EDUCATION AND HEALTH STANDING COMMITTEE

INQUIRY INTO ATTENTION DEFICIT DISORDER AND ATTENTION DEFICIT HYPERACTIVITY DISORDER IN WESTERN AUSTRALIA

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
WEDNESDAY, 15 SEPTEMBER 2004

Members

Mrs C.A. Martin (Chairman)
Mr M.F. Board (Deputy Chairman)
Mr R.A. Ainsworth
Mr P.W. Andrews
Mr S.R. Hill

Co-opted Member
Mr M.P. Whitely

Committee met at 10.30 am

DAVIDSON, DR ROWAN MORTON
Chief Psychiatrist, Department of Health,
189 Royal Street,
East Perth, examined:

The CHAIRMAN: Welcome. I need to go through a couple of formalities and read a statement. Before we can commence this part of the hearing I am required to advise you that the committee hearing is a proceeding of the Parliament and warrants the same respect that proceedings in the House itself demand. Even though you are not required to give evidence on oath, any deliberate misleading of the committee may be regarded as a contempt of Parliament. Have you completed the "Details of Witness" form?

Dr Davidson: I have.

The CHAIRMAN: Have you read the information for witnesses briefing sheet?

Dr Davidson: I have.

The CHAIRMAN: As you are aware, the committee is conducting an inquiry into attention deficit disorder in Western Australia, and has been for some time. We have asked you to come before us to answer some questions. I understand that you have had those questions in writing.

Dr Davidson: Yes, I have.

The CHAIRMAN: Before we get into those questions, are there any issues to which you would like to direct our attention or is there anything that you would like to discuss?

Dr Davidson: No, thank you. I am sure that the majority of the issues will arise out of the response and perhaps questions from members of the committee.

The CHAIRMAN: We have a list of the questions.

Mr M.F. BOARD: You do not mind if, during the course of this hearing, we depart from formal questions and move around a little to explore other issues, do you?

Dr Davidson: Not at all. That is fine with me. The questions that I have deal first with the details of programs that have been implemented in line with the two policies; that is, the statewide policy on attentional problems in children, diagnosis and management of attention deficit disorder and associated disorders, and the broader policy of "Infancy to Young Adulthood: A Mental Health Policy for Western Australia".

If I could begin slightly in reverse order, I will first allude to the broader policy, which I believe fits the policy in relation to the specific disorder. The broader policy of "Infancy to Young Adulthood: A Mental Health Policy for Western Australia" definitely outlines a number of tiers of service delivery. The first tier in the service delivery is primary service providers. The second tier is independent professionals, be they paediatricians, psychiatrists or the full range of independent professionals who are in fact available from a variety of agencies and also from private practice. That is the next tier of service delivery. The third tier we would regard as specialist mental health services. They would be, for instance, child and adolescent clinics and, indeed, any of the inpatient services in this area.

The fourth tier tends to be even more specialist. It may, for instance, include some of the super regional mental health services, such as the telepsychiatry services that are obviously provided to a variety of agencies and services throughout the State. There are therefore essentially four tiers of service delivery to try to pay attention to the issues for the community and, indeed, for identified patients. Children with attention deficit hyperactivity disorder may indeed be treated within this broad policy at any of those service tiers. They are in fact treated and managed at all four tiers. Within those the specialist mental health services are targeted to children with severe mental disorders, including those with what would be regarded as serious or severe levels of attention deficit hyperactivity disorder, which I will refer to as ADHD. Those who essentially would require a level of tier 3 service would have substantial impairment in functioning, severe symptoms in the past 30 days coupled with substantial impairment in functioning at the current time. Within the broad group it is a specialist group for which tier 3 services are provided.

The fourth tier of services would include the Bentley Child and Adolescent Unit inpatient service. There are also specialist teams provided out of such services. The Bentley site has a specialist ADHD team. I have referred to other super regional services, such as the telepsychiatry service which is provided by child and adolescent mental health services but which is provided statewide. The fourth level again deals with issues of complex assessment and treatment of what might be regarded as perhaps the most difficult group, the persistent or severe cases. Also that level is to provide services for training the range of professionals and also, as I referred to, consultation with other tiers as well as generally about the difficult case, and also perhaps research and in general develop programs that are intended to improve services.

From the infancy to young adulthood policy the Office of Mental Health of the Department of Health has convened a working group. That has a focus on the child and adolescent components of the plan and document “Partnerships Create Good Outcomes: Western Australia’s Future Directions 2004 to 2008”.

[10.40 am]

Generally, the key directions for child and adolescent mental health are highlighted in that document and plan. The key directions include an understandable approach that mental health services support and contribute to a population model of mental health care. The document contains also a broad range of assessments, interventions and expertise at an individual level and also at the broad, total population level, for an individual or groups of people who have ADHD. The plan pays particular attention to a direction for the promotion of prevention interventions. Within that there is a continuation of programs such as what is referred to as the Positive Parenting program - PPP. That program is already being applied but can be further developed. There is also in this approach of health promotion and illness prevention the Aussie Optimism program, which is run through schools. Since a plan of this type must have an overall approach, attention is paid to other vital areas, including the service of emergency or crisis care. There is also within the plan a defined need to adequately resource the emergency responses on a metropolitan and a statewide basis, particularly for children and adolescents.

In the area of community based mental health care, the plan identifies the need to address all the aspects, including biopsychosocial developmental aspects, family aspects and the school, training and, indeed, where it is relevant, work contexts. It is intended to have a very broad approach to the types of issues that will obviously arise. In a proper, developmental approach it builds on the strengths that the individual has; it is not simply an approach that identifies an area of difficulty. In essence, it has a broad approach that acknowledges the need to identify and build on strengths. The approach is to identify strengths in the wholeness of a person and his environment and to continue to build on those strengths. It is a very appropriate and broad approach. Similarly, it builds also on some environmental aspects such as the school situation, and identifies where additional supports are available through those types of environmental factors.

With regard to community accommodation it is generally acknowledged that it is highly desirable to maintain the child or indeed the adolescent in his or her own environment and there is a reluctance to take the child or adolescent out of that supportive environment. Only a very small number of patients from this group would be likely to require community accommodation. Certainly there is a severe and persistent group that has had some difficulty responding to the range of interventions that has been tried. Therefore, although the number of people who will require community accommodation is anticipated to be very small and must work in conjunction with the inpatient unit, it is seen as an area of contextual development. I use the word "contextual" because I acknowledge that I am talking about just a small group.

Within the more specific ADHD policy are a number of approaches and developments. They include the more effective monitoring of the use of psychostimulant medication. Indeed, the data that is gathered from that monitoring will be used to gain a better and much greater understanding of the patterns of use in Western Australia than we have presently. It will be possible to use the data from the monitoring to develop some aspects of research into the use of stimulants that may also similarly form the approach that will be taken in the future. That approach has been very much in consultation with the field - I refer to paediatricians, child and adolescent psychiatrists, other psychiatrists and paediatric neurologists who are very much involved in this area. A workshop has been conducted with those groups and another workshop will be conducted in October this year to similarly review some of the changes that have been made in that area and also to inform the field about some of the directions that are being considered presently.

It is recognised also that an important issue is the equity of access to services. The Office of Mental Health is currently coordinating a working group, which I am sure will be widely seen as necessary, so that, with a wide range of key stakeholders, it will be possible to further identify what is needed to provide access to services and to formulate and develop a plan for those needs. The range of stakeholders includes the Department of Education and Training, the Department for Community Development, the Learning and Attentional Disorders Society - LADS - paediatricians and clinicians from the mental health sectors, and other paediatricians, including neurologist paediatricians. That group has a good focus on the interface that occurs between the areas of service delivery, in particular, between child and adolescent paediatric and adult sets of services. Transitions, including transition of care, occur between those services. The group to which I have referred will consider ways to make those transitions effective and to make sure that there is an ability to provide services between those agencies and across those transitions.

The specialist ADHD team at the Bentley Family Clinic - the Bentley site - is continuing to conduct its service delivery. It is looking also at the areas in which it might develop a further understanding from the available data of the type of care that can be provided to a group that is having more difficulty responding to treatment. It will look also at the general issues that bedevil this particular area; that is, accuracy of diagnoses and the standardisation of diagnosis.

[10.50 am]

Princess Margaret Hospital for Children, in conjunction with the Office of Mental Health, has commissioned a review of the family partnerships team. This includes the relationships with the families at work area and will certainly include families in which there are children with a diagnosis of ADHD. Again, the review will pay attention to the environmental parts that clearly need that attention in a holistic approach to this issue and this problem.

I now move to the second question, which is to provide details of support for community-based organisations. The principal community-based organisation that has received support from the Department of Health is the Learning and Attentional Disorders Society. It is acknowledged as a group that provides a range of services for both families and the individuals who have the disorder. The types of services provided by this particular group include a good amount of information. It also acts, with knowledge that it has gathered, as essentially an information or referral service; that

is, it provides lists of available services to those who might make inquiries. It also directly provides some support for parents and some of the other support groups, and it also extends its support to the area of adults who either have the disorder or are making inquiries about the disorder. This group or society provides a series of seminars and workshops, and the group also maintains a database on research that is both national and international. Indeed, it has its own web site so that it is possible to access information from the society or group. The Department of Health provided emergency funding to enable this society to continue its range of services in 2003-04; however, that was one-off funding. It is not provided as recurrent funding at this stage.

Mr M.P. WHITELY: How much was that?

Dr Davidson: I am not able to provide the amount from the information that I have with me.

I now move to the third question, which is details of intersectorial and cross-agency programs. It is absolutely the intention of the Office of Mental Health to provide an integrated system of care, and in that endeavour there has been the development of a child and adolescent mental health services cohesion group. The intention essentially is to enhance the cohesion of services that are provided in the general area of child and adolescent mental health services and to support the development of those services, or services that are seen as necessary. This group looks essentially at the whole-of-system resources. It promotes the optimal approaches to assessment and ongoing management. That includes the area of disorders such as ADHD. The group has developed and is trialling protocols for emergency assessment of children and adolescents and also the enhancement of community follow-up and continuity of care. That is work that the group is progressing.

In terms of the parental situations and the general support that can be provided, there is also the Children of Parents with a Mental Illness project. That is a collaborative interagency project that is aimed at improving the heath and wellbeing of children of a parent with a mental illness in Western Australia. That is done through a process of improving the strategic linkages between the service providers and an endeavour to build capacity. A statewide strategic committee oversees that project. It has representation from a wide range of government agencies, including the Department of Justice, the Department for Community Development, the Department of Education and Training, non-government and community stakeholders. The Office of Mental Health component of the project is also enhanced by the commonwealth Department for Family and Community Services through the stronger families and communities strategy. That indeed has provided funding to support this project. Ruah Inreach, a non-government agency with considerable standing in the field, is similarly playing an important role in the development and implementation of that particular project.

The Department of Health is also involved in a number of collaborative initiatives with the Department of Education and Training, particularly in relation to the area of child development, including the early years screening for at-risk students project, which is a joint Department of Education and Training and Department of Health initiative. That is done in partnership with the Child Study Centre at the University of Western Australia. That particular initiative focuses on the cumulative information across this range on at-risk students across all the developmental areas from the ages of 18 months, three years, four years, entry to kindergarten and preschool. It covers those particular periods. The aim is essentially to provide an intervention, through things such as parenting skills and behaviour management. In some of those particular developmental stages - for instance, at three years - the initiative is to focus on language development issues. A screening tool has been developed and is being piloted for the kindergarten and preprimary stage. The aim of that screening tool is to provide intervention for students at risk, and obviously an early intervention with a preventive approach. One of the development areas that receives consideration within that particular initiative or program is attention, so clearly there are relationships to the ADHD issue.

The Albany education district, in collaboration again with the Department of Health, has developed a set of protocols for both the agencies - the Department of Education and Training and the

Department of Health - to use in dealing with ADHD and has formalised this in a book form. This is seen as a local initiative that has strong support from both departments. Obviously, those protocols will be further examined for efficacy or good effect. The Albany district has a half-time school psychologist and half-time child and adolescent mental health services clinician who work between the two agencies - education and health - focusing on the best management of students. This is regarded as successful in Albany. It was introduced in the Peel district in 2002-03, but has stopped as the funding is not currently available, although it is seen as an initiative that may be repeated. The Department of Education and Training is working on a teacher resource for students with learning difficulties. This includes a section on attention problems and ADHD, so there is also some cross-agency work involved in that Department of Education and Training initiative.

Mr M.P. WHITELY: Who provided the information? What was the source of the information that the Department of Education and Training is using?

Dr Davidson: It is, as I have said, from some of the resources of the Department of Health and also from some of the resources within the Department of Education and Training itself. It was developed in conjunction with but primarily from the resources of the Department of Education and Training.

The CHAIRMAN: A question was asked earlier about the funding level for LADS. Could you make that information available to the committee?

Dr Davidson: Certainly.

[11.00 am]

Mr P.W. ANDREWS: Rowan, you are the Chief Psychiatrist so it is appropriate to ask this question first. You used the expression "severe symptoms". "Symptoms" implies a disease or disorder. From your perspective, what is ADHD?

Dr Davidson: My perspective is that it is a disorder that is certainly complex in that there is no clear biological marker for the disorder. It is identified clearly from a set of symptoms that relate to the three primary areas of inattention, hyperactivity and impulsivity. It has been defined as a syndrome; therefore, there is a particular grouping of the symptoms into the syndrome that has some consistency over time and also has some consistency in terms of its response to a particular form of treatment.

Mr P.W. ANDREWS: Is it clear in your mind that there is possibly a biological base to it?

Dr Davidson: I would have to respond that it is not clear. I think it is likely to have a biological basis since the form of symptoms would appear to relate clearly to some areas of core activity that we would tend to group, including particular executive functions.

Mr P.W. ANDREWS: Are there any particular studies that you would direct us to that would prove a biological basis?

Dr Davidson: I do not believe there are any studies that prove a biological basis.

Mr P.W. ANDREWS: As a psychiatrist, what does psychiatry bring to ADHD that paediatrics and neurology do not bring? What is the particular sphere that psychiatry brings to this issue?

Dr Davidson: I would regard it as an approach that is across psychiatry, which is particularly well developed especially with diagnosis and diagnostic issues, that psychiatry has managed and will continue to manage. Hence, the international classifications are those that have been developed from within psychiatry. I believe there is a particular approach that is certainly well developed within psychiatry and will continue to be well developed. In terms of the management I believe that the approaches from within psychiatry - certainly the psychopharmacological approach and also the approaches to the management of behaviour - have not necessarily been exclusively developed by psychiatry but are nevertheless well developed within psychiatry and are part of the training of psychiatrists and the range of mental health clinicians and professionals, such as psychologists and

mental health nurses. When I talk about psychiatry I am also, at times, referring to the mental health approaches as distinct from what you have described.

Mr P.W. ANDREWS: Can you contrast that with paediatrics?

Dr Davidson: Paediatrics, I believe, has a particularly well developed approach in terms of the developmental issues that are, as I understand it, very clearly involved in the issues of ADHD. As well as being experts in child development, paediatricians are also experts in the physical disorders. It is very clear at times that there is an absolutely necessary distinction that needs to be made between the syndrome of ADHD and other disorders that may have similar symptomatology that are in fact related to disorders that paediatricians have expertise in. I also believe that paediatricians have considerable expertise in the management of behavioural disorders. There is clearly an overlap in that particular area.

Mr P.W. ANDREWS: What do they not have expertise in that psychiatrists do?

Dr Davidson: I believe that they do not have expertise in perhaps two areas, one of which I should have mentioned previously but which is obvious. That is the comorbid conditions that may accompany ADHD. That is certainly the area of expertise that psychiatrists have to a much greater degree than paediatricians. I believe that, in general, psychiatrists have a greater degree of expertise in some of the psychopharmacological approaches, not just the stimulants but also the antidepressant medications that also have indications at times for ADHD.

Mr P.W. ANDREWS: We have evidence from paediatricians that when they have diagnosed children with ADHD they very rarely refer the children to a psychiatrist. Why do you think that is?

Dr Davidson: I believe that, for the most part, paediatricians would see that they are able to well manage the identified patients. I accept that paediatricians have some expertise in the management of comorbid conditions. They may elect to also manage a comorbid condition themselves, which is entirely appropriate. The subgroup of psychiatrists that has the closest parallel in expertise is the child and adolescent psychiatrists who have additional training in child and adolescent issues and management. I understand that what has been presented to this committee is that there is rarely a referral from a paediatrician to a child and adolescent psychiatrist. However, I believe that nevertheless does occur, in particular when the overlap involves, for instance, the comorbid condition or perhaps at times appears to indicate the need to involve other types of services that are more readily available through the child and adolescent sector, such as I referred to earlier, at the Bentley site.

Mr P.W. ANDREWS: In your submission you made reference to the fact that there is a wide variety of research being done on all aspects of ADHD. You also make the point that, despite the huge numbers, there are many methodological flaws in the research. Quite frankly, I found that as well. Why? If it is such a broad area of interest, why is the methodology so consistently poor?

Dr Davidson: I believe it is in part because there is such great interest coming from different directions and different sets of expertise. That means that the involvement is not in just one sector; it is across a number of sectors. Indeed, there may sometimes be disagreement. I have already referred to the issues of diagnosis and diagnostic formulation. There will be some significant differences between approaches to those diagnostic formulations. For instance, I am aware that we have, in a sense, two competing classifications: the DSM classification and the ICD classifications. At times there may be differences in preference for the use of those classifications. Acknowledging the diagnostic difficulties, even when used within a research setting, there can be differences in the population that is being studied. We referred earlier to a number of different sectors of interest. At times, those sectors of interest can pick up different populations of those who suffer from this disorder.

Mr P.W. ANDREWS: What you are saying is that the researcher will pick the population.

Dr Davidson: A researcher coming from a different sector will often be interested in that particular population. It may be at the severe end or, for instance, at the primary care end, which is often a less severe end. It is often the researcher's interest that causes him to select that particular population for study.

The CHAIRMAN: I am sorry, but I will have to pull you up there. We need to move on because other members have questions.

Mr M.F. BOARD: I thank you for the way in which you came back to us outlining the policies and current procedures and plans for the future. Anything I am about to say is not a criticism of you or the Department of Health. Nevertheless, I need to explore some things. Much of the evidence that has been given to our committee, both verbally and by submissions, does not quite bear out that picture in that most of the information given has been critical of access, information and a range of services, particularly access to public services. Hence there seems to be a disproportionate amount of services provided by the private sector. You would be familiar with the report and the policy I am holding. The policy states up front that one of the biggest concerns is the diagnosis and prescription rate in Western Australia. I think we have explored this before, but no studies have been done or there is no evidence to show that long-term use of psychostimulant medication is beneficial; in fact, it could be adversely effective. One of the reasons for having this inquiry is that there seems to be a lot of confusion amongst parents in our community about whether they are doing the right thing or the wrong thing for their children. Based on the fact that there is a very high rate of psychostimulant medication prescriptions in Western Australia, and given that we do not have any evidence that that is not doing damage, is it incumbent upon the Department of Health to take a stronger stand about prescription medication being a last-case scenario rather than a first-case scenario, and a whole range of other possibilities being considered prior to that? I just ask for your opinion on that.

[11.10 am]

Dr Davidson: Yes, I do think it is very important that we clearly identify individuals suffering from the disorder. I acknowledge that this has already been alluded to as an issue. Once the diagnosis has been made there should be absolute consideration. If I can go back a little bit, I mean that the diagnosis be made and it is clear that alternative diagnoses have been well considered and that therefore, as far as possible, there is some accuracy of diagnosis. At that point, in terms of management, exactly as you have described, it is incumbent on both the service and the individual clinician to consider the full range of approaches to the disorder in that individual. I acknowledge that that is one of the key factors we must recognise when we are dealing with individuals with the disorder. It is well recognised that individuals with the disorder show a range of responses to interventions.

Mr M.F. BOARD: The evidence we have been given, both by parents and professionals in the system, has indicated that, first, it is not really happening that way and, secondly, that range of services is not available, particularly in a public sense, and if it is, access to the services is very limited. Hence, people go and see a paediatrician, a script is written and that is the end of the story. Although that might be the plan, it is not being implemented. As the Chief Psychiatrist, do you play a role in implementing a stronger regime for that in Western Australia? If so, what tools do you need? If our committee is going to have a positive impact - and it has some grunt to do so - we need to know what needs to be done. We need information from people such as you about what tools or resources are required to get where you need to be.

Dr Davidson: I will deal with that in two parts. First, I believe that the approach that has been taken through the stimulants assessment panel, which replaced the stimulants committee, is to have a much stronger regime for trying to ensure that the prescription habits and patterns in this disorder are made as appropriate as possible considering the types of issues, just as you have indicated. The panel's approach also acknowledges the issue of the diagnosis and accuracy of diagnosis. Indeed, it

also enables a monitoring of an individual clinician's prescribing pattern. It is intended that the new assessment panel will be able to have an impact on prescribing patterns in Western Australia. It is at this point very early in the institution of the processes for that assessment panel. Nevertheless, I believe that we can expect to see some real impact on the activities of the panel and that we will also receive some information from the data that is coming out of the requirements for a prescriber to advise the panel. It will be known what their prescribing pattern is, but also such important factors as response to treatment.

Mr M.F. BOARD: I have one more quick question before Martin asks his questions. Would you support a regime that required - and this is the difficulty - professional medical practitioners to take a number of steps before a prescription was written?

Dr Davidson: Essentially, yes. I acknowledge the point that it is also not desirable to necessarily specifically direct clinicians as to what they can do, but as you have described, putting on such provisions so that they feel that the prescribing pattern is being adhered to in a standardised way, accepting the issues that need to be addressed. I am sorry that is a long answer.

Mr M.F. BOARD: I think it is what I needed.

The CHAIRMAN: I have to apologise. I have to go and catch a plane. I will hand over the chair to Mike Board. I would just like to thank you very much. It has been an enlightening discussion.

Mr M.P. WHITELY: I will start off with a bouquet. I think the family health service in mental health is doing a fantastic job. We have heard evidence to that effect. It has received a good deal of public praise, but Bentley is dealing with the back end of the problem. Bentley is dealing with kids who have been diagnosed with ADHD and typically receive very high doses and in many cases are involved in being detoxified after having been on a cocktail of drugs. Information we have received from Bentley has shown that it is dealing with those problems because very young children, some younger than the guideline age of four years, are actually medicated with amphetamines and then other drugs to deal with some of the side effects of the amphetamines. Bentley is doing it very well but it is fixing the problem for a small number of children who are in some cases being toxified, for want of a better word, by inappropriate diagnoses about the use of medication at the front end. Do you see a role for services such as Bentley at the front end of the problem, at the diagnosis stage, because Bentley often identifies family counselling and other sorts of interventions that are appropriate? Do you see a role for that sort of service?

Dr Davidson: In an advisory role rather than a direct service role. My concern would be that if it were to take place at the front end as you have described as a direct service role rather than a tertiary role, it would be overwhelmed all too quickly and then would become ineffective in providing the other service.

Mr M.P. WHITELY: What about the Victorian model? Victoria has rates of diagnosis that are about one-sixth to one-ninth of the rates of prescription in this State. I admit that Victoria has a front-end service in child and adolescent mental health services that is not as much of a Rolls Royce model as Bentley is, but it does have a multidisciplinary approach to the diagnosis, which we lack in Western Australia. Those in Victoria account for the high rates of prescription in Western Australia as being the result of single, private sector paediatricians who are very enthusiastic to diagnose and medicate, as opposed to Victoria's more cautious multidisciplinary approach.

Dr Davidson: Just as you have described, a multidisciplinary approach is highly desirable. My pause is that I am still not sure that we will be able to develop in Western Australia the same resourced program that they have developed in Victoria. That certainly is the area I referred to previously in the CAMHS cohesion group, which is trying to work on improving access for a specialist mental health service for those who have the diagnosis of ADHD, rather than keeping as it is at present. I acknowledge, as you have described, that it is a tertiary service for those who have ADHD. I think it is possible that we can impact on the prescribing habits, as I described, through

the activities of the assessment panel. That is not denying the desirability of a multidisciplinary program at the very outset when a practitioner might first consider that as a diagnosis. Nevertheless, it is part of the approach by the Department of Health to closely examine those prescribing patterns and it is also hoped that we will have the data. We hope that that data indicates why we have a difference in those prescribing rates State to State.

[11.20 am]

Mr M.F. BOARD: Rowan, you said that we cannot do that in Western Australia. Why?

Dr Davidson: I must apologise if I said that we cannot do that. I certainly believe we could do that.

Mr M.F. BOARD: Is it just a resource factor?

Dr Davidson: It is a resource factor and, as the panel members might be aware, it is also the availability of the clinicians, particularly child and adolescent psychiatrists, but also the full range, for instance, of clinical psychologists who specialise in the CAMHS area and also the mental health nurses who similarly specialise in that area. We have huge problems in terms of staff resources.

Mr P.W. ANDREWS: The lack of resources in terms of psychiatrists and mental health nurses then clears the way for the medical model to be applied in Western Australia, as opposed to Victoria.

Dr Davidson: In my view, the multidisiplinary approach is absolutely still a required approach. I still see it as a significant disorder.

Mr P.W. ANDREWS: In your submission you said that there is no indication that the use of stimulant medication in Western Australia reflects clinical practices as being any better or any worse than that of any other State. You then said something to the effect that it is because of the different clinical perspective. Is that not sitting on the fence to say that it is no better or worse in Western Australia than it is in Victoria, which takes a different approach? Surely one approach must be better than the other approach.

Dr Davidson: What I was talking about when I answered Mr Whitely was in reference to the ability of the Child and Adolescent Mental Health Service, particularly Bentley, to provide a much greater degree of support at what we refer to as the front end, or the first part of management. I was talking to that and in terms of resources I was similarly referring to the issues for Bentley and similar services to be able to provide earlier intervention than they are able to provide at the moment. That is what I was talking to in terms of one of the restricting or limiting factors - the absolute availability of child and adolescent psychiatrists and other related mental health clinicians. I clarify that that comment was in reference to the limiting factor of available clinicians.

Mr P.W. ANDREWS: If we were not in Western Australia or Victoria but in a neutral State, what would be the ideal model?

Dr Davidson: The ideal model would involve an ease of access for the referral, for instance, of an individual who has had at least a preliminary diagnosis. That preliminary diagnosis may come from a number of different sectors. For instance, it may come from the education sector or it may come from a general practitioner.

Mr P.W. ANDREWS: A preliminary diagnosis of attention deficit hyperactive disorder from the educational sector?

Dr Davidson: Yes. Not a diagnosis - I should correct that - but a preliminary suspicion.

Mr P.W. ANDREWS: That is fraught with danger.

Mr M.P. WHITELY: The second point I want to make - I have given you the okay about Bentley, but here comes the brickbat - is that you made reference to the role that LADS plays in providing information to the working group and the provision of services. You said that it provides a good

amount of information. I agree that it provides a good amount of information; however, what concerns me is the quality of that information. Before I give examples, what quality vetting of LADS information do you and the Department of Education and Training undertake?

Dr Davidson: I am not able to give an exact answer to that question. However, I do not believe that there is departmental policy of directly vetting information that that society may provide. It is the intention, as I understand it, to work with the society to try to ensure that the information that it is providing is appropriate without vetting or clearly stating to the society what information it may provide.

Mr M.P. WHITELY: I will give you two examples of public information that was provided on a television program by LADS officers. When referring to the illicit use of dexamphetamines and the level at which a person reached a hit, Michele Toner said - I will paraphrase her - that a person would need to take up to 200 tablets. That is a 1 000 milligrams. Do you have any comment to make about the quality of that information?

Dr Davidson: Certainly, I would not have wanted -

Mr M.P. WHITELY: I will put this in context. She was not suggesting that people do this. I need to put this in context. She was suggesting that it is not a harmful drug in the sense that the addictive and hit potential of it requires a high dose. I am interested in your views on a person taking up to 1 000 milligrams before he or she gets a hit. Do you have any comment about the quality of that information?

Dr Davidson: In my view that is absolutely incorrect. A person would clearly reach a toxic level well before that level.

Mr M.P. WHITELY: The web site of one manufacturer of dexamphetamine states that toxic symptoms occasionally occur as an idiosyncrasy dose as low as two milligrams. It further states that they are rarely doses of less than 15 milligrams, that thirty milligrams can produce severe reactions, but doses of 400 to 500 milligrams, which is less than half of 1 000 milligrams, are not necessarily fatal. We need to be cautious about the source of our information. The other information that is probably a little less startling was given by Roger Paterson who was part of the advisory panel for LADS. He stated that the drugs themselves are not addictive at all or had very low addiction rates. Do you have any comments about the addictive properties of dexamphetamines?

Dr Davidson: The addictive potential is certainly not seen in general as high. Nevertheless, as in all situations, the complication is that a person may have, in terms of an addiction, either a psychological or a physical addition. One would need to be careful about those sorts of statements since they might appear to indicate that it is a perfectly safe drug. The stimulants in particular have some addictive potential always.

Mr M.P. WHITELY: On its web site GlaxoSmithKline Australia, which is a manufacturer of Dexadrine, an American brand name of the same product, indicates on its prescribers information that amphetamines have a high potential for abuse and that the administration of amphetamines for prolonged periods may lead to drug dependence and must be avoided. It also states that particular attention should be paid to the possibility of subjects obtaining amphetamines for non-therapeutic use or distribution and that the drug should be used as prescribed and dispensed sparingly. The manufacturer’s own information seems to conflict with that advice. I am concerned that LADS is giving information and that that information is being relied on when some of its quality is at best dubious.

Dr Davidson: I agree that it is a concern that some parts of that information may have been provided by a society that is seen as having some standing.

[11.30 am]

Mr M.F. BOARD: I will take you back to a question that I started with, but I will elaborate on it a little. In the past 12 months we have had evidence from a range of experts such as paediatricians and psychiatrists from various jurisdictions in Australia, as well as international experts, some of whom are recognised as such. Their expert advice is diametrically opposed. We find that very difficult. If it is difficult for the medical profession, and it is very difficult for people like us. Yet, what I find most surprising is that, in terms of public policy, in just about everything else we err on the side of caution. We do not allow anybody to do anything in this society, particularly when it comes to drugs and medical matters, unless there is a degree of certainty. However, in this area there is not only a huge amount of uncertainty but also expert advice against what is being practised; yet the Department of Health does not seem to err on the side of caution in this regard. As a public policy maker, I find that interesting and difficult. I know there are sensitivities here, but I will say it anyway: I guess that is because the medical profession often controls these areas of expertise. That is fine; we understand that. However, the debate is within the medical profession itself. Hence, I think that medical bodies, government bodies and public policy makers should be saying, "Look, we have concerns, particularly about the growing level - the sort of asymptotic rise - of this in Western Australia. Surely we must cap this until we have more information." However, that is not happening. We have some nice guidelines and policies, and some fluffy stuff about direction, but no real grunt in trying to give our community some certainty. I guess that is why we are here.

At the end of this inquiry we are hoping that we can come down with some stronger guidelines that will assist with both financing and support for the department and others, so that they can get on and do what they need to do. I guess we need to know what those things are. We have our ideas at this point, but I would like to hear your views. If you were to walk out of here today with a chequebook and control over a range of public policy areas, what would you implement?

Dr Davidson: I would continue to implement, as I have referred to - I believe this is an important initiative in terms of management - measures to address the concern about prescription rates. The work of the stimulants assessment panel, I think, is very much directed at trying to provide a degree of control of and support for issues such as accuracy of diagnosis and monitoring, so that we monitor not just the overall patterns but also individual clinician prescribing patterns, and can then ask an individual clinician for appropriate explanations about prescribing patterns. I am talking about appropriate controls that should be in place in terms of the prescription of stimulants. We should also pay attention to the areas that complicate it, such as diversion of stimulants and being able to try to identify where that may be occurring and the steps that individual clinicians take to try to make sure that they minimise the possibilities of diversion. Also, additionally, there should be the ability overall to have comparative data so that we can indeed compare ourselves more accurately with other States and understand what the patterns mean in our State compared with those in other States.

I would say to you that I believe that is a very appropriate initiative. It should be supported. My belief is also that it may in fact be further developed. Obviously, that is something that the department will consider, both in terms of monitoring and in terms of the actual processes involved in trying to support factors such as accuracy of diagnosis. That is referring mostly to the very concerning area of the difference in prescribing patterns.

There is, in my view, also a considerable need to try to make progress in terms of some of the real central issues that you have addressed previously and spoken to briefly today. That is because we have a cross profession and a wide number of professions that are involved in early identification. This is always an issue that is close to my heart. The earlier we can identify, and clearly identify, a particular disorder and then provide a range of management, the better. I am sorry; may I, with your permission, digress for just a moment?

Mr M.F. BOARD: Sure.

Dr Davidson: It is with reference to your previous question, Mr Andrews, and the concern that you described about any possibility of the schoolteachers or the school system being involved in this. My view of that is that they are to some degree already involved, because what we require in terms of the diagnostic analysis is often reports from teachers to supplement the reports from the parents and, indeed, to have a whole picture. That was my reference to the suspicion. Therefore, when, for instance, the school is able to identify and say that it thinks there is a possibility, I think that plays a part in the whole system of being able to identify as early as possible where there is an issue that needs to be addressed. Whether that is or is not ADHD is a matter absolutely for the professionals and those who have the expertise in diagnosis and who will then have to make the diagnosis. However, there are contributions.

Mr P.W. ANDREWS: I agree with that. However, our worry is that we have taken evidence that it goes well beyond that. Rather than it being referred to as, "This child has a number of problems. What do you think it is?" it becomes, "We're sure this child has some problem, probably ADHD. I'll refer it to the psychologist." The psychologist then says, "Yes, it is probably ADHD." The psychologist then refers it to a paediatrician, who says, "Yes, it's ADHD." Quite frankly, both from personal experience and from evidence that we have taken, that process is very dubious.

Dr Davidson: Yes, and may indeed be biased unfairly or inappropriately to some individuals. I would agree with that.

Mr P.W. ANDREWS: And with large variations between one school and another.

Dr Davidson: Yes. I appreciate that point. Certainly, I would not wish to have added to that suspicion, but would be clear that I see it often as part of a progression. However, that needs to be a careful process, and a process that, if it is possible, avoids the bias of previous opinion and re-examines the whole picture at each step.

Mr P.W. ANDREWS: I think you have hit it on the head. I think your words then were re-examination at each step.

Dr Davidson: Yes; that is correct.

Mr P.W. ANDREWS: One of the key things in my mind is that there is not the re-examination at each step; that the kids tend to become funnelled, and then no-one steps back from it and says, "Hang on a second. This needs to be re-examined." I find your point to be very good. Without getting too personal, would you be happy for a child of yours, aged between, say, four and eight, to start off and be on psychostimulants for five years?

Dr Davidson: May I answer that directly: no, I would not. However, if the situation was clear to me that a careful diagnosis had been made and that all of the other management approaches had been considered, I would accept it. I would not ever be happy about it.

Mr M.F. BOARD: Dexamphetamine is a fairly cheap drug that is available because it is on the PBS.

Dr Davidson: Yes.

Mr M.F. BOARD: Because of that, it is a quick solution to a problem, whereas alternative methods or alternative treatments, if that is the right term to use, are more expensive, less freely available, time consuming etc. To go down an alternative route is a difficult task because it is not publicly available and access to it is difficult. Would you agree with that comment?

[11.40 am]

Dr Davidson: I think that what would appear to be a more straightforward and easier solution is always attractive. As has been stated by some members of the committee, it is absolutely necessary to try to prevent the kind of influence that comes from an available resource that is straightforward and perhaps easily accessed. Rather, we should consider, just as you have described, the more complex and difficult approach. It is certainly a more involved approach that at times clearly goes

across a number of professions as well as a number of sectors. My view is, yes, I think that is true. There is attractiveness in what would appear to be a simpler and more straightforward solution, which has to be resisted.

Mr M.F. BOARD: I might be wrong in what I am about to say but I do not think so. It is certainly not wrong given the evidence we have taken. If a greater range of alternative services were available prior to prescription medication being offered, I think the majority of parents would be prepared to take those paths because they are not that keen, as you indicated yourself, to see their children on psychostimulants, particularly at a young age. There is a sense of failure and a concern about the long-term effects. Social pressure goes with that as well. We have had a lot of evidence about parents being singled out as failures because their kids are being treated. They go down that path solely because there is nowhere else to go. That is our major concern. Yet in Victoria it seems that there are other services available up-front at the front door, which is why the prescription rate is so low. That seems fairly clear to us, yet there does not appear to be a major push down that way in Western Australia. I wonder why that has been the case. Is it a historical thing?

Dr Davidson: My perspective is that there is absolutely an endeavour to progress down that particular pathway, for the good reasons that you have described. We should be providing a full range of services. We should be able, or at least we should be attempting, to provide some equity of access to those services, whether we are talking about Derby, Albany or Perth. I acknowledge that that is very true. Therefore, that is absolutely one of the matters or issues to which the department and the Office of Mental Health do pay attention. I reiterate that it is the intention to move in a variety of ways to try to ensure exactly what you have described.

Mr M.F. BOARD: I am sure that at the end of this we will be giving you a hand with that side of things.

Mr M.P. WHITELY: I want to touch very quickly on the issue of informed consent. We have taken evidence and I have also heard this a lot in discussions with parents. Parents go to a paediatrician's office and the paediatrician says that little Johnny has a biochemical imbalance in the brain that is best treated with medication. He says that the medication is harmless and the parents will see an improvement in Johnny's performance, and the dose will be monitored. I do not have a problem with adults taking dexamphetamine, but children do not have the capacity to make rational decisions about them. Often the evidence that will be portrayed is that it is working; the kid is sitting in the room and will say he feels better. When his mum and dad and the paediatrician are sitting there, what is a kid expected to say? I have a huge ethical issue with the informed consent that parents are giving. I believe that parents should be told how ADHD is diagnosed and be given the checklist. It is all behavioural. There is no biological marker. No physiology is associated with it. They should be told that the drugs may manage some of the symptoms and be presented with the potential side effects of the drugs. I will not list them, because I know you would be familiar with them all. Parents would then ask what else they could try, as you did when you were asked what you would do if you had a child in that situation. What capacity is there for government to ensure that parents are giving informed consent? They should be told that it is an entirely subjective diagnosis, how it has been diagnosed, what checklist was used, what are the drugs and what are the effects of the drugs. Is there a capacity for government to ensure that private sector paediatricians do this? I do not think they do at the moment. In fact, I know they do not.

Dr Davidson: I agree with what you are describing as good clinical practice. It is good clinical practice to provide that sort of information and certainly to maximise the ability of the parent to ask the appropriate questions that are important to them. Good clinical practice is driven by a number of mechanisms. One is the relevant college, if we are talking about specialists. If we are talking about general practitioners, it is some of the divisions of general practice. It is the ability to drive what is good clinical practice. Another part that I believe is relevant to what you are describing is that on the form that is received by the assessment panel there is a requirement for the patient to

sign that form. That is not informed consent as you describe it, but it is at least one part of trying to ensure that there is some involvement of the parent in understanding what this actually means and how the process occurs. The signing is intended to be an acknowledgment by the patient that those matters on the form are described accurately by the relevant practitioner. I believe there are two parts. The first part is some way that the department - in that sense government - is trying to ensure that there are those kinds of steps. The second part is driving good clinical practice.

Mr M.P. WHITELY: Could we get a copy of that form, obviously depersonalised or whatever, so that it shows the process?

Dr Davidson: Absolutely.

Mr M.P. WHITELY: If there were good clinical practice, I would not be raising this concern. I have heard it from numerous sources, both as evidence here and also in my work with constituents. If there are opportunities to strengthen that, fine. I think adults have a right to know how it is diagnosed now. At least adults can make an assessment of how they feel and react, whereas children rely on their parents to do that. If their parents are not given information, it is a huge issue.

Mr M.F. BOARD: I am about to close. One thing has just come out of that. What we found in other jurisdictions, particularly Victoria, was that there seems to be an emphasis within the education and training provided by colleges and institutions on the need for some stronger protocols in this area. It is driven from that area forward, particularly with young medical practitioners coming out. Do you think that is lacking here to some degree? Do we need to develop or resource that area more?

Dr Davidson: I think it can be strengthened.

Mr M.F. BOARD: I need to close the committee, because we have to be in Parliament at 12 noon. Thank you so much for your attendance today and for your generosity with your time. The intellectual property you have provided has been very valuable to us, particularly your honesty with your opinions. You will receive a transcript of your oral evidence and a letter that explains what to do if you need to make any alterations. You can make alterations only if there are any errors. If you want to clarify some issues or give supplementary information, you can do so and should send that back within 10 working days of receiving the transcript. If you do not send it back, we will assume that it is correct. On behalf of us all, thank you very much, Rowan. We appreciate it. It has been very valuable to us.

Committee adjourned at 11.48 am