Letters

Many thanks for Alison Poulton's excellent article about attention deficit hyperactivity disorder (ADHD; *AJGP* March 2021), highlighting the importance of the general practitioner's (GP's) role in identifying undiagnosed ADHD, and confirming that 'timely and effective treatment can make an enormous difference to the individual'.[1] GPs are indeed well placed to identify patients of all ages affected by ADHD or previously diagnosed but lost to follow-up. Sadly, referrals for suspected ADHD to our local mental health service in Midland, Perth, WA, are routinely refused; worse still, referrals for other problems such as bipolar disorder are also routinely refused if there is a history of ADHD.

We therefore have two avenues of referral: private (which few patients in our socioecomonic area can access) or via Medicare Benefits Schedule item 291, which 'prepares a written diagnosis of the patient; and prepares a written management plan for the patient that covers the next 12 months'. GPs such as myself would typically perform an ADHD assessment; however, we are unable to prescribe stimulant medication listed on the Pharmaceutical Benefits Scheme unless a shared care arrangement has been made with a psychiatrist.

Patients with private insurance are typically seen quickly, commenced on treatment and monitored in follow-up psychiatric appointments. For others, the only option is item 291: a single 45-minute psychiatrist assessment, a 'suggestion' for medical treatment and no further review for a year. Patient monitoring now becomes the sole domain of the GP, who also needs to manage coincident mental health conditions, polypharmacy, potential abuse of stimulant medication and failure to respond to treatment. In no other medical specialty would this paucity of support from secondary care be deemed acceptable.

I would be interested to hear Dr Poulton's opinion as to why ADHD is not regarded as a valid reason for referral to our local mental health service, and why its very inclusion on a problem list invalidates a referral for a more pressing and coincident mental health complaint.

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Reference

1. Poulton A. Recognising attention deficit hyperactivity disorder across the lifespan. Aust J Gen Pract 2021;50(3):110–13. doi: 10.31128/AJGP-09-20-5623.

Reply

Thank you for your thoughtful letter highlighting the lack of accessible treatment for people with attention deficit hyperactivity disorder (ADHD) who cannot afford private specialist fees.

The issue of inadequate resources for patients with ADHD within the public mental health services is unfortunately not restricted to Perth, WA, but is more likely endemic. As ADHD is a stable condition rather than one characterised by exacerbations and remissions, referral pathways should provide ongoing care, not just assessment and diagnosis. The established pathways for children involving treatment by paediatricians are usually more accessible than those for adults. Transition can also be challenging for those diagnosed in childhood who require ongoing treatment in adulthood.[1]

In Nepean Blue Mountains Local Health District (LHD), NSW, we are striving to address this shortage within the public sector by piloting a model for integrated care. The goal is to establish a Lifespan Community ADHD Clinic at Cranebrook Community Health Centre. Interested GPs would train at the clinic to a level at which they would be competent to diagnose and treat children and adults with ADHD in their own practices. These GPs would have privileged access to the clinic for more complex patients, peer support and ongoing education. Suitable clinic patients could be referred back to an increasingly experienced cohort of GPs, who could provide continuity of care into adulthood.

Establishing this clinic, even as a pilot program, is a long and complex process. It requires not only the full support of the LHD but also regulatory approval for prescribing privileges for the clinic-trained GPs. However, once the regulatory and governance issues have been resolved, it is a model that is potentially scalable and could be replicated within NSW and ultimately also in other states and territories.

Provision for affordable ADHD services requires advocacy, and effective advocacy requires data. Further research is required to collect data to inform decision makers.

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Reference

1. Poulton AS. Transition in ADHD: Attention to the lifespan. Australas Psychiatry 2017;25(2):126–29. doi: 10.1177/1039856216671665.