THE HOUSE OF ASSEMBLY GOVERNMENT ADMINISTRATION COMMITTEE B MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART ON FRIDAY, 16 MAY 2025

INQUIRY INTO THE ASSESSMENT AND TREATMENT OF ADHD AND SUPPORT SERVICES

The Committee met at 9.01 a.m.

CHAIR - Welcome and thank you for being here for today's hearing of our Tasmanian parliamentary inquiry into the assessment and treatment of ADHD and support services. Thank you for the written submission, which we've all received and read. Could I ask each person please, maybe starting with the Minister, to state your name and the role in which you're appearing before the Committee?

Mrs PETRUSMA - Minister Jacquie Petrusma, Minister for Health.

Mr WEBSTER - Dale Webster, Secretary of the Department of Health.

Dr BEGGS - Sean Beggs. I'm the Clinical Director of Women's and Children's Services in the south and the Chair of the Women's and Children's Health Network across the state.

Ms BADCOCK - Sally Badcock, Associate Secretary of the Department of Health.

Dr ARYA - Dinesh Arya, Chief Medical Officer.

CHAIR - Thank you. I'll introduce the Committee. I'm Ella Haddad, member for Clark and Chair of the Committee. We're joined online by Cecily Rosol, who is a member for Bass, Simon Wood, member for Bass. You've got most of Clark here, Kristie Johnston, Independent member for Clark, Simon Behrakis, Liberal member for Clark, and Meg Brown, who's the Labor member for Franklin.

Could I confirm that you've each received and read the guide sent to you by the Committee Secretary?

A witness - Yes.

CHAIR - Everybody? Great. Thank you.

I'll just remind you of the pertinent parts, which is that the hearing is covered by parliamentary privilege, which allows each of you to speak with freedom and without fear of being sued or questioned in any court or place outside of parliament. The only exception to that is the protection is not accorded to you if statements that you make may be considered defamatory and you repeat those statements outside of these proceedings. The hearing is public. Members of the public may be watching online or might attend in the gallery.

Could I ask each of you now to make the statutory declaration? You don't need to. I think ministers are automatically sworn in, but maybe starting with Secretary Webster.

Mr DALE WEBSTER, SECRETARY, **Dr SEAN BEGGS**, CLINICAL DIRECTOR, WOMEN'S AND CHILDREN'S SERVICES, **Ms SALLY BADCOCK**, ASSOCIATE SECRETARY, AND **Dr DINESH ARYA**, DEPUTY SECRETARY, CLINICAL QUALITY, REGULATION AND ACCREDITATION, CHIEF MEDICAL OFFICER AND CHIEF PSYCHIATRIST, DEPARTMENT OF HEALTH, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Thank you very much. If at any point during the hearing there's anything that you would like to share in an in camera session, that's also an option that's available. Please just make that request. We'll have a short deliberative meeting to decide on that, and we can proceed in an in camera session, which means the public broadcast would stop. There'd still be a written transcript from Hansard, but it wouldn't be published.

In terms of it being a public hearing, we have agreed as a committee to read a sensitive content statement for anybody accessing this broadcast later, or today, or reading the Committee's transcript. That is: as a committee we recognise that during these hearings we may discuss highly sensitive matters and themes that have deeply impacted the lives of Tasmanians. This may be a trigger or distressing for individuals listening to or participating in these proceedings. As a committee, we encourage anyone impacted in that way to contact services including Lifeline on 13 11 14, the ADHD Foundation Helpline on 1300 39 39 19 or Kids Helpline on 1800 551 800.

Would you like to make an opening statement?

Mrs PETRUSMA - Thanks, Chair and good morning, Chair and members of the Committee. Thank you for the invitation for us to attend, for the opportunity to contribute to this Committee's very critical and important work.

Firstly, I want to thank each and every person and organisation who came forward and made a submission to this Committee. We acknowledge here today the challenges, the frustrations, the concerns that have been expressed, but also welcome the ideas and positive solutions that have been shared in these submissions.

As Minister for Health, my portfolio includes public paediatric services, which provides care to children and young people with Attention Deficit Hyperactivity Disorder (ADHD), while my colleague, the Honourable Roger Jaensch MP, who has outlined before this inquiry in April, has oversight of public mental health services and the treatment of adults with ADHD and psychostimulant medications.

Both I and the Tasmanian Government are very committed to supporting meaningful change and ensuring our children and young people with behavioural and developmental issues are better able to access the care and the support that they need.

Across Australia, there has been a significant rise in presentations to health services of young people with neurodivergence. The most common pathway for ADHD assessment and diagnosis for children in Tasmania is through referral by a GP to a paediatrician either in the private or public healthcare sector. I'm advised that Tasmania's public paediatric service currently receives around 305 to 380 new referrals each month for behavioural and neurodevelopmental concerns.

Due to increasing demand, the Department of Health has increased the number of paediatricians employed in the Tasmanian Health Service (THS) by 44 per cent during the five years to 2023. In 2023 there were 53 paediatricians working across Tasmania's public and private sector, including 49 paediatricians employed in Tasmania's public sector, and I'm delighted to confirm that an additional 3 paediatricians have been employed by the THS in the past 12 months. As well, since our submission to the Committee, which was based on 2022 data, the number of psychiatrists working across Tasmania's public and private sector has increased by 13 from 86 in 2022 to 99 in 2023, and the number of psychologists by 43 from 573 to 616.

The Department of Health has also implemented the necessary changes to enable specialists and GPs with Special Interests in ADHD and the appropriate training to be authorised to prescribe medications for up to three years, which is an increase from two years.

I'm also pleased to share that we have also established a specific service for neurodevelopmental assessment and management with a new joint model of care between paediatrics and Child and Youth Mental Health Services now being established in April. We expect that this ADHD clinic pilot will deliver multiple benefits, including reducing the significant paediatric waitlist for specialist neurodevelopmental assessment, enhancing care coordination and improving timely access to care that meets the needs of Tasmanian children and their families.

This initiative will also support our government's commitment of $2.5 million, plus we are now providing another $500,000 to make a total of $3 million over three years to establish a new GP specialist service for children with ADHD so their families can access support sooner statewide.

The new joint model of care initiative that was launched in April follows a successful launch of Kids Care Clinics in 2023, which provides targeted healthcare and support to Tasmania's most vulnerable children and their families. Kids Care Clinics have a focus on early identification of health and wellbeing concerns, including ADHD, and through the Kids Care Clinics we're also trialling parent and school education sessions on ADHD.

Chair, we look forward to answering your questions today and to considering the final report of the Committee into the assessment and treatment of ADHD and support services. Importantly, the findings of this inquiry will also inform the department's broader statewide service planning to improve access to health services for children and young people under our Long-Term Plan for Healthcare in Tasmania 2040.

I'll now hand over to the Secretary, Dale Webster, for further comments, if that's okay with you, Chair?

CHAIR - Of course, thank you.

Mr WEBSTER - Thank you, Minister. Thank you, Chair. As the Committee would be aware, Tasmania, like other states and territories, is experiencing increased demand for specialist assessment of children with behavioural and developmental management issues, including ADHD.

We have to acknowledge the challenge that families are facing accessing specialist appointments for assessment, diagnosis and ongoing care as a result, and we empathise with those experiencing those challenges. That's why, working with government, we're taking proactive steps to ensure children and young people are better able to get the care they need. This includes, as the Minister has said, the development of new clinics specialising in ADHD diagnosis and management, as well as ongoing recruitment efforts to boost our staffing resources in this particular space.

While this is pleasing progress, we know there's more work to be done to address the needs of our community and we will continue to progress this as one of our priorities. We look forward to answering your questions today and continuing to engage constructively on this issue.

CHAIR - Thank you, and on behalf of the Committee, we're also very much looking forward to providing robust recommendations that will hopefully assist with that work. We echo the gratitude that you've shown to the people who've presented to this Committee. We've heard incredible stories from practitioners as well as from individuals that we hope will inform a really useful report to increase access to diagnosis and treatment for Tasmanians.

You've outlined some of the workforce challenges both today in your opening statements and in your written submission. I'd like to ask a little bit more detail about the new clinics that you mentioned and the three new paediatricians employed in the THS. Just wondering if you can give us more detail about how those clinics are operating or will operate - whether their diagnosis is limited to children and young people or if they'll be handling adult diagnosis as well? And then specifically on the three paediatricians in THS: where they are, how they're operating and the effect of that increased workforce.

Mrs PETRUSMA - I'll start off and then the Secretary and Dr Beggs will outline more. Yes, we have established a specific service with a joint model of care between paediatrics and Child and Youth Mental Health Services (CYMHS) for neurodevelopmental assessment and management. This model will be delivered through the paediatric outpatient department and is being designed to address the paediatric waitlist for ADHD assessments. This will, from 1 July, also include the $3 million of Tasmanian government funding that we've now committed over three years. We believe that this is a unique opportunity to pilot a joint Child and Youth Mental Health Service and Women's and Children's Services ADHD Clinic with multidisciplinary staff, including a paediatrician, clinical nurse consultant, a psychiatrist, a psychiatric registrar and a range of allied health professionals.

Eligible children and young people with suspected ADHD will be drawn from the current paediatric waitlist for neurodevelopmental assessments and treatments as appropriate. We expect that this initiative will deliver multiple benefits, including reducing the significant paediatric waitlist for specialist neurodevelopmental assessment, it will enhance care coordination, and it will improve timely access to care that meets the needs of Tasmanian children and their families.

Stage 1 of this new model,focused on children, not adults, with suspected ADHD, commenced in April this year and is staffed by paediatricians, child psychiatrists and nursing staff. To further bolster staffing, this service will expand in the first quarter of the 2025-26 financial year under stage 2 and will employ GPs and more paediatricians to support the model of care and to expand capacity to see more children.

Initially, this model will be trialled in the south, while planning for statewide implementation is also now underway, with the model to be rolled out to all three regions to support ADHD assessments and treatment.

This initiative, of course, follows the launch of the Kids Care Clinics in 2023 to provide targeted healthcare and support to Tasmania's most vulnerable children and their families, with a focus on early identification of health and wellbeing concerns, including ADHD.

Mr WEBSTER - Thanks, Minister. Paediatricians, like most of our workforce, are - you know, there is a shortage worldwide and the fact that we have been able to increase our staffing is very pleasing to me, but we need more staff in this space, so I wanted to say that up-front.

To answer your question about if this resource is going to be available for adults, these particular initiatives we're talking about today are focused on paediatrics, but the CYMHS model actually floats these days. The reason why we changed from Child and Adolescent to Child and Youth was that if there is someone who is reaching adulthood, who the clinicians within CYMHS believe would benefit from staying within the CYMHS service, then they actually do stay there. Every client doesn't automatically move from CYMHS to adult at 18. There is a floating -

CHAIR - Is there an age limit for that floating cohort?

Mr WEBSTER - Yes, it's 24. It's up to six years of that floating. That acknowledges that levels of maturity are actually what may affect the types of treatments that are required rather than a fixed birthday as such. Not many of our clients would float through that, but if there is a need, they do. That's important, it wasn't just a name change, it was a model of care change when we moved from CAMHS to CYMHS.

Mrs PETRUSMA - We are actually focusing on prioritising patients who are about to reach that age when they'll no longer be eligible for this service, so that we can try to get them before they become adults. That's the priority for us on the waitlist now as well.

Dr Beggs has been integral to the development of this new model of care. I'd ask him to provide some comment.

Dr BEGGS - I can't answer necessarily where all three of those positions have gone, but certainly one of those paediatricians in the last year who has been employed has gone towards the establishment of the new service. The new service, as has been mentioned, is outlined to be a multidisciplinary clinic to be robust in the diagnosis of ADHD. I mean, I guess that's our main aim, to make sure that the diagnosis and management is as robust as possible.

The service at the moment in the stage 1 is combined of the paediatrician and the psychiatrist with the support of the nurse, the CNC, with a focus on streamlining the assessments so that the information gathering and everything happens pre the patient coming, or the client coming, to the clinic, to ensure that the time spent by the key clinicians is as productive as possible and as useful as possible. There's a lot of work to be done in terms of setting up those systems as well, which is happening at the moment.

As was key, knowing that the waitlist - there was a number of children who had been sitting on that waitlist for a number of years and were about to hit the age where they would no longer qualify for paediatric services, they were emphasised as being the ones to be seen. They were a bit more time consuming and maybe not getting through as many volumes as we would have ideally liked, but they were the priority to get done.

The service model has started and it is running and is established outside of the actual hospital setting, at the moment it's running out of Glenorchy, so that it's in a community setting, so it's more appropriate.

CHAIR - In the health centre opposite Northgate, opposite that back end?

Dr BEGGS - Exactly, yeah, so the idea is that it's in a community setting because it's more appropriate than bringing them into the hospital setting for that sort of assessment.

That clinic is up and running and has just started really in April. There's continuing lots of work on the model of care in terms of those processes to get the information in and streamline them, all of which would be able to be shared around the state once it's streamlined.

The next part of the model will kick in when we get the funding for - when we bring GPs into running that service. There's going to be a big emphasis on not only those GPs, but also collaboration with patients' own GPs, to make sure it's - not exactly a shared-care model, but a model where there's a degree of the management is continued with the GPs in the community.

Obviously, there's not a capacity for - with the increase in the numbers of people seeking diagnosis and management, we need that involvement, or else the clinic will become full of all the review appointments that need to be made. There'll be a big emphasis on that shared care - for want of a better term - model where there'll be the use of having the GPs who are happy in the community to be able to be helped with their management as well. That will be facilitated hopefully by the GP or the GPSI (GPs with Special Interest model coming through. There'll be that level of upscaling in the GPs, and maybe even have some who rotate through, so they may not be permanent GPs in that clinic, but they'll be able to come in for a while, upskill and then return to their own clinics and have those skill sets and that comfort.

CHAIR - Thank you for that extra detail. Those GPs, that'll be from 1 July that that funding kicks in - will that be an extension of the GP with Special Interest program that's been running in the THS in a pilot or is this different and separate?

Dr BEGGS - Well, it's ongoing funding, so yes, it's a continuation of the sort of the beginnings of that, that happened in the last couple of years with funding from a different source, but it's an ongoing commitment for this particular group.

Mrs PETRUSMA - Can I also add to that, along with it to assist GPs, we're also developing a new Statewide Referral Criteria to ensure -

CHAIR - That was my next question. I was going to go to those criteria, thank you.

Mrs PETRUSMA - that children - yeah, so we want to ensure children are referred with comprehensive supportive documentation to minimise the time between their initial appointment and full assessment. This will enable general practitioners to specifically refer a patient for neurodevelopmental concerns as opposed to general paediatric concerns. The Statewide Referral Criteria is due to be implemented in the first quarter of 2025-26, so from

July, because once implemented, this new criteria will be linked to the existing HealthPathways portal to support GPs to ensure that as much assessment as possible can occur while awaiting the paediatric appointment.

We know that behavioural presentations in children can reflect several possible underlying diagnoses. Therefore, we believe it is crucial that healthcare professionals with specialised paediatric training conduct thorough medical assessments of children presenting with neurodevelopmental or behavioural issues like ADHD, so that we can accurately diagnose conditions that also may mimic ADHD, and we also want to identify any comorbidities. As part of this program, developmental and behavioural training will be a core component of training for all the general paediatricians. It's about improving the whole scope.

CHAIR - Thank you. My next question was going be on those referral criteria and whether you'd seen a reduction in that wait time, but if they haven't been implemented yet - I can't expect that there has been - but I wondered maybe since 1 April whether you've seen a reduction in that waitlist, whether you have any data on the waitlist numbers changing since the beginning of the -

Mrs PETRUSMA - They've been able to assess I think 11, but I think it's - there was the last figures I saw, in a couple of weeks.

Dr BEGGS - No, partly from what I was - I mean, slightly, but because of that emphasis on the older children who would have a more difficult timeline to get the diagnosis assessment done. It will take a while for that to kick in because of the streamlining and all those other factors that have to line up will take a while in terms of - meaning months - for us to see a significant change in the trajectory of the waitlist.

CHAIR - What is the waitlist at the moment? Do you have a number?

Dr BEGGS - I can tell you for the south, it's around about - which I have access to more easily - is about 1200. Across the state, more than half of it sits in the south.

CHAIR - That's just paediatric waitlist, isn't it, not adults?

Dr BEGGS - Yeah, that's paediatric waitlist. To be clear, that's neurodevelopmental. The reason why the south numbers are a little clearer than the north and north-west is that in the south we've been separating out the referrals by developmental versus general, which hasn't been happening in the north and the north-west for as long. It is happening now. It's hard to actually -

CHAIR - Split that data in the north and the north-west.

Dr BEGGS - Yeah, because there's a bit of mix.

Mr BEHRAKIS - It's not necessarily there's more, but the data is there where it's not -

Dr BEGGS - We would expect it to be proportional across the state for population, allowing for maybe some socioeconomic differences that might mean they're slightly different. Overall, we would expect the rates to be the same. ADHD is meant to be consistent in rates across the country. The separating of the waitlist has been happening longer. As the Minister mentioned, once we have the formalization of the referral criteria coming in next financial year, it will be much clearer.

Mrs PETRUSMA - I can give the waitlist data as at 25 February. In the south, Category 2 is 203 versus Category 3 is 1098. In the north, 323 is Category 2 and it's 516 in Category 3. In the north-west, it's 110 which is Category 2 and under Category 3, it's 255. As Dr Beggs is outlining, it does show there are quite wide disparities across the state.

CHAIR - Thank you. I will open up to the Committee for questions.

Ms BROWN - On the waitlist, do you have that data broken down into ages and also the sex of the children?

Mrs PETRUSMA - We've just got this from the Paediatric Neurodevelopmental and Behavioural Clinic, including ADHD assessment. This is all neurodevelopmental and behavioural disorders -

CHAIR - Would that be available if we took it on notice, or is it not broken down that way?

Mrs PETRUSMA - We can provide it.

CHAIR - Thank you.

Mr BEHRAKIS - Thank you, Minister., I've got a couple. On the referral criteria that you mentioned, that sounds really good and like I said, hopefully once it's bedded in and it's working, we'll see some good outcomes. I know we're focusing on paediatrics today, but is there similar being looked at for the adult space? You talk to 10 people and their story of how they've navigated getting diagnosed and supported as an adult and you'll have that many different stories of the paths that they've taken. There's not a lot of consistency there. Is there similar being worked on for adults?

Mrs PETRUSMA - We also have to remember that adults are largely the responsibility of the Australian Government, as well, because the process for adults seeking ADHD assessment and treatment requires a referral from a general practitioner to a private psychiatrist. We do appreciate that about the adult services, which do come under Minister Jaensch. It is really largely an Australian Government responsibility for adults.

Mr WEBSTER - At a very general level - and then I'll hand over to Professor Beggs - we are developing referral pathways with our GP services across almost every possible category that we can. It's really important for us, that - our assessment is that probably a third of the people that are on our waitlist are there inappropriately because the referral pathway isn't clear. As Sean used the example, we get a general paediatric referral when, in fact, if they referred specifically, we'd be able to clarify it better, so those sorts of things.

We've been working with Primary Health Tasmania over now three or four years, to develop what are called The Pathways, and they are embedded in electronically and GPs can work their way through a pathway and it actually says, 'Okay, this is where you should refer or in fact you shouldn't refer. This is where you should go for that.' We're a long way into that process, but still got a few to go. On a general level, we want pathways for every possible referral.

Mr BEHRAKIS - For that pathway, are there already mechanisms or are there things being worked on as far as help in identifying which kids might need to go through that pathway in the first place? I understand it might overlap a fair bit with the education space, but as far as which of the kids that might need to be, or the parents get tapped on the shoulder and say, 'Maybe you should consider taking a child to get assessed' first, so then they don't get to teenager or adult years and look back on, 'This could have been done 15 years ago.'

Mr WEBSTER - That's also one of the primary ideas of the pathways, that actually with GPs you might have a presentation that they're not familiar with, by working their way through the pathway, they're actually saying, 'Okay, here's where I should go.' It may be that the referral, as I said, isn't to the THS, but it says that you need this service as a way of doing that. The idea of the pathways is to assist the GP in referring the client to the most appropriate service to get either a diagnosis or management or treatment.

There's a wide variety of these, and we're building these also into our eReferral process so that they're almost like a gateway, you get to that gateway and you pass it, then that's a referral that comes through to us. You get to that gateway and you don't pass it because the diagnosis isn't clear, et cetera, then you're sent back to do a bit more investigation. That's not just in this space, but could be anything from you diagnosing RSV through to this, that we try to actually have pathways for referral rather than have just generic referral of, 'There's something wrong here, I'll get the THS to investigate', so that it helps us stream and know what our workloads are. Secondly, it helps speed up the process for the patient. As Sean said, we've got a lot of work to do to work out the documentation, et cetera, prior to a referral, but that's the idea of pathway.

Mrs PETRUSMA - Just to also assist GPs, we're going to be recruiting soon to employ additional staff, including for the Tasmanian Paediatric Rehabilitation Service (TPRS), the Paediatric Intensive Care Unit consultants, clinical geneticist, paediatric specialist and cardiology, gastroenterology, endocrinology and a range of other additional nursing and allied health practitioners. That way GPs will be able to further go through and work out what is the primary diagnosis that needs to be assessed by who, because ADHD might not be the primary concern, it might be another concern so what can we just specifically get -

Mr BEHRAKIS - It's one of those things where people say it's underdiagnosed and other people say it's overdiagnosed. I think the truth is it's one of the most misdiagnosed because people might have a million other conditions that might present themselves with similar symptoms to ADHD and they might be convinced themselves that they've got it, doesn't mean they've got it themselves.

CHAIR - The increase in diagnosis doesn't mean increase in prevalence.

Mr BEHRAKIS - Yes, correct. If I could ask one more before I get accused of dominating -

Mr WEBSTER - Just on the referral pathways, I know Sean has -

Dr BEGGS - I was just going to say - I think you probably have the most - but I think the referral pathways have been there for a while. The referral criteria will support the use of those and the eReferrals will make it even more useful. They've been separated by having to go to them, and by linking them all together by the one electronic system pointing to them, they'll make it much more accessible for GPs and make sure that they are adhered to a bit more.

To your question about whether they have clear guidance and where to go prior to, they're really good, in terms of having links out to where to support kids and families, to direct them to and that sort of thing.

Mr BEHRAKIS - Before you even get to the GP, how do you help a parent that might be dealing with a hard-to-manage kid because of a neurodevelopmental condition, to even know that that's something they should be looking at in the first place - before we even start on the how do we get them into the system, that we're talking about with the referral criteria in the first place? How do we help - if it's an education thing or if it's the schools or if it's the family doctor? How do we get that process started with parents that might not even know what they need to do?

Mrs PETRUSMA - That's why we're also trialling through the Kids Care Clinics. We're also trialling parent and school education sessions on ADHD, the first of these have already been trialled in rural communities. If successful, they will be further developed and rolled out more widely to address, like you're saying, just to provide more education especially for parents and schools.

Mr BEHRAKIS - With GPs -

Dr BEGGS - On your point about the assessment, and I think that's why we're really keen about this new joint model of care, because as I was saying earlier, the robustness of the assessment is really, really important for all those points you were just making about making sure that we get the right diagnosis for the kids, so we get them the right help and direct them in the right direction. We think that this model of care, which is a little bit novel - it's built on models that have been done in other places in the country and around the world, but it's actually the first one that we know of that actually is bringing together the child psychiatrists and the paediatricians in the one clinic -

CHAIR - That's great.

Mr BEHRAKIS - It's fantastic.

Dr BEGGS - so we can get them to the right thing without having them to go onto another waiting list to be seen by the other group that hasn't already been involved. Historically, other places you would see the paediatrician, they would say, 'Oh, actually that's not us, you need to see the child psychiatrist' or vice versa and go back onto a different waiting list. We're actually using the waiting list that we've already got. There's no new waiting list for this clinic, it's the one that's currently in place.

CHAIR - That is going to speed things up significantly. I know Cecily has got her hand up to too, Simon. Is this on the same theme?

Mr BEHRAKIS - We can come back to it.

Ms ROSOL - Thanks, Chair. I just had a couple of questions actually, but one is about CHaPS (Child Health and Parenting Service) and how CHaPS fits in with this, because we know that's often the first place that parents go to and where things are picked up. Will there be a formal relationship between CHaPS and this clinic? How will they work together?

Dr BEGGS - At this point, there's not a formal relationship with CHaPS for this clinic per se, but we do work with CHaPS. CHaPS is part of our (WaCS) (Women and Children's Service) network in terms of interacting to put systems in place. CHaPS pathways at the moment, generally, if they have a concern of this sort of nature would be primarily to GPs who would then refer to the service. In terms of systems in place, we would certainly have lots of dialogues with CHaPS in terms of our formal network that we have with them.

Ms ROSOL - You were talking about referral pathways and criteria before. Is there space there do you think for CHaPS formally being included in those pathways because that could take a step out of it couldn't it? If CHaPS can refer in to you, then it could take the GP referral out of it and make a smoother pathway.

Dr BEGGS - Yeah, and to be clear we do take referrals directly from CHaPS if there's a time nature of it that we think - it's always important to have the primary care physician involved as well, so we would still, if they refer directly to the paediatric clinics, they would also expect them to be corresponding with the GPs to say that that's happened. If there's a time nature of it where we think that that extra step is going to be detrimental, then CHaPS can refer directly into the paediatric clinics.

Ms ROSOL - Thank you. A question about, you called it a multidisciplinary clinic, I'm interested about allied health's involvement in it, maybe not so much in the diagnosis, but if it's a clinic for treatment as well, will there be space for allied health? How do you envisage that developing?

Mrs PETRUSMA - Yes, there's going to be - it includes a paediatrician, clinical nurse, consultant, psychiatrist, psychiatric registrar and a range of allied health professionals are involved in the model of care. Dr Beggs will -

Dr BEGGS - Thank you. The ultimate aim would be, yes, particularly psychologists and maybe speech pathologists would be the two main ones that we would think that could be of value going forward. That's the aim, to bring those into it as well, to make it truly multidisciplinary.

Ms JOHNSTON - I'm interested - back again to the waiting lists in terms of how you categorise people waiting on the waiting list. Obviously at the initial process of referral, there's an assessment made about where they sit on that. What's the process then for reviewing that in terms of an escalation or de-escalation, in terms of that? How often do people move up the categories in terms of, you know, they might have been initially put in on Category 3? I appreciate that you said beforehand that older children, trying to get them assessed quickly before they slip throughout the system is a priority, but how do GPs or the person who's referred - the particular young person - escalate, how often does that happen, and what are the escalation points?

Dr BEGGS - When the referral comes in, there's a number of referral criteria and they will be published - some of them - we work towards them, but they're not necessarily all published. They will come in when the Statewide Referral Criteria - and they're coming out in tranches because they're happening across the whole of the health system. These ones will be coming in in the first quarter of the next financial year.

What happens is, when they come in, we assess them against that - and there's ones that, whether they fit criteria 1, 2 or 3, when they sit on that, they would remain on that unless there was more information provided from the GP or the family. Sometimes, obviously, you can imagine, the families do ring up and say, 'I haven't heard anything yet, I’ve been waiting for a long time.' The wait time is long, so that does happen. If more information is provided that means that the criteria needs to be reassessed; they would be. Then, if there is something that's changed, that means that, against the same criteria, they would shift onto those. You don't shift criteria just by, obviously, being waiting for a longer time, you stay at the criteria you're at, but hopefully the time - and by the nature of these conditions, all these diagnoses, they do predominantly fall into Category 2 or 3.

Ms JOHNSTON - It would generally be the GP, that if a parent had a concern that, for instance, there's an escalation in behaviours and it's now more greatly impacting on schooling or whatever it might be, the pathway for that parent to have that matter reviewed and escalated perhaps is through the GP?

Dr BEGGS - Primarily, yeah.

Ms JOHNSTON - Okay, thank you.

Mrs PETRUSMA - Under the new referral criteria too, because the GP can narrow it down to neurodevelopmental concerns and everything else, and also because of their HealthPathways that we've developed with Primary Health Tasmania as well, the more information that the GP can provide and the more assessment that's done, the quicker it will be for us, for when Dr Beggs and his team review it, it's easier for them to - because if a referral comes through with just a couple of lines then it's -

Ms JOHNSTON - Or if the child suddenly comes into out-of-home care, for instance, and the child's circumstances change, that automatically triggers a referral review, maybe?

Dr BEGGS - That's a good example of the ones that do hit to Category 1. Also, that's where the Kids Care Clinic or the Community Paediatric Team is. They primarily see those kids, the kids, not only those in out-of-home care, but those who are - for want of a better word - vulnerable. That's often had some contact with child safety. They don't necessarily have to be in out-of-home care, but it's one of the pathways to be seen then. Those kids would definitely be prioritised and seen because it's seen as that extra vulnerability. If they're actually having concerns from a child safety point of view, they would be prioritised.

Ms JOHNSTON - Interaction with youth justice, is that a trigger at all for review?

Mrs PETRUSMA - Children in out-of-home care and youth justice are a priority.

Ms JOHNSTON - That's a priority.

Mrs PETRUSMA - I encourage you, if you ever go to your GP, ask them about their HealthPathways portal, it's quite fascinating to actually see how it works. It's actually really,

really good how it actually steps them through as to what they need to do and provide. It makes it easier, we're not talking about adding to the GPs' workload here. It actually shows them quick and easy steps they need to do, so it actually streamlines it for them. It takes the thinking out for GPs and the stress of actually working out, 'What do I need to do?' It's actually really, really, really good.

CHAIR - Is that a national product, or is that a Tasmanian thing, the HealthPathways portal?

Mrs PETRUSMA - I've seen it in action here, I'm not sure about nationally.

Dr BEGGS - They're regionalised, but it's happening in multiple places. Various Primary Health Network (PHN) areas take them up and have done them.

CHAIR - Okay, so it's through the PHNs.

Dr BEGGS - It's a model that's been around for a few years. It came out of Christchurch in New Zealand originally and it was strongly taken up by the Hunter Region in Australia and it has spread to other regions now.

CHAIR - Spread around, sounds really positive.

Dr BEGGS - Yeah, so it's not us totally redesigning, we are using and localising models that have been done elsewhere, but we've been doing it for years as well.

Mrs PETRUSMA - It's very good.

Mr BEHRAKIS - Thank you, and through you, Minister, there was mention earlier with the clinic and having to make sure the GPs are incorporated or engaged in this so that the clinic doesn't just immediately fill up. One of the things that we've heard - and I've heard personally, talking to people and GPs - is that there is, in some cases, in both paediatric and adult, a reluctance by a lot of medical practitioners to engage in the ADHD space. I've seen it myself where I went to a GP who just refused to - he was like, 'I don't go anywhere near that.'

CHAIR - Didn't they tell you had an iron deficiency?

Mr BEHRAKIS - That was a different GP.

CHAIR - A different GP.

Mr BEHRAKIS - For the same thing, in the adult space, only the psychiatrist can do the initial prescription, but then the idea is to pass it onto a GP; go to the GP, he goes, 'I don't want to go anywhere near that.' There is a bit of reluctance in that community. Are there reasons identified? Talking specifically paediatrics here, are there reasons identified for that? What's inhibiting GPs from engaging in that system and what can we do or should we be doing to try and remove those perceived or actual issues to make GPs more willing to take part in this? There's that capacity there, but we need to get them involved to actually activate that.

Mr WEBSTER - The feedback we have from the colleges and through Primary Health Tasmania is because it's complex. General practice, unfortunately, in Australia, is based on a 15-minute appointment type of process, et cetera, this takes time and it's complex, et cetera. This is why things like pathways are really valuable, because they really give clarity as we develop our criteria that allow that level of clarity.

The third part of it is that we also need to educate - educate through the Primary Health Tasmania network, et cetera, and through the colleges, so that people understand that yes, this has been complex in the past and it's been complex because referral pathways are not clear, but as we've responded to the volume, we are clarifying all of those things.

We've got to always double back and make sure that our primary care network is actually understanding that things have changed. Otherwise it will prevail that this is complex, it's, 'I'm going to spend hours on one patient while the waiting room's full.' If we can actually simplify it, give pathways and criteria back and forth, so that it's not this patient getting sent off and 18 months later they suddenly come back to me by that referral, back and forth from clinics, et cetera - we actually simplify the role of the GP and through education, we can probably bring them back into this. We've got to deliver on our side so they get confidence in the referral pathways.

Mr BEHRAKIS - Are there liability issues as well? I know obviously the medication becomes a big part of it, because like I said, on the way in, as far as getting the assessments and referrals - there's a lot of complexities and I 100 per cent get and appreciate that. On the other side of it, though, say once the clinic's done the heavy lifting as far as the assessment, the prescription, the titration of medicines, and what support and they get them to a maintenance phase - that would be the ideal place to then hand them to the family doctor or a GP to just manage and continue the scripts and whatnot. There's a reluctance for GPs to even just take part in that side of things. Is it a kind of risk in engaging with that Schedule 8 medication, or what's -

Dr BEGGS - I think it's a familiarity thing. I think, historically, ADHD hasn't been something that's been in the space of primary care, so I think there's a degree of familiarity and comfort. I think that's, again, hopefully what this model of care will help in doing - and also having GPs coming through and not staying with, maybe going back out, is that that familiarity would happen. Also, the idea of having a dedicated service that builds the resources and is also a place that people can get information from so that the referrers can hopefully also be like a secondary consult service as well. It may mean that every time the GP has a question they have to send the patient in, but they might be able to get information in. The idea is that if we build a really good service, it's able to provide a resource as well as a place to - and we can build the community of GPs' familiarity with ADHD and their comfort with looking after it, and knowing that they have the backup of, 'Well, actually, if it gets to a point where I don't feel comfortable, there is somewhere I know I can go back to get professional help with this.'

Mr BEHRAKIS - Professional guidance, yeah.

Mrs PETRUSMA - Chair, do you think, in regards to this, because GPs are the responsibility of the federal government, I'd welcome a recommendation saying that the state government actually lobbies the federal government for funding towards the RACGP (Royal Australian College of General Practitioners) to actually do training in regards to ADHD so that the GPs feel more familiar with diagnosis and treatment. I think it does come down to that training that they have during their -

CHAIR - Degrees.

Mrs PETRUSMA - Well, during their degrees but also when they're a resident and registrar and doing their GP training. This is an issue Australia-wide, it's not just in Tasmania. I think if the federal government provided funding to RACGP to do this - we're trying to do what we can at our end, but fundamentally, GP training is the federal government.

CHAIR - Yep, we need to see an increase in that understanding.

Mrs PETRUSMA - If they can provide that sort of funding to support it, because, unfortunately, ADHD is not part of the NDIS, so if there's something that they can do to help, whatever we can do to decrease the number of children and make sure that they're in the right referral pathway at the primary care end would be really welcome.

CHAIR - Noted. Thank you. The Committee can make recommendations that are outside of Tasmania's jurisdiction. We're cognisant of the Senate inquiry that happened recently, or a couple of years ago now. Certainly we'd be wanting to make recommendations that would advance the capacity for Tasmania's workforce, ultimately, so that it benefits Tasmanian patients. Simon's shared his personal experience a few times at the table as well with that reticence of GPs to engage, and I think the questions today have been very important ones around what are those reasons and if it is familiarity and training and understanding of the conditions, if it's a hesitation, like you said, to work with Schedule 8 drugs.

I wonder whether if there's still, and I say this with respect, a cohort who are still a little cynical around the increase - I don't think it's an increase in prevalence - of neurodiverse conditions, I think it's an increase in understanding and an increase in options for people to be diagnosed and treated. I wonder if there's still maybe a cohort of GPs who are just generally a little cynical about -

Mrs PETRUSMA - This is where the college can again provide training, because every GP is required to do CPD (Continuing Professional Development) points, so this can be another module that can be offered for all GPs. You can have it during their training, but also, once they are a GP, just so that they understand. Ideally, it would be for PHT to actually come through and do some training and show them also how HealthPathways works and everything else, so that it makes it easier for the GP to assess, to understand, and to actually work out who to refer and to get that familiarity, as we've discussed, with Schedule 8 medications as well. I think it does really come down to training. We're trying to equip the GPs on our end, but it also requires the other side as well. I think I'd welcome to a lobby for it.

Ms BROWN - Do you have the data for the average wait time that a child will experience between each of the categories?

Mrs PETRUSMA - I do, I can provide that information. The average wait time for Category 2 in the south is 329 days, for Category 3, it is 390 days. In the north, for Category 2 it is 278 days, for Category 3 it is 358 days. In the north-west, it is 185 days for Category 2, and for Category 3 it is 301 days. We acknowledge the fact that those wait times are high, which is why we're bringing in this new model of care, and it's also why the $2.5 million is now $3 million. It's so that we can provide a state-wide model of care to try and get these waitlists down as well.

Ms BROWN - I have one more question. In the government's submission on page 32, it outlines the increased risks that people with ADHD experience. We've talked about misdiagnosis, if a patient was to present to the hospital with one of these illnesses or disorders, how likely is that to be picked up that that's actually ADHD that's the underlying factor, in the hospital setting? I know that's kind of a bit of a tricky one.

Mrs PETRUSMA - These are comorbidities associated with ADHD, so it depends on if the comorbidity is high-risk at that time when you present to an accident and emergency department, you'd be treating the initial outcome, but what they're presenting with before, then you could go into ADHD. Dr Beggs would be able to talk about when he sees children with comorbidities.

Dr BEGGS - This is more talking about the benefits of treating people with ADHD because of the significant comorbidities they have, rather than necessarily knowing that we'll pick up a diagnosis of someone with ADHD because they presented with one of them, if you understand what I mean. It's a bit different. Certainly, in the acute setting, someone presenting with a problem - as in, presenting to the hospital acutely - maybe not, but if they were referred for one of those problems to the out-patients and they were being assessed, yes, there is a likelihood that the ADHD would be detected as the underlying problem or one of the diagnoses associated with it. A child might be referred in for aggressive behaviour, and then worked through and work out whether it was a trauma history, ADHD, a conduct problem, and work out which one of it was contributing, anxiety, which one of those things were contributing, and the primary problem.

Mr WEBSTER - Because the list is acute, it will vary about the amount of time. Are you focused on treating someone with a brain injury or are you treating the underlying of the acute phase in the ED? We're very much at the, 'We've got to treat the life-threatening element of it initially', so time is the thing that varies there. For instance, eating disorders are on the list. Perhaps Professor Arya can talk to this one, but if you're treating an eating disorder, then you are spending time with the client, the patient, so you're probably going to look at an underlying diagnosis as well.

Dr ARYA - Thank you, through the Minister. I think whenever anyone comes to our hospital or to our community services, they obviously have a very comprehensive specialist assessment. Even though they may be coming with one issue or one condition, the assessment that we do also looks for comorbidities. If ADHD or any other neurodivergent issue is there, then it will get picked up as part of our comprehensive assessment. As we were discussing before, our teams are multidisciplinary. There are doctors, allied health professionals, there are nurses who will pick up the very specific conditions that are very specific to their expertise.

CHAIR - I guess that's the benefit of a multidisciplinary service.

Dr ARYA - Yes.

Mrs PETRUSMA - Exactly.

Mr BEHRAKIS - Just off that, I suppose with the comorbidities there's also how do you differentiate and what difference does it make at the end of the day? If you have someone with ADHD, I think, as I understand, one of the common comorbidities is ADHD and a condition like anxiety, in which instances is that someone has ADHD and they have anxiety, those two are sort of two things that they have, versus a situation where a young person might have ADHD, and the under-performance in school and the constantly getting yelled at and being in trouble because you're acting up - the untreated ADHD puts them in a situation where they're getting anxiety and that's a causal link to having the untreated ADHD, versus having both at the same time in independently, if you get what I'm asking?

Mrs PETRUSMA - That's why psychiatrists and psychologists are very much part of the multidisciplinary team, because we appreciate that quite often they do present with anxiety and depression.

Dr ARYA - I think that is probably the important point to consider, that when someone is referred to a specialist, even though the referral may be for ADHD, but it is a comprehensive assessment, you are not only looking for ADHD. You are looking at ADHD, anxiety, autism, and any other related condition that may be there. At the end of the day, what you want to do is to make sure that the care and treatment plan that you're developing is pretty comprehensive, it covers the whole spectrum of issues that the person may be struggling with.

CHAIR - Can I ask a question about that, it just reminded me of some evidence the Committee's previously heard around when there is a difference of opinion, and sometimes there's a bit of a block in the system, I suppose, if a psychologist who's got a longitudinal relationship with a patient suspects ADHD, does those initial screeners and tests, and then refers their patients to a psychiatrist or to a paediatrician who disagrees with that diagnosis, then there can be a bit of kind of ping-ponging between those two professionals. I just wondered if that's something that's been encountered through the early work of this multidisciplinary system or if there's any observations anyone would make about that?

Dr ARYA - I think that's the complexity of multidisciplinary teams and assessment, there will always be some difference of opinion. The idea of multidisciplinary teams is that you resolve those differences by way of discussions, by way of expert opinions that are available in that team. ADHD is one of those diagnoses that is a very clinical diagnosis, even though there are rating scales that can be used. At the end of the day, it is your clinical judgement and clinical impression, and that can only be resolved through those multidisciplinary discussions -

CHAIR - Okay, between the patients -

Dr ARYA - so that people can consider each other's viewpoints, opinions, and then make a final decision.

Dr BEGGS - I would say that yes, that can happen, and I think that whilst we haven't seen anything yet through this model, I think it is the idea of having a single point assessment team who can talk easily. I think the difficulty is that - the examples I suspect you've heard about have some degree of time between them as well -

CHAIR - Yeah, that's right.

Dr BEGGS - and some distance between the two people who are doing the assessments in terms of -

CHAIR - Yes. Correct.

Mr BEHRAKIS - Better to put everyone in the one room and hash it out -

Dr BEGGS - Yeah, exactly.

Mr BEHRAKIS - rather than referrals and appointments over the course of weeks and months.

Dr BEGGS - Yep.

Mr BEHRAKIS - Just to skip to the other end of the paediatric stream. I've heard, anecdotally from a couple of families where the child's aged out of paediatric space, and there hasn't been a lot of, for lack of a better term, transitional support to adult care. People hit - is it 18 when you age out?

Mrs PETRUSMA - 24.

CHAIR - 24.

Mr BEHRAKIS - Okay.

Dr BEGGS - 18 for paediatrics.

Mr BEHRAKIS - Yeah.

Mrs PETRUSMA - We're doing a model of care after 24.

Dr BEGGS - That's the CYMHS model

Mrs PETRUSMA - The CYMHS model.

Mr BEHRAKIS - I'm talking sort of historically up until now. They'll age out and suddenly the paediatrician says, 'I can't look after you anymore, you're going to have to find a GP', and then you go through that system again. People get there, they've had their whole life of going through that model, they've had the medication and other supports that they've come to rely on, then, 'Sorry, you've got to figure it out.'

You have a condition that when not supported you have the procrastination, poor organisation, all those things, and then they have to do the 18-month waiting list again in the adult space, rather than if they, maybe, a year earlier or 18 months earlier you have the paediatrician having some sort of mechanism to say, 'Look, in a year's time we won't be able to see you anymore, now might be the time to start going through these avenues to make sure you can hit the ground running.' I can imagine a lot of young people hit that age, they've had their parents effectively making all their doctor's appointments and paediatric appointments for them, suddenly you no longer have access to your scripts, you have to go through all the rigmarole of the trouble that people are having in the adult space now, and you're doing it suddenly untreated after being treated for years and years and years.

You can just see people spiral. It's almost like they hit that age and they get left for dead. Are there mechanisms that exist for that transitional support, or should there be? Is that being worked on?

Mr WEBSTER - We absolutely acknowledge this has been a problem. It's always a problem with age-based criteria. It becomes this -

CHAIR - What happens at the barrier.

Mr BEHRAKIS - Yeah.

Mr WEBSTER - Part of why we're prioritising those that are close to that age at the moment is because we acknowledge that we're going to have that issue with that cohort if we don't do something now. In designing our models of care and pathways - and I think Sean said this - it's important that the primary care sector is part of the team so that it isn't a drop dead at 18 because all of your management and treatment have sat with paediatrics, a GP hasn't really been involved, and then suddenly, you turn 18 and it's just a, 'Here's a letter of referral back to your GP.' We want to avoid that by having the GPs as part of the broader team in the lead-up and, in fact, throughout the paediatric years so that it becomes a bit more seamless, if you like. Can't guarantee that we'll get it 100 per cent right straight away, but that's the ideal. I can throw to Sean on model of care, but that's the vision, if you like, to overcome that.

Dr BEGGS - A key part of any paediatric long-term management is transition. The difficulty is when there's not a lot of places to transition to. I think, as we know, the acceptance of the importance of continuing to manage ADHD into adult life is something that's evolved over the last 10-plus years. Those services haven't necessarily kept up with that space to transition. I think the difficulty has been that whilst it would be standard for most paediatricians to be thinking about transition from 15 on, it's about where to and finding those places. Historically, having to primarily find a psychiatrist to continue to prescribe has been one of those limiting factors.

There are processes, we have whole frameworks around transition in general for kids who have conditions that will transition into adult life. Historically, a lot of the default has been back to your GP in this space, which, as we're saying, those pathways need to evolve. Again, hopefully our models of care will help support that and help engage with people who are keen to pick up that.

Mr BEHRAKIS - Under the new model of care that you're talking about, and going forward, we talked about, we all agree about engaging GPs. If we've gotten the GP to the point where they can provide the ongoing scripts rather than the specialist, and that maintenance, we've got someone who's aged out, they're transitioning from paediatric to adult care, if that GP has the script that they've been providing that young person, now that they're an adult and they've aged out of paediatrics, can that GP then continue or does that person then have to go back to an adult psychiatrist and start again from scratch, or can they just continue on with that GP if they've already got the script on the assessment?

Dr BEGGS - My understanding, and we're going into adult space, my understanding is they still need to have a psychiatrist to be the primary overseer of the management every few years. I think it's still the three years for the adult psychiatrist to be able to get the scripts under the current regulations -

Mr BEHRAKIS - You still hit that -

CHAIR - We have talked to Pharmaceutical Services Branch about that.

Mrs PETRUSMA - Because it's in Minister Jaensch's space, we'll ask Dr Arya.

CHAIR - We did ask some questions of Minister Jaensch around this too.

Mrs PETRUSMA - We'll ask Dr Arya.

Dr ARYA - Yes, I think all those things are important considerations. When young people are transitioning to become adults, the script will continue for a while. However, for ADHD diagnosis and treatment, we do want people to have a review every two years, every three years. There is that period of two or three years of transition, if you like, where the GP can carry on prescribing, but then hopefully that is a long enough time for people to have an assessment with a psychiatrist, for example, so that a reassessment can occur and then the treatment can continue.

Mr WEBSTER - I think it's also relevant to say that the primary care space for mental health or mental ill health is still developing. With the introduction of Headspace, now probably 15 years ago, we have adult - what do they call it now - Medicare Mental Health Centres coming on stream as well. I think we only have one so far in Tasmania but they will develop. There is actually a primary care space that will develop. This space will change over the next few years as Medicare acknowledges that mental health -

CHAIR - Yeah, there's a role here.

Mr WEBSTER - or mental ill health is actually - there is a primary care element to it. It is a bit of a 'watch this space' because as those services develop, it will change the space.

CHAIR - I'll go to Cecily in a second who I know has a question on this topic as well. I just wanted to jump back in to the multidisciplinary team and it might be a question for Dr Beggs, but refer it if it's not. The paediatricians, psychiatrists and GPs who will be part of that clinic once it's fully operational, will they be full-time THS employees or are they likely to be people who are working in a private practice and working part-time for the THS as well?

Dr BEGGS - They're employed by the THS but not necessarily one FTE, is that what you mean?

CHAIR - Okay.

Dr BEGGS - They're fractional appointments.

CHAIR - Okay, so there could be many different people spending part of their time in this THS-based clinic.

Dr BEGGS - Yes. They'll be primarily - there are not lots and lots of them. There's a key paediatrician and a key psychiatrist, but they're not full time, but this is all they do for the time that they are employed by the THS.

CHAIR - Yep, got it. I'm just thinking about those conversations that need to happen between professionals when we were talking about that in terms of the clinical side of the diagnosis, is whether it's going to be those same people. If there's a young person going through the state clinic, they might have a GP in the private system as well as seeing a GP with Special

Interest through this THS-based clinic as well as paediatrician, psychiatrist, if required, and so on. I'm just wondering who it is who is going to be having those kinds of conversations around an individual patient.

Dr BEGGS - The model will probably evolve a bit, but the idea is that there will be a whole lot of pre-work done probably by a combination of the allied health team, the GPs, registrars if involved. Not all of those, but one of those doing a whole lot of the pre-information gathering work-up. By the time they get to see the psychiatrist or the paediatrician, who at the moment are the ones who primarily can make the diagnosis and prescribe, if that's what it is, have got all that information. Instead of having to be seen multiple times by those people, they only need to be seen maybe once or twice to confirm the diagnosis.

If there's confusion or ambiguity about the diagnosis, then there would be a time for that team to meet together to discuss those things. I think the GP component outside of that clinic would be very much about the ongoing management once returned to primary care, whereas the GPs in the service would be very much about supporting the initial diagnosis and the formulation about what the most appropriate management going forward would be and they would come together.

CHAIR - Got it, thank you.

Dr BEGGS - It would be suspected that there would be a time when that team all met together and particularly discussed challenging patients. When I say challenging patients, I mean challenging diagnoses, working out whether this one really is or isn't, whether and which way they should go.

CHAIR - Yeah, that makes a lot of sense. Thank you, Cecily.

Ms ROSOL - Thank you, Chair. We've been talking a little bit about that transition from child to adult and you've talked about the patients that will be able to float - I think you called it floating - in that 18 to 24-year age group, and being in CYMHS. If they have a diagnosis of ADHD, they're being seen in the clinic, they reach 18, but then they float in the clinic still, would they be reassessed? We've heard evidence of people who had an ADHD diagnosis as a child and then they have to be reassessed as an adult. Would that reassessment potentially happen in that floating stage so that once they reach 24 and then they age out of CYMHS as well, they don't have to go through that reassessment process there, it's just a smooth transition through? Is that the goal with that? I'm trying to understand how that might work for them and whether that will remove those obstructions and barriers that we've heard about from lots of people?

Mr WEBSTER - I think Professor Arya mentioned there has to be regular review, but that regular review will occur if the consumer actually floats - and I emphasise that not every 18 year old will be in this floating category; it is based on maturity assessments and need assessments as to, it's not appropriate for this person to transition to adult yet. We'll keep them in the CYMHS service. It's not going to be every patient or every consumer and it's certainly not the vast majority. It really is an assessment of maturity.

Once they're in the CYMHS service, they've moved away from paediatrics, then CYMHS would be responsible for that assessment through that period. Of course, because they've done that assessment, it will transition to adulthood, but they'll still have their regular two- to three-year reviews beyond CYMHS as well. It's a transition, a long transition phase is how I describe it for those that require it.

Not every young person who, around 17-18, is of a maturity level that they would require to stay in CYMHS, some of them are ready to transition to adult services. There is this cohort that gets a little bit lost if they transition just because of an age. That's the group we're trying to pick up with CYMHS.

Ms ROSOL - Thank you. I suppose I'm just trying to - oh, sorry Jacquie.

Mrs PETRUSMA - I was just saying especially for the priority groups of young people in out-of-home care and youth justice. That's why, out-of-home care, we also extend services up to 24 for the similar reasons.

Mr WEBSTER - Many of the people in this cohort would probably have comorbidities also.

CHAIR - They might be seeking adult services for those as well.

Mr WEBSTER - Exactly.

Ms ROSOL - I think what I'm hearing is there seems to be - review, of course they have to be reviewed every two to three years. I think we've heard that they've, as adults, had to be reassessed and that's where the difficulty is. I was trying to understand that. Thank you for explaining that.

Mrs PETRUSMA - Cecily, we'll get Dr Arya to respond to that.

Dr ARYA - It's important to consider that the purpose of reassessment is not to put a barrier. The purpose of reassessment is to consider whether the needs have changed, whether the need for treatment has changed. For most people, continuity is maintained. That reassessment just provides an opportunity to consider do we need to do something more, something different?

Mrs PETRUSMA - It's not actually the diagnosis -

Ms ROSOL - Thank you. I think that's the best-case scenario, isn't it?

Mrs PETRUSMA - I think the question is specifically in regards to do they need to be re-diagnosed again?

Dr ARYA - No, and again I think as part of reassessment you're considering what the needs are.

Mrs PETRUSMA - It's not re-diagnosed.

Dr ARYA - Yeah, it's not re-diagnosed, diagnosis once made does not mean the diagnosis will stay with the person lifelong. Needs may change, diagnosis may change, but that's the whole idea of having those frequent reassessments, that you're considering diagnosis, you're considering need, you're considering treatment, just to make sure that support that the person is getting is appropriate for their needs.

Mr BEHRAKIS - Sorry, I had another question, but just off the back of that, I 100 per cent get, as far as when we talk about reassessment or reviewing, people's needs change, people's conditions change and severities and whatnot. As far as I understand, ADHD is not something that goes away. The symptoms might get better or worse, however you want to put it, but if you if you're diagnosed with ADHD as a child or as a teenager or an adult, it's not like 10 years from now I'm not going to not have ADHD, right?

I got diagnosed as a child and then had to go through the entire diagnosis process again from scratch as an adult. We're not talking about reviewing symptoms and reviewing my condition. It was going through the whole thing again from scratch. I suppose there's two different things here. There's reviewing and reassessing and making sure that the treatment's appropriate as things change. That's different to applying somebody who was diagnosed as a child or an adolescent to have to get re-diagnosed again as an adult. I had to do that.

Dr ARYA - I think it's probably difficult to generalize these things but let me perhaps give a scenario and hopefully that will explain what I mean by reassessment. For ADHD, we use medication for treatment, we also use behavioural treatment, we also use psychotherapy and we use ADHD coaches. There are many different ways in which we can support the person with ADHD.

A young person may be on medication, but when they become an adult we probably would do an assessment to consider is medication really required? Has this person now developed some strategies to be able to manage their ADHD much better? Therefore, medication may not be the mainstay of their treatment. It may be emotional support, it may be therapy, it may be an ADHD coach. What you're trying to do is to assess those needs and then tailor your treatment to meet those needs.

You're quite right, the diagnosis may not necessarily change, however, the needs may change and therefore ADHD may not necessarily be the primary diagnosis or primary condition that you're trying to treat, if that makes sense.

Mr BEHRAKIS - Right, okay. Just so I get this question I've been wanting to ask for a little while on a slightly different note. We talk about there's long waiting lists and we're hoping these clinics once they're up and running and working and bedded in will reduce that, but there'll always be waiting times of some kind and there's waiting times in the adult space as well. Is there material or support or guidance, resources for parents and people that are on that waiting list? Say it's going to be 18 months or less in the future, rather than being put into that position of treading water, you're in limbo for 18 months, in the meantime, here are some resources that might help you create a home environment where that kid's going to, maybe not be getting all the support he needs like medication and psychotherapy, but here are some things that we can put in place to help make things easier in the meantime, so that you've got some way of supporting a child while you're waiting for 18 months, not just sit there and struggle to keep your head above water and hope that you get through on the other side okay.

Dr BEGGS - There is, but it could be better. Hopefully, again, the model will help with that a little bit. Part of that is through the pathway, so part of it is on the point of at the time of seeing GP and stuff, there are these things that may help. Part of the difficulty is going, in terms of the clinic actually putting much more back is it's hard, because they haven't made the assessments and the diagnosis to be specific about what they should need. There are points that we can provide and we do provide that, hopefully with a proper concentrated clinic will be able to do it in a better way. These are the services you could consider going to in the interim.

In terms of formalising the triage component of it as well, there may be something that comes up and says, 'Actually this doesn't look like this is the right place for you to be coming.' What we suggest is you go somewhere else, whether it be to a parenting service or something else and try that. We won't take you off the waiting list, but you try that.

Mr BEHRAKIS - In the meantime. Sort of.

Dr BEGGS - Yeah, try that. If that is what actually works, then you can let us know that you don't need the appointment anymore, but otherwise you'll still be on the waiting list whilst that happens. That's all part of the model of care that we want to formalise.

Mr BEHRAKIS - Great, because even the literature and fact sheets of what parents or people can, you know, 'These are things you can do yourself in the meantime.' One of the things we've heard, and you see it in online reporting, is the prevalence of social media ADHD influencers or what have you. Genuinely - 99 per cent of them are all well-meaning, but the reason why they're been popularized is because there isn't a source of information for people that are trying to figure it out and don't know what to do. When you've got a million different social media people telling their own little bits and bobs of advice, that doesn't lead to the best outcomes. It's the lack of available trustworthy information from a health department. This is not just Tasmania. Having a -

CHAIR - Tool kit.

Mr BEHRAKIS - Yeah, 'You might be on this waiting list for a while, here's some information for you so you can put your best foot forward.'

Dr BEGGS - We definitely want to do that. If I may, on an interesting note, because trying to get that information to families in a way - one of the things the Kids Care Clinic team has tried to look at is health literacy in a TikTok type manner, not on TikTok, because we can't do it on that. It's really hard to counter and get that information out into a way that is - so yes, we are experimenting with various ways of trying to do it in a way that is more contemporary.

CHAIR - Through school psychologists as well might be - I know it's a different department, but that might be another avenue to get that information.

Dr BEGGS - Yeah, I think on that point it's the next key thing for us, not just this clinic but us as a service, to do. We do it with a bit of networking already, that gap between education and health around ADHD and possibly to a lesser extent with ASD, is that sharing of information and expectations. Again, hopefully this service and then when it becomes more statewide the correspondence, the information sent back, the information that the school wants and the information we want from the schools will all become standardised and not clinician-dependent. I think when you don't have a service that's consolidated, where it's each individual paediatrician doing what they like, it's fine for them, but it's not so good for the schools and everywhere else that needs to know -

Mr BEHRAKIS - No one knows what the best -

CHAIR - About the needs of that child, yeah.

Dr BEGGS - Yeah, and if it's all coming in the same way, obviously the diagnosis and the individual plans will be different, but knowing that this is, 'I picked this letter up, this is clearly the letter from one of the ADHD centres or services, and this is what I expect to see in this letter, it's going to be really clear that this is where the instructions are about the medications, and this is where the instructions are for more information, and when we need to provide that information and what sort of information the clinic's going to need.' I see the standardisation of that information-sharing and stuff as one of the biggest possible benefits from this.

Mrs PETRUSMA - In regards to the Kids Care Clinics, I think there's about 20 across the state?

Dr BEGGS - They run out of 20 centres.

Mrs PETRUSMA - I know that one runs out of Kingston Neighbourhood House, for example. We're taking the clinics to lower socioeconomic areas and rural areas, and, getting back to your point, Simon, that's why we are trialling parent education sessions on ADHD, especially in rural communities through our Kids Care Clinics, so that that information is getting out to parents. There are 20 different clinics statewide in our rural, regional and lower socioeconomic area, so we're trying to take the clinics to the people so that they don't have to come in to us too. It's a pretty good system.

CHAIR - Did you have anything else that you wanted to share with the Committee, Minister?

Mrs PETRUSMA - No, I just want to really welcome the opportunity to have come here today. I can assure you that the government, alongside the Department of Health - as you can tell, we have some very passionate clinicians here who are really passionate about doing what we can do in this space, so we do welcome the inquiry. We will also welcome the recommendations.

We are determined to also work together with our federal colleagues, especially in regard to GPs, because that is a federal government responsibility. The fact that ADHD isn't on the NDIS - we do need federal government assistance to step up in this space, because, as we heard, we have too many children being referred for neurodevelopmental disorders. Australia-wide this is an issue. I'm very happy to advocate for what we need through Health Minister's meetings as well, with the federal government. We welcome your recommendations.

CHAIR - Thank you. We look forward to providing them.

The witnesses withdrew.

The Committee adjourned at 10.24 a.m.