THE HOUSE OF ASSEMBLY GOVERNMENT ADMINISTRATION COMMITTEE B MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART ON FRIDAY, 11 APRIL 2025

INQUIRY INTO THE ASSESSMENT AND TREATMENT OF ADHD AND SUPPORT SERVICES

The Committee met at 9.00 a.m.

CHAIR (Ms Haddad)- Good morning and welcome to the Government Committee B hearing of the inquiry into assessment and treatment of ADHD and support services in Tasmania. Could each of you please state your name and the role in which you are appearing today?

Mr JAENSCH - My name is Roger Jaensch, I am the Minister for Mental Health and Wellbeing.

Mr WEBSTER - Good morning. I am Dale Webster, Secretary of the Department of Health.

Dr ATHERTON - Good morning, Dr Sonny Atherton, Statewide Specialty Director of the Forensic Mental Health Service.

Mr HALLIDAY - Morning, Sam Halliday, Acting Chief Pharmacist.

CHAIR - Great. Thank you very much. Can I confirm that you have received and read the guide sent to you by the committee secretary, each of you? I will just remind you that the pertinent part of that guide is that what you say today is covered by parliamentary privilege, which means you are able to speak freely to us without any fear of being questioned or sued in a court or any place outside of parliament.

The only exception is that that protection does not accord to statements that you might make if they are considered defamatory and then repeated outside of these proceedings. It is a public hearing; members of the public or media may attend in the gallery or may be watching online. I probably do not need to introduce all of the members of the committee, but they are Mrs Beswick and Mr Behrakis. I am Ella Haddad. There also is Cecily Rosol and Meg Brown. We have got a couple of apologies today, but the Committee includes all parties and independents and all areas of the state are represented.

Mr DALE EDWARD WEBSTER, SECRETARY, **Dr SONNY RYAN ATHERTON,** STATEWIDE SPECIALTY DIRECTOR OF THE FORENSIC MENTAL HEALTH SERVICE, and **Mr SAMUEL WILLIAM GARTH HALLIDAY**, CHIEF PHARMACIST, PHARMACEUTICAL SERVICES BRANCH, DEPARTMENT OF HEALTH, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Thank you very much and I will just read the sensitive content statement that I discussed earlier. 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 may be distressing for individuals listening to, participating or later reading or accessing these proceedings. As a committee, we encourage anyone impacted in that way to contact services and supports, including Lifeline on 131 114, the ADHD Foundation Helpline on 1300 393 919 and Kids Helpline on 1800 551 800.

That is all of the formalities dealt with. Minister, would you like to start with an opening statement?

Mr JAENSCH - I would. Thank you very much, and thanks again for the invitation to attend today. I will start by acknowledging the Tasmanian Aboriginal people as the original owners and continuing custodians of the land we are meeting on today and pay my respect to ancestors and elders. I also note that I am not the first Minister for Mental Health and Wellbeing that you have had across the table from you and my predecessor in the role, Minister Barnett, appeared, I think, last October.

One of the things that he gave a commitment to at the time was the development of amendments to the *Poisons Act 1971*, enabling interstate prescriptions to be dispensed in Tasmania, including for psychostimulants and a range of medications relevant to the subject of this inquiry. I am happy to advise that that legislation has been drafted. That is currently in consultation and we will be bringing it to parliament as soon as possible.

That will be important, I think, to people who are listening to this, who are taking an interest, that the things that we talk about at these places change; change the law, change the services that are available to people. And we are committed, and I am committed as minister, to enhancing services and support for people with ADHD across Tasmania, across all life stages as well.

So, given that I am no expert in this area, I am a relatively new minister, it is a very complex area. I have had a number of briefings and a lot of material to work through, but I am treating this inquiry in this discussion as part of my education on the subject as we work through it. I am very open to the process that you are running. I think my job here today is to give you, in your role on behalf of the submitters and the public interest, access to people who have answers and information.

There will be times, I am advised, where, if questions follow the experience of an individual case, where we need to be sensitive to privacy and the prospect of people or their circumstances being identifiable. Both in terms of individual case examples, but also some of the statistics, which, given the relatively small population and the smaller population of individuals affected here, might get us into a small-numbers situation where even just relaying statistics might enable people to be identified. In those cases, I understand the committee has the option of going *in camera*, and so we may need, if the Department advises that, to divert proceedings into that and/or to take matters on notice. I'm very happy for us to take matters on notice today to follow up and provide information to the committee that can be dealt with appropriately at the time.

I'll just also foreshadow that a more fulsome review of the *Poisons Act* has begun and will continue, with consultation kicking off later this year. I am hopeful that that means that if there are further matters identified through this inquiry process, that we will have a live legislation review for them to feed into as well. So again, for those who have their needs and hopes for change linked to this inquiry, there is a vehicle there for your findings to be fed into another process of legislative change later this year.

CHAIR - Thank you. Can I just ask a quick question about that review, because we had heard whispers that that was beginning. So, that's really positive to know that, because a lot of the evidence we've heard does go to some of the complexities in that legislation. Will members of the public be able to provide input into that review of the *Poisons Act*? Or will it be more of a targeted consultation with practitioners?

Mr JAENSCH - I would expect we would be receiving advice and input from wherever we can get it. In terms of the specific process, maybe the Secretary would like to comment.

Mr WEBSTER - Thanks, Minister. Yes, we have actually been underway for some months now doing that background research, comparing to interstate legislation, all those sorts of steps that we take in that process. But there are two public consults that will happen. One is generally about comments, but secondly, the legislation will be released for a period of time so that people can have a look at it.

CHAIR - Did any of your team want to make an opening statement as well, or should we move straight into questions?

Mr JAENSCH - No, happy to move straight in?

CHAIR - I will open it up to the committee.

Mr BEHRAKIS - Thank you for coming and helping us with this committee, Minister. One of the questions that's been asked has been regarding people not getting approved access to ADHD medication that need it. One of the things that, I think, we heard when the former minister came to this inquiry was that the vast majority of those do get approved. However, with the ones who do get approved, there are quite a few who have come to me, and I'm sure other members as well as people who have presented to the inquiry, who have had onerous restrictions and conditions placed on their approval.

That includes things like having to pick up their prescriptions on a weekly basis or sometimes shorter, or having to perform urine tests and other such things. Some have said that that puts them in a position where they feel like they're being treated like criminals or drug addicts for trying to access the necessary medication. Are there ways to mitigate these? There are risks with stimulant medication, but is there a way to mitigate these risks without putting people in those situations where they're being made to feel that way when they haven't necessarily done anything wrong? To be penalised in that way?

Mr JAENSCH - Thank you very much. I've had limited briefing in this area, but what I've picked up from that is that, as you mentioned, by the nature of some of the medications involved, control and supervision of their availability in the community is an important consideration and that there are individual decisions made on the basis of individual cases and the circumstances of people who are having medications dispensed to them. I'll pass to the secretary and whoever is best positioned to give you more detail.

Mr WEBSTER - Perhaps if I kick off, so these are called section 59E applications and assessment process. Now, under that process, we look at both a risk evaluation and a mitigation strategy approach. We need to ensure that we're not actually increasing the risk of preventable harm to someone when we prescribe Schedule 8 [of the Standard for the Uniform Scheduling of Medicines and Poisons] psychostimulants, as in this case, and that we identify that where there are risks and then weigh that against the benefits of the prescription. We do put in a number of mitigation steps. Now, you know the public may see them as restrictions, but they're actually mitigations. It is about looking at their background, doing a risk assessment. Now, the other thing I would say about the risk assessment, it's not an individual officer who does the risk assessment. It is more than one person and involves both medical practitioners as well as our Pharmaceutical Services Branch (PSB). So, there is a look at it.

The idea is to minimise that harm to the person, but also minimise the harm to the general public from the possible diversion of the psychostimulant. That's, you know, an important part of our role is to prevent illicit use of these particular Schedule 8 drugs. In other cases, it's about protection of children, for instance. So, when we're prescribing for children, we need to make sure that the child is going to get that psychostimulant with the regularity that's prescribed and those sorts of things. So, we will actually consider childrens' situations and may put restrictions around the parents around the giving of that drug, rather than the child itself. So, there are two circumstances, but it is risk-based.

Now, we do have some examples, but because of the small groups in this one, this is one category where if we go into the detail, we might actually be identifying individuals but there are several -

CHAIR - Well, could I give an anecdotal example of my own then that might mitigate that risk of identifying anyone who's subject to one of these approvals at the moment. You gave the example, Secretary, about a child's prescription. My child is in that process at the moment. We've kind of given up. The first prescription that she received did take quite some time from the psychiatrist's assessment to receiving the prescription. It took over a month. I think it was probably about five to six weeks, but I could be wrong about that.

Could you talk us through how those decisions are made. You said there's a team of practitioners who make that assessment, including - it sounds like, not to put words in your mouth - an assessment of the parents. I'm assuming that there was some assessment of me made in the decision about my daughter's prescription. I wondered how that information reaches your team in the Department and what communications your team have with that original prescriber, or any other medical treatment team, you know, that patient's doctor, psychiatrist, paediatrician, psychologist, and so on. Can you just talk us through the kind of nitty-gritty of the process?

Mr WEBSTER - Firstly, as to the time is that - and we gave evidence with Minister Barnett, about the time had blown out because of the large number - the volume of applications we're getting. The Chief Pharmacist and his team have worked to bring that down again, so we're actually - the timelines have come back down again by the process.

In terms of the detail of the practice, I'll just go to the general, which is, if they're complex, they go off to a panel. We involve medical officers so they get that information, but in terms of the detail of how it goes back and forth between the treatingphysicians, that's probably something that Sam can comment on.

Mr HALLIDAY - Probably not talking about your individual scenario, but usually what would happen with child applications is that there's an application form completed by the prescriber, and that application form currently includes fields for providing either parent or carer details. Part of the Good Medical Practice: Code of Conduct for Doctors in Australia includes - I think there was a question on notice about this as well - includes this discussion between the treating physician and the family, in the case of a child patient, to talk about how information is going to be shared with the department. In the case of most prescribers, we understand that they talk about the safe custodianship of these medicines in the home, but we are aware there are circumstances where those conversations may not be happening.

So, the application would come in with the details of parents and carers on there. Our pharmacists assess the patient scenario, which in the case of most children is reasonably straightforward, and then for the parents, most of the information that we would refer to is the records that we hold within the real-time prescription monitoring database that we administer the authorities from. That includes information such as declarations of drug seeking, notifications of drug seeking, past authorities for treatment for parents around certain Schedule 8 medicines, so that could be Schedule 8 opioids, stimulants, cannabis, benzodiazepines, and a small number of other types of Schedule 8s. Within that database, that is most of the information that we hold and would refer to in terms of saying, 'Okay, are there any custodianship issues here that mean that the child might not be getting their medicine?' That is, fundamentally, the focus of that check.

CHAIR - And that is based on information that's already held by the Department or the Tasmanian Health Service?

Mr HALLIDAY - Correct, yes.

CHAIR - Do you have a need to seek information from other departments like from police or courts or anything like that?

Mr HALLIDAY - No. In the past we have, where there has been published information about events happening - that information may or may not have been held in our previous database, for example, if a person was convicted. We don't go out of our way to go, 'Dear police, are there any concerns here?' because the focus of the application is about a patient getting clinical care and access to a medicine and treatment overall for their condition and that is the same for any other patient, not just children as well.

The team within PSB, they're pharmacists. So, in the case of ADHD medicines, we have multiple staff who are diagnosed and treated currently. We have staff who are parents of kids who are treated as well.

CHAIR - So, a real-time understanding of the issues.

Mr HALLIDAY - Yes, and also all the pharmacists in there have had at least three to five years practical experience in clinical or community pharmacies. So, they've had experience in also providing care, so, I suppose, there is a sort of an avenue or focus there. It's really front and centre for us about - we really want people to be able to access this medicine and our check is about triangulating safety and custodianship.

CHAIR - Thank you for that information; it is really pertinent. I suppose what it goes to is the bigger picture of our increased understanding of ADHD and the written submission from the government really points to that in terms of comparing figures from decades ago of how many prescriptions there were and even how many providers and prescribers there were to now. My personal view is that that doesn't indicate an increase in prevalence; it indicates an increase in understanding of ADHD and other neurodiverse conditions.

One of the things that I wanted to ask about is a statement in the written submission on page 18, which says all forms of dexamphetamine - I am probably not going to pronounce all these right - lisdexamfetamine and methylphenidate in Australia are contraincidented -

Mr HALLIDAY - Indicated.

CHAIR - Contraindicated, thank you, should not be used - see, I'm showing that I don't have a clinical background - but basically, those drugs of dependence, particularly stimulants, should be used carefully in patients with a known drug dependence or alcohol abuse. That is one of the things that we've heard from some practitioners, but particularly from - and again I'm not going to indicate, we had some closed roundtables with individuals, so not to indicate their personal experience, but Mr Behrakis's question kind of went to it as well - people feel like they're not only treated like drug seekers when they are seeking stimulant medication with medical support, but they are penalised for something that is now understood to be quite prevalent in undiagnosed people, which is self-medication. So even speaking to friends of mine who are not trying to be medicated, but they know they've been diagnosed with that actually, they said well there's no point, people would go 'I wouldn't ever receive a prescription because I've got a history of self-medication either with legal drugs, alcohol', you know, illicit use of other drugs. And I just wondered how much the Department's thinking is changing in terms of understanding that quite often once people are correctly medicated for ADHD, all of that other what might be seen as drug seeking or drug dependent behaviour completely disappears from a clinical perspective because what was going wrong in that person's life is that they were not diagnosed and treated for their actual condition, which was ADHD. Have I explained that?

Mr BEHRAKIS - Yeah, I suppose if it’s drug seeking, self-medicating, I suppose, and that impulsive decision making of taking drugs is a very is a common is a known common symptom of untreated ADHD, is identifying that as a risk and then therefore reducing or making it harder to access the medication that would reduce those symptoms and those behavioural traits the right way to go about things or is there a better way to mitigate those risks? I suppose would be my -

Mr HALLIDAY - There's a couple of parts I can talk from the medicines, the authority side of things if you like, and so you may be able to provide more input. So on the contraindications sort of thing, there's sort of three pillars in Australia around regulating access to medicines. One is state based legislation around poisons and medicines access, so these authorities are an example. There's the Therapeutic Goods Administration’s (TGA’s) Registration of Medicines process and then there's the PBS, the Pharmaceutical Benefits Scheme, around how patients can access subsidised medicines. So the contraindications and precautions around medicines that are marketed in Australia are related to the TGA’s approval of those medicines to be on the Register of Therapeutic Goods and so currently, totally hear what you're saying. Currently there is black and white contraindications which means these medicines should not be used in these scenarios and -

CHAIR - And they're outside of Tasmania's control really if they’re TGA guidelines-

Mr HALLIDAY - Well in terms of how that relates to current clinical understanding, there's definitely changing views in the clinical sphere and that's where Sonny might be able to talk better to get that sort of things about whether substance use disorder is a direct contraindication for the use of stimulants. Now in the case of our authority process, it's probably a bit more dynamic than ‘This happened at a certain time point in someone's history, therefore this equals this for the rest of time’.

There are clinically informed decisions. So our pharmacist delegates don't unilaterally make a decision in circumstances where that information becomes available, we will refer to a specialist medical practitioner to assess the risks and benefits because that's very much the focus of it, is to sort of look at this is saying there might have been a risk factor that was quite apparent in the past, but the benefit of treatment based on the psychiatric review or the circumstances that are happening now outweighs that. When that risk benefit profile starts to become a little bit more close, that's where the clinical expertise is really relied upon in terms of saying, ‘Okay, this person needs to have access, they've been diagnosed, but this certain staged supply condition, for example of weekly collection, allows for a pharmacist to say good day to the patient a little bit more frequently just to check that things are going okay’.

The authorities that are issued can vary in time frame and usually in cases where there are staged supply conditions, they may be a bit shorter than, for example, for kids, they're usually issued until the age of 18. And then for adults where there aren't any of those past or current substance use issues, they'll probably be issued for 36 months, so three years.

CHAIR - For adults?

Mr HALLIDAY - Yeah, in the cases where there are some clinical risk factors, they're mostly issued a bit shorter so that there is a point in time when the next application can say, look, we've had a demonstrated period of great stability here. The medicine is working, their behaviours are actually, as you pointed to, improved and this might be a time to have a look at that to say, ‘Do we relax the restriction?’ That's generally how the trajectory works in those cases where the substance use disorder that might have happened in some of these cases isn't persisting and there're still risky behaviours that are in play. That's sort of the picture about how that happens.

Mr BEHRAKIS - I have so many questions, Chair, so cut me off when you're ready. With those conditions, and I appreciate what you're saying, especially, I suppose there's a difference between someone who has a substance use disorder for a myriad of reasons - if the substance use disorder is a symptom of ADHD and if treating the ADHD can reduce that, then I believe that if there's a reason why there's a risk of diversion for ADHD medication. Because it is similar in nature to some of the recreational drugs that are on the streets because they are stimulants. That is why I think some people might self-medicate with illicit drugs. So, giving people access to legitimate medication reduces the need for those illicit drugs and that's a mitigating thing as well.

With the conditions - and there's the approval and non approval and there's approval with conditions and you said weekly pick-up. I've heard cases of it being every couple of days and I know that it is obviously rare - I know and I appreciate that. As someone that's gone through life with treated and untreated ADHD - I imagine I'm on the milder side of the scale - where one of the major issues that people deal with on a day-to-day basis is, having a hard time with personal organisation, keeping to schedule, remembering to do those little things that individually add up to important big things.

Expecting someone with ADHD to have in their day-to-day lives that organisation to remember to go to the pharmacy on every Wednesday or every Friday or whatever you have -

CHAIR - Even the 28th day. Not even regarding organisation, but if you are away from home or something.

Mr BEHRAKIS - Then they miss it because of that organisation and then they're untreated and I can see that just snowball and spiral. So, is there consideration of the nature of the condition that we're treating when we're putting in some of these restrictions?

Mr HALLIDAY - Yes, absolutely. I believe I have talked to the fact that, that is front and centre when the staged supply conditions are being considered. The perceived stigma around it is definitely not how it's intended. I think the part of the tension of regulating these medicines is what we see as objective safety issues. We would seek clinical advice on risk and benefit. This person needs the treatment, acknowledging that the condition that they may have and their organisational skills related to symptoms of ADHD may be affected. There's also a part of that, I hope, that for ADHD treated with a stimulant, some of those symptoms, if it's effectively treated start to resolve.

Mr BEHRAKIS - Yes, they do, until you don't have access to it. If you miss a day then you notice the difference. Then you are screwed, if that makes sense.

CHAIR - We have heard that from people who are on a regular pick-up at the same chemist every 28 days who are well-treated and are professional working people in their lives. But if they're away travelling, they can't get to that pharmacist on that day, then they do have a lag and a period of time where they're unmedicated. It can then snowball - the issues that Simon's talking about.

Mr HALLIDAY - There's a more general control around Schedule 8 medicines and a subclass of prescription Schedule 4 medicines, in terms of intervals for repeats that exists in our legislation in Tasmania and in the other jurisdictions. The intention there is oversight with those medicines. That's a degree above what would be, for example, a normal blood pressure medicine.

Mr BEHRAKIS - A question that was put to me and as far as ways to mitigate the risks - and I have a few questions on the risks. I've heard stories of people that don't have ADHD who have probably gotten hands on mate's dexies or what have you had described the process as quite a manic sort of experience. I can understand why it would be recreational or something that people would seek out, but that is for people who don't have ADHD. With the other drugs, such as, I think, I am on the strongest or the highest prescription Vyvanse that the regulations allow to be given out, but it is the long release, I think it is over nine hours or what have you. That slow-release nature of that drug, the slower release and longer-acting nature of that drug would make it by definition less recreationally beneficial, would that then make it, you know you are not going to get your rocks off taking a Vyvanse, you know, no matter what the dosage is because of the slow-release nature of it. If we are talking about -

Mr JAENSCH – That’s a clinical term, obviously.

Mr BEHRAKIS - The technical term - if we are talking about risk-mitigation and trying to manage those risks without necessarily making life harder for people, are there situations where we could have a different way of looking at things and say, 'Look, maybe given the risk factors, you know, past drug-seeking behaviour, what have you, we are not sure we are comfortable to give you access to dexies or to Ritalin, but we might give you access to Vyvanse because there is less -

CHAIR - Diversion risk.

Mr BEHRAKIS - There is less diversion risk and less misuse risk because of the fact that -

Mr WEBSTER - And it is actually not a question for PSB, that is a question for the treating physician because the clinician that is prescribing the drug makes the decision about what is the most appropriate treatment for the patient.

Mr BEHRAKIS - Okay, but would you be any more or less likely for, and I know we are talking about hypotheticals and theoreticals here, and I appreciate that. You have got a theoretical patient, they have got a level of risk that the PSB - say I am the physician, I have sent an authority to the PSB for this patient who has a level of risk for Ritalin or for dexies and you have said, 'Look, no because of the risks', or 'Look, yes but with three-day pick-up or weekly pick-up because of the diversion risk'. Would the response from the PSB be different if the physician was applying for that patient for a short-acting thing like Ritalin or something like Vyvanse, which is more long-acting? Would that change the nature of the response by the PSB as far as authorisation? Do you understand the question? Obviously it is up to the physician to send the authority.

Mr WEBSTER - Yes. So, the short answer is, within the risk assessment, if one of the factors was the risk of diversion, then that might have an impact. But that is only one factor and it could be any other factors. But at the core of it is, PSB is assessing the prescription made by the clinician and the clinician has made an assessment, on what is most appropriate. So, what I would say is that if the risk of diversion was one of the factors for that individual person, then you may compare. Ritalin would be seen different to long-acting drugs, but if that is not one of the risk factors, then you would not consider it.

Mr BEHRAKIS - So, I suppose a different way to - sorry, not to - flip that question around, both long-acting Vyvanse, the short-acting drugs like Ritalin, dexies, what have you, they all sit within Schedule 8 but they are not necessarily treated exactly the same. It is not like a blanket thing, it is Schedule 8 so they all get treated the same way. They have got their own different risk considerations and risk profiles, is that right? So, it is not a blanket thing?

Mr HALLIDAY - Yes, so from a classification perspective in seeking an authority, they are treated the same way. Sonny might be better to talk to this than me, but the way we see ADHD treated from a medication perspective is there is titration periods where review is required to actually assess whether or not medicines are working. There's different ways in which that titration occurs based on whether they are kids or adults, the weight of the person, things like that. Every individual scenario, particularly where there are risk factors raised or considered, and that is where the clinical advice comes in about - the applying psychiatrist might have views about a particular regimen and most often that is actually where the information about that consideration occurs. So, the assessment by the psychiatrist who is applying actually provides, in most cases, 'Here is my consideration of the risks and what this looks like.'

Mr JAENSCH - Ms Haddad, I just wanted to pick up on a thing that you raised in this last conversation, to do with people who may be travelling and needing to maintain, when we've talked about the interstate prescribing, that's what we're trying to cover those eventualities for visitors to Tasmania as well. But I will just ask the Secretary if he could comment on what advice we might have for Tasmanians who are travelling -

CHAIR - Or even travelling around the state, if they're limited to one pharmacy. That's something that has been raised on the public record at these hearings, is they just can't get to that physical pharmacy on, and you can't go on day 27, you have to go on day 28. And correct me if I'm wrong about the regimen, but that's how it's been described to us as a committee.

Mr WEBSTER - And Sam's just giving me the nod that that might be how it's done for a particular person, so it will vary. But for the intrastate, we'd recommend that you contact your treating physician before you travel and they may then make contact, well they will then make contact with PSB, and it may be that a separate pharmacist is nominated for that period.

Mrs BESWICK - This whole system seems incredibly inefficient. Like, I'm getting the impression here that we've got a psychiatrist. He's, you know, they've made their assessment and then they go to you and go, am I right? And then you spend three weeks thinking about it and then you know, if there's like, 'Oh, no, I've got 24 hours out of the date' - this seems like a, 'Oh, we couldn't possibly give you medication a day earlier, that would be horrifying.' Like the whole thing seems ridiculously litigious.

Mr WEBSTER - I guess I would say to you that as we said right up front, it's an assessment of risk. So for someone where the risk factors are incredibly low and the benefits are high, there aren't these steps. We're describing a very small number that actually have conditions applied to them, but it is this assessment of risk. These are Schedule 8 drugs; worldwide, these are seen as the drugs that could do the most harm to an individual and most harm to society if they were freely released into society. We have to consider that risk. It may seem bureaucratic, but I think the Minister and I would be back here being questioned by this Committee if we suddenly had a breakout of prescribed drugs sitting in the community, freely illicit transactions, et cetera, and we had no controls on.

We do actually have controls that match to risk, and Schedule 8 drugs are high-risk drugs. So therefore the controls match to that level of risk. We don't have the same controls on a Schedule 3; you can go in and talk to your pharmacist and if they are satisfied, they will give it to you. We don't have the same controls on Schedule 4. You get a prescription, you take it to your pharmacist, 15 minutes later, if you're lucky, they hand it over to you.

Mr JAENSCH - I think one of the scenarios that also needs to be in our mind is that sometimes we'll have a situation arise where, because we didn't get this right, we end up with two victims and possibly more, someone who's not getting their medication, someone else who is getting that medication on top of a range of other things in a very complex cocktail, and possibly because of either or both of those, behaviours manifesting in the community that do other people harm as well. It can be a very complex web of interactions that we're trying to guard against that trace back to the provision of a substance that can do great good, but also harm in the wrong circumstances. I know that you understand that; it's just one of the things that there is a liability associated with administering these chemicals.

CHAIR - There is no doubt there has to be controls and, I suppose, from a committee perspective, we're just hoping to provide some real-life community examples of the experience of the system. I'll come to Ms Rosol.

Ms ROSOL - Thank you, Chair. I have a question about the risk assessment criteria that you use when you're making decisions. I don't know if that's something that could be tabled or - I'd be interested in looking at what the criteria are and seeing that. My question about that is, how often is that criteria reviewed? When was it most recently reviewed? Is there a regular review process of the assessment criteria?

Mr HALLIDAY - Good question. Fundamentally, it's looking for, on an application or in the recent history provided, around risk factors in the Diagnostic and Statistical Manual around certain substance-use disorders or certain types of behaviours; they're sort of categorised in there. In terms of adjusting or considering the particular thresholds, if you like, there isn't anything like that in the risk assessment. It's clinically informed.

Our medical specialists that we seek advice from, in the case of ADHD medicines, are psychiatrists, child and adolescent psychiatrists, paediatricians, and addiction medicine specialists. We take the case, the pharmacist will prepare on the concerns that are visibly evident from the application, and here's what the requested regimen is from the prescriber, and these are questions for you about if is this okay to be provided for three to six months, no conditions or are there concerns here that you think need to be clinically managed?

Ms ROSOL - Would you say there's an element of subjectivity to it? There's kind of a broad criteria, but there's subjectivity within the criteria.

Mr HALLIDAY - I think it is experience-based, regarding their clinical experience for sure. I suppose, reflecting back on Mrs Beswick's comments, the small number of cases - and most applications that we receive will be done within a day or two, it's not a three-week process - but, for this smaller cohort of patients, they do take longer because in a lot of cases we will have information in our system about previous authorities that the prescriber who's applying might not have any idea about.

CHAIR - Is that when they - sorry, I know you still have the call - but is that when you go back to the treating practitioner? Is there a conversation there?

Mr HALLIDAY - Yes. I understand there was some evidence given in previous hearings about how we communicate from - I can't remember who it was from - but we have a very open dialogue with the prescribers who are applying because that's who we directly - and strictly speaking, that's what the Act regulates. We're very open to receive calls from patients, but we're really limited in terms of how we can actually interact with their cases, regarding confidentiality and things like that. In the case of staged supply conditions, we have a standard operating procedure that if advice is given and the decision is then made by a pharmacist that that would be on the authority with the staged supply condition. We ring the prescriber, we have a verbal conversation with them. If they're not available, we leave a message. We then follow up a week later if we haven't heard back from them, and that type of thing - they're busy people, we totally get it, but that's the sort of thing that we try to do because we understand that, also for the prescriber, these aren't easy conversations to have. We then will provide a written record of that decision to them.

Ms ROSOL - What I'm hearing from my original question is that there is no protocol for regular review, or there's no kind of time frame for regular review of the criteria. There's flexibility within the criteria based on clinical expertise.

Mr HALLIDAY - Yes, they keep up with emerging clinical practice standards, clinical guidelines, for example. I think there's also been evidence provided by Australasian ADHD Professionals Association (AADPA) around the release of their prescribing guidelines and a prescribing manual.

Ms ROSOL - That's informally incorporated through individual clinicians keeping up with the research and the guidelines that are coming out?

Mr HALLIDAY - Yes, correct. Yes, it's absolutely - like any other area of medicine, I suppose, when new evidence becomes available it either gets incorporated into best practice guidance or clinical guidelines. Sonny could probably talk better to this than I can. Or if there's large-scale evidence that gets published that hasn't yet been incorporated into studies, they'd be considering those sorts of things as well.

Ms ROSOL - Do you think there's room for a review of the criteria now, or are you happy with the way it's working and the use of current evidence in decision-making?

Mr HALLIDAY - I think what we are getting is absolutely as best as we can get, in terms of the clinical advice. I have great confidence in the clinicians that we have. It's sort of a rotating pool of clinicians. I suppose the AADPA guidelines or prescribing manual is great because that's provided something quite detailed around what previously didn't exist. For general practitioners who have been prescribing these medicines, they haven't had very much to turn to in terms of clinical guidance and things there. So, yes, that helps.

Ms ROSOL - Thank you. I've just a couple more lines. I have a question about reviews and people requesting reviews. Do you keep statistics on the number of reviews and how many people seek reviews, or what percentage of people seek reviews about the decisions?

Mr HALLIDAY - I think we provided that back in the question on notice.

CHAIR - It might have been covered, but I was going to ask a similar on notice question, just data. I was wondering if you had numbers for each of the points in the flow chart on page 25 of the written submission. I'm happy for the Minister to take that one on notice if that's - it's not something I imagine we’d need read into - even if it is information you have to hand.

Mr HALLIDAY - Over a certain timeframe, or as at now?

CHAIR - Maybe a snapshot. I don't know. I don't want to make things difficult for you in terms of data collection, but what Cecily raises is pertinent. That's the final point on the flow chart, which is a review of decisions. It would be interesting to know how many reviews are requested and where that review results in a different decision from the original decision, not to put words in your mouth.

Ms ROSOL - That would be good.

Mr WEBSTER - So we're clear, and we get you the right data. So, level one, two and three, and review?

CHAIR - Level one, two and three, and probably the third line down, the number of refusals, approved with conditions, supported pending additional information or approved, and then, yes, number of reviews, and where that review has resulted in an alternative decision.

Mr HALLIDAY - I think this became everything. There was that information given, but not with level one, two and three into the question on notice so -

Mr WEBSTER -Yes, the Minister provided that on the 22 November.

CHAIR - Former Minister, Mr Barnett?

Mr WEBSTER - No, Mr Jaensch was in place as Minister by then.

CHAIR - Sorry. We have a lot of competing committees and things -

Mr WEBSTER - Just for today -

CHAIR - It's probably in our folder, so maybe if we can come back to you with a written request at the end of today about what data we have and what we'd love to expand on and if it's possible to expand on from your perspective. Keep going Cecily.

Ms ROSOL - I just have a question - because a lot of the feedback from me professionally before I was elected and what we've heard on committee here is the PSB seems opaque, bureaucratic, disconnected from people. It's really distressing for people, the decisions that are made, for some people. I wonder where you see room to perhaps humanise it more or include the voices. Is there room for people to be heard? You've said that the interaction is with the prescribing practitioner.

Mr HALLIDAY - But the outcome affects the patient.

Ms ROSOL - Yes. How can their voices be heard more in this process, from your experience and in your opinion?

Mr HALLIDAY - I'm open to feedback from the Committee about how that could be facilitated. What we have heard thus far from the Committee, because we've been keeping up with it obviously, is the need for clearer information to be available about this part of ADHD treatment; it probably points to some of the other issues raised during the Committee hearings around the full picture of ADHD assessment and how that flows through in a process. Fundamentally, we'd be open to providing more accessible information about how the process works.

CHAIR - I think Mr Behrakis had a question in the same line.

Mr BEHRAKIS - You mentioned that you are using some of those AADPA guidelines to inform the way you guys are operating. I think earlier in response to Ms Rosol's question, was that right?

Mr HALLIDAY - I think that the AADPA guidelines would be considered by the clinical advice being provided to us. I can't speak for them individually though -

Mr BEHRAKIS - As in the treating physicians, or?

Mr HALLIDAY - If we have the need to seek clinical advice to make a decision.

Mr BEHRAKIS - Okay, because one of the people, and I will not name him, but he gave a written submission to this inquiry - I have spoken to him, I think other members have spoken to him as well - has provided me with some correspondence that he had between the government and what the response from the government was. I think this is sort of mid-last year he wrote about the Senate inquiry and how that recommended that the other guidelines be adopted or be seriously taken on board and the response that he was provided was: 'Thank you for sharing the passage published in the guidelines provided by the Australian ADHD Professionals Association. I suggest you raise any potential discrepancies between their guidelines and nationally approved product information and scheduling classification of psychostimulant medicines with AADPA.'

That sort of seemed that there was not an inclination to take on board those AADPA guidelines. Are there parts of it that - and in fairness, I do not have it in front of me - but are there parts of it that we could adopt to make the system a bit more streamlined and improve outcomes, or, what are the issues with those guidelines?

Mr WEBSTER - Yes, I guess if you reread that sentence, the person is raising some concerns that there is a difference between the guidelines and some of the TGA.

Mr BEHRAKIS - No, this was the response from the government.

Mr WEBSTER - Yes, so they are raising those and we are responding. If there is a discrepancy between AADPA and the TGA guidelines, then it is not actually an issue for the Tasmanian Government because we are not the TGA. So, that is why we said go back to those organisations because we cannot actually change either the AADPA or TGA guidelines. They are not us.

Mr BEHRAKIS - I know there is a sort of jurisdictional element to the ADHD issue, where parts of it are state, parts of it are federal.

Mr WEBSTER - Yes, so he is raising discrepancies between the two bits of advice and we are saying, 'Well, we are in the middle of that.'

Mr BEHRAKIS - So, that is one for the federal government, to really change if it is going to be changed.

Mr WEBSTER - or AADPA to align with the TGA, so yes.

Mr BEHRAKIS - But are there elements of the guidelines that could be adopted or taken in by -

Mr HALLIDAY - But they are clinical practice guidelines, so they are really a matter for the clinicians giving us advice. The issue you have raised, and I think we spoke about it earlier as well, that product information is effectively the legal instrument that says this product is able to be safely, effectively and provided in a quality formulation to the public. So, when it has a direct contraindication, there is a black and white thing there that raises concern for anyone who looks at that, just black and white, you sort of go 'Okay, what is the mismatch here?'

Now, I think what you are referring to is that there is evidence that has been presented - I think the guidelines do talk to this - around the topic we talked earlier about, which is about substance use or drug-related behaviours that, if ADHD is treated and it is part of the cause of those behaviours or related to those behaviours, do we then get to a much better place for that patient? And that is the clinical nuance, you know?

CHAIR - That is right. We are not doctors, but -

Mr HALLIDAY - But that is the nuance and every single patient has different scenarios. Again, if we are focusing on those sort of scenarios, there might be really recent or current safety issues. There might be not so recent, but in the last 12 months, for example, the frequency of those issues like, is it happening every week or is it once-off? It might be 10 years ago, and all of those things get considered.

CHAIR - Those are quite subjective though, I think as well, which is why - I suppose what we are getting to is that I understand there are things that are in the federal jurisdiction here, but how this Committee might have a voice in when and how those clinical guidelines are reviewed and how they are reviewed in terms of that broadening understanding and increasing understanding of ADHD and other neurodiverse conditions in the community and in the medical profession.

Cecily, did you still have a question?

Ms ROSOL - Not along this line, but just that I asked whether it would be possible to table the assessment criteria and - kind of slipped past it. Just wondering if that is something that you have available and that you would be willing to table?

CHAIR - Yes, so we actually do have quite a bit of this data, so we might come back to you with written questions about this, but I think what Cecily is asking for is something different.

Ms ROSOL - So, the PSB, the criteria that you would use when you have an application coming in, that you are like 'Okay, these are the things that we are checking it off against.' Is that a written criteria or is it just a broad - what are the risks? What are the needs?

Mr HALLIDAY - There's a sort of a binary question, I suppose, in an application. Are there any perceived clinical risks?

CHAIR - Is there a document or something that can be shared with the Committee?

Mr HALLIDAY - No, because that's where there's a threshold of saying, ‘Are there safety risks here that we haven't previously made a decision on?’ For example, you have a new patient who hasn't had an application sent in by a prescriber before and that application might have clinical information in there about safety with medicines. Effectively, that is a step to go, 'Okay, we need to seek some advice.'

CHAIR - Step one is, check what you have regarding information about that patient?

Mr HALLIDAY - Yes. We could provide a written response on that if the Minister is happy to take that on notice.

Mr JAENSCH - We can look at the intent of what you're asking for.

CHAIR - I know we're drilling down a lot on the detail, but I had one more question about that decision-making process. I know that we've also got some questions for Sonny and I know that Simon and I both have hogged the questions. I wanted to ask one more question about that decision-making process.

One of the things that we've heard is that getting medication right is like tuning a radio, particularly for young people. That can be the case for many medical conditions, but when it comes to conditions like this one, treated with stimulant medication, there's the added barrier of these approval processes which are there for a reason. What I want to know is if a patient goes to - and this is where we stopped with my daughter. She tried dexamphetamines for a month. It's completely the wrong medication for her. It might have been what this parent described as tuning a radio. It could be the right medication; wrong dose. It could be the wrong medication. You might want to try different things as you might do for any other condition.

Mr BEHRAKIS - Four.

CHAIR - Four. There you go. Mr Behrakis tried four before helanded on the right one. Some people give up during that process. My family is one of them, partly because of the complexity. But also, what I wondered is when a subsequent request comes in from a practitioner for that same patient - so they trial dexamphetamine, the prescriber comes back and says, 'No, we want to try Vyvanse or we want to try dexamphetamine at a different dose.' How is that looked at, without trying to expose any individuals? Like you said, we need to be careful around individuals. Is there a general feeling that, 'Oh, hang on a minute, why are they asking for a different script?' or is there a general feeling of, 'Yes, this practitioner is clearly trying to get the medication right for this patient?' I know that's a very objective lens, but I am wondering, because there is a perception, at least in the community, that if your first script isn't right, don't keep going back and forth, you'll look like a drug seeker. That is the feeling that patients have shared with us at the Committee.

Mr HALLIDAY - No, sorry. There's probably a couple of parts to that. A prescriber can make an application for multiple ADHD Schedule 8 medicines.

CHAIR - For the same patient?

Mr HALLIDAY - Yes. In the case of paediatric patients, that's often what happens because there is such fine tuning that needs to happen across the different types of substances and to get the dose right. Within PSB though, we totally understand as pharmacists, there's a titration process and identification and the same thing happens with other Schedule 8 medications regularly. For opioids for persistent pain, same story. There are changes to regimens based on adverse effects or whether or not there's a clinical benefit from the treatment.

We're very used to receiving that. In the case of applications, particularly for children, prescribers can apply for the three common substances and an authority can be issued across those three. They can choose how they do -

CHAIR - Go back and forth with their patients?

Mr HALLIDAY - Correct.

CHAIR - Cecily, did you have more questions down this line? Do you want to - Simon has some questions as well.

Mr BEHRAKIS - I have so many questions. When Minister Ogilvie, came, we didn't get through all the questions. Then we wrote to her with the remaining questions. Would you mind if we did the same?

Mr JAENSCH - I am happy for us to receive your request for information. Absolutely.

Mr BEHRAKIS - With that response, and thank you for giving us another copy of that -

Mr JAENSCH - We will keep sending the previous response -

Mr BEHRAKIS - It's good to have it handy. On the second page, you have counts of outcomes of applications for review of a decision between 14 May 2024 and 14 November 2024; there are 11 applications that were reviewed, 100 per cent of those resulted in an outcome where the conditions were decreased, relaxed or removed.

If, and I appreciate we are talking about a small sample size here, but if 100 per cent of the reviews are resulting in changes in the conditions, does that not, at the very least, suggest that maybe some consideration needs to be given to whether the conditions that are being placed in the first place are perhaps too onerous or too risk-averse, perhaps, if every single time they are being reviewed, the review has been upheld effectively. So, if it was 50 per cent of the time, you would say maybe, but if 100 per cent of reviews are being successfully reviewed and brought down, does that not signify that something needs to be looked at with the initial conditions that are being placed?

Mr HALLIDAY - I probably would not speculate on that based on every single request for review we would get, they usually have much more additional information provided either by the clinician who is applying for review or by the patient or their carer. And often that information starts to actually say okay - and there also may have been a period of time since the authority was first issued where safety has been demonstrated.

So, I'd be speculating to say yes or no to answer your question, but what tends to happen in practice is that there is much more information where the specific safety concerns have been raised in the initial decision, they are actually investigated a bit further. Because of the, I suppose, the demand on the incidents or the presentation and the understanding of ADHD in the clinical setting, and the demands on the time of the prescribers, is often, 'Here is the application form, fill it out'. They fill it out and then, if we have more information, or if they provide information with the psychiatrist report that does not say 'Okay, is this safe or not?' - then we will ask for more information in making a decision, particularly if we are going to get some clinical advice back to us to make a decision. There is mixed return of information when we request it from the prescribers. So, sometimes we do not receive any reply, sometimes we receive really good replies.

Mr BEHRAKIS - I appreciate you cannot make a concrete fact statement based on that, but would that not at least indicate some need to review things? Because if the nature of a large number of those reviews are a factor of more information is coming back, then is it a case that maybe we need to look into whether or not we need to ask for more information at the front? If there are 13 people putting in reviews for applications, I would be confident in saying there would be almost as many, if not more, who have gotten these conditions, the conditions have been onerous, and they do not review it and they just sort of try to deal with it and maybe they are conditions that should be reviewed.

Mr WEBSTER - I will probably answer that in two ways. The first is that we could put in a whole process up front for this, but that is going to delay the prescription and that means delaying it for all 6000 applications, for this six-month period in the document. So, you can get to a point where you are getting more and more information, but you are diminishing return and you are delaying every application because you are following through a process. Similarly, there are 500 with conditions: if we followed them through to the nth, you would still be delaying applications, so you have got to get a balance between time and information. Thirteen out of 500, and you are probably right, there is probably double that number, again, that didn't apply, that felt it was a bit onerous.

That's why, as Sam explained, we don't say these conditions are in place for a child until they are 18 or for an adult there for the whole 36 months. We shorten the period. So, there is an inbuilt review there to say, 'Are the conditions working, have they proven themselves?'

Mr BEHRAKIS - Is that the two-year thing?

Mr WEBSTER - No, it can be any period of time. So, it might be that we put a condition in and then you will say we will do the conditions there for six months and then you do a new authorisation. Or it could be, you know, 12 months, there's no time on it.

Mrs BESWICK - If you have 6500 applications, would that include those sorts of automatic reviews?

Mr WEBSTER - Yes, it would. This is only a six-month snapshot.

Mr HALLIDAY - I mean we've seen about 2500 per cent increase in the number of applications we receive, and there's about 18,500 patients in Tasmania who are currently receiving Schedule 8 stimulant medications.

Mr WEBSTER - And I think the other thing that, and Sam sort of went straight through it, was part of the reconsideration by the second delegate is by then they'll have some history because they'll have started using the psychostimulant and we'll have an actual history of them this time around. Are they comply - you know, what's their level of compliance, those sorts of things. So that piece of information is quite vital. It's the same information we have if we give them six months or 12 months of, you know, extra authorisation. So the historical information or that, if you like, the information about how they've used it on this prescription regime is actually relevant to the review. So, you know, this legislation works on the basis of it's actually the Secretary that's the decision-maker and Sam and his team are the delegates.

Sitting at my level, I look at those stats and think that's good. We are actually making fresh decisions and we're taking into account all of the most relevant and most recent decisions to make new decisions. Because if the opposite were true and that said 13 and none of them was overturned, then I'd be saying to Sam, ‘Have we got groupthink going on?’ So, it's a good indicator rather than from what, where I sit as, under the Act, the decision-maker. I just want to reassure the Committee I've not made any of these decisions. But I look at it from a statistical point of view and think it's a positive, not a negative.

Mr BEHRAKIS - There was talk about some people being fearful of being seen as drug-seeking or when applying for ADHD medication, and not wanting to be - and being fearful of the fact that they are being seen as being drug-seeking. I suppose one part of that we've heard of, and I've been told as well, people can go out on the streets right now, and it's easier to source, you know, cocaine or other illicit drugs than it is to go through the process of getting necessary, needed ADHD medication at the moment. So just on the topic of diversion. But one of the other things that I've been told, and I think we've heard in this inquiry, has been that there are clinicians who are fearful of being seen as supporting or enabling drug-seeking behaviour. If you have a sharp increase in prescriptions for ADHD, there's a fear that that clinician will be treated as or seen as enabling people who go doctor-shopping.

One of the problems at the moment is - I'm not sure what the total number of registered psychiatrists are in Tasmania - but there are four, I think, maybe five psychiatrists who are willing to deal with ADHD for adults, which I'm sure is much less than what the number of psychiatrists are in Tasmania. There are GPs who will refuse to go anywhere near even already-diagnosed, already-prescribed people with ADHD, and when you talk to them and ask them why, they say it's just too much from the perspective of liability and regulatory and there's a fear of actually engaging in that space. Why might that be? Are there any consequences to doctors? You know, they're scared of getting it wrong. Are there any issues in that space? And if not, is there a perception issue that needs to be addressed, because there's, I think it's safe to say, we've got a resource issue broadly, and in ADHD specifically, there's only a limited number of people who engage in that. How do we remove that reluctance for people to engage with it so we can build that resource? Because at the moment there's a fear for a lot of GPs and psychiatrists to even go anywhere near it because it's seen as being too dangerous.

Mr JAENSCH - We would want people to be encouraged to have a conversation with whoever their treating physician is and to get the referrals they need to people who can help them. We wouldn't want anybody to feel that they shouldn't or can't, or feel inhibited from seeking help. The question then is the availability. I will ask the Secretary if he can start a response on that.

Mr WEBSTER - Thanks, Minister. Look, there is a shortage of psychiatrists in Tasmania, both private and public. There's a shortage of psychiatrists in Australia, both private and public. The health ministers and mental health ministers are doing some regulatory changes around the Australian Health Practitioner Regulation Agency (AHPRA) to make it easier for us to bring psychiatrists from international. There is a shortage. In addition to that, psychiatrists specialise. Sonny is a specialist in forensic. We could have more psychiatrists and still not address this issue because of their levels of specialisation. Lastly, there will be some who are reluctant to be in this space, either from their own experience or because they have a misperception of what the process is and things like that. You have that - very similar with GPs, but also, with GPs, they're most, they are, nearly all - we employ very few GPs in the public sector, so they're mostly private. They'll be taking advice from medical insurers and things like that about the types of patients they can tolerate within their practices. We can't really influence that side of it.

One of the learnings of this process, to be fair, is that there is a misunderstanding of what PSB does out there. You know that there is evidence upon evidence of timelines etc that blow out and things like that. A couple of things we've learned as we’ve gone - interstate prescribing was one where we thought, 'Well, that's a change we can make quicker than waiting for the *Poisons Act*.' The fact that we're doing the *Poisons Act* review is about the fact we want to modernise a piece of legislation that is the same age as the Minister.

CHAIR - Did you get consent before you outed the Minister's age?

Mr WEBSTER - No, he told me that I'm not allowed to call it old.

Mr BEHRAKIS - I think you were okay until you said the word 'old' just then.

Mr WEBSTER - We have to modernise it and a part of that is re-educating GPs and specialists across all the fields, about what the role of PSB is, because they're an enabler. If they disappeared, it would almost be impossible to get Schedule 8s in Tasmania. So, they do operate as an enabler and they operate very effectively, but at the moment they seem to have a bad rap. We need to reinvigorate that perception.

Ms ROSOL - I'd like to ask some questions of Dr Atherton about - is it correctional health facilities? Can you clarify for me where your role fits, so I ask the right questions of you?

Dr ATHERTON - I am the Specialty Director of the Forensic Mental Health Service and there's a number of different elements to the Forensic Mental Health Service. The Wilfred Lopes Centre, you might be familiar with, is our secure hospital in Tasmania. We have a Community Forensic Mental Health Service and a number of other services that come under that umbrella. We have recently commenced development of a Prison Mental Health Service, and we're in stage one of that service development. We work alongside our colleagues in prison, in Correctional Primary Health, which is essentially a GP-led health service that provides the core health service delivery in prison. The Director of that service is Dr David Onu. That service doesn't come under me, but the Prison Mental Health Service does.

Ms ROSOL - Thank you. I have some questions about what the wait times are like for people in prison to access mental health services at the moment and what criteria you use to prioritise people seeking mental health services in prison facilities, and where ADHD fits in terms of the priorities?

Dr ATHERTON - We are a recently established service and I guess the focus in our first stage of the service development has been to try to provide a community-approximate level of care for people who have serious mental disorders, mainly schizophrenia, bipolar disorder, and severe depression. That really is the primary focus of the service and within the resources that we have, we have to triage those people, some of them under the *Mental Health Act*, and really prioritise them in our service delivery.

Our criteria - I guess we're aiming to provide a community-equivalent service, so our criteria of our Prison Mental Health Service, to some degree, aims to mirror the criteria that general adult services in the community would be guided by and who they would accept into their service. So, that really is the main threshold for us in terms of who we would accept into the service, the presence of a serious mental disorder, somebody being treated under the *Mental Health Act*, and we would then triage according to, I guess, severity of symptomatic presentation and the need for specialist psychiatric input.

Ms ROSOL - So, potentially, people with ADHD would be far down the order because they may have a mental illness as well, but if they don't, then they would be considered further down the order of things?

Dr ATHERTON - Yes. So, prison mental health services across Australia are grappling with similar challenges with the level of resourcing and meeting the mental health needs in prison. We do have a particular pathway for people who have established diagnoses of ADHD in prison to continue treatment in prison and that wouldn't be dependent on them having a particularly severe symptomatic presentation. Outside of that it really would depend on the level of the severity of the symptomatic presentation. Somebody could have really severe mental health symptoms that are not clearly formulated - it might not be clear at that point what the diagnosis is - that could potentially be triaged at a high level and it may emerge later that they do have a diagnosis of ADHD and there is nothing to preclude clinicians in our service from considering that amongst the diagnostic possibilities.

Ms ROSOL - I have two more questions if that is all right. First, I understand that people who go into prison are not able to continue with their stimulant medication. Potentially, they're needing extra psychosocial support because they are not getting the positive effects of that stimulant medication. Are they able to access that and what do you think would be an appropriate level of psychosocial support for someone who's not able to access stimulant medication while they're in prison?

Dr ATHERTON - I guess the broader psychosocial support in the prison setting doesn't come directly under my service, but-

Ms ROSOL - Therapeutic support then, that would come under?

Dr ATHERTON - Yes, so there is a Therapeutic Services Unit directly under the Tasmanian Prison Service (TPS), which I think you may have heard from Bronwyn Hocking, who is the leader of that team, at a previous hearing.

Ms ROSOL - So, they wouldn't be coming under your service for support if they weren't receiving stimulant medication?

Dr ATHERTON - No. Sorry, not specifically stimulant medication. If they were being prescribed a non-stimulant medication, then they would be open to our service and, depending on the severity of their presentation, they would be allocated a case manager and we call that 'case management light' for scenarios where, really, the main support we are providing is the ongoing prescription of an ADHD medication. The psychosocial support in prison would predominantly fall under the Therapeutic Services Unit and other supports in prison.

Ms ROSOL - Thanks for clarifying that.

Mr JAENSCH - Just to clarify, there are people in our prisons who are receiving medication for ADHD that isn't stimulant.

Ms ROSOL - Is non-stimulant, yes, I think we heard about that at the last hearing. Just one more question, I've had someone who's been in touch with me, who was not able to access stimulant medication and - sorry, I've just lost track of my question, my brain's not working very well. Lockdowns prevented them from receiving the therapeutic or the health services they needed. What impact are you seeing with lockdowns? How many appointments are having to be cancelled with your service because of lockdowns in prison?

Dr ATHERTON - Just given the nature of our work in prison, we have a fairly mobile in-reach into prison. So, we don't purely rely on people being able to be brought up to a clinic to be seen. So, we have the capability to go into prison to see people. There are some challenges with that, you know; we have to be cautious regarding confidentiality and other things if a person isn't allowed out of their cell, but we have really good working relationships with the prison, with the Therapeutic Services Unit. I guess what I found generally is that there's a good collaboration around trying to make sure that even during lockdowns people are able to access review. But it can't always be guaranteed.

Ms ROSOL - Do you keep statistics on that?

Dr ATHERTON - We don't make appointments in the same way as the GP service would, but I can take that on notice if the Minister is okay with that. I'll clarify that.

Mr JAENSCH - Provide a response regarding what information is held or just the number of patients not seen because of lockdown? Is that something you think you'd be able to produce in a confidential way?

Dr ATHERTON - Yes, so we are logging contacts with patients through IPM and would be able to track any appointment that was made that wasn't able to go ahead. But again -

Mr JAENSCH - Would there be a reason attached to that record?

Dr ATHERTON - I'm not sure.

Mr JAENSCH - Or just appointments missed for various reasons?

Dr ATHERTON - Yes, so that might not just be lockdowns; that might take into account if that person's gone off to court all of a sudden because they've got extra charges or, you know -

Mr JAENSCH - Our response to that might be a bit of an exploration of what we know, but where we can attribute it and not.

CHAIR - Can I ask a question of Dr Atherton as well, and correct me if some of what I'm asking about might be under Dr Onu's team, but when people are in the scenario that Ms Rosol described - we understand that people are unable to continue a stimulant-based medication. So they might go to court, get their sentence, they're transferred directly to Risdon and they're off their medications. Would those inmates be referred routinely to see somebody with psychiatry qualifications in your team or perhaps to the Correctional Primary Health Team relatively quickly in terms of understanding that they're coming into prison and they're being taken off a regular medication to explore what, as Ms Rosol said, other psychosocial supports, therapeutic supports might be available or potentially other medications that might still assist them that are non-stimulant and are able to be prescribed in a prison environment?

Dr ATHERTON - Yes. So, I guess the most common scenario is that people are being taken into custody or on remand. They might spend a long time on remand before their matter is adjudicated. There's an intake process, which is under the Correctional Primary Health Service, called the Tier One process where there is some basic screening around a whole range of different categories including mental health, previous mental health diagnoses. It relies on self-report mostly, but there is also other collateral information that can assist with that. The pharmacy could look into what previous prescriptions have been dispensed. The GP can get a health summary from the person's GP in the community.

CHAIR - That screening discussion happens with someone when they're taken into remand?

Dr ATHERTON - Yes.

CHAIR - Is that pretty soon? Do you know? Or could there be a long wait time from processing in the remand centre and when you actually get to have that conversation?

Dr ATHERTON - The policy is within 24 hours, and then typically within a few days they then have a second intake assessment with the GP.

CHAIR - Okay.

Dr ATHERTON - The GP will then have an opportunity to explore some of the things that have been raised in the Tier One and then consider if the person has been on treatment for ADHD in the community, then refer that person to the Prison Mental Health Service.

CHAIR - Just so I am understanding you correctly, that first conversation is with a correctional officer, not with a medical practitioner?

Dr ATHERTON - With an RN, a registered nurse.

CHAIR - A registered nurse, okay, and then a GP, if required, and then one or both of those medical practitioners will discover if they need to speak to a psychiatrist. How quickly does that happen in terms of potentially prescribing meds that might help that person in prison? How quickly do you see that person if either that registered nurse or the GP sees that as necessary?

Dr ATHERTON - I do not have the exact average wait time to be seen and, as I mentioned before, it would be triaged against the other priorities that the service has in assessing people with really acute presentations. I cannot give an exact answer to that.

Ms ROSOL - I have a few questions stacked together. One of them was about wait times within the prison service for people to access forensic mental health. What are the time frames?

Because I have heard from people who have said that they have tried to access mental health services and had to wait weeks, so I am just curious what official wait times are or what you know about that.

Mr WEBSTER - I think there is recognition that we needed to increase mental health services for the prison, which is why Sonny has separated his service in a sense. So, we now have a specific prisoner focus because forensic mental health, which was providing a level of in-reach to the prison, actually has a specific client group which are not the prisoners. They are defined by legislation - what a forensic patient is. So -

CHAIR - And they are just at Wilfred Lopes, is that right?

Mr WEBSTER - No, they may be in the community, they actually may be in the prison, but yes, there is a criteria for what is a forensic patient versus a general mental health patient, but Sonny has put forward a proposal that we needed to have a specific-to-prisoners mental health service. We are, as he said, at stage one of that, so this story about weeks is probably true and that is what we did about it, is actually create some additional resources within Sonny's team that could focus on the prison rather than draw resources from the forensic team as and when we could.

Ms ROSOL - Thank you.

Dr ATHERTON - I think Dale has summarised the situation well. So yes, it could be weeks for somebody to be seen and again, it would depend on the triage and I guess how symptomatic the person was, how much that was interfering with their function in prison and it would be uncommon or probably even unlikely for ADHD to be triaged ahead of acute psychosis or other presentations.

CHAIR - We are almost at time, we have got about four minutes remaining and I think Simon wanted to return to some PSB questions.

Mr BEHRAKIS - Just some broader stuff. I know we have said that it is widely acknowledged there is a shortage of psychiatrists especially and so, there are two aspects of the broader issue, I think; one is the resourcing issue and the other one is, is the system working as efficiently as it could be? One of the points that has been made to me, by my psychiatrist actually, was: things like the two-year prescribing window - for a condition that, as far as I understand, doesn't go away - I am never going to not have ADHD. It is not something I get cured of - why do we need that two-year window and can someone explain the rationale - I think it was in 2022 - when rules were changed to no longer allow dual co-prescribing - what it used to be was that the psychiatrist, obviously, would prescribe and do the titration and the initial diagnosis and that stuff which rightfully should be in that specialist space. Then the patient's GP was listed as the second prescriber and they could go get their scripts filled by the GP.

The combination of that two-year window and the inability for that dual co-prescriber is that a lot of people aren't taking their prescribing authority from the psychiatrist to a GP, because in two years you'll have to go back and get it. Then there's that back and forth. So, you stay with the psychiatrist. What happens is the four psychiatrists in Tasmania who treat ADHD, their books are full and three-quarters of their time they're seeing people who are in a maintenance phase, just getting their scripts renewed when they could be seeing the year-long waiting list of people who are struggling and waiting to see a psychiatrist.

As we talk about modernising the Act and modernising regulations in this space, are things like that being looked at to make sure that with the very few psychiatrists and specialists that we have, as much as we want to build those numbers, we are using those resources efficiently? I believe that at the moment, they would be the first to tell you that they're not being used that efficiently.

Mr HALLIDAY - There are a few parts to that.

CHAIR - Can there be dual prescribers?

Mr HALLIDAY - Legally, no. Not at the moment.

CHAIR - Is that Tasmanian law preventing that or something national?

Mr HALLIDAY - Yes, section 59E nominates a prescriber. The idea is that it triangulates. Effectively, there is a person who's looking after that person's care with Schedule 8 medicine or medicines, if they're prescribed more than one.

Mr BEHRAKIS - Why was that changed?

Mr HALLIDAY - I'll get there. Section 59E allows, though, for a prescriber in the same medical practice because obviously they're going to have access to the medical records to treat. The framework was built, as I understand it, very much with the GP setting in mind, because you're going to have, maybe in 1971, you might have had a couple of doctors at a particular clinic and one goes away and then they can actually look after the patient.

CHAIR - You've said in the written submission that 83 per cent of prescribers are GPs.

Mr HALLIDAY - Yes, correct. The Department actually realised in 2022 that there wasn't a facility legally to enable co-prescribing, and that was communicated quite a lot with the prescribing community to understand that and work through that. I think that would be something of interest down the track in terms of any modernisation of the *Poisons Act* and to look at other models in other jurisdictions around how that works.

There's a second part of that about two components. One's the diagnosis and then there's the ongoing treatment, which I think -

Mr BEHRAKIS - I think we're on the same page with diagnosis.

Mr HALLIDAY - Yes. The question in a broader piece is, if there are changes that are going to happen to treatment, who does that? How is that assessed and managed? At the moment, as I understand it, and Sonny can correct me if I'm wrong here, but effectively the diagnosis is a psychiatry or a paediatrics sort of setting at this point in time. Then there's a maintenance bit. The framework that we've got at the moment is a psychiatrist can absolutely provide that diagnosis, after an assessment, to the GP and we authorise the GP to prescribe. Any changes to that can be done by the GP according to the instructions of the psychiatrist.

For example, if the authority is for Vyvanse 20mg and the dose needs to go up based on the advice of the psychiatrist to 50mg, the GP would then need to re-apply. However, if the GP originally applied at a higher dose, but they were prescribing at a lower dose, that would be okay. Then they'd have the facility. There's nuance in there about how the application will be made and how the psychiatrist determines what a starting dose would be, up to a maximum dose, for example. If that's not communicated, then we don't actually have any visibility on 'Right, you want to go up to 70mg potentially at another point in time'. Talking about a specific there but -

CHAIR - Can I ask a question on that too? What Simon described is that you might switch to your GP as your sole prescriber for that maintenance phase, but you need to have your checkup with the psychiatrist or paediatrician every two years or every year, whatever it may be. Sorry, two years. Could you have that checkup, but the psychiatrist not need to become the prescriber again because that is where we are hearing this frustration from patients. They have to go to their psychiatrist for their checkup, their GP's prescribing rights need to drop away and their psychiatrist now needs to apply to be the prescriber, then you have to drop away their prescribing rights and be back to your GP and there's paperwork and a bureaucratic process that is involved in that. One solution to that might be co-prescribing. Could another solution be that you have your checkup with the psychiatrist, but the GP remains your prescriber and the psychiatrist speaks to the GP about changes?

Mr HALLIDAY - That is what happens now.

CHAIR - That is what happens now? Okay, great.

Mr BEHRAKIS - Is there then a bit of a clarity in communications, because I think there is a huge amount of - I think there is, and I am not just saying with people who are trying to figure out things in the world of being diagnosed with ADHD, but also, you talk to different clinicians and they have - is there a communications issue then?

Mr HALLIDAY - PSB obviously issues these authorisations, but our activities are across the whole spectrum of regulation and policy in the space. For example, the women's and children's services have an ADHD working group that we contribute to. HealthPathways -

Mr WEBSTER - Primary Health Tasmania Pathways.

Mr HALLIDAY - Thank you. Primary Health Tasmania has also had working groups that we contribute to, to help build the pathways that clinicians can use there, as well as any fact sheets that they are providing on those sorts of things. So, it's not through lack of effort or desire but, absolutely, if we can provide more information, if there's a need for that information to be clearer, we are happy to do so. It is just - in terms of the avenues we have available, we're trying to get the word out there about these things and, at the moment, I think we are actually issuing those authorities for 36 months, not 24 months as standard. The review period by a psychiatrist - that relationship between patient, psychiatrist and GP is really a clinical matter, though.

So, if the GP and the patient sort of go, 'I think we need to actually have a review more frequently,' I think, Sonny, you'll probably want to validate this, but if you have a patient who you're caring for with any type of condition, you'd probably want to see them, at minimum, between one to two years whilst they are getting care from their GP. It is not, 'I see them once and then don't see them for five years,' is it?

Dr ATHERTON - It depends on the presentation and the condition. Some referrals might be for a diagnostic opinion that then guides the GP in their future management - it may not be something that needs future specialist psychiatric follow-up.

CHAIR - We have gone a bit over time Minister, and we have our next minister about to appear. Thank you all very much for appearing and thanks for going a little over time. Did you have anything you wanted to share before we finish? I know you need to be somewhere.

Mr JAENSCH - Earlier, you made reference to there being some other questions.

CHAIR - Yes. If you are happy for us to provide written questions?

Mr JAENSCH - I'm happy to receive a list of questions, but a couple of provisos that I'd like to just put on that. Given I can't accept matters on notice unseen, what I would undertake is that where - this might come as a surprise to you - this is quite a complex area in terms of the administrative arrangements. I will endeavour to get you answers on things that I have authority to take on notice. I won't take anything on notice for another minister. The other thing is, if there are questions which go to - the answers need to be a general nature about how the system works rather than a commentary on any individual case matters. So, that's the only other rider -

CHAIR - I wouldn't expect you, as you said, to take anything on notice that you haven't seen. What we did with Minister Ogilvie was just provide a list of written questions. She may come back and say exactly that - 'This is outside my jurisdiction or there is no data or information about this'. So, if you are happy to take it on faith that we will absolutely accept the advice that your Department gives you on what can and can't be answered, we would be grateful to be able to provide some of those questions on notice and treat them a bit like the ones you get in the Chamber. There might be ones that you get in the Chamber that aren't actually answerable because the data isn't collected or doesn't exist or it's not in your jurisdiction. We won't be waving it around in Estimates saying you haven't answered the question. We're really just after the evidence that will be best to inform our Committee's work.

Mr JAENSCH - Happy to do that. I'd like to thank the Department officials at the table for their work and their answers, and to thank the Committee for your genuine interest in the topic.

The witnesses withdrew.

CHAIR - We are a few minutes overtime, but welcome to today's hearing of the inquiry into the assessment and treatment of ADHD and support services in Tasmania and thank you for giving us your time. Thank you for the written submission as well. We enjoyed the fact that it was a cross-department Government submission. That made it very helpful for the Committee. Could I start by asking each person who will be giving evidence to state their name and the role in which they are appearing before the Committee. That's pre-swearing in. Thank you.

Ms WEBSTER - Ginna Webster, Secretary of the Department for Education, Children and Young People.

Mr POTITO - Adam Potito, Director of Inclusion and Support for Diverse Learners at the Department for Education, Children and Young People.

Ms WILSON - Jodee Wilson, Deputy Secretary, Development and Support at the Department for Education, Children and Young People.

Ms BROOKS - Alison Brooks, Director of Student Support with the Department for Education, Children and Young People.

CHAIR - Thank you. Can I confirm that you've each received and read the guide sent to you by our committee secretary, Michael?

All - Yes.

CHAIR - Just to remind you of the pertinent part, this hearing is covered by parliamentary privilege, which allows individuals to speak with freedom without fear of being sued or questioned in a court or any place outside of parliament. The only exception is that this protection does not extend to statements that may be considered defamatory, if they are repeated or referred to outside of these hearings. It is a public hearing, so people might be watching online. We may have members of the public attend in the room. We don't have any at the moment. There is the option for the Committee to move to *in camera* as well, and we have had other people request that if there's something that you want to share with us that you think might identify people but would still be of use to the Committee's deliberations, at your request, we can move into an *in camera* session.

I've introduced all the members of the Committee. We've got every party and Independents represented in every part of the state, every electorate, except Lyons. We don't have Lyons on this Committee, but every part of the state, more or less. Could I ask the two people at the table, Ginna and Adam, if you could make the statutory declaration in front of you?

Ms GINNA WEBSTER, SECRETARY, **Ms JODEE WILSON**, DEPUTY SECRETARY DEVELOPMENT AND SUPPORT, (VIA WEBEX), **Ms ALISON BROOKS**, DIRECTOR STUDENT SUPPORT (VIA WEBEX) and **MR ADAM POTITO**, DIRECTOR INCLUSION AND DIVERSITY SERVICES, DEPARTMENT FOR EDUCATION, CHILDREN AND YOUNG PEOPLE WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - That's all of the formalities dealt with. Minister, did you want to start with an opening statement?

Ms PALMER - Thank you very much for that Chair. I appreciate the opportunity. Can I also just acknowledge in the room here in Launceston, I have Sarah Quayle from my ministerial team and also in the room with you in Hobart, you have my chief of staff, Carol Roger. They won't be giving evidence today, but they are here to support my team and I thank them for that. I begin by acknowledging the Tasmanian Aboriginal people as the original owners of the land on which we meet. For those of us here in Launceston, we're joining you from the banks of the Kanamaluka river. We would also like to acknowledge the over-representation of Aboriginal people when you're looking at the data that we have on children and adults that are impacted by disability. That's important for us to acknowledge that.

I thank you and the Committee for the opportunity to appear here today to discuss the important inquiry into the assessment and treatment of ADHD and support services. I do want to begin by acknowledging the families and the individuals, some of whom are around these tables today, and the organisations which are impacted by ADHD and those who have been really courageous and made submissions because it is their insights and it is their experiences and their openness to share their stories that helps to give us, as a Government and as a Department, a much deeper understanding of the needs of children and young people with ADHD and what we can do to better support them across our Tasmanian government schools on their educational journeys.

ADHD is one of the most common neurodevelopmental presentations in our classrooms. We recognise that it can affect learning, regulation and wellbeing in really different ways depending on each child. We also know that the community's understanding of ADHD, it does continue to grow, but it does have some way to go and we also acknowledge that early identification and supports are so critical. As the Minister for Education, I am certainly committed to making sure every child and young person in our system is known, safe, well and learning and this means ensuring that learners with ADHD can participate, that they do feel that they are supported and that we are creating an environment in which they can absolutely thrive in our schools.

In Tasmania, we have taken some really strong steps over recent years to support inclusion in our government schools. In 2020, we introduced the Educational Adjustments Disability Funding Model. Now, this is a needs-based model and it allows schools to plan and then apply support based on a student's individual need. Funding and adjustments are provided based on what students require in their classrooms and this includes many students with ADHD and other forms of neurodivergence, which would not have received funding support under previous approaches prior to 2020.

So, each year we do see this model continue to grow. In 2019, under the previous disability funding model, we had 2600 students who received funding support and now, in 2024, that number was 7200 students. Alongside that, annual funding to schools through the Educational Adjustments Model has more than doubled from under $60 million in 2019. We now see a funding commitment of over $125 million last year. Much of this growth is supporting students with ADHD and with other forms of neurodivergence.

It also reflects a growing understanding across our schools of how these needs impact learning and a strong commitment to provide the right support early. I do want to share with the Committee that Tasmania was one of the first states to introduce a needs-based funding model and it has been fantastic that, since then, we have seen a number of other jurisdictions have begun shifting their models to have a very similar approach to what we are doing here and we are seeing implementation still underway in many other parts of the country.

Some states, including Queensland and South Australia, have drawn on Tasmania's experience when designing their own systems and this certainly reflects the leadership that Tasmania has shown in inclusive education and the strength of our model as a nationally recognised leader in support for students with disability. We also absolutely continue to learn and continue to refine our practices here in Tasmania. We are not resting on our laurels in any way.

The independent Review of the Educational Adjustments Model, which was conducted by KPMG in 2023, certainly confirmed the positive outcomes that we are seeing in our schools, and the review found that more students with disability are now receiving supports - and it was good that we were also able to identify that our teaching staff and our school staff also felt that their confidence was increasing and that the support was being delivered earlier. It also highlighted opportunities of how we can improve our model and we are certainly looking at improvement across how the adjustments are planned, how they are documented and then how they are reviewed in particular.

So, there were 12 recommendations that came out of the KPMG report and we accepted all of those and are working through all of those and acting on them now. This includes delivering new professional learning, clearer guidance for school, practical tools to help educators make and monitor adjustments with confidence, a new learning plan platform is now in place to support more consistent and effective planning across schools, and we're also strengthening our school-based teams, with every government school now supported by a School Support and Wellbeing Team to coordinate planning and support for students.

Then, as part of our Lifting Literacy Strategy, we're rolling out the multi-tiered system of supports. This is a framework that gives schools that consistent structure for identifying and responding to students' needs. It includes universal screening for learning and wellbeing, targeted intervention when needed, and coordinated planning for students with more complex needs. At the same time, we are building greater understanding across our schools and our school communities about disability. This year, we're delivering an awareness campaign on the Disability Standards for Education, supported by new resources distributed to all schools. They'll also be distributed to our Child and Family Learning Centres and also our Early Childhood Intervention Services. These actions all form part of our commitment under the Strategic Plan to make sure every child and young person is known, safe, well and learning.

I absolutely acknowledge that while in some respects we are leading the nation in the work that we are doing throughout educational adjustments, we know that we are always trying to improve on that model. We know that we, on a regular basis, come up with a set of circumstances that haven't presented before, and we're always trying to be flexible in our approach and the work that we do in this space. We know that we are seeing these numbers increasing, not just here in Tasmania but certainly across Australia, and so we're always conscious of making sure that, while we need a solid framework and a really great model, we know that we have to be flexible. We have to be able to adjust as things change.

So I want to thank the Committee for your passion in this space. I think it's when we have inquiries like this that we can really flesh out and challenge each other in our thinking and about the work that we're doing. So, as a Government and as a Department, we're grateful for the opportunity to appear before the Committee and we're certainly happy to take any questions. Thank you, Chair.

CHAIR - Thank you so much, Minister. And from a committee perspective, we feel very much the same. This is not an interrogation or an Estimates-style attempt to criticise the very important work that's happening across government. It's much more about hearing from community, hearing about experiences from individual families in the health system, in the education system, and being able to put forward to parliament the very best evidence-based work we can as a committee in providing recommendations.

I want to recognise that there's significant work happening in your Department and we're really grateful for that as a committee.

I want to ask a question, and I know the beginning of it is going to sound like it's immediately outside of your ministerial portfolio, because it kind of is, but bear with me. One of the things that we've heard from families is the difficulty in getting into early intervention supports, even when ADHD or other neurodiverse conditions are identified very early in a child's life. So somebody, a child, might be identified at 18 months or one year old, or certainly pre-school age, as potentially needing some early intervention supports. And in the health system, there are significant delays. That's the part that I understand is very much outside of your jurisdiction, and the Committee is hearing evidence on that from other ministers. But the part of it that I would really love to hear reflections from you and your Department on is the challenge that that presents when a young person starts kindergarten, or perhaps Launch into Learning, but they come to you with quite often known neurodiversity that that child hasn't been able to access treatment for in an early intervention pre-school-age environment, and what kind of challenges that provides for teachers and others working in schools to support those children who may still well be on those Health Department waitlists for interventions in that system.

Ms PALMER - I think that's a really good question, and it's something we've actually really challenged ourselves with in preparation for this appearance today before the Committee. And I think it also really lays out the importance of our Child and Family Learning Centres and the work that is able to be done there. I mean, ideally, we are hoping that by the time children are getting to kindergarten that, where they have had an interaction, whether that be through the Early Childhood Inclusion Service (ECIS) or particularly Child and Family Learning Centres, early learning for three-year-olds, that, if there is any indication, that there might need to be further investigation or supports put in, that we can actually have the opportunity to do that prior to them getting to kindergarten. But we absolutely acknowledge that, for a cohort of families, sometimes for a student, their very first start on their educational journey is when they step into a kindergarten class.

So, I will pass to Jodee to speak a little bit to you about what that actually looks like. But I can say that this is something we really focus on when it comes to teacher training and what happens when someone is learning to become a teacher and the work that is done through the university, which is really important. All our pre-service teachers at university actually complete a unit on inclusive education and understanding student differences, and so that is giving them that first taste of what they might need to, even as a new teacher, be looking for in their classrooms.

There is also a lot of support for teachers in the classroom to help them navigate their way through, especially in term one. But I will hand over to Jodee and Alison to give you a more in-depth understanding of the support that is given in the classroom.

Ms WILSON - Great. Thanks, Minister. Certainly, the early identification for what a teacher notices about the way in which a child is presenting is really important to determine their learning needs and what the school and the classroom needs to cater for in order to support their introduction into school and their learning journey. As the Minister indicated, the association, with participation in CFLC programs, or in the ECIS programs, gives those children the avenue to progress and maintain those supports well before they enter the kindergarten classrooms.

As you mentioned, the Launching into Learning is another way, another avenue, another program where there are early insights gained by the teachers and by the professionals in those spaces in order that the learning needs can be determined. The early identification isn't dependent on a diagnosis; teachers are really skilled at being able to identify the behaviours of a young person and a little person to be able to really see what their strengths might be, where there might be challenges by way of gaps in their learning or gaps in their ability to regulate their behaviour, and are supported not only through their own expertise, but through connecting with other adults in the school setting to be able to meet their needs.

In each of our schools, there are a number of people, professionals, who have a level of skill and expertise that can augment what the classroom teacher is able to provide, whether it is the support teacher who is able to supplement the skills that the classroom teacher might have in being able to recognise what the student needs and plan for their next steps; or whether it is a focus for the Student Support and Wellbeing Team by being able to triage the information they are getting and prioritise that that young person may need to be prioritised for further assessments, potentially, in the first instance through the professional support staff. Alison, is there more to add?

Ms BROOKS - I guess just to focus on it being a strength-based approach for teachers. So, rather than looking at it as a deficit, they're treating every child as an individual and looking at their strengths, their behaviours and intervening with their skillset, and I think that is something to consider, that it is not all doom and gloom for these little people when they come in. Because teachers are very skilled in looking for the strengths and developing the behaviours and working with the behaviours they are presented with, but to pick up on what Jodee had said, all of those teachers have access to professional support staff, inclusive practice coaches, school health nurses - in those spaces to get support, to build their toolbox of skills to be able to work with these young people. So it's not as if - I guess the best way to describe it is that we come from an educational perspective of intervention rather than a health perspective. So, things don't stop or stall until an intervention or a diagnosis has happened, we continue to work.

Ms PALMER - I think that's a really important point, even from a funding perspective, that, no, we don't have to have a diagnosis of a young person to get that resourcing. That's been a change in the model, which means we're seeing a lot more young people who we are supporting because we accept that, across health and education, we have an issue with waiting lists to get in to see some of our allied health professionals. We don't want to wait for that before we are able to support a young person. So it's a very proactive model.

CHAIR - Yes, it is good and it does help families. Thank you for that very detailed description of the educational supports that are available. I know that they help families, but I suppose the sentiment that I was trying to get at with what we've heard from parents is, the frustration that they have in knowing what their child needs, and they can't access it until school-based. And then, as you've described, minister, Jodee and Alison, there are a range of supports available which are really beneficial to those young people when they are there. From the perspective of some of these parents, they often have done a lot of their own research, or they've managed to travel and pay for some interventions through the private system, either here or interstate, and they know that their young person is starting their education journey on the back foot because they haven't been able to access early intervention supports from a young age. As I said, I know that part's outside of your jurisdiction, but I just wondered why there is really - what you've described as very intensive support available inside the school system. How much easier would it be for teachers and for those learners if they had had access to that early intervention support and were starting school on the front foot? Does that make sense?

Ms PALMER - It does, but I think it's difficult. I mean, obviously, at a very high level, the earlier any intervention is, we know the benefits of that, but for us here today, and staying in my lane as Education Minister, the minute we can get our hands on a little person, we're doing everything that we possibly can. I think this is where the importance lies in ensuring that communities are aware of our CFLCs, getting families into our CFLCs. We know that there is support there, it's free, they can be there in a very comfortable, non-judgmental, it's not a medical facility, it's a play area.

CHAIR - I might go to Ms Rosol. I don't want to hog the Committee's entire time.

Ms ROSOL - Thank you so much for all that information you've shared. It kind of - the questions that I've prepared, I wrote based on diagnosis being important and what you're saying is that you look at the bigger picture and don't see diagnosis as critical to students receiving support, or children in CFLCs. So, thank you for that. I am curious to know, because I know that CFLCs have psychologists and allied health in there, what's the FTE allocation in CFLCs for the different roles, and what kind of wait times are you seeing for referrals? Children who've been referred, or haven't been referred but their behaviours and needs have been identified, how long are children needing to wait before they can be seen and assessed or supported?

Ms PALMER - Thank you very much for that question. I'll ask Alison to address that one for you.

Ms BROOKS - Thank you, Minister. First of all, the allocation for professional support staff to CFLCs is not the same as it is to schools, so it's slightly different. They each have access to speech and language pathology, but not to psychology. We don't have a diagnostic service within CFLCs. That's important to note. I guess, in saying that, we also acknowledge that the little people in those spaces may not always be ready for a diagnosis at that point in time. I guess it's the beginning of the journey. Once they hit school, so once they come into contact with school through the kindergarten, that's when they would have direct access to a psychologist, for example, for diagnostic purposes.

One thing I wanted to note is our partnership with health through the Head to Health Program. Currently, there are three new Head to Health for kids clinics that are co-located in three spots across the state: one at Brighton, one at East Tamar here in Launceston and one in Burnie. The purpose of that program is to work with other professionals and other agencies, in particular, Education, to be able to work in that early identification space. That effectively is a multidisciplinary team working with the resources that are available within the CFLCs to look at diagnosis and early intervention for children and families. I guess that's one way that we're working into that space to help with that early identification. Does that answer your question?

Ms ROSOL - I don't know. Do you gather data on wait times and that kind of thing?

Ms WEBSTER - Alison might be able to provide some information on wait times.

Ms BROOKS - We do, but it's not solid data because we don't have a consistent mechanism for gathering that data. Individual professional support staff would keep that data. I know that the raw data that we look at is something like 18 months wait time for a diagnosis from a psychologist. I just want to add into that, it's also within a triage system and prioritising early identification is within that. I can't speak to the wait time for little people because that would be in amongst that data. Certainly, the emphasis is on early identification and early diagnosis for younger people so that we can get that intervention as early as possible.

Ms ROSOL - Some of my knowledge comes from working in a school quite a few years ago. It's a little bit out of date. I know that there used to be quite a lag time when children were diagnosed and there was a process that had to be gone through before funding was allocated the next year. With the new model that you have, the Educational Adjustment Funding Model, what kind of lag time, or how long does it take for a child or a student to be identified as needing extra supports and that being provided within the school?

Ms PALMER - I will hand over to Adam to talk to that, but in preparation for today, we had a deep dive into this. In that first term of school is where there is an opportunity when you have a new little one coming into the class. There's a three-week mark, a seven-week mark and a 10-week mark. We end up with the teacher having about 12 weeks where they can go, 'Something's not quite right here and we need to move in support of that little person.' They have that whole first term where using their expertise and the support that the Department is able to give, to ascertain, 'Okay, I might have a couple of children here who haven't been on our radar before, we're going to need some extra support there.' Then they're able to apply for that support without having to wait.

Please step in, Adam, if I've got that wrong, but that's my understanding of how the model works to ensure that in that first term we're able to identify if there are children who need to be supported. Adam, can I hand over to you? I'm sure you'll say that in a much more eloquent way.

Mr POTITO - Thank you, Minister. There are some levels to this or some different approaches depending on the circumstances. For new students to a government school, within the first 12 weeks of their enrolment, a process can be undertaken at any point throughout the school year, whenever they arrive, for that funding to be backdated to the date of enrolment.

The point that you've raised is still true though for students that have been identified for the first time, who have been an existing enrolment, they’ve been at the school for maybe a longer time than 12 weeks, maybe years even, and there's a new point of need that's arisen. It wasn't there last year; it's there this year. Our process for educational adjustments, moderation, determination of the adjustment levels, et cetera, is in line with the NCCD (Nationally Consistent Collection of Data). We've aligned that for efficiency. That gets completed by mid-year, and then the funding, at this point in time, for those students arrives in the next year. That's similar to what you've described. There are some students that will get funded straight away if they're new to our system, but if there is a new need or a change level for an existing student, there is a delay at this stage.

Ms ROSOL - Is there any way of that being reduced? What's the reason for there needing to be that delay?

Mr POTITO - Yeah, we're definitely actively looking at that, and the KPMG review recommendations 10, 11 and 12 went to that, and that's currently being explored about how we do that.

Mr BEHRAKIS - I'm just jumping off there. When we're talking about that sort of conscious early identification, and we're talking about first term and getting in, what grade level were we talking about? I might have missed that.

Mr POTITO - That's at any grade level. It's obviously most pertinent at kindergarten. There's a point on that, that we did talk about in our deep dive in preparation for this. Just giving a really good understanding of it. Many of our young people come through our ECIS centres. However, not all do. Those that are coming through the ECIS centres, the educational adjustment team work with the ECIS staff to put in a funding moderation for them, so they can be supported with additional funding in their school from the commencement of kindergarten. If a new need is identified in kindergarten within the first 12 weeks, then that can be funded, as we've just described.

What we've talked about is if that emerges later in the year because we haven't known that student particularly well or for whatever reason it just hasn't been identified, that's where the delay comes in. The first 12 weeks would be true for a student arriving at any year level, right through to year 12.

Mr BEHRAKIS - Either if it became apparent later on - not later on in the year, but say maybe it didn't become apparent until grade six or if you had somebody that's moved to Tasmania or moved schools or whatever, and you've got someone in grade eight - teachers have that ability to say, 'I think that student needs to or should get assessed.' From the perspective of the school, we're talking about the diagnosis - you don't base things based off diagnosis - but for that child, the teachers that work with them every day are probably the ones that are most able to identify that early on because, obviously, the earlier the better.

Mr POTITO - You're absolutely right. There is a capacity at any year level for that to occur. There are some different approaches we have for students that are new to Tasmania or moving from the non-government system into our government schools. That approach is more responsive, but as it currently stands, the money that supports them can be given to the school from the date of enrolment rather than waiting for the next year, but that's at any year level.

A really key point there - I'm not sure if I can speak about it, but Alison can too - is about the School Support and Wellbeing Team. The School Support and Wellbeing Team was a team that's been in many schools for a long time, but it’s been formalised through COVID to make sure that all students were known. It has now become a procedure. It's a must. It's been a subtle shift. I wouldn't say it's a high degree of compliance, because schools were largely doing it anyway, but it gives some formality around a multidisciplinary team within the school for matters to be escalated to for consideration. That includes part of what you mentioned there about diagnosis, about then ensuring that referrals through to professional support staff, whether it's speech and language, social work, or school psychology, can be considered by that team and then put forward, and that's a team that meets - in the procedure, I think it's at least a couple times per term, but I'd need to check on that. It's a minimum standard that we have. It often meets weekly or fortnightly within a school to bring that forward and then, based upon the need, whether that diagnosis happens really soon or is pushed out further, their diagnosis, as Alison described, is triaged. It's not based upon the point of when the information has gone, you haven't gone to the back of the list. It's with, obviously, an early intervention focus as well.

Ms PALMER - Listening to your question before, I wonder if Alison could have the opportunity just to talk you through what actually happens to support a child in this circumstance that sits outside of educational adjustments anyway. I think that would be good to have an understanding of, of in a classroom what is absolutely already there and available to support any child that we might find with a condition like ADHD.

Ms BROOKS - I might just go back to the ECIS. I just wanted to pick up on ECIS intervention because we do have professional support staff that are allocated through our ECIS programs and in many cases an assessment would be done at that level, and whilst sometimes diagnosis doesn't result from that assessment, what comes from that is a really comprehensive learning and transition plan that identifies some of the supports and adjustments that need to be made as the young person transitions into formal school. I think that's a very important step that we need to be reminded of. Then as that young person comes into school and those behaviours are identified, that's when we have the learning plan mechanism that is a way of capturing the adjustments that are needed.

I think the easiest way to talk about them is what the individual teacher does and that's based on the teacher's understanding and skill level. They would be things like making those adjustments around visual schedules, understanding how the young person communicates, putting in supports for communication by making things more visual, making things more tactile for example, whether or not an alternative communication device or mechanism needed to be used. Sometimes, that might be through assisted technology - through an iPad - sometimes it might be through visual schedules or just normal everyday activities. The way that the classroom is structured, being able to have movement breaks, making sure that there's support through a teacher assistant (TA) in that classroom.

I want to make it very clear that I'm not saying that support is provided by the TA for a student with a disability, but the TA provides support to the teacher within the classroom to be able to meet the needs of all the children in that class, freeing up the teacher to be able to do more in depth work around what's needed for that young person.

Teachers have amazing skills, as we know, and I think if we talk to individual teachers they would undersell their skill level and they would think, 'I need more support.' What we do know is that teachers have an amazing level of skill and understanding of how young children learn and what they do is they look to, 'Where is that young person now and where do I need to take that young person next?' They're always homing in on what is the next skill level that

that young person needs. For example, someone with ADHD might present with some dysregulated behaviours and an inability to manage their emotions. That would be the first step that the teacher would take, is to build those skills and help that young person to manage their emotions. That might be through sensory play, it might be through breaks, it might be managing the climate of the classroom, for example.

Then we'd look at what are the school wide supports and that taps into where Adam was talking about the School Support and Wellbeing Team, the multidisciplinary approach. Those young people would be talked about at those meetings which generally happen twice a term or could happen more frequently as the need arises. Then we would be tapping into the expertise sitting around that table, whether it be the speech and language pathologist, the psychologist, social worker, school health nurse, and they would talk about what else we can offer in this space - do we need to provide professional learning to the school, to the cohort of teachers?

The other layer of support we have is through student support, which is the team that I lead and that, again, includes the professional support staff, but also accessibility services and the inclusive practice team. Our inclusive practice coaches provide that at-the-shoulder coaching around interventions and adjustments for young people with disability or significant complex behaviours.

Ms ROSOL - Beautiful, thank you. Thanks, Chair.

CHAIR - Can I ask a question that goes to some of that information? Alison, thank you very much for describing the different levels of assessment and support that can be provided. Much of what you told us would go to specific disabilities, very specific supports such as learning electronic devices or a particular TA or mobility supports that might be required. One of the things that we've heard from psychologists at this committee is about the kind of adjustments that might be needed in a classroom, particularly primary school classrooms, to support a neurodivergent child. You did go to some of those, Alison, in the information that you shared, thank you. Things like movement breaks or making the classroom just physically feel a little different in terms of its presentation. The way that they have described those kind of interventions for neurodiverse children and learners is that they - well, to put it in layperson's terms, and forgive me, I don't have a teaching background, but the way that psychologists have described it is many of those interventions that benefit neurodiverse kids would not disbenefit a non-neurodiverse child. If a classroom was set up, for example, to have regular movement breaks or be more visual or physically presented in a different way, any neurodiverse kid, identified or not, would benefit from that kind of changed environment and a neurotypical child wouldn't suffer in any way - and just whether, in terms of pedagogy and future planning, whether that's in the thinking of the support teams and the Department going forward - recognising that, as the Minister said in her opening statement, there is an increase not only in diagnosis and identification of neurodiversity, but of the understanding of neurodiversity as well.

As I said with the Mental Health Minister at the table an hour or so ago, I don't think that indicates an increase in prevalence, it indicates an increase in understanding - that neurodiversity is more common than not and I suppose, in a nutshell, from these psychologists, what they're seeing with their patient base is, if we all operated in a world that is suitable for a neurodiverse person, everyone wins. I know that sounds like a bit of a 'change the world' kind of question, but I'm wondering, when it comes down to tangible things that could happen in classrooms, particularly primary school classrooms - but high schools and colleges too -

whether that's in the thinking of those support teams that you manage, in terms of changing things that might not be a terribly expensive or huge structural change, but just day-to-day things that might benefit all learners. Sorry, that was a very long question, but I hope that you get the gist of where I am coming from.

Ms PALMER - No, we absolutely do, Chair, and if you were in the room up here in Launceston with us, you would see that Jodee and Alison are almost fighting to be able to answer this question because it is something that is very much part of what is happening. So, I will hand to Jodee to answer that question.

Ms WILSON - Thank you. In the Minister's opening remarks, she referred to the proactive framework of multitiered system of supports. A multitier system of supports goes to the point that you are making. At the tier one level, it is universal practices and supports that benefit everyone. So, those practices, as you identified, such as the way in which classrooms are set up, brain breaks, calm spaces - they are of benefit to all students - yes, maybe introduced as a consequence of those students with neurodivergent conditions, but not necessarily. Then the second tier is for those students who require just a little bit more of that sort of dosage of experience, exposure to the sorts of practices that are going to help them be able to access the learning that the teacher is offering. Then, the third tier is, for a very few students, there needs to be some very specific one-to-one strategies that the teacher deploys or that the school works to provide, so that the student is meeting their need. It's a bit like if you put in a ramp, everyone can access the next level, you don't need stairs. It's 'What are those things that benefit everybody?' But, more specifically, Alison?

Ms BROOKS - Thank you, Jodee. That sings to my heart. That is the work of student support, how do we create universally designed classrooms that allow access for every young person who walks through or comes through our doors? That is our bread and butter. I would like to point out the work of our Inclusive Practice Team and what they're doing with schools. As an example, we talk about executive functioning. It's probably something teachers wouldn't have talked about a few years back, but now if we mention executive functioning to a teacher, they would know exactly what that means. That means this young person has trouble with decision-making, this young person has trouble with impulse control. Through the professional learning that's provided through our inclusive practice coaches, teachers are equipped to understand what that means and, therefore, can provide a classroom that tailors to those needs.

One of our biggest issues is the complex behaviours that arise as the result of things like deficits in executive functioning and impulse control. Then we see negative behaviours. We see consequences and punishment, and this is something that we're trying to work really hard against, to understand that this is a function of the disability, and it is not bad or naughty behaviour. I think in that way, we're minimising exclusionary practices and maximising those inclusionary practices within the classroom.

CHAIR - That's great to hear.

Ms PALMER - I certainly think when you look at the new schools that have been built in Legana and Brighton, primary and high schools, the way that those schools have been designed, the way those classrooms have been designed, very much goes to what you were saying Chair, about, 'This is good for everyone'. It's not just in schools that are fabulous new builds. Pretty much every school I visit now has found a space that is a quiet, safe space with all the sensory needs, and it's not even identified by the students as a place where, 'That kid with ADHD has to go there.' Quite often, girls around grades five and six, will say, 'When I can't stop crying, I'll come in here.' So it is being used by all students. You're quite right in saying that it's good for everybody and it's very much part of that inclusion that it is for everybody. It's not a service just for one cohort of kids.

CHAIR - That's great to hear, thank you. I'll go to Ms Rosol. I think you had one about funding.

Ms ROSOL - I had a follow-up question on the funding because you were talking about the process for accessing the funding. Once it's been allocated to a school or a student - it's allocated to the school. If that student moves, what's the process for that funding moving with them?

Mr POTITO - The money does follow the student to the new school.

Ms ROSOL - How long does it take?

Mr POTITO - It's straightaway - if it's a government school to government school. If it's a non-government sector, they have a parallel process in their sector about how they would manage. Within our schools, it follows the student immediately.

Ms ROSOL - Staying with funding, if that's alright. You talked a lot about the enormous increase in need that you've observed in the schools and there's been the increase in funding that you've allocated to providing supports. What kind of measures are you taking for whether the funding is matching the level of need? Do you have data? I've got some questions here on the ratio of school psychologists to numbers of students, and have you got before and after information on that, that shows how that's going? What measures are you using? What are the wait times? How have wait times changed with that increased funding - understanding that need has increased at the same time, so it is not a simple answer?

Mr POTITO - If that question is to me, I wonder if the need has increased or our understanding has increased. I think that the need -

Mr BEHRAKIS - Yes, capturing more kids that we did not capture before.

Mr POTITO - I think we have identified and are now including adjustments and funded adjustments and supports for students who were always there - that are now growing that. So, the key measure is there, and Alison might speak to the growth in professional support staff after the last decade, and I'll go to Alison in a moment, but in terms of the growth of the Educational Adjustments Model, the Minister spoke about that in the opening - that under the old model we had 2600 students. I think it was something like that -

CHAIR - Yes, I wrote that down and now you have 7200.

Mr POTITO - Yes, and now the 7200, but parallel to that, the funding for those students, in the Educational Adjustments Funding at last year - just to reiterate that- in 2019 it was under $60 million allocated to schools, which includes two elements. One of those is the allocation of support teachers and the other part of it is funding, they call it 'cash', but funding to schools to be able to support the need as they see fit, and that was around just under $60 million. Last year was $125.6 million, I think, or $125.8 million, so $125 million; that's continued to grow and, likewise, it's part of a national trend in better understanding the needs of students; certainly neurodiversity, autism, ADHD in particular, the growth areas, and we have continued to see that growth and the funding has grown with it.

So yes, Alison might want to speak about the growth rates in professional support staff, and there is some good news there.

Ms BROOKS - Thanks, Adam. Absolutely there is, and look, in bare figures, we've seen a 60 per cent increase in approved establishment for professional support staff, including psychologists, since March 2014. So, that's an enormous growth. I guess there are a couple of points to make in terms of the multidisciplinary approach of those professional support staff. So, we are not just relying on psychologists or speech and language pathologists. From a student support perspective, we work together as a multidisciplinary team so that we are making sure that there are no gaps in that service.

The managers of those teams meet weekly to talk about how they can improve that service to schools and also, to note, that we don't wait for a diagnosis for funding for a student to get support; that happens and I can use an example: a principal that I spoke to in the last couple of weeks was having some issues with the family, saying, ‘My child hasn't been funded’ and he said to that family, 'Even with funding, the support for your child would not change because we would give the same level of support to your child with or without funding'.

Support teachers, Jodee, I think just to note, that in 2022, there were 117 support teachers in schools, and in 2024, there are now 286 - 2020 sorry.

Mr POTITO - That's FTE, Allison.

Ms BROOKS - So, from 2020 to 2024, we have seen that double, more than double.

Ms ROSOL - So, just one more question following up on that because I think one measure might be wait times for seeing the support staff. What's happened with wait times over this period where you have increased the funding and changed the model?

Ms BROOKS - We've probably not seen a huge change in wait times, and I think that speaks to Adam's point that we are identifying needs and we are making sure that those young people are referred. So, I think early identification of need, increasing the number of support staff, but we're still seeing wait times, I have to say, but I think our sophistication in working in that multitiered system of support and working more holistically across schools to build the capability of staff means that we are getting support to children when they need it.

Ms PALMER - And I think this is also where the strategies come in. We're offering scholarships and recruiting far and wide across Australia, which is difficult because every state and territory across Australia is experiencing issues in getting speech and language pathologists and psychologists.

We have gone out internationally in our search and offered scholarships to graduate psychologists. We had five, I believe, come on board under that program. We have five new psychologists and five new speech and language pathologists who are now in our schools. I had the opportunity to meet a couple of them the other day, one from Western Australia, one from Victoria. We still have another 10 of those scholarships that we've gone out again across

Australia and internationally to encourage new graduates to come to Tasmania and to work in our schools environment.

Mrs BESWICK - I have a little question about support staff.

Ms PALMER - Miriam, sorry, could you speak into your microphone? Sorry, it's just a bit hard to hear.

Mrs BESWICK - When the funding is allocated how much control is with the school and the principal versus, 'This is what you do with it’ from a departmental point of view?

Mr POTITO - Thank you for the question. It's a really good question. It's an area that there is some confusion, particularly for those families that are also engaging with the NDIS because the process is different. It comes in two parts, as I said earlier: every school in Tasmania gets a minimum of 0.2 of a full-time equivalent of a support teacher, and that scales proportionally based upon the number of students within the school with disability.

No school has less than 0.2, but many schools have way more than 0.2 in terms of an allocation. The other part of it - the work of the support teachers - and we've talked about capability-building, and that is skilled work and the type of learning that they would get from our potential guidance, including the Inclusive Practice Team and our teams around the work that they do, and that spreads through the school. So that's the central guidance in that space.

The funding that goes to the school is for the school to make the adjustments as they see fit, and a really key consideration there, and it's tied in with work that we've identified within the Department around our Strategic Plan, is ensuring families have a voice. That happens through the development of the learning plan. So the process is that a school identifies need or a family identifies need, have a conversation about what that may be, the parents might come to the school with evidence of disability, and they have the conversation, and a learning plan gets developed early, they agree upon adjustments and goals for that young person. Our educational adjustment moderator's process comes in, and that gets funded.

It's around the funding for those adjustments and goals that are agreed at the learning plan development stage. So it is very flexible for a school to determine how they use it. Most schools use it largely for employment of teacher assistants, but that's not prescriptive; they can use it as they see fit in that space.

And so it could be, and we're talking there about universal inclusive education practices, if they wanted to create modifications to a room to decrease its sensory profile, to make it quieter, they could use that money for that if that's how they think it's best going to be used.

CHAIR - That decision is made at a school level.

Mr POTITO - Did you have any more -

CHAIR - I just had a question about NDIS that came to my mind as you were speaking, Adam. If a student has an NDIS support worker, is it routinely possible for that worker to be with them in a school environment, or is it kind of student-by-student based on -

Mr POTITO - I'm happy again to answer that question. No, it's not. There's a demarcation there. We have an external NDIS visitor policy. It's not the right word for it, but if an NDIS provider requests for some work to occur within the school, then we've got some processes around that. It's at a school level decision-making whether that works for the school but in terms of the provision of daily operational support, that's with the school, not with the NDIS and it's very clear.

It has been called a major shift of the applied tables of support under the NDIS - which bits are the NDIS, which bits are the responsibility of education, like a scope kind of document. In that scope document it's very clear. We have some things such as personal care which is an in-kind support through the NDIS but there's no practical way to deliver personal care such as toileting or other hygiene considerations other than by school staff. That's a way that's done. In the school day, it's school staff doing the work. NDIS providers can visit under certain circumstances to do particular work, but there are some limits around that.

Ms PALMER - Through you, Chair, I'll ask Alison just to add a little bit more about the interaction between an NDIS team and the school team for a child.

Ms BROOKS - Thank you, Minister, I agree with what Adam is saying. That's absolutely correct. One area where we may see some interaction is through the care team structure where schools would be very open to including NDIS support people through that structure and taking on board their recommendations to make sure that that's reflected in the learning plan and the supports that are available to support children whilst they're at school.

Ms PALMER - You have that continuity about how they're being supported outside of school and how they're being supported inside of school.

Ms BROOKS - That's right. For example, we don't have occupational therapists within our system, so we would be very open to including any occupational therapist that was part of a child's NDIS plan into the planning for that young person and having them on site all through that care team structure to be able to build on and capitalise on their advice and skill set.

Mr BEHRAKIS - When we talk about the capacity and having schools equipped to provide that ongoing support for neurodiverse students, is that a bare minimum for all schools or are different schools differently equipped to support neurodiverse students? I stress anecdotally, because I think it's important to stress anecdotally. I've had some members of the community tell me that they've had students that have been diagnosed with ADHD and then their schools have told them, 'Sorry, we're not really equipped to support your child here', and similar stories. Once again, I stress anecdotally because no one's really felt comfortable to come forward with specific details, but are there instances of that happening and is that an issue where some schools aren't as equipped?

Ms PALMER - Obviously, I don't know the schools you're referring to. If they were outside of our government schools, then I obviously can't speak to families' experiences there. But I can say if you were to have an example of that happening to a family in one of our government schools, I would hope you would reach out immediately because that is not our policy. That is not how we roll. Every child is entitled to an education in our government schools. I hope today that you'll go away from this session seeing the passion and commitment that we have in this space to ensuring that every child has an opportunity to thrive.

We know we don't always get it right. We know that and that's why we're constantly trying to improve. That's why we have the KPMG inquiry into educational adjustments. If you ever did have anyone that had an issue like that, we have an inquiries and complaints process. We would hope that they would feed into that. It's very accessible through the website but, of course, a representation to your local member, often for families in distress, is a good place to start and members can certainly help people step through that process.

That is not our policy and we would take issue if we knew that that was happening in a school. Again, can I stress that I'm talking about our government schools and our policy in this space. We don't have leverage over policies in independent or Catholic schools around that.

Ms ROSOL - I have some questions around professional learning because you mentioned with the KPMG inquiry that there were recommendations and that some of your responses were to increase professional learning for teachers. I'm curious about what's available at the moment and how do teachers access that? Is it a school responsibility for teachers to access that, or is that something that is being planned at a department level?

Ms PALMER - There's a lot happening in this space because we absolutely recognise that good support depends on the skills and in particular the confidence of our educators, which is why, as a Department, there's quite an emphasis on prioritising that practical training and clear advice. I'll hand over to Jodee for a more in-depth analysis of that for you.

Ms WILSON - Teachers develop the skills that they need, in order to become more confident with their inclusive practical strategies that are needed to support all our learners. They access training at multiple levels. Our improvement practice coaches provide mentoring and at-the-shoulder support to build the skills in a practical way, as I say, at the shoulder. There's also professional learning that is undertaken by the support teacher allocated to each school.

Going back to the previous question, every school has a resource that covers an allocation of a support teacher, allocations of access to professional support staff, to the in-practice coach team, to the School Support and Wellbeing Team. There is a lot of human resource that exists in the school and there is also resource outside the school, through the Student Support Team, through the team that works with Adam in relation to supporting students with diverse learners that all go to providing levels of support and training and professional learning bespoke to the areas of need. There would be direct professional learning related to supporting students with ADHD and other neurodivergent conditions, equally to those that are also available for supporting students with other disabilities.

Ms PALMER - Another point that's probably good to mention with regard to first-year teachers who are starting out and beginning their career, they actually attend a specialised learning program with the Inclusive Practice Team at the beginning of their teaching careers. We try to get that support in there straight up.

Ms ROSOL - How often would external education be provided or accessible for staff? I think a lot of what you talked about there was internal within the Education Department, but say if there was an expert education day that was available, are staff able to access that? Are they supported to access that with relief teachers?

Ms PALMER - I'm going to get Jodee and Alison to talk to this. Schools are able to say, 'We would like an external provider to help us in that space.' There is obviously quality controls that have to be carefully looked at and thought through. I might ask Jodee to expand.

Ms WILSON - Definitely, schools have the ability to access a variety of external providers to deliver professional learning to their staff. Generally speaking, as a Department, we try to be really responsive to the needs that we identify from the ground. The people resources that exist within the school and those that exist within the Department more broadly are really skilled at being able to galvanise the interests and needs of the people that are working directly with the children to determine what additional professional learning and supports they might need. On occasion, we would outsource and broker people to come in and deliver that professional learning. We've done so in relation to the modules around the disability standards in education. Generally speaking, we would be wanting to be sure that the guidance that the schools access is well curated to be sure that it lines up with the evidence that exists more broadly and not necessarily delivered by a provider that doesn't meet the threshold of quality.

Ms ROSOL - Thank you. Just one more question coming from that is around - you've talked about the improvement practice coaches and that team having the skills to provide the information and the education to teachers on the ground. What education are they accessing? If they're the specialists within the Department, where do they get their training and expertise from?

Ms PALMER - Yes, that's a really good question. I'll ask Alison to step you through that.

Ms BROOKS - I'll just clarify. We're talking about the Inclusive Practice Team, which includes a team of 16 inclusive practice coaches. Each of those coaches is allocated to a school across the state, so every school has access to a coach; then there are two leads who offer an extra level of support and expertise as needed. That team is very proactive in its professional learning. The manager of that team is very proactive in accessing evidence-based, up-to-date professional learning for the team.

They learn on two levels. One is about pedagogical practices, which is led by the manager. The other is around expert input. Of particular note is that last year, four members of that team participated in a Hardie Fellowship and visited the United States of America to look at best practice in inclusive practice. They are very active in that space. They are also highly connected with other professional organisations across the nation, looking at best practice. They're also very discerning in their collection or advocacy for particular people. One of the people they have supported after visiting him in America is Dr Ross Green, in relation to collaborative problem-solving. Dr Green visited Hobart earlier this year and, through the Inclusive Practice Team, that network went out to say, 'Here's someone we think schools need to be accessing. His practices will positively impact how we are managing to meet the needs of our people.' That's just one example. So the answer is yes, very proactive in building their capacity and professional learning.

Ms ROSOL - Thank you. If an individual teacher found out about a learning day and wanted to go to that, is there a way for them to do that? Would that be supported?

Ms BROOKS - Just maybe to add, yes, but I guess we're relying on the leadership of the school. One way that the Inclusive Practice Team supports that approach is they develop a plan with each principal at the beginning of the year around the needs of that school. That’s one way of building in that accountability. If, for example, a principal was saying we have a significant number of young people diagnosed with ADHD, then the coach would be talking specifically to that principal about, 'This is the need then, of your school that you've identified based on the data. We need to write that up in the plan.' So, what are the things we would need to do, including professional learning.

CHAIR - Just coming out of that, I wonder, it’s a bit of an administrative question really, but one that you might be happy to take on notice. You've mentioned lots of different teams, the Inclusive Practice Team, but also other student support teams that work across schools, which are probably at a more granular level than the departmental organisation chart that I’ve opened up while we’ve been chatting. I just wonder if there’s another organisation chart, if that makes sense, that might be useful for the Committee to understand the different teams that work in this space and where the different lines of responsibility sit across those teams, or if there’s much overlap between them?

Ms PALMER - Yes. I think it would be good for us to give that to you in writing rather than trying to explain it verbally. I think, you know, in your head. So if we could take that on notice, Chair, and we’ll provide that to you.

CHAIR - That would be really helpful. Thank you.

Mr BEHRAKIS - When students, children, are identified as neurodiverse or specifically, in this context, with ADHD, is there support given to the parents to help them navigate that? That could be something that sits outside DECYP, but is that something that there is scope for, to help parents know how to manage and support their own children and what to do and how to navigate things with school and whatnot? Often you hear about parents not even knowing what to do and not having easy access to that information.

Ms WILSON - Each child who requires educational adjustments has a learning plan and the learning plan is co-constructed with the family. As the family work with the school to identify the child's strengths and their assets and the goals for their learning, the family has input into the plan and, as a consequence of that, has a better idea about what the school can do and then flow-on is that that would then follow through to the family.

Our work, certainly, is around supporting the educational adjustments in order for the young person to be able to thrive in their learning trajectory but, through those conversations, reviewed at least twice yearly with the families, are a really important part to ensure that the school, the teacher, and the family are working in partnership, in the best interest of the child, accessing their learning needs and being sure that they are known, in a way that supports the information to be clear for what occurs at home but also at school.

Ms PALMER - I think it's probably important to add that we absolutely know, and it was identified in the recommendation from the independent education review, that the more families are involved in their children's education and kept engaged, the better educational outcomes we have. The intent is that families are involved in that process and we believe that is best practice but, of course, families make their own decisions about the level of involvement they wish to have and we have to work and be respectful of that.

Ms WILSON - Certainly one of the positives from the KPMG report was that there were much improved, stronger family partnerships as a consequence of the work that we've been undertaking.

Mr POTITO - Can I just add two little pieces to that? To support that, in response to the KPMG review and our work around disability standards for education, the Australian Government produced some terrific resources with Children and Young People with Disability Australia (CYDA) for families. We thought they were great too, and we sought the opportunity to print them and they were delighted that we did. We have shared them to all schools, Child and Family Learning Centres and ECIS Centres at the start of the school year as the Minister said in the opening address.

There are two documents. One, 'Advocating for your child in the early years,' so helping to transition to school, and the other point of need that we thought was really targeted was around moving into secondary school. We have thousands of those documents now in the public domain to help build community understanding, both for educators and for families as well, to be able to know how to support their advocacy to enable their children to have their needs met at school.

Ms ROSOL - Just a question about medication access and if you are able to maybe outline the processes that you have in place to support children to access their medication at school?

Ms PALMER - I think Alison should be able to step you through the guidelines for that.

Ms BROOKS - To clarify, we do have medication procedure processes and they're overseen by our school health nurse program in conjunction with Adam's team, Jodee's team, so there were very clear guidelines around administration. I'm just checking, is that what you're asking? Is it around administration of medication?

Ms ROSOL - It's maybe not so much the nuts and bolts, because that's probably fairly self-explanatory, but are there issues with students accessing medication at school that you see? How do you respond to that, or what do you have to do around that to make sure that runs smoothly so that students are receiving their prescribed medication in a way that's helpful for them in a school day?

Ms BROOKS - We hear very few issues around medication, so that would indicate to me that on the whole that that process runs very smoothly. On occasion, there are issues around families being able to access that level of medication. Things are usually set up through the paediatrician and the local pharmacy so that the school receives that medication directly and then administers that. We try to work around ways that inhibit or prohibit young people getting the regular dose of medication by taking on some of those responsibilities at a school level, and that seems to work quite successfully.

CHAIR - Anything else?

Mr BEHRAKIS - I imagine, because I've heard from a few people in some of the submissions, they vary, but there are a few that still talk about a level of stigma around ADHD, both as parents and as students. Understandably, it's changed over time. It's getting better. What work's being done to continue to remove that stigma?

I know, when I was young, I'm talking very early 2000s, and then talking to my mum about how that unfolded, not only was there none of the supports that exist today as far as helping with early identification, it was actually when I was diagnosed in high school, the school was, you know, 'Oh, you're trying to drug your kids.' There was that sort of attitude and then the stigma within students. Obviously, it's improved over time, but it still does exist. What's being done to help fix that or address that?

Ms PALMER - Yeah, we can certainly talk to that. I think, at a high level, it goes back to the question our Chair asked earlier about what's good for one child can actually be good for the entire classroom. It's looking at how our schools are set up, how our classrooms are set up for neurodivergent children. As I said to you before, some of the supports that I've actually seen in schools, all students use them to regulate their behaviour. It was not seen as a place for kids with disability. It was seen as rooms where any student could go. One of them was even telling me, 'We know we've pushed it too far with our teacher when they step into the room' because they have to have some time to themselves.

CHAIR - We need those rooms in parliament, Minister.

Ms PALMER - I'm happy to advocate for that if you are, Chair. I think another great example of that is sometimes complaints that come into me as Minister will be from a parent saying, 'My child's got funding for an educational adjustment and they're supposed to have a TA working in that classroom just for them, and they're not. That resource is being shared with other kids, and that's not right.' What we actually try to do, which I think is really beautiful, is that support staff member might be assigned to one child but might work with three or four children because we don't want a child with ADHD sitting in a separate part, in another room, not part of the classroom. That support might be for that child, but by working in that group, that child is working in a group just like all the other kids are working in different groups. It's not because they have ADHD or whatever their disability might be, they're just part of a classroom. There's really careful consideration by teachers about how to make sure that a child gets what they need to have the best learning outcomes.

They're not seen as different. They're not taken away. They're not ostracised. They're still part of the classroom. A lot of work does go in and a lot of really careful thinking goes into that, which I actually loved hearing. You can see how a parent could look at that and go, 'Oh, well, that's not right.' Actually, that is what's right. That is what's best for your child because they are just part of the class, which is great. Did you want to add something?

Ms WILSON - That's at the heart of inclusive practice. Everybody's included. What is needed in order to support the development of one child is just that. It is under the auspices of inclusive practice being a daily practice.

CHAIR - I think that's a really positive place probably to wind up our committee hearings. We've reached time. Really grateful for the time that you've given us, Minister, but, in particular, also your team, who are obviously all very passionate leaders in this field. That has really come through in today's hearing. My younger child is only 16 now. She's back in the public school system now, but she was in the Catholic school system for a little while. In her short time in education, I've seen those attitudes change. It sounds like things are, hopefully, going to continue to improve and, with the input of families, students, educators and support staff who are seeing these things first hand, on the ground - can make recommendations that will make life more positive for all learners.

We're really glad to have heard what you've told us today. Thank you for those questions that you agreed to take on notice. Something that we've asked of other ministers as well - and not to put you on the spot - but if we come to our report writing stage and there's other information that would benefit the Committee in making recommendations, are you happy for us to reach out in writing at that point and ask any other questions? I know you can't take things on notice that you haven't seen, which Mr Jaensch was quick to point out in our last hearing. We're very cognisant of that as a committee, but if you're happy for us to write to you further, as we do our work, that would be really beneficial.

Ms PALMER - I think we're actually all on the same team here. Anything that we can do to see great benefits and depth in any recommendations that you can bring forward - we are more than happy to expand on anything that we've said today. As you said, if you find something that you didn't ask that you want to know about - we are excited about what you may come up with that can help us to further develop, to strengthen and to challenge our thinking. At the end of the day, we want to see great educational outcomes for any child and all children that come through our schools. Yes, we're more than happy.

CHAIR - Thank you everybody.

The witnesses withdrew

The Committee adjourned at 12.19 p.m.