THE HOUSE OF ASSEMBLY GOVERNMENT ADMINISTRATION COMMITTEE B MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART ON FRIDAY, 7 MARCH 2025

INQUIRY INTO THE ASSESSMENT AND TREATMENT OF ADHD AND SUPPORT SERVICES

The Committee met at 9.30 a.m.

CHAIR (Mr Behrakis) - Welcome to today's hearing of the Inquiry into the Assessment and Treatment of ADHD and Support Services meeting of 7 March. Thank you, Minister, for attending. For the benefit of the committee, can you please state your name and capacity which you are appearing?

Ms OGILVIE - I'm the Minister for Corrections and Rehabilitation. I have with me Rod Wise, Deputy Secretary of Corrective Services, Department of Justice, a very long title. He'll be able to provide context and have answers to particular questions. I also have Bronwyn Hocking, Manager, Crisis Support Services, Department of Justice, who has more of an expertise in clinical operations. I think that would be helpful, and, of course, me if I can be helpful.

CHAIR - Can I double check that everyone has read and received the guide sent to you by the committee secretary.

Witnesses - Yes.

CHAIR- This hearing is covered by parliamentary privilege, which allows individuals to speak with freedom without fear of being sued or questioned in any court or place outside of Parliament. This protection is not accorded to you if statements that may be defamatory are repeated or referred to by you outside of the parliamentary proceedings. This hearing is public. The public and media may be present. Should you wish aspects of your evidence to be heard in private, you must make this request to the committee at the time.

Mr ROD WISE, DEPUTY SECRETARY CORRECTIVE SERVICES, DEPARTMENT OF JUSTICE, AND **Ms BRONWYN HOCKING**, MANAGER, CRISIS SUPPORT SERVICES, TASMANIA PRISON SERVICE, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Minister, would you like to make an opening statement?

Ms OGILVIE - Yes, thank you. I'll keep it relatively brief so that you have the opportunity to hear from people at the frontline.

Good morning, thank you for having me here. This is a very important inquiry and it is good to be able to be here to talk a little bit about what happens in our corrections process and facilities, particularly those serving custodial sentences.

As Minister for Corrections and Rehabilitation, I view ADHD as a significant issue within our custodial system. It does deserve attention, but it's also, I think, important to know

that's alongside other complex needs and situations and scenarios, so nothing happens in isolation in our world.

We have the nation's highest disability rate here in Tasmania at 30.5 per cent. Our estimates of about 40 per cent of prisoners nationally having ADHD, and it's often linked to other comorbidities or issues like abuse or trauma, but it is a key part of the health and wellbeing landscape that we manage in our custodial facilities.

I'm really proud of the strong collaboration between the Department of Health and the Department of Justice which ensures that we work across these fronts, none of which are easy. We need to do this effectively as part of our broader commitment to prisoner care.

Historically, ADHD has not been a major focus, like, in the Custodial Inspector's recent adult healthcare report, which mentions it once, I think, on prescribing differences, showing how our efforts have balanced multiple priorities while our understanding continues to grow - part of the reason we're here today.

Our staff's dedication in this challenging environment is commendable. I'm joined by Rod. I recommend asking him questions around context and how things are run, and Bronwyn Hocking, Manager of Crisis Support - that clinical side of things - and we welcome questions.

CHAIR - Thank you. Before we start, I do have to read out the following statement: as a committee, we recognise that during these hearings we may discuss highly sensitive matters and themes that have deeply impacted the lives of Tasmanians. This may be a trigger or distressing for individuals listening to or participating in these proceedings. As a committee, we encourage anybody impacted by the content matter during this hearing to contact services and supports such as Lifeline on 13 11 14 or 1800 98 44 34, ADHD Foundation Helpline 1300 39 39 19 or the Kids Helpline at 1800 551 800.

Does anybody want to start with questions? Okay, I'll kick it off then.

Minister, I know it might be difficult talking about undiagnosed ADHD by virtue of it being undiagnosed, but we've heard from a few witnesses that untreated or undiagnosed ADHD can lead to higher likelihoods of ending up in in the correction system and higher rates and risks of recidivism - if the impulsive behaviours and things that are symptomatic of ADHD aren't being treated.

Is there any understanding or knowledge about how that's interacting within the corrections system?

Ms OGILVIE - That's a great place to start. I think it would be helpful, if the committee is open to it, for us to explain how we approach these issues when people arrive - to give a general overview both of the process side and the clinical side. That might take us into more of a deep dive on particular issues, but to touch on that.

Rod, would you like to start or more of a clinical - when someone arrives?

Mr WISE - Well, Bronwyn is probably better, but I can paint a picture if you like.

We have a very ill prison population and high levels of disability and comorbidity, and ADHD is certainly one part of that. However, very frequently, the people who come into prison with ADHD also have a range of other issues that impact on their offending behaviour and their capacity to do a range of things. A high proportion have substance abuse issues. That varies from year to year and state to state, but generally in Australia we're looking at probably 70 per cent-plus of males using drugs on the outside - some of whom have addictions, clearly, and a large proportion have addictions. In the women's system, it's probably higher than that. It's probably closer to 80 to 90 per cent are drug users on the outside.

Some of the things from substance abuse disorders are clearly interwoven with ADHD issues. There are cognitive disabilities, there are experiences of trauma, there's a whole range of things that the prisoners bring with them into the prison system and, you know, we can't isolate just the issues relating to ADHD because they are often very similar to some of the issues that are presented by those other disorders and challenges.

In terms of the diagnosis, which was your initial question, it's really difficult to say, as you say, but back in 2023 they started having a look in London at prisoners coming into custody there. One of the charities, ADHD Liberty, had a look at every person when coming into custody. They found in the initial stages of that study that 66 per cent of people had undiagnosed ADHD, and that's clearly on top of those who came in with known diagnoses. Now that is at the high end of everyone's assessment, I think, of the prevalence of ADHD in a custodial setting. Ours is somewhat less than that, but then there are differences, as you would have heard through other witnesses and through the submissions, that there are differences in people's preparedness to diagnose ADHD and different thresholds and so on. But there's clearly a large number of people who have some of the symptoms who meet the ADHD diagnostic definitions. Bronwyn can talk about that more.

But can I also just say, before Bronwyn gets into how we deal with it, that sometimes prison's not a bad place for people with ADHD. Now, I'm not pretending to be an expert on ADHD, but there are some features that people say are useful for people who are ADHD sufferers, and they include things like a balanced diet and a lot of the people who come into prison, although our diet might not be the best in the world, it certainly goes through dieticians and it's probably better than a lot of the people who come into custody experience on the outside.

Sleep is another issue and it's something that we are good at - allowing people time to sleep, and so they get more regular sleep. We're probably not so good on exercise. And I know, Ms Rosol, you've been critical of us in terms of our lockdowns and that's something that we're working on, but people getting exercise is an opportunity inside prison as well.

Screen time is seen to be a factor that impacts negatively on ADHD and we don't have a lot of screen time inside prison.

One of the other things that is important is structure. That is one of the things.

On some of the elements that are supposed to be helpful in allowing people to manage their ADHD, we do quite well in a prison environment, and some of the things we don't do so well in.

But we are very often dealing with a large group of people who need assistance in some way, some of whom will have ADHD and very many of whom will have substance abuse issues, many of whom will have intellectual disabilities or cognitive disorders and other things that impact on the way that they behave and they interact.

What that means is that our staff are used to dealing with difference and different presentations and so they are very open to that. Bronwyn will no doubt speak about the responsivity issues when we're trying to deliver programs and treatment to them, but we are very well acquainted with people who present in an impulsive, different, agitated, anxious way because that probably describes the vast majority of the people who are in our custody. That's probably just by way introduction.

Ms OGILVIE - That's a great start, and are you happy for us to continue?

Just by way of handing over to Bronwyn, I want to reiterate for anybody who happens to be watching this that many prisoners present with co-occurring conditions: substance abuse, trauma, acquired brain injuries, mental health issues, which do complicate ADHD diagnosis. And of course it's a personal thing too. That journey is as much one for the person as it is for the services providing it and the agency of that person in wanting to know and engage with facilities and the capabilities of Bronwyn's team. It's important to acknowledge that.

Ms HOCKING - Thank you. Through you, Minister, my intention is to provide an overview of someone touching base with our service who may have an ADHD diagnosis or undiagnosed ADHD symptoms. I suppose first of all, just touching on previous comments around the Tasmania Prison Service (TPS) inheriting a lot of those comorbid sort-of presentations when someone touches base with us in custody, the diagnostic and statistics manual, which defines the diagnostic criteria for ADHD, recognises and acknowledges all of those comorbidities within that as well. Things like oppositional defiance disorder, conduct disorder, intermittent explosive disorders, intellectual disability, attachment disorders - the list is extensive. As a service, we are inheriting individuals who meet so many of those particular things as well. I'll touch on that again later when we look at what actually goes into a diagnosis and how we do that within the prison service.

First off, every prisoner in Tasmania undertakes a tier process when they touch base with us at a reception prison. In the first instance, that's a correctional tier 1, which looks at their general wellbeing and any kind of major concerns that are presenting at that particular time. Lots of logistics questions, demographic information gets asked at that time. There are also some screens around suicide and self-harm risk, and questions around disability in terms of whether or not they're an NDIS participant, whether or not they're on the DSP or whether or not they identify as having a disability.

One of the really challenging things in this particular field is that we're relying a lot on self report. A lot of our individuals who come to our service don't actually know that they would meet criteria for a lot of these diagnostic things either. And they've never been told, ‘This might be a problem for you,’ or ‘That might be a problem for you.’ Generally, they've just been told that they're a problem.

CHAIR- There's no mechanism - sorry to jump in. There's no mechanism if you know there's someone in the prison system who clearly exhibiting some of those symptoms to suggest or put them through some sort of -

Ms HOCKING - Yes. The tier questions are answered. Within that they then progress to a nursing tier 1 through the Department of Health, where they meet with an RN and they ask their own series of health questions. Within that, any kind of urgent needs that are required: if there's any kind of suicidal self-harm risk or any kind of identification of vulnerability and needs that may need to be addressed, there are specific referral points that they can then progress those to. Our staff at reception prisons are really astute at picking up when someone isn't in the best of health or when there are vulnerabilities around young, first-time-in-custody attention issues, ability to really cope in a prison environment.

As a means of some statistics, I suppose, my team is called the Crisis Support Services Team, which is made up of counsellors and psychologists. We are responsible for overseeing the suicide and self-harm risk assessment process and providing coping and adjustment support to prisoners as they're coming through custody or at any time throughout their custodial sentence or their journey with us.

Since 1 July last year, we've had 640 referrals to our service just for general coping and support. Within that, there's the opportunity for our clinicians to be picking up on vulnerabilities, on certain things that may need further assessment and to be able to really support those individuals. Our crisis response suicide and self-harm - 1 August to 28 February this year, so 2024 through 2025, over that five-month period there were 1227 risk assessments undertaken by our team. Within that, that's our highest-risk prisoners within the prison population. That's looking at not just risk of suicidal [or] self-harm, but that's looking at also risk in terms of vulnerability - in terms of appropriate placements for individuals within our service to be able to make sure that they're the safest that they possibly can be. That is a joint collaborative approach with correctional staff, health staff and therapeutic services staff.

We also have a Disability Support Service underneath our Specialist Support Services that is a new branch that's opened up within our Therapeutic Services Team. That disability team is looking at supporting prisoners with cognitive impairment, ABI or other neurodiverse presentations.

At the moment we have a senior psychologist as the team leader of that space. We have two dedicated people working in that space, one a high-needs support counsellor and the other are senior planning officer, who help identify and support prisoners that may be presenting with neurodiverse presentations, whether that be ADHD or autism within the prison, and trying to really help collaborate with correctional staff on how to support that individual in a custodial environment.

CHAIR- Have people been diagnosed through that process?

Ms HOCKING - Yes. We have, in terms of diagnosis, we have the capacity within our team and the psychologists in our team to undertake screening for ADHD and looking at specific suites of assessments that may lead to us believing that there's an ADHD diagnosis there. On an individual basis, we collaborate with the Prison Mental Health Service, which is a new service over the past six months which has just initiated their first phase of operating within the prison. They sit under the Forensic Mental Health Team and are part of the Health Department. Within that, they have psychiatric consultants or psychiatrists working for them. With our information, with the information coming across to us from the correctional space, each individual is looked at individually if it's indicated that there's a significant diagnostic clarification that's required.

CHAIR - Yes, great. I've got one more and then I'm very mindful about not hogging the questions for the whole session.

There was a mention about the interaction with substance abuse and risks of substance abuse. I think, especially, when we've heard quite a lot about people with especially untreated ADHD, the interplay with the risk of substance abuse, but then also how one of the main and effective treatments to that is access to medication, we've heard from a number of witnesses who have spoken about the difficulty or impossibility of getting access to those medications in the prison system. Obviously, I 100 per cent appreciate why, given it'd be very easy for someone to slip a stimulant medication under their tongue and take it back to their room with them and do who knows what with it. But at the same time, having access to those medications is a very proven way to treat a lot of those symptoms that can lead to bad behaviours and impulsive behaviours. What access do people in the prison system have to pharmaceutical treatment for ADHD?

Ms OGILVIE - I think we ought to give you two parts to this: first, the medication practices and what we do and why, which goes to the question of stimulant medications that may be a security risk, which are, as you've pointed out, highly sought after for non-therapeutic use, and the use of non-stimulant medications and how we go about that.

I also think it might be helpful, Rod, just to talk about that concern about how we manage prisoners and the drugs issue, and we've got our new X-ray machines, et cetera. Maybe just a little context around that. Perhaps we'll start with the specific and then go to the context, if that's okay.

Ms HOCKING - Sure. Through the Minister, prescribing medication is obviously undertaken by the Health Department and within that they need to meet their prescribing guidelines. In terms of correct information around that, that will need to be addressed to the Health Minister.

My understanding, though, is that there are a number of prisoners in our care who are prescribed non-stimulant medication for ADHD and that that is, I believe, somewhere between 10 and 22 prisoners at this particular time.

CHAIR - No-one has access to stimulants?

Ms HOCKING - No, that I'm aware of.

CHAIR- Is that due to the risk of it being diverted?

Ms HOCKING - I think that's one aspect of it, yes.

CHAIR - One of my questions, and I'm not sure who is best to answer it, because I do appreciate that risk, especially in the particular concerns of the prison system.

I don't think it's something that's typically prescribed in Tasmania, but I know there's a product that exists with liquid stimulant ADHD medication. The one I've just looked up on online: Quillivant, which is a liquid form of effectively Ritalin. Would investigating the use of something like - if you have someone in the system who is already diagnosed and already has a prescription outside and they find themselves in a correction facility - to replace say a

Vyvanse or Ritalin tablet for obvious reasons - with something like a liquid version that's a lot harder - you can give them their daily dose - it's a bit hard for them to hide it. Is there scope to look into things like that to try to help make sure people have access to those medications? Then I'll pass on to whoever wants to go next.

Mr WISE - Minister, through you. You're right. There are some things that we can put in place to reduce the risks of abuse of prescribed medication. As I said before, we have high numbers of people who are drug users on the outside and a high proportion of people inside seek drugs, either prescription drugs or illicit drugs. The Minister is right in saying we've introduced body scanners into our reception prisons and into a couple of our other prisons as well to assist us in trying to identify drugs that are being trafficked into the prison, either on the person or internally. That's one part of the overall war against drugs.

The diversion of prescribed medication is always significant. In most cases we dissolve medication and have it taken as a fluid, but the issue is still there in that people will move the liquid onto clothing and then retain it for later. There have been examples of people vomiting up what they have just taken and other people taking in the vomitus. It's really, really difficult to control.

We've been able to do it in some cases. Buprenorphine and methadone have been highly sought after by opiate users for a long time, but we've just gone to a depot injection for Suboxone, which has made a big difference. We don't have an equivalent for the ADHD stimulant medications at the moment. We'd love that.

Different jurisdictions have different practices in relation to some of those S8 highly attractive medications that drug users would love to get their hands on. Some will just ban them completely. South Australia, I think, is one jurisdiction that does that. I'm sure if someone from the Health Department were here, they'd be able to clarify that. But we are acting very cautiously in relation to those stimulant medications at the moment. Victoria, I think, has just started administering stimulant medications, and we'll be watching very closely how that goes - the impact on detected drugs in people because drug testing is done nationally on a random basis and a targeted basis, and if there are more of these S8 medications coming up in the testing, then we have to make a decision. But if there's not so much diversion, then it might be something that we would entertain here.

In my discussions with doctors here, they indicate that if there were a really pressing need to retain someone on stimulant-based medication on a case-by-case individual basis, then they would give consideration to that. But their general practice, to my understanding, is that they are more likely if someone comes in on a stimulant-based medication to try to move them onto a non-stimulant medication and that meets a correctional manager's needs much better. But if the clinical requirements were that a stimulant medication were to be prescribed, then they would give consideration to that.

Ms ROSOL - Thank you, Chair. Thanks, Minister, and others for sharing here.

There's been some talk about the statistics and the numbers of people in prison with ADHD. You've given us a national figure of 40 per cent. The research in the UK came up with 66 per cent undiagnosed. You've talked about the numbers of people in prison at the moment who are on non-stimulant medication. Do we gather statistics on the number of people in Tasmanian prisons who have ADHD? Do we have any idea how many there are?

Ms OGILVIE - I'll start with the stats that I have and then refer, if that's okay.

The statistics that I can give you are: the Tasmanian disability rate is 30.5 per cent, which is the highest in Australia. The national prisoner ADHD estimate is 40 per cent and ADHD medication in the Tasmanian Prison Service is approximately 2 per cent of prisoners. They're the stats that I'm able to provide. I think Bronwyn might have some more on-the-ground experience.

Ms HOCKING - Sure, through you Minister, the statistics that we have around ADHD - that's not a statistic that we keep in terms of how many people have ADHD or how many do we suppose have ADHD.

What I can say is that at present we have 88 participants currently on the NDIS and, of those, seven have ADHD as part of their diagnostic profile that we're aware of. We know obviously that we have prisoners in custody who are being treated for ADHD with non-stimulant medication. And we also know that since March 2023, our psychometric testing capacity increased with the introduction of new psychologists into the team and in that time we've undertaken 15 ADHD suites of assessments.

As I mentioned earlier, with all of the comorbidities that we inherit when someone comes to our service, it's very challenging in that environment to pinpoint what is as a result of ADHD symptoms and, importantly, rather than focusing necessarily on diagnosis, we're trying to treat the behaviours and the symptoms that we're experiencing with that individual in the best way we can in the prison environment. So be that collaboration with the Health Department, be that putting alcohol and drug counselling for the individual when there is specific substance use disorder questions around their presentation and looking at counselling supports and criminogenic programs to tailor the needs to the individual that we have and based on the symptoms and the profile that we're seeing in front of us.

We don't have a clear definition of how many people in our service have ADHD, but it would look as though, with the health patients, those that are accessing medication are obviously given and our NDIS participants, I'm not actually sure what the crossover between whether they're the ones receiving medication or not.

Ms ROSOL - Thinking about risks because we've talked a lot about the risk of a redirection of stimulant medication. I'm assuming that there are significant risks with people being untreated for their ADHD and we know that contributes to all sorts of behaviours. You've talked about the difficult cohort, you've described it as, of people in prison. Is there any work that's been done around risk assessment of the risks - I understand that you've done work around the risks of redirection of medication - but the risks of ADHD not being treated and what that does to increase tricky behaviours, put staff at risk, maybe put other people in prison at risk? How are you balancing those risks? We seem to be a little bit heavy on the risk of redirection, but there are other risks with people not being treated that could be contributing to incidents within the prison.

Ms OGILVIE - If I could underscore again that I think suggesting that people who have been diagnosed and not being treated is probably not an accurate reflection of the situation. Stimulant medication like Ritalin is not prescribed due to the security risks. Those medications are highly sought after for non-therapeutic use and we've heard the extent to which some people

might go. Non-stimulant medications for ADHD are prescribed to approximately 2 per cent of prisoners and that's determined by the Correctional Primary Health Service on a case-by-case basis. It's a matter of the nature of the medication that's provided.

Having said that, I think we have heard that first it is important that people who wish to be assessed have agency in that process. Second, that it is a challenging cohort with the comorbidities. Bronwyn, if it's okay, given that clarification I've just made, perhaps you could give us a little bit more detail on the process of identifying and how you might reach out to somebody who you think might benefit from engagement?

Ms HOCKING - Through you, Minister, there are a number of teams within the prison and it's challenging in writing to put forward just how collaborative those teams are, but on the ground we have a number of core businesses within the prison that are looking at prisoners who are consistently being raised either for behavioural concerns or well-being concerns. When that does occur, there is a multidisciplinary lens on those individuals to try and really work together to achieve the best outcomes for that individual.

For example, we have the High-Risk Assessment Team which looks at the prisoners who are in our high-risk area for continuing to engage in violence or behaviours that disrupt the good order of the prison. Within that team, there's a multidisciplinary approach between the Crisis Support Team, the Disability Team, the Maximum Rehabilitation and Reintegration Team and senior correctional staff from those units. Each week, those individuals are looked at.

When there's assessments being undertaken in that space, if there is concern that ADHD may be a significant factor or impulse control or something going on for that individual, the referral can be made to the Prison Mental Health Team and that diagnostic clarification can occur in that space. We have another unit called Mersey or the Needs Assessment Unit where we have prisoners with a lot of vulnerabilities in terms of their mental health and cognitive ability. That's a place where we can spend a lot more time getting to know those individuals with the goal of having as safe an environment as possible and also being able to get them into an environment that's least restrictive and able to be involved in all daily prison activities to the best of their ability.

Within that, again, our collaboration with the Prison Mental Health Team, the Crisis Support Team, the Disability Team, the correctional staff, it's all linked in together as well as the Community Correctional Primary Health Team.

On the ground, the multidisciplinary aspect of each individual case that's presented to us is phenomenal in terms of the ability to actually achieve diagnostic clarification for that individual in our prison service. Does that answer your question?

Ms ROSOL - Thank you.

Ms JOHNSTON - We've heard some evidence about when people receive a diagnosis and they're given stimulant medication that sometimes that takes quite some time to find the right levels and right medication that will respond to their particular needs. When a person moves into the prison service and has previously had stimulant medication and they're transferred onto non-stimulant medication, how are they managed in terms of their response to being taken off stimulant medication and put onto a non-stimulant medication, and their

behaviours and monitored around that in terms of the effectiveness of the non-stimulant medication to manage their symptoms? What's the process in monitoring that and assisting the person through that transition? It's a big change for someone to go from a stimulant to a non-stimulant.

Ms OGILVIE - I think it's helpful if I sketch out the steps that the process goes through, which this issue will be picked up in relation to the Correctional Primary Health Services engagement. When somebody arrives, it's true to say that universal ADHD screening is not conducted. That's due to high costs and that agency issue as well, can be as much as $3000 per comprehensive test. As I understand it, there is an unreliability associated with the inexpensive screening tools. However, all prisoners undergo a tier 1 assessment within 20 to 48 hours of reception. The custodial component, which is the Tasmanian Prison Service, their role is to evaluate security, safety and self-harm risks. That's the immediate response.

The health component, the Correctional Primary Health Service piece, assesses physical and mental health needs. That's where those conversations and decisions are made. In relation to specifics about changes of medication or how that's managed from a medical perspective, that is a question that would have to be referred to Health. However, I can also say that prisoners will self-report disabilities. Staff can identify potential issues for further assessment. If we're seeing things on the ground, that is something that can be reported and supported, and referrals to specialist services, including mental health or disability teams, are made as required.

Ms JOHNSTON - Minister, I appreciate that there's the Health aspect of it in terms of they will monitor the actual levels of the drug given, whether it's a stimulant or non-stimulant. I'm interested in the behaviour management because it is a significant change. If I understand correctly, that's where your team would be interacting with them in terms of how do they put other non-medication mechanisms in place to manage their behaviour whilst they're transitioning to a different kind of medication. Are they given extra support in doing that? In trying to transfer from a similar to a non-stimulant in terms of behaviour modification.

Ms HOCKING - Again, it depends on each individual and what their experience of that is. Certainly, through the direction of the Prison Mental Health Team or the Correctional Primary Health Team, depending on who's doing the prescribing, those supports would be available to that individual as required. We can provide one-on-one counselling, we can provide additional support, we can provide behaviour support plans to help correctional officers understand the differences in what they may see for an individual who's going through that sort of change in medication. There is the opportunity for accommodation in specific areas within the prison to really assist with helping that individual to be understood in that transition. We have regular meetings with correctional officers in specific units, like the Needs Assessment Unit that I talked about before in terms of who they have in that unit and what's going on for that particular person at that time.

Through our risk intervention process, a lot of those conversations would be in that as well, which is meeting with correctional officers really regularly to be able to say, whether it's from our knowledge as our team or whether it's coming directly from one of the health teams - Correctional Primary Health or Prison Mental Health - in terms of this individual is going through medication change, be that for ADHD or be that for depression, psychosis, any other medical condition, to alert correctional staff that there may be changes in behaviour. It's not breaching confidentiality and saying, 'This person has A, B, C and D.' It's saying, 'This person may start to experience withdrawal or a different mood or they may become a little

different in their presentation than you're used to.' It's helping unit staff to be able to really understand what's going on for that individual at that particular time.

The one-on-one support that we can provide is, again, from that multidisciplinary lens, be that their planning officer, be that the program staff that can work with the individual, not necessarily in a group, but as an individual, one-on-one, to help them take in the information from the criminogenic program more readily. There's our team that can be strong advocates for them if they are experiencing challenges or if they find themselves repeatedly in trouble. We can help to navigate that with them in terms of explaining why that might be happening and what might be going on for them. They're things that occur on the daily regardless of medication changes.

Ms JOHNSTON - At the other end of the spectrum, in terms of prisoners who are expecting to leave the service, what kind of assistance or connections or referrals are you able to make, either for a prisoner who's come in with a diagnosis already - so you're aware of that diagnosis - or someone who has got a diagnosis whilst they're in prison? What kind of referrals, connections do you make to assist them when they are released so that there's a continuity of care and treatment for them exiting the service?

Ms OGILVIE - I think we'll approach this one a little bit similarly to the other one because there's two layers to the process. I'll ask Bronwyn to speak about the continuity of care piece. For the benefit of the committee, Rod, I think it is helpful to give an overview of what happens when somebody's leaving prison and those steps, just the process of it, particularly if there's any community corrections engagement, et cetera. We'll start with Bronwyn.

Ms HOCKING - Through you, Minister. Our planning and reintegration officers within the team, if we have a prisoner that's sentenced, work with that individual to really ensure that their community transition is smooth. That can include having doctor's appointments booked for them in advance at their preferred clinic or the clinic that's closest to the home that they're going to be going to. There's that through care from our end as well as referrals through to drug and alcohol services in the community.

My knowledge of working collaboratively with the health team - and again, this will need confirmation from the Health Department - for acute cases, particularly relating to major mental illness, they have community transition plans in place for the individuals that are being case managed in the prison to continue that into the community and saying if we have information about their health needs in the prison that need follow up with medical agencies in the community, that Health are responsible for passing on those referrals as well. Our planning officers can have referrals through to services like Just ACE and, you know, for acquired brain injury, they're really looking at Beyond the Wire for that overall help with life skills and things like that.

Really importantly, in the last three or four years, our involvement in partnering with NDIS support coordinators has grown. We know that when we have participants who have been able to be accepted onto the NDIS scheme from prison that we're sending them out into really supported placements in the community as well. There is there is a lot of through care that that does occur and it really does depend on what's available for individuals as well in terms of where they're going and where they're returning home to. Obviously, services in rural Tasmania are very different to what you might achieve in one of the cities.

Ms OGILVIE - Just briefly, Rod, would you mind, at that process level, lay out for the committee - because I don't know whether you're all aware of how it works - when somebody is getting ready to leave the prison, what are the steps that are taken?

Mr WISE - Through you, Minister, I think Bronwyn has covered some of those and the planning that goes into preparing somebody for release. Unfortunately, a number of our prisons are not able to be prepared for release because they go to court and they get bail and those sorts of things, so that changes things. In very many cases, people move on to parole or on to a community correction order and that allows us to continue to monitor their progress in the community and pick up on the things that they should be doing and could be doing and making links with community health services and those sorts of things. For the proportion of our prisoners who go out under some supervision, we're able to absolutely monitor how they go and the manifestation of ADHD or whatever else in terms of their behaviour and their criminogenic needs and their likelihood to re-engage in reoffending.

Mrs BESWICK - You spoke about there being 15 - you've done 15 assessments in the last half dozen months. I understand that you're saying there's a high level of disability and comorbidities going on in the population. When we've got a percentage of 40 being kind of standard, and we know in Tasmania that we have a very high level of ADHD, more than normal. It does seem very strange to hear that you think you've only got 2 per cent in the prison. Out of those 15, how many?

Ms OGILVIE - We clarified the numbers. I think the 2 per cent is a non-stimulant medication treatment, the ones who are getting that non-stimulant medication, but I will ask Bronwyn to expand on that. Obviously, it's a higher number.

Mrs BESWICK - Yes. How many of your 15 assessed did you actually assess as having ADHD, or is that what you meant when you said that?

Ms HOCKING - Of the 15 assessments that were undertaken, it was in the context of other kind of presentations for each of those individuals. It might have been that we're assessing for cognitive impairment or intellectual disability. As part of that, ADHD screening was a contributing factor to what the overall presentation of that person was. I don't disagree that there is a high likelihood of many more people in our prison having and meeting and endorsing symptoms of ADHD. We don't have standard screening procedures that we're doing with everyone. Again, we're relying on treating the behaviours of those that are continually coming to our attention or needing that reassurance and that wellbeing. We're really prioritising our focus on the prisoners who are presenting, whether it's distress or behavioural concerns and things like that. We're really looking at that multidisciplinary lens.

ADHD always plays a part in what could be a causation of those behaviours. It doesn't necessarily always get assessed at that particular time because we're looking at what are the needs of the individual and how can we support them in our prison environment. For our team in particular, if we undertake a suite of assessments looking at ADHD, we would still be relying on the psychiatrist to really confirm that diagnosis and undertake an assessment for ADHD. I'm sure you've heard already from community providers the level and the extent of what an ADHD assessment looks like. To be able to undertake that in the prison environment is challenging for a number of reasons. One, we're relying on being able to access historical information from when the individual was a child and often times they don't know the answers

to a lot of those questions and we don't have the ability to be contacting other sources to be able to comment on their behaviour as well.

The Minister has already outlined that an assessment can cost upwards of $3000 in the community. What we have in the prison is treating what we have in front of us and looking at how we can best support the individual based on what they have, on an individual basis at each and every time.

CHAIR- I'm mindful of the time, I think we could have another two hours and still have questions. I've got one last one off the back of that. On the topic of the cost and the $3000 - and I appreciate that's it's a lot to screen every single person in the system - is there any comparison or is there any thought about comparing that to the cost of not treating people? The cost of the higher rates of incarceration and the higher risk of misbehaviour and bad behaviour and damage and health problems that come from that. Are we comparing $3000 to zero or comparing $3000 to the costs of all the other things that come from that?

Ms OGILVIE -I think what you're pointing to is the very real challenge that we have before us in prioritizing what we deploy our limited resources on and in what priority order. I should also say, particularly as the Minister, I take a lot of interest in the rehabilitation side of my portfolio. At the end of the day, unless we're rehabilitating people, we're just getting that cycle of recidivism, it keeps people safer in the community, et cetera. Take it as read that that is really important to us.

What I can perhaps point you towards is comparison with other jurisdictions as well. I think it's probably helpful. We know that most Australian jurisdictions do not routinely screen for ADHD upon prisoner reception. That's a similar situation to Tasmania. We and others rely on that self-reporting or staff observations. A lot of energy and effort goes into that followed by specialist referrals. Our collaborative approach with Health - between Justice and Health - is really good. It's robust, it's effective, it's integrated and across the process of custodial system as well.

I also want to highlight that through the Disability Royal Commission, recommendations to enhance disability supporting custodial settings are being implemented and the Tasmanian Government is actively progressing these recommendations in collaboration with relevant agencies. There's a cross-agency piece of work.

Before I sort of hand to specialists, I do want to say very clearly that the work our staff does, particularly in Risdon, is incredible. It's a difficult working environment. I'm always incredibly grateful for the people we have on the frontline there doing this work. It is a challenging environment and I want to really underscore, and through Rod as well, how commendable it is and how professional our prison staff are generally.

The collaboration piece is incredibly important. Tasmanian Prison Service and the Department of Health address ADHD within that comprehensive health and disability framework. I take your point, Mr Behrakis, we can always do more and we are always seeking to do more. That's more of the general statement, but Bronwyn may want to add some additional pieces.

Ms HOCKING - Only that it's a growing research area. It's really important, I think, to recognise that -

CHAIR - That's across the board? Not just in corrections?

Ms OGILVIE - Exactly right.

Ms HOCKING - Yes. Articles that are being produced from 2024 onwards I think are going to have a huge focus on how we address ADHD nationally. I think that's exciting and I think that's a really good thing to occur. Also, looking for us to address those comorbidities. For someone with ADHD that also has substance use disorder and a conduct disorder or an antisocial personality, those are key risk factors for reoffending. If we're addressing that holistically rather than just focusing on ADHD, I think that's really important as well.

Ms OGILVIE - Yes, it's a person-centred approach. If I could close by saying that I really appreciate you bringing this committee inquiry on. It's really helpful for us to be able to explain to people what we're doing. We don't often get that opportunity. It's not the most high-profile area of government services, but what we do in corrections and what we do through the prison system is remarkable and the work that we do to get people's lives back on track is really quite something. It takes everybody's shoulder to the wheel and I again thank my team here for that.

CHAIR - Thank you. We are over time. I have plenty of questions. I know the Chair, who wasn't able to attend today, Ella Haddad, has a few questions as well and I'm sure other members might. We might actually send some questions through if we can.

Ms OGILVIE - Please feel free to write.

CHAIR - Thank you, and I appreciate the things that you guys have to balance as far as all the risks and constraints of diversion and also helping people get the treatment they need. Thank you, and thanks for attending.

What you have said to us here today is protected by parliamentary privilege. Once you leave the table, you need to be aware that privilege does not attach to comments you may make to anyone, including the media, even if you are just repeating what you said to us. Do you all understand that?

Witnesses - Yes.

THE WITNESSES WITHDREW.

The committee adjourned at 10.25 a.m.