Senate Select Committee on Mental Health
PUBLIC HEARING
FRIDAY, 7 OCTOBER 2005

Questions on Notice
Department of Health and Ageing

Question 1 - Hansard pp. 32-33.
CHAIR—No, the clinical guidelines is what you were asked about.
Mr Smyth—I would have to take that on notice, I am sorry, Senator.
Senator MOORE—This is in terms of tracing through. We had highly publicised clinical guidelines for other key priority conditions in the country and we are trying to trace through, because there was an expectation—and I think Professor Whiteford talked about the things that were available—that there would be a package with the same kind of promotion and general accessibility across the whole of the community that had that a focus on depression.
Mr Smyth—A focus on depression?
Senator MOORE—I think that what you have said is that there are a range of things available but they are not quite at the same standard as what we have for diabetes or cancer.
Mr Davies—Guidelines come from a variety of sources.
Senator MOORE—Absolutely. Where did the ones on cancer come from? Maybe we will put it on notice so that we can have it really clearly seen. Promoted through the cancer inquiry was the value of having this particular product and that everybody in the network—consumers, practitioners—could refer to those guidelines and that it was the expectation of government that there would be such a product for other key conditions, and I know there is one on diabetes because we have asked questions at estimates, and I know there is one on cardiovascular disease. I am trying to find out if there is a similar product for the area of mental health. I know that the issue of depression was given prominence when the government accepted it as a priority after there was so much public pressure and public tragedy. Is there an expectation to have such a product? If not, I think it would be useful for us to have something to have a look at that linked together the answers that you have given us, because Mr Smyth linked the various things that you have got, how they work and how they differ from the one on diabetes, for instance.
Mr Davies—I think it would be useful if we offered, as we have, to come back to you with a sort of mud map of what standards and guidelines are out there, what their status is, what level of endorsement they have.
Senator MOORE—That would be very useful. Can I have a comparison?
Senator WEBBER—Depression versus cancer versus diabetes.
Mr Davies—We could do that, yes.
Senator MOORE—It would be useful and also it would respond to the process.

Response

Guidelines have been developed to assist in the management of depression and for other mental disorders.

- *beyondblue* has developed evidence based guidelines for treating depression in primary care which provide treatment guidance across the spectrum of depressive disorders. The *beyondblue Guidelines* provide treatment choices for:
  - Mild depression without complications;
  - Moderately severe depression and dysthymia;
  - Uncomplicated, melancholic or atypical depression;
  - Moderately severe depression with co-morbid substance abuse;
  - Moderate to severe depression with physical disorders;
  - Severe depression with melancholia;
  - Recurrent depression or failure to respond to a preferred first-line treatment;
  - Psychotic depression and severe depression with risk of suicide.

  These were published in the Medical Journal of Australia (MJA 2002; 176 (10 Suppl): S77-S83) (website: www.beyondblue.org.au).

- The Royal Australian and New Zealand College of Psychiatrists (RANZCP) has developed evidence based Clinical Practices Guidelines (CPGs) on:
  - Anorexia nervosa;
  - Bipolar disorder;
  - Deliberate self harm (youth and adult)
  - Panic disorder and acrophobia;
  - Schizophrenia; and
  - Depression

  The RANZCP CPGs development was supported by both the Australian and New Zealand Governments. Two guidelines were developed for each of the six disorders – one for consumers/carers, and one for mental health clinicians (primarily psychiatrists). These guidelines are available on the RANZCP Internet site at www.ranzcp.org.

  The RANZCP CPGs are a result of extensive consultation, overseen by a Steering Committee chaired by Professor Phillip Boyce, which included:
  - direct contact with State, Territory and New Zealand Governments;
  - meetings with key professional colleges;
  - bi-national consumer/carer workshops and forums;
  - electronic consultation through relevant websites and associated marketing to alert stakeholders to the process; and
  - presentations at conferences and workshops.

  The development of the both of the above sets of guidelines was the subject of extensive consultation to ensure consistency in approach to the management of depression. They are available on the RANZCP Internet site at www.ranzcp.org

- *A Manual of Mental Health Care in General Practice* (Davies, J., 2000) was developed under the National Mental Health Strategy in collaboration with Queensland Health and the Queensland Divisions of General, and is available from www.mentalhealth.gov.au .

- GPs who have undertaken the Better Outcomes in Mental Health Care level two training were provided with copies of *Management of Mental Disorders*, a resource developed by the World Health Organization Collaborating Centre for Mental Health and Substance Abuse as part of the Treatment Protocol Project. The resource was developed for use by GPs and generalist mental health clinicians working in community mental health services.

Question 2 - Hansard p. 37
Senator SCULLION—I appreciate that. Perhaps you may be able to take on notice, Mr Davies, that again with this siloisation, that answer the professor just gave me is appropriate to his specific field. It is the kind of answer that I would be very grateful to receive in terms of the medical and nursing field—that we are adjusting curricula. What is happening? What have we adopted? Have we got a similar sort of process? How is it being funded? And like it or not, the police are a fundamental part of the front line and perhaps we should have called the police to appear before us as a separate entity. In terms of responsibility about a curriculum across the board, which is fundamentally about understanding mental health, perhaps you could take on notice about how we could have a look at that and how you are approaching it in a holistic sense, rather than siloisation.

Response

The Department of Education, Science and Training has advised that relevant education and training is provided in the higher education sector (medicine and nursing) and vocational education and training sector (nursing). Arrangements for curriculum development vary in each sector, as outlined below.

In higher education, the extent to which mental health is addressed in relevant medical and nursing curricula would be determined by each university through its own curriculum development and quality assurance processes.

- Universities are self-accrediting bodies established by or under Commonwealth, State or Territory legislation. They are responsible for designing their own curricula and for maintaining the quality of their own academic standards, which is independently verified every five years by the Australian Universities Quality Agency. Universities also voluntarily comply with related codes of practice and guidelines set by the Australian Vice-Chancellors' Committee. Universities assure the quality of their course offerings in a number of ways, including through external academic and industry input, peer review, and evaluation of student feedback.

- DEST is currently conducting a study of undergraduate medical education, to assess "What makes for success in training our doctors?" Findings of this study are expected to help to inform future development of medical education curricula.

In the Vocational Education and Training (VET) sector, Training Packages describe the skills and knowledge needed to perform effectively in the workplace.

- Mental health competency units are included in the Health Training Package (HLT02) and the Aged Care qualifications in the Community Services Training Package (CHC02). However, at present nursing qualifications are not included in either of these packages. Enrolled nurse preparation currently occurs within the VET system, but outside the Training Package framework, in courses accredited by State or Territory regulatory authorities. These courses are at the Certificate IV or Diploma level and include basic mental health units.

- Training Packages are developed by industry through national Industry Skills Councils or by enterprises to meet the identified training needs of specific industries or industry sectors. To gain endorsement by the National Training Quality Council (and its successor the National Quality Council), developers must provide evidence of extensive consultation and support within the industry area or enterprise.

- The Community Services and Health Industry Skills Council is currently reviewing the Health Training Package (HLT02), including development of new qualifications in Enrolled Nursing. The review process to date has indicated the need for the inclusion of mental health units of competency in all new qualifications in Enrolled Nursing at a more comprehensive level than offered in current State and Territory courses. A mental health specialty practice area is being considered for inclusion in a proposed Advanced Diploma of Enrolled Nursing.

The following initiatives aim to improve the understanding of mental health for workers in non-health occupations who are likely to encounter people with mental health issues. This is reflected in:

- the National Suicide Prevention Strategy, which recognises the importance of training and support to emergency personnel and others responding to mental health crises; and
- the *National Mental Health Plan (2003-2008)* which aims to decrease levels of stigma experienced by people with mental illness by raising mental health literacy in the general community, not just in the health professions.

Specific existing programs funded by the Australian Government include the following:

- The Mindframe National Media Initiative seeks to influence the media industry to report mental illness and suicide issues responsibly, accurately and sensitively. This has included the development of resources and conduct of training for media professionals across Australia.
- The ResponseAbility project has had success in integrating mental health and suicide prevention issues into the undergraduate curriculum for secondary school teachers and journalists.
- The MindMatters suite of initiatives provides mental health promotion resources and professional development for teachers and other key secondary school staff. Staff from 85% of Australian secondary schools have participated in MindMatters professional development activities.

- The CommunityMindEd project has developed a training package on mental health issues for use within Vocational Education and Training (VET) sector non-clinical community courses, for example youth and aged care workers.
- The Aboriginal Writer's Project is developing a number of mental health resources, including a mental health first aid resource for Aboriginal and Torres Strait Islander communities.

Funds have also been allocated for the production and dissemination of resources and training to promote effective and responsible use of the media in the mental health and judicial sectors.

Question 3 - Hansard p. 39
Senator SCULLION—Perhaps you could provide the committee, on notice, a schedule of those programs that provide mental health funding to Indigenous communities and clinics, and the period of time under which they are reapplied for and the sustainability of those funds.
Ms Savage—Most certainly.

Response

A total of $24.540m has been provided in the 2005/06 financial year, as indicated below:

- $8.704 million allocated directly to the Mental Health Program, comprising:
  - Mental Health Services $2.602m
  - Social Emotional Well Being Regional Centres $5.568m
  - National Projects $0.534m

- $15.836 million allocated directly to the Bringing Them Home programs, comprising:
  - Bringing Them Home Program $11.679m
  - Link Up Program $4.157m

These funds are under Outcome 7 Appropriation which is an annual appropriation, meaning the funding is not officially approved outside of the current financial year. Funding for the suite of Mental Health/Social Emotional Well Being programs is included in the forward estimates until the 2008/2009 financial year. The Mental Health/Social Emotional Well Being programs are not lapsing programs.

- Funding for the suite of Mental Health/Social Emotional Well Being programs is automatically allocated to organisations on an annual basis, subject to previous year compliance. No application process is required.

Under ATSIC and ATSIS administration, the Link Up Services applied for funding through an annual electronic submission (eSub) process. Annual funding allocations were based upon these submissions. In the 2005/2006 financial year the Link Up Services became part of the OATSIH funding process and were not required to apply for ongoing funding.

Question 4 - Hansard p. 40
Senator WEBBER—How do I feel reassured about [the priority accorded to mental health] when, in addition to that, the committee gets evidence about the increasing prevalence of mental health difficulties that our community faces? We have heard evidence that up to one in five people in our community at any one time are suffering from some kind of mental health challenge, shall we say. That can be up to 20 per cent of our community, yet to look at a Commonwealth key responsibility I have to go a long way. Maybe if I did actually know the [organisation chart of the Department of health and Ageing], I would be a lot clearer on where the priority is.
Mr Smyth—Perhaps we could provide you with a lower level breakdown of the area.
Senator WEBBER—That would be good.

Response

Information at Attachments A, B and C provides the Department's structure from a top down perspective:

- Attachment A shows the Heath Service Improvement Division (Ms Margaret Lyons) as one of the Cross Portfolio Divisions.
- Attachment B shows the Health Priorities and Suicide Prevention Branch (Mr Nathan Smyth) is a Branch within the Heath Service Improvement Division; and
- Attachment C shows the four sections within the Health Priorities and Suicide Prevention Branch which deal predominantly with mental health issues: Quality and Effectiveness Section, Mental Health Strategies Section, Mental Health Promotion and Prevention Section; and Suicide Prevention Section.

Question 5 - Hansard p. 42.
Senator WEBBER—If we could perhaps have as close as possible the 2003-04 version of this [data on financing of mental health], I will try and work it out. You are obviously spending money that you have not accounted for in your submission, if it adds up to more than what I have. But $1.2 billion is not a big increase from $1.1 billion from 2001-02.
Mr Davies—Certainly tables 3 and 4 do not tell the whole story of what is in figure 1.
Senator WEBBER—No. Then there is this stuff here.
Mr Davies—There are some balancing numbers that need to come into play.
Senator WEBBER—That is right.
Mr Davies—The Productivity Commission tend to be quite rigorous with their embargoes but, subject to that, we will see what we can get for you, Senator.

Response

The latest publicly available data on Australian Government mental health expenditure are for 2001–02 and are contained in the *National Mental Health Report 2004.* This shows that the Australian Government spent $1.145 billion on mental health in 2001-02.

The National Mental Health Reports present state and territory level data gathered through an organisational level annual National Survey of Mental Health Services, and a breakdown of how specialised mental health are provided. It also reports on progress under the National Mental Health Strategy.

The *National Mental Health Report 2005* is being finalised and contains data for 2002-03.

Data provided by states and territories from the 2003–04 National Survey of Mental Health Services are being validated and the forms for the 2004–05 survey distributed in October 2005.

Australian Government spending on mental health covers grants to states and territories, Medicare-funded psychiatrists and general practitioners, pharmaceuticals, Department of Veterans' Affairs and private hospital subsidies.

Preliminary estimates of Australian Government expenditure on mental health in 2003-04 is $1.273 billion. The breakdown of this expenditure, in the table below, is to be included in the *Report on Government Services 2006*, which is due to be released in January 2006. The figures will vary slightly to those that appear in the *National Mental Health Report 2006*, as further validation of the data is necessary to ensure consistency both across services and survey years.

Table: Australian Government expenditure on mental health
Data as provided to Productivity Commission for *Report on Government Services 2006*

	1999–00	2000–01	2001–02	2002–03	2003–04
Expenditure current prices ($000s)					
National Mental Health Strategy	62,952	74,212	94,172	94,829	92,635
Research	6,253	9,455	14,543	18,511	19,439
MBS - Consultant Psychiatrist services	193,385	196,674	196,928	197,663	201,604
Pharmaceutical Benefits Schedule - psychiatric drugs	374,474	440,481	497,756	543,994	594,428
General practitioners (est)	149,572	156,226	167,272	168,740	173,556
Private Hospital Insurance Premium Rebates (est)	30,967	44,381	44,618	46,754	51,818
Department of Veterans' Affairs	85,991	118,270	126,793	129,420	131,474
Other	8,051	8,617	9,207	8,208	8,742
Total	911,643	1,048,316	1,151,289	1,208,119	1,273,696
Expenditure constant prices 2004 ($000s)					
National Mental Health Strategy	71,781	81,017	100,504	98,065	92,635
Research	7,130	10,322	15,521	19,143	19,439
MBS - Consultant Psychiatrist services	220,507	214,710	210,169	204,409	201,604
Pharmaceutical Benefits Schedule - psychiatric drugs	426,994	480,875	531,223	562,558	594,428
General practitioners (est)	170,550	170,552	178,519	174,498	173,556
Private Hospital Insurance Premium Rebates (est)	35,310	48,451	47,618	48,349	51,818
Department of Veterans' Affairs	98,052	129,116	135,318	133,837	131,474
Other	9,180	9,408	9,826	8,488	8,742
Total	1,039,502	1,144,450	1,228,697	1,249,347	1,273,696
Per head expenditure constant 2004 prices ($)					
Total	55.25	60.11	63.75	63.97	64.37

Question 6 - Hansard pp. 60-61.
Senator HUMPHRIES—It would be useful, I think, if it is possible to put all that down without too much time taken in doing so, to know what the response of GPs is to mental illness. We have heard this is the front line for the majority of people. Perhaps it should not be but it is, and having information about just what they are doing to respond to mental illness would be useful. .....
Senator HUMPHRIES—It would be useful to know, I would think, whether Australian doctors are preferring non-pharmacological treatments over pharmacological ones, and we apparently do not even have that information, do we? We know how much is being prescribed overall but we could not say with accuracy what the responses to particular mental illnesses are by doctors in terms of what is happening in their surgeries. .....
Senator HUMPHRIES—It would be better to have this information in any case, irrespective of whether there is no control sample to put against it.
Mr Davies—Yes.
Senator HUMPHRIES—The absence of that information is a matter of concern to me. I think the overwhelming majority of those mental illnesses being treated and dealt with each year in Australia is happening in GPs surgeries, but we do not know exactly what they are doing.
Mr Davies—There are a number of surveys and data collections that do look at GP activity at a level of detail that Medicare Australia does not have. The question is could we, short of commissioning a special study, extract that information from any of those databases? GPRN, I am told, is one of the other—
Senator HUMPHRIES—Anything you could extract would be useful.
Mr Davies—We will certainly have a look.
Senator HUMPHRIES—I am interested in seeing that. It would be interesting to have medium- to long-term surveys of doctors if there were funds available for that kind of work by the department or somebody else.

Response

There are a number of mechanisms in place to assist general practitioners (GPs) to manage patients with a mental health disorder. These include:

- GP Attendance Items - GPs are able to use the general attendance (consultation) items in providing services to people with a mental health disorder. Under the Medicare Benefits Schedule (MBS), there are four categories of attendances items (levels A to D). These categories relate to task complexity and the length of the consultation. Longer consultations (level C and D attendance items) are more likely to be used in managing patients with a mental health disorder. However, it is not possible to monitor what proportion of attendances are related to mental health disorders from the MBS data, as these items are not specific to particular conditions.

- The 3 Step Mental Health Process - GPs who complete the required training and register with the Practice Incentives Program (PIP) are provided an incentive for completing the *3 Step Mental Health Process*. The 3 steps of this process include:
    - assessment or diagnosis of the mental health disorder;
    - provision of a written mental health plan and appropriate education to the patient and/or the carer; and
    - a review of the patient's progress against the goals in the mental health plan.

  As part of the mental health plan, GPs are able to refer patients to allied health professionals.

GPs who complete the *3 Step Mental Health Process* receive an incentive payment called a Service Incentive Payment (SIP). Information regarding the number of SIPs paid can be found on Medicare Australia's website. Since November 2002 the total number of SIPs provided, and hence completion of 3 Step Mental Health processes, has been 41,177. The quarterly pattern of these payments is:

Nov 2002	Feb 2003	May 2003	Aug 2003	Nov 2003	Feb 2004	May 2004	Aug 2004	Nov 2004	Feb 2005	May 2005	Aug 2005	Total SIPs calculated to date
702	2,052	2,941	3,403	3,493	3,247	3,765	4,279	4,534	4,040	3,895	4,826	41,177

Overall, it can be noted that there has been an increase in the number of SIPs made over time, with the largest calculation in August 2005.

In 2004-05 the total amount paid in Service Incentives Payments (SIPs) for the 3 step mental health process was $2.512 million. A SIP is payment amount is $150.

Consultation fees range from $59.70 to more than $87.90 for GPs, and from $38 to more than $61 for non vocationally registered GPs, as outlined in the Medical Benefits Schedule Book, November 2005.

In 2004-05, total GP Attendance items (ie consultation fees for last step of the 3 step mental health process) was $0.96 million. Total non vocationally registered GPs attendance items (ie consultation fees for last step of 3 step mental health process) was $0.043 million.

- Focussed Psychological Strategies - GPs who complete further mental health skills training, that is, in addition to the *3 Step Mental Health Process* training, and are registered at a higher level are able to deliver up to six sessions of psychological therapy to their patients, with the option of a further six sessions in a 12 month period, if deemed appropriate by the GP. GPs are able to access MBS rebates for these sessions.

  In 2003-04 the total amount paid for Focussed Psychological Strategies (FPS) was $1,328,395. FPS payment also depends on the length of consultation and ranges from $75.25 to over $107.70, as outlined in the Medical Benefits Schedule Book, November 2005.

- Chronic Disease Management items - The Enhanced Primary Care (EPC) Medicare items introduced in November 1999 provided rebates for GPs to coordinate multidisciplinary care plans and to organise and/or participate in multidisciplinary case conferences, for patients with chronic or terminal medical conditions and complex needs. This included patients with chronic mental health conditions and complex care needs, although EPC services are not identified by the specific condition treated.

  From November 1999 to June 2005 a total of 751,102 EPC care plans (for patients in the community or being discharged from hospital) were claimed on Medicare, with a total of $130,348,694 paid in Medicare benefits.

- The EPC care planning items were withdrawn on 1 November 2005 and have been replaced with new Medicare items for Chronic Disease Management (CDM) that commenced on 1 July 2005. These new items were developed in response to, and in consultation with, the profession. They allow rebates to be claimed for the preparation of GP Management Plans for patients with chronic or terminal conditions(including mental health disorders), and for the coordination of Team Care Arrangements for patients who also have complex needs requiring team-based care.

  In the first three months of the new items 132,571 GP Management Plans and 30,490 Team Care Arrangements were claimed on Medicare, with a total of $18,793,812 paid in Medicare benefits. These are likely to include CDM services provided to patients with chronic mental health conditions, although CDM services are not identified by the specific condition treated.

With respect to the use of non-pharmacological treatments and pharmacological treatments:

- Pharmacological treatments are required to control many mental health conditions, but are often not sufficient and a combination of treatments is required. A number of mental health problems can also be treated with non-pharmacological interventions.

- There is currently no available information held by the Department which would inform questions about prescribing preferences of GPs. The Australian Government only collects information on subsidised prescriptions through the Pharmaceutical Benefits Scheme (PBS). The Drug Utilisation Sub-Committee of the Pharmaceutical Benefits Advisory Committee provides advice on the utilisation of prescription drugs in Australia, however, it does not examine the use of pharmacological treatments compared to non-pharmacological treatments.

- Medicare data does not include information about patient consultations or diagnosis.

- Several organisations collect patient consultation information. This includes:
  - the University of Sydney, through the BEACH data collection; and
  - the General Practice Research Network

  The extent to which these organisations collect detailed information on mental health encounters and treatments is unknown.

- The General Practice Research Network does collect information on approx 1.5 million consultations per year. This is a private organisation that can collect information at a cost, should specific questions be asked.

- Designing a study to establish a comparison between the behaviour of GPs who have specifically been trained in mental health versus those who have not undertaken any additional training would be complex and costly and has not been attempted to date.

Question 7 - Hansard pp. 62.
Senator HUMPHRIES—.....I do not know if you have seen the evidence that the committee received about that particular issue and the apparent extensive overprescribing or prescribing much above the national average—put it that way—in that state for ADHD type conditions. If anyone has seen that evidence, do you have a response to it? Do you have a view about what it suggests is going on in Western Australia?
Prof. Horvath—Senator, thank you. This has been an issue that has come to the department on a number of occasions. We sought advice from Professor Jill Sewell from the Centre for Community Child Health in Melbourne University. .....
Senator HUMPHRIES—Is that advice on a record that we could see?
Prof. Horvath—I will just have to seek some bureaucratic help here, Senator. It is a letter from Professor Sewell to me, which then was a part of policy advice to our minister. I think we need to check with Professor Sewell.
Senator HUMPHRIES—Sure.
Prof. Horvath—I suspect she will be quite happy about it.
Senator HUMPHRIES—Whatever you could provide would be good.

Response

Rebekah Lawrence, Executive Assistant to Associate Professor Sewell at The Royal Australasian College of Physicians, has advised that Associate Professor Sewell is currently overseas and unable to be contacted. Professor Frank Oberklaid, who works with Associate Professor Sewell at the Centre for Community Child Health, has given permission for the letter to be copied to the Inquiry. A copy of the signed letter has been faxed to the Secretariat.

Professor Oberklaid has also noted that the letter written in February 2005 by Associate Professor Sewell to Professor Horvath is out of date in that RITALIN (methylphenidate hydrochloride) is now listed on the Pharmaceutical Benefits Scheme. This occurred on 1 August 2005.

Question 8 - Hansard p. 71
CHAIR—Is it worth the committee having access to those figures, the breakdown of each of the programs within chronic disease management?
Mr Learmonth—Of the allied health services used? Yes. I think it probably would not have changed since the last table we provided. Yes, we can provide that data, certainly.

Response

This information is provided in the table below.

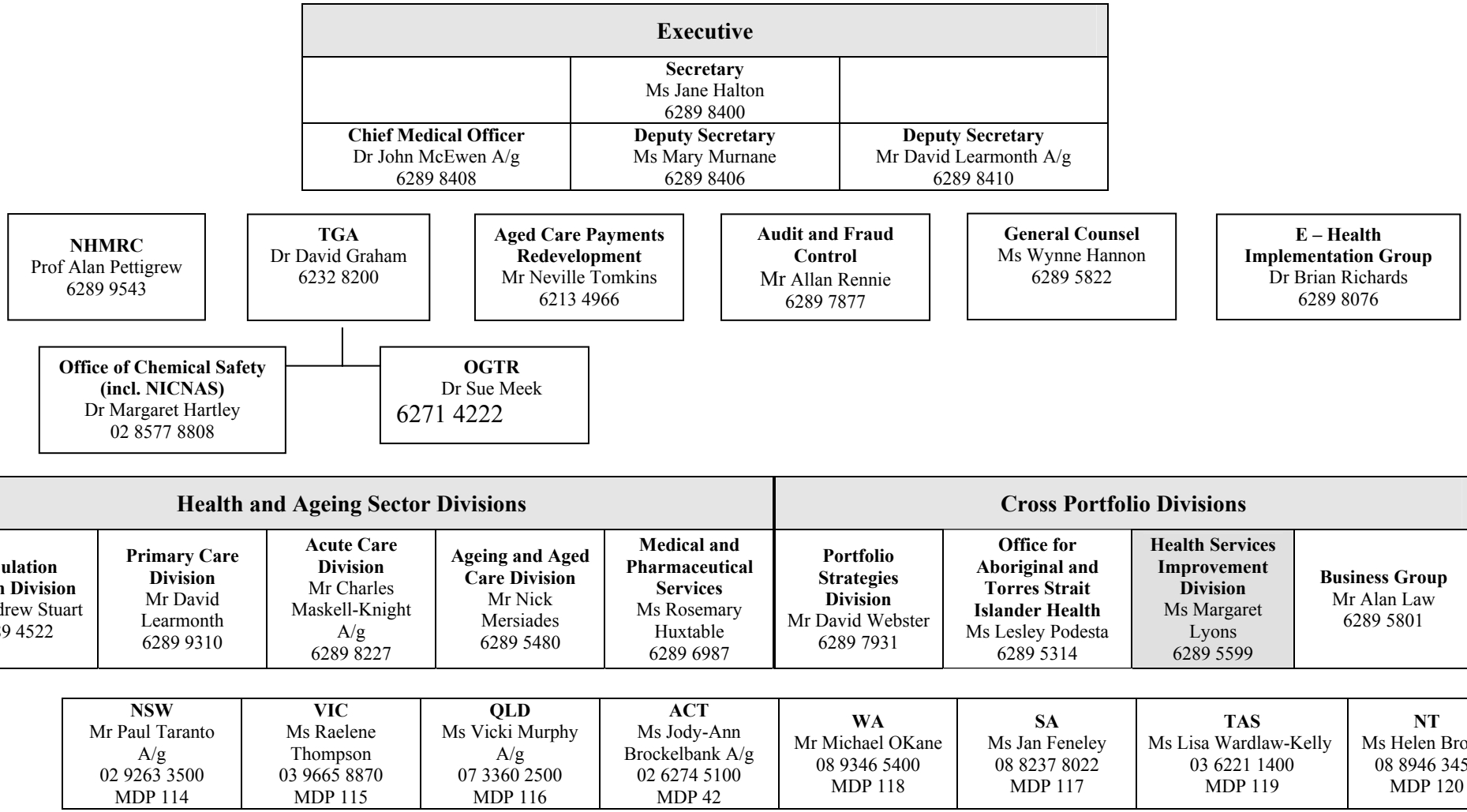
Table: Medicare Allied Health and Dental Care Initiative 2004-05: Number of services and patients, benefits paid and out-of-pocket costs - date of service data

Item Descriptor	No. of services	No. of patients	Average Services per patient	Medicare benefits paid ($)	Average benefits per patient ($)	Average out-of-pocket cost per service ($)
Aboriginal Health Worker 10950	40	27	1.5	1,782	66	Nil
Diabetes Educator 10951	1,061	776	1.4	47,654	61	7.48
Audiology 10952	182	153	1.2	8,605	56	21.06
Dietitian 10954	47,426	25,271	1.9	2,125,950	84	11.44
Mental Health Worker 10956	810	298	2.7	39,119	131	30.69
Occupational therapy 10958	1,672	654	2.6	78,075	119	19.64
Physiotherapy 10960	116,228	34,526	3.4	5,196,816	151	4.44
Chiropody/ Podiatry 10962	55,285	28,273	2.0	2,462,841	87	3.74
Chiropractic 10964	11,210	3,066	3.7	483,082	158	2.68
Osteopathy 10966	4,904	1,484	3.3	220,787	149	9.22
Psychology 10968	24,857	8,645	2.9	1,204,718	139	37.81
Speech Pathology 10970	3,276	907	3.6	154,903	171	16.76
Dental Assess 10975	1,481	1,476	1.0	111,388	75	31.51
Dental treatment 10976	1,849	1,233	1.5	212,063	172	67.97
Assess or treat by Dental spec 10977	18	17	1.1	5,978	352	178.44
TOTAL	270,299	91,399*	3.0	12,353,761	135	

* Patients accessing more than one service type are only counted once.

Attachment A

HEALTH AND AGEING ORGANISATIONAL CHART
November 2005



Attachment B

Cross Portfolio Divisions

Portfolio Strategies David Webster	**Office for Aboriginal & Torres Strait Islander Health** Lesley Podesta	**Health Services Improvement** Margaret Lyons	**Business Group** Alan Law
Budget	**Program Planning & Development**	**Safety & Quality** Mary McLarty A/g	**Finance**
Parliamentary & Portfolio Agencies	**Health Strategies**	**Health Workforce** Brett Lennon	**Corporate Support** 8
Policy & International	**Policy & Analysis**	**Rural Health & Palliative Care** Sharon Appleyard A/g	**Strategic Management Branch**
Minister-Counsellor (Health)	**Medical Officer**	**Health Priorities & Suicide Prevention** Nathan Smyth	**People Branch**
Economic & Statistical Analysis		**HSID Taskforce** Jan Bennett	**Technology Group**
TGA Transition Branch		**E-Health Policy Branch** Lynda Powell	**Communications**
			Legal Services

Attachment C

HEALTH PRIORITIES AND SUICIDE PREVENTION BRANCH
BRANCH STRUCTURE

Health Services Improvement Division

Health Priorities and Suicide Prevention Branch
Has responsibility for leading and coordinating a strategic approach to mental health reform, research and chronic diseases/national health priorities

Quality and Effectiveness Section
Development of both national and local information systems and reporting processes to promote access, effectiveness and safety and quality of mental health services

Mental Health Strategies Section
Improve primary mental health care by strengthening the role of general practitioners and by providing access to psychiatric and allied mental health services

Mental Health Promotion and Prevention Section
Consolidate promotion, prevention and early intervention initiatives for improved community understanding around mental health and mental illness , including youth mental health initiatives

Suicide Prevention Section
Consolidate promotion, prevention and early intervention initiatives for improved community understanding around suicide prevention

Asthma and Arthritis Section

Diabetes and Cardiovascular Health Section

Cancer Section

National Chronic Disease Strategies Section

Health*Insite* Section

Quality Improvement and Research

QON 7

CENTRE FOR
Community
Child Health

14 February 2005

Professor John Horvath AO
Chief Medical Officer,
Australian Department of Health and Ageing.
MDP 84
GPO Box 9848
Canberra ACT 2601

Dear John,

Regarding your request for information about the treatment of Attention Deficit Hyperactivity Disorder (ADHD) with stimulant medication, I offer the following comments.

ADHD is a disorder manifested by developmentally inappropriate and maladaptive behaviours which have a significant effect on the life of the child. Diagnosis does not assume the cause, although there is very significant evidence for a genetic contribution as well as environmental factors. The formal diagnosis calls for onset of symptoms before the age of seven years. Some children will display significant problems from infancy, whilst others develop problems during early childhood or early school years.

Over 50% of children with ADHD also have other diagnosable disorders such as learning disabilities, language disorders, and other mental health problems such as anxiety disorders, mood disorders and conduct disorder.

Many studies have demonstrated the overall prevalence of ADHD in childhood to be 3 to 5%.

Treatment of ADHD by stimulant medication has been unequivocally demonstrated to be of significant therapeutic benefit. Educational support is very important, particularly with associated language and learning problems. Other psychosocial treatments are of lesser benefit in treating core ADHD symptoms, although may be of great value in treating associated disorders and improving family functioning.

There is no regularly collected national data on the prevalence of treatment of ADHD with stimulant medication in Australia. This is partly because of different systems of regulation of these drugs in each State and partly because of different prescribing mechanisms for the two most commonly used medications. Dexamphetamine is available on PBS authority. Methylphenidate is only available on private prescription, therefore its use amongst different age groups is not routinely known.

The best available prevalence data is from New South Wales, 2000, demonstrating that 1.1% of children aged 2 to 17 years were being prescribed the stimulant medications Dexamphetamine and Methylphenidate. This compares with the accepted prevalence of ADHD of 3 to 5%. Rather than over prescribing, the conclusion could be made that some children with ADHD in Australia are not receiving appropriate treatment.

Variation between regions in prescribing rates per childhood population have been noted in all states. A number of explanations have been proposed for this, including variation in diagnostic methods, the availability of services, socio-economic factors and variations in clinical practice.

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From time to time concerns are raised about the safety of stimulant medication. Serious medical side effects are extremely rare. Less serious side effects occur, but can usually be effectively managed. One of the concerns relates to the possibility of a future increase in risk of drug abuse. Recent studies from the USA, including a meta-analysis, demonstrate that effective treatment of ADHD in these vulnerable children actually significantly reduces the risk of Substance Abuse Disorder during adolescence.

A study conducted in my own Centre for Community Child Health in 2000, describing the prescribing patterns of psychotropic medication by paediatricians and child psychiatrists in Australia, showed that stimulant medication is frequently prescribed by 50 - 60% of these professionals. Paediatricians are more frequent prescribers than child psychiatrists, demonstrating the very common referral of children with ADHD to paediatricians. Clearly, effective training and continuing professional development is an important responsibility of the profession. You may be pleased to know that the Australian Department of Health and Ageing funded the development in 2003 of a CD-ROM, entitled 'Pharmacotherapy for children with ADHD' as a component of funding to my own Centre for a pilot in specialist training in the community. This CD ROM is made available to paediatric trainees by the RACP, and can also be used for CPD.

One of the major concerns of paediatricians and child psychiatrists is access to the best available medication for children with ADHD. Dexamphetamine is prescribed more frequently than Methylphenidate, because it is on the PBS. Methylphenidate has a somewhat better side effect profile and would be preferred by many prescribers.

In addition, a long acting form of Methylphenidate, Ritalin LA, has recently been made available in Australia. It is even more expensive than Ritalin and there is therefore limited access to a large number of children. The benefits of Ritalin LA include a more even distribution of drug during the day, and most importantly, once only use of medication in the morning. This eliminates the need for taking medication at lunchtime, which is important for the privacy of the child and also protects against the possible diversion of tablets to other children at school. Once daily preparations are also likely to result in greater adherence to treatment, which has been associated with better outcomes.

I understand that Novartis Pharmaceuticals has previously made unsuccessful applications to the PBAC for Ritalin to be added to the PBS. I believe that adding Methylphenidate, and a long acting preparation such as Ritalin LA to the PBS would be of great benefits to the vulnerable population of children with ADHD. I do not believe that this would increase the rate of prescribing stimulant medication, but rather improve access to a more effective range of medications for a significant number of children.

John, I would be happy to discuss this further, either with yourself or with the Minister Health as required. I could also nominate other skilled and experienced clinicians to contribute to such a discussion.

Yours sincerely,

Jill Sewell

Dr Jill Sewell
Deputy Director

JS ltrs Prof John Horvath CMO ADHD ltr 2006.doc