Record of the Mental Health Advisory Committee Meeting held on 25 October 2024

Mental Health Advisory Committee records are published in accordance with the Terms of Reference for the Specialist Advisory Committees 2021.

Note that this document is not necessarily a complete record of the Mental Health Advisory Committee meeting; only the relevant portions of the meeting record relating to Mental Health Advisory Committee discussions about an application or Pharmac staff proposal that contain a recommendation are generally published.

The Mental Health Advisory Committee may:

(a) recommend that a pharmaceutical be listed by Pharmac on the Pharmaceutical Schedule and the priority it gives to such a listing;

(b) defer a final recommendation, and give reasons for the deferral (such as the supply of further information) and what is required before further review; or

(c) recommend that Pharmac decline to list a pharmaceutical on the Pharmaceutical Schedule.

Pharmac Advisory Committees make recommendations, including priority, within their therapeutic groups of interest.

The record of this Advisory Committee meeting will be reviewed by PTAC at an upcoming meeting.

Specialist Advisory Committees and PTAC may differ in the advice they provide to Pharmac, including recommendations' priority, due to the committees' different, if complementary, roles, expertise, experience, and perspectives.

Pharmac is not bound to follow the recommendations made below. Applications are prioritised by Pharmac against other funding options and progressed accordingly. The relative priority of any one funding choice is dependent on a number of factors, including (but not limited to) the recommendation of PTAC and/or Specialist Advisory Committees, the mix of other applications being assessed, the amount of funding available, the success of commercial negotiations and/or the availability of clinical data.

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1. Attendance

Present
Matthew Dawes (Chair)
Bronwyn Copeland
Cathy Stephenson
David Chinn
David Menkes
Giles Newton-Howes
Jeremy McMinn
Karyn Whatson
Kyra Sycamore
Paul Vroegop
Verity Humberstone

Apologies
Sean Hanna

2. The role of Specialist Advisory Committees and records of meetings

2.1. This meeting record of the Mental Health Advisory Committee is published in accordance with the Terms of Reference for the Pharmacology and Therapeutics Advisory Committee (PTAC) 2021 and Specialist Advisory Committees 2021.Terms of Reference describe, *inter alia*, the establishment, activities, considerations, advice, and the publication of such advice of Specialist Advisory Committees (SAC) and PTAC.

2.2. Conflicts of Interest are described and managed in accordance with section 6.4 of the SAC Terms of Reference.

2.3. The Mental Health Advisory Committee is a Specialist Advisory Committee of Pharmac. The Mental Health Advisory Committee, PTAC and other Specialist Advisory Committees have complementary roles, expertise, experience, and perspectives. The Mental Health Advisory Committee and other Specialist Advisory Committees may therefore, at times, make recommendations for treatments for mental health that differ from PTAC's, including the priority assigned to recommendations, when considering the same evidence. Likewise, PTAC may, at times, make recommendations for treatments for mental health that differ from the Mental Health Advisory Committee's, or Specialist Advisory

Committees may make recommendations that differ from other Specialist Advisory Committees'.

2.4. Pharmac considers the recommendations provided by both the Mental Health Advisory Committee and PTAC and any other relevant Specialist Advisory Committees when assessing applications for treatments for mental health.

3. Welcome and introduction

3.1. The meeting commenced with an opening karakia.

4. Stimulant medicine access for ADHD – Proposed regulation change and considerations for Pharmac

Discussion

Background

4.1. The Committee noted that the prescribing, supply and administering of stimulant treatments are regulated in accordance with Regulation 22 of the Misuse of Drugs Regulations 1977. The Committee noted the current regulations determine specific prescriber types who can initiate and prescribe stimulant treatment for ADHD, which include vocationally registered psychiatrists or paediatricians. The Committee noted that medical practitioners or nurse practitioners can only prescribe stimulant treatment for attention deficit hyperactivity disorder (ADHD) on the written recommendation of a psychiatrist or paediatrician.

4.2. The Committee noted that Pharmac funding restrictions to initiate treatment for stimulant treatments were aligned with the current regulations, requiring applications from a psychiatrist or paediatrician, or a medical or nurse practitioner who confirms that a psychiatrist or paediatrician has been consulted within the last two years and has recommended treatment for the patient in writing.

4.3. The Committee noted there are issues with access to specialist psychiatrists and paediatricians to support ADHD assessment and diagnosis. The Committee noted there are long wait times in the public health system, with significant variation by region, and adults were much less likely to be seen in the public system compared to children and adolescents. The Committee noted that for many, the alternative is to pursue ADHD related care privately which is costly and can also have long wait times. The Committee considered access to private health care for specialist treatment is likely inequitable, with access challenges disproportionately affecting people with less resources, Māori, Pacific people and/or people experiencing socioeconomic deprivation.

4.4. The Committee noted that Medsafe has worked with Pharmac and stakeholders representing medical practitioners in general practice, psychiatry, paediatrics, and nurse practitioners (NPs) to identify proposed amendments to the regulations for stimulant treatments. The Committee noted the proposed regulatory changes would expand the number of eligible prescribers who can prescribe stimulant treatment with the aim of improving equitable access to treatment.

4.5. The Committee noted draft proposed changes to the regulations by Medsafe which included additional prescriber types authorised to prescribe or recommend stimulant treatment for ADHD:

- Children and Adolescents: the addition of nurse practitioners working in paediatric services or children and adolescent mental health services.
- Adults: the addition of medical practitioners with a vocational scope in general practice and nurse practitioners working within their scope of practice.
- All age groups: medical practitioners without a specialist vocation or nurse practitioners not working in a relevant scope of practice would be able to prescribe stimulant treatment on the recommendation of a practitioner eligible to initiate stimulant treatment.

Attention deficit and hyperactivity disorder (ADHD) APPLIES TO PRODUCTS CONTAINING METHYLPHENIDATE, DEXAMFETAMINE & LISDEXAMFETAMINE		
PATIENT AGE	**INITIATION OF PRESCRIBING**	**ONGOING PRESCRIBING**
17 years and under	Medical practitioners with a vocational scope of practice of paediatrics or psychiatry may initiate prescribing. **Nurse practitioners working within Health New Zealand (paediatric services or child and adolescent mental health services), within their scope of practice, may initiate prescribing.**	Any medical practitioner or nurse practitioner may prescribe when acting on the written recommendation of one of the practitioners who have initiated prescribing.
18 years and above	Medical practitioners with a vocational scope of practice of paediatrics, psychiatry or **general practice** may initiate prescribing. **Nurse practitioners working within their scope of practice may initiate prescribing.**	

4.6. Members noted the regulation changes and the inclusion of nurse practitioners working within their scope of practice would be able to initiate prescribing for people with ADHD aged 18 years and over. Members considered that nurse practitioners working within a mental health scope of practice would more likely acquire or have the relevant training and experience to support ADHD assessment and diagnosis compared to nurse practitioners working outside of a mental health scope of practice. Members noted that nurse practitioners are proficient in working appropriately within their scope of practice.

4.7. The Committee noted Pharmac sought advice from the Committee on appropriate amendments to the Special Authority criteria for stimulant medications, to align with the proposed regulation changes to support treatment access while targeting treatment to people most likely to benefit from stimulant treatment.

4.8. The Committee noted Pharmac also sought advice from the Committee on the potential changes to usage of stimulant treatment associated with regulation and funding restriction changes, to inform budgetary impact considerations and to inform supply planning for any anticipated increases.

Considerations regarding the widening of prescriber type and risks of inappropriate or under treatment of ADHD

4.9. The Committee considered that with access to ADHD diagnosis and treatment there are both risks of under treatment and inappropriate treatment for ADHD. The Committee noted that for some people with ADHD the benefits from stimulant treatment can result in considerable improvements in daily functioning and quality of life. The Committee noted that timely treatment for ADHD was important, and insufficiently treated ADHD can have a negative impact on long term outcomes such as academic achievement, and employment opportunities. The Committee considered that people under-treated for ADHD were likely to be disproportionately Māori, Pacific peoples, female-gender identifying children and adolescents, and that there was a need for more equitable access to ADHD-related care for these groups.

4.10. The Committee considered there is a risk of potential harms from inappropriate treatment and risk of these being overlooked or not mitigated as part of the work to improve access to stimulant treatments for ADHD. The Committee noted the risks of inappropriate stimulant prescribing can include: people receiving stimulant treatment with limited benefit(s) and associated side effect risk, increased risk of misuse and diversion from

inappropriate prescribing, and serious adverse effects such as stimulant induced psychosis.

4.11. Members noted that in a mental health and addiction inpatient setting it is common for people to be assessed with psychosis likely related to stimulant prescribing for ADHD. Members considered that adult ADHD assessment and diagnosis is rarely combined with alcohol and drug screening assessment and review, despite being emphasised in guidelines and by addiction specialists. Members considered that atomoxetine as first line in case of substance use risks is also not commonly prioritised.

4.12. Members considered that there is greater risk of psychosis and addiction related harms from stimulant treatment in adults, rather than in children and adolescents. Members noted the current frameworks in place in child and adolescent ADHD treatment settings lend themselves to more multidisciplinary and comprehensive assessment of ADHD and lower risks of inappropriate treatment in younger age groups as compared to common practice in adult settings.

4.13. Members noted at a minimum, assessment of ADHD is recommended to occur over multiple hours of comprehensive assessment and patient/caregiver interview(s). Members considered, that currently in the adult treatment setting, best practice may not always be followed and that private psychiatry assessments can be completed in a fraction of the time needed to inform a comprehensively formulated ADHD diagnosis. The Committee noted that in both public and private treatment settings clinical practice would benefit from clearer guidelines for comprehensive ADHD assessment and diagnosis.

4.14. The Committee noted the following international clinical guidelines encompassing the management of ADHD most relevant to the New Zealand context:

- ADHD Guideline Development Group. Australian evidence-based clinical practice guideline for Attention Deficit Hyperactivity. Melbourne: Australasian ADHD Professionals Association; 2022.
- CADDRA - Canadian ADHD Resource Alliance: Canadian ADHD Practice Guidelines, 4.1 Edition, Toronto ON; CADDRA, 2020.
- National Institute for Health and Care Excellence. Attention deficit hyperactivity disorder: diagnosis and management [NG87]. Author. 14 March 2018.

4.15. The Committee noted the guidelines outline specific assessments and criteria that must be met in order to diagnose ADHD. The Committee considered a biopsychosocial assessment may take place over several hours and integrate observer reports (including from a caregiver, partner, co-workers), evidence of impairment across multiple settings, and investigate existing or potential co-morbidities that may exacerbate ADHD symptoms and differentiate ADHD from other mental health conditions.

4.16. The Committee noted that following the proposed regulation changes, the number of eligible prescribers legally able to prescribe stimulant treatments would increase significantly. The Committee considered the key support and education practitioners would require to be able to diagnose ADHD and recommend appropriate treatment included:

- training in diagnostic assessment using DSM or ICD
- education and training with conducting clinical interviews, administering, and interpreting rating scales and assessment of functional impairment
- training on differential diagnoses for ADHD.
- regular ADHD-specific supervision with an experienced clinician to support training and education among prescribers and practitioners
- training in harm reduction, including identifying and recommending appropriate treatment where there are physical and/or psychiatric comorbidities
- medicines training on the various release profiles and utility of different treatment options, to optimise pharmacodynamic effects for patients when prescribing

- time and resources to support assessment in a primary care setting.

4.17. The Committee considered there were likely to be significant challenges with implementing a consistent practice approach while balancing and mitigating the risk of inappropriate or under-prescribing of stimulants. Members considered within any eligible prescriber group, due to the subjective nature of the ADHD diagnosis, there is the potential for substantial variation in the diagnosis of ADHD and prescribing of stimulants amongst prescribers, regardless of clinical experience and training.

4.18. The Committee considered that appropriate training (supported by educational resources), resourcing, and practice support for treating clinicians and increasing the availability of multi-disciplinary care and individualised multimodal treatment approaches would support objective ADHD assessment, diagnosis and appropriate treatment across all settings. The Committee noted however, both primary care and secondary care resources are constrained in parts of Aotearoa New Zealand, such as the Northern region, and considered regional resource constraints would be important to consider during any implementation of a national approach to ADHD management.

4.19. The Committee considered clinical psychologists have a significant role in the sector with supporting ADHD assessment and diagnosis. The Committee noted that clinical psychologists currently support many specialist psychiatrists and paediatricians in child, adolescent, and adult settings with diagnostic reports, and are well placed to support interpreting clinical interviews, rating scales and differential diagnosis for mental health conditions. The Committee considered, with proposed regulatory changes, that clinical psychologists will likely have an expanded role in supporting primary care with timely assessment, diagnosis, and supervising others with undertaking assessments.

4.20. The Committee noted there are digital technologies recommended by the National Institute of Health and Care Excellence (NICE) to support objective ADHD assessment and diagnosis and further research to help diagnose ADHD (NICE. Diagnostics guidance, October 2024). The Committee considered digital technologies may have a role to support objective and more efficient ADHD diagnosis and treatment targeting in Aotearoa New Zealand. The Committee considered it would be useful for Health NZ and professional organisations who support medical practitioners, nurse practitioners and specialists to explore digital technologies in further detail, specifically their utility and value in Aotearoa New Zealand.

4.21. The Committee considered that the resourcing and implementation of appropriate training, certification and support for prescribers is out of the scope of Pharmac's role as New Zealand's medicine purchasing agency. The Committee considered Pharmac has a role in engaging relevant professional organisations who support medical practitioners, nurse practitioners and specialists about wider training and implementation considerations and how they may relate to funded access to treatment. However, the Committee considered training implementation would be the responsibility of relevant regulatory and professional organisations and should be led by a multi-disciplinary clinical reference group representing relevant prescribers and mental health pharmacists.

Considerations regarding amendments to the eligibility criteria for use of stimulants

4.22. The Committee considered the following Special Authority criteria would be appropriate to target treatment to people most likely to receive the greatest benefit from stimulant treatment(s) in both first and second line settings.

Ritalin, Rubifen, Rubifen SR, methylphenidate ER Teva

Special Authority criteria – for first line stimulant options
Initial application — (ADHD) from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:
Both:
1. Either:
   1.1. Individual has ADHD diagnosed according to DSM-IV criteria; or
   1.2. All of the following:
      1.2.1. Individual has ADHD diagnosed according to DSM-5 criteria; and

1.2.2. Individual was diagnosed as having experienced at least six inattentive and or at least six hyperactive-impulsive symptoms persistently for at least 6 months; and
1.2.3. Symptoms cause persistent clinically significant functional impairment in two or more important settings (social, familial, educational and/or occupational); and

2. Either:
   2.1. All of the following:
      2.1.1. There is no significant uncertainty about the diagnosis of ADHD; and
      2.1.2. The individual has no current or history of significant psychiatric comorbidity; and
      2.1.3. The individual has no risk factors for a severe substance use disorder due to personal history or family history; or
   2.2. A second clinical opinion has been considered.

Concerta, Ritalin LA and lisdexamfetamine

Special Authority criteria – for ***Concerta and Ritalin LA***
Initial application — (ADHD) from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:
All of the following:

1. Either:
   1.1. Patient has had an initial Special Authority approval for first line stimulants (dexamfetamine, immediate, sustained release or extended release methylphenidate) for ADHD; or
   1.2. Patient meets the initiation criteria for first line stimulants (dexamfetamine, methylphenidate immediate or sustained release or methylphenidate Teva ER); and
2. Either:
   2.1. Patient is taking a currently subsidised formulation methylphenidate hydrochloride (immediate-release or sustained-release) for ADHD and treatment has not been effective due to significant administration and/or treatment adherence difficulties; or
   2.2. There is significant concern regarding the risk of diversion or abuse of immediate release methylphenidate hydrochloride.

Special Authority criteria – ***for lisdexamfetamine***
Initial application — (ADHD) from any relevant practitioner. Approvals valid without further renewal unless notified for applications meeting the following criteria:
All of the following:

1. Either:
   1.1. Patient has had an initial Special Authority approval for first line stimulants (dexamfetamine, immediate, sustained release or extended release methylphenidate) for ADHD; or
   1.2. Patient has ADHD and meets the initiation criteria for first line stimulants (dexamfetamine, methylphenidate immediate or sustained release or methylphenidate Teva ER); and
2. Any of the following:
   2.1. Patient is taking a currently subsidised formulation of atomoxetine or methylphenidate hydrochloride (extended-release) and has not received sufficient benefit or has experienced intolerable side effects; or
   2.2. Patient is taking a currently subsidised formulation of dexamfetamine sulfate or methylphenidate hydrochloride (immediate-release or sustained-release) and treatment has not been effective due to significant administration and/or treatment adherence difficulties; or
   2.3. There is significant concern regarding the risk of diversion or abuse of dexamfetamine sulfate or immediate release methylphenidate hydrochloride; or
   2.4. Both:
      2.4.1. Patient would have been prescribed a subsidised formulation of methylphenidate (extended release) but has been unable to access due to supply issues with methylphenidate (extended release); and
      2.4.2. Other alternative stimulant presentations (methylphenidate or dexamfetamine) are not appropriate; and
3. Funded lisdexamfetamine dimesilate is not to be used in combination with another funded methylphenidate presentation.

4.23. The Committee noted that Pharmac sought advice on appropriate amendments to Special Authority access criteria for stimulant treatments, that would align with proposed regulatory changes to support equitable access, while targeting treatment to people with ADHD most likely to benefit from stimulant treatment.

4.24. The Committee considered that the DSM-5 is the predominant system used to diagnose ADHD in New Zealand. The Committee noted previous discussions from its meetings in February 2022 and July 2023 regarding ADHD diagnostic criteria, key differences between DSM-IV and V, and the broadening of DSM revisions overtime encompassing people on the milder end of the ADHD spectrum. The Committee noted there is significantly less randomised trial evidence for people diagnosed with ADHD under the

DSM-5 and treated with stimulant treatments. The Committee noted that the available evidence to support the benefit of stimulant treatments in treating ADHD were largely undertaken in study populations diagnosed with DSM-III or DSM-IV criteria. The Committee noted that many trials also included people with moderate to severe ADHD symptoms by rating scale. The Committee noted this was highlighted in various Cochrane reviews and indirect comparison network meta-analyses:

- Cortese et al, Lancet Psychiatry. 2018;5(9):727-738.
- Storebø et al, Cochrane Database Syst Rev; 2023 27;3(3).
- Castells et al, Cochrane Database Syst Rev. 2018 9;8(8).

4.25. The Committee considered that it would be reasonable for Pharmac Special Authority criteria to require a diagnosis of ADHD with the DSM-5, but to include targeting criteria that aligns with aspects of the DSM-IV diagnosis. The Committee considered that having a Special Authority set in this way would align with both the diagnostic criteria used in clinical practice and the clinical evidence that supports the benefit of stimulant treatment in people with ADHD.

4.26. The Committee considered including criteria that required evidence of symptoms presenting before the age of 7 years, in line with DSM-IV diagnostic criteria, may support treatment targeting. Members noted that a DSM-5 diagnosis requires evidence of symptom presentation before 12 years of age. Members considered that there would likely be practical limitations with requiring evidence of symptom presentation before the age of 7 years instead of 12 years, particularly for adults assessed and diagnosed retrospectively. Additionally, the Committee considered that while the trial evidence for stimulant treatments supports a health benefit in people diagnosed using the DSM-IV criteria instead of the DSM-5 criteria, there was limited clinical evidence to suggest a different capacity to benefit based on the precise age of symptom presentation in childhood. The Committee considered criteria specifying having at least six inattentive and or at least six hyperactive symptoms, reflective of DSM-IV diagnostic criteria, would support treatment targeting, while at the same time the Committee considering clinical assessment for meeting many of these domains can be subjective and is commonly based on family and patient reporting of symptoms.

4.27. The Committee considered it would be appropriate to include criteria that target treatment to people who are experiencing clinically significant impairment in two or more important settings (including social, familial, educational and/or occupational settings). The Committee considered that people with the highest health need and capacity to benefit from stimulant treatment would experience clinically significant functional impairment in at least two of these important settings. The Committee considered that the evaluation of clinically significant impairment would be based on clinical opinion and noted that multidisciplinary assessment where possible would improve consistency in defining objectively whether an individual is experiencing clinically significant impairment.

4.28. The Committee considered that people with ADHD and who were also experiencing a lower level of functional impairment were less likely to benefit from stimulant treatment(s). The Committee considered that people with less severe presentations of ADHD may experience short term symptomatic improvement in some areas however, there was a lack of evidence for long term clinically significant outcomes in people without clinically significant functional impairment (in at least two important settings) from ADHD. The Committee noted that people with ADHD with lower levels of functional impairment would benefit from access to other pathways for ADHD management, which may include but are not limited to modifications to biopsychosocial stressors and risk factors, cognitive-behavioural therapy, and non-stimulant medicines such as atomoxetine.

4.29. The Committee considered a severity-based scale, such as the Weiss Functional Impairment Rating Scale (WFIRS), may have some use in measuring impairment severity and treatment targeting. The Committee considered there is a lack of consensus across international guideline recommendations for severity-based (mild, moderate or severe) approaches to stimulant treatment(s) and considered rating scales can often be interpreted differently and would be challenging to implement consistently on a national

scale as part of Special Authority applications. The Committee noted the key role of rating scales were as an adjunct to support diagnostic assessment and they should not be used to solely determine a diagnosis or inform treatment(s).

4.30. Members considered whether it would be appropriate to include criteria that would support the reduction of harms associated with inappropriate stimulant treatment, such as requiring appropriate addiction and drug screening. The Committee noted that the purpose of Pharmac's Special Authority is to target treatment to those individuals (and their whānau) most likely to receive health benefit, and that criteria would need to be consistent with this and not for the purpose of managing safety or prescriber competency.

4.31. The Committee considered that where there is diagnostic uncertainty or for people with ADHD who also have a history of psychosis or addiction (personally or within their family), treatment targeting, and treatment benefit would be supported by a second clinical opinion from a psychiatrist prior to stimulant initiation. The Committee highlighted the implementation of more multidisciplinary models of care would support treatment of ADHD in this cohort, particularly in a community setting. The Committee also considered that people with a personal or family history of addiction may benefit from concurrent treatment of ADHD and substance use disorder which is better managed in a secondary care setting. The Committee also considered it appropriate for people with addiction risk may benefit from trialling a non-stimulant alternative such as atomoxetine prior to initiating stimulant treatment.

4.32. The Committee noted that Pharmac had received multiple funding applications for guanfacine for the treatment of ADHD. The Committee noted that guanfacine is not currently Medsafe approved or undergoing evaluation at the time of this meeting. However, the Committee considered it would be useful to review a funding application for guanfacine as a potential non-stimulant alternative in the management of ADHD, if a submission to Medsafe were to eventuate. The Committee noted the current funding context in Australia for guanfacine, where it is funded for people with ADHD aged 6 to 17 years of age contraindicated/intolerant to stimulant treatments, where stimulant treatment is not appropriate due to psychiatric comorbidity, or as an adjunct to stimulant treatment where maximal tolerated doses are not effective. The Committee considered that funding in this context would be useful to consider further by Pharmac and was supported by the available evidence.

Prevalence of ADHD and stimulant prescribing rates

4.33. The Committee noted the following when considering the prevalence of ADHD and prescribing trends:

- Beaglehole et al. NZ Med J. 2024.137:23-30
- Salari et al. Ital J Pediatr. 2023;49:48
- Moffitt et al. Am J Psychiatry. 2015;172:967–977
- Espinet et al. Brain Sci. 2022;12:1051
- Kessler et al. Am J Psychiatry. 2006;163:716-23
- Coghill et al. Eur Child Adolesc Psychiatry. 2023;32:1337-61
- Danielson et al. J Clin Child Adolesc Psychol. 2024;52:343-60
- Ayano et al. Psychiatry Res. 2023:328:115449
- Chan et al. EClinicalMedicine. 2023;58:101780
- IQVIA 2023:Stimulant Prescription Trends in the United States From 2012-2022
- PBS 2023: Attention Deficit Hyperactivity Disorder: Utilisation Analysis
- Debois et al. Emerg Trends in Drugs Addictions and Health. 2024;4:100159
- Palis & MacDonald. CMAJ.2023;195:E934-5.

4.34. The Committee noted the growing usage of stimulant treatments in Aotearoa New Zealand (NZ) and internationally and that the highest consumption of stimulant treatments was in North America (Canada and the United States) followed by the Oceania region (Australia and NZ). The Committee noted that ADHD assessment and diagnosis in primary care is common in North America and enabled by local regulation and clinical guidelines. The Committee noted that the majority of practitioners assessing and diagnosing ADHD in Canada were general practitioners. The Committee considered that stimulant usage trends in Canada were useful to consider when estimating potential changes to stimulant usage rates in New Zealand. The Committee noted that in New Zealand and internationally increased rates of stimulants was seen in young adults, middle-aged adults, and people identifying as female gender.

4.35. The Committee noted that Pharmac dispensing data for 2023/24 indicates that 68,500 people or 1.3% of the total population (2.5% of children and adolescents, 1% of adults) were dispensed ADHD related medicines (methylphenidate, dexamfetamine or atomoxetine). The Committee noted that funded ADHD medicine usage was estimated to continue to grow to approximately 100,000 people in four to five years' time in the current regulatory and funding environment. The Committee considered that relative to prevalence estimates of ADHD, the evidence would suggest a sizeable group of people with ADHD are not receiving stimulant treatment currently.

4.36. The Committee considered that the evidence suggested an overall prevalence of ADHD to be between 2.5% to 4% among the adult population and 6% to 8% among children and adolescents. The Committee considered that the overall prevalence of ADHD and how it relates to the estimated number of people who would be treated is uncertain, noting that with successive DSM revisions the prevalence of ADHD has increased. The Committee considered the estimated prevalence of ADHD is likely to continue to increase with any subsequent DSM revisions. The Committee considered the prevalence estimates most relevant to Pharmac would align with the DSM criteria reflected in Pharmac funding restrictions.

Information to inform budgetary impact of changes to prescriber restrictions of stimulant medicines

4.37. The Committee considered that if there were no access barriers to ADHD assessment and diagnosis, most people with an ADHD diagnosis would be considered for stimulant treatment.

4.38. The Committee considered, the high rates of stimulant treatment rates in Canada where ADHD is commonly managed in primary care and noted that this may similarly occur in NZ in future following the proposed regulatory and funding changes.

4.39. Members considered that over time, rates of treatment could exceed any given prevalence estimates. Members noted the social and marketing influences at play across different age groups to engage with diagnosis and stimulant treatment and how this may create a risk of overprescribing within this rapidly changing sociocultural environment.

4.40. The Committee considered that personal and or social factors can interplay with the decision to undertake assessment for diagnosis or take pharmacological treatment if diagnosed. Members considered that anecdotally, around up to a third of child and adolescents with ADHD or their guardians choose not to use stimulant medication due to contraindications, intolerable side effects, personal choices, or benefit from non-stimulant or non-pharmacological alternatives. However, the Committee also considered that for people diagnosed with ADHD as adults, the vast majority would likely to be initiated on and continue taking stimulant treatment(s).

4.41. The Committee considered that on balance the long-term treatment rate for stimulant treatments would likely be lower than the estimated prevalence of ADHD. However, the total number of people treated would be greater than the projected number of people (approximately 100,000) forecasted to receive treatment by Pharmac in the current regulatory and funding environment. The Committee considered that with any regulatory and funding change(s), the growth rate of people on treatment would initially be similar to currently forecast by Pharmac, with a modest additional increase (5%-10%) considering some primary care practitioners may already be adequately trained to assess and

diagnose ADHD. However, as more primary care practitioners are trained and resourced to assess and diagnose ADHD, access would improve, resulting in an additional increase in people on treatment(s) after five years of 50%.
