TRANSCRIPT

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into services for people with autism spectrum disorder

Melbourne — 7 November 2016

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Ms Amanda Cattermole, Deputy Secretary, Community Services Programs and Design Division,
Mr James MacIsaac, Acting NDIS Project Director, and
Dr Neil Coventry, Chief Psychiatrist, Department of Health and Human Services.

The CHAIR — Welcome, everyone, to this public hearing of the Family and Community Development Committee's inquiry into services for people with autism spectrum disorder. This is the sixth public hearing to be held by the committee in a series of hearings that will continue through to the end of the year. In addition to hearings in Melbourne, the committee has already travelled to Geelong and Bendigo to meet with stakeholders and hold public hearings, and next week the committee will hold a public hearing in Shepparton. The committee is thankful for the support this inquiry has received from the public, particularly from people with ASD and their families who have participated in each of our public hearings to date.

Today, in a shorter format than usual, we will hear from officers of the Department of Health and Human Services and the principal of Kalianna School Bendigo. These proceedings today are covered by parliamentary privilege, and as such nothing that is said here today can be the subject of any action by any court or to any proceedings for defamation.

If you have any special needs today, see the committee staff, who will assist you. We have made available a separate room as a quiet room if anyone wishes to make use of that today. That room today is G5, which is just down the hall from this room, and again please see our staff if you require assistance.

I welcome to our public hearing Ms Amanda Cattermole, Deputy Secretary, Community Services Programs and Design Division; Mr James MacIsaac, Acting NDIS Project Director; and Dr Neil Coventry, Chief Psychiatrist, from the Department of Health and Human Services. Thank you all for attending this afternoon.

All evidence taken by the committee is protected by parliamentary privilege as provided by the Constitution Act 1975 and is subject to the provisions of the Parliamentary Committees Act 2003 and other relevant legislation. Any comments you make outside the hearing will not be afforded such privilege. It is a contempt of Parliament to provide false evidence. Recording of the proceedings will commence today, and you will be sent a proof copy of the transcript and be able to make factual or grammatical corrections if necessary. Thank you once again, and I now hand over to you for a 15-minute presentation.

Ms CATTERMOLE — Thank you very much, Chair. We have got slides set up here, but would you like some hard copies as well? We have got those available.

The CHAIR — That would be great.

Ms CATTERMOLE — We are conscious of time — we want to make sure that we provide as much opportunity as possible for members to ask questions. Neil, I think it might be worth just doing your introduction.

Dr COVENTRY — Yes.

Ms CATTERMOLE — Maybe we will not do too much on that from James and I; we are public servants, working in various areas. I will just say that the division that I look after is responsible for operational policy and funding frameworks across community and social services in Victoria, and that includes homelessness, family violence, family services, disability, child protection, out-of-home care and youth justice. That is just to situate me. James is responsible for work on the NDIS. Neil, would you like to introduce yourself a bit more fully?

Dr COVENTRY — I am a psychiatrist. My role is Chief Psychiatrist, so I have a statutory role under Victoria's Mental Health Act, but prior to that in my clinical work I was a psychiatrist in public practice. Relevant to this inquiry, I ran a fairly large child and adolescent mental health service and coordinated my autism assessment team for developmental disorder, so I am very pleased to be able to be here and contribute.

Visual presentation.

Ms CATTERMOLE — Thanks, Neil. Our intention is to take you through a fairly short set of slides. I will start, then Neil is going to talk a bit and then James. What we are trying to do is to cover off the things that you have asked us to consider. Firstly, from me, I will do a quick overview of the frameworks within which support for people with autism spectrum disorder have been developed in Victoria since 2009, which was the first one — the autism state plan. I am sure you know all of this, so do not hesitate to tell me to skip something if you have already heard any of these things. Then I want to walk through for the committee the programs and services that are available to people with autism spectrum disorder in Victoria now, and then just take a little bit of a look at the state disability plan that is coming next. Then Neil is going to go a little bit more deeply, just to try to unpack a bit more about what that journey looks like for families and children in the system now and some of the issues that we have identified, the things that we think work really well and perhaps some that work less well. Then James is going to look at the impact of the NDIS rollout. So plenty of time for questions — we will certainly try to do that, but do not hesitate to ask questions at any point.

Just to sort of run through the background, the Victorian government acknowledged autism spectrum disorder as a neurological impairment under the Disability Act 2006 in December 2008. Before that, people with autism spectrum disorder who did not also have an intellectual disability could not access disability services delivered or funded by the former Department of Human Services. The 2008 policy change made people with autism spectrum disorder eligible for disability services if they met the criteria of the Disability Act.

To be considered for support a person must meet the definition in section 3 of the Act. Are committee members familiar with that? Shall I just walk through that or are you very familiar with it?

The CHAIR — I think from our last inquiry we are fairly familiar with the Disability Act.

Ms CATTERMOLE — Great, so I apologise. Do not hesitate to tell me to move through.

There are two primary entry points into the disability services system from the Department of Health and Human Services and community service organisations, and as I am sure you are aware, multiple referral sources, including hospitals, schools and criminal justice or disability supports. After a referral there is an initial intake point for families that often occurs over the phone, and then assessment often involves a two-step process determining eligibility in accordance with the Disability Act and then determining priority of access. Again, do you want me to walk through the priority indicators that services are required to consider or are they matters you have also already covered?

The CHAIR — Only if it is in relation to autism-specific identifiers.

Ms CATTERMOLE — That is right. It is more general, the work, so how about I move through that. I just do not want to spend too much time on anything that you have already covered fully. So perhaps just looking at the Autism State Plan in 2009 — —

The CHAIR — That would be good.

Ms CATTERMOLE — Once autism spectrum disorder was acknowledged as a neurological impairment and covered by the act, an Autism State Plan was developed and released in 2009. It had six priority areas. They were: making it easier to get support; strengthening the expertise of the workforce around autism spectrum disorder; improving linkages between services and support, especially during transition points, such as a child with autism spectrum disorder moving from primary school to high school; enhancing and providing appropriate educational opportunities; facilitating successful participation in the community; and developing a robust evidence base.

The implementation was led by the former Department of Human Services in collaboration with the former Department of Education and Early Childhood Development and Amaze, formerly known as Autism Victoria. Actions against the priority areas were implemented by relevant departments. In late 2009 the key focus areas and strategies of the plan were incorporated into the Victorian State Disability Plan 2013–2016. That plan, as I am sure you know, outlines a vision for an inclusive Victorian society that enables people with a disability and their families to fulfil their potential as equal citizens. It has four goals. Again, I am sure you are familiar with those.

The actions relating to autism spectrum disorder in the state disability plan relate to goal 4, a contemporary approach through disability system reform. They have strong synergies with the priority areas for work that were in the earlier Autism Plan and were as follows: to provide support in a more coordinated and complementary approach across government; to support an integrated early years in school approach through identifying regional priority areas such as professional learning and transition support for education providers; to provide training to disability support professionals to better equip them to meet the needs of people with autism, their families and carers; to implement and evaluate a new family and carer behaviour support service and to release operational guidelines for practitioners in Child and Adolescent Mental Health Services; to improve the assessment and treatment of people with complex presentations of autism; and to provide training to mental health clinicians to increase their knowledge and skills in assessment, diagnosis and early intervention for autism spectrum disorder and mental illness. The Department of Education and Training was responsible for the delivery of actions that address professional learning and transition support for education providers.

In 2014 the State Disability Plan implementation plan was publicly reported on, including the six autism actions. During 2015 and into 2016 work has continued, and reporting for the latter years of the State Disability Plan is currently underway. Early reports back show a continued focus on delivering improved outcomes for Victorians with autism and their families and carers. You may have heard already that the Department of Education and Training has ensured that the eligibility criteria for the NDIS have been expanded to include children with autism spectrum disorder, and just as another example, the Victorian Opera alongside Museum Victoria have developed successful inclusion programs. Those are the sorts of actions that are arising under the plan.

If I may, I just want to take you through a couple of the actions that were implemented as part of the state plan and the state disability plan, then talk a little bit about the range of programs and services that are available and then touch just a bit on the upcoming plan. In terms of autism-specific disability services, the department funds a range of those. Amaze — the peak organisation, as I am sure you know — is funded to provide an information and support service. Mansfield Autism Statewide Services is funded to deliver community-based respite, flexible support packages, individual support packages, outreach support, supported accommodation, case management and behaviour support. Aspect is funded to deliver individual support packages, respite and futures for young adults, and it is also funded to deliver behaviour support. That initiative commenced in 2012 as part of autism initiatives in the state disability plan. Over 2300 families and carers have attended Aspect's positive behaviour workshops. They have been delivered in several languages, including Cantonese, Mandarin and Vietnamese, and in rural and metro locations. The program enables families to access support before reaching crisis point and provides the opportunity for families to connect with each other. Six hundred and forty families have been provided with more intensive individualised support to implement behaviour support plans at home and in other settings that their child might engage in.

Other supports include individual support packages. People who are assessed as meeting the eligibility criteria and the priority of access guidelines are of course able to access a range of disability supports. In 2015–16, 15 205 people were in receipt of a Disability Services individual support package, of which nearly 11 per cent were allocated to people with autism. That is, as I am sure you may have heard, a self-directed individualised support program, and the person and the family can choose the type of support they need and the service provider who will deliver it.

Futures for Young Adults funding can be used to purchase supports to develop school leavers' independence, such as support to learn to budget or to work successfully as a member of a team, and funding can be used to help young people achieve their community and economic participation goals, including engaging in everyday activities with increasing independence.

Then there are a series of respite programs. The community-based respite program allows for more individualised approaches to provide families and carers with a break from their caring responsibilities. Children with autism have been supported to attend school holiday programs and other non-facility-based respite options.

There are also day services, providing activities for groups of people to enhance community and social participation, including things like skills development and recreation. There is also a supported accommodation program. As I am sure you know, it provides accommodation support for one or more people with a disability on a long-term basis. It is linked to the service rather than the individual, and it is not transferable when a person moves from the service. As at 30 June of this year, there were 1671 people registered on the disability support register as waiting for supported accommodation.

The department has purpose built some accommodation facilities, such as the facility in the outer East which is owned by the department, for tenants with autism spectrum disorder who display behaviours of concern. It consists of four self-contained units to house four tenants. The support model at the facility includes input from clinicians who have experience with clients with behaviours of concern; they would assist the support staff to implement positive behaviour plans, including learning techniques for de-escalating situations.

Eligible people with the highest need for support who are on the Victorian disability support register and children on the early childhood intervention service list will enter the NDIS over the first 18 months regardless of their location. That might mean that we have opportunities for people who do not then need to move into shared supported accommodation but can have a look at other options.

There are then a range of supports to reduce the use of restrictive practices in disability services. I do not know how familiar you are with those, and if you want us to walk you through that, around the work of the Senior Practitioner or — —

The CHAIR — Yes, if you could touch on it, thanks.

Ms CATTERMOLE — Okay, can do. The Senior Practitioner — disability is responsible for ensuring that the rights of a person subject to a restrictive intervention and compulsory treatment are protected and that appropriate standards in relation to these practices are complied with. Inappropriate use of restrictive practices in disability services can be brought to the attention of the senior practitioner in a number of ways, including as a result of inquiries by families, carers and advocates, and disability support providers, through information exchange with the Disability Services Commissioner and the Public Advocate or through a practice review.

Disability services providers are required under the Disability Act to report to the senior practitioner on the use of restrictive interventions. The Senior Practitioner becomes involved in individual cases and provides staff training and consultancy and broader system strategies, such as ongoing refinements to the Restrictive Intervention Data system used to record the use of restrictive interventions, and monitors behaviour support plans.

Other important initiatives include that there is a senior officer from the Senior Practitioner's office who has been seconded to the Department of Education and Training. The role of that person is to develop the oversight of restrictive interventions in Victorian government schools, and that person reports back directly to the Senior Practitioner.

There is regular delivery of training programs that are aimed at building skills in developing positive behaviour support, understanding the needs of people with autism and managing behaviours of concern. Since 2010 over 7000 staff have attended these courses. The Senior Practicioner – Disability has also developed of practice guides to address sexual behaviours of concern in people with intellectual disability and autism spectrum disorder and wandering or elopement in people with autism spectrum disorder. In addition to that training program the department has also worked on a range of other programs that assist in improving and growing staff skills in developing positive behaviours and understanding behaviours of concern.

To support this *Access Policy Practice Advice — Autism Spectrum Disorder* was released and updated in 2011. In June 2016 additional funding was provided to enable the Mindful Centre for Training and Research in Developmental Health to continue to deliver autism spectrum disorder training in assessment, diagnosis and early intervention for mental health services, and that is to continue until June 2018. The Centre was also funded to develop *A Guide to Identification, Diagnosis and Treatment of Autism Spectrum Disorder in Victorian Mental Health Services*. That is a guide that is available online. In fact, Neil will talk a little bit more very shortly about that work on mental health action to respond to the need for access to assessment for autism.

Reflecting on things we could do better, I think there is still a view that we could definitely do better in supporting children, adults, families and carers by providing a more coordinated approach across government and in particular during transitions. I think that is something that we need to continue to actively work on, particularly when a child needs to exit an early intervention program, for example, and access a disability support program.

We also need to work, we think, on really augmenting transition support in the Futures for Young Adults program to make sure that we just provide, again, as much assistance as possible, particularly in that transition to post-school options. Of course, with the NDIS, there will be a whole lot of work that will go into that that will hopefully help with that whole-of-life support which will augment some of these areas that we have identified that we need to continue to work on.

Just to touch on, if I may, the upcoming plan: the Victorian State Disability Plan 2017–2020 is currently under development and due to be in place by 1 January of next year. Obviously we are not quite there yet, so there is only so much I can say, but I can certainly say that it is intended to have a strong focus on people's experience of the system, including equality, inclusion and participation, and a focus on shifting outmoded and negative attitudes towards disability held by some members of the community. It is intended to be about the future and how to help remove the barriers that prevent people with a disability from having the same opportunities as everyone else. That is my overview.

The CHAIR — Did any of you want to present as well, or shall we jump straight to questions?

Dr COVENTRY — Yes, we will present. Do you want to go straight on?

The CHAIR — Yes, probably that is best. Thank you.

Dr COVENTRY — I am going to be hopefully complementing what Amanda has been presenting from my role as chief psychiatrist. I am coming from a clinical perspective. There are a couple of areas I want to talk to you about. One is to take you through how a family actually gets the diagnosis if they have a young child suspected of having autism. Then I want to amplify a bit about what Amanda was saying around restraint and seclusion — these are what we call restrictive practices — and how that might be relevant to the work that I have been doing to reduce those sorts of practices for autism. Then I want to talk about two quite exciting initiatives to hopefully improve the outcomes for people with autism.

I will start with assessments and talk about public mental health services. We have autism assessment teams across all child and adolescent mental health services in both metropolitan and rural services. That is not something we used to have. When I started training you could not actually get that assessment if you were in rural Victoria and even in metropolitan Melbourne it was very hard.

These are multidisciplinary teams, so they follow the internationally accepted golden standard, the NICE guidelines, for having a multidisciplinary assessment, which includes a child psychiatrist or paediatrician, a psychologist or neuropsychologist, a speech pathologist, plus or minus other allied health staff. It is a fairly comprehensive assessment. Each team has a funded coordinator who assists in making sure it works fairly efficiently, and we also have a funded statewide autism coordinator.

The system is designed in Victoria to give to some extent some degree of choice so that people can either choose to go private and have a number of these assessments done if they have the capacity, or there will be some community centres and non-government agencies that can provide this. My job with Child and Adolescent Mental Health Services is to make sure they are seeing particularly the most complex cases where they have the specialist expertise.

How does it work in practice? It is really mainly an early diagnosis intervention service, particularly for children aged around about three to six. As you know, it is very important to assess and make the diagnosis as early as possible and link families into the appropriate support.

How it works in practice is that the coordinator will gather a lot of background information and make sure there has been the usual paediatric and other assessments to exclude other diagnoses. Then the team meets with the family and takes a comprehensive family developmental history. Usually that is done through a one-way screen so the family can actually observe the staff interviewing and assessing the child. Various assessment mechanisms are used. There is no one particular perfect diagnostic tool. People sometimes use a mixture of the DSM-5 criteria, the ADOS criteria and other criteria as well. Then the feedback is given to the family. It usually takes somewhere between 3 and 4 hours.

This is very different to the bad old days when diagnoses were made by one clinician, sometimes during an on-the-spot assessment, without a comprehensive assessment. These teams also have the capacity if required to go and do a kindergarten or school visit or a home visit for some of the complex cases where it is not exactly clear. The outcome, after giving the feedback to the family and supporting the family, is to try to link them into appropriate services. In some cases that might be staying within the public mental health service in the community outpatient teams where they might need ongoing help, but often it is linking into appropriate education and early intervention support services.

I will just talk a little about restrictive practices. As I am sure you are aware, unfortunately there is quite a high comorbidity or coexistence of psychiatric illness and autism. It means that some autistic young people and adults end up in our public mental health services. Particularly because of their difficulties around verbal communication often their distress is communicated by challenging behaviours, and it is challenging for everyone to understand how best to try and manage them.

In Victoria we have had a very successful project across all mental health services and also including emergency departments to try and reduce what we call restrictive practices. This means seclusion, where someone is in an isolation room, or bodily restraint, either using the old-fashioned bodily restraint mechanisms we used to call shackles — we do not call them that anymore — or physically holding. In some cases people with diagnoses like autism get subjected to these practices. We have now got very strict criteria about how they can be used under the Mental Health Act. They can only be authorised in particular, specific situations. They have to be authorised by a psychiatrist. They have to be regularly reviewed, and there are a number of hoops people have to jump through in terms of documentation and review. My job in the department is to audit all of this on a monthly basis. I can go to investigate if I have got particular concerns about any individual patient.

With respect to autism we hope to train staff to look at what the meaning of the challenging behaviour might be and to try and do a more sophisticated analysis of that before jumping into using these restrictive practices, which can be for people with autism quite detrimental and very frightening and traumatic. They really need to be a last resort, so we are training all of our staff to diminish, and if possible totally diminish, the use of these practices but particularly to think about people with autism and intellectual difficulty disorders who may be subject to these sorts of practices.

Lastly, I wanted to talk about what I think is a very exciting initiative: the MHIDI — the Mental Health Intellectual Disability Initiative. This is not just specifically for autism, but it will have a major cohort of autism. It is looking at both teenagers and adults. There will be two separate teams; one will be working with 12 to 25-year-olds and one will be looking at people 16 and above. They are community-based specialist multidisciplinary response teams in two different geographical areas of Melbourne. The target is going to be people with intellectual disability who either have a mental illness or are at risk of having a mental illness. The teams provide comprehensive reviews and secondary consultation. They develop partnerships with health and disability services to hopefully train health personnel to understand these difficulties in a different way and also to help disability support services understand the mental health issues, because they are quite significant and sometimes get neglected.

Also very importantly they will have a role in reviewing the ISPs, which Amanda was talking about, and the medication regime, because one of the concerns is that sometimes young people and adults get put on quite complex medication regimes which may not be helpful or, at worst, may even be quite harmful. It will be an opportunity to try and review that.

I was very pleased that when we set up these pilots one of them was looking particularly at young people, teenagers, because they can sometimes get a bit forgotten about. It is early days yet, but we are hoping that this will give us some increased practice wisdom and some links, and hopefully it will be able to be rolled out across the state.

The CHAIR — Thank you very much. Did you want to make a contribution, James?

Mr MacISAAC — Finally, just in terms of the NDIS, I know the committee has probably heard a lot around some of the opportunities and challenges with the NDIS, but I thought I would just try and provide a bit of a general overview of the arrangements here in Victoria for the NDIS.

The slide there details some of the broader dimensions of the NDIS. I do not want to go through all of those, but fundamentally, while we have got 460 000-odd estimated participants that will have an approved plan across Australia, our estimates in Victoria are that by the time we reach full scheme in 2019–20 around 105 000-odd Victorians will be in the scheme with an approved plan. That is a significant increase on what we estimate now is currently around 78 000 people across Victoria who are receiving services that are in scope of the NDIS. That is a significant increase. Overall there will be almost a doubling of funding for Victorians in the scheme from current funding sources — an increase of $5 billion overall and a $2.5 billion contribution from the Victorian government.

Fundamentally of course the three pillars of the NDIS focus around a social insurance model that, critically, will provide an early intervention pathway into the scheme in addition to supporting people under 65 with ongoing, enduring permanent disability. Again it is centred on the individual and choice and control to put them at the centre of their funding, their services and the choice that they will have to purchase those services. Of course also it will be critically building on community and mainstream service systems, which will also continue to support people in the scheme.

Just in terms of transition in Victoria and the next slide, the committee is well aware of course that the trial of the scheme in Barwon was a very informative opportunity to assist not just the Victorian government but also the Commonwealth around how we designed the rollout of the scheme over the current three-year period that we have just commenced, which runs from 1 July 2016 to 2019. In Victoria through the bilateral agreement, which outlines the approach that we are taking, we are taking a staged approach to the rollout where we will move across Victoria over that three-year transition period. The number of people that will access the scheme are outlined there, with 15 000 additional people to come into the scheme over the course of this current financial year.

The final outcome of the trial result in Barwon was very close to what was originally estimated. We had 5284 participants that had an approved plan in Barwon at the end of the trial period, and this number is still growing. What we will be looking to do now, as well as taking an area-based approach, as Amanda mentioned earlier, is allow people with a priority need on our waitlist to come into the scheme more urgently over the next 12 to 18 months.

Just in terms of the next slide, the committee will also be well aware of course that the commonwealth legislation guides participation in and access to the scheme, so there is the pathway around significant and permanent disability but also importantly a second pathway around early intervention, which is very important in the context of people experiencing autism. I think the early evidence from the trial site — and I think this also is the experience across other jurisdictions — is that around 28 to 30 per cent of people are coming in through that early intervention pathway, as opposed to 70 per cent through the disability pathway.

Most of the supports of course will continue until the NDIS arrives in particular areas across the state. Victoria will continue to provide those services, and the Commonwealth and Victoria will also continue to provide ongoing continuity of support arrangements for those individuals that are not deemed to be eligible in the scheme. Importantly Victoria, along with the Commonwealth, will continue to provide existing quality and safeguard arrangements. So through transition up until the Commonwealth implements new national quality and safeguard arrangements, Victoria and the commonwealth will continue those interim arrangements which are outlined in the bilateral agreement. We have invested significantly in transition support, both to provider groups and also to consumer groups, both provider and participant readiness activity, and more recently the Victorian government announced its workforce strategy for NDIS with its commitment for a further $26 million in a range of activities.

Just in terms of what we now know from our experience in trial, we have had around 1164 people supported through the Barwon trial with a diagnosis of autism and related disorders, so that roughly is around 22 per cent. That figure is roughly comparable to other jurisdictions. It is slightly higher in those jurisdictions like South Australia, where they have got more of an age-based cohort with younger people coming into the scheme. That is the highest primary disability of all people coming into the scheme.

What we are looking to do — and I know you have heard from the NDIA more recently — is introducing the early intervention, early childhood pathway. The scheme and the agency are very focused on how we can support children into the scheme in that early childhood area, so that is something we are working with them on closely. They are working with their service partners around bringing children into the scheme and importantly focusing on a holistic approach to assessment. It is not diagnostically focused, so a diagnosis will be an important indicator, but it will not be the only thing that the agency uses to identify people coming through that early childhood, early intervention approach.

Critically there are a range of mainstream service system responsibilities that the state will continue to have, as will the commonwealth. Some of those systems are outlined on the overhead there. Governments have agreed to a set of principles that guide what the NDIS will cover and what other mainstream service systems will provide. Critically for the department there are a number of areas there, including health, mental health, child protection and family support, where the department will continue to have a strong role, where there will be many participants in the scheme that are continuing to receive those services, where the department will continue to provide funding and support in those service systems outside of the NDIS. We are doing a lot of work with the

NDIA around the practice training and support that we can provide to various workers in those service systems to assist with better understanding of the scheme, better understanding of how we assist people moving through access into the scheme, and we will continue to monitor that closely over the next three years.

The CHAIR — Great, thanks very much, James. Yes, we have heard quite a bit about the NDIS, as you would be aware from our previous inquiry, so we are quite familiar with the transition and how it is rolling out. I have a couple of questions. Neil, you mentioned the multidisciplinary teams, ages three to six years. I just had a question around that. Is there a waiting time for assessment?

Dr COVENTRY — Yes, there is, unfortunately. It is not as bad as it used to be, but probably across the state it would be an average waiting time of about six months, I think.

The CHAIR — Is that variable between regions?

Dr COVENTRY — Probably to some extent. It is probably a little bit less in metro regions and probably in rural regions a little bit more, partly because in rural areas there is not the other access to private capacity, really, so they have all got to go public.

The CHAIR — So are they situated in the main centres?

Dr COVENTRY — Every CAMHS — every Child and Adolescent Mental Health Service — has that specialist team.

The CHAIR — And they are Bendigo, Ballarat, Geelong?

Dr COVENTRY — Bendigo, Ballarat, Mildura, Warrnambool, Barwon-Geelong, plus all the metro areas.

The CHAIR — I also had a question for my own particular interest in this, actually. It is probably not for you; it is probably more for the department. We actually came across this at one of the schools we visited, and it was quite concerning. They had 20 of their students who were in out-of-home care who were diagnosed with ASD. I was just wondering: do you have any data on how many children in out-of-home care have ASD across the state?

Ms CATTERMOLE — I would have to take that on notice, Chair.

The CHAIR — That is fine. I thought you might.

Ms CATTERMOLE — I do not know, actually, whether we do.

The CHAIR — I did not want to put you on the spot, but I think it is important for us to know that information.

Ms CATTERMOLE — That is a significant number. I will take that on notice and come back to you on that.

The CHAIR — That would be great; thanks very much. My other question was, with the previous Autism State Plan and the new Victorian state disability plan, which hopefully will incorporate some fantastic recommendations, I just wondered how you are going to incorporate the Autism State Plan into the new disability state plan and, if you can tell me, what the future priorities for supporting people with ASD will be, without sort of telling me what the plan is. Do you have an overall sort of idea?

Ms CATTERMOLE — I do not have a great deal more than I shared at the beginning, which is that the way in which it has been conceived is that that plan rolled into the previous plan, whether or not you think there is anything extra there. That was certainly the idea — that the goals, principles and actions folded in there, and then we are continuing to take that same approach into the next plan, with I think the extra being that we have learned as we go along what is the next way for future-focused implementation.

The CHAIR — And be able to fill the gaps where we know the gaps were, following the last Autism State Plan, and perhaps not meeting all of those directives within that plan, and stepping it up a bit to actually fill those gaps.

Ms CATTERMOLE — That is my understanding — that absolutely all of those learnings roll in, and then anything we think has not been properly acquitted we will drive further.

The CHAIR — Just on the ISPs that we currently have, and there is a waiting list as well — you will probably want to take this on notice as well — I just wondered how many people with ASD currently receive an ISP. Do we have that data?

Ms CATTERMOLE — Yes, we do. So for the financial year 2015–16, 1722, so that is just on 11 per cent of the total number of people with ISPs.

The CHAIR — Most of those people with the ISPs, would they have comorbidities, as in intellectual disability?

Ms CATTERMOLE — I do not have that information.

The CHAIR — You do not have a breakdown of the data?

Ms CATTERMOLE — No, I do not have anything more granular than that on me, but I can — —

Dr COVENTRY — I would imagine it would be very high.

The CHAIR — Yes, I would imagine so too.

Mr MacISAAC — Some of that data will be available.

The CHAIR — But some of that data might be useful for our committee.

Ms CATTERMOLE — We can certainly chase that down for you.

Ms McLEISH — I do not know if you are able to answer this. I am trying to get a bit of a feel about the amount of money you actually give annually to autism support services, because you mentioned that you support Mansfield Autism Statewide Services, Amaze and Aspect — and you listed a whole lot of them. Do you know what it is annually — how much you — —

Ms CATTERMOLE — Overall, annual, I do not have that here. I can certainly see how much we can aggregate, particularly those autism-specific services. If you would like an aggregate amount on an annual basis, I can certainly get that.

Ms McLEISH — That would be good. Just following from that, and with all of the different programs — I know you threw around a number of participation rates and things like that — how do you measure the outcomes?

Ms CATTERMOLE — Sorry, in which — —

Ms McLEISH — You are providing funds to a lot of areas. How do you measure outcomes as distinct from participation rates?

Ms CATTERMOLE — Again I would have to take that on notice in terms of tackling each one and providing you with what the outcomes framework is for each of these different services. I do not have that kind of detail.

Ms McLEISH — So do you have a specific outcome framework for all of the different services?

Ms CATTERMOLE — Yes, and we have been working at departmental and state level on a broad-based outcomes framework that we are then going to try and test further down. That is a work in progress at the moment. There have been outcomes frameworks in various of these, but they differ because a lot of them have been more focused on participation until now, so I would have to really unpack which of those and how far they go — the ones we have got here. Certainly at the moment that is exactly where we are trying to head — to frame it.

Ms McLEISH — The reason for my question is that I am aware of the Auditor-General's briefings — I go to them every time Parliament sits — and the lack of rigour around outcomes is absolutely noted. It is great to be funding programs, but we want to know what areas are getting best value for money and whether we should be looking as governments to channel more funds to particular areas because you think that is getting a better bang for the dollar or more effective.

Ms CATTERMOLE — That is absolutely what we are trying to achieve at the moment with a broad-based outcomes framework across the Victorian state government that then has much more specific detail in each of the departments and then will flow into the way in which we measure services. That has happened in various ways for various services, but has not happened in the holistic way that we are trying to achieve now.

Ms McLEISH — For us to try and get a good feel about, from the government's point of view, what works best, is that difficult to ascertain?

Ms CATTERMOLE — I guess it depends on how broadly you are asking that question. Certainly we have evidence about what works on some services. Once you start to get into the interrelatedness of what works best across a range of services, that is exactly the work that we are really trying to embark on right across the state at the moment. I can sort of try and unpack that a bit more for you in terms of some of these.

Ms McLEISH — That would be good.

Ms CATTERMOLE — It will just be a question of how much in relation to each one.

The CHAIR — Yes, that would be great.

Ms COUZENS — Thanks for coming along today. I have just got a couple of questions, particularly around the assessments. In the Barwon South West, for example, the assessment waiting period is well over six months. Regional and rural areas tend to suffer a bit more with those waiting lists, but one of the things that keeps coming up is actually getting onto the waiting list and having that assessment done prior to the child beginning school. Any child that is not in that criteria is being pushed to the back of the list because the therapists are making a priority of the children about to start school. Is there anything being done around that demand to ensure that that early intervention is going to happen much more quickly?

Dr COVENTRY — Yes, there was, and we still need to improve on this. I think you might have already had a submission from Professor Bruce Tonge from Monash University. Some years ago Bruce was involved in helping us across Victoria with the waiting lists, and it was a waiting list reduction. I am ashamed to say that at that stage the waiting list was much greater than six months across the state. That got the waiting list down quite dramatically.

The problem we are finding, and I am sure you have had some submissions on this, is the demand for assessment seems to be increasing. It is not clear if there is actually an increase in the rate or epidemiology of the condition or if more people are aware of it and needing to have that comprehensive assessment. All the teams have been trained to work on the same model, so they all do this as efficiently as possible within the international standards. Yes, you would be right that priority would be given for the cases where children are needing to start school and actually need that diagnosis to get support services.

The other group that is missing out would be the older group. Again I am sure you are aware of this. We do not tend to use this label anymore, but there is a condition called Asperger's, which is the higher functioning children with autism, usually with normal or near normal IQ level. As Amanda was saying, they sometimes only present at the transition between primary and secondary school, as a crucial point, and that is another group that is missing out.

So, yes, I think there is a problem in terms of the demand. There is also a problem, I think, in terms of the choices because, as you know — you are from that particular region — in some rural areas there are not the private practitioners that can offer an alternative, or people do not have the capacity to afford that.

Ms COUZENS — Yes, I think affordability is a big issue on that one. You mentioned referral links to services. One of the difficulties — I know in my region, for example — is there have been services that have actually closed their doors because the NDIS has come into play, and that is affecting their funding. Given that, as I said, services in my region are closing and it is potentially going to happen across the state, how are you dealing with ensuring that the links to services are there? That is one question. The other question is: we have heard from a lot of parents that once the diagnosis happens no other information is provided, or it is very limited, and they do not know where to go to get that support.

Dr COVENTRY — Yes. Look, that would be concerning because it is a diagnostic assessment service, but it is meant to be providing that, so that would be concerning if that was the experience.

Ms COUZENS — That is not necessarily at Barwon, but I am just saying we have heard from parents.

Dr COVENTRY — But if that is people's experience, because they do need to be given a lot of education, one of the focuses is actually parent education to help them understand the significance and the impact. In terms of how it might be affecting local services and closing, I would hope that the autism coordinators of each team would be employing the statewide coordinator who could manage that to up to Amanda and me so that we could be aware of that. I think the NDIS did obviously create some confusion about who was going to go where. One of the advantages with the NDIS is that you do not need the diagnosis. It is looking at your level of function, which is a better way of looking at the sorts of supports that might be required. But it is certainly something I can take on notice and check with the statewide coordinator if there are particular pockets of Victoria where people are not able to access the support services because of that.

Ms COUZENS — We have an organisation called The Treehouse in Geelong, which supports over 1000 parents who have children with autism at varying ages. That is a voluntary organisation, and they are under the pump to provide families with information because these families cannot get it anywhere else or they are not getting it or do not know where to get it. They are playing a significant role in our community with no funding, just basically running on a volunteer basis.

Dr COVENTRY — That is certainly something I will take on notice and look into, because I would be expecting that the public mental health services should be supporting them and they should be providing that sort of information. Linking parents in is part of their responsibility.

Ms COUZENS — Just one more question around the NDIS — and it is probably more directed to you, James: one of the things that we have heard in going around, particularly talking to schools and teachers and principals, is the confusion about therapists coming into the school during school time. Has that come up for you; is that something that you are working on?

Mr MacISAAC — I think our colleagues over in the department of education are probably more involved in some of those discussions with schools. I think the experience from Barwon was that this was a challenge — working through with parents and even existing state clients who are receiving services, less probably so in the early childhood intervention area, but within schools, trying to get good information out to schools and principals to give them information about what the scheme was able to provide. I think there is probably a need to do some more work around how we work across the state. As further areas across the state are rolling out, it is what we can do around activating an understanding of those arrangements. My understanding is that most state system schools will be accommodating around working through what can be done in terms of bringing practitioners into the school to look at assisting particularly at the assessment end. I think again schools have various arrangements in regard to accessing support services. There are state-funded support services in terms of allied health professionals — practitioners that support schools. Those conversations would be had with parents and with the school, with the principal, about what is most appropriate in any individual setting.

Ms COUZENS — It is more about children with packages who have got a speech therapist requirement on a regular basis and how they actually access the school, so it is more around that individual service.

Mr FINN — Thank you, Chair. I think your first question was how many people are on the spectrum in Victoria?

The CHAIR — How many with ISP were on the spectrum.

Mr FINN — Okay, well, I will take it one step further. How many people are on the spectrum in Victoria? Does the department have that figure?

Mr MacISAAC — I do not think there is really any national prevalence or state level data on total statewide population levels of — —

Mr FINN — Do you think it would be helpful to get that?

Ms CATTERMOLE — Yes, I think the more information that we have the better.

Mr FINN — Is there a way of actually doing that then?

Dr COVENTRY — It would be somewhat challenging. The difficulty in mental health would be we would only get the cases that have come to mental health, and there are quite a number of people who have particularly the higher functioning level of autism that would not be known to services. We only get the ones who have actually presented. It is certainly something we in mental health could track down. That would not be everybody though.

Mr FINN — But it would be good to have even a vague idea?

Mr MacISAAC — I think the Australian Bureau of Statistics carries out regular surveys as part of the general census. Also as part of the special disability and ageing carers survey there is work done around identifying people with disabilities more broadly and that is broken down into various levels of primary diagnosis. I think we are just about to go through another cycle of that survey. The ABS runs that survey and it is funded both by states and the commonwealth government. I would imagine that some of that data might be becoming available from this latest round of the 2015 survey. I think they did some similar work previously that they released in 2014, again identifying national prevalence.

Mr FINN — Let us hope they do not do it on the net!

Could I ask about the role of the NDIS in funding early intervention programs, because we know that early intervention in Victoria for children with autism is manifestly inadequate. Does the NDIS propose that there will be more funding for children with autism once it is up and running?

Mr MacISAAC — I think the answer to that is a positive yes! Overall there are significant amounts of new people who will access the scheme, so we have estimated an increase of around 30 per cent of existing clients who will receive services, and there is a significant amount of additional dollars that will flow into the scheme that will mean a significant uplift in existing client packages but also a broader amount of supports that will be available based on the individual needs of any participant who is eligible. I think, as I indicated earlier, the evidence already is significant in terms of the amount of people that are coming through the early intervention pathway. That is roughly around 30 per cent of people that are accessing the scheme, which is not necessarily those individuals who have lifelong disability but would benefit from early intervention. That is not just supports that would be supporting people on the spectrum but more generally supported through early intervention.

I think you are also seeing a significant amount of increase of new participants coming into the scheme in the younger age groups. When you look at the data that the scheme actuary presents — and you can have a look at this on the NDIS website — you can see the high numbers of children coming into the scheme. So a large majority of new clients accessing the scheme are younger people — 0 to 6, 7 to 14 — coming into the scheme, so again the scheme actuary has some more data on their website, where it breaks it down into the sorts or types of services and the funding that those services are providing. There is one particular report there where they report on the nought to six age group, which is not specifically autism, but would be a fairly good proxy for both children with autism and related developmental disorders.

Mr FINN — World's best practice demands that children with autism receive at least 20 hours of early intervention per week. Now, in Victoria at the moment if they get 2 or 3 hours per week, they can consider themselves extraordinarily fortunate, and there is a significant waiting list in most areas. How will the NDIS improve that situation? Will there be more early intervention for those children who are receiving far less than they should at the moment, and will those children on the waiting list be able to access early intervention programs?

Mr MacISAAC — When we looked at designing the transition schedule we were quite mindful — while acknowledging an area-based approach was going to be logistically the most appropriate way to move forward in moving all of the existing clients across into the scheme — of the fact that we wanted to focus on those individuals who were on state waiting lists. So in particular the early childhood intervention services waitlist was a clear focus for us. There were about 1800 people estimated that would come in and off that waitlist and there is a significant amount of churn, so people go on the waitlist but the most urgent people tend to get into services within a reasonable time frame based on their need.

One of the things we were mindful of was to give priority access, so a number of those individuals will now come off that waiting list over the first 18 months of the scheme, as will a number of people off the Disability Support Register. So there is priority access into the scheme.

There are additional levels of funding available for people on the spectrum and for other younger people who are coming into the scheme through the early intervention pathway. So I think the data already that is being reported on by the scheme actuary is indicating that a significant percentage — and I think the data in Victoria was suggesting around 70 per cent — of people would be receiving a package over $10 000 per annum. I think the large percentage is around about 50 per cent of people receiving a package between $10 000 and $20 000 per year in terms of the average package cost, with another 19-odd per cent above that $20 000. So a significant amount of people are getting higher than $10 000.

There are a number of the existing programs of course — not just the state programs but commonwealth programs — so the HCWA program has a series of caps. You are probably well aware that the HCWA program has a $12 000 cap, so the idea of the scheme is not to have a funding cap per se but people would receive what would be reasonable and necessary under the NDIS legislation for their particular needs, based on those assessments that would be undertaken with those individuals.

Mr FINN — So what would be the average per week that each child would receive in early intervention — how many hours per week under the new system?

Mr MacISAAC — I am not quite familiar with an hourly rate per week, but that is something we could have a look at with the scheme actuary. I am not sure. I have not seen that particular level of data being provided.

Mr FINN — It is particularly important given that 20 hours is a bare minimum and it is a mere fraction of that at the moment. How many children do you think will actually go off the waiting list for early intervention as a result of the NDIS coming in?

Mr MacISAAC — Off the ECIS waitlist we estimated around 1800 across the state. That waitlist changes because there is a dynamic based on the — —

Mr FINN — That is purely autistic children?

Mr MacISAAC — No. That is the broader set of people who are eligible for the early childhood intervention services program, so that would be children with autism but also with broader developmental delay issues.

Mr FINN — As you know we are talking about a spectrum here. So you have got people up one end who are university professors and you have got kids down the other end who are banging their heads against a wall and causing a great deal of distress to themselves and others. At what point in that spectrum does the NDIS kick in?

Mr MacISAAC — The NDIS is going to be available for the two general pathways into the scheme: those people who have permanent significant disability but also the other cohort being those that would benefit from early intervention. So I think, as I mentioned, we are seeing around 30 per cent of people enter the scheme through that early intervention pathway, which would be supporting a whole range of people across the spectrum in terms of their functioning levels. But at some point the scheme will be looking at making decisions not based on diagnosis but based on a need for functional improvement and opportunity to make that improvement in terms of any developmental deficits for individuals.

Mr FINN — What criteria will be used in that judgement?

Mr MacISAAC — Neil is probably more across some of those diagnostic tools. I think he mentioned some of those areas before — the same sorts of tools that are currently being used.

Dr COVENTRY — I do not know if I can give a definitive answer to this, but I think what you are alluding to is the higher functioning student with autism who may not be eligible currently under our system for integration support.

Mr FINN — I will just give you an example of the education system, where 70 is the IQ level where everything magically changes. I am just wondering if there is a similar starting point for the NDIS?

Dr COVENTRY — No, I do not think it will be. My hope as a clinician is that it will be a lot more comprehensive and sophisticated than just an IQ level. The concern we have as clinicians is that the higher functioning people with social and language difficulties that might actually not have an obvious language impairment but their social use of language is really impairing them get missed in some of these fairly crude measures of cutting off. If we see an NDIS system that is actually much more inclusive and looking at the level of disability — as to how that gets measured I would have to say there is no international standard. Unfortunately for this, that is still a work in progress. But I think it will hopefully pick up that group who currently are being missed, certainly in the education department standard, because the subtleties of their language difficulties is not being picked up in that sort of scoring. It is a very crude measure, and particularly when they are higher functioning intellectually they just miss out.

Mr FINN — Doctor, just while we have got you there. You mentioned earlier restraint and those sorts of things. We have heard some horror stories about children being put in boxes and cages and just totally dehumanising scenarios. How common is this level of restraint?

Dr COVENTRY — I probably cannot talk about that more than what you know, just anecdotally. I do know that the education department is very concerned about this, and one of my colleagues from the department is working with them specifically to look at those sorts of restrictive practices. My brief as Chief Psychiatrist is when these young people — children or adults — end up in mental health services that they get managed much more appropriately. So I take a very strong view about anyone with autism or any intellectual disorder who is subject to any of these sorts of interventions, and I have the capacity to actually go out and do a review of the patient, interview staff, find out what the management plan is. And, as I said earlier, if it is a management plan that is not comprehensive in looking at the meaning of the behaviour, then that is really very concerning to me, so I would bring in my colleagues from disability and the department to assist. I do not have jurisdiction over schools, but I do have some concerns and I am very pleased that they are now taking that seriously as well. My legislation only covers the Mental Health Act.

Mr FINN — We have had people with Asperger's who have expressed to me personally and indeed to this committee their concern that the term Asperger's is no longer used. Why was that done away with, if I could use that rather crass term?

Dr COVENTRY — I am not sure it was a particularly good move. What you are alluding to is under our diagnostic and statistical manual, which is sort of like the Bible that psychiatrists have to use to make diagnoses, the term Asperger's has been used in the past for children and adults who have more subtle social language disorder but may be of normal or near normal intellectual capacity. The difficulty is that the term was used somewhat loosely, so it was very hard to validate.

The concern from people in the field, including my patients, is that many are worried that they are going to miss out on having that diagnosis and therefore will not get support. There are others who much prefer to have a diagnosis of Asperger's rather than autism spectrum disorder, as you are alluding to. It is a spectrum, so you have people who are very severely disabled and people who can be very high functioning but still have the same condition, so it is a very confusing label in many ways. I would hope that that group does not get lost. My concern is they are often not presenting to services until they go into secondary school because their functional difficulties are much more subtle, and sometimes they do not get diagnosed at all. Once you understand they can make the diagnosis and help the teachers and support staff and families, things can really improve for those young people. They can be subject to bullying and learning problems et cetera. Unfortunately it is a done deal with Asperger's not being in, but I hope that the criteria are inclusive enough that they will still find a place in getting the right sort of attention that they need.

Mr FINN — Who did the deal?

Dr COVENTRY — It was very complicated because these changes involve a whole lot of consensus from practitioners across the United States. I can say that was probably one of the most controversial decisions that was made. These things change, so you never know; by the time the DSM-6 comes out, we might find with Asperger's that they realised that probably was not the right direction to go in with a clearer criteria. I think that was the concern. It is basically meant to be quasi-scientific to have clear criteria that would be unambiguous, because you do not want to mislabel people who do not have a condition, which can sometimes happen, as you know, with attention deficit disorder, which would be one of the classics where that could become too inclusive.

The CHAIR — I am just mindful of the time, but I did have a couple of other questions. In relation to Bernie's question around diagnosis and early intervention and transition to the NDIS, there would be some data, would there not, available from the Barwon trial around autism, how many extra were diagnosed and what the early intervention figures might be?

Mr MacISAAC — What we know mostly comes from the scheme actuary of course, so those figures that I mentioned earlier are published on the NDIS website run by the NDIA. There is data out of the trial experience not just in Victoria but in those other jurisdictions. There are some distortions, of course, because not all of the jurisdictions had a full cohort population in their trial sites, so some are a bit weighted towards younger people, but most of the data really is the data in the scheme as opposed to making comparisons with existing — —

The CHAIR — So there is no breakdown of eligibility and diagnosis in terms of people who might have ASD and their transitioning to the NDIS?

Mr MacISAAC — The agency will have primary level diagnosis where that is available, but I think, as we mentioned earlier, their access requirements do not require a formal diagnosis, so they are making assessments based on functional level. Not on all occasions would they have that primary level diagnosis.

The CHAIR — Sure. Bernie also mentioned that the committee had heard quite a bit about exclusion and restraint. We certainly heard a lot about that during our previous inquiry in relation to abuse in disability services and made some significant recommendations around all of that. The principal practice leader is now working with the senior practitioner.

Mr MacISAAC — Yes.

The CHAIR — Does the advice that is being received from the principal practice leader refer specifically to restraint and exclusion, or does it cover all areas of abuse?

Dr COVENTRY — I probably cannot comment completely on that. Certainly in my field with mental health we do focus on the use of restrictive practices, but I have a broader brief than just monitoring that. If it was around someone with any sort of disability getting less than appropriate care or treatment in an inpatient facility, then I can do my own investigation. I can also do that in conjunction with the Principal Practitioner and the Disability Practitioner. They do not have jurisdiction over inpatient mental health, but I do, so I can work with them to try to look at transition plans and make sure that people are treated with appropriate dignity and respect and that they have to fulfil the Mental Health Act requirements, which they may not outside a mental health inpatient unit. I would hope that we can develop some liaison — picking up the previous question about schools — to try to also change that sort of culture in special schools as well.

The CHAIR — It is not just special schools.

Dr COVENTRY — No, that is right. It can be mainstream schools as well.

The CHAIR — And it is not all schools either by the way.

Dr COVENTRY — No.

The CHAIR — Thank you for that. I have one last question which relates to our hospital system. We have heard quite a bit through the duration of our hearings around hospital staff and, in particular, dental staff not being familiar with ASD or how to deal with people with ASD, which means that they often do not get access to the proper medical care that they require. I am just wondering what you think. How as a government could we actually ensure that our health system is supporting people with ASD? I am not just talking about hospitals and emergency departments but the whole of the allied health professions and dental surgeries et cetera.

Dr COVENTRY — A big question.

The CHAIR — If you could answer briefly, that would be very helpful. You can put it in writing to the committee later if you choose.

Dr COVENTRY — Very briefly, in terms of my jurisdiction with mental health, I am particularly concerned about my hospital colleagues in emergency departments. Usually an emergency department is very busy and a very different sort of role, and sometimes people with autism do not get treated with the right sort of care and respect. We have what are called consultation liaison services and also psychiatric staff who are specialists who work in emergency departments.

The CHAIR — How many and where?

Dr COVENTRY — In just about every area mental health service that has an emergency department there would be psychiatric trained nursing staff and staff trained in other mental health conditions that are actually based in the emergency department, and a number of larger area mental health services would have psychiatrist-led consultation liaison teams who also work in the medical and surgical wards.

The CHAIR — Would they be available 24/7?

Dr COVENTRY — No, not usually 24/7. They do not necessarily need to be available 24/7, but to really try to do a lot of education and training, because what you are picking up is that sometimes this is misguided from people's lack of information. Sometimes people will be picking up a patient with an intellectual disorder, but they do not understand the autism component of that, which might need very different treatment, and they are just responding to the behaviour, so they need to be a lot more sophisticated.

I would say in the department, since I have been Chief Psychiatrist working with the Chief Mental Health nurse — one of my colleagues in my team — we have had very good connections with emergency departments who are very concerned not just about mental health patients but all patients who come into their emergency departments with any sort of disability to make sure they get treated appropriately. So we are doing quite a lot of training specifically focusing on the pointy end at emergency departments and that first assessment where it may not be a mental health condition.

The other area, I guess, that is concerning is there is a discrepancy between certain child and adolescent mental health services, where they would see a lot of people with autism and adult inpatient services would not. In many services we are encouraging the child and adolescent staff to provide some in-region consultation to their mental health adult colleagues to help them manage these patients better.

The CHAIR — Thank you very much. We are indeed out of time and over time. Thank you for coming in this afternoon. We have quite a few more questions that we did not get to. Would you be happy for us to put them in writing to you?

Dr COVENTRY — Yes, certainly.

Ms CATTERMOLE — We will get back to you about the ones on notice that you have raised today.

The CHAIR — Thank you.

Witnesses withdrew.