can help you to improve your experience living with ADHD now, and into the future…[301]

7.37 Maintaining relationships is another challenge for those with undiagnosed or unsupported ADHD. Matthew McDonagh shared his experience:

After the Psychiatry consultation I had to go back to the GP to get the authority from pharmaceutical services, which brings me to the next part of my story.

When I received my psychiatry report, my wife had been telling me I was depressed for months, but I had my head in the sand. Reading the report and the psychometric questionnaires showing high levels of anxiety, extreme depression, and poor quality of life, was confronting.

Again, I am an allied health professional, and I was struggling to navigate my mental health. For someone without a health background this would be more challenging and not helped by the system of short GP consultations and lack of awareness in the medical field of ADHD.

In hindsight, this was true. My mental state was driving my erratic behaviour, my inability to concentrate at work, and my failing marriage. My wife and I eventually separated.

[300] Submission No. 29, Mental Health Families and Friends Tasmania, p. 9.
[301] Submission No. 28, Private Witness, p. 9.

I have to take responsibility for my actions and behaviour. However, this highlights the cost of the delays to access diagnosis and treatment. It's not just the individual its their family.

The eight months it took from my initial conversation with my psychologist friend to finally getting medication had a significant impact. My marriage was a casualty of the delays...[302]

7.38 MHFFTas further explained:

...those who support a friend living with ADHD have described the difficulty of maintaining that friendship. Friends have told MHFFTas that the trauma they have experienced supporting their loved one who experiences self-harm and suicidality, as well as relational trauma of managing the irritability, impulsivity, and emotional dysregulation. People supporting their friends have disclosed the guilt and grief they experience as they have had to make the difficult decision to distance themselves from their friend to protect their own mental health.

...

...the family unit is deeply shaken as a result of undiagnosed and untreated ADHD. the families and friends we support, and our consultation findings uphold research and literature where marriage breakdown is common[9]. This compounds the family's financial strain and the emotional and social health of the family and the individual... [303]

Findings

The Committee finds:

100. For adults, the social and economic costs of not receiving adequate assessment, treatment or support services for ADHD can include impacts on employment, study and participation in community life, family breakdown, impulsive decision-making, incarceration, and substance use disorders.

101. Anxiety and/or depression are common among adults with undiagnosed, untreated, or poorly managed ADHD. It is also common for people with unrecognised ADHD to be misdiagnosed with these conditions.

102. Adults with ADHD have better lived experience and outcomes when their ADHD is recognised and supported in their workplace.

[302] Submission No. 9, Matthew McDonagh, p. 4.

[303] Submission No. 29, Mental Health Families and Friends Tasmania, p. 9, including reference to Footnote 9 - Peñuelasr-Calvo et. al (2020).

Cost to children

7.39 For children with undiagnosed and unsupported ADHD, the negative impacts on their schooling, mental health, and perceptions of their behaviour can continue into adulthood.

7.40 A Tasmanian GP, who wished to remain anonymous, made a written submission which included a comment on the importance of early intervention and the costs if it is not provided:

> *My key point to make regarding social and economic cost of ADHD is that early intervention works. I have noted repeatedly as a clinician that early support of families with a young child displaying some symptoms of hyperactivity or inattention can often rapidly reduce disruption to a point where the child can thrive and not necessarily even reach an ADHD diagnosis. Conversely if this support is not provided problems around home and school only seem to grow from there and rely on much more pervasive and longitudinal usage of health care systems as a result...*[304]

7.41 The Royal Australian College of General Practitioners' (RACGP) submission expanded on this issue:

> *Children who live with undiagnosed ADHD are at higher risk of mental health issues in adulthood including an increased risk of anxiety, depression, personality disorders and antisocial behaviour...*[305]

7.42 Hobart ADHD Consultants discussed the impact on students with ADHD:

> *Students with ADHD who are inadequately supported and who experience negative consequences at school learn that school is an unsafe environment. There is a threat to their social and emotional safety daily, and they very quickly develop a hypervigilance to this threat. With this hypervigilance comes increased stress leading to increased severity of ADHD symptoms (via the cascade of related neurochemical events).*
>
> *We then see increasing use of self-protection measures (fight/flight responses) which creates further difficulties for teachers to manage e.g. defiance and angry outbursts, emotional overwhelm and anxiety, and learned helplessness and disengagement with learning tasks...*[306]

7.43 A private witness reflected on their time in school, before receiving a diagnosis and treatment for their condition:

---

[304] Submission No. 15, Private Witness, p. 4.
[305] Submission No. 40, Royal Australian College of General Practitioners, p. 6.
[306] Submission No. 30, Hobart ADHD Consultants, p. 7.

> *In school by* [sic] *brain was always buzzing, I couldn't concentrate, I experienced impulsivity and emotional dysregulation.*[307]

7.44 Another Tasmanian provided their experience, and the ongoing impact of not being supported in school:

> *I failed at school due to never handing in homework, even though I excelled at exams and demonstrated that I understood the work. It pains me that children are shoehorned into a system that is like the adage of judging the skills of a fish by its ability to climb a tree. If a child can't sit still, stare at a blackboard for a whole lesson or hand in homework they (I was) are left feeling inadequate for the rest of their lives.*[308]

7.45 Carers Tasmania discussed the impact when a child does not have access to a diagnosis:

> *…Without the diagnosis it can be difficult for other people to acknowledge that the difficulties sometimes experienced by a person with ADHD are not a choice. This is especially true for children who are often labelled as 'naughty' or 'disruptive', and due to these negative stereotypes, their strengths are often not seen or supported…* [309]

7.46 Another private witness shared their experience of school without a formal ADHD diagnosis:

> *My experiences date back to primary school where I was always seen as an out cast* [sic]*, didn't fit in and missed out on special treats as I could keep it together so long then loose* [sic] *it.*[310]

7.47 National Disability Services outlined the consequences for children unable to access services in its submission:

> *…Not supporting students adequately at school can translate into worse employment and economic outcomes. The known increased risk-taking behaviours associated with ADHD can not only risk an individual's health and wellbeing, but increase the probability of having interactions with the justice system, a system that is void of a therapeutic approach in Tasmania.*[311]

7.48 MHFFTas raised the social and economic cost for children and their families:

> *…Due to the school system being ill equipped, unsupported, under resourced, and the stigma still surrounding young people with ADHD, parents are often called away from work to pick up their child due to their child's challenging*

[307] Submission No. 17, Private Witness, p. 1.
[308] Submission No. 42, Private Witness, p. 3.
[309] Submission No. 19, Carers Tasmania, p. 11.
[310] Submission No. 32, Private Witness, p. 1.
[311] Submission No. 48, National Disability Services, p. 8.

behaviours. In some cases, families have opted to utilise home-schooling for their child as they were falling behind in the education system, requiring parents to remain unemployed.

…

Families and friends told MHFFTas that their children, as young as primary school age, experiences [sic] *bullying, lack of self-identity, loss of self-confidence, lack of self-worth, anxiety, and social isolation. Of significant concern of families and friend*[s]*, and unsurprisingly so, is the impact on their child's education. Families and friends talk about how the education system is failing their children due to the lack of neuro-affirming support and learning, the lack of understanding of ADHD, and loss of opportunities that their children face. This is a reality for many, as dropping out of school and academic difficulties is a common theme for young people living with undiagnosed, untreated, and unsupported ADHD.*[312]

Findings

The Committee finds:

103. Children with undiagnosed or untreated ADHD face challenges in their schooling, which impacts on future study and employment opportunities.

104. Children with undiagnosed or untreated ADHD may also experience bullying, low self-esteem, anxiety, and social isolation which can lead to mental health issues continuing into adulthood.

105. Early diagnosis and intervention for children with ADHD leads to better educational and life outcomes.

Cost to families and caregivers

7.49 Families and carers of individuals unable to access assessment and support services for their ADHD reported feelings of stress and judgement, as well as a loss of income resulting from a decreased capacity to work.

7.50 This issue was emphasised by Carers Tasmania in its submission:

> *…The primary focus of our submission is to emphasise that inadequate access to diagnosis and support for people with ADHD not only impacts people who have ADHD but also their carers. In addition, we highlight that many family and friend carers have ADHD. Although the ToR do not specifically include a question around the impact of ADHD on family and friend carers, we seek for carers' needs and experiences to be considered alongside other feedback collected throughout this inquiry process.*[313]

[312] Submission No. 29, Mental Health Families and Friends Tasmania, pp. 8 and 10.

[313] Submission No. 19, Carers Tasmania, p. 5.

7.51 MHFFTas's submission provided evidence from the perspectives of families and friends:

> *…Families and friends reach out in distress for a myriad of reasons that eventuate as a result of their loved one struggling with their ADHD, more often than not, because they are unsupported, untreated, and undiagnosed. Supporting their loved one living with ADHD who struggles with their condition encompasses managing distressing and difficult behaviours, supporting day to day activities in which their loved one might find difficult, advocating for their loved one, responding to crises, and defusing distress. Furthermore, more often than not, families and friends are supporting their loved ones living with co-occurring conditions…*
>
> *…*
>
> *Families and friends' health, wellbeing, and quality of life are significantly impacted when their loved one is undiagnosed and or untreated for their ADHD. Many families and friends told stories of becoming mentally unwell themselves, having to seek treatment for clinical levels of anxiety and depression. Feelings of inadequacy and failures as a support person is heartbreakingly common. Parents who have a child with ADHD experience higher levels of parental stress compared to parents whose children don't experience ADHD[4] and face more barriers to employment and subsequent financial stress[5]. Furthermore, parents who have children living with ADHD experience poorer mental health and wellbeing and higher rates of divorce and AOD* [Alcohol and Other Drugs] *use compared to parents who don't have children living with ADHD[6].*[314]

7.52 Navigate Family Services submitted:

> *The most common presentations are families feeling judged (by Education system as well as by 'everyone'). They feel defeated.* [315]

7.53 The Carers Tasmania submission expanded on the cost and strain experienced by those caring for someone with undiagnosed or unsupported ADHD:

> *Many people caring for a person with ADHD experience high levels of stress. This is particularly relevant to carers of children who have ADHD, who often worry about how their child is coping at school, or if the school is going to call and ask for the child to be picked up early. This can lead to parents being absent from employment, having to reduce their employment hours, or giving up employment entirely.*
>
> *…*

[314] Submission No. 29, Mental Health Families and Friends Tasmania, pp. 4 and 7-8, with reference to Footnote 4 - Leitch (2019); Footnote 5 - Hill (2015); and Footnote 6 - Peasgood (2020).
[315] Submission No. 6, Navigate Family Services, p. 1.

…the Caring Costs Us Report, which was commissioned by the Carers Australia Network of State and Territory organisations, found that on average, for every year a person is a primary carer, they will lose $39,600 in employment earnings and $17,700 in superannuation.[316]

Findings

The Committee finds:

106. Families and caregivers of people with undiagnosed or poorly treated ADHD experience challenges in day-to-day life, including managing behaviours and responding to crises. This can lead to poor mental health.

107. Caring for someone with undiagnosed or poorly treated ADHD can affect employment and earning capacity.

Recommendations

The Committee recommends:

26. The Tasmanian Government acknowledge and address the social and economic costs of failing to provide adequate and appropriate ADHD services.

[316] Submission No. 19, Carers Tasmania, pp. 7 and 16.

8 RELATED MATTERS RAISED WITH THE COMMITTEE

8.1 This Chapter considers related matters that were raised and considered during the Committee's Inquiry.

8.2 A significant area of concern was the treatment of inmates with ADHD in the Tasmania Prison Service (TPS), and the limitations on access to ADHD assessment and treatment within the Justice and Corrections system.

8.3 Another matter of interest was the need for further research into ADHD to increase the understanding of this disorder.

Access to assessment and support in the Tasmania Prison Service

8.4 In its submission, Royal Australian and New Zealand College of Psychiatrists (RANZCP) provided evidence on the prevalence of ADHD in custodial settings, as well as the services currently available in the TPS:

> *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 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.[317]

8.5 At the 18 October 2024 public hearing, then Acting Secretary of the Department of Health, Mr Dale Webster, gave evidence on the services available in custodial settings for the assessment and treatment of ADHD:

> ***Ms ROSOL*** *- …I wonder what services are available for people in prison knowing that a large percentage of them are likely to have ADHD. What health services and mental health services are available for them? Are they able to access assessment, treatment and medications in that place?*
>
> *…*
>
> ***Mr WEBSTER*** *- Specifically within the prison, we have a team within our state-wide mental health services called the Forensic Mental Health Service. That particular team - little bit misnamed - provides both the primary health service to the prison service and to youth detention as well as providing the mental health services to those who are found not guilty by reason of insanity or, indeed, not fit to plead-type categories.*
>
> *Forensic Mental Health Services, for a number of years, provided services to the prison and youth detention, as well as having their focus on their primary role of forensic. From this year's State Budget, we have separated prisoner mental health from forensic mental health. We are establishing a Prisoner Mental Health Service, so that we can have better diagnosis and support within the prison services for, not just ADHD, but a range of mental illness and psychosocial support. The model of care development is underway to establish that. In fact, we have just started to advertise the roles to go into that service.*
>
> *…*
>
> *The Forensic Mental Health is the specialist part of the current service and that will be replaced by Prisoner Mental Health and then the Correctional Primary*

[317] Submission No. 46, Royal Australian and New Zealand College of Psychiatrists, pp. 6-7, with reference to the submission's Footnote 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; Footnote 24 - Harpin V & Young S J The Challenge of ADHD and Youth Offending Cutting Edge Psychiatry in Practice 2012 January: 138-143; Footnote 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; Footnote 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; Footnote 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; Footnote 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; Footnote 29 - Prisoners in Australia. Australian Bureau of Statistics; 2023; and Footnote 30 - Tasmania's Prison Mental Health Care Taskforce reveals system failing inmates, advocates say. ABC News; 2020.

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

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

***Mr WEBSTER** - Yes, it is, because in the community, what we have just discussed, the high-level restrictions are an automatic in the prison service. Prisoners do not have medications in their cells. They are actually taken to them, around the prison, on regular medication rounds. It is possible because, in effect, the restrictive practice is an automatic practice with how medications are delivered within the prison service.*[318]

8.6 Mr Webster also provided evidence on the support individuals receive when transitioning out of prison:

***Ms JOHNSTON** - ...When they exit, what's the support and the continued treatment plan for them in the public health system...How do they continue without being able to afford private services?*

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

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

***Mr WEBSTER** - Through the Medicare system. A mental health plan can be developed in the Medicare system... Their initial treatment plan is established, it can be monitored by their GP, but they have the same access as everyone else through Medicare.*[319]

8.7 At the 7 March 2025 public hearing, the then Minister for Corrections and Rehabilitation, Hon. Madeleine *Ogilvie* MP, and representatives from the

[318] Mr. Dale Webster, Acting Secretary, Department of Health, Transcript of Evidence, 18 October 2024, pp. 30-31.
[319] Mr. Dale Webster, Acting Secretary, Department of Health, Transcript of Evidence, 18 October 2024, p. 31.

Department of Justice provided the Committee with further evidence on the assessment and treatment of ADHD in custodial settings:

> ***Ms OGILVIE*** *- … As Minister for Corrections and Rehabilitation, I view ADHD as a significant issue within our custodial system. It does deserve attention, but it's also, I think, important to know that's alongside other complex needs and situations and scenarios, so nothing happens in isolation in our world.*
>
> *We have the nation's highest disability rate here in Tasmania at 30.5 per cent. Our estimates of about 40 per cent of prisoners nationally having ADHD, and it's often linked to other comorbidities or issues like abuse or trauma, but it is a key part of the health and wellbeing landscape that we manage in our custodial facilities.*[320]

8.8 Mr Rod Wise, Deputy Secretary Corrective Services at the Department of Justice, provided the Committee with an overview of individuals with ADHD within the TPS:

> ***Mr WISE*** *- … We have a very ill prison population and high levels of disability and comorbidity, and ADHD is certainly one part of that. However, very frequently, the people who come into prison with ADHD also have a range of other issues that impact on their offending behaviour and their capacity to do a range of things. A high proportion have substance abuse issues. That varies from year to year and state to state, but generally in Australia we're looking at probably 70 per cent-plus of males using drugs on the outside - some of whom have addictions, clearly, and a large proportion have addictions. In the women's system, it's probably higher than that. It's probably closer to 80 to 90 per cent are drug users on the outside.*
>
> *Some of the things from substance abuse disorders are clearly interwoven with ADHD issues. There are cognitive disabilities, there are experiences of trauma, there's a whole range of things that the prisoners bring with them into the prison system and, you know, we can't isolate just the issues relating to ADHD because they are often very similar to some of the issues that are presented by those other disorders and challenges.*
>
> *… back in 2023 they started having a look in London at prisoners coming into custody there. One of the charities, ADHD Liberty, had a look at every person when coming into custody. They found in the initial stages of that study that 66 per cent of people had undiagnosed ADHD, and that's clearly on top of those who came in with known diagnoses. Now that is at the high end of everyone's assessment, I think, of the prevalence of ADHD in a custodial setting. Ours is somewhat less than that, but then there are differences, as you would have heard through other witnesses and through the submissions, that there are differences in people's preparedness to diagnose ADHD and different thresholds and so on.*

[320] Hon. Madeleine Ogilvie MP, former Minister for Corrections and Rehabilitation, Transcript of Evidence, 7 March 2025, pp. 1-2.

But there's clearly a large number of people who have some of the symptoms who meet the ADHD diagnostic definitions…

On some of the elements that are supposed to be helpful in allowing people to manage their ADHD, we do quite well in a prison environment, and some of the things we don't do so well in.

But we are very often dealing with a large group of people who need assistance in some way, some of whom will have ADHD and very many of whom will have substance abuse issues, many of whom will have intellectual disabilities or cognitive disorders and other things that impact on the way that they behave and they interact.

What that means is that our staff are used to dealing with difference and different presentations and so they are very open to that. Bronwyn [Hocking] *will no doubt speak about the responsivity issues when we're trying to deliver programs and treatment to them, but we are very well acquainted with people who present in an impulsive, different, agitated, anxious way because that probably describes the vast majority of the people who are in our custody.*[321]

8.9 Ms Bronwyn Hocking, Manager of the Crisis Support Services at the TPS, outlined the prison intake process:

***Ms HOCKING** - …my intention is to provide an overview of someone touching base with our service who may have an ADHD diagnosis or undiagnosed ADHD symptoms. I suppose first of all, just touching on previous comments around the Tasmania Prison Service (TPS) inheriting a lot of those comorbid sort-of presentations when someone touches base with us in custody, the diagnostic and statistics manual, which defines the diagnostic criteria for ADHD, recognises and acknowledges all of those comorbidities within that as well. Things like oppositional defiance disorder, conduct disorder, intermittent explosive disorders, intellectual disability, attachment disorders - the list is extensive. As a service, we are inheriting individuals who meet so many of those particular things as well. I'll touch on that again later when we look at what actually goes into a diagnosis and how we do that within the prison service.*

First off, every prisoner in Tasmania undertakes a tier process when they touch base with us at a reception prison. In the first instance, that's a correctional tier 1, which looks at their general wellbeing and any kind of major concerns that are presenting at that particular time. Lots of logistics questions, demographic information gets asked at that time. There are also some screens around suicide and self-harm risk, and questions around disability in terms of whether or not they're an NDIS participant, whether or not they're on the DSP or whether or not they identify as having a disability.

[321] Mr. Rod Wise, Deputy Secretary Corrective Services, Department of Justice, Transcript of Evidence, 7 March 2025, pp. 3-4.

One of the really challenging things in this particular field is that we're relying a lot on self report. A lot of our individuals who come to our service don't actually know that they would meet criteria for a lot of these diagnostic things either. And they've never been told, 'This might be a problem for you,' or 'That might be a problem for you.' Generally, they've just been told that they're a problem.

…

… The tier questions are answered. Within that they then progress to a nursing tier 1 through the Department of Health, where they meet with an RN and they ask their own series of health questions. Within that, any kind of urgent needs that are required: if there's any kind of suicidal self-harm risk or any kind of identification of vulnerability and needs that may need to be addressed, there are specific referral points that they can then progress those to. Our staff at reception prisons are really astute at picking up when someone isn't in the best of health or when there are vulnerabilities around young, first-time-in-custody attention issues, ability to really cope in a prison environment.

As a means of some statistics, I suppose, my team is called the Crisis Support Services Team, which is made up of counsellors and psychologists. We are responsible for overseeing the suicide and self-harm risk assessment process and providing coping and adjustment support to prisoners as they're coming through custody or at any time throughout their custodial sentence or their journey with us.

Since 1 July last year [2024]*, we've had 640 referrals to our service just for general coping and support. Within that, there's the opportunity for our clinicians to be picking up on vulnerabilities, on certain things that may need further assessment and to be able to really support those individuals. Our crisis response suicide and self-harm - 1 August to 28 February this year, so 2024 through 2025, over that five-month period there were 1227 risk assessments undertaken by our team. Within that, that's our highest-risk prisoners within the prison population. That's looking at not just risk of suicidal* [or] *self-harm, but that's looking at also risk in terms of vulnerability - in terms of appropriate placements for individuals within our service to be able to make sure that they're the safest that they possibly can be. That is a joint collaborative approach with correctional staff, health staff and therapeutic services staff.*[322]

8.10 Ms Hocking raised the Disability Support Service in the TPS:

Ms HOCKING *- … We also have a Disability Support Service underneath our Specialist Support Services that is a new branch that's opened up within our Therapeutic Services Team. That disability team is looking at supporting prisoners with cognitive impairment, ABI* [Acquired Brain Injury] *or other neurodiverse presentations.*

[322] Ms. Bronwyn Hocking, Manager Crisis Support Services, Department of Justice, Transcript of Evidence, 7 March 2025, pp. 4-5.

At the moment we have a senior psychologist as the team leader of that space. We have two dedicated people working in that space, one a high-needs support counsellor, and the other, our senior planning officer, who help identify and support prisoners that may be presenting with neurodiverse presentations, whether that be ADHD or autism within the prison, and trying to really help collaborate with correctional staff on how to support that individual in a custodial environment.

CHAIR [Mr Behrakis] - *Have people been diagnosed through that process?*

Ms HOCKING - *Yes. We have, in terms of diagnosis, we have the capacity within our team and the psychologists in our team to undertake screening for ADHD and looking at specific suites of assessments that may lead to us believing that there's an ADHD diagnosis there. On an individual basis, we collaborate with the Prison Mental Health Service, which is a new service over the past six months which has just initiated their first phase of operating within the prison. They sit under the Forensic Mental Health Team and are part of the Health Department. Within that, they have psychiatric consultants or psychiatrists working for them. With our information, with the information coming across to us from the correctional space, each individual is looked at individually if it's indicated that there's a significant diagnostic clarification that's required.*[323]

8.11 The Committee heard evidence on the prevalence of ADHD within the prison population:

Ms ROSOL - *…Do we gather statistics on the number of people in Tasmanian prisons who have ADHD? Do we have any idea how many there are?*

…

Ms HOCKING - *… the statistics that we have around ADHD - that's not a statistic that we keep in terms of how many people have ADHD or how many do we suppose have ADHD.*

What I can say is that at present we have 88 participants currently on the NDIS and, of those, seven have ADHD as part of their diagnostic profile that we're aware of. We know obviously that we have prisoners in custody who are being treated for ADHD with nonstimulant medication. And we also know that since March 2023, our psychometric testing capacity increased with the introduction of new psychologists into the team and in that time we've undertaken 15 ADHD suites of assessments.[324]

[323] Ms. Bronwyn Hocking, Manager Crisis Support Services, Department of Justice, Transcript of Evidence, 7 March 2025, p. 5.

[324] Ms. Bronwyn Hocking, Manager Crisis Support Services Department of Justice, Transcript of Evidence, 7 March 2025, pp. 7-8.

8.12 Ms Hocking and Minister *Ogilvie* provided further evidence on the 15 ADHD assessments:

> ***Mrs BESWICK*** *- … How many of your 15 assessed did you actually assess as having ADHD… ?*
>
> ***Ms HOCKING*** *- Of the 15 assessments that were undertaken, it was in the context of other kind of presentations for each of those individuals. It might have been that we're assessing for cognitive impairment or intellectual disability. As part of that, ADHD screening was a contributing factor to what the overall presentation of that person was. I don't disagree that there is a high likelihood of many more people in our prison having and meeting and endorsing symptoms of ADHD. We don't have standard screening procedures that we're doing with everyone. Again, we're relying on treating the behaviours of those that are continually coming to our attention or needing that reassurance and that wellbeing. We're really prioritising our focus on the prisoners who are presenting, whether it's distress or behavioural concerns and things like that. We're really looking at that multidisciplinary lens.*
>
> *… For our team in particular, if we undertake a suite of assessments looking at ADHD, we would still be relying on the psychiatrist to really confirm that diagnosis and undertake an assessment for ADHD. I'm sure you've heard already from community providers the level and the extent of what an ADHD assessment looks like. To be able to undertake that in the prison environment is challenging for a number of reasons. One, we're relying on being able to access historical information from when the individual was a child and often times they don't know the answers to a lot of those questions and we don't have the ability to be contacting other sources to be able to comment on their behaviour as well.*
>
> *… an assessment can cost upwards of $3000 in the community. What we have in the prison is treating what we have in front of us and looking at how we can best support the individual based on what they have, on an individual basis at each and every time.*
>
> ***CHAIR*** [Mr Behrakis] *- … On the topic of the cost and the $3000 - and I appreciate that's it's a lot to screen every single person in the system - is there any comparison or is there any thought about comparing that to the cost of not treating people? The cost of the higher rates of incarceration and the higher risk of misbehaviour and bad behaviour and damage and health problems that come from that. Are we comparing $3000 to zero or comparing $3000 to the costs of all the other things that come from that?*
>
> ***Ms OGILVIE*** *- I think what you're pointing to is the very real challenge that we have before us in prioritizing what we deploy our limited resources on and in what priority order. I should also say, particularly as the Minister, I take a lot of interest in the rehabilitation side of my portfolio. At the end of the day, unless*

we're rehabilitating people, we're just getting that cycle of recidivism, it keeps people safer in the community, et cetera… [325]

8.13 The Committee received evidence on the access of pharmaceutical treatment for those with ADHD in custodial settings:

> ***CHAIR*** [Mr Behrakis] - *…What access do people in the prison system have to pharmaceutical treatment for ADHD?*
>
> *…*
>
> ***Ms HOCKING*** *- …prescribing medication is obviously undertaken by the Health Department and within that they need to meet their prescribing guidelines. In terms of correct information around that, that will need to be addressed to the Health Minister.*
>
> *My understanding, though, is that there are a number of prisoners in our care who are prescribed non-stimulant medication for ADHD and that that is, I believe, somewhere between 10 and 22 prisoners at this particular time.*
>
> ***CHAIR*** *- No-one has access to stimulants?*
>
> ***Ms HOCKING*** *- No, that I'm aware of.*
>
> ***CHAIR*** *- Is that due to the risk of it being diverted?*
>
> ***Ms HOCKING*** *- I think that's one aspect of it, yes.* [326]

8.14 Mr Wise provided evidence on the risk of providing access to Schedule 8 medications in custodial settings:

> ***CHAIR*** [Mr Behrakis] - *…I don't think it's something that's typically prescribed in Tasmania, but I know there's a product that exists with liquid stimulant ADHD medication. The one I've just looked up on online: Quillivant, which is a liquid form of effectively Ritalin. Would investigating the use of something like - if you have someone in the system who is already diagnosed and already has a prescription outside and they find themselves in a correction facility - to replace say a Vyvanse or Ritalin tablet for obvious reasons - with something like a liquid version that's a lot harder - you can give them their daily dose - it's a bit hard for them to hide it. Is there scope to look into things like that to try to help make sure people have access to those medications?*

[325] Hon. Madeleine Ogilvie MP, former Minister for Corrections and Rehabilitation, and Ms. Bronwyn Hocking, Manager Crisis Support Services, Department of Justice, Transcript of Evidence, 7 March 2025, pp. 12-13.

[326] Ms. Bronwyn Hocking, Manager Crisis Support Services, Department of Justice, Transcript of Evidence, 7 March 2025, p. 6.

...

***Mr WISE** - There are some things that we can put in place to reduce the risks of abuse of prescribed medication. As I said before, we have high numbers of people who are drug users on the outside and a high proportion of people inside seek drugs, either prescription drugs or illicit drugs... we've introduced body scanners into our reception prisons and into a couple of our other prisons as well to assist us in trying to identify drugs that are being trafficked into the prison, either on the person or internally. That's one part of the overall war against drugs.*

The diversion of prescribed medication is always significant... It's really, really difficult to control.

We've been able to do it in some cases. Buprenorphine and methadone have been highly sought after by opiate users for a long time, but we've just gone to a depot injection for Suboxone, which has made a big difference. We don't have an equivalent for the ADHD stimulant medications at the moment. We'd love that.

Different jurisdictions have different practices in relation to some of those S8 [Schedule 8] *highly attractive medications that drug users would love to get their hands on. Some will just ban them completely. South Australia, I think, is one jurisdiction that does that... But we are acting very cautiously in relation to those stimulant medications at the moment. Victoria, I think, has just started administering stimulant medications, and we'll be watching very closely how that goes - the impact on detected drugs in people because drug testing is done nationally on a random basis and a targeted basis, and if there are more of these S8 medications coming up in the testing, then we have to make a decision. But if there's not so much diversion, then it might be something that we would entertain here.*

In my discussions with doctors here, they indicate that if there were a really pressing need to retain someone on stimulant-based medication on a case-by-case individual basis, then they would give consideration to that. But their general practice, to my understanding, is that they are more likely if someone comes in on a stimulant-based medication to try to move them onto a non-stimulant medication and that meets a correctional manager's needs much better. But if the clinical requirements were that a stimulant medication were to be prescribed, then they would give consideration to that.[327]

8.15 The Minister and Ms Hocking discussed support services available outside of stimulant medications:

***Ms ROSOL** - ... I understand that you've done work around the risks of redirection of medication - but the risks of ADHD not being treated and what that does to*

[327] Mr. Rod Wise, Deputy Secretary Corrective Services, Department of Justice, Transcript of Evidence, 7 March 2025, pp. 6-7.

increase tricky behaviours, put staff at risk, maybe put other people in prison at risk? How are you balancing those risks?...

***Ms OGILVIE** - If I could underscore again that I think suggesting that people who have been diagnosed and not being treated is probably not an accurate reflection of the situation. Stimulant medication like Ritalin is not prescribed due to the security risks. Those medications are highly sought after for non-therapeutic use...*

Having said that, I think we have heard that first it is important that people who wish to be assessed have agency in that process. Second, that it is a challenging cohort with the comorbidities...

***Ms HOCKING** - ...there are a number of teams within the prison and it's challenging in writing to put forward just how collaborative those teams are, but on the ground we have a number of core businesses within the prison that are looking at prisoners who are consistently being raised either for behavioural concerns or well-being concerns. When that does occur, there is a multidisciplinary lens on those individuals to try and really work together to achieve the best outcomes for that individual.*

For example, we have the High-Risk Assessment Team which looks at the prisoners who are in our high-risk area for continuing to engage in violence or behaviours that disrupt the good order of the prison. Within that team, there's a multidisciplinary approach between the Crisis Support Team, the Disability Team, the Maximum Rehabilitation and Reintegration Team and senior correctional staff from those units. Each week, those individuals are looked at.

When there's assessments being undertaken in that space, if there is concern that ADHD may be a significant factor or impulse control or something going on for that individual, the referral can be made to the Prison Mental Health Team and that diagnostic clarification can occur in that space. We have another unit called Mersey or the Needs Assessment Unit where we have prisoners with a lot of vulnerabilities in terms of their mental health and cognitive ability. That's a place where we can spend a lot more time getting to know those individuals with the goal of having as safe an environment as possible and also being able to get them into an environment that's least restrictive and able to be involved in all daily prison activities to the best of their ability.

Within that, again, our collaboration with the Prison Mental Health Team, the Crisis Support Team, the Disability Team, the correctional staff, it's all linked in together as well as the Community Correctional Primary Health Team.

On the ground, the multidisciplinary aspect of each individual case that's presented to us is phenomenal in terms of the ability to actually achieve diagnostic clarification for that individual in our prison service.[328]

8.16 Ms Hocking provided further evidence on the support available to individuals when they transition out of prison:

> ***Ms JOHNSTON*** *- At the other end of the spectrum, in terms of prisoners who are expecting to leave the service, what kind of assistance or connections or referrals are you able to make, either for a prisoner who's come in with a diagnosis already - so you're aware of that diagnosis - or someone who has got a diagnosis whilst they're in prison? What kind of referrals, connections do you make to assist them when they are released so that there's a continuity of care and treatment for them exiting the service?*
>
> *...*
>
> ***Ms HOCKING*** *- ...Our planning and reintegration officers within the team, if we have a prisoner that's sentenced, work with that individual to really ensure that their community transition is smooth. That can include having doctor's appointments booked for them in advance at their preferred clinic or the clinic that's closest to the home that they're going to be going to. There's that through care from our end as well as referrals through to drug and alcohol services in the community.*
>
> *My knowledge of working collaboratively with the health team - and again, this will need confirmation from the Health Department - for acute cases, particularly relating to major mental illness, they have community transition plans in place for the individuals that are being case managed in the prison to continue that into the community and saying if we have information about their health needs in the prison that need follow up with medical agencies in the community, that Health are responsible for passing on those referrals as well. Our planning officers can have referrals through to services like Just ACE and, you know, for acquired brain injury, they're really looking at Beyond the Wire for that overall help with life skills and things like that.*
>
> *Really importantly, in the last three or four years, our involvement in partnering with NDIS support coordinators has grown. We know that when we have participants who have been able to be accepted onto the NDIS scheme from prison that we're sending them out into really supported placements in the community as well. There is... a lot of through care that... does occur and it really does depend on what's available for individuals as well in terms of where they're*

[328] Hon. Madeleine Ogilvie MP, former Minister for Corrections and Rehabilitation, and Ms. Bronwyn Hocking, Manager Crisis Support Services, Department of Justice, Transcript of Evidence, 7 March 2025, pp. 8-9.

going and where they're returning home to. Obviously, services in rural Tasmania are very different to what you might achieve in one of the cities.[329]

8.17 At the 11 April 2025 public hearing, Dr Sonny Atherton, Statewide Specialty Director of the Forensic Mental Health Service, Department of Health, gave evidence on the mental health support available to those in custodial settings:

> ***Ms ROSOL*** *- …I have some questions about what the wait times are like for people in prison to access mental health services at the moment and what criteria you use to prioritise people seeking mental health services in prison facilities, and where ADHD fits in terms of the priorities?*
>
> ***Dr ATHERTON*** *- We are a recently established service and I guess the focus in our first stage of the service development has been to try to provide a community-approximate level of care for people who have serious mental disorders, mainly schizophrenia, bipolar disorder, and severe depression. That really is the primary focus of the service and within the resources that we have, we have to triage those people, some of them under the Mental Health Act, and really prioritise them in our service delivery.*
>
> *Our criteria - I guess we're aiming to provide a community-equivalent service, so our criteria of our Prison Mental Health Service, to some degree, aims to mirror the criteria that general adult services in the community would be guided by and who they would accept into their service. So, that really is the main threshold for us in terms of who we would accept into the service, the presence of a serious mental disorder, somebody being treated under the Mental Health Act, and we would then triage according to, I guess, severity of symptomatic presentation and the need for specialist psychiatric input.*
>
> ***Ms ROSOL*** *- So, potentially, people with ADHD would be far down the order because they may have a mental illness as well, but if they don't, then they would be considered further down the order of things?*
>
> ***Dr ATHERTON*** *- Yes. So, prison mental health services across Australia are grappling with similar challenges with the level of resourcing and meeting the mental health needs in prison. We do have a particular pathway for people who have established diagnoses of ADHD in prison to continue treatment in prison and that wouldn't be dependent on them having a particularly severe symptomatic presentation. Outside of that it really would depend on the level of the severity of the symptomatic presentation. Somebody could have really severe mental health symptoms that are not clearly formulated - it might not be clear at that point what the diagnosis is - that could potentially be triaged at a high level and it may emerge later that they do have a diagnosis of ADHD and there is nothing*

[329] Ms. Bronwyn Hocking, Manager Crisis Support Services, Department of Justice, Transcript of Evidence, 7 March 2025, p. 11.

to preclude clinicians in our service from considering that amongst the diagnostic possibilities.[330]

8.18 Dr Atherton provided the Committee with evidence on the intake process:

> ***CHAIR*** [Ms Haddad] - *…we understand that people are unable to continue a stimulant-based medication. So they might go to court, get their sentence, they're transferred directly to Risdon and they're off their medications. Would those inmates be referred routinely to see somebody with psychiatry qualifications in your team or perhaps to the Correctional Primary Health Team relatively quickly in terms of understanding that they're coming into prison and they're being taken off a regular medication to explore what…other psychosocial supports, therapeutic supports might be available or potentially other medications that might still assist them that are non-stimulant and are able to be prescribed in a prison environment?*
>
> ***Dr ATHERTON*** *- Yes. So, I guess the most common scenario is that people are being taken into custody or on remand. They might spend a long time on remand before their matter is adjudicated. There's an intake process, which is under the Correctional Primary Health Service, called the Tier One process where there is some basic screening around a whole range of different categories including mental health, previous mental health diagnoses. It relies on self-report mostly, but there is also other collateral information that can assist with that. The pharmacy could look into what previous prescriptions have been dispensed. The GP can get a health summary from the person's GP in the community.*
>
> ***CHAIR*** *- That screening discussion happens with someone when they're taken into remand?*
>
> ***Dr ATHERTON*** *- Yes.*
>
> ***CHAIR*** *- Is that pretty soon? Do you know? Or could there be a long wait time from processing in the remand centre and when you actually get to have that conversation?*
>
> ***Dr ATHERTON*** *- The policy is within 24 hours, and then typically within a few days they then have a second intake assessment with the GP.*
>
> *…*
>
> *The GP will then have an opportunity to explore some of the things that have been raised in the Tier One and then consider if the person has been on treatment for ADHD in the community, then refer that person to the Prison Mental Health Service.*

[330] Dr. Sonny Atherton, Statewide Specialty Director of the Forensic Mental Health Service, Department of Health, Transcript of Evidence, 11 April 2025, p. 21.

***CHAIR** - Just so I am understanding you correctly, that first conversation is with a correctional officer, not with a medical practitioner?*

***Dr ATHERTON** - With an RN, a registered nurse.*[331]

8.19 Dr Atherton also discussed the impact of lockdowns for those accessing mental health services:

> ***Ms ROSOL** - …I've had someone who's been in touch with me… Lockdowns prevented them from receiving the therapeutic or the health services they needed. What impact are you seeing with lockdowns? How many appointments are having to be cancelled with your service because of lockdowns in prison?*
>
> ***Dr ATHERTON** - Just given the nature of our work in prison, we have a fairly mobile in-reach into prison. So, we don't purely rely on people being able to be brought up to a clinic to be seen. So, we have the capability to go into prison to see people. There are some challenges with that, you know; we have to be cautious regarding confidentiality and other things if a person isn't allowed out of their cell, but we have really good working relationships with the prison, with the Therapeutic Services Unit. I guess what I found generally is that there's a good collaboration around trying to make sure that even during lockdowns people are able to access review. But it can't always be guaranteed.*[332]

8.20 The Committee heard further evidence from advocacy organisations and health practitioners, who provided their perspective on the adequacy of assessment and treatment services in custodial settings.

8.21 At the 8 November 2024 public hearing, representatives from the Alcohol Tobacco and Other Drugs Council raised this with the Committee:

> ***Mr VAUTIN** - …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.*

[331] Dr. Sonny Atherton, Statewide Specialty Director of the Forensic Mental Health Service, Department of Health, Transcript of Evidence, 11 April 2025, pp. 22-23.

[332] Dr. Sonny Atherton, Statewide Specialty Director of the Forensic Mental Health Service, Department of Health, Transcript of Evidence, 11 April 2025, p. 22.

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 [Mr Behrakis] *- 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.*[333]

8.22 Dr Jackie Hallam and Mr Daniel Vautin gave evidence that the inaccessibility of stimulant ADHD medications is indicative of a lack of treatment options in custodial settings generally:

***Ms ROSOL** - …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…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.*[334]

8.23 Recently retired GP, Dr Clare Smith, representing the Australian Medical Association (AMA) Tasmania Branch, also provided evidence on the treatment of ADHD in custodial settings:

[333] Mr. Daniel Vautin, Director of Policy and Impact, Alcohol Tobacco and Other Drugs Council Tasmania, Transcript of Evidence, 8 November 2024, p. 43.

[334] Dr. Jackie Hallam, Chief Executive Officer, and Mr. Daniel Vautin, Director of Policy and Impact, Alcohol Tobacco and Other Drugs Council Tasmania, Transcript of Evidence, 8 November 2024, p. 46.

Dr SMITH *- … 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 is 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 [Mr Behrakis] *- 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… 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 stimulant medication could be managed safely in the prison population, but it isn't because of historical practice and policy really.*

> ***Dr SMITH*** *- ...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.*[335]

Findings

The Committee finds:

108. ADHD is underdiagnosed and undertreated in correctional settings.

109. There is likely to be an overrepresentation of people with ADHD in the Tasmanian correctional system. This is due to the affects of ADHD on behaviour and the increased exposure to circumstances that may result in crime and interaction with the criminal justice system.

110. Assessment of ADHD in the Tasmania Prison Service only occurs incidental to other health or behavioural assessments.

111. Stimulant medication is not prescribed or dispensed in the Tasmanian prison system.

112. Some other Australian jurisdictions are trialling the use of stimulant medications in correctional settings.

113. Correctional settings can exacerbate the ADHD symptoms and behaviours of people whose ADHD is undiagnosed, untreated, or their medication is withheld.

114. The lack of diagnosis and treatment of ADHD in correctional settings makes the environment more challenging to manage and live in.

115. Correctional settings provide a unique opportunity to address and provide intensive treatment for many health conditions, including ADHD.

116. Accurate diagnosis and treatment of ADHD in correctional settings may reduce recidivism and crime.

Research

8.24 Evidence was received by the Committee that emphasised the need for increased research into ADHD to improve effective assessment and support services.

8.25 AADPA raised the importance of research in its submission to the Inquiry:

> *Research is critical for advancing our basic understanding of ADHD, and the development of improved ADHD treatments, support and services. Australia is home to some of the top ADHD researchers worldwide. AADPA has brought this*

[335] Dr. Clare Smith, retired General Practitioner, Australian Medical Association (AMA) Tasmania Branch, Transcript of Evidence, 8 November 2024, p. 56.

group together over the past four years during which time they have produced a series of highly impactful projects that have generated a wealth of new knowledge and pushed the field forward. There has also been a strong focus on developing the next generation of ADHD researchers…

However, this work has been conducted on a shoestring budget and funding and support for ADHD research in Australia is very limited. If not addressed this will hinder the further development of new clinical approaches and the implementation of the ADHD Guideline.[336]

8.26 Women's Health Tasmania and Royal Australasian College of Physicians (RACP) also made recommendations to increase research to support those with ADHD. In its submission, Women's Health Tasmania suggested:

In partnership with universities and researchers, advocate for the Federal Government to provide funding to support research focused on ADHD in women, girls, gender-diverse individuals, and culturally and linguistically diverse (CALD) communities. This research should aim to close the knowledge gap and improve diagnostic accuracy.[337]

8.27 Similarly, RACP emphasised the need for:

Further research into a range of issues related to ADHD, particularly epidemiology, modifiable and causative risk factors; prevention; case finding, particularly among women with risk factors; benefits of early treatment; non-pharmacological treatments; and medium to long term outcomes.[338]

8.28 AADPA provided insight on the barriers faced by First Nations and Culturally and Linguistically Diverse (CALD) communities:

A key aspect… is the presentation, assessment and treatment options of ADHD for First Nations people and for those in CALD communities.

Very little is known about the understanding and meaning of ADHD in First Nations people or whether different approaches to identification, assessment and support are needed for them and for those in CALD communities.

For Aboriginal and Torres Strait Islander peoples, mental health interconnects with numerous domains[11] including spiritual, environment, country, community, cultural, political, social emotional and physical health[12].

Indigenous communities and other CALD communities can view the symptoms of mental health conditions differently. For example, there could be

[336] Submission No. 44, Australasian ADHD Professionals Association, p. 23.
[337] Submission No. 20, Women's Health Tasmania, p. 10.
[338] Submission No. 54, Royal Australasian College of Physicians, p. 3.

misidentification of symptoms that are otherwise considered as culturally appropriate.

We need more information to effectively deliver culturally appropriate and competent care; especially when working with Aboriginal and Torres Strait Islander peoples, clinicians need more support to know how to frame mental illness and how treatment (clinical and cultural) can be articulated, building on the already existing strengths, beliefs and practices held within Aboriginal and Torres Strait Islander cultures. These key areas have been identified by AADPA as research priorities.[339]

8.29 RACGP echoed the need for specific research to develop culturally appropriate services, as well as the need for further research into ADHD more broadly:

> *More research into ADHD is needed, with potential areas for further research including screening tools, shared care models, effective non-pharmacological therapies, and development of culturally appropriate assessment tools for Aboriginal and Torres Strait Islander peoples, and those from culturally and linguistically diverse groups.*[340]

8.30 Another required area of research was raised by a lived experience witness about the impact of medication of females:

> ***Mr SPOHN*** *- …my wife's experience is the way it's medicated: the medication does not take into consideration the female monthly cycle. That is probably something that needs to be scrutinised as far as the treatment is concerned because when you're treated on this day, you might be very different to this day.*[341]

Findings

The Committee finds:

117. Further research and funding are required to improve knowledge, assessment, treatment, and support for people with ADHD.

118. Specific research into ADHD presentations in women, girls, gender-diverse people, culturally and linguistically diverse and Aboriginal and Torres Strait Islander communities is required to reduce knowledge 'gaps' in diagnostic and support services.

[339] Submission No. 44, Australasian ADHD Professionals Association, p. 22 with reference to the submission's Footnote 11 - Dudgeon P, Milroy H and Walker R. Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice 2nd Edition. ACT: Commonwealth of Australia, 2014; and Footnote 12 - Loh P-R, Hayden G, Vicary D, et al. Attention Deficit Hyperactivity Disorder: an Aboriginal perspective on diagnosis and intervention. Journal of Tropical Psychology 2017; 7.
[340] Submission No. 40, Royal Australian College of General Practitioners, p. 6.
[341] Mr. Nicholas Spohn, Transcript of Evidence, 21 February 2025, p. 47.

Recommendations

The Committee recommends:

27. **The Tasmanian Government acknowledge and address the social and economic impact of undiagnosed and untreated ADHD on the prison population, management of prisons, and recidivism.**
28. **The Tasmania Prison Service include screening for preexisting ADHD diagnoses and prescriptions in standard prison intake processes.**
29. **The Tasmania Prison Service facilitate the assessment of inmates displaying ADHD symptoms where they do not have a preexisting diagnosis.**
30. **The Tasmania Prison Service trial the provision of stimulant medication for inmates diagnosed with ADHD.**
31. **The Tasmanian Government advocate for increased and ongoing research into ADHD.**

APPENDICES

Appendix A - List of submissions

1. Private Witness
2. Private Witness
3. Maddie O'Keeffe
4. Gavin Adamson
5. Private Witness
6. Navigate Family Services
7. Private Witness
8. Jason Andrews
9. Matthew McDonagh
10. Private Witness
11. Kelly Warburton
12. James Allston and Georgia Costello
13. Private Witness
14. Private Witness
15. Private Witness
16. Private Witness
17. Private Witness
18. Private Witness
19. Carers Tasmania
20. Women's Health Tasmania
21. Tasmanian Adult ADHD Support Group
22. Private Witness

22a. Private Witness

23. Private Witness
24. Private Witness
25. Regional Autistic Engagement Network (RAEN)
26. Private Witness
27. Private Witness
28. Private Witness
29. Mental Health Families and Friends Tasmania (MHFFTas)
30. Hobart ADHD Consultants
31. Private Witness
32. Private Witness
33. Niall Harden
34. Gracie Patten
35. Chris Anderson
36. Private Witness
37. Tinkers Farm
38. Private Witness
39. Dr Kate Bendall
40. Royal Australian College of General Practitioners (RACGP)
41. Private Witness
42. Private Witness
43. Private Witness
44. Australasian ADHD Professional Association (AADPA)
45. Richard Hill
46. Royal Australian and New Zealand College of Psychiatrists (RANZCP)
47. Alcohol, Tobacco and other Drugs Council Tasmania
48. National Disability Services
49. ADHD Australia
50. headspace
51. Australian Medical Association (AMA) Tasmania Branch
52. Australian Psychological Society (APS)
53. Tim Sanderson
54. Royal Australasian College of Physicians (RACP)
55. Health Consumers Tasmania
56. The Association for Children with Disability Tasmania
57. Men's Health and Wellbeing Western Australia
58. Advanced Pharmacy Australia (AdPha)
59. Private Witness
60. Tasmanian Government

Appendix B - List of witnesses

PUBLIC HEARING – 18 October 2024

1. Professor David Coghill, President, Australasian ADHD Professionals Association.
2. Dr Madelyn Derrick, Clinical Psychologist and Director, Hobart ADHD Consultants.
3. Hon. Guy *Barnett* MP, Deputy Premier, former Minister for Health, Mental Health and Wellbeing, Tasmanian Government, Mr Dale Webster, Acting Secretary, Ms Michelle Searle, Acting Deputy Secretary, Community Mental Health and Wellbeing, Mr George Clarke, Chief Executive, Public Health Services, Department of Health, and Ms Melissa Snadden, Senior Health Adviser for Minister Barnett.
4. Ms Vikki Ryall, Chief Clinical Officer, and Ms Natasha Marston, Manager of Practice Development, headspace.
5. Dr Tim Jones, General Practitioner, Royal Australian College of General Practitioners Tasmania.
6. Mr Matthew Tice, Chair, Ms Jane Endacott, Vice Chair, and Ms Melissa Webster, Chief Executive Officer, ADHD Australia.

PUBLIC HEARING – 8 November 2024

1. Professor Nitin Kapur, Paediatric and Child Health Division President and Paediatric Respiratory and Sleep Physician, Dr Theresa Naidoo, Tasmanian Committee Chair and Community and Child Health Paediatrician, and Associate Professor Heinrich Weber, Tasmanian Committee Member and Paediatric Respiratory Physician, Royal Australasian College of Physicians.
2. Mr Tim Davern, Senior Policy Advisor, Australian Psychological Society.
3. Mr Jerry Yik, Head of Policy and Advocacy, and Ms Michelle Paine, Member Paediatrics and Neonatology Specialty Practice Group, Advanced Pharmacy Australia.
4. Dr Jacqueline Hallam, Chief Executive Officer, and MR Daniel Vautin, Director Policy and Impact, Alcohol, Tobacco and other Drugs Council Tasmania.
5. Dr Natasha-Ann Laidler and Dr Clare Smith, Representatives of Australian Medical Association (AMA) Tasmania Branch.
6. Dr Honor Pennington and Dr Anil Reddy, Psychiatrists and Members of Royal Australian and New Zealand College of Psychiatrists – Tasmania Branch.

PUBLIC HEARING – 21 February 2025

1. Ms Ellen MacDonald, Chief Executive Officer, Health Consumers Tasmania.
2. Mr Chris Anderson.
3. Mr Scott Wynands.
4. Mr Nick Spohn.

PUBLIC HEARING – 7 March 2025

1. Hon. Madeleine *Ogilvie* MP, former Minister for Corrections and Rehabilitation, Tasmanian Government, Mr Rod Wise, Deputy Secretary Corrective Services, and Ms Bronwyn Hocking, Manager Crisis Support Services, Tasmania Prison Service, Department of Justice.

PUBLIC HEARING – 11 April 2025

1. Hon. Roger *Jaensch* MP, former Minister for Mental Health and Wellbeing, Tasmanian Government, Mr Dale Webster, Secretary, Mr Samuel Halliday, Chief Pharmacist, Pharmaceutical Services Branch, and Dr Sonny Atherton, Statewide Specialty Director, Forensic Mental Health Services, Department of Health.
2. Hon. Jo *Palmer* MLC, Minister for Education, Tasmanian Government, Ms Ginna Webster, Secretary, Ms Jodee Wilson, Deputy Secretary Development and Support, Ms Alison Brooks, Director Student Support, and Mr Adam Potito, Director Inclusion and Diversity Services, Department of Education, Children and Young People.

PUBLIC HEARING – 16 May 2025

1. Hon. Jacquie *Petrusma* MP, former Minister for Health, Tasmanian Government, Mr Dale Webster, Secretary, Ms Sally Badcock, Associate Secretary, Dr Dinesh Arya, Deputy Secretary, Clinical Quality, Regulation and Accreditation, Chief Medical Officer and Chief Psychiatrist, and Dr Sean Beggs, Clinical Director, Women's and Children's Services, Department of Health.

Appendix C – Informal roundtable

On 15 November 2024, the Committee invited people with lived experience of ADHD who did not wish to appear at a public hearing, to attend a private, informal roundtable with Members to share their experiences.

The roundtable was closed to the public, not transcribed, broadcast or recorded, and proceeded on the basis that participants consented to the Committee Secretariat taking deidentified dot points summarising the issues raised, which could inform Members and be included in the Report.

Eight (8) participants attended the roundtable separately, some attending with a support person. These participants either had lived experience of ADHD, were a parent or carer of someone diagnosed with ADHD, or both.

The Committee provided participants with five (5) questions relevant to the Inquiry's Terms of Reference to guide the informal discussion. The dot points below summarise the key points made during the roundtable.

1. **What has your experience been of accessing an ADHD diagnosis?**
    - There was a shared experience amongst most participants that ADHD assessments and diagnoses in Tasmania take months to years to access, and are very expensive to secure, particularly where there are multiple members of a family with ADHD symptoms.
    - Some participants shared that stigma or stereotypes associated with ADHD were a barrier to seeking a diagnosis.
    - Delays and difficulties in obtaining a diagnosis compound the poor mental health of the person seeking treatment.
    - ADHD diagnosis validated them and improved their self-worth, after being perceived or labelled as lazy, difficult or some other character flaw.

2. **Have you been able to access appropriate ADHD practitioners?**
    - There were common experiences of being unable to access local ADHD practitioners in Tasmania, such as paediatricians and psychiatrists.
    - This led to many people turning to interstate ADHD practitioners either in person or via telehealth.

3. **What supports after an ADHD assessment have you been able to access?**
    - A common theme was that the accessibility of supports after an ADHD assessment was dependent on the level of disposable income to access private practitioners and services.

- Amongst participants who were parents or guardians, a shared theme was difficulty accessing supports for children with ADHD in the education system.
- A lack of supports during the transition from paediatric care was a concern raised by some participants.
- A lack of supports for adults with ADHD was noted by participants, particularly employment supports.

4. **What has your experience been regarding access to ADHD medication?**
    - Most participants shared a frustration with how ADHD medication is regulated in Tasmania and how it impacts access for those seeking medication.
    - Participants reported an over-complicated system to access stimulant ADHD medication, where previous drug-taking behaviour is overemphasised as a risk and becomes a barrier to access.
    - Some participants shared that they feel like people with ADHD are treated differently to people with other conditions because they access stimulant medication.

5. **What would you like to see happen to improve ADHD services?**
    - Publishing online an accessible, basic but comprehensive level of information on ADHD assessment, diagnosis, supports, and treatments and a step-by-step guide to accessing services.
    - Improved public health services to facilitate more efficient assessment, diagnosis, and treatment for Tasmanians with ADHD.
    - Prioritising early intervention by providing more opportunities for assessments, as well as increased treatment and supports in Tasmania's education system for children with ADHD and other neurodivergent conditions.
    - Greater fairness in the rules and procedures of the Pharmaceutical Services Branch for those with illicit drug-use histories.
    - More services for adults with ADHD to provide employment skills and supports to obtain and maintain employment, and more Medicare-covered psychological sessions.

Appendix D – Minutes

Fifty-First Parliament

TUESDAY 25 June 2024

The Committee met at Parliament House, Hobart, in Committee Room 1 and by Webex videoconference, at 12.05 p.m.

MEMBERS PRESENT:

Mr *Behrakis*
Ms *Haddad* (proxy for Mr *Winter*)
Ms *Johnston* (from 12.23 pm)
Mrs *Pentland* (by Webex)
Ms *Rosol* (by Webex)
Ms *White* (by Webex)
Mr *Wood* (by Webex)

APOLOGIES:
There were no apologies.

PROXY MEMBERSHIP:
The Chair noted that she had received written advice from the relevant substantive Member that Ms Haddad would proxy for Mr Winter for this inquiry.

The Chair also noted the briefing note regarding proxy arrangements that had been circulated by the Deputy Clerk on 24 June 2024.

INQUIRY INTO THE ASSESSMENT AND TREATMENT OF ADHD AND SUPPORT SERVICES:
The Committee discussed the inquiry process briefing note, proposed inquiry timeline, and indicative stakeholder list as circulated.

Resolved, That the Committee proceed with a Full Inquiry Process in relation to this inquiry, and that the inquiry be open to public submissions. (Mr *Behrakis*)

The Committee noted that an advertisement would be placed in the three major newspapers on the weekend of 19-20 July, and a media release prior.

Resolved, That the Committee proceed with the proposed inquiry timeline, opening and closing of dates for submissions, deliberative meetings and hearings as circulated, including:

Submissions open: Friday 19 July

Submissions close: Friday 30 August

Meeting 2 to consider submissions and identify witnesses: Monday 16 September

Hearing 1 (Hobart): Friday 18 October

Hearing 2 (Launceston): Friday 8 November

Hearing 3 (tbc): Monday 11 or Friday 15 November

Chair's Draft Report completed: Monday 17 February 2025

Meeting 4: tbc

Meeting 5 (if required): tbc

Report to be tabled by: Monday 31 March 2025 (Mr *Behrakis*)

Resolved, that the following stakeholders be invited to make a submission to the inquiry:

- Tasmanian Government Minister for Health, Mental Health and Wellbeing, Hon. Guy Barnett MP
- Australian Government Minister for Health and Aged Care, Hon Mark Butler MP
- Tasmanian Health Service
- CHAPS, Tasmanian Health Service
- Tasmanian Chief Psychiatrist
- Australian Department of Health and Aged Care
- Centre for Mental Health Service Innovation, Statewide Mental Health Service, Tasmania
- Australian Institute of Health and Welfare
- National Mental Health Commission
- Primary Health Tasmania
- ADHD Foundation
- ADHD Support Australia
- ADHD Australia
- Hobart ADHD Consultants
- Australasian ADHD Professionals Association (AADPA)
- The Royal Australian and New Zealand College of Psychiatrists
- Australian Psychological Society
- Australian Medical Association Tasmania
- Mental Health Council of Tasmania
- Mental Health Families & Friends Tasmania
- Advocacy Tasmania
- Mental Health Lived Experience Tasmania Inc.
- The Royal Australasian College of Physicians
- Australian Clinical Psychology Association
- Headspace - Australia's National Youth Mental Health Foundation
- AADHDIG Australian Adult ADHD Interest Group
- National Drug and Alcohol Research Centre
- UTAS College of Health and Medicine
- Pharmaceutical Services Board
- Dr Ross Kirkman
- Dr Clare Smith
- Tasmanian Association for the Gifted
- Tasmanian Adult ADHD Support Group
- RACGP
- Disability Voices Tasmania
- Autism Tasmania
- Autism Awareness Australia
- Speakout Advocacy
- ACD ADHD
- Dr Anil Reddy
- Carers Tasmania

- Headspace Launceston & Cornerstone Youth Services
- Senate Community Affairs References Committee
- Any other key national organisations which made a submission to the relevant Senate Committee Inquiry (Mr *Behrakis*)

Ms *Johnston* joined the meeting.

The Chair noted that a media release announcing that submissions were open would be issued closer to the appropriate date.

***

At 12.28 p.m. the Committee adjourned until:

- ***
- Monday 16 September (for the inquiry into the assessment and treatment of ADHD and support services)

Confirmed,

FRIDAY 26 July 2024

The Committee met at Parliament House, Hobart, in Committee Room 1 and by telephone and Webex videoconference, at 12.50 p.m.

MEMBERS PRESENT:

Mr *Behrakis*
Ms *Haddad*
Ms *Johnston*
Mrs *Pentland* (by Webex)
Ms *Rosol* (by telephone)
Ms *White*
Mr *Wood* (by Webex)

OBTAINING EVIDENCE THROUGH OTHER MEANS OUTSIDE OF WRITTEN SUBMISSIONS:

The Committee discussed other ways to allow interested persons to participate in the inquiry outside of the written submission process.

Resolved, that the Committee allow for interested persons who may not wish to make a written submission to contact the secretariat to:

a) Register their interest to participate in an informal round table with the Committee (including an option by videoconference), or
b) Register their interest to give evidence at a formal public hearing, or
c) Register their interest in providing a video submission to the Committee. (Mr *Behrakis*)

Resolved, that the Chair issue a media release regarding this decision, and that the Inquiry webpage and invitations to stakeholders seeking a submission be updated accordingly. (Ms *White*)

Resolved, that the Chair be empowered to consider and accept any applications for late submissions prior to the next meeting of the Committee for this inquiry. (Ms *White*)

The Committee agreed that the website and the media release to be made reflect that persons and organisations making submissions can request their submission be kept

confidential or that their name be withheld from publication.

Resolved, that the Department of Education be invited to make a written submission to the inquiry. (Mr *Behrakis*)

At 12.55 p.m. the Committee adjourned *** until a time to be determined on 16 September 2024.

Confirmed,

MONDAY 16 September 2024

The Committee met at Parliament House, Hobart, in Committee Room 1 and by Webex videoconference, at 12.00 p.m.

MEMBERS PRESENT:

Mr *Behrakis*
Mrs *Beswick*
Ms *Haddad*
Ms *Rosol* (by Webex)
Ms *White*
Mr *Wood*

APOLOGIES:

Ms *Johnston*.

PROXY MEMBERSHIP:

The Chair confirmed to the Committee that she had received written advice that Mrs *Beswick* would proxy for substantive member, Mrs *Pentland*, for this inquiry.

MINUTES:

Resolved, that the minutes of the previous meetings be confirmed. (Mr *Behrakis*)

CORRESPONDENCE:

Resolved, that the following incoming correspondence be noted: (Mr *Behrakis*)

a) Request for extension for submission from the Department of Premier and Cabinet until 2 October 2024 for whole-of-government submission.
b) Request for further extension for submission from The Association for Children with Disability (Tas) Inc until 20 September 2024.

RECEIPT OF SUBMISSIONS AND PUBLICATION:

At 12.03 p.m., Ms *Haddad* joined the meeting.

Resolved, that submissions 1 to 54 to be received. (Ms *White)*

Resolved, that submissions numbered 1, 3, 4, 6, 8, 14, 18-21, 25, 29, 30, 37, 40, and 44-51, be published in full, with personal contact details redacted as standard. (Ms *Haddad)*

Resolved, that submissions numbered 5, 13, 15, 16, 26, 32, 36, 41, and 42, where the submitter has requested their name and personal details remain private, be published with such information redacted. (Mr *Wood*)

Resolved, that submissions numbered 17, 22a, 28, and 43, where the submitter has requested their name and personal contact details remain private and specified information in the submission remain confidential, be published with such information redacted. (Mr *Behrakis*)

Resolved, that submissions numbered 7, 10, 22 and 24, provided in confidence, not be published. (Mr *Wood*)

Resolved, that consideration of publishing submissions numbered 2, 9, 11, 12, 23, 27, 31, 33-35, 38, 39 and 39a, be deferred until after further consideration and/or consultation. (Mr *Behrakis*)

Resolved, that consideration of publishing submissions 52-54 be deferred until after further consideration and/or consultation. (Mrs *Beswick*)

Resolved, that the extensions sought by the Department of Premier and Cabinet and the Association for Children with Disability (Tas) Inc for providing their respective submissions be granted. (Mr *Wood*)

PUBLIC HEARINGS:

The Committee agreed for the secretariat to be able to raise any further publication issues identified in the course of submission processing to the attention of the Committee at a future meeting.

Resolved, that the following be invited to appear at a public Committee hearing on 18 October 2024 at Parliament House, Hobart:

- Tasmanian Government – Minister for Health, Mental Health and Wellbeing (1 hour)
- Hobart ADHD Consultants (45 minutes)
- headspace (45 minutes)
- Royal Australian College of General Practitioners (RACGP) (45 minutes)
- ADHD Australia (45 minutes)
- Australian ADHD Professionals Association (AADPA) (45 minutes). (Mr *Behrakis*)

REGISTRATIONS OF INTEREST TO PARTICIPATE IN ALTERNATIVE MEANS:

Resolved, that the Chair issues a media release regarding public hearings prior to their commencement. (Mrs *Beswick*)

At 12.14 p.m., Ms *Rosol* joined the meeting.

Resolved, that:

- the Committee proceed with holding informal roundtables using the structure outlined in the circulated briefing note.
- the Committee receive video submissions from interested participants in accordance with the proposal in the circulated briefing note.
- the Chair and the secretariat coordinate the participation of those persons who have registered interest in an informal roundtable or a video submission, with the roundtables to take place on 15 November 2024. (Ms *Haddad*)

NEXT MEETING:

The Committee asked the secretariat to research possible appropriately qualified persons to brief or provide guidance to the Committee on how best to engage with possible vulnerable persons participating at public hearings or informal roundtables.

Resolved, that an additional deliberative meeting be held on Thursday 3 October 2024 at 1.00 p.m. (Ms *White*)

At 12.22 p.m. the Committee adjourned until 1.00 p.m. on 3 October 2024.

Confirmed,

THURSDAY 3 October 2024

The Committee met at Parliament House, Hobart, in Committee Room 1 and by Webex videoconference, at 1.00 p.m.

MEMBERS PRESENT:

Mr *Behrakis*
Mrs *Beswick* (by Webex)
Ms *Haddad* (by Webex)
Ms *Johnston* (by Webex)
Ms *Rosol* (by Webex)
Ms *White* (Chair)
Mr *Wood* (by Webex)

MINUTES:

Resolved, that the minutes of the previous meeting (16 September 2024) be confirmed. (Mr *Behrakis*)

RECEIPT OF SUBMISSIONS AND PUBLICATION:

Resolved, that submissions no. 55 to 58 be received, and be published in full, with personal contact details redacted as standard. (Ms *White)*

Resolved, submissions no. 9, 11, 12, 33 to 35, 39, and 52 to 54, be published in full, with personal contact details redacted as standard. (Ms *White)*

Resolved, that submissions no. 14, 18, 31, and 39a, where the submitter has requested their name and personal contact details remain private, be published with such information redacted, and that submission no. 39a be allocated a new submission number. (Ms *White*)

Resolved, that submission no. 38, where the submitter has requested their name and personal contact details remain private, be published with such information redacted, together with redactions proposed by the secretariat to redact the name of a General Practitioner and a Medical Centre, and the submitter's mother's name. (Ms *White*)

Resolved, that submissions no. 2, 23, and 27 be taken as provided in confidence and not be published until submitters have provided positive consent to publish. (Ms *White*)

Resolved, that a further extension sought by the Department of Premier and Cabinet for the lodging of a whole-of-government submission by Tuesday 15 October 2024 be granted. (Ms *White*)

PUBLIC HEARINGS:

Resolved, that the following be invited to appear at a public Committee hearing on 8 November 2024 at Parliament House, Hobart:

- Australian Psychological Society (45 minutes)
- Royal Australian and New Zealand College of Psychiatrists (45 minutes)
- Dr Kate Bendall, General Practitioner (45 minutes)
- Advanced Pharmacy Australia (45 minutes)
- The Royal Australasian College of Physicians
- AMA Tasmania (45 minutes)
- Alcohol Tobacco and other Drugs Council Tasmania (45 minutes) (Ms *White*)

REGISTRATIONS OF INTEREST TO PARTICIPATE IN ALTERNATIVE MEANS:
Resolved, that:

- the Committee proceed with holding informal roundtables on 15 November 2024 as outlined in the circulated briefing note.
- the Secretariat draft discussion questions based on the terms of reference, in consultation with the Chair, and provide them to participants for their consideration prior to attending an informal roundtable. (Ms *White)*

NEXT MEETING:
At 1.28 p.m. the Committee adjourned until 9.00 a.m. on 18 October 2024.

Confirmed,

FRIDAY 18 October 2024
The Committee met at Parliament House, Hobart, in Committee Room 1, at 9.13 a.m.

MEMBERS PRESENT:
Mr *Behrakis*
Mrs *Beswick*
Ms *Haddad*
Ms *Johnston*
Ms *Rosol*
Ms *White*

PRIVATE DELIBERATIVE MEETING:
The Committee met at 9.13 a.m.

APOLOGIES:
Mr *Wood*

PREVIOUS MINUTES:
Resolved, That the minutes of the previous meeting for this inquiry (3 October 2024) be confirmed. (Mr *Behrakis*)

SUBMISSION:
Resolved, That the submission no.60 be received and published (Ms *White*).

SCHEDULE OF WITNESSES:
The Committee agreed to proceed with hearing evidence from the Minister for Health and Mental Health and Wellbeing and Government witnesses despite the late delivery of submission no. 60.

PUBLIC HEARING:
The private meeting concluded at 9.17 a.m.

At 9.18 a.m. Professor David Coghill was called, made the Statutory Declaration and was examined by the Committee in public via Webex.

At 9.31 a.m. Ms *Haddad* withdrew.

At 9.33 a.m. Ms *Haddad* returned.

At 9.57 a.m. the witness withdrew.

Suspension of sitting from 9.57 a.m. to 10.00 a.m.

At 10.00 a.m. the hearing resumed.

At 10.00 a.m. Dr Madelyn Derrick was called, made the Statutory Declaration and was examined by the Committee in public.

Dr Derrick requested to provide evidence *in camera*.

Public hearing suspended at 10.41 a.m.

Dr Derrick provided reasons for proceeding to give evidence *in camera* and then withdrew.

PRIVATE DELIBERATIVE MEETING:
At 10.42 a.m. the Committee held a private meeting to deliberate on the request to give *in camera* evidence.

Resolved, that the Committee proceed to hear evidence from Dr Derrick in an *in camera* hearing. (Ms *White*)

***IN CAMERA* HEARING:**
At 10.44 a.m. the Committee commenced an *in camera* hearing with Dr Derrick.

At 10.59 a.m. the witness withdrew.

Suspension of sitting from 10.59 a.m. to 11.02 a.m.

PUBLIC HEARING:
At 11.02 am the public hearing resumed.

The Minister for Health, Mental Health and Wellbeing, the Honourable Guy Barnett MP was called and examined by the Committee in public via Webex

Mr Dale Webster, Acting Secretary, and Mr George Clarke, Chief Executive, Public Health Services, Department of Health, were called, made the Statutory Declaration and were examined by the Committee in public.

Ms Michelle Searle, Acting Deputy Secretary, Community Mental Health and Wellbeing, Department of Health, and Melissa Snadden, Senior Health Adviser, were called, made the Statutory Declaration and were examined by the Committee in public.

At 12.02 p.m. the witnesses withdrew.

Suspension of sitting from 12.02 p.m. to 12.17 p.m.

At 12.17 p.m. the hearing resumed.

Ms Vikki Ryall, Chief Clinical Officer, headspace, was called, made the Statutory Declaration and was examined by the Committee in public via Webex.

At 12.19 p.m. Ms Natasha Marston, Manager of Practice Development, headspace, joined the meeting and proceeded to make the Statutory Declaration and was examined by the Committee in public via Webex.

At 12.55 p.m. the witnesses withdrew.

Suspension of sitting from 12.55 p.m. to 2.18 p.m.

At 2.18 p.m. the hearing resumed.

Dr Timothy Jones, General Practitioner, Royal Australian College of General Practitioners Tasmania, was called, made the Statutory Declaration and was examined by the Committee in public.

At 3.02 p.m. the witness withdrew.

Suspension of sitting from 3.02 p.m. to 3.03 p.m.

At 3.03 pm the hearing resumed.

Mr Matthew Tice, Chair, Ms Jane Endacott, Vice Chair, and Ms Melissa Webster, Chief Executive Officer, ADHD Australia, were called, made the Statutory Declaration and were examined by the Committee via Webex.

At 3.36 p.m. the witnesses withdrew.

NEXT MEETING:

The meeting adjourned at 3.36 p.m. until 9.00 a.m. Friday 8 November 2024 at Committee Room 1, Parliament House, Hobart.

Confirmed,

FRIDAY 8 November 2024

The Committee met at Parliament House, Hobart, in Committee Room 1, at 9.09 a.m.

MEMBERS PRESENT:

Mr *Behrakis* (Chair)
Ms *Haddad*
Ms *Johnston*
Ms *Rosol*
Mr *Wood* (via Microsoft Teams)

PRIVATE DELIBERATIVE MEETING:

The Committee met at 9.09 a.m.

APOLOGIES:

Mrs *Beswick*
Ms *White*

PREVIOUS MINUTES:

Resolved, That the minutes of the previous meeting for this inquiry (18 October 2024) be confirmed. (Ms *Johnston*)

TRANSCRIPT OF EVIDENCE:

Resolved, That the Chair writes to Dr. Madelyn Derrick and provide a copy of the *in camera* transcript of her evidence given at the 18 October 2024 meeting for consideration of any correction of mistranscriptions. (Ms *Haddad*)

INFORMAL ROUNDTABLE:

Resolved, That the Committee proceeds with the private roundtable on 15 November 2024 and invite the participants listed in the draft schedule as circulated and allow participants' nominated support person(s) to attend if requested. (Ms *Haddad*)

Resolved, That the draft questions as circulated be endorsed and provided by the secretariat to roundtable participants in advance. (Ms *Haddad*)

The private deliberative meeting concluded at 9.11 a.m.

PUBLIC HEARING:

At 9.15 a.m. Professor Nitin Kapur, Royal Australasian College of Physicians (RACP) Paediatrics and Child Health Division President; Dr Theresa Naidoo, RACP Tasmanian Committee Chair and Community and Child Health Paediatrician; and Associate Professor

Henrich Weber, RACP Tasmanian Committee member and Paediatric Respiratory Physician were called (all via Microsoft Teams), made the Statutory Declaration and were examined by the Committee in public.

At 10.04 a.m. the witnesses withdrew.

Suspension of sitting from 10.04 a.m. to 10.15 a.m.

At 10.15 a.m. Tim Davern, Senior Policy Advisor, Australian Psychological Society, was called (via Microsoft Teams), made the Statutory Declaration and was examined by the Committee in public.

At 11.05 a.m. the witness withdrew.

Suspension of sitting from 11.05 a.m. to 11.15 a.m.

At 11.15 am Jerry Yik, Head of Policy and Advocacy at Advanced Pharmacy Australia (AdPha), and Michelle Paine, Member of AdPha Paediatrics and Neonatology Specialty Practice Group, were called, made the Statutory Declaration and were examined by the Committee in public.

At 12.05 p.m. the witnesses withdrew.

Suspension of sitting from 12.05 p.m. to 12.15 p.m.

At 12.15 p.m. Dr Jackie Hallam, Chief Executive Officer, and Daniel Vautin, Director Policy and Impact, Alcohol Tobacco and other Drugs Council Tasmania, were called, made the Statutory Declaration and were examined by the Committee in public.

Mr Vautin provided *Guidelines on the Management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings* (3rd edition) for the consideration of the Committee.

At 1.00 p.m. the witnesses withdrew.

Suspension of sitting from 1.00 p.m. to 2.18 p.m.

At 2.18 p.m. Dr Natasha-Ann Laidler (via Microsoft Teams), and Dr Clare Smith, AMA Tasmania Branch representatives, were called, made the Statutory Declaration and were examined by the Committee in public.

At 3.03 p.m. the witnesses withdrew.

Suspension of sitting from 3.03 p.m. to 3.05 p.m.

At 3.05 p.m. Dr Honor Pennington, Adult Psychiatrist, and Dr Anil Reddy, Adult Psychiatrist, and members of Royal Australian and New Zealand College of Psychiatrists – Tasmania Branch, were called, made the Statutory Declaration and were examined by the Committee in public.

At 3.48 p.m. the witnesses withdrew.

NEXT MEETING:

The meeting adjourned at 3.49 p.m. until 9.00 a.m. Friday 15 November 2024 at Committee Room 2, Parliament House, Hobart.

Confirmed,

FRIDAY 15 November 2024

The Committee met at Parliament House, Hobart, in Committee Room 2, at 10.15 a.m.

MEMBERS PRESENT:

Mr *Behrakis*
Mrs *Beswick* (via Webex)
Ms *Haddad*
Ms *Rosol* (via Webex)
Ms *White*
Mr *Wood* (via Webex) from 3.00 p.m.

PRIVATE DELIBERATIVE MEETING:

The Committee met at 10.15 a.m.

APOLOGIES:

Ms *Johnston*

PREVIOUS MINUTES:

Resolved, That the minutes of the previous meeting for this inquiry (8 November 2024) be confirmed. (Mr *Behrakis*)

FUTURE HEARINGS AND EXTENSION OF REPORTING DATE:

The Committee agreed to provide the secretariat with a list of witnesses by the end of January 2025 for the 21 February 2025 public hearing earmarked for persons with lived experience of ADHD.

The Committee discussed the need for public further hearings. The Committee agreed to schedule a further hearing in early-2025 to hear evidence on the treatment of ADHD in Tasmania's education and prison systems, and from the Pharmaceutical Services Branch in the Department of Health.

Resolved, That a further hearing be scheduled in March 2025 at a date to be determined. (Ms *White*)

Resolved, That the Chair writes to invite the Minister for Corrections and Rehabilitation, the Minister for Education, and the Minister for Mental Health and Wellbeing together with the Pharmaceutical Services Branch to appear at the hearing in March 2025. (Ms *White*)

Resolved, That the Chair move a motion in the House altering the reporting date for this inquiry to 13 May 2025. (Mr *Behrakis*)

Resolved, That the Chair be authorised to advise other Members of the House in advance of the motion altering the reporting date being moved. (Ms *White*)

INFORMAL ROUNDTABLE:

Resolved, That the roundtable participants and support persons listed in the circulated schedule be permitted to attend this meeting to share their lived experience of ADHD. (Ms *White*)

The Committee agreed that the secretariat take deidentified dot points for future reference of the Committee upon agreement of the participants.

At 10.45 a.m. Participant 1 attended the meeting to share their lived experience of ADHD and withdrew at 11.25 a.m.

Suspension of sitting from 11.25 a.m. to 11.30 a.m.

At 11.30 a.m. Participant 2 and support person attended the meeting to share

their lived experience of ADHD and withdrew at 12.05 p.m.

Suspension of sitting from 12.05 p.m. to 12.09 p.m.

At 12.09 p.m. Participant 3 and support person attended the meeting to share their lived experience of ADHD and withdrew at 12.30 p.m.

Suspension of sitting from 12.30 p.m. to 12.33 p.m.

At 12.33 p.m. Participants 4 and 5 attended the meeting to share their lived experience of ADHD and withdrew at 1.02 p.m.

Suspension of sitting from 1.02 p.m. to 2.15 p.m.

At 2.15 p.m. Ms *White* withdrew and Mr *Behrakis* took the Chair.

At 2.15 p.m. Participant 6 attended the meeting to share their lived experience of ADHD and withdrew at 2.45 p.m.

Suspension of sitting from 2.45 p.m. to 3.00 p.m.

At 3.00 p.m. Mr *Wood* joined the meeting.

At 3.00 p.m. Participant 7 attended the meeting to share their lived experience of ADHD and withdrew at 3.32 p.m.

Suspension of sitting from 3.32 p.m. to 3.35 p.m.

At 3.35 p.m. Participant 8 attended the meeting to share their lived experience of ADHD and withdrew at 4.02 p.m.

The Committee discussed the experiences shared by roundtable participants.

NEXT MEETING:

The meeting adjourned at 4.13 p.m. until 9.00 a.m. Monday 21 February 2025 at Committee Room 1, Parliament House, Hobart.

Confirmed,

FRIDAY 21 February 2025

The Committee met at Parliament House, Hobart, in Committee Room 1, and via Webex, at 9.41 a.m.

MEMBERS PRESENT:

Mr *Behrakis*
Mrs *Beswick* (via Webex)
Ms *Haddad* (Chair)
Ms *Johnston*
Ms *Rosol*

PROXY MEMBERSHIP:

The Chair confirmed to the Committee that she had received written advice that Meg *Brown* MP would proxy for substantive member, Mr *Winter*, for this inquiry

APOLOGIES:

Ms *Brown*
Mr *Wood*

PREVIOUS MINUTES:

Resolved, that the minutes from the previous meeting on 15 November 2024 be confirmed. (Mr *Behrakis*)

CORRESPONDENCE:

Resolved, that the incoming correspondence be received and that the outgoing correspondence be endorsed. (Mr *Behrakis*)

Resolved, that the responses to questions on notice received from the Australian Psychological Society, Minister Jaensch, headspace, RACP, and AdPha be published on the Committee's webpage, with redactions for personal contact information where required. (Mr *Behrakis*)

SENSITIVE CONTENT STATEMENT:

Resolved, that the Chair reads out a sensitive content statement at the beginning of each witness's evidence today and at future hearings for this Inquiry. (Ms *Haddad*)

Suspension of sitting from 9.50 a.m. to 10.02 a.m.

PUBLIC HEARING:

At 10.04 a.m. Ms Ellen MacDonald, Chief Executive Officer, Health Consumers Tasmania, was called, made the Statutory Declaration, and was examined by the Committee in public.

At 10.44 a.m. the witness withdrew.

Suspension of sitting from 10.44 a.m. to 11.02 a.m.

At 11.02 a.m. Mr Chris Anderson was called, made the Statutory Declaration, and was examined by the Committee in public via Webex.

At 11.48 a.m. the witness withdrew.

Suspension of sitting from 11.48 a.m. to 12.01 p.m.

At 12.01 p.m. Mr Scott Wynands was called, made the Statutory Declaration, and was examined by the Committee in public.

At 12.44 p.m. the witness withdrew.

At 12.44 p.m. Ms *Rosol* left the meeting.

Suspension of sitting from 12.44 p.m. to 1.39 p.m.

At 1.39 p.m. Mr Nick Spohn was called, made the Statutory Declaration, and was examined by the Committee in public via Webex.

At 2.26 p.m. the witness withdrew.

NEXT MEETING:

The meeting adjourned at 2.26 p.m. until 9.15 a.m. 7 March 2025 in Committee Room 2, Parliament House and via Webex.

Confirmed,

FRIDAY 7 March 2025

The Committee met at Parliament House, Hobart, in Committee Room 2, at 9.18 a.m.

MEMBERS PRESENT:

Mr *Behrakis* (Deputy Chair)
Mrs *Beswick*
Ms *Johnston*
Ms *Rosol*

APOLOGIES:

Ms *Brown*
Ms *Haddad*
Mr *Wood*

PRIVATE DELIBERATIVE MEETING:

PREVIOUS MINUTES:

Resolved, that the minutes from the previous meeting on 21 February 2025 be confirmed. (Ms *Rosol*)

FUTURE PUBLIC HEARINGS:
The Committee agreed to hold a public hearing on 11 April 2025 with both the Honourable Roger Jaensch MP, Minister for Mental Health and Wellbeing, and the Honourable Jo Palmer MLC, Minister for Education, to be invited, together with relevant Departmental representatives, including the Pharmaceutical Services Branch.

The Committee considered inviting the Honourable Jacquie Petrusma MP, Minister for Health, to a public hearing. The Committee agreed for the secretariat to contact the Minister's office to ascertain her availability to attend a hearing.

At 9.30 a.m. the deliberative hearing was suspended.

PUBLIC HEARING:
At 9.30 a.m. the Honourable Madeleine Ogilvie MP, Minister for Corrections and Rehabilitation; and Mr Rod Wise, Deputy Secretary Corrective Services, Department of Justice, and Ms Bronwyn Hocking, Manager Crisis Support Services, Tasmania Prison Service, were called, made the Statutory Declaration, and were examined by the Committee in public.

At 10.25 a.m. the witnesses withdrew.

PRIVATE DELIBERATIVE MEETING:
At 10.25 a.m. the deliberative meeting resumed.

ANY OTHER MATTERS:
Resolved, that the Chair sends correspondence to Minister Ogilvie seeking answers to further questions to be provided by the Members for the Chair's consideration. (Mr *Behrakis*)

NEXT MEETING:
The meeting adjourned at 10.29 a.m. until 9.00 a.m. 11 April 2025 in Committee Room 1, Parliament House and via Webex.

Confirmed,

FRIDAY 11 April 2025
The Committee met at Parliament House, Hobart, in Committee Room 1, at 8.50 a.m.

MEMBERS PRESENT:
Mr *Behrakis*
Mrs *Beswick*
Ms *Brown*
Ms *Haddad* (Chair)
Ms *Rosol*

APOLOGIES:
Ms *Johnston*
Mr *Wood*

PRIVATE DELIBERATIVE MEETING:

PREVIOUS MINUTES:
Resolved, that the minutes from the previous meeting on 7 March 2025 be confirmed. (Mr *Behrakis*)

CORRESPONDENCE:
Resolved, that the outgoing correspondence be endorsed:

i. Letter from the Chair to Minister Ogilvie dated 24 March 2025. (Ms *Rosol*)

FUTURE PUBLIC HEARINGS:
Resolved, that the Committee holds a public hearing on 16 May 2025 with the

Honourable Jacquie Petrusma MP, Minister for Health, to be invited, together with relevant Departmental representatives. (Ms *Haddad)*

EXTENSION OF REPORTING DATE:
Resolved, that the Chair move a motion in the House altering the reporting date for this Inquiry to 26 August 2025. (Ms *Haddad*)

Resolved, that the Chair be authorised to advise other Members of the House in advance of the motion altering the reporting date being moved. (Ms *Haddad)*

Mrs *Beswick* joined the meeting at 8.57 a.m.

At 8.58 a.m. the private deliberative meeting was suspended.

PUBLIC HEARING:

At 9.00 a.m. the Honourable Roger Jaensch MP, Minister for Mental Health and Wellbeing; and Mr Dale Webster, Secretary, Mr Sam Halliday, Chief Pharmacist - Pharmaceutical Services Branch, and Dr Sonny Atherton, Statewide Specialty Director - Forensic Mental Health Services, Department of Health, were called, made the Statutory Declaration, and were examined by the Committee in public.

At 10.42 a.m. the witnesses withdrew.

Suspension of sitting from 10.42 a.m. to 10.50 a.m.

At 10.50 a.m., the public hearing resumed.

The Honourable Jo Palmer MLC, Minister for Education; and Ms Jodee Wilson, Deputy Secretary Development and Support, and Ms Alison Brooks, Director Student Support, Department for Education, Children and Young People, were called, made the Statutory Declaration, and were examined by the Committee in public via Webex.

Ms Ginna Webster, Secretary, and Mr Adam Potito, Director Inclusion and Diversity Services, Department for Education, Children and Young People, were called, made the Statutory Declaration, and were examined by the Committee in public.

At 12.19 p.m. the witnesses withdrew.

PRIVATE DELIBERATIVE MEETING:
At 12.19 p.m. the private deliberative meeting resumed.

ANY OTHER MATTERS:
Resolved, that the Chair sends correspondence to Minister Jaensch seeking answers to further questions to be provided by the Members for the Chair's consideration. (Ms *Haddad*)

NEXT MEETING:
The meeting adjourned at 12.24 p.m. until 9.00 a.m. 16 May 2025 in Committee Room 1, Parliament House and via Webex.

Confirmed,

FRIDAY 16 MAY 2025
The Committee met at Parliament House, Hobart, in Committee Room 1, at 8.51 a.m.

MEMBERS PRESENT:

Mr *Behrakis*
Ms *Brown*
Ms *Haddad* (Chair)
Ms *Johnston*
Ms *Rosol* (via Webex)
Mr *Wood* (via Webex)

APOLOGIES:

Mrs *Beswick*

PRIVATE DELIBERATIVE MEETING:

PREVIOUS MINUTES:

Resolved, that the minutes from the previous meeting on 11 April 2025 be confirmed. (Mr *Behrakis*)

CORRESPONDENCE:

Resolved, that the incoming correspondence be received:

i. Letter from Minister Ogilvie providing additional information dated 14 May 2025.

(Ms *Rosol*)

Resolved, and that the outgoing correspondence be endorsed:

i. Letter from the Chair to Minister Jaensch dated 12 May 2025.

(Ms *Rosol*)

Resolved, that the letter from Minister Ogilvie providing additional information be published. (Ms *Brown*)

At 9.01 a.m. the private deliberative meeting was suspended.

PUBLIC HEARING:

At 9.01 a.m. the Honourable Jacquie Petrusma MP, Minister for Health; and Mr Dale Webster, Secretary, Ms Sally Badcock, Associate Secretary, Dr Dinesh Arya, Deputy Secretary - Clinical Quality, Regulation and Accreditation, Chief Medical Officer and Chief Psychiatrist, and Dr Sean Beggs, Clinical Director - Women's and Children's Services, Department of Health, were called, made the Statutory Declaration, and were examined by the Committee in public.

At 10.24 a.m. the witnesses withdrew.

Suspension of sitting from 10.24 a.m. to 10.35 a.m.

PRIVATE DELIBERATIVE MEETING:

At 10.35 a.m. the private deliberative meeting resumed.

ANY OTHER MATTERS

At 10.42 a.m. Ms *Brown* withdrew from the private deliberative meeting.

Resolved, to hold deliberative meetings on the Chair's draft report on the following dates:

- Friday, 4 July 2025 from 2.00 p.m. to 5.00 p.m.
- Monday, 11 August 2025 from 9.00 a.m. to 5.00 p.m.
- Friday, 15 August 2025 from 9.00 a.m. to 5.00 p.m.
- Thursday, 4 September 2025 from 9.00 a.m. to 5.00 p.m.

(Ms *Haddad*)

Resolved, that the Chair move a motion in the House altering the reporting date for this Inquiry to 16 September 2025. (Ms *Haddad*)

Resolved, that the Chair be authorised to advise other Members of the House in advance of the motion altering the

reporting date being moved. (Ms *Haddad*)

NEXT MEETING:

The meeting adjourned at 10.53 a.m. until 2.00 p.m. 4 July 2025 in Committee Room 1, Parliament House and via Webex.

Confirmed,

Fifty-Second Parliament

WEDNESDAY 24 September 2025

The Committee met at Parliament House, Hobart, in Committee Room 1, at 2.02 p.m.

MEMBERS PRESENT:

Ms *Brown*
Mr *Fairs*
Mr *George*
Ms *Haddad* (Chair)
Mr *Jaensch*
Ms *Johnston*
Ms *Rosol*

APOLOGIES:
There were no apologies.

ELECTION OF CHAIR:
The Secretary took the Chair, noted the Resolution establishing the Committee, and called for nominations for Chair.

Mr *Jaensch* nominated Ms *Haddad,* seconded by Ms *Brown.*

Ms *Haddad* consented to the nomination.

There being no further nominations, the Secretary declared Ms *Haddad* elected as Chair.

Ms *Haddad* took the Chair.

ELECTION OF DEPUTY CHAIR:
The Chair called for nominations for Deputy Chair.

Ms *Rosol* nominated Ms *Johnston,* seconded by Mr *Fairs.*

Ms *Johnston* consented to the nomination.

There being no other candidates nominated, the Chair declared Ms *Johnston* elected as Deputy Chair.

CONDUCT OF THE COMMITTEE:
Resolved, that unless otherwise ordered, Officers of the Parliamentary Research Service be admitted to the proceedings of the Committee whether in public or private session. (Ms *Haddad)*

Resolved, that the Chair be the spokesperson in relation to the operations of the Committee. (Ms *Johnston)*

Resolved, that unless otherwise ordered, press statements on behalf of the Committee be made only by the Chair after approval in principle by the Committee or after consultation with Committee Members. (Ms *Rosol)*

WORK OF THE COMMITTEE:
Resolved, that all evidence and papers received by the inquiry into the assessment and treatment of ADHD and support services in Tasmania, of the Standing Committee on Government Administration B, of the Fifty-First Parliament, be received by

this Committee for its consideration. (Ms *Haddad)*

***

NEXT MEETING:
At 2.27 p.m., the Committee adjourned to a date to be determined.

Confirmed,

FRIDAY 10 October 2025
The Committee met at Parliament House, Hobart, in Committee Room 1, at 10.42 a.m.

MEMBERS PRESENT:
Ms *Brown* (via Webex)
Mr *George*
Ms *Haddad* (Chair)
Ms *Johnston* (via Webex)
Ms *Rosol* (via Webex)
Mr *Vermey*

APOLOGIES:
Mr *Fairs*

PROXY ARRANGEMENTS:
The Chair advised that she has received written notice from Mr *Jaensch* that Mr *Vermey* will be his proxy for the duration of this inquiry.

MINUTES:
Resolved, that the minutes from the previous meeting on 16 May 2025 be confirmed. (Ms *Haddad*)

CORRESPONDENCE:
Resolved, that the incoming correspondence be received and published on the inquiry's webpage:

i. Response to Question on Notice from Minister for Education, Hon. Jo Palmer MLC, dated 2 June 2025.
ii. Responses to Questions on Notice from then Minister for Mental Health and Wellbeing, Hon. Roger Jaensch MP, dated 10 June 2025.

(Ms *Haddad)*

PROCESS FOR THE INQUIRY:
Resolved, that the Chair send correspondence to Hon. Bridget Archer MP as Minister for Health, Mental Health and Wellbeing seeking an update on new developments in the Government's ADHD-related policies and answers to questions taken on notice by the previous Minister for Health on 16 May 2025. (Ms *Haddad*)

The Committee discussed the potential timeline for the inquiry. They agreed to extend the draft report considerations to the end of January or early February. Further discussions on the timeline are planned to occur once the 2026 sitting schedule is released.

Resolved, that the Chair sends correspondence to stakeholders involved with this inquiry to notify of its recommencement, with an explanation of the prorogation of the Fifty-First Parliament, once the 2026 sitting schedule is released and the Committee further discusses the inquiry's timeline. (Ms *Haddad)*

ANY OTHER MATTERS:
Resolved, that Submission No. 1 be made confidential and removed from the inquiry's webpage as requested by

the submitter and that the Chair sends correspondence confirming the Committee's decision. (Ms *Haddad)*

NEXT MEETING:
At 11.01 a.m., the Committee adjourned to a date to be determined.

Confirmed,

FRIDAY 13 February 2026
The Committee met at Parliament House, Hobart, in Committee Room 1, at 1.34 p.m.

MEMBERS PRESENT:
Ms *Brown* (via Teams)
Mr *Fairs* (via Teams)
Mr *George*
Ms *Haddad* (Chair)
Ms *Johnston*
Ms *Rosol* (via Teams)
Mr *Vermey*

APOLOGIES:
Nil.

MINUTES:
Resolved, that the minutes from the previous meeting on 10 October 2025 be confirmed. (Ms *Haddad)*

CORRESPONDENCE:
Resolved, that the incoming correspondence be received and the outgoing correspondence be endorsed:

a. Incoming
   i. Letter from the Minister for Health, Mental Health and Wellbeing, Hon. Bridget Archer MP, to the Chair, dated 26 November 2025.
   ii. Letter from the Minister for Health, Mental Health and Wellbeing, Hon. Bridget Archer MP, to the Chair, dated 29 January 2026.

b. Outgoing
   i. Letter from the Chair to the Minister for Health, Mental Health and Wellbeing, Hon. Bridget Archer MP, dated 24 October 2025.
   ii. Letter from the Chair to ***, dated 24 October 2025.

(Ms *Haddad*)

Resolved, that the correspondence from Minister Archer be published on the Inquiry's webpage. (Ms *Haddad)*

TIMELINE FOR COMPLETING THIS INQUIRY:
The Committee considered a draft letter from the Chair to stakeholders updating them on the Inquiry, and agreed to include an indication that the final report will be tabled in the first half of 2026.

PRELIMINARY CONSIDERATION OF THE CHAIR'S DRAFT REPORT:
The Committee undertook preliminary consideration of the Chair's Draft Report.

At 1.56 p.m. Ms *Johnston* joined the meeting.

The Committee's preliminary consideration of the Chair's Draft Report continued.

At 2.18 p.m. Mr *Fairs* joined the meeting via Teams.

The Committee's preliminary consideration of the Chair's Draft Report continued.

At 2.47 p.m. Ms *Brown* withdrew.

The Committee's preliminary consideration of the Chair's Draft Report continued.

Suspension of sitting 3.20 p.m. to 3.36 p.m.

At 3.36 p.m. Mr *George* withdrew.

The Committee's preliminary consideration of the Chair's Draft Report continued.

At 4.10 p.m. Ms *Brown* returned.

The Committee's preliminary consideration of the Chair's Draft Report continued.

At 4.29 p.m. Mr *George* returned.

The Committee's preliminary consideration of the Chair's Draft Report continued.

At 4.30 p.m. Ms *Johnston* withdrew.

The Committee's preliminary consideration of the Chair's Draft Report continued.

NEXT MEETING:
At 4.53 p.m. the Committee adjourned until 2.30 p.m. 26 February 2026.

Confirmed,

THURSDAY 26 February 2026
The Committee met at Parliament House, Hobart, in Committee Room 1, and via Teams, at 2.39 p.m.

MEMBERS PRESENT:
Mr *Fairs* (via Teams)
Mr *George*
Ms *Haddad* (Chair)
Ms *Johnston*
Ms *Rosol* (via Teams)

APOLOGIES:
Ms *Brown*
Mr *Vermey*

MINUTES:
Resolved, that the minutes from the previous meeting on 13 February 2026 be confirmed. (Ms *Haddad)*

CORRESPONDENCE:
Resolved, that the outgoing correspondence be endorsed:

a. Outgoing

i. Letter from the Chair to the Stakeholders dated 20 February 2026.

(Ms *Haddad*)

PRELIMINARY CONSIDERATION OF THE CHAIR'S DRAFT REPORT:
The Committee undertook preliminary consideration of the Chair's Draft Report.

At 2.51 p.m. Ms *Johnston* joined the meeting.

The Committee's preliminary consideration of the Chair's Draft Report continued.

At 4.22 p.m. Mr *George* withdrew.

The Committee's preliminary consideration of the Chair's Draft Report continued.

At 4.27 p.m. Mr *George* returned.

The Committee's preliminary consideration of the Chair's Draft Report continued.

NEXT MEETING:
At 4.51 p.m. the Committee adjourned until 9.00 a.m. 27 March 2026.

Confirmed,

MONDAY 30 March 2026
The Committee met at Parliament House, Hobart, in Committee Room 1, and via Teams, at 9.10 a.m.

MEMBERS PRESENT:

Mr *Brown*
Mr *George*
Ms *Haddad* (Chair)
Ms *Johnston*
Ms *Rosol* (via Teams)
Mr *Vermey*

APOLOGIES:

Mr *Fairs*

MINUTES:

Resolved, that the minutes from the previous meeting on 26 February 2026 be confirmed. (Ms *Johnston*)

PRELIMINARY CONSIDERATION OF THE CHAIR'S DRAFT REPORT:
The Committee undertook preliminary consideration of the Chair's Draft Report.

Suspension of siting from 10.31 a.m. to 10.46 a.m.

The Committee's preliminary consideration of the Chair's Draft Report continued.

Suspension of sitting from 11.59 a.m. to 1:09 p.m.

The Committee's preliminary consideration of the Chair's Draft Report continued.

At 1.52 p.m. Ms *Rosol* withdrew.

The Committee's preliminary consideration of the Chair's Draft Report continued.

At 2.24 p.m. Mr *George* withdrew.

The Committee's preliminary consideration of the Chair's Draft Report continued.

At 2.29 p.m. Mr *George* returned.

The Committee's preliminary consideration of the Chair's Draft Report continued.

NEXT MEETING:

At 2.49 p.m. the Committee adjourned until 9.00 a.m. 31 March 2026.

Confirmed,

TUESDAY 31 March 2026
The Committee met at Parliament House, Hobart, in Committee Room 1, and via Teams, at 9.04 a.m.

MEMBERS PRESENT:

Ms *Haddad* (Chair)
Ms *Brown*
Mr *Fairs* (from 9.08 a.m.) (via Teams)
Ms *Johnston*
Ms *Rosol* (via Teams)
Mr *Vermey*

APOLOGIES:

Mr *George*

MINUTES:
Resolved, that the minutes from the previous meeting on 30 March 2026 be confirmed. (Ms *Haddad)*

PRELIMINARY CONSIDERATION OF THE CHAIR'S DRAFT REPORT:
The Committee undertook preliminary consideration of the Chair's Draft Report.

At 9:08 a.m. Mr *Fairs* joined via Teams.

The Committee's preliminary consideration of the Chair's Draft Report continued.

ANY OTHER MATTERS:
The Committee agreed to the following deliberative meetings:

- Friday 1 May 2026 from 3.00 p.m. to 5.00 p.m.
- Friday 8 May 2026 from 9.00 a.m. to 1.00 p.m.
- Thursday 14 May 2026 from 2.00 p.m. to 5.00 p.m.
- Friday 15 May 2026 from 9.00 a.m. to 5.00 p.m.

NEXT MEETING:

At 10.27 p.m. the Committee adjourned until 3.00 p.m. on 1 May 2026.

Confirmed,

FRIDAY 8 May 2026
The Committee met at Parliament House, Hobart, in Committee Room 1, and via Teams, at 9.36 a.m.

MEMBERS PRESENT:
Ms *Haddad* (Chair)
Ms *Brown* (via Teams)
Mr *George* (via Teams)
Ms *Rosol* (via Teams)
Mr *Vermey*

APOLOGIES:
Mr *Fairs*
Ms *Johnston*

MINUTES:
Resolved, that the minutes from the previous meeting on 31 March 2026 be confirmed. (Ms *Brown)*

MEETING SCHEDULED FOR 1 MAY 2026:
The Committee noted that the meeting scheduled for 1 May 2026 did not proceed due to want of quorum.

PRELIMINARY CONSIDERATION OF CHAIR'S DRAFT REPORT:
The Committee undertook preliminary consideration of the Chair's Draft Report.

Suspension of sitting from 10.47 a.m. to 11.00 a.m.

At 11.00 a.m. the Committee's preliminary consideration of the Chair's Draft Report continued.

At 11.16 a.m. Mr *Vermey* withdrew.

The Committee's preliminary consideration of the Chair's Draft Report continued.

At 11.21 a.m. Mr *Vermey* returned.

The Committee's preliminary consideration of the Chair's Draft Report continued.

At 11.52 a.m. Ms *Rosol* withdrew.

The Committee's preliminary consideration of the Chair's Draft Report continued.

At 12.22 p.m. Ms *Rosol* returned.

The Committee's preliminary consideration of the Chair's Draft Report continued.

At 12.25 p.m. Mr *George* withdrew.

The Committee's preliminary consideration of the Chair's Draft Report continued.

At 12.38 p.m. Mr *George* returned.

The Committee's preliminary consideration of the Chair's Draft Report continued.

ANY OTHER MATTERS:
The Committee agreed to the following deliberative meetings:

- Thursday 14 May 2026 from 2.00 p.m. to 5.00 p.m.
- Friday 15 May 2026 from 11.00 a.m. to 2.00 p.m. (subject to further agreement to extend to 5.00 p.m.)
- Friday 19 June 2026 from 12.30 p.m. to 5.00 p.m.
- Wednesday 24 June 2026 from 10.30 a.m. to 3.30 p.m.

NEXT MEETING:

At 1.01 p.m. the Committee adjourned until 2.00 p.m. on 14 May 2026.

Confirmed,

THURSDAY 14 May 2026
The Committee met at Parliament House, Hobart, in Committee Room 1, and via Teams, at 2.08 p.m.

MEMBERS PRESENT:

Ms *Haddad* (Chair)
Ms *Brown* (via Teams)
Mr *Fairs* (via Teams)
Mr *George* (via Teams)
Ms *Johnston*
Ms *Rosol*
Mr *Vermey*

APOLOGIES:
There were no apologies.

MINUTES:
Resolved, that the minutes from the previous meeting on 8 May 2026 be confirmed. (Ms *Rosol*)

UPCOMING MEETINGS:
The Committee noted that the time for the 15 May 2026 meeting is 11.00 a.m. to 2.00 p.m., with the option to extend to 5.00 p.m. if agreed to.

At 2.12 p.m. Ms *Johnston* joined the meeting.

PRELIMINARY CONSIDERATION OF THE CHAIR'S DRAFT REPORT:
The Committee undertook preliminary consideration of the Chair's Draft Report.

At 2.32 p.m. Ms *Brown* withdrew.

The Committee's preliminary consideration of the Chair's Draft Report continued.

At 2.50 p.m. Mr *Fairs* withdrew.

The Committee's preliminary consideration of the Chair's Draft Report continued.

At 2.51 p.m. Ms *Brown* returned.

The Committee's preliminary consideration of the Chair's Draft Report continued.

At 2.52 p.m. Mr *Vermey* withdrew.

The Committee's preliminary consideration of the Chair's Draft Report continued.

At 2.56 p.m. Mr *Vermey* returned.

The Committee's preliminary consideration of the Chair's Draft Report continued.

Suspension of sitting from 3.41 p.m. to 3.51 p.m.

At 3.51 p.m. the Committee's preliminary consideration of the Chair's Draft Report continued.

At 4.21 p.m. Mr *Vermey* withdrew.

The Committee's preliminary consideration of the Chair's Draft Report continued.

At 4.47 p.m. Ms *Johnston* withdrew.

The Committee's preliminary consideration of the Chair's Draft Report continued.

NEXT MEETING:
At 4.53 p.m. the Committee adjourned until 11.00 a.m. on 15 May 2026.

Confirmed,

FRIDAY 15 May 2026
The Committee met at Parliament House, Hobart, in Committee Room 1, and via Teams, at 11.03 a.m.

MEMBERS PRESENT:
Ms *Haddad* (Chair)
Ms *Brown*
Mr *George* (via Teams)
Ms *Johnston*
Ms *Rosol* (via Teams)
Mr *Vermey* (from 12.19 p.m.)

APOLOGIES:
Mr *Fairs.*

MINUTES:
Resolved, that the minutes from the previous meeting on 14 May 2026 be confirmed. (Ms *Haddad*)

PRELIMINARY CONSIDERATION OF THE CHAIR'S DRAFT REPORT:
The Committee undertook preliminary consideration of the Chair's Draft Report.

At 12.00 p.m. Ms *Rosol* withdrew.

The Committee's preliminary consideration of the Chair's Draft Report continued.

At 12.12 p.m. Ms *Rosol* returned.

The Committee's preliminary consideration of the Chair's Draft Report continued.

At 12.19 p.m. Mr *Vermey* joined the meeting.

The Committee's preliminary consideration of the Chair's Draft Report continued.

At 1.02 p.m. Mr *Vermey* withdrew.

Suspension of sitting from 1.02 p.m. to 1.33 p.m.

At 1.33 p.m. the Committee's preliminary consideration of the Chair's Draft Report continued.

At 1.38 p.m. Mr *Vermey* returned.

The Committee's preliminary consideration of the Chair's Draft Report continued.

At 1.54 p.m. Ms *Haddad* withdrew.

The Committee's preliminary consideration of the Chair's Draft Report continued.

At 2.03 p.m. Ms *Brown* withdrew.

The Committee's preliminary consideration of the Chair's Draft Report continued.

At 3.23 p.m. Ms *Haddad* returned.

The Committee's preliminary consideration of the Chair's Draft Report continued.

At 3.54 p.m. Mr *George* withdrew.

The Committee's preliminary consideration of the Chair's Draft Report continued.

NEXT MEETING:
At 4.08 p.m. the Committee adjourned until 12.30 p.m. on 19 June 2026.

Confirmed,

FRIDAY 19 June 2026
The Committee met at Parliament House, Hobart, in Committee Room 3, and via Teams, at 12.32 p.m.

MEMBERS PRESENT:
Ms *Haddad* (Chair)
Ms *Brown* (via Teams)
Mr *George* (via Teams)
Ms *Johnston*
Ms *Rosol* (via Teams)
Mr *Vermey*

APOLOGIES:
Mr *Fairs.*

MINUTES:
Resolved, that the minutes from the previous meeting on 15 May 2026 be confirmed. (Ms *Haddad*)

PRELIMINARY CONSIDERATION OF THE CHAIR'S DRAFT REPORT:
The Committee undertook preliminary consideration of the Chair's Draft Report.

Suspension of sitting from 1.45 p.m. to 2.04 p.m.

At 2.04 p.m., the Committee's preliminary consideration of the Chair's Draft Report continued.

At 2.44 p.m. Ms *Brown* withdrew.

The Committee's preliminary consideration of the Chair's Draft Report continued.

At 3.00 p.m. Ms *Brown* returned.

The Committee's preliminary consideration of the Chair's Draft Report continued.

At 3.06 p.m. Mr *Vermey* withdrew.

The Committee's preliminary consideration of the Chair's Draft Report continued.

At 3.13 p.m. Mr *Vermey* returned.

The Committee's preliminary consideration of the Chair's Draft Report continued.

NEXT MEETING:
At 3.38 p.m. the Committee adjourned until 10.30 a.m. on 24 June 2026.

Confirmed,

WEDNESDAY 24 June 2026
The Committee met at Parliament House, Hobart, in Committee Room 3, and via Teams, at 10.32 a.m.

MEMBERS PRESENT:
Ms *Haddad* (Chair)
Ms *Brown*
Mr *George* (via Teams)
Ms *Johnston*
Ms *Rosol* (via Teams)
Mr *Vermey*

APOLOGIES:
Mr *Fairs.*

MINUTES:
Resolved, that the minutes from the previous meeting on 19 June 2026 be confirmed. (Mr *George*)

CONSIDERATION OF THE CHAIR'S DRAFT REPORT:
The Committee commenced consideration of the Chair's Draft Report.

At 11.10 a.m. Mr *Vermey* withdrew.

The Committee's consideration of the Chair's Draft Report continued.

The paragraphs in Chapter 1, as amended and as agreed, stand part of the Report, being:-

Paragraphs 1.1 to 1.10 agreed to.
Paragraphs 1.11 to 1.14, as amended, agreed to.
Paragraphs 1.15 to 1.21 agreed to.

The paragraphs, findings, and recommendation in Chapter 2, as amended and as agreed, stand part of the Report, being:-

Paragraphs 2.1 to 2.12 agreed to.
Paragraphs 2.13 and 2.14, as amended, agreed to.
Paragraph 2.15 agreed to.
Paragraphs 2.16 to 2.20, as amended, agreed to.
Paragraph 2.21 agreed to.
Paragraph 2.22, as amended, agreed to.
Paragraphs 2.23 and 2.24 agreed to.
Paragraph 2.25, as amended, agreed to.
New paragraph 2.26 inserted, agreed to.
Findings 1 and 2 agreed to.
Finding 3, as amended, agreed to.
Finding 4 agreed to.
Finding 5, as amended, agreed to.
New Finding 6 inserted, agreed to.
Paragraphs 2.27 to 2.30 agreed to.
Paragraph 2.31, as amended, agreed to.
Paragraphs 2.32 to 2.35 agreed to.
Paragraph 2.36, as amended, agreed to.
Paragraphs 2.37 to 2.43 agreed to.
Paragraph 2.44, as amended, agreed to.
Paragraphs 2.45 and 2.46 agreed to.
Paragraph 2.47, as amended, agreed to.
Paragraph 2.48 agreed to.
New Findings 7 and 8 inserted, agreed to.
Finding 9 (former Finding 7) as amended, agreed to.
New Findings 10 and 11 inserted, agreed to.
Finding 12 (former Finding 8) as amended, agreed to.

Finding 13 (former Finding 10) as amended, agreed to.
Finding 14 (former Finding 9), agreed to.
Finding 15 (former finding 11) as amended, agreed to.
Paragraphs 2.49 to 2.52 agreed to.
Paragraph 2.53, as amended, agreed to.
Finding 16, as amended, agreed to.
New Finding 17 inserted, agreed to.
Paragraphs 2.54 and 2.55, as amended, agreed to.
Paragraphs 2.56 and 2.57 agreed to.
Paragraph 2.58, as amended, agreed to.
Paragraphs 2.59 to 2.61 agreed to.
Finding 18 agreed to.
Findings 19 and 20, as amended, agreed to.
Paragraph 2.62 agreed to.
Paragraphs 2.63 and 2.64, as amended, agreed to.
Findings 21 and 22, as amended, agreed to.
Finding 23 deleted.
Recommendation 1 inserted, agreed to.

The paragraphs, findings and recommendations in Chapter 3, as amended and as agreed, stand part of the Report, being:-

Paragraphs 3.1 to 3.3 agreed to.
Paragraph 3.4 agreed to and moved to be new paragraph 3.2.
Paragraphs 3.5 to 3.7 agreed to.
Paragraphs 3.8 and 3.9, as amended, agreed to.
Paragraph 3.10 agreed to.
Paragraphs 3.11 and 3.12, as amended, agreed to.
Findings 23 to 26, as amended, agreed to.
Paragraphs 3.13 to 3.17, as amended, agreed to.
Findings 27 to 29, as amended, agreed to.
Paragraph 3.18 agreed to.
Paragraphs 3.19 and 3.20, as amended, agreed to.
Paragraph 3.21 agreed to.
Paragraphs 3.22 and 3.23, as amended, agreed to.
Paragraph 3.24 agreed to.
Findings 30 and 31, as amended, agreed to.
New Findings 32 and 33 inserted, agreed to.
Paragraphs 3.25 to 3.28 agreed to.
Paragraph 3.29, as amended, agreed to.
Paragraphs 3.30 and 3.31 agreed to.
Paragraph 3.32, as amended, agreed to.
Paragraph 3.33 agreed to.
Paragraphs 3.34 and 3.35, as amended, agreed to.
Paragraph 3.36 agreed to.
Paragraphs 3.37 to 3.40, as amended, agreed to.
Paragraph 3.41 agreed to.
Finding 34 agreed to.
New Finding 35 inserted, agreed to.
Findings 36 to 39 (former Findings 35 to 38) as amended, agreed to.
Former Finding 39 deleted.
Finding 40, as amended, agreed to.
Paragraph 3.42 agreed to.
Paragraph 3.43, as amended, agreed to.
Paragraph 3.44 agreed to.
Paragraphs 3.45 to 3.47, as amended, agreed to.
Findings 41 and 42, as amended, agreed to.
New Finding 43 inserted, agreed to.

Paragraph 3.48, as amended, agreed to.
Paragraphs 3.49 and 3.50 agreed to.
Paragraph 3.51, as amended, agreed to.
Paragraph 3.52 agreed to.
Paragraph 3.53, as amended, agreed to.
Paragraph 3.54 agreed to.
Paragraph 3.55, as amended, agreed to.
Findings 44 to 46, as amended, agreed to.
Recommendations 2 to 6 inserted, agreed to.

The paragraphs, findings, and recommendations in Chapter 4, as amended and as agreed, stand part of the Report, being:-

Paragraphs 4.1 to 4.3, as amended, agreed to.
Paragraph 4.4 agreed to.
Paragraphs 4.5 to 4.8, as amended, agreed to.
Paragraph 4.9 agreed to.
Findings 47 and 48 (former Findings 49 and 50) as amended, agreed to.
Finding 49 (former Finding 47), agreed to.
New Finding 50 inserted, agreed to.
Finding 51 (former Finding 48) as amended, agreed to.
Paragraphs 4.10 to 4.14, as amended, agreed to.
Paragraphs 4.15 and 4.16 agreed to.
Paragraphs 4.17 and 4.18, as amended, agreed to.
New Finding 52 inserted, agreed to.
Finding 53 (former Finding 52) as amended, agreed to.
New Finding 54 inserted, agreed to.
Paragraph 4.19 agreed to.
Paragraphs 4.20 to 4.24, as amended, agreed to.
Paragraph 4.25 agreed to.
Paragraph 4.26, as amended, agreed to.
Paragraph 4.27 agreed to.
Findings 55 to 57, as amended, agreed to.
New Finding 58 inserted, agreed to.
Paragraph 4.28, as amended, agreed to.
Paragraphs 4.29 to 4.32 agreed to.
Paragraph 4.33, as amended, agreed to.
Paragraphs 4.34 and 4.35 agreed to.
Paragraphs 4.36 and 4.37, as amended, agreed to.
New Findings 59 and 60 inserted, agreed to.
Finding 61 (former Finding 59) as amended, agreed to.
Paragraphs 4.38 to 4.42 agreed to.
Paragraph 4.43, as amended, agreed to.
Paragraphs 4.44 to 4.46 agreed to.
Paragraph 4.47, as amended, agreed to.
Paragraphs 4.48 and 4.49 agreed to.
Paragraphs 4.50 to 4.53, as amended, agreed to.
Paragraph 4.54 agreed to.
Paragraphs 4.55 to 4.59, as amended, agreed to.
New Findings 62 and 63 inserted, agreed to.
Findings 64 to 66 (former Findings 62 to 64) as amended, agreed to.
Recommendations 7 to 12 inserted, agreed to.

The paragraphs, findings, and recommendations in Chapter 5, as amended and as agreed, stand part of the Report, being:-

Paragraphs 5.1 and 5.2 agreed to.
Paragraph 5.3, as amended, agreed to.

Paragraphs 5.4 and 5.5 agreed to.
Paragraph 5.6, as amended, agreed to.
Paragraphs 5.7 to 5.10 agreed to.
Paragraph 5.11, as amended, agreed to.
Finding 67 deleted.
New Findings 67 and 68 inserted, agreed to.
Paragraph 5.12 agreed to.
Paragraphs 5.13 and 5.14, as amended, agreed to.
Paragraphs 5.15 to 5.18 agreed to.
Paragraphs 5.19 and 5.20, as amended, agreed to.
Paragraph 5.21 agreed to.
Paragraphs 5.22 and 5.23, as amended, agreed to.
Findings 69 and 70, as amended, agreed to.
New Finding 71 inserted, agreed to.
Finding 72 (former Finding 71) as amended, agreed to.
Paragraphs 5.24 to 5.29 agreed to.
Paragraph 5.30, as amended, agreed to.
Paragraph 5.31 agreed to.
Paragraphs 5.32 to 5.36, as amended, agreed to.
Paragraphs 5.37 and 5.38 agreed to.
Paragraph 5.39, as amended, agreed to.
Paragraphs 5.40 and 5.41 agreed to.
Paragraph 5.42, as amended, agreed to.
New paragraphs 5.43 to 5.48 inserted, agreed to.
Paragraphs 5.49 to 5.52, as amended, agreed to.
New paragraph 5.53 inserted, agreed to.
Paragraphs 5.54 to 5.65, as amended, agreed to.
Paragraph 5.66 agreed to.
Paragraphs 5.67 and 5.68, as amended, agreed to.
New Findings 73 and 74 inserted, agreed to.
Findings 75 to 77 (former Findings 73 to 75) as amended, agreed to.
New Finding 78 inserted, agreed to.
Finding 79 (former Finding 77) as amended, agreed to.
New Finding 80 inserted, agreed to.
Finding 81 (former Finding 78) as amended, agreed to.
Former Finding 79 deleted.
New Findings 82 to 84 inserted, agreed to.
Recommendations 13 to 20 inserted, agreed to.

The paragraphs, findings, and recommendations in Chapter 6, as amended and as agreed, stand part of the Report, being:-

Paragraphs 6.1 and 6.2 agreed to.
Paragraphs 6.3 and 6.4, as amended, agreed to.
Paragraph 6.5 agreed to.
Paragraphs 6.6 and 6.7, as amended, agreed to.
Paragraphs 6.8 and 6.9 agreed to.
Finding 85, as amended, agreed to.
Paragraphs 6.10 to 6.14 agreed to.
Paragraphs 6.15 to 6.18, as amended, agreed to.
Paragraph 6.19 deleted.
Paragraphs 6.19 to 6.21, as amended, agreed to.
Findings 86 and 87, as amended, agreed to.
Paragraph 6.22, as amended, agreed to.
Paragraph 6.23 agreed to.
Paragraphs 6.24 to 6.27, as amended, agreed to.
Paragraph 6.28 agreed to.

Paragraph 6.29, as amended, agreed to.
Paragraph 6.30 agreed to.
Finding 88 agreed to.
Finding 89, as amended, agreed to.
New Finding 90 inserted, agreed to.
Paragraphs 6.31 and 6.32, as amended, agreed to.
Paragraphs 6.33 and 6.34 agreed to.
Paragraph 6.35, as amended, agreed to.
Paragraph 6.36 agreed to.
Paragraph 6.37, as amended, agreed to.
Paragraphs 6.38 and 6.39 agreed to.
Paragraph 6.40, as amended, agreed to.
New paragraph 6.41 inserted, agreed to.
Finding 91, as amended, agreed to.
New Finding 92 inserted, agreed to.
Paragraph 6.42 agreed to.
Paragraphs 6.43 to 6.45, as amended, agreed to.
Paragraphs 6.46 and 6.47 agreed to.
Paragraphs 6.48 and 6.49, as amended, agreed to.
New Finding 93 inserted, agreed to.
Finding 94 (former Finding 93) as amended, agreed to.
Recommendations 21 to 25 inserted, agreed to.

The paragraphs, findings, and recommendation in Chapter 7, as amended and as agreed, stand part of the Report, being:-

Paragraphs 7.1 and 7.2, as amended, agreed to.
Paragraph 7.3 agreed to.
Paragraph 7.4, as amended, agreed to.
Findings 95 and 96 (both arising from former Finding 95) as amended, agreed to.
Paragraphs 7.5 to 7.7, as amended, agreed to.
Paragraphs 7.8 and 7.9 agreed to.
Paragraphs 7.10 to 7.12, as amended, agreed to.
Paragraphs 7.13 and 7.14 agreed to.
Paragraph 7.15, as amended, agreed to.
Paragraph 7.16 agreed to.
Paragraph 7.17, as amended, agreed to.
Paragraphs 7.18 to 7.21 agreed to.
Paragraph 7.22, as amended, agreed to.
Paragraph 7.23 agreed to.
Finding 97 agreed to.
Findings 98 and 99, as amended, agreed to.
Paragraphs 7.24 and 7.25, as amended, agreed to.
Paragraph 7.26 agreed to.
Paragraph 7.27, as amended, agreed to.
Paragraph 7.28 agreed to.
Paragraphs 7.29 to 7.32, as amended, agreed to.
Paragraphs 7.33 and 7.34 agreed to.
Paragraph 7.35, as amended, agreed to.
Paragraphs 7.36 to 7.38 agreed to.
Finding 100 deleted.
Findings 100 to 102 (former Findings 101 to 103) as amended, agreed to.
Paragraph 7.39, as amended, agreed to.
Paragraph 7.40 agreed to.
Paragraphs 7.41 to 7.44, as amended, agreed to.
Paragraph 7.45 agreed to.
Paragraph 7.46, as amended, agreed to.
Paragraph 7.47 agreed to.
Paragraph 7.48, as amended, agreed to.
Finding 103, as amended, agreed to.
Finding 104, as amended, agreed to.
New Finding 105 inserted, agreed to.
Paragraphs 7.49 to 7.52 agreed to.
Paragraph 7.53, as amended, agreed to.

Finding 106, as amended, agreed to.
New Finding 107 inserted, agreed to.
Recommendation 26 inserted, agreed to.

The paragraphs, findings, and recommendations in Chapter 8, as amended and as agreed, stand part of the Report, being:-

Paragraph 8.1 agreed to.
Paragraph 8.2, as amended, agreed to.
Paragraph 8.3 agreed to.
Paragraphs 8.4 to 8.6, as amended, agreed to.
Paragraph 8.7 agreed to.
Paragraphs 8.8 to 8.10, as amended, agreed to.
Paragraph 8.11 agreed to.
Paragraphs 8.12 to 8.16, as amended, agreed to.
Paragraph 8.17 agreed to.
Paragraph 8.18, as amended, agreed to.
Paragraphs 8.19 and 8.20 agreed to.
Paragraphs 8.21 to 8.23, as amended, agreed to.
Findings 108 to 111, as amended, agreed to.
New Findings 112 to 115 inserted, agreed to.
Finding 116 (former Finding 112) as amended, agreed to.
Paragraph 8.24 agreed to.
Paragraphs 8.25 and 8.26, as amended, agreed to.
Paragraph 8.27 agreed to.
Paragraph 8.28, as amended, agreed to.
Paragraph 8.29 agreed to.
Paragraph 8.30, as amended, agreed to.
Findings 117 and 118, as amended, agreed to.
Recommendations 27 to 31 inserted, agreed to.

The Appendices A to F, as amended and as agreed, stand part of the Report.

Resolved, that the Chair's Draft Report, as amended, be the Report of the Committee. (Ms *Haddad*)

Resolved, that the Secretary has administrative oversight of the Report, and may change references, spelling, layout and other such matters for accuracy. (Ms *Haddad*)

Resolved, that the Report be tabled in the House of Assembly on Tuesday 11 August 2026. (Ms *Haddad*)

Resolved, that the Chair write to stakeholders informing of the Inquiry's conclusion and that the Report will be tabled on Tuesday 11 August 2026. (Ms *Haddad*)

At 11.18 a.m. Mr *Vermey* returned.

At 11.19 a.m. Mr *George* withdrew.

At 11.23 a.m. the Committee adjourned *sine die*.

Unconfirmed,

Appendix E – Glossary of Abbreviations

AADPA	Australasian ADHD Professionals Association
ABI	Acquired Brain Injury
ADHD	Attention Deficit Hyperactivity Disorder
AdPha	Advanced Pharmacy Australia
AMA	Australian Medical Association
ANU	Australian National University
AOD	Alcohol and Other Drugs
APS	Australian Psychological Society
ASD	Autism Spectrum Disorder
CALD	Culturally and Linguistically Diverse
CAMHS	Child and Adolescent Mental Health Service
CBT	Cognitive Behavioural Therapy
CFLC	Child and Family Learning Centre
CHaPS	Child Health and Parenting Service
CMO	Consultant Medical Officer
CPD	Continuing Professional Development
CYMHS	Child and Youth Mental Health Service
DBT	Dialectical Behavioural Therapy
DECYP	Department for Education, Children and Young People
DoH	Department of Health
DSM-5	Diagnostic and Statistical Manual of Mental Disorders
DSP	Disability Support Pension
ECIS	Early Childhood Inclusion Service
ED	Emergency Department
EN	Enrolled Nurse
FTE	Full Time Equivalent
GDG	Guideline Development Group
GP	General Practitioner
GPSI	General Practitioner with Special Interest
HMM	Health Ministers' Meeting
ICD-11	International Classification of Disease
LGBTIQA+	Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, Asexual +
LSO	Learning Support Officer
MBS	Medicare Benefits Scheme
MCH	Mersey Community Hospital
MHCP	Mental Health Care Plan
MHFFTas	Mental Health Families and Friends Tasmania
MLC	Member of the Legislative Council
MP	Member of the House of Assembly

MS	Multiple Sclerosis
NCCD	Nationally Consistent Collection of Data
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NHMRC	National Health Medical Research Council
NICE	National Institute for Health and Care Excellence
NSW	New South Wales
NWRH	North West Regional Hospital
OCD	Obsessive-Compulsive Disorder
ODD	Oppositional Defiant Disorder
OT	Occupational Therapist
PBS	Pharmaceutical Benefits Scheme
PHT	Primary Health Tasmania
PSB	Pharmaceutical Services Branch
QLP	Question Problem List
RACGP	Royal Australian College of General Practitioners
RACP	Royal Australasian College of Physicians
RAEN	Regional Autistic Engagement Network
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RN	Registered Nurse
RTPM	Real-Time Prescription Monitoring
S59E	Section 59E of the *Poisons Act 1971* (Tas)
Schedule 4	Schedule 4 Prescription Only
Schedule 8 or S8	Schedule 8 Controlled Drugs
TA	Teacher's Assistant
TCCRS	Tasmanian Community Care Referral Service
TGA	Therapeutic Goods Administration
THS	Tasmanian Health Service
The Act	*Poisons Act 1971* (Tasmania)
The Committee	House of Assembly Standing Committee on Government Administration B
The Guideline	Australasian ADHD Professionals Association Australian Evidence-Based Clinical Practice Guideline for ADHD
The Inquiry	The Inquiry into the assessment and treatment of ADHD and support services
ToR	Terms of Reference
TPS	Tasmania Prison Service
UK	United Kingdom
WA	Western Australia
WaCS	Women's and Children's Service

Appendix F – Transcripts of Evidence