AutismCRC

A National Guideline for the Assessment and Diagnosis of Autism Spectrum Disorders in Australia

Responses to Public Consultation Submissions

Prof Andrew Whitehouse, Dr Kiah Evans, Prof Valsamma Eapen
and A/Prof John Wray

October 2018

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RESPONSES TO PUBLIC CONSULTATION SUBMISSIONS

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Associated Documents

- National Guideline: Full Guideline (Register to access)
- National Guideline: Summary and Recommendations
- National Guideline: Administrative and Technical Report
- National Guideline: Evidence Tables

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Contents

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We thank Dr Emma Goodall for providing the cover art for this document, titled *The Disconnect in the Infinity of Neurodiversity*. This artwork is described as:

> 'Hidden under the layers of the ¾ of an infinity symbol are a normal distribution curve, a brain and branches seeking connection from a brain/person to an anchor. The ¾ infinity symbol also more explicitly shows the variety within the spectrum but the gaps in knowledge and connections.'

This project was supported by funding from the National Disability Insurance Agency. The views of the funding body did not influence the Guideline.

1. Public Consultation Process

The first draft of the Guideline and online resources were made available for download on the Autism CRC website from 7 September until 19 October 2017. The Administrative and Technical Report and the Evidence Tables were available to any interested party on request, with an agreement that the information would be used purely to inform their submission as part of the public consultation process. It was decided not to place these documents directly on the Autism CRC website for download, as the content will be submitted to peer-reviewed journals with a view to publication.

The Autism CRC webpage contained instructions for making a submission to provide feedback on the Guideline. Submissions could be made by any individual or organisation in the Australian community during this period. A six-week period was chosen (rather than the minimum required period of 30 days) to allow additional time for individuals and organisations to prepare submissions, given that the announcement was scheduled to coincide with an international conference (Asia Pacific Autism Conference 2017 in Sydney). Submissions could be made using the RedCap survey interface or by post or email to the Coordinator of the Research Executive at the Telethon Kids Institute address.

The following key stakeholders were notified about this consultation process via email on 7 September 2017:

- Steering Committee members
- chief executive officer (or equivalent) of the national peak bodies represented on the Steering Committee
- chief executive officer (or equivalent) of other peak bodies and key service providers with an interest in assessment of ASD concerns
- NHMRC Clinical Guidelines Department
- chief medical officers for the Commonwealth and each state and territory
- senior officials within education departments for the Commonwealth and each state and territory (including government, independent and Catholic systems).

In addition, the draft guideline release and public consultation process were advertised in the following ways on and following 7 September 2017:

- email to individuals who had expressed an interest in the ASD diagnostic guideline project
- media release
- media alert
- media interviews;
- keynote presentation by Professor Andrew Whitehouse at the Asia Pacific Autism Conference in Sydney
- banner on the Autism CRC website home page.

At the conclusion of the consultation period, 161 submissions had been received from a range of respondents, including state government departments, public and private clinical service organisations, client and advocacy groups, and individuals. The feedback on the draft Guideline was broadly positive. There was consistent feedback that a national guideline was an important advance for Australia and that the draft Guideline was a comprehensive document reflecting an important starting point. There was also strong support for the Comprehensive Needs Assessment being included in the Guideline. The breadth of the consultation and evidence gathering in the development of the draft Guideline was noted in several submissions. In addition, many helpful suggestions were received as to how to improve on the draft Guideline.

These suggestions were reviewed and discussed by the Research Executive, leading to decisions on amendments to be made to the structure and content of the Guideline. These amendments were integrated into a second draft of the Guideline and supporting documents.

This Responses to Public Consultation Submissions summary was prepared to outline the main amendments made to the draft Guideline and the Research Executive's response to each submission (in the following table). These responses were either a:

- description of changes made to the Guideline or supporting documents
- rationale for not making changes in response to the submission
- statement that the submission was beyond the scope of the Guideline.

2. Structure of this Document

Each submission received during the consultation period has been reproduced – in Chapter 4– and divided into separate feedback items where applicable. Each feedback item shows an individual response from the Research Executive, with reference to any relevant Overview of Major Amendments section. Individual feedback items have been presented to allow them to be read independently of each other, so there is a degree of repetition in the responses. Where pieces of feedback are beyond the scope of this project, this has been clearly indicated in the response. Some duplication in feedback from the same respondent may have been removed, and formatting may differ slightly to the original submission.

Individual or organisational names appear for respondents who advised that they wished to be identified with their submission, whereas respondents who did not want to be identified have been labelled as anonymous. Each respondent has been allocated an identification number that appears in square brackets after their name (e.g. John Smith [12]). Appendix A contains a complete list of respondent names and identification numbers. Within each submission, each feedback item has been allocated a number in the Comment Number column.

The amendments described below were made to the first draft of the Guideline. These amendments were incorporated into the second draft of the Guideline, and are based on feedback received during the public consultation period (described in Chapter 1). Please note that there were two subsequent drafts of the Guideline - the 'third draft' and the 'final draft' – which incorporated additional amendments recommended by the Steering Committee and methodological reviewers. (The full process is described in Chapter 10 of the Administrative and Technical Report). The vast majority of the changes described below remain in the final draft, though there may be minor wording differences in the recommendations (such as referring 'elements' rather than 'stages').

3. Overview of Major Amendments

Clarification of Financial Disclosures

Several respondents requested further clarification of the financial support for this project. The National Disability Insurance Agency funded the development of the Guideline, including the salary for the Coordinator of the project (Dr Kiah Evans), the public consultation activities and an honorarium to the Steering Committee members. Andrew Whitehouse, Valsamma Eapen, Margot Prior and John Wray received no personal financial or other remuneration for their involvement in this project. This information appears on the first page of the revised Guideline.

Conflicts of Interest

There was considerable feedback requesting recommendations to be made on the management of conflicts of interest in the process of assessing ASD concerns. This theme was also raised during the nationwide consultation conducted before the first draft of the Guideline was published. In response to this feedback, Recommendation 28 has been added to the revised Guideline.

Consistent and Flexible Structure

The revised Guideline clarifies that it represents a consistent, yet flexible structure, for the assessment of children, adolescents and adults for a diagnosis of ASD (Section 1.7). Australia is a geographically large country with a culturally diverse and widely dispersed population. This Guideline has been developed with the aim of maintaining assessment rigour while optimising access to clinical services for all Australians, regardless of age, gender, cultural background, socioeconomic status or geographical location.

Guiding Principles

Based on suggestions received, two further guiding principles, Equity and Lifespan Perspective, have been added to the Guideline. In addition, the following statement has been added to the Holistic Framework guiding principle based on feedback received:

> ‘The triggering of referrals for support is best based on the level of functioning and support needs, as reflected in the sector-wide shift towards functioning and need defining eligibility criteria for disability services.’

Broader Neurodevelopmental Context

In response to feedback requesting stronger emphasis that diagnostic assessments for ASD take place within the context of a broader neurodevelopmental assessment, the following statement has been added to the revised Guideline (‘Scope of the Guideline’):

> ‘It is critical that an assessment of ASD concerns takes place in the context of a broader neurodevelopmental and behavioural assessment. This Guideline is intended to operate within the assessment processes applicable for individuals presenting with signs or symptoms of a broad range of neurodevelopmental conditions. To meet the defined objectives of the project, this Guideline focuses on aspects of the neurodevelopmental and behavioural assessment that are relevant to individuals presenting with concerns about ASD signs or symptoms.’

Emphasis on the Importance of Functional Abilities in Referral for Supports

While the importance of an accurate diagnostic evaluation was universally acknowledged, there was considerable feedback that the assessment model should emphasise that referrals for further clinical supports (such as clinical intervention) be based on the level of functioning and support needs, and not the receipt of a clinical diagnosis. This is consistent with the conceptual shift among disability services in Australia (primarily the National Disability Insurance Scheme) towards function and need defining eligibility criteria for disability services. As well as the text reflecting this added to the Holistic Framework guiding principle (see above), this point has been further highlighted in the revised Guideline by:

- Recommendation 3 being amended to:

> ‘It is recommended that the process for assessing ASD concerns follow a holistic framework, where an individual is evaluated in the context of personal, activity and environmental contexts (as outlined, for example, by the World Health Organization’s International Classification of Functioning, Disability and Health), and that referrals for further supports be based on an individual’s functioning and needs, rather than their clinical diagnosis.’

- the assessment structure being revised to describe a Comprehensive Needs Assessment as ideally being the foundational stage of the assessment process (for further information, refer to the next section, ‘Structure of the Assessment Process’)
- Recommendation 27 stating that referral for intervention and other supports be made once level of functioning and needs have been identified in the Assessment of Functioning, without the requirement for a clinical diagnosis of ASD
- Recommendations 46 and 56 stating that if additional support needs are identified at later stages of the assessment, the client should be connected to appropriate services based on support needs, without the requirement for a clinical diagnosis of ASD
- the revised assessment structure emphasising that, at any stage of the assessment process, referral and access to supports be based on functional abilities and needs, not on a clinical diagnosis of ASD (please refer to Figure 2 in the Guideline, specifically the arrow at the bottom of the figure).

Structure of the Assessment Process

Feedback relating to the structure of the assessment process centred on four major themes:

(1) the importance of a Comprehensive Needs Assessment setting the foundation for a Diagnostic Evaluation

(2) the importance of the Guideline being compatible with existing clinical pathways and not resulting in a ‘separate stream’ for ASD diagnosis, which is inconsistent with the guiding principles

(3) the importance of flexibility in the process being adapted to the individual being assessed and to the large range of settings and services in which assessments already take place in Australia

(4) the importance of simplifying the assessment model in order to ensure the highest levels of transparency for individuals being assessed and their families.

In response to this feedback, the structure of the assessment process has been amended. Figure 2 in the revised Guideline is an overview of the revised structure. The amendments are:

- The use of the term ‘tiers’ to describe assessment components has been removed and the term ‘stages’ has been introduced; however, the components are labelled as ‘stages’ because they do not need to be completed sequentially. This amendment makes it clearer that the Guideline describes a progressive approach to neurodevelopmental and behavioural assessment, in which further clinical investigations are based on the need and clinical complexity of the individual being assessed.

- The first stage is now a Comprehensive Needs Assessment, which includes an Assessment of Functioning (conducted by selected allied health or medical practitioners) and a Medical Evaluation (completed by medical practitioners). The aim of the Comprehensive Needs Assessment is to holistically assess an individual's medical symptoms and developmental and functional abilities across a broad range of domains and support needs. The outcome of the Comprehensive Needs Assessment is an understanding of the level of functioning and support needs of the individual (and immediate referral for services based on these needs) and whether a Diagnostic Evaluation should be pursued. The revised Guideline notes that repeated assessments of functional abilities and support needs should occur throughout the individual's life as part of good clinical practice to ensure that changes in these areas are identified and acted on in a timely manner (see Recommendation 37). It is further recommended that these assessments be conducted as required by clinicians engaging with the client at the time, and not necessarily the clinical team involved in the initial Diagnostic Evaluation.
- The second stage is now a Diagnostic Evaluation, which involves either one or two components depending on the complexity of the presentation. If it is determined following the Comprehensive Needs Assessment that a Diagnostic Evaluation for ASD is warranted, the individual progresses to a Single Clinician Diagnostic Evaluation. This focuses on a diagnostic formulation conducted by a single clinician based on all information collected up to this point. The Single Clinician Diagnostic Evaluation is conducted by selected medical professionals (please see 'Qualifications for Medical Practitioners') or psychologists with relevant training and expertise (please see 'Qualifications for Psychologists'). Please note that all individuals being assessed will have received a Medical Evaluation during the Comprehensive Needs Assessment.
- If high diagnostic confidence is not achieved through a Single Clinician Diagnostic Evaluation, an individual progresses to a Consensus Team Diagnostic Evaluation, in which at least one additional allied health (speech pathologist, occupational therapist, psychologist) and/or selected medical professional with relevant training and expertise is invited to join a Consensus Diagnosis Team. The Single Clinician decides which professionals to invite to join the Consensus Diagnosis Team. To ensure a broad range of expertise, it is recommended that at least one other professional from a different discipline or with a different specialty to the Single Clinician be part of the Consensus Diagnosis Team (Recommendation 60).
- If clinician consensus is not achieved by the Consensus Diagnosis Team, the individual is to be reassessed at a later time as recommended by the team.
- An important note has been added to the Guideline regarding interpretation of the model, in particular, the presentation of Figure 2. This note appears beneath Figure 2 in the Guideline, and is reproduced here:

> 'The assessment components are presented sequentially in Figure 2 to emphasise three key elements of the assessment process:
>
> (1) the importance of a Comprehensive Needs Assessment providing the foundation of a Diagnostic Evaluation
>
> (2) the immediate referral of an individual for further supports once level of functioning and needs have been identified
>
> (3) a progressive approach to diagnostic formulation, whereby additional clinical investigations are based on the clinical complexity of the individual.
>
> With these elements of the overall assessment model established, considerable flexibility can be incorporated. The stages described in the model are not necessarily intended to be conducted as consecutive and discrete steps, and their implementation can be adapted based on the clinical history of the individual to that point and the decision-making of the clinical team. If other stages or components of the assessment have recently been conducted with an individual at the point of referral for Diagnostic Evaluation, it is up to the discretion of the

> Assessment Team as to whether to repeat these assessments. See Figure 3 for examples of how this flexible assessment structure may work in practice.'

Progression from Single Clinician to Consensus Team Diagnostic Evaluations

The submissions broadly supported a progressive approach to diagnostic formulation, whereby additional clinical investigations are based on the clinical complexity of the individual being assessed. This is critical to minimising clinical costs and client burden. Several respondents requested further guidance about when to progress a Single Clinician Diagnostic Evaluation (called the 'Tier 1' assessment in the original draft) to a Consensus Team Diagnostic Evaluation (originally called the 'Tier 2' assessment). To ensure sufficient flexibility in the assessment model, it is critical that this decision remains with the Assessment Team. The revised Guideline provides further guidance:

> 'A number of factors may contribute to the perception that a Consensus Team Diagnostic Evaluation is required, including:
>
> - uncertainty about whether behavioural symptoms meet diagnostic criteria for ASD
> - current or previous exposure of the individual to personal or familial trauma and/or psychosocial risk
> - a history or indication of complex medical conditions
> - a history or indication of co-occurring psychopathologies.'

'Consumer' Terminology

Feedback was received that the use of the term 'consumer' to refer to individuals seeking assessment did not adequately reflect the collaborative, participatory relationships with assessing professionals. The revised Guideline uses the term 'client'.

Referral for an Assessment of ASD Concerns

The process of referring an individual for an assessment for neurodevelopmental disorders, such as ASD, must fit within the prevailing clinical systems and funding mechanisms. The Guideline has been revised to recommend that referral for an assessment be made by an individual's primary healthcare provider (see Recommendation 16). Primary healthcare providers may work in public and/or private health settings, and can have any of a number of professions, such as a general practitioner or a child health nurse). All Australians are able to self-refer to a primary healthcare provider to discuss neurodevelopmental concerns and seek referral for further assessment. Because of this amendment, Table 5 from the original version of the Guideline has been omitted from the revised version.

Coordinator Role

There was feedback requesting further clarification of the 'Coordinator Role' in the original draft of the Guideline. The intention was not to create a new role within the assessment process, but rather to emphasise the importance of coordination across the process to ensure optimal clinical care. To clarify the intended meaning, the original 'Coordinator' section has been replaced with a 'Coordination' section in the revised Guideline (3.2):

> 'To ensure optimal clinical care, it is critical that the process for assessing ASD concerns is well coordinated with good communication between all people involved. Centralised coordination helps to ensure the timely and efficient collection of information from multiple individuals across different settings, and assists the client in navigating the complex process of neurodevelopmental assessment.'

Recommendation 9 of the Guideline is relevant to this point.

Professional Roles

Considerable feedback was received regarding the roles, qualifications and expertise of the professionals involved in the diagnostic process, focused on two areas:

(1) The importance of every individual assessed receiving a Medical Evaluation. While this was a feature of the original draft, feedback suggested this required greater prominence in the assessment model.

(2) The importance of the Single Clinician who conducts the Diagnostic Evaluation having formal training in differential diagnosis across the full range of neurodevelopmental disorders. It was widely recognised that speech pathologists and occupational therapists have key skills that are important to the assessment process; however, they do not routinely receive formal training in differential diagnosis as part of their clinical qualifications. The involvement of speech pathologists and occupational therapists remains critical to the assessment process, and this has been incorporated in the Assessment of Functioning and Consensus Team Diagnostic Evaluation of the revised Guideline.

As well as these changes, the professional roles have been amended. The terms ‘professional informant’, ‘functional and support needs assessor’ and ‘diagnostician’ in the original draft have been omitted from the revised version. The intention behind using these terms was to clarify roles within the assessment process; however, there was considerable feedback that this terminology was confusing. The revised Guideline has a more simplified method for designating roles and responsibilities based on professional training.

In addition, the revised Guideline features the following amendments to professional roles and responsibilities:

- The Comprehensive Needs Assessment comprises an Assessment of Functioning and a Medical Evaluation. The Assessment of Functioning can be conducted by selected allied health (speech pathologists, occupational therapists, psychologists, social workers) or selected medical practitioners with relevant expertise and training. The Medical Evaluation can be conducted by selected medical practitioners with relevant expertise and training. Nurse practitioners with expertise in the assessment of neurodevelopmental disorders can contribute to this latter assessment under the supervision of a medical practitioner.
- The Single Clinician Diagnostic Evaluation can be conducted by selected medical professionals (please see ‘Qualifications for Medical Practitioners’) or psychologists with relevant training and expertise (see ‘Qualifications for Psychologists’). The rationale is that these professionals receive formal training and must demonstrate competency in differential diagnosis of complex neurodevelopmental disorders as part of their tertiary qualifications. In addition to these foundational qualifications, it is recommended that professionals have ‘relevant training and expertise’, which is defined as expert knowledge and experience in areas defined in the Guideline (see Recommendation 38).
- If diagnostic certainty is not achieved through a Single Clinician Diagnostic Evaluation, an individual progresses to a Consensus Team Diagnostic Evaluation, in which at least one additional allied health (speech pathologist, occupational therapist, psychologist) and/or medical professional (with relevant training and expertise) is invited to join a Consensus Diagnosis Team. The professional requirements for individuals from these disciplines are described in the following sections. The Single Clinician decides which professionals to invite to join the Consensus Diagnosis Team. However, to ensure a broad range of expertise, it is recommended that at least one other professional from a different discipline or with a different specialty to the Single Clinician be part of the Consensus Diagnosis Team (see Recommendation 47).

Qualifications for Medical Practitioners

There were competing views regarding the most appropriate qualifications for medical practitioners involved in the assessment process. Particular concern was expressed that recommendations in the original draft were too restrictive and excluded a large number of career medical officers who have considerable experience in the assessment of neurodevelopmental disorders. Based on all the feedback on this point, the revised Guideline outlines the qualifications required of a medical practitioner at each component of the assessment process, as follows:

Assessment of Functioning. To be involved in an Assessment of Functioning, it is recommended that a medical practitioner has general or specialist registration with the Medical Board of Australia. This is in addition to relevant skills and expertise outlined in the Guideline (see Table 4 and Recommendations 21–22).

Medical Evaluation. To be involved in a Medical Evaluation, it is recommended that a medical practitioner has general or specialist registration with the Medical Board of Australia. This is in addition to relevant skills and expertise outlined in the Guideline (see Table 4 and Recommendations 30–32).

Single Clinician Diagnostic Evaluation. To conduct a Single Clinician Diagnostic Evaluation, it is recommended that a medical practitioner holds specialist registration with the Medical Board of Australia in the field of community child health, general paediatrics, psychiatry or neurology, or holds general or specialist registration with the Medical Board of Australia and has at least six years of relevant experience, training or supervision in the assessment of neurodevelopmental disorders. This is in addition to relevant skills and expertise outlined in the Guideline (see Table 4 and Recommendations 37–38).

Consensus Team Diagnostic Evaluation. To be part of a Consensus Diagnosis Team, it is recommended that a medical practitioner holds specialist registration with the Medical Board of Australia in the field of community child health, general paediatrics, psychiatry or neurology, or holds general or specialist registration with the Medical Board of Australia and has at least six years of relevant experience, training or supervision in the assessment of neurodevelopmental disorders (see Table 4 and Recommendations 48–49).

Qualifications for Psychologists

Considerable feedback was received regarding the optimal qualifications for psychologists. Different respondents often put forward competing views, in particular regarding the use of the term ‘registered psychologist’ and whether practice endorsement in clinical, developmental/educational psychology and/or neuropsychology should be a requirement for involvement in the ASD diagnostic process. Based on all the feedback on this point, the revised Guideline outlines the qualifications required of a psychologist involved in the assessment process at each stage, as follows:

Assessment of Functioning. To be involved in an Assessment of Functioning, it is recommended that a psychologist has general registration, with or without a practice endorsement, with the Psychology Board of Australia. This is in addition to relevant skills and expertise outlined in the Guideline (see Tables 4 and 5 and Recommendations 21–22).

Single Clinician Diagnostic Evaluation. To conduct a Single Clinician Diagnostic Evaluation, it is recommended that a psychologist has general registration with the Psychology Board of Australia, and have practice endorsement in clinical psychology, educational/developmental psychology and/or neuropsychology. This is in addition to relevant skills and expertise outlined in the Guideline (see Tables 4 and 5 and Recommendations 37–38).

Consensus Team Diagnostic Evaluation. To be part of a Consensus Diagnosis Team, it is recommended that a psychologist has general registration, with or without a practice endorsement, with the Psychology Board of Australia. This is in addition to relevant skills and expertise outlined in the Guideline (see Tables 4 and 5 and Recommendations 48–49).

The rationale for these recommendations is that it is critical for professionals who may act as sole clinicians (such as in a Single Clinician Diagnostic Evaluation) to have received formal training in differential diagnosis across the full range of neurodevelopmental disorders. Tertiary education courses in clinical psychology, developmental/educational psychology and neuropsychology provide this formal training. Yet we recognise the many psychologists without these tertiary qualifications who are highly trained and can provide valuable input into the assessment process. By stipulating in the Guideline general registration with the Psychology Board of Australia, the input of these individuals can be made during an Assessment of Functioning and Consensus Team Diagnostic Evaluation.

Qualifications for Speech Pathologists

Speech pathologists provide highly valuable expertise in the assessment of speech, language and communication skills and abilities. The revised Guideline maintains a strong focus on the importance of a language assessment in the process of assessing ASD concerns. This is recognised in three ways:

(1) The Guideline recommends that the Assessment of Functioning covers a broad range of developmental and functional domains, including language (see Recommendations 23 and 25).

(2) The Guideline further encourages the assessment team to consult professionals with expertise in certain assessment domains, for example speech and language.

(3) The Guideline recommends that speech pathologists can be part of the Consensus Diagnostic Team (Recommendation 48).

Based on all feedback received in this area, the revised Guideline contains the following recommendations:

Assessment of Functioning. To be involved in an Assessment of Functioning, it is recommended that speech pathologists are eligible to be a Certified Practising member of Speech Pathology Australia. This is in addition to relevant skills and expertise outlined in the Guideline (see Table 5 and Recommendations 21–22).

Consensus Team Diagnostic Evaluation. To be part of a Consensus Diagnosis Team, it is recommended that speech pathologists are eligible to be a Certified Practising member of Speech Pathology Australia. This is in addition to relevant skills and expertise outlined in the Guideline (see Recommendations 48–49).

Qualifications for Occupational Therapists

Occupational therapists have training in key skills related to the assessment of adaptive functioning and motor and sensory systems. The revised Guideline maintains a strong focus on the use of these skills in the assessment of ASD concerns. This is recognised in three ways:

(1) The Guideline recommends that the Assessment of Functioning covers a broad range of developmental and functional domains, including adaptive functioning (see Recommendation 23).

(2) The Guideline further encourages the assessment team to consult professionals with expertise in certain assessment domains, for example adaptive behaviours.

(3) The Guideline recommends that occupational therapists can be part of the Consensus Diagnostic Team (Recommendation 48).

Feedback was received that the recommendation that occupational therapists be registered with the Better Access to Mental Health program was too prescriptive, as such reference to this program has been omitted from the revised Guideline. Based on all the feedback on this area, the revised Guideline contains the following recommendations:

Assessment of Functioning. To be involved in an Assessment of Functioning, it is recommended that occupational therapists have registration with the Occupational Therapy Board of Australia. This is in addition to relevant skills and expertise outlined in the Guideline (see Table 5 and Recommendation 21–22).

Consensus Team Diagnostic Evaluation. To be part of a Consensus Diagnosis Team, it is recommended that occupational therapists has registration with the Occupational Therapy Board of Australia. This is in addition to relevant skills and expertise outlined in the Guideline (see Recommendations 48–49).

Duration of ASD-specific Expertise

Considerable feedback was received that the following requirement contained in the original draft was overly onerous and would exclude many qualified and experience clinicians:

> ‘Demonstrating at least four years full-time equivalent of postgraduate experience that is directly relevant to ASD diagnostic evaluations, obtained through university qualifications, formal training programs and/or formally supervised work experience.’

To avoid the exclusion of these highly trained clinicians, and to provide greater flexibility and feasibility in service delivery, this requirement has been omitted from the revised Guideline. The expertise required of clinicians involved in the assessment process has been retained in the revised Guideline and will provide a means of maintaining rigour in clinician expertise.

Use of ‘Standardised’ Instruments

Based on feedback received, the revised Guideline places greater emphasis on standardised assessments of developmental and/or cognitive abilities being an essential element of the Comprehensive Needs Assessment for children (see Section 7.2). Standardised assessments are important in facilitating a comparison of an individual’s ability in relation to age-appropriate developmental and/or cognitive skills as well as benchmarking performance for follow-up assessments. Yet it was also noted that standardised assessments of cognitive function may not be appropriate for adolescents and adults undergoing assessment. Recommendations 43 and 53 of the revised Guideline address this feedback.

Competing feedback was received regarding whether ASD-specific assessments (e.g. ADOS-2, ADI-R) should be a requirement for an ASD diagnostic assessment, with a roughly equal split of individuals and organisations advocating for and against their inclusion. It was the decision of the Research Executive to not make these assessments mandatory for several reasons:

(1) While these tools can be a helpful adjunct to clinical decision-making, the feedback from the consultation period indicated that the use of these tools in clinical practice is often impractical.

(2) Australia has a shortage of clinicians trained in these assessments and making their administration a requirement will substantially increase waiting lists (and, likely, costs) for assessments, which may deprive many families of promptly accessing diagnostic services.

(3) Given evidence that these tools can be helpful in guiding clinical decision-making, the revised Guideline retains several recommendations to use these tools in assessments (and they are listed in the accompanying Web Resources).

Based on all the feedback on this area, Recommendations 43 and 53 were added to the revised Guideline.

Note that the revised Guideline refers to these instruments (e.g. ADOS-2, ADI-R) as ‘ASD-specific assessments’. While these assessments have a standardised protocol, they are not ‘standardised’ in the conventional sense of having normative data.

Inclusion of Specific Assessment Tools

The original draft of the Guideline listed several screening and assessment tools commonly used in assessment of ASD concerns. Given the frequency with which existing tools are updated and new tools are published, it was decided to remove mention of any specific tools in the Guideline itself and instead locate these in a dynamic document on the Guideline webpage (https://autismcrc.com.au/diagnostic-guideline) to enable regular updating.

Telehealth

Considerable feedback was received about the use of telehealth during the assessment process. While there was broad agreement that technology can facilitate better access to assessment services for individuals living in rural and remote locations, it was consistently stated that assessment rigour and standard of care should not be compromised in the process. Recommendation 15 in the revised Guideline directly address this feedback.

Accreditation and Regulation

Respondents requested clarification on the accreditation and regulation of professionals involved in the assessment process. While we agree that such processes are critical to maintaining the appropriate skills and expertise among health professionals, their development is beyond the scope of this project. The revised Guideline contains a Practice Point for relevant professional bodies to continue or establish appropriate accredited training and regulation of professionals involved in the assessment of individuals with neurodevelopmental conditions (see Section 13.3).

Implementation and Evaluation of the Guideline

The project objective was to develop a guideline for the assessment of children, adolescents and adults for a diagnosis of ASD. Recommendations were based on a combination of best evidence and a nationwide community consultation. The Guideline has been developed with a specific focus on being as compatible as possible with the broad range of clinical service organisations and settings across Australia. While the implementation and ongoing evaluation of the Guideline within jurisdictions and systems is beyond the scope of this project, we strongly agree with the necessity of conducting these important activities. The revised Guideline contains a Practice Point (Section 13.2) that there be ongoing evidence updates to the Guideline as well as ongoing evaluation of whether the assessment process meets the objectives described in ‘Scope of the Guideline’.

Cost Implications of the Recommended Assessment Model

There was feedback that the inclusion of a Comprehensive Needs Assessment would lead to an additional cost burden on services and that these costs would likely be passed onto clients. In response to this and other feedback, the structure of the assessment process has been simplified (see earlier section, ‘Structure of the Assessment Process’) The revised structure emphasises the importance of the Comprehensive Needs Assessment in setting the foundation for a Diagnostic Evaluation, and that referral for supports should be made immediately after the identification of impairment in functioning. We note that an ASD assessment structure that incorporates the assessment of developmental abilities and functional needs (which is the model described in the revised Guideline) is already common in many Australian jurisdictions and internationally. The revised Guideline also contains a Practice Point (Section 13.3) that there be a review of the public funding mechanisms for neurodevelopmental assessments.

Pathological Demand Avoidance

Considerable feedback was received requesting further information be included in the revised Guideline about pathological demand avoidance. Yet other feedback questioned its inclusion. The relevant text in the revised Guideline underwent minor revisions from the original, and we have added references to research that highlights the emerging validity for this behavioural profile (see Table 8).

Practice Points for Clinical, Research and Policy Settings

The revised Guideline features several Practice Points (see Chapter 13) for future actions to complement the publication of the Guideline, grouped according to the professional field responsible for implementing the actions. They are called Practice Points to indicate that they fall outside the scope of the project.

4. Individual Submissions and Responses

Respondent Name [ID]	Comment Number	Type of Respondent	Comment	Response from the Research Executive
Anonymous [1]	ID1	Individual – Lived experience (C,D,E)	PDA has been mentioned. But it needs to be more recognised here in Australia. It is very hard for anyone to understand the problems my child faces in school or what our family endures at home. Without diagnosis our children fall through the cracks. I would like more explained, so diagnosis is received earlier	Please refer to the 'Overview of Major Amendments' chapter of this document, under the following heading: • Pathological Demand Avoidance
Tessa Gay Moodie [2]	ID2	Individual – Lived experience (A,C,F)	I also think the section on gender differences would be more beneficial to include a table that outlines specific differences in females versus males. This would provide a more comprehensive guide for professionals assessing or identifying females on the Spectrum.	Thank you for this feedback. A table similar to this has been included in the revised Guideline.
	ID3		Please add Ehlers Danlos Syndrome to the coexisting conditions (genetic disorders). http://onlinelibrary.wiley.com/doi/10.1111/j.1440-1819.2011.02262.x/full	Ehlers Danlos Syndrome has been added as a co-occurring condition in the Web Resources.
Anonymous [3]	ID4	Individual – Lived experience (A,C,F)	Heavily focused on behaviours to the exclusion of the patient's experience.	Thank you for this comment. Given that the purpose of the Guideline is to provide a framework for clinicians to effectively and efficiently undertake an ASD diagnostic assessment, there is a heavy focus on clinical activities. Nevertheless, the Guideline seeks to underscore the importance of the 'patient experience' in the Guiding Principles (Chapter 2).

	ID5		Focusing on behaviours in the diagnostic process could see a continuation of current under diagnosis of females, whose sensory symptoms are equal to those of males but may be better able to mask their signs.	Currently, ASD is a diagnosis that is made based on behavioural observations, and so the Guideline maintains a focus on this aspect. We appreciate that there is concern that the behavioural criteria for ASD in the DSM-5 may be more relevant to males with ASD (and contribute to under diagnosis in females with ASD), and have highlighted this under ‘Important Considerations’ (‘Gender’ subsection) section of the Guideline.
	ID6		I want to underline 'signs' and 'symptoms' throughout the paper because they are not interchangeable terms. And because I have an ASD it is important that I self-identify as correct.	Adjustments have been made throughout the Guideline to ensure these terms are not used interchangeably.
Anonymous [4]	ID7	Individual – Lived experience (C,F,I)	Thank you, looks like an amazing document.	Thank you for the comment. No amendment is required in response to this comment.
	ID8		On page 50 there is a typo at the bottom in Section 4, it states 'Please not that', and should say 'please note that'	This typo has been amended.
Prema Siva [5]	ID9	Individual – Lived experience (F)	Currently in Australia we find it extremely hard to get a diagnosis due to long waiting at health care. This puts a huge emotional burden on the family and specially with kids very young its very valuable time lost with getting help. If Autism is to be taken any seriously there should be services made available that can be obtained in short time and waiting to get follow up funding to assist should be done seamless. Currently we are faced with an issue of lack of information and proper guides around urgency of assessment I find.	Thank you for providing this information. No amendment is required in response to this comment as it is beyond the scope of the project.
	ID10		This has become a more business orientated field with people really struggling to make ends meet. There is proven support	Thank you for providing this information. No amendment is required in response to this comment.

			like ABA and ESDM which Australia is lagging behind and this needs to be well looked at.	
Tessa Gay Moodie [6]	ID11	Individual - Lived experience (A,C,F)	Just another article supporting my previous feedback to include Ehlers Danlos Syndrome as a co-existing condition. A consortium of world experts in EDS was held at the start of the year, and this research article was published as a result. http://onlinelibrary.wiley.com/doi/10.1002/ajmg.c.31544/full	Ehlers Danlos Syndrome has been added as a co-occurring condition in the Web Resources.
Anonymous [7]	ID12	Individual – Lived experience (F)	I have a daughter 12 who was assessed when she was 5 and again at 10y8mo. My daughter was finally dual diagnosed privately by a clinical psychologist and speech pathologist whom are both very experienced diagnosticians. She was diagnosed ASD level 2. She also has PDA but it wasn't diagnosed here in SA at the time, only recently is it starting to be more recognised. Being missed when she was 5 and only being diagnosed with a language disorder was very damaging. When I read the report from that time now with everything I've learnt about both ASD and PDA in this journey even then ASD was VERY obvious.	Thank you for providing this information. No amendment is required in response to this comment.
	ID13		I appreciate that you're doing this, and I hope it's comprehensive and affordable for all. My daughter had a WISC done and a language assessment through the education department but, unfortunately, they decided she didn't need follow up once she started school and even though I gave her school copies of all this info it was never taken into consideration and she deteriorated very rapidly. School can make or break our children. It's very important that Autism, PDA and both learning difficulties and strengths are fully recognised and managed appropriately. There needs to be extensive education given to those that work with children and all (NT) children in schools need to be taught social skills and other relevant interventions to promote acceptance in our	Thank you for the comment. This is beyond the scope of the project, and so no amendment has been made in response to this comment.

			schools. We need to stop punishing ASD children for being different and not understanding NT children. NT children (and adults) can be horrible, acceptance starts with THEM	
	ID14		I really appreciate what you're trying to do with your guidelines and it would be great to see assessments being more straightforward in states such as WA. I feel a dual assessment in SA is quite adequate, my problem lies in how Autism is recognised particularly when young before behavioural problems develop in school. I find your important considerations still carry on stereo types that can be quite damaging for those Autistics that are more social. My daughter for instance was very socially interested especially when younger. I feel this went against her when she had her first assessment. Even though she still had all of the same social difficulties with play and understanding she was equally socially interested. She loved people and kids, this was what motivated her. She wasn't interested in toys. This made her very demanding when she was younger until she was around 3 and discovered drawing. Now, this social interest/extrovertedness is a common sign of Pathological Demand Avoidance so needs to be recognised early before school in my view. But, I don't believe this is exclusive to PDA. I had to pull my daughter out of school at 7 which I may get into later. Since her diagnosis I discovered an organisation run by Autistics called [Name of Organisation] and I have been accessing their services for my daughter in hopes to help her find people that she connects with. One of the things we do is a home-school work shop where they spend the day in a flexible school/social setting which most parents attend also. Anyway, nearly all of the Autistic children that attend are very socially interested.	Thank you for providing this information. No amendment is required in response to this comment.

			They have the usually social and emotional difficulties, but they are DEFINATELY very socially interested in others. One boy who would be at least 15 by now with possibly an intellectual disability who was once non-verbal so very 'stereotype' is also very social. You can see it in his eyes/heart that he just wants to connect with others. My daughter at 12 is going from extroverted to introverted but it's only due to the lack of understanding and acceptance from others. It is really important that we can understand that some Autistics really want to connect and be accepted and understood and that we provide adequate supports to help them achieve that connection because their mental health is more important than anything else, including academics. My daughter deteriorated very rapidly in school, she was treated very badly. Even though she did have a diagnosis of a language disorder and a WISC that showed her difficulties and strengths she was just treated as naughty. She also had no help navigating the playground. The damage it caused was immense. Prior to school she was happy and socially confident. We unknowingly raised her using PDA strategies. Because she was so socially motivated she was always putting herself out there only to be rejected. My daughter is not a good masker, she would verbalise her emotions loudly even over a minor scratch and this would also turn others away. She struggled playing their games so would try to control the play with her very basic games such as pretending to be a dragon or dinosaur. Because of her processing issues she couldn't go beyond many steps, so the game would be very basic and repetitive, and the other girls would tire of it quickly. My daughter needed understanding and scaffolding but never received it, so her self-esteem was lost very quickly. This was when her PDA behaviours really came out. Even at 12 she still refuses anything that looks like school. Her school even went so far as keeping her in at break times to finish her	

work, but they weren't successful. To give you an example of how damaging not being recognised and supported early can be my daughter’s percentile of her non-verbal intelligence went from 96th percentile to 50th.

Both assessments she had a WISC, her first WISC when she was happy was very asynchronous whilst her second WISC when she was unhappy due to the lack of appropriate support was very average to below average. She only scored an IQ of 86. I remember during the assessment process the clinical psych looked very frazzled that day, oh to have been a fly on the wall during my daughters WISC. I never did get to speak to the psych without my daughter so all I have is her comments in the report, but it would seem my daughter avoided her WISC.

I know my daughter has much more potential then that last WISC indicates. I remember when she first learnt to read. It was very quick, almost instantaneous. If you could see the drawings and graphics that she does, her 3D models on her computer. If only I knew of someone knowledgeable in what's she's interested in that knew how to connect with her to help her refine her skills. When we go to these home school workshops, everyone knows when they see a drawing that was done by my daughter, she's immediately recognised for her ability. But since school she's so reluctant to let others teach and instruct her. She also struggles with being interrupted so now avoids groups because she can't think. It causes her to lose the picture in her head.

Sometimes I wonder if some kids that show lack of interest is due to genuine lack of interest or due to their difficulties, so it then becomes their way of protecting themselves.

When my daughter was first assessed I believed it because I also believed in the social stereo types, this really needs to change. I kick myself every day for not understanding Autism but that's no excuse for professionals. It wasn't until I learnt about PDA years later that I started to understand it. Reading

			about PDA was such a light bulb, it's really important it's recognised as the strategies are so different. ASD strategies cause so much anxiety for my daughter. I suspect there's many out there needing to be recognised and finally understood. Also, none of these kids at these workshops except perhaps the 15-year-old have a monotone voice! But one of my daughter's cousins who is Autistic (initially diagnosed with ADHD but later changed to Asperger's) does have a monotone voice. Another cousin was also diagnosed with Autism. I remember it was called classic Autism at the time or at least that's how I remember my partner telling me. both is these boys were social too!	
Julian Wojtulewicz [8]	ID15	Individual - Professional experience (PS)	Congratulations on the initiative and thank you for considering feedback. I write as a respiratory and sleep paediatric physician who reviews children, some of whom have ASD. I refer to Table 7, commencing page 42, relating to co-occurring concerns. Currently sleep is placed in the 'Functional' category, suggesting that poor sleep in ASD is an outcome, rather than a contributing factor. Mentioning 'disordered' sleep breathing confirms the category error. Recurrent nocturnal obstruction, hypoxemia and resultant fragmented sleep is not an outcome of ASD but may certainly contribute adversely to any child's growth and development. Similarly sleep initiation and maintenance (non-breathing examples of sleep disorder) difficulties may be noted in ASD individuals yet they are very common where iron deficiency (ID) is present, manifesting in restless legs syndrome, rhythmic movement disorder, periodic limb movements, fractiousness and resultant fragmented sleep. ID may be more prevalent in kids who are picky eaters and like a white diet. Allowing many of the children undergoing initial evaluation for ASD are of preschool age, some of whom (should be)	Sleep has been moved to 'Neurological and other medical' and this table has been relocated to the Web Resources.

			spending half their lives in good quality sleep, I think sleep assessment is an important part of evaluation of these kids that risks being overlooked. I would suggest sleep difficulties be elevated to the first part of the table, under physical and sensory concerns. Perhaps thought could be given to mentioning the value of a sleep history and where relevant, iron studies as part of the assessment process at outset, as well as ongoing surveillance in the text of the document. Thanks again for considering submissions.	
Catherine Asciak [9]	ID16	Individual - Professional experience (PS,PD)	I was very impressed by how thorough this guideline is. As best practice - these guidelines are very exciting, and I can see they will be of great benefit in ensuring accurate diagnosis. I have 1 comment/concern and 2 further questions: 1. Will all clinicians be expected to comply with these guidelines? I personally think it is important that all comply (especially if rebates through Medicare or NDIS are involved).	Please refer to the ‘Overview of Major Amendments’ chapter of this document, under the following headings: • Accreditation and Regulation • Practice points for clinical, research and policy settings
	ID17		2. When will we be expected to comply (time frame)?	Thank you for this comment. This issue is out of scope of the project terms of reference, and so no amendment has been made.
	ID18		**Further comment/concern** I am already complying with most of these guidelines. However, some things have been scaled back purely as a cost saving measure for clients and their families. As a privately practicing psychologist working in Western Sydney and the Blue Mountains, it is a big challenge to balance best practice with economic reality for families. ASD	Please refer to the ‘Overview of Major Amendments’ chapter of this document under the following headings: • Emphasis on the Importance of Functional Abilities in Referral for Supports • Cost Implications of the Recommended Assessment Model

			assessments are VERY labour intensive and therefore the cost is quite high to families seeking these privately. My concern is that adding additional assessments (e.g. functional assessments, strengths based assessments and environmental impact assessments) increases the cost to families. At present, families can only access 4 Medicare rebates of approximately $85 for an ASD assessment (if referred by a paediatrician or child psychiatrist - with autism assessment item numbers). Is there scope to increase this? or potentially use MHCP Medicare item numbers? The other option is to have NDIS potentially include these assessments. However, I understand this also has its limitations. I am an NDIS provider but so many of my colleagues are reluctant to do so.	Please also note that the revised Guideline includes a recommendation regarding costs for ASD assessments. Please refer to the 'Overview of Major Amendments' chapter of this document under the heading: • Practice points for clinical, research and policy settings
Dr Paul Williams [10]	ID19	Individual - Professional experience (PR,PD,PS)	The guidelines are a waste of time while autism has special status as a support enabling diagnosis. If the level of support was based on upon the level of function or level of impairment, irrespective of diagnosis - then people would have no motivation to shoe-horn clients into autism diagnoses, and clients will stop shopping for professionals that will diagnose autism. Until you address this, no matter what system you develop, the same problems will re-occur as everyone adjusts.	Please refer to the 'Overview of Major Amendments' chapter.
Anonymous [11]	ID20	Individual - Professional experience (PD,PS)	Concerned about the specificity of requiring clin or ed/dev psych to be involved in assessment of cognitive functioning. Registered psychologists without endorsement are also capable of providing these assessments with adequate experience. If the ASD guidelines do not specify the need for endorsement it seems excessive to require that for assessment of intellectual functioning.	Please refer to the 'Overview of Major Amendments' chapter under the heading: • Qualifications for Psychologists

Hayley Clapham [12]	ID21	Individual – Lived experience (A,C)	I refer to page 29, 'Table 5 Additional factors to consider in determining whether to refer for an ASD assessment'. You do not list having a family member who has been diagnosed, as a factor that would increase the weight of the consumer warranting an ASD assessment. If a child has been assessed using one of the developmental screening tools listed in Table 4, and some concerns were identified, and the child's parent or sibling for example were diagnosed as having an ASD, would that not provide extra weight to the justification of an assessment. It is my opinion through personal research & experience that a commonly occurring theme when a child is diagnosed, is for parents to identify symptoms in themselves or for a sibling to subsequently be diagnosed.	This table has been omitted from the revised version of the Guideline. For further information, please refer to 'Overview of Major Amendments' chapter under the heading: • Referral for an Assessment of ASD Concerns
	ID22		I refer to page 42, ' Table 7 Professional discipline specialists for co-occurring concerns observed during ASD assessments'. You have a paediatrician as being the Diagnostician / Functional and Support Needs Assessor. I feel it would be in the consumer's best interest to have a Gastroenterologist as being the Diagnostician / Functional and Support Needs Assessor, and the paediatrician being listed alongside the General Practitioner & dietician as a suitable additional informant. Gastroenterologists are physicians who have additional training in the functionality of the gastrointestinal organs, and in the assessment, diagnosis & treatment of gastrointestinal conditions. Their training & qualifications give them the means to not only diagnose and treat, but more importantly assess. A paediatrician cannot perform an endoscopy nor refer a patient to have one at their local hospital, as opposed to a Gastroenterologist. If a child is suspected to have gastrointestinal issues, the paediatrician has to refer the child to a gastroenterologist to assess, diagnose then treat. Paediatricians have not only limited training in gastrointestinal	Thank you for this comment. Based on feedback received, this table has been omitted from the revised Guideline. However, Gastroenterologists have been added to the list of other professionals who can provide information to support the ASD assessment.

			conditions, but also they do not have the means to assess & diagnose, which is why they refer their patients to gastroenterologists.	
Anonymous [13]	ID23	Individual – Lived experience (C,F)	I am the parent of a child who has been privately diagnosed with PDA in New Zealand. New Zealand are currently looking to Australia for their guidelines and research into PDA. I would like to stress how life changing finding PDA was for us and hope that you can include it in your guidelines. Many thanks.	Thank you for the comment. No amendment is required in response to this comment.
Anonymous [14]	ID24	Individual – Lived experience (C,F)	A broken leg in Germany is assessed & diagnosed in much the same way as any other '1st' world country, yes? Is ASD a uniquely Australian phenomenon? Why is it being treated as an Aussie discovery of an Aussie-only thing?	Thank you for the comment. No amendment is required in response to this comment.
Prof Bruce Tonge [15]	ID25	Individual - Professional experience (PD,PS,AR)	I am able to provide further comment and information on the DBC and my comments above if requested. Congratulations to the Authors and research team on this excellent document.	Thank you for the comment. No amendment is required in response to this comment.
	ID26		The Developmental Behaviour Checklist: DBC, (Einfeld and Tonge 2002) completed by parents/carers and Teachers, an evidence based Australian normed screening tool for ASD is not mentioned. It is available in 21 languages and used internationally. It includes an autism screening algorithm with high sensitivity and specificity for children aged4-18years. There is also a DBC early autism screen for children aged 18-48months.	Recommendations relating to specific instruments that measure functioning have been removed from the Guideline, and information about resources will instead be located on the Guideline webpage to enable updates to occur more readily.
	ID27		See above The DBC can also be used to provide reliable and valid information on a range of associated emotional and	Recommendations relating to specific instruments that measure functioning have been removed from the Guideline,

			behavioural problems that often present in a child with an ASD (or adult when the DBC adult form can be used). This assists in planning of management and assessment of co-occurring conditions.	and information about resources will instead be located on the Guideline webpage to enable updates to occur more readily.
	ID28		With regard to differential and comorbid conditions there is evidence that Schizotypal disorder occurring in children is an important and probably relatively frequent condition and perhaps contribute to diagnostic difficulty particularly in females. See Jones,H., Testa,R.etal. BioMed Research International 2015	Schizotypal disorder has been added as a differential and co-occurring condition in the Web Resources.
Anonymous [16]	ID29	Individual - Professional experience (PD)	Dear all, I just read that the range of diagnosticians has been expanded to allied health professionals like psychologists, speech pathologists and occupational therapists. If this were to be true I would be absolutely amazed. First of all, I would like to underline that an autism spectrum disorder is a psychiatric diagnosis. Although I do appreciate the input and assessments of psychologists, occupational therapists and speech pathologists, they are in no way educated and/or trained to sign off on a diagnosis of an autism spectrum disorder. Dr Perry Janssen, a concerned Dutch Consultant Psychiatrist	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Professional Roles
Bernadette Benson [17]	ID30	Individual - Professional experience (PR,PD,PS)	Three typos also found in the document. Page 47, I believe 'criteria' at the top should be singular (criterion). Apologies that I did not note the location of the other two - one was a non-existent word, though, so should show up on spell-check.	This typo has been amended.
	ID31		Table 7. Though it's indicated that Table 7 should 'provide guidance' on finding the appropriate specialist, I am concerned it will be misconstrued as 'requisite.' A note should be included within the table itself to clarify this.	Thank you for this comment. Based on feedback received, this table has been omitted from the revision Guideline, and the information included in the table has been incorporated in other sections of the document.

	ID32		There is no evidence provided to support naming specialist psychologists in these areas (e.g.clinical or ed/dev for those with query ID and clin only for adaptive behaviour). Many psychologists might have the requisite training to complete ID/adaptive/learning disability assessments. For example, I am North American educated and trained, with 2 Masters degrees, but have not pursued a specialist title in Australia, as it was prohibitively difficult at the time I immigrated.	Please refer to the 'Overview of Major Amendments' chapter under the heading: • Qualifications for Psychologists
	ID33		Also, it appears confusing to me that an ed/dev psych could complete a cognitive assessment, but not the adaptive behaviour component, which would be necessary for an ID query - when in fact most psychs trained in one tool would be in the whole area.	Please refer to the 'Overview of Major Amendments' chapter under the heading: • Qualifications for Psychologists
Janet Elizabeth Dutton [20]	ID34	Individual – Lived experience (F)	The lack of help and professional awareness of PDA is a real problem in Australia and New Zealand. There are hundreds of parents who all belong to support groups to help each other with strategies to manage our PDA children. So many children are violent and/or avoiding school or being subjected to strategies that make their anxiety worse. Parents are being made to feel inadequate or 'bad parents' when seeking help from professionals because those professionals are lacking awareness and information about this sub-type of Autism.	Thank you for providing this information. No amendment is required in response to this comment.
	ID35		My feedback is to thank you for recognising and including the mention of Pathological Demand Avoidance in the guidelines. It is important to note that many children with PDA do not present as typically ASD. They can have eye contract and be charming and seem 'social'. Also, the strategies to use with	Please refer to the section of this document entitled, 'Overview of Major Amendments' under the following heading: • Pathological Demand Avoidance

			individuals with PDA are quite different from those with typical ASD and it is important for clinicians to realise this. It would be helpful if clinicians could be directed to the Extreme Demand Avoidance Questionnaire' (EDA-Q) found at www.pdasociety.org.uk	
Dr Anne Chalfant [21]	ID36	Individual - Professional experience (PR,PD,PS)	I think the broadening of the 'diagnostician' category to include Speech Pathologists and Occupational therapists operating as potentially independent diagnosticians at Tier 1 is a big problem. Whilst skilled in other areas, it is not the training or ongoing skill set of either professional group to make diagnoses that require an understanding of a broader developmental context, familiarity with the nuances of the diagnostic manuals, sound abilities in differential diagnosis. I do not think it wise to equate being good at detecting what Autism is with being good at detecting what it is not. They are quite separate skill sets, the latter requiring broader training in assessment and diagnosis of other childhood presentations not just Autism. Including Speech Pathologists and Occupational Therapists at the diagnostician level brings greater risk of misdiagnosis and lack of consistency across professionals, the total opposite of what the national guidelines are aiming to achieve.	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Professional Roles
Anne Rhodes [23]	ID37	Individual - Lived experience (C)	I am so pleased to see Pathological Demand Avoidance mentioned. I admin the Australian Facebook support group for PDA of over 489 members. Most have a child diagnosed with ASD and identify with the PDA criteria. I also run an awareness website at pdaanz.com for Australia and New Zealand. It is so important that the differing strategies for PDA can be provided by professionals to families, as the usual autism strategies often don't work and can cause regression. This document will be read by all professionals involved in the diagnosis of autism and hopefully by General Practitioners too, so I am very pleased to see PDA mentioned. Thank you.	Thank you for providing this information. No amendment is required in response to this comment.

Jaqueline Pollack [24]	ID38	Individual - Professional experience (PD)	**Reference: ASD Assessment Roles 6.4 (Pages 15 to 19)** The draft guidelines as they stand presently exclude a sizeable group of highly skilled and experienced Senior Career Medical Officers and Senior Child Health Medical Officers who are working in the public sector as key diagnosticians within multidisciplinary teams (Table 3Page 18). We believe we have equivalent training, expertise and skills competencies as outlined in Table 3 (Page 18). In terms of our memberships, although we are not Fellows of the Royal Australasian College of Physicians (RACP), we are members of the Chapter of Community Child Health within the RACP Paediatrics and Child Health Division, as well as being active members of the Neurodevelopmental and Behavioural Paediatric Society of Australasia (NBPSA). Senior Career Medical Officers are required and expected to work independently at the level of a specialist physician in the public sector, and this grading is only granted to those with greater than 7 years' experience whose training, skills and experience meet this level of competency. We have extensive expertise in health and medical assessment, multidisciplinary teamwork, and developmental, autism specific and adaptive behaviour assessments (6.4.2 page 16). We are routinely involved in integrating findings, clinical report writing, and communicating results to families. We are active participants in formal training courses and peer and case review. We strongly believe we should be included as diagnosticians in the draft guidelines.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Qualifications for Medical Practitioners
Anonymous 25	ID39	Individual – Professional experience	Sorry, I got lost as to which category I need to comment on as it will take me more time to scroll through the long but excellent document. Thank you for your hard work.	Thank you for this comment. Changes have been made to the 'Referral for an Assessment of ASD Concerns' section of the Guideline. Please refer to the 'Overview of Major

		(PD, PS)	As a paediatrician I feel that children with developmental deficiencies including ASD are presenting late, as the concerns are brushed off by GPs and are later picked up by teachers or child care professionals. As GPs have limited training in such area and are too busy to make time for more learning, I feel that parents and carers of children with developmental concerns should be able to self-refer to paediatricians. Communication should then be patient-focused rather than doctor-focused. This will improve follow ups and the handling of sensitive information. Often the referring GPs are not the family doctors and seeing them for a referral letter is a waste of time as it does not include any relevant information. Parents with disabled children have limited time to spare sitting in a noisy medical centre to get a referral letter often seen by paediatricians as a waste of time. Self-referral is particularly important for children born prematurely as they are at higher risk, as you mentioned, and also for siblings of children affected by autism, but should be standardised to all children at least the ones under 6 years.	Amendments' chapter of this document, under the following heading: • Referral for an Assessment of ASD Concerns
	ID40		You did not mention that many times children with developmental problems are also picked up in the children's wards of hospitals as they are assessed by paediatric doctors and nurses, as they have been missed by their GPs and many are not seeing a child and family nurse consistently.	Thank you for this comment. Please note that the recommended referral pathway has been amended in the revised Guideline. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Referral for an Assessment of ASD Concerns
	ID41		I also like to suggest that use simpler terms such as 'primary and secondary services' rather than Tier 1 and Tier 2. Thank you for asking us to give feedback and thank you for all your hard work.	This terminology has been amended. Please refer to the 'Overview of Major Amendments' chapter of this document under the heading: • Structure of the Assessment Process
Anonymous	ID42	Individual –	It appears to defeat the purpose it was intending to achieve, in fact it is likely to compound it further.	No amendment is required in response to this comment.

[26]	ID43	Professional experience (PD,PS)	Mentioned in my next comment. Instead of refining already existing diagnosticians, the proposed addition of diagnostician to the list and suggested two-tiered approach is likely to cause confusion to families, educational institutions and therapists as well. This will in turn overburden the diagnosis process.	The revised draft has sought to simply the structure of the ASD assessment. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Structure of the Assessment Process
	ID44		Two-tiered diagnostic strategy and additional diagnostician a is likely to cause more confusion, invariably going to inflate the rate of diagnosis even further and cause further stress on families, exacerbate waiting times and likely going to cause pressure on NDIS budget and tax payers alike. I believe there could have been better options of dealing with this conundrum.	The revised draft has sought to simply the structure of the ASD assessment, and the diagnosticians involved. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Structure of the Assessment Process
Melita Cullen [28]	ID45	Individual – Lived and professional experience (C,F,PR,PS)	I was astonished when I read then the CRC guidelines for ASD diagnosis. I was part of the Brisbane consultation group and in none of our conversations did OT or speech therapists discussed as alternate diagnosticians. Psychologists were discussed secondary to many already doing ADO assessments. There is a significant risk of conflict of interest with these practitioners being able to diagnose. I agree there is currently significant delay in children being diagnosed both in the public and private sectors. I can commend the CRC for trying to find a solution, but I don't think this is the right one. So where can we go from here? How can we effect change in these guidelines? One proposal I made to the committee was that suitably qualified GPs be able to diagnose tier 1 patients. These GPs would need to have a diploma of child health or dip in developmental disability (or similar) and have done the ADOS course (or similar). There are already a fair number of GPs who would easily fit the criteria plus there is no financial conflict of interest.	Thank you for this comment. This comment is addressed in the section of this document entitled, 'Overview of Major Amendments' chapter under the heading: • Professional Roles • Conflicts of Interest

Susanna Johnson [30]	ID46	Individual – Lived experience (P)	My beautiful partner of 16 years has suffered his whole life with what I think is undiagnosed low-level autism / Asperger's. (I worked as a health professional - BSc hons neuroscience; MSc health). He is the most intelligent person I know and did very well academically, but has suffered socially through his entire life with a long-term legacy of frustration; depression with suicide wishes; unemployment since he was 43 and effectively forced to take a redundancy package; terrible loneliness due to rejection or marginalisation from extended family and the few friends he did manage to make; anger management issues and more. He lived alone until we met when he was 42. I wonder about the collateral cost to society, families and individuals of this poorly understood and poorly managed condition. My partner is a beautifully loving, caring, warm, gentle, perceptive human being. He is on anti-depressants for life. They are not always effective as he does appear to 'cycle' through very low moods for days, occasionally. As medical/ biochemical technologies become more sophisticated, more research is needed. I do wonder about the significance of total costs to society for this group of people.	Thank you for providing this information. No amendment is required in response to this comment.
	ID47		I also feel very sad that families are often in denial about the needs and rights to appropriate health care for such people. Social research into family, workplace acceptance should also be addressed. We need our brightest people to be able to contribute to society, surely.	Thank you for providing this information. No amendment is required in response to this comment. Thank you for this comment. This issue is addressed in the document entitled 'Overview of Major Amendments' chapter.

Anonymous [31]	ID48	Individual - Professional experience (PS)	I do not think it is appropriate for a professional who has not been trained in wholistic assessment, differential diagnosis, child development and DSM 5 diagnostic criteria to diagnose autism on an individual basis. However, I do believe that their contribution as part of a team from their professional perspective is important to form a whole picture of the child in order to make (or not make) a diagnosis of ASD.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Professional Roles • Structure of the Assessment Process
Anonymous [32]	ID49	Individual - Professional experience (PD)	I fully support inclusion of the functional and support needs assessment but, done well, this will add considerable time and cost, increasing waitlists for funded services and blowing out costs for private services. I think we should be asking that once a diagnosis has been made that funding for these kinds of assessments should be clearly allocated within an NDIS plan.	Please refer to the 'Overview of Major Amendments' chapter under the following headings: • Cost Implications of the Recommended Assessment Model Please also note that the revised Guideline includes a recommendation regarding costs for ASD assessments. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Practice points for clinical, research and policy settings
	ID50		I do not think it is appropriate for speech pathologists or occupational therapists to act as sole diagnosticians in Tier 1. They are not trained in differential diagnosis - there is a real risk of incorrect diagnoses being made.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Professional Roles
Ganesh Thambipillay [33]	ID51	Individual - Professional experience (PR,PS)	ASD diagnosis has long term implications for the individual, family and community. It is important that the process is conducted in a systematic and professional manner. Diagnosing ASD should NOT be a ticking box exercise. Developmental assessment and differential diagnosis should be considered. Paediatrician/Child psychiatrist and psychologist are crucial during the diagnostic evaluation. Speech pathologist and Occupational therapist play an	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Professional Roles • Structure of the Assessment Process

			important role in further management ONCE the diagnosis has been confirmed. It is very inappropriate to allow important support personnel to assume the role during the initial diagnostic evaluation.	
	ID52		I have been a Consultant Paediatrician for more than 30 years and seen the various changes over the years. If a proper structure is not in place it is highly likely there will be an 'explosion' similar to what has happened in USA.	Thank you for providing this information. No amendment is required in response to this comment.
Anonymous [34]	ID53	Individual - Professional experience (PD)	It is great that this document acknowledges that 'diagnostic assessments must appraise the full range of clinical symptoms...'	Thank you for the comment. No amendment is required in response to this comment.
	ID54		In order to assess for the full range of clinical symptoms as stated in the guiding principles, it is somewhat problematic if allied health professionals such as speech pathologists and occupational therapists are included as Tier 1 clinicians. ASD is classified as a neurodevelopmental disorder and a comprehensive assessment, regardless of whether it is Tier 1 or Tier 2, must take into account differential diagnoses or co-occurring conditions. These differential diagnoses commonly seen in ASD include ADHD, anxiety, global developmental delays, trauma/attachment related disorder, ODD etc. While it is crucial to have input from speech and occupational therapists in the overall consideration of ASD, tier 1 clinicians should have the expertise in making differential diagnoses. Therefore, to include allied health professionals who do NOT have the training to make these differential diagnoses in the Tier 1 process, it is somewhat contradictory to the guiding principles and is opening doors for more inaccurate diagnosis of ASD.	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Professional Roles

Anonymous [35]	ID55	Individual - Professional experience (PD,PS)	I do recognise there is a place for speech pathologists and occupational therapists to assist in a team of diagnosticians when making decisions regarding ASD. However, I fear without the depth of knowledge of an individual who has studied and practices differential diagnosis daily, incorrect diagnoses may occur, which, in the end, only harms families.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Professional Roles
	ID56		I would like to raise concerns regarding speech pathologists and occupational therapists being able to conduct 'Tier 1' evaluations independently. Common practice currently is that psychologists, paediatricians and/or a multidisciplinary team conduct diagnostic assessments. My understanding for this is that the process of diagnosing psychiatric conditions is just as much about ruling out differential diagnoses as it is about making a clinical diagnosis. This requires a thorough knowledge of all psychiatric and developmental conditions and not just ASD. This is something psychologists and paediatricians spend years learning, developing clinically and practicing daily. Even when presentations may appear 'obvious' or 'clearly' ASD, without understanding other conditions which present with similar and in some cases identical symptoms, you can provide an incorrect diagnosis. Whilst I acknowledge speech pathologists and occupational therapists offer a wealth of knowledge regarding aspects of ASD diagnoses, they do not receive the same level of training nor do they practice diagnosing a range of other psychiatric or developmental conditions on a daily basis. I understand there is to be a level of training and experience required for speech pathologists or occupational therapists to undertake in order to make a Tier 1 diagnoses on ASD. However, I doubt this can substitute for the years of training and experience psychologists and paediatricians have undertaken and put into practice daily. Moreover, speech pathologists and occupational therapists are not required to adhere to the strict supervision and professional development requirements that psychologists are. These ensure we are held accountable,	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Professional Roles

			practice ethically and clinically appropriately, continue to further develop our understanding and remain up to date with our methods and skills.	
Anonymous [36]	ID57	Individual - Professional experience (PD,PS)	I agree that child and adolescent ASD assessments warrants either an individual / independent assessment by a highly skilled diagnostician with expertise in ASD or a multidisciplinary approach comprising: a Paediatrician or Child Psychiatrist, Clinical Psychologist, and if needed, Speech Pathologist and/or Occupational Therapist. I strongly disagree that Speech Pathologists and Occupational Therapists should be able to individually / independently diagnose ASD (if they think it obvious and they have some extra training in ASD assessment). There is no training that would suffice to match the clinical diagnostic skills required for ASD diagnosis that would equate to the skills of a Child Psychiatrist, Paediatrician, or Clinical Psychologist, who are the only professionals qualified for the ASD diagnostic assessment role. As it stands, allowing Speech Pathologists and Occupational Therapist to adopt the role of ASD diagnosticians, despite their under-qualifications, blatantly disregards the risk of misdiagnosis or under diagnosis, particularly of females with ASD, and poses serious concerns ethically and regarding Duty of Care for clients undergoing ASD assessment. The problematic proposal hinders the diagnostic advancement and uniformity being sought for ASD assessment.	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Professional Roles
Anonymous [37]	ID58	Individual - Professional experience (PR)	Page 42 - Professional discipline specialists for co-occurring concerns observed during ASD assessments. I think in the 'Example of Additional Professional Informant' for the co-occurring concerns of gastrointestinal difficulties you	Gastroenterologists have been added to the list of other professionals who can provide information to support the ASD assessment.

			should list a Gastroenterologist as an 'Example of Additional Professional Informant'. Paediatric Gastroenterologists are the experts in this area, more so than Dieticians or GP's.	
Anonymous [38]	ID59	Individual - Professional experience (PR,PD,PS)	I have significant concern that the ability to diagnose individuals is being opened up to Speech Therapists and Occupational Therapists as a sole practitioner. Whilst they provide a very valuable role in the ASD evaluation process they do not receive the training required about ASD and in relation to the possible differential diagnosis options in their university training. Professional development is limited in their ability to understand the complexities of ASD in relation to other possible diagnosis options. This could potentially open up mistakes and or over-diagnosing of individuals based on practitioners limited experience. I also truly believe that final sign off of a diagnosis should occur with a Paediatrician, so whilst it is appropriate and relevant for an ASD experienced Psychologist to conduct an ASD assessment, I do think in all cases a Paediatrician should be consulted as well just to completely rule out genetic/chromosomal and or medical complexities, however I do not think this should hold up funding or access to resources.	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Professional Roles
Anonymous [40]	ID60	Individual - Lived experience (C,F)	Could you please include a bit more info in regard to Pathological demand Avoidance	Please refer to the ‘Overview of Major Amendments’ chapter under the following heading: • Pathological Demand Avoidance
Anonymous [41]	ID61	Individual -	I have concerns regarding OT and Speech therapists being sole diagnosticians. as whilst they have a very important role in assessment and intervention planning they are not trained	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading:

		Professional experience (PD)	in differential diagnosis and therefore should not be completing diagnostic assessments as a sole clinician. I also have concerns about not including a medical doctor in all diagnosis and assessment, as I think that makes the allied health team, and the individual having the assessment, vulnerable to missing treatable and genetic conditions and co morbidities. The current recommendation of at least a psychologist and a paediatrician/neuro/psychiatrist remains the most optimum combination as all other possible contributing reasons for behaviours i.e. chromosomal conditions can be ruled out. In my opinion multidisciplinary input (medical, OT, Speech, CNC and of course Psych) would seem best practice when it comes to the complexities of ASD diagnosis.	• Professional Roles • Structure of the Assessment Process
Julia Delaforce [42]	ID62	Individual - Lived experience (C,F,S)	In QLD - the Education Adjustment Program and subsequent funding for school children with a funded EAP is used at the discretion of the school principals. Meaning the principal can spend this money where and on who they prefer and not necessarily on the child with the EAP funded position. In my experience I have seen this cause care givers frustration causing conflict with Principals and further dividing the ASD community. In QLD caregivers will move schools in order to ensure their child is supported to the best of the schools' ability as this differs immensely. Why is this? It should be the same inclusive attitude and supported the same in every school across Australia, but it is not, and 'diagnosis' aka funding plays a part of why it is not working: **State Schools** 1.It is considered lucky for an ASD child to be included in the mainstream classroom and lucky if any of their funding is actually used to support them. I witnessed cases where the	Thank you for providing this information. No amendment is required in response to this comment.

			Principal used the funding to support undiagnosed challenging children (aggressive child hitting trumps a child hiding under table not participating) leaving the diagnosed children to flounder unsupported who in turn then disrupt the classroom. 2. In contrast some Principals encourage (even funding diagnosis pathway at schools' convenience) to a majority of parents to diagnose their children with 'anything' (many fake diagnosis) so they reap the EAP funding which is used to fund the majority of challenged children regardless of diagnosis or not, thus providing a classroom fully supported for all children. (They wonder why so many fake diagnoses out there!) **Private Schools** At private schools the options for an IEP -Individual Education plan are 'non-existent' despite a Child funded under the EAP. Caregivers have in effect No voice and No say on ANY support. It is considered lucky to have an ASD child in a private school at all. No parent wants to rock the boat for fear of expulsion. No parent can question the school on supports for their child or lack of despite your paying school fees in addition to any EAP funding. Even the Independent Schools Qld wont rock the boat. Caregivers lump it or leave. To my knowledge the EAP and IEP are not physically audited by the state to check with the diagnosed caregiver (not principal) that the child is actually being supported in anyway shape or form. I believe whatever the changes are to diagnostic guidelines, that the decision makers thoroughly consider why diagnosis is even required (access support) and how diagnosis then benefits school politics (money, money, money).	
	ID63		My husband Kevin self-diagnosed his ASD when our 4year old daughter was diagnosed. He was 27 years old. A year later Kevin had more official diagnostics performed including an MRI of his brain in 2011 which the radiologist	Thank you for the comment. There is currently a lack of robust evidence that any type of neuroimaging investigation adds value to clinical decision making for ASD diagnosis, and this

			reported as having 'large frontal lobes indicating his down syndrome, cerebral palsy or other neurological factor. (ASD was not even listed). Recently I saw Dr Temple Grandins TED presentations where she too had the MRI test displaying enlarged frontal lobes. I think this simple brain MRI should be part of the official diagnostic evaluation with accurate Radiologist feedback.	has not been added to the Guideline document. Please see the following scholarly publication for further information: Ecker C, Bookheimer SY, Murphy DGM. Neuroimaging in autism spectrum disorder: brain structure and function across the lifespan. The *Lancet Neurology*. 2015;14(11):1121-34.
Anonymous [43]	ID64	Individual - Professional experience (PR)	As professionals, we need the clear on roles and responsibilities, based on areas of expertise. I am very concerned to hear about the possibility of speech and occupational therapists diagnosing autism. Speech therapists are trained and have expertise in diagnosing speech disorders. OTs have expertise in diagnosing gross/fine motor skills and rehabilitation. Psychologists have expertise in development milestones across the lifespan including psychological/ neurodevelopmental disorders. The proposed changes defy logic.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Professional Roles • Structure of the Assessment Process
Debbie Fear [44]	ID65	Individual - Professional experience (PD, PS)	I have very serious concerns about the proposal to include Speech Pathologists and Occupational Therapists in the list of professionals deemed appropriate to independently and individually diagnose ASD. Irrespective of whether they have undertaken extra training in assessing ASD; a rigorous, clinical assessment (the international standard) does not try to answer a yes or no question about the presence of autism spectrum disorder. I believe it is this approach to assessment that has largely contributed to the situation we have in Australia currently, with high levels of misdiagnosis of ASD, (false positives and false negatives), huge variability in assessment approaches and loose standards for assessing ASD. Rather, a thorough assessment of any condition, and particularly ASD, must look at the child's presentation in the	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Professional Roles • Structure of the Assessment Process

			context of his or her developmental history and generate hypotheses about a range of possible explanations for that presentation. A rigorous assessment will then review the data generated by the assessment against ALL of these considered hypotheses to determine the most appropriate diagnosis. This is the process of differential diagnosis that psychiatrists, paediatricians and psychologists are expertly trained in and undertake every day in clinical practice. DSM-5 lists as one of the ASD diagnostic criteria that 'symptoms are not better explained by another diagnosis'. It is impossible to answer this criterion without a thorough working knowledge of differential diagnoses that cover the breadth of child development. With the proposed inclusion of speech pathologists and occupational therapists as diagnosticians in the draft guidelines, we are asking them to look at and assess the symptoms of ASD in isolation. This is entirely the wrong approach to any clinical assessment! The presentation of children, particularly young children, experiencing cognitive, communication and developmental difficulties is usually complex, and requires careful consideration of overall development of the child and considered, differential diagnosis to ensure that no other conditions or disorders might better account for the child's presentation. Diagnosis requires thorough understanding of the main diagnostic manuals (e.g. DSM 5), how to use them and a thorough working knowledge of the other disorders and conditions within them that may account for the way a child presents. These skills and experiences do not form part of the training or regular work of Speech Pathologists or Occupational Therapists. We should therefore not be recommending that such professionals take up roles as diagnosticians with ASD, whether the symptoms are apparently obvious or not.	

Anonymous [45]	ID66	Individual - Lived experience (C)	I strongly believe paediatricians, developmental psychologists and psychiatrists are the best qualified professionals to diagnose ASD. I don't believe opening up diagnostic opportunities to speech and occupational therapists will benefit families, and it risks everything being seen as ASD, especially if you're 'looking' for it. Families may also go 'therapist shopping' in order to get the diagnosis they want in order to access services. Giving a diagnosis of a lifelong disability is a serious thing and it doesn't make sense to broaden the range of professionals who are qualified to give it. This does not in any way take away from the exceptional work many speech and OTs do in the field of ASD.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Professional Roles • Structure of the Assessment Process
Meroe Robertson [46]	ID67 ID68	Individual - Professional experience (PR,PD,PS)	There are significant strengths to the proposed guidelines, however I am extremely concerned with the major change in who makes the final diagnostic decision. It greatly concerns me that you are changing the scope to allow OT and SP clinicians to make a final diagnostic decision. I believe these clinicians can play an important role in the diagnostic process, however the final decision requires additional training and expertise in order to KNOW criteria related to other DSM-V diagnoses/conditions and therefore be able to differentiate other potential diagnoses verses ASD. OTs and SPs do not have the training that Psychiatrists, Paediatricians and Psychologists have in terms of other disorders and conditions. While it is stated in this draft that 'it is critical for the diagnostician to use the information collected .... to consider the full range of clinical explanations for symptom presentation...' (p. 70), clinicians that do not have the training in making DSM diagnostic decisions will not necessarily know that an alternative (or co-morbid) explanation is possible and therefore be able to make a differential diagnosis. I truly believe that there is a fundamental flaw in broadening the clinical scope to make final diagnostic decisions. This flaw	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Professional Roles • Structure of the Assessment Process

			will be reflected in the validity of ASD diagnoses as well as the potential miss of comorbid diagnoses.	
Dr Elizabeth Green [47]	ID69	Individual - Professional experience (PD)	I have forwarded a submission response for the New National Autism Guidelines Draft to Dr Kiah Evans via the provided email. Word document attached to email.	No amendments are required in response to this comment.
Raelene Dundon [48]	ID70	Individual - Lived and professional experience (C,PD,PS)	6.3 Coordinator - Having one person coordinating the whole assessment can be difficult when multiple private practitioners are involved in the diagnostic process. Appointing a separate coordinator or expecting a diagnostician to take on this role in addition to their assessment work is likely to add significant cost to the family. I think it should either be the role of the referring clinician or the diagnostician themselves on intake to describe the assessment process, what the individual or family should expect and support them on feedback to understand the results of the assessment and what to do moving forward.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Coordinator Role Please also note that the revised Guideline includes a recommendation regarding costs for ASD assessments. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Practice points for clinical, research and policy settings
	ID71		6.4.2 ASD Specific Expertise 1. Demonstrating at least four years fulltime equivalent of postgraduate experience that is directly relevant to ASD Diagnostic Evaluations, obtained through university qualifications, formal training programs and/or formally supervised work experience; Most private clinicians will not only be seeing and diagnosing ASD, but also seeing other children/adults etc. Four years full time equivalent of ASD diagnostic specific training seems unrealistic - it doesn't factor in clinical practice and the need for clinicians to be seeing neurotypical children to have a broader view of development and be able to consider	This requirement has been omitted from the revised Guideline. For a rationale, please refer to the 'Overview of Major Amendments' chapter under the heading: • Duration of ASD-specific Expertise

			differential diagnosis. Expecting this extremely high level of specific experience is also likely to limit the number of clinicians able to complete diagnostic assessment, consequently increasing wait times for families for assessment.	
	ID72		Table 3: Training and key skills areas for Diagnosticians Registered Psychologist - Training The definition in the guidelines is confusing and seems inaccurate regarding 2 years supervised training plus masters/ doctorate and an intern year. Current registration as a Psychologist requires a 4-year accredited sequence in Psychology and 2 years supervised training, a 5-year sequence in Psychology and 1-year supervised training, or a 4-year sequence in Psychology and a Masters or Doctorate in Psychology. Endorsement is another 1 or 2 years in addition to a Doctorate or Masters under supervision of an endorsed Psychologist	Please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Qualifications for Psychologists
	ID73		Table 5: Additional factors to consider in determining whether to refer for an ASD Assessment. Should family history of ASD and a child having a sibling or siblings with ASD be included here?	This table has been omitted from the revised version of the Guideline. For further information, please refer to the Overview of Major Amendments’ chapter under the heading: • Referral for an Assessment of ASD Concerns
	ID74		8.3 Acting on a referral for an ASD Assessment. This point again appears to assume that all parts of the assessment are occurring in one place and are being coordinated by one person which may not be possible, particularly in a Tier 2 assessment where multiple private clinicians from different practices are involved.	We believe that the Structure of the Assessment Process in the revised Guideline addresses this comment. For further information, please refer to the Overview of Major Amendments’ chapter under the headings: • Referral for an Assessment of ASD Concerns • Structure of the Assessment Process

	ID75		Table 7: Professional discipline specialists for co-occurring concerns during ASD assessments. In the 'Functional' section, a Psychologist with a Clinical Specialty is listed as being able to assist with 'General Function or Adaptive Behaviour Difficulties' and 'Sleep Difficulties', however generally registered Psychologists with appropriate experience would equally be able to support individuals or families with these difficulties.	Thank you for this comment. Based on feedback, Table 7 has been omitted from the revision Guideline, and the information included in the table has been incorporated in other sections of the document.
	ID76		10 Functional and Support Needs Assessment, While I understand the benefits of a functional assessment and strengths-based recommendations as part of an ASD assessment, I am concerned that the additional time and cost to families for a comprehensive assessment in this area will make this unachievable. A comprehensive functional assessment would be better considered on an as needs basis depending on the person's age, abilities, and how the results of the assessment would be being used (e.g. employment).	Please refer to the 'Overview of Major Amendments' chapter under the following headings: • Emphasis on the Importance of Functional Abilities in Referral for Supports • Structure of the Assessment Process • Cost Implications of the Recommended Assessment Model Please also note that the revised Guideline includes a recommendation regarding costs for ASD assessments. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Practice points for clinical, research and policy settings
Autism Queensland [49]	ID77	Organisation - Professional experience (Senior Speech Pathologist)	We would like to acknowledge the overall high quality and thoroughness of these draft guidelines and the opportunities that it will provide in terms of equitable access to diagnostic services to the families of Australia.	Thank you for the comment. No amendment is required in response to this comment.
	ID78		The focus on improving consistency of diagnostic practices is wonderful to see. As an organisation who sees firsthand the challenges faced by families in more rural and remote areas,	Thank you for the comment. No amendment is required in response to this comment.

			in terms of accessing diagnostic services for ASD, in order to access ongoing support and interventions, improvements to consistency would have a tremendously positive impact.	
	ID79		The inclusion of functional needs assessment alongside the diagnostic process is great to see. Quite often our organisation has contact with families who don't know where to turn and what to do next, after diagnosis, which can be emotional, stressful and confusing. With a clear plan and options for ongoing support, particularly as the NDIS rolls out nationally, many families will feel more supported through and after the diagnostic process, which is wonderful.	Thank you for the comment. No amendment is required in response to this comment.
	ID80		It is great to see the recommendations around diagnostic roles expanded within reason, to formally include other allied health professionals, with the relevant formal training in gold standard ASD diagnostic assessments and minimum experience in the field of ASD. This is common and accepted and recommended practice internationally and acknowledges the importance of a multidisciplinary team in the diagnostic process. One area that will need to be considered in some states, such as Queensland, is how the education systems acknowledge diagnoses for verification purposes, in line with the new guidelines.	Thank you for this comment. While the structure of the Guideline has been revised in light of feedback received, the important of allied health professionals in the diagnostic process remains prominent. Please refer to the 'Overview of Major Amendments' chapter under the following headings: • Structure of the Assessment Process
	ID81		Again, it is great to see such a clearly thought out diagnostic care pathway for families in rural and remote settings. As mentioned elsewhere, increased Medicare support around video conferencing and telehealth will be key in terms of these guidelines being deliverable in a way that is equitable in terms of cost for families and adults requiring diagnostic services.	Thank you for the comment. A recommendation regarding this point has been added to the revised Guideline. Please refer to the 'Overview of Major Amendments' chapter under the following heading: • Practice points for clinical, research and policy settings
	ID82		It is wonderful to see the recommendations around how diagnostic services can be delivered in a way that takes into consideration the challenges of diagnostics in rural and	Thank you for the comment. A recommendation regarding this point has been added to the revised Guideline. Please refer to

			remote areas. The guidelines give a clear pathway to how diagnostics can at least in part, be completed by diagnosticians in consultation with professionals in more rural and remote communities. One of the challenges that will need to be addressed is how Medicare can further support a wider range of diagnostic services. Consideration around how Medicare items can be accessed, in terms of referrals for diagnostic assessment, is required, so that families can access this support more easily. consideration around how Medicare can support a wider range of diagnostic services to be conducted via video conferencing or telehealth, to ensure equitable access to services for families in rural and remote areas, where diagnosticians are based elsewhere, is also an important consideration if equitable access to services are to occur.	the 'Overview of Major Amendments' chapter under the following heading: • Practice points for clinical, research and policy settings
	ID83		It is wonderful to see that the NICE guidelines from the UK have been consulted extensively in these guidelines, as well as a myriad of other excellent sources of well-established clinical best practice with respect to diagnostics. With the ever-increasing opportunities for health professionals to gain international experience, these guidelines would further allow for professionals who have worked in well established, effective and evidence informed diagnostic services internationally, to use their skills and expertise to benefit Australian families and communities.	Thank you for the comment. No amendment is required in response to this comment.
Australian Association of Social Workers (AASW) [50]	ID84	Individual - Lived and professional experience (C,PR,PS)	Social Workers should definitely be on the list for appropriate discipline in being able to diagnose ASD and to provide the functional and needs assessment. Am shocked to see Occupational Therapists on this list and Social Workers left out. I don't feel we as Social Workers with a 4yr Bachelor degree in allied health (the same as OT's and Speech Paths) should be discriminated against due to the AASW not putting a representative forward on the steering committee. It is not the individual Social Worker's fault this happened. I am really wanting to be able to offer diagnostics in this area again. I	Social Worker have been included as Allied Health clinicians at Stage 1 of the revised Guideline. For further information, including a rationale for Stage 2 clinicians, please refer to the 'Overview of Major Amendments' chapter, under the headings: • Structure of the Assessment Process • Professional Roles

			used to co-ordinate a diagnostics assessments program for Autism. Please contact the AASW to get input from this before proceeding forward.	
	ID85		As above, Social Workers are much qualified to perform these as any of the other disciplines mentioned but we are missing off the list once again.	Social Worker have been included as Allied Health clinicians at Stage 1 of the revised Guideline. For further information, please refer to the ‘Overview of Major Amendments’ chapter.
	ID86		Please consider this discrimination against social workers to leave us off this list as being able to diagnose Autism.	Social Worker have been included as Allied Health clinicians at Stage 1 of the revised Guideline. For further information, please refer to the ‘Overview of Major Amendments’ chapter.
Wenn Barnabas Lawson [51]	ID87	Individual - Lived and professional experience (A,C,F,PR,PD)	The Overview section covers all relevant information and is a good summary of what's involved with referral through to assessment with proposed recommendations based upon strengths and not only limitations, both for the present and the future for the consumer.	Thank you for the comment. No amendment is required in response to this comment.
	ID88		The ASD assessment guiding principles are rigorous, well thought through, based upon extensive research & history. They are appropriate, considerate and doable, especially if adopted by all concerned.	Thank you for the comment. No amendment is required in response to this comment.
	ID89		The scope of the ASD assessment is able to reach individuals throughout Australia and in all manner of circumstances. It is suitable for gender difference, age difference and cognitive variations.	Thank you for the comment. No amendment is required in response to this comment.
	ID90		The Roles of and for an ASD assessment are well considered and should, if team work flows cooperatively, mutually support the consumer throughout the entire procedure.	Thank you for the comment. No amendment is required in response to this comment.

	ID91		The ASD assessment settings for individuals cover a variety of natural situations as well as clinical and aim to see the individual in a variety of settings. This allows for a full scale of opportunity, both community and clinic based.	Thank you for the comment. No amendment is required in response to this comment.
	ID92		It's important that initially individuals, carers and professionals can voice concerns that may lead to an ASD assessment. When this is formalised, in the guidelines, it gives permission and may help overcome stigma.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter, under the heading: • 'Referral for an Assessment of ASD Concerns'
	ID93		The diagnostic evaluation section in the guidelines should allow for individual differences but note both strengths as well as limitations. This leads individuals on and into ways to accommodate their interests and concerns. This is well captured.	Thank you for the comment. No amendment is required in response to this comment.
	ID94		A functional and support section gives opportunity for growth and development. This is an essential aspect to the guidelines previously unknown. I am very happy to see this!	Thank you for the comment. No amendment is required in response to this comment.
	ID95		Having spelled our important considerations in the guidelines compliments and extends the assessment. It is holistic and considers the whole of life experience, covering both young and older. It will help to rule out those who do not fit the ASD criteria.	Thank you for the comment. No amendment is required in response to this comment.
	ID96		I am wondering if the guidelines are explicit enough when it comes to areas of gender variance and also to issues related to differing genders? I think they are amazingly comprehensive, which is needed, but still wonder about these 2 areas...	Thank you for the comment. We have re-reviewed the scholarly literature, we are confident that this section provides the most up-to-date information currently available. The Guideline also includes a table for further guidance (Section 12.3)

Department for Education and Child Development (South Australia) [52]	ID97	Organisation - Professional experience	I think it is important to note that the suggested diagnostician roles will still leave children and adults in regional and remote areas of Australia struggling to obtain a diagnosis due to the lack of availability of these professionals.	Significant effort has been made to ensure that the Guideline does not reinforce inequity in access to services. (Please refer to the Guiding Principle of 'equity'). The challenge has been to achieve a balance between facilitating broad access to assessment services while still maintaining assessment rigor. Informed by the extensive consultation that was performed as part of the Guideline development, we feel that the revised version of the Guideline achieves this balance as optimal as possible.
	ID98		We note the far wider range of people able to co-ordinate a diagnosis and worry that this could cause a level of confusion.	The revised draft has sought to simplify the structure. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Coordinator Role
	ID99		From an access perspective, it is often a GP (or senior educator for a child) that refers a person for an AS assessment. It would be useful if people in these professions with assessment/diagnosis training and qualifications would be able to diagnose too. Perhaps something like doing ADI-R or ADOS training or CPD for the GP specialists	Please refer to the 'Overview of Major Amendments' chapter under the heading: • Qualifications for Medical Practitioners Under this definition, a GP may be able to play a diagnostic role in ASD if they have acquired the stated expertise and skills.
	ID100		It is vital that assessment information is gathered from at least two settings for both adults and children, so that strengths and support needs can be observed across a range of contexts.	Thank you for the comment. No amendment is required in response to this comment.
	ID101		It is good to see a move towards a useful assessment approach that will provide a report that will be informative from education providers from pre-school through to high-school.	Thank you for the comment.

Anonymous [53]	ID102	Individual - Professional experience (PD)	As a general psychologist whom has been specializing in the area of ASD for many years, I do not think there should be a mandatory requirement to have college specific endorsement. This would eliminate many expert psychologists that specialize in ASD whom have not chosen to seek 2-year college specific endorsement within clinical psychology, educational/developmental psychology etc.	Please refer to the 'Overview of Major Amendments' chapter under the heading: • Qualifications for psychologists
	ID103		Furthermore, undertaking observations in different settings is not always possible in private practice sessions and therefore I do think that the video recordings in different settings would be valuable however should not be made mandatory.	Thank you for providing this information. No amendment is required in response to this comment.
Anonymous [54]	ID104	Individual - Professional experience (PR,PD,PS)	I have often noted inconsistencies in the diagnostic assessments conducted by different organisations and welcome these guidelines as a significant step towards improving both the process and the outcomes. Thank you in advance.	Thank you for the comment. No amendment is required in response to this comment.
	ID105		In Australia, an allied health professional cannot call themselves a psychologist unless they are registered with AHPRA, therefore, it is unnecessary to refer to a 'Registered Psychologist'. Please consult AHPRA/the APS on this matter for further clarification. It is similar to calling an Occupational Therapist a 'Registered Occupational Therapist' as they are also registered with AHPRA to practice within Australia.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter, under the heading: • Qualifications for Psychologists
	ID106		9.5.1 Table 7, Under 'Functional' section termed 'General function or adaptive behaviour difficulties...' and 'Sleep difficulties...' please add educational and developmental speciality along with clinical speciality for psychologists. Educational and Developmental training includes a significant component of functional and adaptive behaviour analysis	Thank you for this comment. Based on feedback, Table 7 has been omitted from the revision Guideline, and the information included in the table has been incorporated in other sections of the document.

			expertise as well as training in sleep difficulties throughout development. I have training in both clinical psychology (currently completing) and educational and developmental psychology (completed) and strongly believe the educational and developmental course provides extensive training, experience and expertise in these areas.	
Noah's Ark Inc. [55]	ID107	Organisation - Professional experience	The overview provides a clear definition and diagnostic criteria of ASD using accessible terminology. It is pleasing to see that the targeted consultations included individual perspectives from adolescents and adults with ASD and caregivers. The instructions for using the guidelines are straightforward and highlight the importance of tailoring the assessment process to meet the needs of individuals.	Thank you for the comment. No amendment is required in response to this comment.
	ID108		It is encouraging to see an individual and family centred approach at the forefront of the guiding principles. The other three principles provide a thorough basis on which assessment should be conducted. These four tenets are based on a partnership between families and professionals which represents a considerable shift in the manner in which some assessments are currently conducted. This will require consideration in terms of professional learning and development opportunities that focus not just on what professionals do during the diagnostic process, but how we do it.	Thank you for the comment. No amendment is required in response to this comment.
	ID109		We are concerned that that a Tier One assessment could be conducted without input from a Paediatrician or Psychiatrist as we believe this expertise is a critical component of a robust assessment to investigate co-morbid or associated conditions. For example; the guidelines indicate that a Tier One diagnostic decision is possible from an Occupational Therapist (Diagnostician), along with input from a Dietician	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Professional Roles • Structure of the Assessment Process

			(Professional Informant) and information from the child's caregiver about their participation at home and school.	
	ID110		It is important to note the expertise that Specialist Teachers (with Master Level Special Education qualifications) can bring to the role of Coordinator, or Functional and Support Needs Assessor.	Special education teachers have been added to the list of other professionals who can provide information to support the ASD assessment.
	ID111		There is a discrepancy in the stated requirements of a Functional and Supports Needs Assessor. 6.5.1 indicates that a Paediatrician, Psychiatrist, Neurologist Psychologist, Speech Pathologist or Occupational Therapists meet requirements. 10.3.1 indicates that a Diagnostician or a Professional Informant meets requirements	The revised Guideline incorporates substantial changes to the professional roles. For further information please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Professional Roles
	ID112		The focus on obtaining information on behaviours in multiple settings, and relevant to daily life, is encouraging. It would be useful to make note of the importance of gathering information from multiple informants in this section of the guidelines.	Thank you for this comment. The importance of collecting information from multiple informants is enshrined in the Guideline structure.
	ID113		We recommend that information from the early childhood or school setting is considered an essential component of the assessment if the child is participating in one of these educational settings. The use of an additional setting in Tier 2 is advantageous, although the emphasis on the observation being made by the Diagnostician may be limiting in terms of resources.	In the attempt to achieve balance between assessment rigor and feasibility/flexibility of administration, it was decided to not make child observation within a school setting a mandatory component of the Guideline. However, the early childhood or school setting was suggested as an important setting for children and adolescents, as was the important role of educators as other professionals involved in the ASD assessment. Further clarification was provided that any member of the ASD assessment team may collect regarding community settings.
	ID114		It would be helpful to include tools that could be recommended for gathering information from Professional	Recommendations relating to specific instruments that measure functioning have been removed from the Guideline,

			Informants in community settings (e.g. Developmental Behaviour Checklist - Teacher version).	and information about resources will instead be located on the Guideline webpage to enable updates to occur more readily
	ID115		The inclusion of telehealth is a welcome option in supporting rural and remote consumers to access high quality assessment services.	Thank you for the comment. No amendment is required in response to this comment.
	ID116		In Victoria, the Ages and Stages Questionnaire and Parents' Evaluation of Developmental Status are commonly used by universal early childhood service providers (e.g. Maternal and Child Health Nurses), so provide a critical link for referral. The specialist Early Childhood Intervention (ECI) field rarely use the Brigance, Battelle or Denver, but many use the Psycho-Educational Profile (PEP-3). The inclusion of the PEP-3 in Table 4. could be considered.	Recommendations relating to specific instruments that measure functioning have been removed from the Guideline, and information about resources will instead be located on the Guideline webpage to enable updates to occur more readily
	ID117		Table 5. provides five risk factors that are known to be associated with ASD. Neither developmental regression, nor having a sibling with ASD, are included.	This table has been omitted from the revised version of the Guideline. For further information, please refer to the ’Overview of Major Amendments’ chapter under the heading: • Referral for an Assessment of ASD Concerns
	ID118		Table 7 indicates the range of professionals that can provide information for co-occurring concerns. The addition of Specialist Teachers (Masters of Special Education) would be a welcome addition to the areas of; a) Global developmental functioning; b) Social relationships; and, c) General function or adaptive behaviour. Clarity is also required in relation to the exclusion of Developmental and Educational Psychologists in some of these areas (e.g. Trauma/deprivation).	Thank you for this comment. Based on feedback, Table 7 has been omitted from the revision Guideline, and the information included in the table has been incorporated in other sections of the document.

	ID119		We recommend that further detail is provided in relation to the relevant experience required of Diagnosticians.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Professional Roles • Structure of the Assessment Process
	ID120		Consideration needs to be given by state government departments on how the new guidelines inform and intersect with the existing funding requirements. For example; the current Department of Education and Training (DET) requirements are for a multidisciplinary assessment containing reports from a paediatrician/psychiatrist, speech pathologist and psychologist.	Thank you for the comment. We have added this recommendation in the revised Guideline. For further information, please refer to the 'Overview of Major Amendments' chapter under the heading: • Practice points for clinical, research and policy settings
	ID121		The Functional Support Needs Assessment provides an additional structure that should provide clear information and direction for future support. However, consideration should be given to the breadth of information gathered and how it can be used to support programming and appropriate intervention; particularly for young children and their families. It would also be useful to make note of the importance of gathering information from multiple informants for the Functional Support Needs Assessment.	This comment is addressed in the 'Overview of Major Amendments' chapter under the headings: • Structure of the Assessment Process
	ID122		We recommend that a consistent approach between the Functional Support Needs Assessment documents and those being developed by the National Disability Insurance Agency (NDIA) for planning purposes are considered.	Thank you for the comment. No amendment is required in response to this comment.
Anonymous [56]	ID123	Individual -	I am a Registered Psychologist and I have been working at Autism Assessment for one year and was hoping to go start doing Autism Assessments in 2018. I am concerned with the stipulations in terms of needing four years of experience in	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading:

		Professional experience (PS)	ASD, specifically in assessing ASD. Firstly, the four-year requirement I feel is not necessary. As a Registered Psychologist we are trained to administer assessments without needing specific training in that area as we have been trained in Psychometric Assessment. Furthermore, in regards to needing experience working in ASD diagnosis, how would we be able to get this experience if we are not eligible due to lack of experience?	• Qualifications for Psychologists
Anonymous [57]	ID124	Individual - Professional experience (PR, PS)	How long will the turnover be between the guidelines being released and being in use - our Disability Support Program (South Australian DECD - Education Department) criteria will need to be updated to ensure that children with a single professional diagnosis are recognised under our program?	Thank you for this comment. This issue is out of scope of the project terms of reference, and so no amendment has been made.
	ID125		http://www.autism.org.uk/about/diagnosis/children.aspx NICE Guideline 128: https://www.nice.org.uk/guidance/CG128 National Autism Plan for Differential diagnosis Also provide intervention guidance. Therefore, it appears that international standards say that a multidisciplinary team is an essential in an ASD diagnosis. A Tier 1 diagnosis would be well below these international standards.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Professional Roles • Structure of the Assessment Process
	ID126		Some concerns have been raised about speech pathologists and occupational therapists conducting Tier 1 evaluations, due to their specific knowledge only about certain aspects of ASD (e.g. speech pathologists are very knowledgeable about communication, but are they best placed to examine restrictive and repetitive behaviours?). Maybe they could conduct Tier 2 diagnoses, but not Tier 1?	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Professional Roles • Structure of the Assessment Process

	ID127		Page 17 - further details are required about the exact nature of the formal training required in order to assess for ASD. The current wording of the guidelines is unclear, and could lead to different interpretation by different professionals. A standard pathway for clinicians to follow may be warranted.	Please refer to the ‘Overview of Major Amendments’ chapter under the following heading: • Accreditation and Regulation • Practice points for clinical, research and policy settings
	ID128		Table 3 on page 18 needs to be more specific about the training pathways to be a psychologist - and it would typically be a 2-year intern program, rather than a 1-year intern program (see the diagram on the APS website: https://www.psychology.org.au/studentHQ/studying/study-pathways/)	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Qualifications for Psychologists
	ID129		In several of the tables, particularly in Table 7, different types of psychologists are mentioned (e.g. clinical psychologists, educational and developmental psychologists, psychologists). It is recommended that these are all changed to 'psychologists with appropriate experience in this area', as each speciality of psychology is able to assess and report on each of these areas (e.g. sleep, cognitive abilities etc.).	Thank you for this comment. Based on feedback, Table 7 has been omitted from the revision Guideline, and the information included in the table has been incorporated in other sections of the document
	ID130		Do all people who undergo an ASD assessment get a Functional and Support Needs Assessment, even those for whom the diagnostic outcome is Not ASD?	This comment is addressed by the structure of the revised Guideline. Please refer to the ‘Overview of Major Amendments’ chapter under the headings: • Emphasis on the Importance of Functional Abilities in Referral for Supports • Structure of the Assessment Process
	ID131		Table 10 p. 59 - from what I have seen, Pathological Demand Avoidance subtype of ASD is quite controversial, and only diagnosed by selected diagnosticians. Does it need to be mentioned at all?	Please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Pathological Demand Avoidance

	ID132		Table 15 p. 71 Clinical differences in multiple areas of functioning **- add Post Traumatic Stress Disorder and Acute Stress Disorder**	Acute stress disorder and post-traumatic stress disorder have been added as conditions that may have an overlapping sign and/or symptom profile with ASD in the Web Resources.
	ID133		Will reports have to justify why they have used a Tier 1 diagnosis? Will the clinician have to go through the diagnostic algorithm in the report to prove the individual has met each of the criteria?	The template for the diagnostic report that has been provided along with the Guideline indicates that clinicians should highlight which ASD criteria has been met (and evidence for this).
	ID134		Will Tier 2 diagnoses be looked down upon because they are more complex and less obvious? It would be detrimental for these individuals for a two-tier model of intervention and support created as a result of these diagnostic guidelines (we wouldn't want people to think that Tier 2 diagnoses need a lower level of support).	Thank you for providing this information. No amendment is required in response to this comment.
	ID135		Will Tier 1 diagnoses be moderated, to ensure rogue diagnosticians do not over-diagnose ASD? We would not want some diagnosticians to always diagnose ASD - they would quickly become known in the ASD community, and people would go to them to ensure they get a positive ASD diagnosis, rather than a comprehensive assessment which may result in no ASD diagnosis.	Please refer to the 'Overview of Major Amendments' chapter under the following heading: • Accreditation and Regulation • Practice points for clinical, research and policy settings
	ID136		Alternate diagnostic algorithm - see page 4 for my alternative algorithm (as the current algorithm Fig 5 p. 39 indicates that a person could have an uncertain number of social communication criteria met, and go straight to a Tier 2 assessment, even if they do not meet any of the other criteria)	Please refer to the 'Overview of Major Amendments' chapter.

	ID137		Should telehealth assessments only be Tier 2 assessments, or should there be more professional informants in these assessments (maybe there should be two professional informants from two different settings in these instances)? It is important for a clinician to develop a strong relationship with a client who is being assessed for ASD. This is very challenging in a tele-conferencing setting.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Telehealth
	ID138		Will clients have to pay more for a Tier 2 diagnosis? Could create barriers to diagnosis.	Thank you for this comment. This issue is out of scope of the project terms of reference, and so no amendment has been made.
	ID139		This two-tier system is a less rigorous diagnostic procedure than the current procedures in place in South Australia (two professionals are required to complete a diagnosis). Concern was raised about the implications of decreasing the requirements for diagnosis - will this result in an explosion of diagnoses?	The revised structure presented in the updated Guideline addresses this comment. Please refer to the 'Overview of Major Amendments' chapter under the headings: • Consistent and Flexible StructureStructure of the Assessment Process
	ID140		Tier 1 assessments should have to use standardised assessments. This will ensure that these are rigorous assessments that are based on clinical decision making and empirical results of assessment data.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Use of 'Standardised' Instruments
Anonymous [59]	ID141	Individual - Professional experience (PD)	A tier 1 level should include a Paediatrician, Psychiatrist, Neurologist or Clinical Psychologist who has experience in diagnostic assessment using DSM 5 criteria and looking at the individual as a whole. I do not support Speech Pathologists or Occupational therapists as Diagnosticians for Tier 1, however do agree they have a role as part of a Tier 2 Multidisciplinary team.	The revised structure presented in the updated Guideline addresses this comment. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Professional Roles

Anonymous [60]	ID142	Individual - Professional experience (PD)	I support recommendations that diagnosticians have experience with diagnosis (i.e. Drs & Psychologists only) and that the criteria to be a diagnostician be more comprehensive and able to be measured i.e. assessed through days training, a course or online assessment or interview of skills. However, who will complete this and then monitor this?	Please refer to the 'Overview of Major Amendments' chapter under the following heading: • Accreditation and Regulation • Practice points for clinical, research and policy settings
Anonymous [61]	ID143	Individual - Professional experience (PD)	National Guidelines for Autism Diagnosis - recommendations I support recommendations that diagnosticians be only trained Doctors and Clinical Psychologists for Tier 1. I do not think that Speech and Occupational therapists have DSM 5 diagnostic training as part of their internship or every day skills (e.g. how will they differentiate between mental health such as anxiety disorders, attachment disorders and ASD?).	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Professional Roles • Structure of the Assessment Process
	ID144		I recommend that the criteria to be a diagnostician be more comprehensive and be able to be measured i.e. assessed through a day's training, a course or online assessment or interview of skills. However, who will complete this and then monitor this? How did the researchers come up with 4 years as competency?	Please note that the requirement for 4 years' experience has been omitted from the revised Guideline. For a rationale, please refer to the 'Overview of Major Amendments' chapter under the heading: • Duration of ASD-specific Expertise • Accreditation and Regulation • Practice points for clinical, research and policy settings
	ID145		I support the Tier one and Tier two assessment process with more complex presentations for Tier two involving a multidisciplinary team approach. I support a Tier 2 multidisciplinary team including Dr, Psychology and allied health such as SP & OT.	Thank you for the comment. No amendment is required in response to this comment.

	ID146		The assessment process should include standard guidelines regarding the use of evidence based tools as indicated to support clinical assessment. I would go further to suggest that all diagnosticians be trained in ADOS 2 and ADI-R clinical interview as a baseline whether these tools are used in tier 1 assessment and as a mandatory requirement for assessment for tier 2. I support an annual review of skills via face to face day training or online testing renewal.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Use of 'Standardised' Instruments
	ID147		I support a comprehensive and person-centred approach to diagnosis including developmental, psychometric and functional assessment as well as diagnostic assessment in the context of other cultural and psychosocial issues. These assessments can only be completed by trained Drs and Psychologists. The inclusion of reports by SP & OT therapists and educational professionals are also extremely beneficial to see the individual and their strengths and supports needs as a whole.	Thank you for the comment. No amendment is required in response to this comment.
Anonymous [62]	ID148	Individual - Professional experience (PD,PR, PS)	Who determines who is a 'Diagnostician'? Does completion of the Graduate Certificate in Autism diagnosis give 'diagnostician' status? Will there be a register or list available of 'diagnosticians' as a way to evaluate people's credentials? Can an OT adequately assess social communication skills?	Please refer to the 'Overview of Major Amendments' chapter under the following heading: • Accreditation and Regulation • Practice points for clinical, research and policy settings
	ID149		Will GPs be given specific training on how/when to make referral?	Thank you for this comment. This issue is out of scope of the project terms of reference, and so no amendment has been made. However, we note that we have made recommendations regarding professional bodies developing competency-based training programs for professionals involved in the ASD assessment process. Please refer to the 'Overview of Major Amendments' chapter under the following heading: • Accreditation and Regulation

				- Practice points for clinical, research and policy settings
Maria Papillo [63]	ID150	Individual - Lived experience (F)	Perhaps this is off topic. But my concern is the follow up of a child who has been diagnosed. No one has ever randomly rung us to see how we are going and ensuring that we are on track and doing the right thing for our child. So many children out there are missing out on the fundamental years of intervention, in order to make their lives full of purpose in their adult years.	Thank you for this comment. We appreciate the feedback. The Guideline includes specific recommendations that professionals involved in the assessment process are to link clients with appropriate service provider pathways, who then assume clinical management responsibilities for families.
	ID151		Living in a rural town does not make things easy for accessing support for our child. Thankfully we are well supported by the school and our child is low on the spectrum and we always need to be mindful of her needs as they arise.	Thank you for providing this information. No amendment is required in response to this comment.
	ID152		This was a tough long process to go through. Thankfully we had supporting doctors. Early intervention was another key element. Living in rural South Australia made this process very tricky.	Thank you for providing this information.
Heidi Brandis [64]	ID153	Individual - Lived and professional experience (C,F,PS)	This is an outstanding step forwards in the autism sphere for Australia. I applaud all of your efforts in contributing to this important work. I sincerely hope that families and particularly children on the spectrum greatly benefit from this excellent progress! Congratulations to all involved.	Thank you for the comment. No amendment is required in response to this comment.
	ID154		Typo page 50, point 4 'Please note (not NOT)' that administration of the PEDI-CAT.	This typo has been amended.
	ID155		Fantastic to have standardised reporting for ease of interpretation by laypeople, educators, education funding	Thank you for this comment.

			bodies and other involved parties. Long overdue. Hopefully leads to nationwide consistency of reporting.	
	ID156		In the Resources section of the Diagnostic Evaluation p9 and the F&SN Assessment document, suggest added subheading of Funding Resources	Thank you for this suggestion, which has been included in the revised draft of the Guideline.
	ID157		Also, have the researchers considered what the F& SN Assessor will write if there are no strengths evident? It's a lovely idea to have strengths based assessment but potentially could be quite depressing for carers/parents if no or very few strengths identified/observed.	International best practice clearly highlights the importance of identifying the challenges and strengths of an individual, and so this section has been retained in the updated Guideline.
	ID158		It is excellent that you have recognized the significant variability in ASD diagnosis across states of Australia. It may be worth adding that this causes enormous and unnecessary additional stress to families who relocate interstate and the child then requires reassessment. This involves going back to the bottom of lengthy waitlists, repeated (considerable) expense, and further strain on the child and family unit. It is also very positive that you are looking to reduce the subjectiveness of existing assessments which rely too heavily on clinician experience/skill via use of report templates and provision of diagnostic guidelines such as this comprehensive document.	Thank you for these comments and information. No amendment is required in response to this comment.
	ID159		Thank you for acknowledging that the individual with ASD and their family members are 'to be considered equal partners in the process of assessing ASD'. This is certainly not how most families I've met feel during the process.	Thank you for the comment. No amendment is required in response to this comment.

	ID160		I applaud your inclusion of a Support Needs Assessment. When our daughter was diagnosed, scant information was provided on how to meet her support needs. While struggling with our own stress levels, it was indescribably difficult to access services when we didn't know where to start. Regarding the Coordinator Role in 5.2 and 6.3, my questions are: 1) Who funds this/pays for this service? 2) Who employs this person in this role? 3) Does the family have any choice over who is their Coordinator? 4) How does this fit in with NDIS LC role? Overlap? Replace? 5) For those who are not going to be in an NDIS / WANDIS area for another two years, will Medicare cover rebates for this service? More codes needed and most importantly MORE FUNDING!	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Coordinator Role
	ID161		In 6.3.1 The Coordinator is listed as potentially having an Administration background. Personally, and professionally, I believe the Coordinator should be an allied health professional with qualifications, skills and experience in understanding the complex field of autism.	This comment is addressed in the revised version of the Guideline. For further information, please refer to the 'Overview of Major Amendments' chapter under the heading: • Coordinator Role
	ID162		6.6 Professional Informant - typo in word 'another' in first line.	This typo has been amended.
	ID163		In 6.6.2, ASD Specific Expertise, do General Practitioners and especially Educators have adequate knowledge on typical and atypical development across the age range in which they are providing information? From my experience and that of many hundreds of families that I have contact with, most educators	The revised guideline has made amendments to the professionals involved in the assessment process. For further information, please refer to the 'Overview of Major Amendments' chapter.

			do not have an adequate understanding of developmental delay and/or autism spectrum disorder.	
	ID164		Would it be useful under 6.6.2 to add to the list of knowledge and experience maintenance some of the following: journal articles, websites, online professional forums, webinars, YouTube videos, etc to capture some of the more contemporary learning formats?	This comment is addressed in the revised version of the Guideline. For further information, please refer to the 'Overview of Major Amendments' chapter under the heading: • Accreditation and Regulation • Practice points for clinical, research and policy settings
	ID165		In 8.1.2 Table 5, under category of Presence of other factors known to be associated with ASD, should genetic links be included i.e. presence of ASD diagnosed in an immediate or extended family member? Given that it is now well established that there is a genetic link in many cases, may be worth your consideration?	This table has been omitted from the revised version of the Guideline. For further information, please refer to the 'Overview of Major Amendments' chapter under the heading: • Referral for an Assessment of ASD Concerns
	ID166		In Table 7, under Sensory processing differences, such as hypersensitivity or hyposensitivity, the Diagnosticians/Functional and Support Needs Assessors include OT's and Registered Psychologist (Clinical or Ed/Developmental). To the best of my knowledge, Psychologists do not do ANY training on Sensory Processing Disorder either assessment and/or treatment and are therefore not skilled or qualified to assess SPD. This is an area of specialty for Occupational Therapists. However additional Professional Informants who may be able to have observed signs of sensory processing issues may include psychologists working with the child and/or Educators.	Thank you for this comment. Based on feedback received, this table has been omitted from the revision Guideline, and the information included in the table has been incorporated in other sections of the document.
	ID167		Table 7, Under Mental and Social category, 2nd point Behavioural Concerns - I'd like to request that 'extreme demand avoidance' be added to the list of included concerns	Based on the current evidence base within the scholarly section, it was decided that Pathological Demand Avoidance is best included in other sections of the Guideline.

	ID168		Table 7, should Educators not be included in the Professional Informant list of professionals under many of the categories, especially mental, social and functional?	Thank you for this comment. Based on feedback received, this table has been omitted from the revision Guideline, and the information included in the table has been incorporated in other sections of the document.
	ID169		Table 7 p 44, under Literacy Issues, in the Diagnostician/F & SN Assessor column, Occupational Therapists are qualified, skilled and trained to assess and remediate handwriting issues and should be included together with Speech Pathologists and Psychologists.	Thank you for this comment. Based on feedback received, this table has been omitted from the revision Guideline, and the information included in the table has been incorporated in other sections of the document.
	ID170		In Table 6, DSM5 point 2. restricted, repetitive patterns of behaviour etc, it is disappointing that the word 'abnormal' is used in the 3rd dot point. It would be great if this stated 'Clinically considered extreme in intensity or focus'.	This text is the DSM-5 criteria for Autism Spectrum Disorder, and we are unable to change the wording.
	ID171		in 9.4.3, paragraph commencing with 'Where the Tier 1 Diagnostician......' If you follow the flow chart in figure 5 or 6, does this mean that a one-off visit to a Paed/Neuro/Psychiatrist could result in a diagnosis if all criteria are met? If so, this would be ideal in that it could significantly reduce the existing excessive waitlist timeframes and reduce associated assessment costs. However, does it of inconsistency and variability between states?	Thank you for this comment. Based on feedback received, these figures have been omitted from the revised Guideline. Clear guidance is provided regarding the required elements of an ASD assessment. For further information, the 'Overview of Major Amendments' chapter.
	ID172		In 9.5.4 Information Collection - Specialist Assessments, An assessment of Pathological or Extreme Demand Avoidance should be included under all 3 categories (social/comm, repetitive and differential/co-occurring diagnosis). It is an atypical type of autism presentation, with features in all of these categories. Further information is available at: https://www.pdasociety.org.uk/what-is-PDA/about-pda and at: http://www.autism.org.uk/about/what-is/pda.aspx	Based on the current evidence base within the scholarly literature, it was decided that Pathological Demand Avoidance is best included in other sections of the Guideline.

	ID173		Congratulations on including Functional and Support Needs Assessment in order to identify support needs, establish goals and link to the most appropriate support services. This is an excellent addition to the existing diagnostic process. Our own diagnostic process was isolating, depressing and unsupported. The Clin Psych gave us our daughter's diagnosis at 6pm on a Friday night over the phone, with no offer of help or support or where to go next. This led to a long period of depression for me (primary caregiver) and a feeling of being lost, not knowing what services were available, which we needed to use, and subsequently our daughter missed invaluable early intervention and our family missed essential support, respite and funding that we could otherwise have accessed.	Thank you for providing this information. No amendment is required in response to this comment.
	ID174		In 10.5 Repeated Assessment, will Medicare/NDIS fund such a repeat? Unlikely	Thank you for this comment. Issues pertaining to procuring additional Medicare / NDIS funding were beyond the scope of project the terms of reference, and so no amendment has been made in response to this comment.
	ID175		We are very pleased that you've recommended face-to-face meeting for sharing the diagnosis with the caregivers/family. Our daughter's diagnosis was delivered via phone late on a Friday with no chance of support over the coming weekend. It was the start of a long and depressing and extremely difficult period for our family that could have been alleviated by a face to face meeting offering explanations, support, resources, guidance and encouragement i.e. 'It's not the end of the world, and there's help available, and you're not alone, etc'. Also, can one depend on the fact that every diagnostician and F&SN professional in Australia know which resources and supports to refer the family to? Certainly not in our experience.	Thank you for providing this information. No amendment is required in response to this comment.

	ID176		Table 10, Signs and Symptoms Under Spoken Language, the use of terms 'Formal or odd language' should be included as Prof Tony Attwood frequently refers to these as signs of Aspergers/HFA and in our experience of Pathological Demand Avoidance too. Our daughter had very advanced language as a toddler, and this not uncommon in girls with autism, particularly those with PDA signs. For example, when she was almost 2 years old, we were at the beach and she pointed at the sun and said 'Mum, is that not the most magnificent sunset you have seen in your entire life?' !! Under Interacting with Others, it may be useful to include 'reduced awareness of social hierarchy and social identity, as well as socially manipulative behaviour typically seen in PDA' Under Restricted Interests and Rigid/Repetitive Behaviours, I am extremely pleased to see PDA listed as a subtype of autism spectrum disorder. Thank you for acknowledging its existence. Is it necessary however to state that it is recognised in the UK? 50 years ago, autism wasn't recognised in Australia and other developed countries! This may imply that it is not a valid subtype in Australia. PDA is an unusual type of autism, but distinctive with very differing characteristics, and most importantly entirely different management and handling strategies are required. Typical strategies (visuals, schedules, timers, etc) used with children on the spectrum not only do NOT work for those with PDA, but in fact can aggravate symptoms and behaviours to a significant extent, making life even more stressful for the child and family. We consulted with 4 autism 'experts' in Perth, all Clinical Psychologists with extensive experience in working with children on the spectrum, and every strategy they instructed us to employ made things worse for our daughter and family. When we discovered PDA, a massive light bulb moment! Everything changed for us in that day. I'm happy to elaborate if required in person or electronically.	Please refer to the ‘Overview of Major Amendments’ chapter under the following heading: • Pathological Demand Avoidance

	ID177		p 59, table 10, Sharing Findings, 2nd line, 'including with their child' - add 'or not with their child' so that parents see they have a choice	The sentence has been amended to: "Discuss with parents or caregivers how they would like the diagnostic decision communicated, including if this will be shared with their child, taking into account the child's ability to understand this information."
	ID178		Next section starting with 'Receipt of an ASD diagnosis', Positive reactions can include - add 'relief and/or validation that their observations and suspicions/worries had some merit/basis'	The sentence has been amended to: "Positive reactions can include relief and validation that a diagnosis has provided an explanation and understanding of the behaviours and previous experiences of the individual."
	ID179		Page 60, Table 11, Spoken Language Include under Very Limited Use - or excessive use of language in some cases	"Excessive use" has been added to this list of ways spoken language may be unusual in school aged children.
	ID180		Under 'Interacting with Others' please include - Refusal to participate / engage - Avoidance and resistance of everyday demands Under 'Restricted Interests and/or Rigid and Rep Behaviours', PDA (Pathological or Extreme Demand Avoidance) is most likely to be evident at this age/stage (6 to 16 years) when social demands have dramatically increased from the early childhood years. Therefore, some of the signs and symptoms of PDA could / should be listed in this section (e.g. resists and avoids the ordinary demands of life, obsessive behaviours, socially manipulative strategies used in avoidance, all due to anxiety based need for control) 12.3 Gender While typically far more males than females are diagnosed with ASD, for PDA presentation of autism, the ratio is 50:50 i.e. equal numbers of males and females present with	Please refer to the 'Overview of Major Amendments' chapter under the following heading: • Pathological Demand Avoidance

			PDA symptoms which may be worth noting. 12.6 Differential Diagnosis and Co-occurring conditions. Under Psychiatric and Neuro Disorders please add Pathological or Extreme Demand Avoidance I note that you have listed PDA in Table 16 under the Psych/Neuro subheading but not in Table 14. Can you please amend this, many thanks	
	ID181		Under Restricted Interests, common manifestations include: Problems in obtaining or sustaining employment or education, ADD including unreliable or intermittent attendance Another manifestation: Refusal to engage in work or study (due to anxiety)	The phrase “regularly attending” has been added to problems with employment or education in older adolescents and adults.
	ID182		In 6.4.2, it is noted that Diagnosticians must have demonstrated ASD specific expertise in the listed areas. My questions are: Who will assess the Diagnosticians to determine if they meet the required list of expertise? Who will pay for the time required to do this assessment? Who has the time required to do so? These are not part of the AHPRA requirements, as they are so specific to autism only, so how will this be achieved? I think it is a very comprehensive list of requirements and an excellent standard/goal, however am very concerned about the practicality of its implementation and whether it is realistic to achieve (I certainly hope so!).	Please refer to the ‘Overview of Major Amendments’ chapter under the following heading: • Accreditation and Regulation • Cost Implications of the Recommended Assessment Model • Practice points for clinical, research and policy settings
	ID183		Additionally, 6.4.2 and 6.5.2 if private health practitioners are required to observe peers conducting ASD diagnostic evaluations, receive peer support, feedback and mentoring (as well as the list of expertise in 6.5.2) how will this be accounted for from a commercial perspective? I understand that DSC, CDS and other government agencies will allocate	Please refer to the ‘Overview of Major Amendments’ chapter under the following heading: • Accreditation and Regulation • Cost Implications of the Recommended Assessment Model

			professional development time and resources for therapy staff to undergo this type of mentoring and development, however in private enterprise this is unrealistic, particularly if the therapist is not self-employed i.e. working under the instruction of their employer/manager with daily hourly billing targets to achieve etc. Complicated but needs to be addressed as the majority of assessments into the future will be conducted by private providers (particularly as DSC and CDS are outsourcing more and more of their ASD assessments). I'm not saying it's right, just that time is money in private business and the amount of time involved in the above may make it unfeasible for providers and therefore the adherence to these standards may be compromised (I'm not a private therapy provider BTW).	• Practice points for clinical, research and policy settings
Dr Shirley Ferguson [65]	ID184	Individual - Professional experience (PD)	I have spent the last eleven years diagnosing children and some adults with autism. I am an Educational and Developmental Psychologist with both a Master's degree and PhD specifically focused on autism. I am a member of both INSAR and ASfAR and have presented research at conferences for both. I have attended multiple conferences for both over the years as well as APAC. I use the 'gold standard' instruments of ADOS-2 and ADI-R (developed for research in this field) as well as a variety of standardized questionnaires (SRS-2, ABAS-2, ASEBA). I also observe individuals in community settings. My reports are comprehensive addressing DSM-5 criteria clearly. I give extensive recommendations and some support following the assessment. Under these new guidelines I, and other highly experienced practitioners like me, will be unable to practice as we are not part of an extensive team. Most of my referrals are from paediatricians whom I regard as 'my team'. This loss of expertise will be an unexpected outcome of what should be a much-needed tightening of diagnostic procedures.	Thank you for this feedback. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Qualifications for Psychologists

	ID185		Adding OT and SP professionals as diagnosticians seems inappropriate given the later emphasis on the importance of differential diagnosis and dual diagnosis.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Professional Roles • Structure of the Assessment Process
	ID186		Why is a functional assessment to be conducted at the same time as diagnosis, instead of later? There is limited funding available under Medicare (4 sessions) which makes an assessment very expensive for families. The Functional assessment could be done with NDIS funding after a diagnosis.	Please refer to the 'Overview of Major Amendments' chapter under the following headings: • Cost implications of the assessment model recommended in the Guideline Please also note that the revised Guideline includes a recommendation regarding costs for ASD assessments. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Practice points for clinical, research and policy settings
	ID187		Why is an ADOS-2 not recommended as a step in Tier 1 as a structured way to do an observation? This 2-tiered system is greatly at risk of dismissing difficult cases as 'obviously not ASD' (False negative error) if not conducted with rigor.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Use of 'Standardised' Instruments
Forrest Parade School [66]	ID188	Organisation - Professional experience	Positives • Recognise the urgent need for a national approach to diagnosing / supporting students and their families in order to ensure a consistent / transparent process • Strength focused approach which is evidence based. • The coordinator will play a vital role in ensuring the process remains within the designated time frame and	Thank you for these comments. No amendment is required in response to these comments.

			also supports families in understanding the process and implications - The tier system is an effective way of fast tracking the process for clear cut cases - effective use of resources and expedites the process for families - Recognition of gender diversity - Recognition of cultural / linguistic diverse backgrounds - The communication style is clear and sets out the timeline. Stating the assessment process should be communicated in a 'compressive and understandable way through face-to-face meeting and report over a 3-month period is music to our ears - In summary we feel everything has been covered and this process with the clear guidelines will be well received by all stakeholders	
	ID189		Food for thought: - Do we have people in the NT with the necessary experience, qualification to meet the Diagnostician requirements of the guidelines? - How will the remote challenge be met? - What impact will this process have on the NT verification process for children meeting criteria for specialist settings? Will we still have functional placements? Thank you for this opportunity to provide feedback. Forrest Parade staff.	Thank you for providing this feedback. Significant effort has been made to ensure that the Guideline does not reinforce inequity in access to services. (Please refer to the Guiding Principle of 'equity'). The challenge has been to achieve a balance between facilitating broad access to assessment services while still maintaining assessment rigor. Informed by the extensive consultation that was performed as part of the Guideline development (including a workshop in the Northern Territory), we feel that the revised version of the Guideline achieves this balance as optimal as possible.
Philip Andrew Christie [67]	ID190	Individual - Professional experience (PD,PS)	It is encouraging to see that Pathological Demand Avoidance (PDA) is included in Table 16, under the section on co-occurring conditions. PDA was first described in the 1980's by Professor Elizabeth Newson and conceptualised as a separate condition within the pervasive developmental disorders, related to but distinct from autism. With wider definition and interpretation of the autism spectrum PDA has	Please refer to the 'Overview of Major Amendments' chapter under the following heading: - Pathological Demand Avoidance

			become widely understood in the UK to be a diagnostic profile that is part of the autism spectrum. This view has been supported by developments in research prompted by Prof Francesca Happé and her team, led by Dr Liz O'Nions, which have helped to develop an understanding that the characteristics of PDA are dimensional within the autism spectrum. The demand avoidant profile is distinctive and identifiable in children when a number of these features exist at a particular frequency and intensity. This research has led to the production of the Extreme Demand Avoidance Questionnaire (EDA-Q) (O'Nions et al 2014), which is proving an invaluable tool for those wishing to carry out further research. Subsequently there has been consideration of which items within the Diagnostic Interview for Social and Communication Disorders (DISCO) differentiated individuals with this profile from others across the autism spectrum (Onions et al, 2015). A small group of professionals from different disciplines in the UK have been working to produce guidance on what constitutes a good assessment for children with a PDA profile and the following text was agreed in its advice for parents Exploring the PDA profile in an assessment is especially complex. Aspects of the profile may be variable at different times and in different places. There is also the potential for some behaviours and their causes to be confused with different conditions. Sometimes clinicians can focus on one aspect of a child's presentation and miss the underlying difficulties that contribute to this. This makes a detailed and comprehensive process critical. The key elements to this would be: • more than one professional involved in the assessment • direct observation of the child • a detailed history from the parents or carers • information gained from more than one setting • extensive clinical experience within the assessment team	

			During many assessments of autism spectrum disorders diagnostic tools are used to collect information in order to help to decide whether someone has a profile that is on the spectrum. The ADOS (Autism Diagnostic Observation Schedule) and the ADI-R (Autism Diagnostic Interview-Revised) are examples, both of which are based on the diagnostic manuals. The DISCO (Diagnostic Interview for Social and Communication Disorders) uses a more dimensional approach and gives an understanding of an individual's profile and needs, as well as a diagnostic formulation. An advantage of these diagnostic tools is that they can help to provide some consistency in the assessment process followed in a particular region, or within a service. They are not, though, intended to be screening instruments or stand-alone tools. They are there to gather information, or structure the observations, that professionals make as part of their assessment. They have to be used with some flexibility and are still reliant on an individual clinician's experience, judgement and interpretation. This is especially the case when picking up less typical presentations of autism (such as PDA), where some of the difficulties in social understanding and social communication can be more subtle and are less apparent at first. In recent years there has been a surge in interest, from parents and educational professionals in particular, who find that the profile resonates with their own experiences of living and working with such a child. They have found that it helps them make sense of the child and gives them pointers in how best to support them. This has led to the formation of the PDA society http://www.pdasociety.org.uk, which acts as a resource for both parents and professionals. A great deal of attention has also been generated internationally and there has been significant interest from Australia. Prof Happé's team (Onions et al, 2016) have underlined the importance of better understanding children with this profile as they respond to more flexible and negotiative approaches than those usually recommended for children with more typical autism	

			spectrum presentations. In the UK the Autism Education Trust, with funding from the Department for Education, have produced a set of National Standards by which schools and other organisations can benchmark their ability to meet the needs of pupils across the autism spectrum. Specific guidance on approaches to children with PDA are included as part of this guidance. (Christie, 2012) References: Christie, P (2012). The Distinctive Clinical and Educational Needs of Children with Pathological Demand Avoidance Syndrome: Guidelines for Good Practice. National Autism Standards, Autism Education Trust O'Nions, E., Christie, P., Gould, J., Viding, E. & Happé, F. (2014) Development of the 'Extreme Demand Avoidance Questionnaire' (EDA-Q): Preliminary observations on a trait measure for Pathological Demand Avoidance. Journal of Child Psychology and Psychiatry, 55, 758-768. O'Nions E, Gould J, Christie P, Gillberg C, Viding E. & Happé F (2015). Identifying features of 'Pathological Demand Avoidance' using the Diagnostic Interview for Social and Communication Disorders (DISCO). European Child and Adolescent Psychiatry, 25,407-19 O'Nions E, Happé F & Viding E. Extreme/'Pathological' Demand Avoidance (2016). BPS DECP Debate, issue 160 Phil Christie, Consultant Child Psychologist	
Anonymous [68]	ID191	Individual - Lived experience (C,F)	PDA needs to be recognised and included in the assessment and supports of people with autism. Please consider the findings in the UK where this condition is recognised.	Please refer to the 'Overview of Major Amendments' chapter under the following heading: • Pathological Demand Avoidance
	ID192		Pathological Demand Avoidance (PDA) is only mentioned twice briefly in this draft yet it is the one diagnosis that has completely changed my son's life. This is a tangent of autism - not a subset of behaviours and the management and support people with PDA need are markedly different from just 'plain autism' and in fact most of the techniques and adjustments that work fairly well with people with autism do not help people with PDA at all. This condition is recognised in the UK and the	Please refer to the 'Overview of Major Amendments' chapter under the following heading: • Pathological Demand Avoidance

			support and information I have found from there have been invaluable.	
Anonymous [70]	ID193	Individual - Lived experience (C,F)	With regards to the mention of PDA (Pathological Demand Avoidance) as a comorbid condition, this should be explained further. My son's psychologist is working with him in areas affected by his PDA as she has witnessed how his refusal to participate in activities due to his extreme anxiety affects those around him and their reaction to him, as well as how it affects his quality of life.	Please refer to the 'Overview of Major Amendments' chapter under the following heading: • Pathological Demand Avoidance
Anonymous [71]	ID194	Individual - Lived experience (C,F)	Sensory Processing Disorder also needs more awareness as it can result in very similar traits to ASD.	Sensory processing disorder has been added to the table listing differential diagnosis and co-occurring conditions.
	ID195		Pathological Demand Avoidance is a very real diagnosis that needs to be included not only to raise awareness but also for it to be included in professionals training guidelines. It took far too long and too many visits to different professionals to final get a diagnosis and understand what was going on with my child. If professionals were trained and armed with the knowledge about PDA it may not have taken so long to get the right supports in place. PDA also has a number of overlapping distinctive traits with ASD.	Thank you for this comment. No amendments are required.
Anonymous [73]	ID196	Individual - Lived experience (C,F)	Pathological Demand Avoidance (PDA) should be included as additional subtype of ASD in diagnosis and all other categories in this text. Support needs, strategies and treatment for PDA will differ significantly from those in 'the classic ASD diagnosis'. PDA can stand alone or be in addition to other forms of ASD.	Please refer to the 'Overview of Major Amendments' chapter under the following heading: • Pathological Demand Avoidance
Anonymous	ID197	Individual -	Signs and symptoms: Add PDA signs and symptoms.	Please refer to the 'Overview of Major Amendments' chapter under the following heading:

[75]		Lived experience (C,F)		• Pathological Demand Avoidance
	ID198		Add PDA signs and assessment to all relevant sections.	Please refer to the ‘Overview of Major Amendments’ chapter under the following heading: • Pathological Demand Avoidance
	ID199		It would be wonderful for PDA (Pathological Demand Avoidance Syndrome) to be recognized as an atypical subtype of ASD. Individuals showing these traits would benefit from a more specific official diagnosis in this regard as strategies for assistance are often quite different from the more typical presentations of ASD.	Please refer to the ‘Overview of Major Amendments’ chapter under the following heading: • Pathological Demand Avoidance
Tara Randall [76]	ID200	Individual - Lived experience (C,D,E)	It would be fantastic if pathological demand avoidance was recognised as an atypical type of autism or sub type of autism in Australia.	Please refer to the ‘Overview of Major Amendments’ chapter under the following heading: • Pathological Demand Avoidance
Anonymous [77]	ID201	Individual - Lived experience (CDE)	Signs and symptoms -add PDA signs and symptoms.	Please refer to the ‘Overview of Major Amendments’ chapter under the following heading: • Pathological Demand Avoidance
	ID202		Diagnostic evaluation - 9.5 in Table 7. Mental and social section - add PDA signs to the Behavioural concerns list, and also to Social Relationships. Table 8. Add PDA assessment under all 3 categories in table.	Please refer to the ‘Overview of Major Amendments’ chapter under the following heading: • Pathological Demand Avoidance

	ID203		12) important considerations Table 10. P59, PDA - delete reference to UK. Acknowledged across the globe on an increasing basis. Table 11. Add PDA signs in relevant categories e.g. refusal to participate, socially manipulative/avoidant strategies p60/61/62. Then, finally, P69 12.6, Under Psychiatric and Neuro disorders, add Pathological Demand Avoidance (as per Table on p72).	Please refer to the 'Overview of Major Amendments' chapter under the following heading: • Pathological Demand Avoidance
Lisa Hallett [78]	ID204	Individual - Lived experience (CDE)	Feedback please before I post. It is necessary to have PDA recognised as a sub group of ASD in Australia as it is in the UK. There are many children/ adults that are in this sub group. It needs its own mention as diagnosis and guidelines/strategies are very different. Professionals that work with these children i.e. teachers etc. need to be made aware of these different strategies in order to help the child reach their potential. I have struggled to get an ASD diagnosis for me son as he is too social. I now know this is due to masking and only to a shallow depth. This is a very important aspect of PDA and I feel it is very relevant to this issue as many go undiagnosed or incorrectly diagnosed because of this (especially females).	Please refer to the 'Overview of Major Amendments' chapter under the following heading: • Pathological Demand Avoidance
Jackie Sharp [79]	ID205	Individual - Lived experience (C)	PDA needs to be recognised as a subgroup of ASD in Australia. Medical professionals and teachers need to be educated on how to help these children and their families deal with their special needs. Strategies for dealing with ASD, ADHD, ODD, etc, do not work with these children and only serve to exacerbate their problems. Schools put a lot of pressure on the parents of PDA children to try to force the parents into ensuring that their children conform to the standard expectations which the schools have of students and their families. This pressure is toxic to both child and family.	Please refer to the 'Overview of Major Amendments' chapter under the following heading: • Pathological Demand Avoidance

Michelle van Hees [80]	ID206	Individual - Lived experience (C,F)	Include signs and symptoms of PDA.	Please refer to the 'Overview of Major Amendments' chapter under the following heading: • Pathological Demand Avoidance
	ID207		9.5 in Table 7 - Mental and social section - add PDA signs to the Behavioural concerns list and also to Social Relationships. Table 8 - Add PDA assessment under all 3 categories in table.	Please refer to the 'Overview of Major Amendments' chapter under the following heading: • Pathological Demand Avoidance
	ID208		Had we known about PDA in our son's early years, his current outcome could have been quite different. Due to the difference in PDA behavioural management strategies to that of ASD strategies, all implemented ASD strategies have had a negative impact on him. Those strategies when applied to a PDA child actually cause anxiety and make the behaviour worse. Our son cannot function in a school setting and is being home-schooled due to the lack of acceptance of PDA existence by staff and their refusal to 'pander to a child' who needs coercion as opposed to authority, and understanding of their inability to comprehend hierarchy. For years we have been inadvertently abusing our child, causing him high anxiety by using prescribed behavioural modification techniques. Since our discovery of PDA and our subsequent changes in strategies, he is a different child. He is content, learning to recognise his feelings and communicate them in socially acceptable ways, and he is trying to improve himself. Having PDA included in diagnostics is absolutely imperative to the outcomes of these unique children.	Please refer to the 'Overview of Major Amendments' chapter under the following heading: • Pathological Demand Avoidance
Autism Association of Western Australia	ID209	Organisation - Professional experience	This feedback is provided on behalf of a team of multidisciplinary clinicians who contribute to a not-for-profit ASD diagnostic service at the Autism Association of Western Australia for children under the age of 13 years.	Thank you for these comments.

[81]			We value the purpose of these guidelines and agree that standardising diagnostic assessment within Australia is important. We also welcome the focus on evidence-based best practice within the guidelines, and of increasing access to a timely diagnosis for individuals in rural or remote areas. In summary, whilst we appreciate the complexity of meeting multiple needs within the ASD community (including facilitating eligibility assessments and rural diagnosis), we have strong concerns that the current proposals could lead to over (or under) diagnosis. We hope that this feedback is helpful in reaching a consensus that improves the standard and accessibility of diagnoses for individuals with ASD across Australia. However, we have the following concerns/considerations regarding the proposed assessment model:	
	ID210		1) The model is, in our opinion, relatively complicated (with regards to informers vs. diagnosticians, and the varying requirements for each tier). The transparency of this process for families who may be undergoing a difficult part of their "journey" is something we are concerned about. Families need to know and understand the process and potential cost of assessment from the beginning, and we believe that this would be challenging within the tier system.	Thank you for this feedback. The revised version of the Guideline has sought to simplify the assessment process and requirements. For more information, please refer to the 'Overview of Major Amendments' chapter under the heading: • Structure of the Assessment Process
	ID211		2) The proposed tier model allows for a single diagnostician (albeit with an informant) to diagnose. Based on the data presented in the Taylor et al. (2016) review, single clinician diagnosticians result in an increase in diagnosis. ASD is a complex disorder characterised by multiple aspects of social communication and behaviour, and we believe that diagnosis must be multidisciplinary in order to reduce the risk of inappropriate diagnosis and to ensure that all differential (and co-morbid) diagnoses are considered by diagnosticians with the relevant experience. Misdiagnosis has significant implications for individuals, the community (e.g. funding and	Significant effort has been made to ensure that the Guideline does not reinforce inequity in access to services. (Please refer to the Guiding Principle of 'Equity'). The challenge has been to achieve a balance between facilitating broad access to assessment services while still maintaining assessment rigor. Informed by the extensive consultation that was performed as part of the Guideline development, we feel that the revised version of the Guideline achieves this balance as optimal as possible.

			access to services), in addition to the public understanding and perception of ASD. We would strongly advocate for a minimum 2 diagnostician model as a safeguard, with the existing suggested allowances for telehealth adaptations for individuals in rural/remote areas.	
	ID212		3) The proposed tier system also appears to lean towards a "piecemeal" approach to assessment, with Diagnostician 1 identifying which criteria or differential diagnoses need further exploration, and Diagnostician 2 answering these specific questions. Our experience is that criteria need to be evaluated within the whole context of the assessment information, rather than a single clinician focusing on a single criterion.	Thank you for this feedback. We believe the revised Guideline describes a structure that guides a more coherent assessment process.
	ID213		4) Including language assessments for younger children is crucial, and in our opinion, Speech Pathologists are the most appropriate people to conduct these assessments. Under the current proposed model, a child under 5 could receive a diagnosis without seeing a Speech Pathologist, and the presence or absence of language delay in young children is a significant differential or comorbid diagnosis.	The importance of a language assessment is recognised in the Guideline in two ways: 1. The Guideline recommends that Stage 1 assessment covers a broad range of developmental and functional domains, including language. 2. The Guideline further recommends that professionals with expertise in certain assessment domains are consulted. e.g., speech and language (speech pathologist).
	ID214		5) Similarly, screening of other developmental disorders in children (including co-existing or differential medical conditions, e.g. Fragile X, Prader Willi etc) is, in our experience, best provided by a Paediatrician. In our experience, GPs do not always have the necessary expertise to recognise and diagnose these conditions. Thus, GPs providing medical assessments in lieu of assessments by developmental Paediatricians is concerning.	The revised structure of the Guideline has further emphasised the importance of specialist medical expertise. For more detail, please refer to the 'Overview of Major Amendments' chapter under the heading: • Structure of the Assessment Process • Professional Roles

	ID215		6) Whilst the stipulations regarding clinician experience are helpful in upholding the quality of assessments, the list of eligible diagnosticians is interesting, particularly within a single diagnostician model. For example, the category of evidence for the inclusion of Neurologists or OTs in diagnosis is CBR 3, and thus the inclusion of these diagnosticians within a single clinician model would concern us – although we strongly believe that both professions have important contributions to make regarding diagnoses. Within a single clinician model there is the potential for an individual to be diagnosed by a single clinician (e.g. a neurologist with a GP or school informant). Similarly, the list of co-occurring concerns with associated appropriate assessing professionals (p. 42-44 of the guideline) suggests that neurologists are less appropriate assessors for the majority of criteria/conditions – thus highlighting the importance of inclusion of these professionals within a multiple clinician model, rather than as sole diagnosticians. **We would highlight that we do not support a single clinician model from within any discipline**, and that our concerns are not limited to neurologists (or OTs) – this is just an example.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Consistent and Flexible StructureProfessional Roles • Structure of the Assessment Process
	ID216		7) Whilst we have a highly skilled administrator in the coordination role for our not-for-profit multidisciplinary clinic, we have concerns about who would be willing or able to offer this role in the private sector? If there were to be a shortage of clinicians/others willing to offer this role, would this create a "bottle neck" in accessing assessments privately, and would it increase costs for families/individuals?	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Coordinator Role Please also note that the revised Guideline includes a recommendation regarding costs for ASD assessments. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Practice points for clinical, research and policy settings

	ID217		8) Given the recommendations regarding diagnostician experience and training, will there be regulation/oversight in this area? E.g. a register of professionals? If so, who will maintain it, and how will it be funded?	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Accreditation and Regulation • Practice points for clinical, research and policy settings
	ID218		9) Could there be a trial of proposed guidelines before they are rolled out Nationally?	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Implementation and Evaluation of the Guideline
	ID219		10) Regarding assessment tools/measures – the "gold" standard consistently shown in research is a combination of a standardised direct assessment such as the ADOS 2 and an ASD-specific clinical interview (such as the ADI-R). We did not feel that this combination was adequately emphasised within the guidelines, and there was a suggestion that other measures can be substituted.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Use of 'standardised' ASD instruments
	ID220		Thanks for all of the work that has gone into the guidelines, and we look forward to seeing the final version in the future.	Thank you for these comments.
Speech Pathology Australia [82]	ID221	Organisation - Professional experience	Thank you for accepting Speech Pathology Australia's additional feedback. The guidelines offer an aspirational framework for ensuring timely and appropriate diagnosis of and interventions for persons with ASD. There is potential for the costs associated with diagnoses to be increased. It will be important that mechanisms are put in place to avoid the costs for an improved standard of diagnosis and intervention creating barriers to access as a result of increased out of pocket costs	Thank you, we greatly appreciate the feedback provided. No amendment is required in response to this comment. However, please note that the revised Guideline includes a recommendation regarding costs for ASD assessments. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Practice points for clinical, research and policy settings

			to individuals, or delays and waiting lists for access through the public system.	
	ID222		The term "autistic people" as used in the document would not be appropriate for parents with newly diagnosed young children with autism. We are aware of the contemporary discussion about the use of this language in the ASD community however we are of the understanding that the disability community prefers the terminology "person with autism spectrum disorder."	Thank you for this comment. The use of identity first language in the Guideline was based on feedback from the autistic community and other stakeholders. Nevertheless, it is critical that individual practitioners use their judgment as to the most appropriate language for their clients and patients. This has now been emphasised on page 8 through the inclusion of the following statement: “However, it is recognised that practitioners may have their own preferences in terms of terminology, such as "person with autism", and that personal judgment is used as to the most appropriate language in their clinical practice.”
	ID223		Speech Pathology Australia feel the strengths-based approach is positive for families, especially when addressing ASD criteria which requires professionals to so often focus on what the child cannot do.	Thank you for the comment.
	ID224		Speech Pathology Australia has concerns regarding how will it be determined that a person has sufficient skills in this area to be an 'assessor'?	Please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Accreditation and Regulation • Practice points for clinical, research and policy settings
	ID225		Speech Pathology Australia feels social interaction needs to be made clearer in relation to point 7.2.2 particularly for inexperienced clinicians.	The introductive text to the Community Setting section was expanded to include: “Observe typical behaviours and/or social interactions within their usual context”.

	ID226		Table 5 - Risk Factors should include: Family history/sibling with ASD.	Based on feedback received, this table has been omitted from the revised version of the Guideline. For further information, please refer to the 'Overview of Major Amendments' chapter under the heading: • Referral for an Assessment of ASD Concerns
	ID227		9.4.3: Speech Pathology Australia strongly recommends that every child under 12 years of age with behavioural concerns should have a language assessment. Therefore, every child undergoing an ASD assessment should have a language assessment as part of a differential diagnosis and to understand the child's language comprehension and expression fundamentals. Please see suggested references which apply for behavioural concerns and differential diagnosis. When looking especially at clients with mental health problems, a language assessment and pragmatic communication assessment is pivotal to a differential diagnosis particularly for those clients with high functioning ASD. References: - St Clair, M. C., Pickles, A., Durkin, K., & Conti-Ramsden, G. (2011). A longitudinal study of behavioral, emotional and social difficulties in individuals with a history of specific language impairment (SLI). Journal of communication disorders, 44(2), 186-199. - Tomblin, J. B., Zhang, X., Buckwalter, P., & Catts, H. (2000). The association of reading disability, behavioral disorders, and language impairment among second-grade children. The Journal of Child Psychology and Psychiatry and Allied Disciplines, 41(4), 473-482.	Thank you for this feedback. Based on extensive feedback, the structure of the assessment model has been revised. Further information is provided in the 'Overview of Major Amendments' chapter under the heading: • Emphasis on the Importance of Functional Abilities in Referral for Supports • Structure of the Assessment Process The Guideline maintains a strong focus on the importance of a language assessment in the ASD assessment process. This is recognised in two ways: 1. The Guideline recommends that Stage 1 assessment covers a broad range of developmental and functional domains, including language. 2. The Guideline further recommends that professionals with expertise in certain assessment domains are consulted. e.g., speech and language (speech pathologist). Please also note that the Guideline recommends that Speech Pathologists (with relevant skills and expertise) are able to be part of the Consensus Diagnosis Team for clients involved in a Stage 3 assessment.
	ID228		Speech Pathologists should be additional professional informants for sensory processing (auditory/speech	Thank you for this comment. Based on feedback received, this table has been omitted from the revision Guideline, and

			hyper/hypo sensitive, eating/food hyper/hypo sensitive) and mental health or psychiatric concerns.	the information included in the table has been incorporated in other sections of the document.
	ID229		Speech Pathologists should be diagnosticians as part of a Tier 2 assessment for mental health or psychiatric concerns as the differential diagnosis process between mental health concerns, language disorder and ASD is dependent on a pragmatic language assessment.	Thank you for this comment. Based on feedback received, this table has been omitted from the revision Guideline, and the information included in the table has been incorporated in other sections of the document.
	ID230		Attention difficulties - Speech pathologists, as additional professional informants can assist in the differential diagnosis of attention difficulties as distinct from a language disorder and/or an auditory processing disorder. In addition, speech pathologists are able to assist with the differential diagnosis regarding whether a child's attention difficulties are part of ASD, or related to receptive language difficulties and/or auditory processing disorder.	Thank you for this comment. Based on feedback received, this table has been omitted from the revision Guideline, and the information included in the table has been incorporated in other sections of the document.
	ID231		Table 7: Feeding issues - should include eating and drinking (chewing and swallowing) as the domain of a speech pathologist.	Thank you for this comment. Based on feedback received, this table has been omitted from the revision Guideline, and the information included in the table has been incorporated in other sections of the document.
	ID232		Will there be guidelines as to what needs to be included in such an assessment? We understand the importance of there being a bridge between assessment and intervention, based on the child's functioning, but practically how is this going to be implemented with consistency? Members felt it is unclear exactly how the Diagnostic Evaluation and the Functional and Support Needs Assessments are to be conducted simultaneously. The authors specify that people involved in the diagnostic process can be involved in the functional/support needs assessment, and that the functional/support needs assessment is a 'parallel	Thank you for this feedback. We believe that the revised structure more clearly describes the interplay between the Functional and Support Needs Assessment. For more information, please refer to the 'Overview of Major Amendments' chapter under the heading: • Emphasis on the Importance of Functional Abilities in Referral for Supports • Structure of the Assessment Process

			assessment process', but exactly how this is going to occur? The wording is ambiguous i.e., on page 49 it states the functional/support needs assessor may be 'a diagnostician or professional informant who was involved in the diagnostic evaluation'. It is recommended that more guidance be provided on the logistics around this, or an example be provided as per the Tier 1 & Tier 2 Evaluations.	
	ID233		9.5.5: where consensus cannot be reached in Tier 2 then the client could be referred to a tertiary team.	Tertiary assessment services for individuals with complex neurodevelopmental disorders are not available in every Australian state. For this reason, a reference to these services was not included in the main figure describing the assessment model in the revised guideline. However, the following text has now been included in the revised draft (Section 10.1): “In some Australian states, tertiary services are available for the assessment of individuals with complex neurodevelopmental disorders. If these services are available, then it is recommended that clients are referred to these services if a consensus decision cannot be achieved at Stage 3.”
	ID234		Can the authors consider adding a section on what Referral for an Assessment of ASD Concernss should do in the event that a family/individual declines a referral (particularly if the Referral for an Assessment of ASD Concerns feels strongly that a Diagnostic Evaluation is needed). Obviously, the family cannot be forced into an assessment, but it might be worth adding here the importance of documenting that a referral was suggested and discussed with the family, and that the family (or individual) declined referral for evaluation at that time.	Thank you for this comment. The following text was added to the Decision Making and Outcome section of the Stage 1 Comprehensive Needs Assessment (Section 8.4): “If a client declines this referral, it is recommended that the clinician documents that a referral was discussed with the client, however they declined the referral at that time.”
	ID235		The authors state that the diagnostic evaluation should take an 'individual and family centred approach'. Could this be reworded to: 'The diagnostician may have a role in advocating	Thank you for this helpful feedback. The following text was added to the Individual and Family Centred Guiding Principle: “This involves advocating around the rights for children, adolescents and individuals with intellectual and / or

			around the rights for children and adolescents to have a voice and be an active participant in the diagnostic process.'	communication restrictions to have a voice and be an active participant in the ASD assessment process to the extent of their capacity."
	ID236		It is not clear that this process will help families access a diagnosis more quickly, or closer to home as there may be few clinicians who meet the guidelines.	Thank you for this feedback. The revised structure of the Guideline also includes a revision of the professional roles, which we believe addresses this comment. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Structure of the Assessment Process • Professional Roles
	ID237		Tier 1 diagnosis: - Applicable only when the diagnosis is very obvious; There is a concern that this Tier may be overused even when the case is more complex; Concern that ASD may be ruled out incorrectly and then the diagnosis will be critically delayed if not missed altogether. Can this be clarified more in this document?	Thank you for this feedback. We believe that the revised structure provides greater clarity on this issue. Please refer to the 'Overview of Major Amendments' chapter under the headings: • Structure of the revised assessment • Progression from Stage 2 to Stage 3
	ID238		Who is going to monitor the level of 'expertise' that diagnosticians should have? How is the public going to know that the person they are seeing has the required level of experience and expertise? Perhaps professional associations may have a role in this. Need to have a skilled and trained local workforce for families to access. Professional associations could be part of a coalition contributing to developing the competencies of the AHP workforce.	Please refer to the 'Overview of Major Amendments' chapter under the heading. • Accreditation and Regulation • Practice points for clinical, research and policy settings

	ID239		It's important for the diagnosis to form a starting point for families in terms of planning 'where to from here' and to help identify priority areas for intervention.	Thank you for this feedback. We believe that the revised structure addresses this comment – in particular, the recommendation for an initial comprehensive functional and support needs assessment and the immediate referral for further supports. For further information, please refer to the 'Overview of Major Amendments' chapter under the headings: • Structure of the revised assessment
	ID240		Query regarding who follows up after the assessment? E.g. Team, paediatrician, ASD assessment co-ordinator? It is unlikely that a single individual could undertake the diagnosis, functional needs assessment and follow up, even at a Tier 1 level. This will require further consideration.	We believe that the revised structure addresses this comment. For further information, please refer to the 'Overview of Major Amendments' chapter under the headings: • Structure of the revised assessment • Professional Roles • Coordinator Role
	ID241		Page 58: The definition of Echolalia is not correct. Echolalia is the repetition of the speech of others and it may be immediate, delayed or mitigated.	Thank you for this helpful feedback. The Spoken Language considerations for preschool children have been edited to: "Repetition of the speech of others which may be immediate, delayed or mitigated ('echolalia')".
	ID242		Table 11 and Table 12: The list for Table 11 should read more like Adult (Table 12) as Table 11 doesn't reflect the higher functioning children.	"Thank you for this helpful comment. This table (Table 9 in the revised draft of the Guideline) now includes a broader range of behaviours with the aim of providing information on children with across the full autism spectrum.
	ID243		12.2: Suggested addition - Individuals with cognitive impairment and/or limited or absent verbal language may benefit from the provision of aided and unaided Augmentative and Alternative Communication (AAC) and strategies. Speech pathologists with experience in AAC should be consulted to identify resources and supports that will facilitate the ability of	The following text was added to the section on Important Considerations for individuals with Intellectual and / or Communication Capacity: "Individuals with cognitive/intellectual impairment and/or limited or absent verbal language may benefit from the provision of aided and unaided augmentative and alternative communication (AAC)

			individuals to participate communicatively, including to reflect their thoughts and feeling, indicate their preferences and choices and to make decisions.	and strategies. Speech pathologists with experience in AAC may be consulted to identify resources and supports that will facilitate the ability of individuals to participate communicatively, including to reflect their thoughts and feeling, indicate their preferences and choices and to make decisions."
	ID244		The 'additional considerations' tables at each age group are a good guideline, however there needs to be clarification regarding the purpose of these tables and who they are designed to be used by, e.g., in the feedback to families, when raising concerns that their child might have ASD, informing families what skills are likely to be assessed at each stage? Can anything be added for infants and young toddlers, especially if we are aiming to capture those children with very early delays and concerns so that we can get them into intervention early?	Thank you for this comment. These tables have been included to guide clinicians regarding key behaviours that may be observed in individuals of different ages. We have now clarified the purpose of these tables in the preamble to the tables. Table 8 also includes several behaviours in early childhood that have been identified as having an acceptable level of predictive power for a later ASD diagnosis (e.g., imitation, proto-declarative pointing, response to name).
	ID245		6.4.2 ASD Specific Expertise - The requirement to demonstrate 'at least 4 years fulltime equivalent of postgraduate experience that is directly relevant to ASD Diagnostic Evaluations' should not be applicable to those who have completed specialised training programs. Programs such as the Graduate Certificate in Autism Diagnosis (GCAD) offered by the University of Western Australia provide directly relevant and intensive training in assessment and diagnosis for paediatricians, psychiatrists, psychologists and speech pathologists, including supervised placement work. Since graduates of the GCAD have a significant amount of theoretical and supervised practical experience, some dispensation from the requirement for at least 4 years of fulltime postgraduate work experience is warranted. Specifying a reduction in the time requirement applicable to graduates from specialised training programs such as the GCAD would encourage the uptake of 'gold standard' training.	Thank you for this comment. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Duration of ASD-specific Expertise

	ID246		It would also be helpful to specify how to identify who is an expert diagnostician by considering some of the following: Will there be a register of expert diagnosticians? If so, which organisation will manage this? How will you assess/ensure whether a clinician meets the requirements of a diagnostician? If a register is created, will you grandfather onto it those who are currently performing the role of assessors but who may not meet the formal requirements of an expert diagnostician?	Please refer to the 'Overview of Major Amendments' chapter under the heading: • Accreditation and Regulation • Practice points for clinical, research and policy settings
	ID247		Table 3, under the section of Training for Registered Psychologists - this is unclear. Is this indicating that an endorsement is necessary by including the last statement about specialisation, or is this written as an alternative option to the minimal level of training required	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Qualifications for Psychologists
University of Western Australia [83]	ID248	Organisation - Professional experience	8.2 Making a referral for an ASD assessment - This section states that a consumer is able to self-refer for an ASD assessment, and may proceed with a referral through their General Practitioner. This therefore leaves it up to the GP to assess which 'expert diagnostician' is going to be most suitable for the consumer. Additional training for GPs will be required in order to increase their ability to determine which discipline is going to be the most appropriate initial referral option for that particular child (in most instances it would be a paediatrician, but there is likely to be inconsistencies in this approach).	Thank you for this comment. This issue is out of scope of the project terms of reference, and so no amendment has been made. However, we note that we have made recommendations regarding professional bodies developing competency-based training programs for professionals involved in the ASD assessment process. Please refer to the 'Overview of Major Amendments' chapter under the following heading: • Accreditation and Regulation • Practice points for clinical, research and policy settings
	ID249		9.3 Diagnostic Evaluation Structure - This structure is likely to be confusing for consumers. They will initially engage with a Coordinator, who will explain to them that they need to see a Diagnostician and Informant at Tier One, which is likely to cost X amount. However, it is possible they may need to go to Tier	Thank you for this comment. This comment is addressed through the simplified structure detailed in the 'Overview of Major Amendments' chapter

			Two, and this will cost an additional X amount. They also need to have a Functional Needs assessment, which can be done either by the diagnosticians, or they need to see separate functional needs assessors, which will cost an additional X amount. The cost and timeline for the assessment is not fixed, which will likely be stressful for families.	Please also note that the revised Guideline includes a recommendation regarding costs for ASD assessments. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Practice points for clinical, research and policy settings
	ID250		9.5.3 Information Collection - Standardised ASD Diagnostic Tool - The ADOS-2 should be administered, in additional to a developmental or IQ assessment when necessary.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Use of 'Standardised' Instruments
	ID251		9.5 Tier 2 Diagnostic Evaluation - The two-tiered approach is likely to present with inconsistencies between diagnosticians and their thresholds for determining which consumers should be referred on for additional assessment, despite the recommendations around diagnostic decision making.	Additional clarification was added to the section on Stage 2 Decision Making and Outcome to outline when a Diagnostic Evaluation should progress to Stage 3. Please refer to the 'Overview of Major Amendments' chapter under the headings: • Progression from Stage 2 to 3
Emma Miller [84]	ID252	Individual - Professional experience (PD)	6.4 Diagnosticians: Occupational therapists can make valuable contributions to understanding a person's sensory needs, emotion regulation and play skills for assessment, and in the treatment of these difficulties (and others, such as fine motor skill delay) for individuals diagnosed with Autism. However, their core business is not generally in the area of differential diagnosis for conditions specific to an Autism assessment, or in addressing the DSM/ICD criteria. For this reason, they should definitely be included as Professional Informants and Functional Needs Assessors, but not Expert Diagnosticians. See Table 7 for an example of this - the only criterion for which OTs are considered as diagnosticians is B4 (Sensory processing differences), the rest are co-occurring	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the headings: • Professional Roles • Structure of the Assessment Process

			conditions and, even then, these are generally not considered the core business of OTs.	
	ID253		6.4.2 ASD Specific Expertise: The requirement to demonstrate 'at least 4 years fulltime equivalent of postgraduate experience that is directly relevant to ASD Diagnostic Evaluations' should not be applicable to those who have completed specialised training programs, such as that implemented in the Child Development Service in WA Health, or the Graduate Certificate in Autism Diagnosis at UWA.	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the headings: • Duration of ASD-specific Expertise
	ID254		It would also be helpful to specify how to identify who is an expert diagnostician by considering some of the following: Will there be a register of expert diagnosticians? If so, which organisation will manage this? How will you assess/ensure whether a clinician meets the requirements of a diagnostician? If a register is created, will you grandfather onto it those who are currently performing the role of assessors but who may not meet the formal requirements of an expert diagnostician?	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the headings: • Accreditation and Regulation • Practice points for clinical, research and policy settings
	ID255		Table 3, under the section of Training for Registered Psychologists - this is unclear also. Is this indicating that an endorsement is necessary by including the last statement about specialisation, or is this written as an alternative option to the minimal level of training required? Later in Table 7, it appears to indicate that endorsed psychologists only should perform certain functions in the assessment. This is confusing.	Please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Qualifications for Psychologists
	ID256		This section states that a consumer is able to self-refer for an ASD assessment, and may proceed with a referral through their General Practitioner. This therefore leaves it up to the GP to assess which 'expert diagnostician' is going to be most	Thank you for this comment. This issue is out of scope of the project terms of reference, and so no amendment has been made. However, we note that we have made recommendations regarding professional bodies developing

			suitable for the consumer. Additional training for GPs will be required in order to increase their ability to determine which discipline is going to be the most appropriate initial referral option for that particular child (in most instances it would be a paediatrician, but there is likely to be inconsistencies in this approach).	competency-based training programs for professionals involved in the ASD assessment process. Please refer to the 'Overview of Major Amendments' chapter under the following heading: • Accreditation and Regulation • Practice points for clinical, research and policy settings
	ID257		9.4.1 Professional Involvement: It is my opinion that a second diagnostician (at least) should be required at Tier 1, and that for all assessments of children (under 12 years) a Speech Pathology assessment is an essential component of an ASD assessment.	The 'Overview of Major Amendments' chapter.
	ID258		9.4.2 Settings: It is not sufficient for an expert diagnostician to assess only using a telehealth setting, and relying on the professional informant to observe the person directly in two community settings. A diagnostician should directly observe and interact with the client (in both Tier 1 and Tier 2).	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Telehealth
Kerry Robertson [85]	ID259	Individual - Professional experience (PD,PS,AR)	Your continual references to 'registered psychologists' is ill-informed. Most health practitioners in Australia are required to be registered however you do not state 'registered paediatricians', 'registered GP', 'registered occupational therapist', and so on. This is inconsistent. The term "psychologist" is restricted, and therefore anyone calling themselves a psychologist is required by law to be registered, and hence the "registered" in the term "registered psychologist" is redundant. The key training description for diagnosticians in Table 3, page 18, describes how to achieve endorsement as a psychologist with a specialty area. It does not however clearly state whether this is necessary. I would question how specialist endorsement gives any advantage in terms of autism diagnosis assessment over experience and autism-specific training. Many psychologists choose not to become specialist endorsed despite having masters/doctorate	Please refer to the 'Overview of Major Amendments' chapter under the heading: • Qualifications for Psychologists

			degrees due to the extra time and cost associated with endorsement and the lack of associated professional and personal benefit associated with endorsement. Table 7 on page 42 also describes specialist endorsement areas suggested as being appropriate to assess specific areas, however these are confusing. For example, it is stated that a "registered psychologist" can perform a behavioural or mental health assessment, yet an endorsed clinical or educational and developmental psychologist is required to undertake a cognitive assessment. Why is a relatively routine simple task (cognitive assessment) requiring a greater level of training compared to a task requiring a far higher level of skill and expertise (a mental health assessment)? I would strongly suggest removal of references to specialist endorsement for psychologists and instead have clearer training and accreditation guidelines, specifically related to the skills and expertise needed to undertake these assessments, for all diagnosticians.	
Anonymous [86]	ID260	Individual - Lived and professional experience (C,F,PD,PS)	There are many excellent points in this document however my concern as an Occupational Therapist who is involved in a diagnostic team is that we are creating a tick a box for diagnosis culture. I believe we should be moving away from ASD assessment and providing Developmental assessments for children with 'behaviours of concern', where a diagnosis of ASD MIGHT be the outcome as might a diagnosis of Reactive Attachment Disorder or Anxiety or anything. There also needs to be a push to provide assistance to individuals who are having difficulty functioning in everyday life regardless of diagnosis as the current system of 'money for ASD' is creating a culture of 'keep trying until you find someone who will diagnose' which is concerning.	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Emphasis on the Importance of Functional Abilities in Referral for Supports • Structure of the Assessment Process
	ID261		The guiding principles outline very relevant and important considerations, however the 'holistic framework' does not go far enough. Agreed that we need to look further than does this person meet criteria for ASD or not, we also need to	The Guideline provides extra information regarding the importance of differential diagnosis in the section entitled,

			consider differential diagnosis and we need to ensure that those diagnosing have the capability to do this.	“Content of an ASD assessment”. Specifically, the following text is added (Section 3.1): “The Diagnostic Evaluation seeks to answer the questions: “*Does the individual meet criteria for a clinical diagnosis, such as ASD?*” and “*If the individual does not meet criteria for a clinical diagnosis, are there other considerations that explain the presentation?*”
	ID262		The role and experience of a 'coordinator' is, I believe, unnecessary to the process and will drive the cost of assessment up. This 'role' should be the responsibility of the lead diagnostician - who should be either a developmental paediatrician or psychiatrist or at minimum the supporting Psychologist/OT or Speech Pathologist with high level experience. The danger with adding another role into a multidisciplinary assessment team is having a professionally 'heavy' side to the assessment process.	The consultative studies provided strong evidence for the importance of a professional involved in the assessment process to adopt a Coordinator Role. The Guideline provides the option of the individuals mentioned in the comment to take on the Coordinator Role. Please also note that the revised Guideline includes a recommendation regarding costs for ASD assessments. Please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Practice points for clinical, research and policy settings
	ID263		Diagnostician - this role should only be taken by a psychiatrist or paediatrician (with registration & experience outlined in the document). A psychologist, OT or Speech Pathologist should be part of the team that is led by the Paediatrician or Psychiatrist. I do not believe, no matter how much experience Allied Health professionals have, that they are qualified to consider differential diagnosis, possible medical conditions etc.	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Professional Roles • Structure of the Assessment Process
	ID264		Professional Informant - I have difficulty understanding the concept of this role - are these the other professionals involved in the clients’ life? If this is the case, requiring them to undergo additional training and be involved in the 'process' seem again like we are pushing a professionally 'heavy'	The term Professional Informant was removed from the Guideline, and wording was edited to clarify the role of other professionals (which is intended to be similar to the role described in this submission):

			approach. Simple questionnaires (such as the Developmental Behaviour Checklist) or written observations should be sufficient additional information for the diagnostician to interpret and include in their decision making.	"The ASD assessment team will liaise with other medical, allied health, disability and/or educational professionals to obtain further information about the individual being assessed, to support the Comprehensive Needs Assessment and Diagnostic Evaluation. The individual being assessed may have an existing working relationship with these other professionals (e.g. a treating health professional or teacher) or require new referrals for specific testing."
	ID265		I agree with the Tiered system, however think that the Tier 1 should still be Paediatrician or Psychiatrist - not other Allied Health professionals	Thank you for this comment. The 'Overview of Major Amendments' chapter.
Kelly Arfuso [87]	ID266	Individual - Lived experience (C,F)	Please include signs and symptoms of PDA-pathological demand avoidance.	Please refer to the 'Overview of Major Amendments' chapter under the following heading: • Pathological Demand Avoidance
	ID267		9.5 in Table 7 Mental and social section add PDA signs to the behavioural concerns list and also to social relationships. Table 8 Add PDA assessment under all 3 categories in table.	Please refer to the 'Overview of Major Amendments' chapter under the following heading: • Pathological Demand Avoidance
	ID268		Table 10 P59 Delete reference to UK Acknowledged across the globe in increasing instances. Table 11 Add PDA signs in relevant categories. I.e. refusal to participate socially, manipulative/avoidant strategies, PhD 60/61/62, Finally, page 69 12.6 Under psychiatric and neurological disorders, add Pathological Demand Avoidance As per table on page 72.	Please refer to the 'Overview of Major Amendments' chapter under the following heading: • Pathological Demand Avoidance
	ID269		Traditional 'autism' strategies, routine therapies and a text book approach did not help our child at all. We were left thinking 'what are we doing wrong?' And 'why isn't this working?' It took a couple of years of effectively going	Thank you for this comment. No amendments are required.

			backwards and being continually disappointed before we learnt about PDA. PDA described our child and his behaviours to the letter! We finally had a better understanding of what was going on with him and what strategies we could use to make life better for all of us. Had we had access to this information as part of the diagnostic process and support for this 'type' of autism, we would have made more progress with him sooner. It would have saved us years of frustration and thousands of dollars in therapies that were not suited to him. It has honestly made the world of difference to our family and I only wish we had known about it sooner.	
Wendy Kiefel [88]	ID270	Individual - Lived experience (F)	I would like to send a formal written submission with references. This portal does not permit such a submission. I am concerned about many aspects of the guideline and believe that it is fundamentally flawed. The amount of material to review was overwhelming in the time frame permitted. I respectfully submit that the review period be extended to permit proper consultation with concerned professional groups, who were not included in the preparation of the guideline. I respectfully request that the guideline be withheld from publication in peer reviewed journals so that problems already identified may be properly addressed.	No amendment is required in response to this comment.
	ID271		This space is inadequate.	No amendment is required in response to this comment.
Anonymous [89]	ID272	Individual - Professional experience (PD,PS)	Thank you for a great effort in putting together this document. The inclusion of a differential diagnosis list was especially helpful as it showed that rather than ' is it ASD or not?' there is a bigger question of who the child and family are, their strengths and needs, what can be offered that would be helpful at this time.	Thank you for this feedback.

	ID273		Clarity is needed especially with the NDIS rollout. It is awkward that ASD is on the 'evidence not required list' when so many other conditions have been omitted, often when children have high need. There is a push to formally diagnose very young children with complicated family and psychosocial factors. Often the pattern and diagnosis become clearer over time e.g. changed family situation, preschool experience, engaging with therapists, increasing developmental skills It is also awkward that functional assessments are being interpreted by non-clinical people in the NDIS.	Thank you for providing this information. No amendment is required in response to this comment.
	ID274		We work with families of preschool aged children. Can I suggest additional comment in the formal diagnosis of children under 6 years of age? As their life experience is highly variable-prenatal, parent, home and preschool experience before school entry there needs to be some caution before deciding ASD/not ASD. Children in care are particularly vulnerable both to being diagnosed incorrectly or missing out.	Thank you for this feedback. The revised Guideline has provided significant details about diagnosis in young children with autism, and has added the additional suggestion that children who have been exposed to psychosocial risk should progress to a Stage 3 (more detailed) assessment (Section 9.4).
	ID275		CMOs to be included with Paediatricians. Historically developmental assessments (e.g. Griffith assessment) often completed by CMOs who diagnose ASD, developmental delay, care and protection issues etc. Certainly, experienced and within multidisciplinary teams. Personally, I have completed 4 years Paediatric training, Dip and Masters in Paediatrics, 10 years part time general in hospital paediatrics and 22 years of developmental Paediatric experience in one area (where we have watched children grow to adulthood).	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Qualifications for medical practitioners
Anonymous [90]	ID276	Individual - Lived experience	It is great to see PDA (Pathological Demand Avoidance) get a mention. However, I feel it really needs to be recognized as an atypical subtype of ASD. Individuals presenting with PDA traits would benefit from a more specific diagnosis. The assistance required for PDA are often very different from the	Please refer to the ‘Overview of Major Amendments’ chapter under the following heading: • Pathological Demand Avoidance

		(C,F)	more typical presentations of ASD and many ASD strategies don't work. By having PDA as its own subtype diagnosis, these people will then be able to receive more appropriate assistance and schools and other professionals can learn better strategies that will help these children and adults integrate into our communities better.	
Tasmanian Autism Diagnostic Service [91]	ID277	Organisation - Lived and professional experience	Feedback has been provided by clinicians and the executive officer of the Tasmanian Autism Diagnostic Service: [Names].	No response is required to this comment.
	ID278		Overall, whilst the Guidelines are helpful, and this service is largely in agreement with them, the cost of implementing them will be considerable. The guidelines come with significant cost to organisations, both public & private, both in terms of money, but also time. They will increase the cost of ASD ax for families in the private sector and this may push families into the public sector, therefore increasing wait times further. Will the CRC lobby government to promote the guidelines to provide funding? There is a need for considerable education to stakeholders who feed into the process such as GP's and the professional informants for example. Who will provide that? They may not want to follow the guidelines.	Thank you for these comments. The issues raised are beyond the scope of the project terms of reference, and so no amendments have been made. Please also refer to the 'Overview of Major Amendments' chapter under the following heading: • Cost implications of the assessment model recommended in the Guideline • Practice points for clinical, research and policy settings
	ID279		In addition, I note there is no recommended time frame for how long an assessment should take or how long families should have to wait for a report. In light of current pressures on wait times and public services, a decision by the Government will need to be made between complying with the guidelines fully or considering what can be achieved reasonably in light of current budgetary constraints.	The Guideline recommends that the first appointment "would ideally occur within three months of the referral" and sharing of ASD assessment findings "would ideally occur within three months of the first assessment appointment."
	ID280		The inclusion of consumers as Referral for an Assessment of ASD Concerns would trump the need for professionals to evaluate whether a referral for ASD assessment is required unless the professional had ASD concerns that were not	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading:

			necessarily shared by the consumer then the use of professional clinical judgement to weigh the strength of evidence for ASD signs and symptoms would be important in discussion in seeking consent to refer from the consumer: NB. There is a risk that without being able to weigh the strength of evidence for ASD signs and symptoms that the consumer maybe put 'off-side' Query- once the question has been raised by someone (consumer or professional) in relation to a child with possible ASD is there a need for assessment regardless to answer the question. A Referral for an Assessment of ASD Concerns may be a Consumer or professional with an adequate awareness of ASD and typical development to initiate the ASD assessment process. [Evidence Table 7] - so parents or clients are able to self-refer? This could have implications for waitlist, as our referral process is restricted to Paeds, Psychs or Psychiatrists, it steadies the flow of referrals somewhat. It also states that Referral for an Assessment of ASD Concerns are to have 'adequate knowledge of ASD' in order to refer for assessment, who monitors and regulates this? Overall, whilst there are clear benefits to consumers self-referring, there is the potential this may lead to significantly increasing waiting lists. Furthermore, whilst it is seen as really helpful to have Referral for an Assessment of ASD Concerns with more knowledge of autism, it was noted it can be difficult to encourage Referral for an Assessment of ASD Concerns to complete referral forms and pre-requisites to the assessment process. It is interesting that for the referrals, a professional needs to have awareness of autism, but consumers can just self-refer. While some parents recognize the symptoms well, I think there should be some sort of screening process, for example, to see if a global developmental delay is behind the concerns and no further assessment is required. The referral numbers may go up a lot otherwise. In the guide it indicates that	• Referral for an Assessment of ASD Concerns

			families are able to self-refer for an autism assessment. I am concerned that this will cause greater waitlists. Whilst I agree that parents are the experts on their children and are normally the first to notice if something is not 'right', everyone has a different level of understanding of ASD, and we may see an influx of 'no' assessments. How will this affect services in terms of wait times for assessments? Also, will parents also be able to self-refer for reviews? Allowing a broader range of referral sources may make it easier for individuals to access diagnostic services. It may also mean that the person writing the referral is more informed, knows the individual better and has a better rationale for the referral (as opposed to a family seeing a Paediatrician once to obtain a referral) I think it's great to have more detailed/experienced referrals. I think it would really help the referral process if the people who can refer are more educated on ASD symptomology, have a more detailed referral form to complete etc. Referral for an Assessment of ASD Concernss having more knowledge of autism will really help ensure that the referrals we receive are appropriate and will cut down our wait times. The flip side of this may be that referrals are difficult to obtain for families and individuals because they need to be more detailed. I would be interested to see how Paediatricians view this process.	
	ID281		How will the increase in professions that can complete autism assessments affect access to funding? Based on the guidelines, neurologists, occupational therapists and speech therapists can diagnose Tier 1 cases independently. However, will these all be accepted by services such as the NDIS? Whilst this at the moment is an issue which may not affect our service directly, it will affect our families, as services such as NDIS may not accept some diagnoses by some professionals, requiring families to go through additional assessments before being eligible for funding. This in turn may increase the	Thank you for this feedback. Please note that this section has changed in the revised Guideline. For more information, please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Structure of the revised Assessment process • Professional Roles

			number of families that are going through more than one autism assessment to become eligible for funding.	
	ID282		Based on this guideline, I am actually not qualified to make autism diagnoses, as I do not have 4 years post graduate experience directly relevant to ASD. I guess I could include my 2 years masters, and my time working as a diagnostician (1.5 years); however, I still do not quite meet the 4-year mark.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • ASD-specific expertise – 4 years' experience
	ID283		I have concerns about the prospect of a practitioner who has little training in differentials may be in a position to diagnose: in particular the possibility an OT and SLT could diagnose ASD. Are speech pathologists & OT's trained to undertake diagnostic assessments with consideration of other diagnoses or explanations that may explain a client's presentation? If not: 1) how will they be trained to undertake an ASD assessment 'where an individual is evaluated in the context of personal, activity and environmental contexts'? and 2) who regulates these standards for speech pathologists? Will each of the above professionals be required to have training in the ADIr & ADOS? Who regulates this for each of the professionals listed above? Will it be the Autism CRC, or is it expected that each discipline's regulation body police this? And have these assessments even been highlighted as the gold standards, or are professionals required to determine this individually based on their review of the most recent literature? It should be clearly laid out for all professionals undertaking ASD assessments which tools are recommended based on the evidence - such as on the Autism CRC website - with links to the relevant research, otherwise there is too much room for interpretation. The inclusion of other non-psychologist allied health (SLP & OT) as diagnostician's may complicate issues arising relevant to section 9 in which it clearly states that diagnostic decisions, even at Tier 1 must include 'testing alternative explanations for symptoms that may warrant differential or co-occurring diagnosis or alternative clinical pathways'- a query is raised in relation to what proportion of	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Professional Roles • Structure of the Assessment Process • Accreditation and Regulation • Practice points for clinical, research and policy settings

			SLP & OT training would be assigned to the study of other DSM V or ICD10 clinical disorders in order that they have the relevant skills in this regard. When I did my teacher training in secondary mathematics having completed an initial BSc (Hons) in Psychology in order to be accepted to train to teach mathematics without a degree in mathematics, I had to demonstrate that a sufficient proportion of my initial degree was directly relevant to the subject I was training to teach in: that is, without the particular options I had taken in statistics and applied statistical analysis as part of my degree I would not have been accepted to teach mathematics. It follows then that if other allied health practitioners are to become diagnosticians is it appropriate that they prove that they have sufficient 'initial' training in the co-occurring diagnoses and alternative clinical pathways- other than psychologists who all study psychopathology at an undergraduate level I am not sure that they do- this raises a concern as to the level of 'specialist skill sets' other allied health disciplines have to 'test alternative explanations' as this may not be a core part of their initial training. Many professionals develop expert ASD knowledge and experience over the course of their careers- the four learning approaches identified are a good way of trying to 'measure' whether an individual would have 'sufficient' ASD expertise to meet the criteria to become a diagnostician. Is this to be checked upon? as with say what currently occurs in relation to other criteria such as that is the requirement to be registered within a particular discipline or obtain annual CPD points to meet requirements for registration. I am also concerned if OT or SP training gives you sufficient skills to be a diagnostician of ASD (even with the further 'qualification', whatever that is?) I have a concern that Speech Paths and OT are listed as diagnosticians, by profession I'm pretty sure they aren't trained to diagnose disorders in the DSM-5 and their training doesn't cover clinical diagnosis of mental disorders. For example, speech and language disorders can be identified as part of the assessment and may form part of a differential diagnosis, same as sensory processing issues could form part of a	

			differential diagnosis but clinical expertise and training needs to be present to address all the other diagnostic criteria. They need more than ASD specific knowledge and expertise, they need to have an understanding of all mental disorders in order to make differential diagnoses. I don't think a speechie or OT can make a diagnosis alone. As far as I understood the 'professional informant' has to be from a different discipline than the diagnostician. What about for example if a psychologist is the diagnostician but there are other psychologists who have worked with the person? Isn't the quality of the evidence more important than from whom it comes from? It is hard to see how this model will make the assessment process 'more consistent'. Not having a minimum requirement if at least having a paediatrician or a psychology consultation makes it dangerous practice in my mind. Looks like one could be diagnosed for example by an OT with a dietitian as a 'professional informant'.	
	ID284		Whilst it can be helpful to use telehealth facilities for rural and remote families, I note it can be make assessment of the child considerably more difficult, particularly in subtle presentations. In addition, there can be concerns in relation to care of the families after a feedback session and so additional planning for family support is required.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Telehealth
	ID285		Table 5 of the Guidelines, outlines some factors for consideration before referring a child for an assessment - I also think this is a little vague and up for varying interpretations. The section that outlines that 'hearing impairments have been ruled out, however communication impairments are present' - this is not a particularly useful factor for consideration for referral, and what is their definition of 'communication impairments'? Is communication in this sense defined as expressive and receptive language skills, or purely social communication (i.e., verbal and non-verbal communicative behaviours used for social purposes)? - as children on the spectrum can also have a comorbid diagnosis	This table has been omitted from the revised version of the Guideline. For further information, please refer to the 'Overview of Major Amendments' chapter under the heading: • Referral for an Assessment of ASD Concerns

			of profound hearing loss, and not all hearing children on the spectrum have 'communication impairments' e.g., thinking about girls on the spectrum and how they can have good use of expressive language skills, both verbal and non-verbal, but do not necessarily use them flexibly and consistently for social purposes. A clearer definition of communication impairments here may be needed and having a hearing test might not necessarily involve 'ruling out' a hearing impairment, but would be used to provide an important piece of information to consider when determining possible differential diagnoses and/or underlying factors of several ASD symptoms such as attention to voice and social responsiveness etc. It does state at the end of the table that the information within the table is not definitive, but making the information in the table clearer would be beneficial.	
	ID286		9.3 Reports provided by caregiver and/or professional informants' - does this mean that parents do not need to be consulted? I think this guideline is a little vague and open to individual interpretation, which is concerning from a diagnostic point of view.	The term “client” is defined under the ASD Assessment Participants section as: “Client is an overarching term to describe an individual being assessed for ASD and any caregiver(s) or support people participating in the process. It is recognised that some individuals will participate in the process independently, whereas others will require assistance from a caregiver due to factors such as their age or communication/intellectual abilities. A caregiver or support person may include a parent, guardian, spouse, sibling, offspring or friend.”
	ID287		9.4.2 *During an ASD assessment, information must be obtained about an individual's behaviour in community settings relevant to their daily life [Evidence Table 30] - by observation or report? It doesn't specify by which means and therefore is open to interpretation.	The following clarifications regarding ‘settings’ have been included in the Guideline recommendations: Stage 1: “It is recommended that the Functional Assessment involve the collection of information about the individual’s functional abilities in relation to all relevant community settings, although it is not essential for the clinician to make direct observations at these locations.”

				Stage 2: “It is recommended that the Single Clinician Diagnostic Evaluation involve the collection of information about the individual’s signs and/or symptoms in relation to a variety of community settings, although it is not essential for the clinician to make direct observations within these locations.” Stage 3: “It is recommended that the Consensus Team Diagnostic Evaluation involve the collection of information about the individual’s participation in all relevant community settings. It is suggested that this information primarily be obtained through communication with the client and/or other professionals, although this may be supplemented by direct observations by member(s) of the ASD assessment team within some of these community settings. It is recommended that the Consensus Team Diagnostic Evaluation involve at least one direct observation of the individual being assessed for ASD in a community setting by at least one member of the ASD assessment team, if adequate direct observation in the community setting has not occurred during the Stage 1 Comprehensive Needs Assessment and/or Stage 2 Single Clinician Diagnostic Evaluation.”
	ID288		9.5.3 At Tier 2 a community observation is required in this model. As we know, sometimes just getting more information from people can assist without observation. Why isn't ADOS/ADI-R not required as the axe tools especially at Tier 2? Reliability and consistency issues....	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Use of ‘Standardised’ Instruments
	ID289		Overall, in straightforward presentations, it is great to have a Tier 1 option. However, there is some concern families will need to wait for a Tier 1, then for a Tier 2 assessment. The	We believe that the revised structure addresses this comment by describing a progressive approach to neurodevelopmental and behavioural assessment that is based on individual need

			impact on families and on services could well be considerable with families becoming frustrated.	and complexity. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Structure of the revised assessment process
	ID290		The other issue raised in our team discussion was if a psychologist conducted a Tier 1 assessment with a differential of trauma, it may well be another psychologist would be deemed to be the most suitable practitioner to undertake the Tier 2 work.	Thank you for this feedback. In this scenario, it would be the responsibility of the Stage 2 clinician to identify additional members of the clinical consensus team based on the areas of diagnostic uncertainty.
	ID291		9.5.4 Query? Certainty 'Not Achieved' is referral for another 'separate' assessment or can you include a second diagnostician for further evaluation so as to ascertain an outcome for the assessment.	Please refer to the 'Overview of Major Amendments' chapter under the heading: • Assessment structure
	ID292		The inclusion of a Functional and Support Needs Assessment maybe an important component of identifying 'strengths'- deficits and needs are often more readily reported at AX, consumers may need prompts to assist in identifying strengths, the inclusion of this assessment for ALL clients would be beneficial. I personally think this is a great idea, but this will add additional time to assessments, which for the individual isn't an issue, but for a service with increasing wait times, this will extend wait times even further and stretch clinicians. Would like to see more guidance around this in relation to what tools are recommended for these. The ICF Core Sets sound interesting, will they be accepted by NDIS? Can we get a hold of this? Can these assessments be done as part of intake? By someone else prior to assessment? On a separate day? I am concerned if the functional and support needs assessment may rely solely on questionnaires, especially if conducted by people who have	Recommendations relating to specific instruments that measure functioning have been removed from the Guideline, and information about resources will instead be located on the Guideline webpage to enable updates to occur more readily

			little knowledge about interviewing people and reliability of such questionnaires...some parents underestimate and some overestimate as we know. Developmental and other assessments may be required.	
	ID293		9.5.5 Diagnostic Decision Making: NB Sometimes there are difficulties making 'consensus' decisions with 2 persons (as opposed to with 3 persons)- no outcome for the consumer?? Re-assessment (a 3rd assessment rather than one linear process that takes longer and involves additional professionals as required?)	If a two-person Consensus Diagnosis Team was unable to reach a consensus decision regarding the diagnostic outcome, it is likely that areas of diagnostic uncertainty remain. In this circumstance, the Guideline recommends that an additional clinician (with expertise in the area of uncertainty) is invited to join the Consensus Diagnosis Team.
	ID294		Is a functional and strengths assessment required for a Tier 1 assessment?	The revised structure of the Guideline addresses this comment, in which all individuals receive an initial functional and support needs assessment. For further detail, please refer to the 'Overview of Major Amendments' chapter under the headings: • Structure of the Assessment Process
	ID295		9.4 Practicality/logistics of completion of medical evaluation prior to Tier 1. Who will communicate these changes & expectations to medical professionals?	Thank you for this comment. We believe this issue is addressed by the revised structure, and the expertise requirements of professionals who conduct medical evaluations at Stage 1. Please also refer to the following section to see recommendations made by the Guideline in this regard: Practice points for clinical, research and policy settings
	ID296		With Tier 1 and Tier 2 diagnostic evaluations we will need to be clear if the referral we receive is for Tier 2 (i.e. a Paed or other professional has conducted the Tier 1 evaluation) or Tier 1 (a Tier 1 evaluation has NOT been conducted and therefore we start at Tier 1)	The structure outlines a progressive approach, whereby individuals progress through the stages sequentially.

	ID297		Who decides whether a 1 or 2 is completed? transitioning from 1-2? Who triggers the transition? Can a 1 escalate into a 2?	This decision is made by the Stage 2 Diagnostician. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Progression from Stage 2 to 3
	ID298		So, no standardised assessment tools are needed, such as the ADIr, for Tier 1 assessments? What about use of a screening tool? I worry that this may run the risk of diagnoses being made without some quantitative evidence behind the decision - most of the above listed means involve qualitative measures.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Use of 'Standardised' Instruments
	ID299		Tier 1 - The GP medical form, families will be required to make double appointments to have this completed. This will be costly, in addition who will explain to the GP and the family why height, weight etc is important for an ASD axe? is this really necessary? If families have to pay additional money for a longer consult let's make it count!	This comment is addressed by the revised structure of the Guideline. For further information, please refer to the 'Overview of Major Amendments' chapter under the heading. • Structure of the Assessment Process Please also note that the revised Guideline includes a recommendation regarding costs for ASD assessments. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Practice points for clinical, research and policy settings
	ID300		9.5 Given families can refer for assessment, and in light of NDIS, there is a possibility a majority may request a Tier 2 assessment.	The revised Guidelines recommend that only primary health care providers are able an individual for an ASD assessment. For a rationale, please refer to the 'Overview of Major Amendments' chapter under the heading: • Referral for an Assessment of ASD Concerns
	ID301		I strongly agree in diagnosing other conditions as part of a comprehensive assessment. It would be great to do some	Thank you for this comment.

			more work on differential and co-occurring diagnosis and be able to provide more concrete diagnoses if applicable.	
	ID302		9.4.1 & 9.5.1 The guidelines state that the additional Diagnostician and Professional Informant should be selected on the basis of areas in which there was diagnostic uncertainty. It also states that all members of the multidisciplinary assessment team should come from different professional disciplines or specialties. Does this mean our service would need to enlist a different discipline if there is diagnostic uncertainty? It makes sense to consult with a Paed or a GP if there are medical concerns but hopefully they would have already been considered but for a lot of our presenting comorbidities (ADHD, behavioural concerns and trauma for example) there doesn't seem to be many examples of additional informants, so who would conduct the assessment? Our service would need OT, Speech, and/or Social Worker on call to conduct these assessments. How would this work? Again, I am concerned that if there isn't speech or OT linked in with the family then the assessment will be extended for quite some time.	The Guideline includes a recommendation that a Stage 3 assessment involves " at least one other professional, with at least one professional from a different discipline or specialty to the clinician involved at Stage 2. If a psychologist (with clinical psychology practice endorsement) performs the Stage 2 assessment, then it is recommended that at least one additional clinician who joins the consensus team at Stage 3 is from a different discipline or a different psychology practice endorsement. This recommendation is based on the evidence highlighting the importance and benefits of a multidisciplinary approach to complex neurodevelopmental disorder assessments.
Sally Anne Jones [92]	ID303	Individual - Lived experience (C,F)	Please include screening for Pathological Demand Avoidance in the Diagnosis process.	Please refer to the 'Overview of Major Amendments' chapter under the following heading: • Pathological Demand Avoidance
	ID304		My son has been dx with ASD with extreme demand avoidance behaviours. I would like PDA to be recognised in Australia so that other families with kids with PDA can be dx as well.	Please refer to the 'Overview of Major Amendments' chapter under the following heading: • Pathological Demand Avoidance
Anonymous	ID305		I am not clear how these guidelines impact those receiving a diagnosis of ASD. I understand they should guide and support better and more accurate diagnosis, but not sure that will be	Thank you for this feedback. We believe that the revised structure addresses this comment – in particular, the recommendation for an initial comprehensive functional and

[93]		Individual - Professional experience (PD)	the outcome. Will this guideline impact people's access to services and support? Is it really such an important focus to get a diagnosis? I thought the NDIS was about function and we had moved away from diagnostic driven funding. Feels very much about driving systems to diagnose again. Also see potential for misuse and new industries opening to diagnose rather than driving service provision and support.	support needs assessment and the immediate referral for further supports. For further information, please refer to the 'Overview of Major Amendments' chapter under the heading: • Structure of the Assessment Process
	ID306		I work with a small community paediatric team in South West Sydney. We have a growing paediatric population with a very diverse socioeconomic background. We have pockets of very vulnerable families including Aboriginal families and refugees, as well as an incredibly large number of non-English speakers. Within South Wet Sydney there are also private paediatricians who are our main referral base, and amongst them a variable level of understanding of and confidence in Autism diagnosis and management. The guidelines pose both positives and negatives to a team such as ours. There needs to be tiered approach. Accessing a multidisciplinary team can be hard - sometimes impossible within a reasonable time frame for some families. There are those children who clearly have a diagnosis of ASD and those private paediatricians who feel confident about diagnosing should be able to make that call independent of a multidisciplinary team. That does not however mean that the child shouldn't be seen by a multidisciplinary team at some stage to look more closely at their abilities and needs, and clarify that diagnosis and the various other issues that go along with it. There are also many cases where children have been given diagnoses where a complex developmental assessment results in a review of that diagnosis because other issues have been overlooked or hidden by behaviours. And then there are the children who need a tier 2 approach - the ones that are not clear. These children definitely need a paediatric input into this diagnosis. Individual therapists being able to make diagnoses also opens the system up to less transparency and diagnoses being made by inexperienced clinicians with no specific training is	Thank you for this feedback. We believe that the revised structure addresses many of the concerns detailed here. For further information, please refer to the 'Overview of Major Amendments' chapter under the headings: • Structure of the Assessment Process • Professional Roles

			ASD because of the financial benefits available through funding and from desperate families. The initial HCWA funding which required clinicians to work within MD teams to access the funding resulted in groups of allied health clinicians popping up across the country, claiming to have speciality experience in ASD management when many were completely lacking in real understandings of ASD and the therapy needs of such children. It also then resulted in massive fee increases as clinicians saw a new way to make money from that available funding	
	ID307		The RACP branch of Paediatrics is the only organisation that mandates training opportunities within community/developmental/psychiatric teams for all of its trainees. Those doing Community training will gain the most experience, but at best a trainee doing General or other speciality training will get 6 months possibly within a developmental/community team. Given the RACP trainees are getting the most opportunities of everyone to learn about ASD diagnosis and management, how could the guidelines possibly mandate 4 years of experience of ASD diagnosis? How would anyone ever reach that other than those already in the field?	Thank you for this comment. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Duration of ASD-specific Expertise
			And given this strict quota of time, how can the OT and Speech Pathology associations possibly feel their clinicians can make a diagnosis independently of a paediatrician given they have absolutely no mandated training in ASD at all? Given there are so many differential diagnoses that can mask or confuse the picture of ASD, specific training does need to be part of the picture of deciding who can make a diagnosis. And who will monitor this? The SPA for example has no requirement for registration with a body such as AHPRA and no independent system monitoring compliance with training requirements. ASD is such a complex condition. there are many differential diagnoses that can look like ASD or mask ASD. professionals involved need to know enough not only	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Professional Roles • Structure of the Assessment Process

			about ASD but about these conditions as well- attachment disorders, trauma and mental health issues, developmental and intellectual disabilities, medical conditions including Retts etc. To what extent do the professions outside of paediatrics and psychiatry get training about these conditions? You have to know they exist and how to diagnose them as well to decide if a child has ASD or something else. I do not mean to imply that allied health staff are not good at picking up the signs and symptoms suggestive of ASD- for example our speech pathologist in our clinic is excellent at seeing and describing social and communication difficulties and stereotyped language much better than I can (the benefit of a MD team). You suggest 4 years' experience in ASD work but that misses the fact that you need experience in recognising when it's not ASD and how to do that.	
	ID309		I also note that there are many professionals who can make the diagnosis, but CMOs have not been included in this list, despite there being CMOs with decades of ASD diagnostic and management experience. We have two CMOs connected to our team who are significantly better diagnosticians than most general paediatricians	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Qualifications for medical practitioners
	ID310		Not sure about the justification for the diagnosticians to declare that they have followed these guidelines- what does this imply? Will it or lack of declaration impact the relevance of findings?	The recommendation to include a declaration in the report that the ASD assessment was conducted according to this Guideline has been removed.
Anonymous [94]	ID311	Individual - Professional experience	There are numerous children being given a label of ASD when they do not have it. There is no process to undiagnose. This is desperately needed.	The revised Guideline includes a recommendation regarding this issue. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Practice points for clinical, research and policy settings

	ID312	(PD)	DSM V Section E involves assessing the child for another condition that may be a better fit. However, you have only indicated the assessors need to be trained in ASD. Many assessors, including myself, are concerned about children with emotional trauma being assessed incorrectly as ASD. The assessments to not ask about trauma background and do not look at the Coventry Grid to distinguish when known trauma has occurred. Some assessors and Referral for an Assessment of ASD Concernss have said 'well at least the child gets funding' to justify the misdiagnosis. The already traumatised child also gets a label that effectively confirms they are the cause of the problem not child abuse or child trauma.	Members of the Consensus Diagnosis Team are recommended to have training and expertise in signs and symptoms associated with ASD and common co-occurring or differential diagnosis conditions. In addition, clinicians are guided to consider current or previous exposure to personal or familial trauma and/or psychosocial risk, and if present, progress to a Stage 3 Consensus Team Diagnostic Evaluation.
	ID313		Diagnostic evaluation section page has nothing about the need for diagnosticians to be trained in other areas.	The Diagnosticians proposed in the revised Guideline includes only professions that have received training in this area as part of their tertiary education qualification.
St Giles Society [95]	ID314	Organisation – Professional experience	Submitted on behalf of the Developmental Assessment Team at St Giles Society - Tasmania. North Team Ella Anderson (Psychologist), Jodi Hill (Occupational Therapist), Karen Mason (Speech Pathologist) South Team Michelle Chadwick (Psychologist), Jill Curtis (Speech Therapist), Anna Fenton (Occupational Therapist) Kathryn Fordyce (manager).	No response is required to this comment.
	ID315		10 Functional and Support Needs Assessment Within our workplace with the increasing role of NDIS and private funding, getting input from therapists working with a child may be difficult, as who is paying for their time	Please also refer to the ‘Overview of Major Amendments’ chapter under the following headings: • Cost implications of the assessment model recommended in the Guideline • Practice points for clinical, research and policy settings

	ID316		10 Functional and Support Needs Assessment The team was slightly confused about the different roles of diagnostician vs. functional assessment. Who is responsible for the functional assessment?	The revised structure Guideline provides greater clarity on this issue. For further information, please refer to the 'Overview of Major Amendments' chapter under the following heading: • Structure of the Assessment Process
	ID317		As a functional assessment needs to be repeated, unclear who is responsible for this long term, as same team may not have funding/support/expertise to revisit functional needs throughout the lifespan. How often does this assessment need to be reviewed? Is this something the family is responsible for, diagnosticians or the client's therapist/s	Please refer to the 'Overview of Major Amendments' chapter under the following heading: • Structure of the Assessment Process
	ID318		9.3. Diagnostic Evaluation Structure Overall, very positive about the Structure of the Assessment Process, with the two tiers. It has made us consider what could be streamlined and altered within our own processes at St Giles. Can see efficiencies being gained with 'clear cut' diagnoses.	Thank you for this comment. The tiers have been retained in the revised version of the Guideline, but have been renamed 'stages'. Please refer to the 'Overview of Major Amendments' chapter under the following heading: • Structure of the Assessment Process
	ID319		Some concern over how a client who is 'clear cut' is determined, different diagnosticians may have different levels of confidence in making a call and as such clarity is required to avoid 'renegade' diagnosticians	Please refer to the 'Overview of Major Amendments' chapter under the following heading: • Progression from Stage 2 to Stage 3
	ID320		Concern with requirement of 'medical evaluation of the individual being assessed for ASD', may hold up diagnostic process with waitlists to get into specialists e.g. paediatrician. While a GP could complete some of the information, they may not be able to complete the entire form e.g. genetic testing. Often long waitlist for public services even if referred prior to	A challenge in developing the Guideline has been to achieve a balance between facilitating broad access to assessment services while still maintaining assessment rigor. Current international best evidence recommends the inclusion of a specialist medical practitioner in the diagnostic decision making for neurodevelopmental. Based on this this evidence,

			ASD assessment. Also, increased burden on public services for specialists.	the recommendation for a specialist practitioner has been retained in the revised Guideline.
	ID321		Also, a single discipline may not offer a family a truly holistic approach that is gained from multi-disciplinary approaches.	Thank you for this feedback. We believe that the revised structure addresses this comment– in particular, the recommendation for an initial comprehensive functional and support needs assessment, which involves both allied health and medical practitioners. For more information, please refer to the 'Overview of Major Amendments' chapter under the heading: • Structure of the Assessment Process
	ID322		Agree with the guidelines in terms of needing two observations conducted in different settings for Tier 2 children.	Thank you for this feedback.
	ID323		Some diagnosticians who have only worked in ASD may not be aware of typical development or the possible differential diagnoses required. Which may be problematic at Tier 1 where only a single diagnostician is required. We would argue the streamlining of time rather than lessening staffing may be more appropriate. This may be different based on the age of the client being assessed e.g. child vs. adult, as for a child they will be a need to talk with parent and also observe the child. Resulting in the most efficient use of time may be two clinicians at the same appointment one with the parent the other with child.	The Guideline recommends that all clinicians involved in the assessment process has 'relevant training and expertise'. The training and expertise is defined in Section 4.2 of the Guideline, and includes expert knowledge and experience in typical development in the age range in which the clinician' practices.
	ID324		Greater recognition of differences between ages i.e. child, adolescent adults.	The 'Important Considerations' section of the Guideline (Section 4.2) provides detailed information about how individual presentations may differ according to age.

	ID325		Potential lack of focus on the need for differential diagnosis throughout the guidelines, though note is included at 12.6., but a stronger focus throughout might be important.	Thank you for this feedback. A focus on differential diagnosis has been highlighted further within the revised structure (Please refer to Figure 2 of the revised Guideline).
	ID326		10 Functional and Support Needs Assessment Potential to increase workload and delay assessments, if this is needing to be added into all assessments.	Please also refer to the ‘Overview of Major Amendments’ chapter under the following headings: • Cost implications of the assessment model recommended in the Guideline • Practice points for clinical, research and policy settings
	ID327		While a strength based, family/client focused approach is beneficial, may be difficult to do justice to this if only meeting the Tier 1 client briefly, then moving straight to a functional assessment. Especially where families aren't linked with other services so there is not capacity to gather information from alternative sources. May be something that is best done over time, which isn't possible with diagnosticians due to waitlists etc.	We believe that the revised structure addresses this comment. For further information, please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Structure of the Assessment Process
	ID328		6.4. Diagnostician - Very pleased to see that Allied Health e.g. Occupational Therapists, Speech Therapists, being recognised as well as the medical professions.	Thank you for this feedback.
	ID329		Psychologists - further clarity regarding qualifications and training for a registered psychologist e.g. 4 + 2 pathway or six-year university pathway (undergraduate and masters) and endorsement required or is either acceptable? Would recommend all psychologists e.g. generally registered and those with practice endorsements (clinical, educational/developmental psychologist) are eligible to be diagnosticians if they meet other requirements.	Please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Qualifications for Psychologists

	ID330		Occupational Therapists - clarity regarding rationale for requiring OTs to be registered via Better Access to Mental Health or perhaps offer some other alternative recognition/training pathway	Please refer to the 'Overview of Major Amendments' chapter under the heading: • Qualifications for occupational therapists
	ID331		We are particularly keen to see more clarity regarding the accountability of adherence to the national guidelines	Please refer to the 'Overview of Major Amendments' chapter under the heading: • Accreditation and Regulation • Practice points for clinical, research and policy settings
	ID332		6.4.2. ASD Specific Expertise - Concerns with how this expertise will be assessed and policed for the required level of competency. Some diagnosticians may believe they have the relevant expertise, but actually do not. There is a lack of clarity regarding what is relevant experience (e.g. is providing ASD intervention sufficient, is more general assessment of children with ASD sufficient, is identifying children with ASD-like symptoms and referring them for diagnostic assessment sufficient?) More details are required. Who will people be accountable to/need to prove their expertise to? Possible avenues to upskill people already in the field e.g. workshops, online training, peer supervision. Peer supervision mentioned, would benefit from clarification around who this can be with e.g. same profession, other professions also working with ASD. Also, how this is recorded as 'evidence' towards expertise.	Please refer to the 'Overview of Major Amendments' chapter under the heading: • Accreditation and Regulation • Practice points for clinical, research and policy settings
	ID333		6.6. Professional Informant - Would like to see childcare workers also recognized as informants, either as a professional informant or in a different section. While they	The list of disciplines for other professionals has been extended to included childcare workers (preschool or early childhood teaching / care) and the requirement has been

			may not always have a four-year degree, they often have important information in regards to children and development and arguably would have a greater capacity to report differences to neurotypical cohort than others that have been included in this list.	adjusted to: "These professionals typically require registration with a professional board and/or accreditation from the peak organisational body relevant to their professional discipline".
			The quality information provided by informants is often a function of the questions asked or assessments given to informants by diagnosticians, not a function of their four-year university degree.	Thank you for this comment. The Guideline includes guidance around the training and expertise that Diagnosticians should have, as well as the information that can be collected to hep inform diagnostic decision making. The requirement to hold a four-year university degree has been removed.
			More focus on what diagnosticians should be requiring of informants e.g. questionnaires to complete, questions to ask	In the attempt to achieve balance between providing guidance and allowing flexibility of administration, it was decided to not specify specific instruments or questions. Instead, the Guideline specifies topics to address and suggests ways in which this information can be collected.
Anonymous [96]		Individual - Professional experience (PD)	You have put a section to document Family History. However, if this is included in the report that is released, I believe there is an issue with the privacy act. When the privacy act was introduced, we had no right to ask family history and special dispensation was arranged. Putting family history in to a document that is so widely distributed, such as an ASD assessment I think is a breech	The probing of family medical history is a standard part of clinical assessment. In most instances in clinical practice, the assessment forms remain the property of the client, and is not to be shared with other parties without their expressed consent.
Rebecca Koncz [97]		Individual - Professional experience (PD,PS)	It is impractical to expect that clinicians will be able to assess all individuals across a variety of settings, given the limited amount of time we are able to spend with patients due to the demands of the public health service. My concern is that this will be an unnecessary barrier for patients attempting to access the appropriate diagnosis and care.	A challenge in developing the Guideline has been to achieve a balance between facilitating broad access to assessment services while still maintaining assessment rigor. Current international best evidence recommends that information is collected about an individual's behaviours in more than one setting. Based on this this evidence, the recommendation for a specialist practitioner has been retained in the revised Guideline. The Guideline clarifies that information about presentation in a variety of settings may be obtained through

				communication with the client and/or other professionals, reviewing video footage and/or direct observations by member(s) of the ASD assessment team within some of these community settings.
			Figures 5 and 6 are confusing with the multiple arrows - please make clearer.	These figures have been removed from the Guideline.
	ID339		'Tier 2 Diagnostic Evaluation should involve the administration of at least one standardised ASD diagnostic tool' yet on the same page acknowledging 'There is <only> emerging/inconsistent evidence that the following instruments may have adequate diagnostic accuracy for ASD'. This is contradictory. I have grave concerns regarding the use of diagnostic scales as a mandatory component, especially when it goes on to note that at the end of the day they should not supersede clinical judgement anyway! Many of the tools have not been robustly validated in adults. There is inadequate evidence to support mandatory use and I strongly recommend replacing the term 'should' have used one diagnostic tool with 'may consider using'.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Use of 'standardised instruments'
Australian Association of Social Workers [98]	ID340	Organisation - Professional experience	We would welcome the opportunity to participate in discussions concerning the implementation of the new guidelines.	We are grateful for you providing feedback.
	ID341		We strongly advocate that accredited members of the Australian Association of Social Workers be included in the professions that are eligible to fulfil 6.3; 6.4 and 6.5. Given that social work is an Allied Health profession, the lists of disciplines should be expanded to include Social Workers and they should be eligible to demonstrate the expertise in the ASD specific criteria for each of 6.3; 6.4 and 6.5. Specifying that they are Accredited members of the AASW will ensure that they hold at least four-year university degrees, that they	Social Worker have been included as Allied Health clinicians at Stage 1 of the revised Guideline. For further information, the 'Overview of Major Amendments' chapter.

			undertake continuous ASD specific CPD, and follow our code of ethics. In other words, they meet the same stringent requirements as the professions already listed and demonstrate equivalent levels of expertise.	
Queensland Child and Youth Clinical Network (QCYCN) - Child Development Subnetwork (CDSN) [99]	ID342	Organisation - Professional experience	The CDSN are feel overall the structure is usable as it includes a summary and a more comprehensive explanation for potential diagnostic services. The document is lengthy however as content has been stepped out for clarity. Could the length and repetition be reduced? We again feel this assessment framework could be applied to other diagnostic groups (the differential diagnostic table are a great reference) as it outlines the importance of viewing neuro development broadly focusing on function and support needs and not just diagnosis.	Thank you for these comments. The Guideline has been reviewed with the purpose of reducing the length and repetition where possible. In addition, the Scope section of the Overview acknowledges “Where possible, this Guideline describes an assessment process that is applicable for individuals presenting with a range of neurodevelopmental and behavioural signs and/or symptoms.”
	ID343		We really value the focus on strengths and of family and client centred practice - this is not fully reflected, however, in the case studies (e.g. case study 2 there is no explicit mention of considering the clients thoughts on the value of the diagnosis.	Thank you for this comment. The case studies now provide further information on this issue.
	ID344		The diagram suggests 2 very separate processes - (Diagnostics vs Autism support needs assessment) leading to risk of a strict delineation between diagnosis and functional assessment. This could lead to confusion with different services being responsible for these - A good quality diagnostic assessment would assume inclusion of functional abilities and strengths and environmental factors. A support needs assessment could potentially be separate, and we wonder if a health practitioner is best placed to conduct this? Could there be a more interactive relationship particularly between the diagnostics and functional abilities? Our teams questioned at what point the NDIS would be involved - We offer the idea of more integration between the diagnostic and functional needs assessment in cyclical/interconnected rather than linear diagram. It remains unclear if the entire diagnostic	Thank you for this feedback. We believe that the revised structure more clearly describes the interplay between the Functional and Support Needs Assessment. For more information, please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Structure of the revised assessment

			process is to be part of a health service (as defined in the COAG applied principles) or as a partnership between health and disability services?	
	ID345		The reporting templates and do not represent a family centred approach to sharing written information as they are highly technical and would not be in keeping with readability for families and carers.	Thank you for this feedback. The templates have been amended to address this issue.
	ID346		The CDSN agrees overall with the 2 tiers of assessment based on complexity of presentation and appreciate the need to balance accessibility for assessment with requirements for a multidisciplinary and multi context view to inform diagnosis. We are in general agreement about the need for 2 components - diagnosis and functional and support needs as a necessary part of the diagnostic process.	Thank you for this comment. No amendment is required.
	ID347		The CDSN, a network of multidisciplinary child development services across Queensland, advocates for an integrated approach to developmental diagnostic understanding for children with complex developmental concerns. Our hope is that the diagnostic framework is applied as part of a differentiated diagnostic process rather than being seen through a single condition lens. As such we feel the importance of considering neuro development as a whole versus ‘ASD' diagnosis needs to be included in the guiding principles. Also including a statement about the importance of an accurate diagnosis and the risk of inaccurate diagnostic labels. While there has been an historic push for over diagnosis for funding purposes (and this is likely to continue with NDIS) there is also the implication across the life course of declaring a diagnosis on employability and insurance etc as an adult.	Thanks for this comment. We believe that the revised structure addresses this comment. Please refer to the ‘Overview of Major Amendments’ chapter under the headings: • Structure of the revised assessment • Emphasis on the Importance of Functional Abilities in Referral for Supports

	ID348		5.1 The CDSN suggests adding that the diagnostic evaluation also seeks to answer the question 'If the individual does not meet criteria for ASD are there other considerations that explain the presentation?	The following question has been added to the section on the Content of an ASD Assessment: “If the individual does not meet criteria for a clinical diagnosis, such as ASD, are there other considerations that explain the presentation?”
	ID349		ASD roles Overall the proposed increased of combination of roles and responsibilities across the workforce promotes flexibility and is welcomed.	Thank you for this feedback.
	ID350		Diagnostician-Multiple services raised concerns and questions about regulation and governance of ASD specific expertise and neurodevelopmental expertise for all roles and particularly role of ‘diagnostician' Who will determine that Diagnosticians the necessary skills or do they self-evaluate? There is concern that expanding who can diagnose ASD could lead to conflicts of interest for diagnosing clinicians who may go on to provide services as an NDIS provider to an individual with ASD for whom they have provided the diagnosis. Will there be a register for diagnosticians’ capabilities and maintenance of skills - to ensure adherence to the guideline accessible to a Referral for an Assessment of ASD Concerns for easy reference?	Please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Accreditation and Regulation • Conflicts of interest • Practice points for clinical, research and policy settings
	ID351		Referral for an Assessment of ASD Concerns - If the consumer is included as a 'Referral for an Assessment of ASD Concerns' it assumes a bypass of screening and primary care services. The CDSN feel it is necessary for the Referral for an Assessment of ASD Concerns to have adequate awareness as outlined in CBR-2 and the consumer needs a primary care link to support ongoing general health care and surveillance. We do not recommend consumer self-referral but rather collaboration with a general practitioner to make a referral.	This has been amended in the revised version of the Guideline. Please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Referral for an Assessment of ASD Concerns

	ID352		Co-ordinator - The CDSN agree with the importance of this role. Our only concern is that, as the role description is inclusive of specialist clinical care (supporting families navigating the diagnostic journey) and not simply an administrative role - extensive training and support would be required if this role was filled by an administrative officer.	Thanks for this comment. We believe that the revised structure addresses this comment. Please refer to the 'Overview of Major Amendments' chapter under the headings: • Coordinator
	ID353		We feel that a thorough medical assessment is not covered at point of referral. Again, the need for GP rather than consumer self-referral would ensure a basic medical assessment has occurred. Concern was raised that a GP assessment only may not be adequate for diagnostic purposes.	The revised Guidelines recommend that only primary health care providers are able an individual for an ASD assessment. For a rationale, please refer to the 'Overview of Major Amendments' chapter under the heading: • Referral for an Assessment of ASD Concerns
	ID354		Although family history is gather as part of the evaluation and 'Reactive attachment' is included in the differential diagnosis table, the CDSN feel the description of the diagnostic evaluation does not adequately highlight the potential diagnostic blurring of ASD vs severe trauma. There is particular risk that the tier one diagnostic process, as described, will continue to miss this important differential unless there is more rigour around defining and regulating the skills of both diagnosticians and professional informants. In particular - Page 36 re- information collection - 'Other relevant behaviours and / or symptoms' - should be a priority to screen instead of being optional.	Wording has been modified to ensure clinicians are guided to consider current or previous exposure to personal or familial trauma and/or psychosocial risk, and if present, progress to a Stage 3 Consensus Team Diagnostic Evaluation.
	ID355		In keeping with the principle of ASD diagnosis being part of a general neurodevelopmental assessment we suggest that the diagnostic algorithm be reversed putting 'not autism' as on the left instead of the last option.	The order of items has been changed within the Stage 2 and Stage 2 Decision Making and Outcome sections.
	ID356		The CDSN feel that not all of the functional needs assessment could best be carried out by a health service. We would like	Thank you for this feedback. We believe that the revised structure addresses this comment – in particular, the

			clarification about how the NDIS links with this part of the process. 'Pedicat' is cited as a tool which is currently used by ECEI service providers. We are concerned that if functional support needs assessment is too prescriptive with specific tools this may lead to a factory approach to assessment rather than a more individualised family centred approach.	recommendation for an initial comprehensive functional and support needs assessment and the immediate referral for further supports. For further information, please refer to the 'Overview of Major Amendments' chapter under the heading: • Structure of the Assessment Process
	ID357		The CDSN feel that on Page 24 the description of 'at least two settings' is very broad and non-prescriptive. Rather than 'ideally through observation', we feel that observation across settings is essential.	Thank you for this feedback. Based on the considerable feedback received regarding the need for flexibility in the assessment model, we have used the following wording (Section 10.3): "It is recommended that the Consensus Team Diagnostic Evaluation involve the collection of information about the individual's participation in all relevant community settings. This information may be obtained through communication with the client and/or other professionals but direct observations by member(s) of the ASD assessment team within some of these community settings may also be helpful."
Amaze [100]	ID358	Organisation - Professional experience	Amaze welcomes the opportunity to comment on the Cooperative Research Centre for Living with Autism's ('Autism CRC') draft national guideline for community consultation, titled 'The diagnostic process for children, adolescents and adults referred for assessment of autism spectrum disorder in Australia' ('draft guideline'). As the peak body for autistic people and their families in Victoria, we strongly support the development of a national guideline capable of supporting all consumers to access timely and reliable diagnostic, and functional and support needs assessments. The autistic community and their families/carers regularly share with Amaze their experiences in accessing an Autism Spectrum Disorder (ASD) diagnosis. The barriers that are repeatedly shared and need to be addressed are:	Thank you, we greatly appreciate this detailed feedback. No amendment is required in response to this comment.

- Lack of understanding of autism and its presentations by primary healthcare professionals such as local General Practitioners and Maternal and Child Health nurses;
- Lack of understanding of presentation of girls on the autism spectrum;
- A reluctance of paediatricians and paediatric psychiatrists to diagnosis autism under the age of three;
- Waiting lists for accessing diagnosis through the public health care systems;
- Limited access to diagnosticians in regional areas;
- Financial constraints for those seeking diagnosis through private diagnosticians, generally not wanting to wait for the public system;
- Lack of clear and concise information and support for families in navigating the diagnosis pathway;
- Having to fight the system to get a diagnosis, and getting confirmation of what they already suspect requires a great deal of persistence.

In 2016, Amaze conducted a survey of the Victorian autism community on a range of subjects, including their experiences of assessment and diagnosis and the need for consistent approaches across sectors, including in schools and for accessing services and supports. The following comments received through this survey further illustrate this experience:

- We had to wait six months to see the specialist for diagnosis. Once we saw him he had confirmed diagnosis within a week. Six months on a new patient list is a long time when you need help.
- No one could tell me how to go about getting diagnosis, it was by chance and pure luck we ended up getting in to see someone who was able to diagnose without too much difficulty after spending months trying to work through OT's and having other assessments done first.
- There seems to be low awareness of how ASD presents in girls, preventing early diagnosis and meaning that girls miss out on funding.

			• I was initially frustrated with our first paediatrician due to her mentioning autism but not being willing to diagnose due to her age. It wasn't until we were lucky enough to get into our second paediatrician that we got the diagnosis she needed. • The public waitlist was nine months, so we paid privately over $1000 so we didn't miss out on early intervention. It was difficult to watch other people wait who couldn't afford it. • (Diagnosis) just took too long and too many misdiagnoses along the way. • The waiting list for the public system is too long! It should be done within weeks of a referral not months and months! Waiting times for appointments are far too long! For one appointment I had to wait 4 hours to be seen!!!! • We had to travel to Melbourne (from Bendigo) to get assessments done - otherwise we would have waited 2-3 years or longer. • Using inexperienced and unsupervised paediatric fellows as the first line of enquiry through the public system is hit and miss. You really need experts to assess kids. • Diagnosis is important as it gives the child or young person a vehicle to reach their potential and independence. Parents are not listened to enough! Many of these experiences were also shared with the Victorian Parliament during its recent Inquiry in services for people with ASD (see Final Report from this inquiry at https://www.parliament.vic.gov.au/fcdc/inquiries/inquiry/400), leading to a number of recommendations to improve access to reliable ASD diagnosis in Victoria (discussed below). These experiences also are consistent with those highlighted in your recent research paper titled, ASD diagnosis in Australia: Are we meeting best practice standards.	

	ID359		We agree that ASD Assessments should be guided by the principles of an individual and family centred, holistic, strengths focussed, and evidence based approach. It is of the upmost importance that consumers and their families/carers are at the centre of all ASD assessment processes and decision making. It is also vital that the voices of autistic people, and those that support them, are central to the development of this diagnostic guideline. Accordingly, we welcome the extensive amount of work by the Steering Committee and research team to date, including extensive community consultations, to ensure the voices of autistic people and those who support them have been heard. Clinicians experienced in the diagnosis of autism must also have a strong voice in the guideline's development to ensure that it is meaningful, practical and has the upmost utility for diagnosticians diagnosing ASD on a day to day basis. Without this utility for diagnosticians, the guideline will be unable achieve the impacts sought. The development of this guideline must also be driven by the principle of equity: aiming to ensure that all Australians, regardless of age, gender, race, or geographical location can access timely, rigorous and reliable diagnostic, and functional and needs assessments. Consistency in diagnostic decision making and functional and support needs assessments, across all Australian states and territories, is essential.	Thank you for this comment. Equity has been added as a Guideline Principle.
	ID360		Amaze understands there are a range of views among individuals and organisations that have been involved in the development of this guideline, regarding the type and breadth of professionals that should qualify as Diagnosticians and Functional and Support Needs Assessors (FSNAs). We are of the view that the professionals identified in the draft guideline bring a valuable range of skills to the assessment of ASD and functional and support needs. However, we are	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Professional Roles • Structure of the Assessment Process

			concerned that the allied health professions identified will be unable to bring the breadth and depth of diagnostic skills required of a diagnostician, to undertake a holistic assessment of a consumer's presentation. As recognised in the draft guideline, when identifying an 'Holistic Framework' as a guiding principle of ASD assessment (Chapter 4), ASD assessments must not occur in a vacuum. They must appraise the full range of clinical symptoms, consider the environmental context and focus on the consumer's unique challenges and strengths, rather than simply matching an individual to a diagnostic category. As also recognised in the draft guideline, under 'Important Consideration' (Chapter 12), the diagnostician must consider whether a person may be presenting with intellectual disability, differential conditions (including genetic, psychiatric and neurodevelopmental conditions) and/or co-occurring conditions (including psychiatric, neurodevelopmental, neurological, medical and genetic conditions known to co-occur with ASD at higher than expected rates). We are concerned that the allied health professionals identified do not have the breadth or depth of training, or subsequently the skills or experience required to undertake a holistic assessment (or in particular, assess the possibility of intellectual disability or these differential or co-occurring conditions).	
	ID361		Reliability and accessibility - The guideline must promote rigorous and reliable ASD assessments by highly skilled and experienced professionals, while also ensuring timely access for all consumers to diagnosis, and functional and support needs assessments. We therefore welcome the prescription in the draft guideline regarding the necessary high level of skills and experience each professional must demonstrate to undertake ASD diagnosis and functional and support need assessments. However, it will be important to ensure timely access to these	Thank you for these comments. A challenge in the development of the Guideline has been how best to strike the balance between assessment accessibility and assessment rigour. Following the extensive consultation, we believe that the revised Guideline document achieves this balance substantially better than the original draft. The 'Overview of Major Amendments' chapter.

			assessments for all Australians, regardless of whether they live in the city or rural or remote areas. As recognised in the draft guideline and your research report titled ASD diagnosis in Australia: Are we meeting best practice standards, there is considerable evidence that people living in regional and remote locations currently experience poor access to diagnostic services and receive ASD diagnosis later than people living in urban communities. Widening the type of professionals that may undertake an ASD diagnosis or functional and needs assessment has the potential to increase accessibility. However, it is also important to ensure that the skills and experiences prerequisites can be met by sufficient numbers of professionals, ensuring that the guideline does not actually reduce the number of professionals across Australia that may undertake these roles, thereby reducing access and/or leading to lengthy waiting lists for services (particularly in rural and remote areas). As also recognised in your research report referenced above, there are currently lengthy waiting lists across Australia, particularly for public services relative to private services. We therefore encourage you to gain an understanding of current numbers of professionals that would meet these requirements.	
	ID362		We understand from your Technical Report that feedback will be sought from Diagnosticians who are early adopters of the guideline recommendations, to determine if recommendations need to be modified or if additional recommendations should be included. We also understand that you have submitted a funding request to the Commonwealth government to conduct a project that evaluates the extent to which guideline recommendations are adopted into routine practice. It will be important that this project evaluate the numbers of diagnosticians and FSNAs available across the country and map their locations.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Implementation and Evaluation of the Guideline • Practice points for clinical, research and policy settings

	ID363		A national register of diagnosticians and FSNAs would also be valuable, ensuring transparency and assisting consumers to find qualified professionals for ASD assessments. A national register could also provide a system of oversight to ensure that professionals undertaking diagnosis, and functional and needs assessments do in fact meet the skills and experiences prerequisites. As a prerequisite to registration, professionals could be required to declare their skills and experience. Registrations could be reviewable annually, ensuring requirements for ongoing professional development are also met. If there is a need to increase the numbers of professionals meeting the prerequisites, particularly in rural and regional areas, the Commonwealth government should be proactive. This is particularly important in the context of the National Disability Insurance Scheme where autistic people are already facing significant difficulty accessing therapy and other services. The government should be encouraged to take a holistic approach to how it will increase access to diagnosticians, FSNAs and service providers. For example, elements of block funding may be required in certain areas to maintain services, incentives for rural and remote professional placement may be required and existing diagnosticians and FSNAs must be supported to facilitate peer to peer training for future diagnosticians and FSNAs.	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Accreditation and Regulation • Practice points for clinical, research and policy settings
	ID364		Telehealth - The inclusion of telehealth as an acceptable method for consumer interview and observation will assist in meeting the needs of people in areas where the number of professionals with the prerequisites for diagnosis, and functional and support need assessments are not available. However, as recognised in your Evidence Table 31, further research is required to support the reliability of telehealth to diagnose ASD and to investigate the best systems and processes for providing telehealth support. However, learnings may be taken from programs to advance telehealth in other	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Telehealth

			areas of healthcare, such as the VidKids program - a telehealth program piloted by a consortium led by Vison Australia, to provide diagnosis and other supports to children with hearing or vision loss in remote and outer regional areas. The project was aimed at delivering qualified allied health and education services where such expertise may otherwise have been scarce. For more information, see http://www.visionaustralia.org/services/children/vidkids and http://www.healthinfonet.ecu.edu.au/key-resources/programs-projects?pid=1354. A range of other telehealth models have also recently been reviewed in Australia - see for example 'One in Four Lives: The Future of Telehealth in Australia' available at https://www.adma.org.au/.../doc.../158-one_in_four_lives_white_paper_v7.html and the Strategic review of telehealth in NSW: Final report available at www.health.nsw.gov.au/telehealth/Documents/strategic-review-of-telehealth-in-NSW.PDF Commonwealth government funding for ongoing evaluation will need to be sought to identify which telehealth methods for ASD diagnosis and functional and support need assessments are proving feasible for consumers, their families and professionals, any barriers to sustainability and to measure the reliability of assessments across the various telehealth models. Professional training for undertaking diagnosis and functional and support need assessments via telehealth models should also be prioritised.	
	ID365		Recommendations: • Review the professionals eligible to perform the role of a diagnostician under the guideline, particularly speech pathologists and occupational therapists. • To ensure the sustainability of the guideline, Commonwealth funding should be sought/utilised to:	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Professional Roles • Accreditation and Regulation • Telehealth

			○ Evaluate the numbers of diagnosticians and FSNAs in Australia that meet the prerequisites for diagnosing ASD and assessing functional and support needs, and map their locations. ○ Develop a national register of diagnosticians and FSNAs, with a requirement that professions declare their skills and experiences; and ○ Identify which telehealth methods for ASD diagnosis and functional and support needs assessments are most feasible for consumers, their families and professionals, any barriers to sustainability and measure the reliability of assessments across the various telehealth models.	For suggestions beyond the scope of this Guideline, recommendations for future clinical practice, research and policy have been made as appropriate. Please refer to the section: • Practice points for clinical, research and policy settings
	ID366		Amaze agrees that ASD assessment should involve the collection of information about an individual's behaviour in at least two settings relevant to the individual's daily life, ideally through direct observation by the Diagnostician, but also through secondary reports provided by the caregiver and/or Professional Informant(s). As recognised in your Evidence Table 28, there is consistent evidence that ASD diagnostic assessments should be conducted across the multiple settings identified in the draft guideline.	Thank you for the comment. No amendment is required in response to this comment.
	ID367		Amaze welcomes the guidance provided in the draft guideline regarding screening tools and the additional factors to consider in determining whether to refer for an ASD assessment. This guidance will need to be accompanied by structured training and information resources to develop the ASD knowledge of General Practitioners and others involved in initiating an ASD assessment, such as Maternal and Child Health Nurses (as per recommendation of the Victorian Parliament in its Final Report to its Inquiry into services for people with ASD, recommendations 3.1 - 3.2).	Thank you for this comment. This issue is out of scope of the project terms of reference, and so no amendment has been made. However, we note that the response from the Victorian Government to the Inquiry has now been released, which included proactive responses to the recommendations you described here.

	ID368		• Autistic females - As discussed below under 'Important Considerations', we are concerned about the historic failure of general practitioners and other professionals engaged in initial assessments/screening to recognise the symptoms of ASD in girls and women • A core aspect of this failure has been the lack of awareness among general practitioners, and others involved in initial ASD screenings, of the different presentation of ASD characteristics in females. In particular, these professionals are often unaware of the potential for females to go to great efforts to mask or hide their autistic characteristics during an ASD assessment, and in everyday life • he historic failure to diagnose ASD in girls and women has also been compounded by the limited reliability of many developmental screening tools for screening ASD in girls and women. There is evidence that commonly used ASD screening and diagnostic tools (such as the Autism Diagnostic Observation Schedule [ADOS] and the Autism Diagnostic Interview-Revised [ADI-R]), reflect a presentation more commonly found in males than females, and may lack the sensitivity and specificity required to identify autistic characteristics in females (See for example, Lai, M., et al 2015. Sex/gender differences and autism: Setting the scene for future research. Journal of the American Academy of Child and Adolescent Psychiatry, vol. 54, no. 1, pp. 11-24, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4284309/; Rynkiewicz, A., et al 2016. An investigation of the 'female camouflage effect' in autism using a computerized ADOS-2 and a test of sex/gender differences. Molecular Autism, vol. 7, no. 1, pp. 1-8, available at https://molecularautism.biomedcentral.com/articles/10.1186/s13229-016-0073-0)	This table has been omitted from the revised version of the Guideline. For further information, please refer to the 'Overview of Major Amendments' chapter under the heading: • Referral for an Assessment of ASD Concerns

			Recommendations: The new diagnostic guideline must prioritise an increase in the reliability of initial autism assessments/screening in women. Accordingly, we recommend that: • Gender be included in Table 5: Additional factors to consider in determining whether to refer for an ASD assessment. Within this table, the different presentation of ASD characteristics in girls and women, and likelihood of girls and women masking their autistic characteristics should be highlighted • The guideline highlights the limited reliability of standardised developmental screening tools for girls and women in Chapter 8.1.2, regarding the Evidence of Signs and Symptoms	
	ID369		9.2 Diagnostic criteria (DSM-5) - An understanding of the diagnostic criteria under DSM-5 and its application must be at the core of any ASD diagnosticians' decision-making processes. These criteria contained in the DSM-5 are two-fold. Firstly, a diagnostician must assess whether the consumer meets each criterion for an ASD diagnosis. Secondly, if the consumer is assessed as meeting the criteria, the diagnostician must assess the severity level of their deficit under each criterion, from Level 1 (requiring support) to Level 3 (requiring very substantial support). While the draft guideline outlines the first part of the criteria (for assessing whether a consumer meets the criteria for an ASD diagnosis) it does not outline the second part of the criteria for determining the consumer's severity level. This second aspect of the criteria must be included in the guideline to guide complete assessments by diagnosticians, and assessment of severity when applying your ASD Combined Assessment Report Template DSM - 5. It is also important in the context of the NDIS as we understand that the assessed severity level under DSM-5 can have a significant impact on access to the	Please refer to the responses to similar comments made by this respondent.

			scheme (with consumers with Level 1 severity assessments often having to provide further information to access the scheme). We also understand that it has a significant impact on services and supports allocated to participants in their support packages, with the severity level impacting the identification of the participants reference group and associated typical support package (under the current NDIS First Plan approach). Reliability and Accessibility - The principle of equity must lead the development of the diagnostic evaluation process, ensuring that it promotes timely and low-cost access to a reliable diagnostic evaluation for all. Reliable diagnostic evaluations are essential to instilling consumer confidence in the process, as well ensuring the cost-effectiveness of supports provided under the NDIS for governments and the broader community. Diagnostic evaluations must be affordable. As your survey of public and private health professionals in 2015 found, there currently exists considerable variability in the cost of ASD assessments, with costs to individuals/families ranging from $0 in the public sector to up to $2750 in the private sector (Autism CRC 2016).	
	ID370		9.2 Diagnostic Criteria Recommendations: Amend Chapter 9.2 of the draft guideline, to include the criteria for assessing severity level in the outline of the DSM-5 criteria.	The Stage 2 and Stage 3 Decision Making and Outcome sections have been edited to include “a decision of current severity level if DSM-5 criteria are utilised.” In addition, the Content of Communication section has been modified to include the requirement to share “Evidence that supports the current severity level (if DSM-5 criteria are utilised).”

	ID371		Review funding model and undertake a cost-benefit analysis of nationwide ASD diagnostic service and Medicare funding all or a significant share of ASD assessments and diagnosis.	Thank you for this comment. We agree that this is an important undertaking. However, this issue is out of scope of the project terms of reference, and so no amendment has been made.
	ID372		Commonwealth funding be sought for ongoing audits and evaluations of the quality of ASD assessments under the guideline.	This issue is out of scope of the project terms of reference, and so no amendment has been made.
	ID373		The guideline highlight, in this chapter, the importance of diagnosticians taking into account the different presentation of ASD in females when undertaking an ASD assessment, particularly the potential for women and girls to mask their autistic characteristics. It should also highlight the limitations of ASD assessment criteria in identifying autistic females.	Thank you for this comment. The revised guideline provides a table that provides further information on this issue (Section 12.3).
	ID374		9.3 ASD diagnosis in Australia: Are we meeting best practice standards). We therefore welcome a tiered process that has the capacity to increase efficiencies in the diagnosis of ASD in very obvious cases, reducing the current strain on public resources and costs to consumers. However, it is equally important that Tier 2 assessments (including in particularly complex cases) can be accessed by consumers of all socio-economic backgrounds and are is cost-effective to diagnosticians and government. A failure to make Tier 2 assessments accessible will continue to cause consumers with more subtle symptoms to be undiagnosed or diagnosed later in life. They will also fail to receive the supports needed, which the evidence clearly shows will lead to increased social and economic costs later in life. An inaccessible Tier 2 process may also lead to gender discrimination (with females incurring higher costs than males) given females may be more likely to appear with a less obvious presentation of autism and be referred to Tier 2	Thank you for this information. This issue is out of scope of the project terms of reference, and so no amendment has been made.

			compared to men (see discussion below under 'Important Considerations'.) It follows that the proposed approach will only be sustainable and capable of ensuring reliable ASD diagnosis for ALL consumers, if a sustainable nationwide diagnosis system and funding model is developed to support it. We understand from your Technical Report that a funding request has been submitted to the Commonwealth government to conduct a project that evaluates the extent to which guideline recommendations are adopted into routine practice, including to estimate the costs for each stage of the ASD assessment. We would also encourage you to engage or if necessary, seek subsequent funding, for a cost-benefit analysis of Medicare funding all or a significant share of ASD assessments and diagnosis (weighing the social and economic costs of failure to diagnose and lack of quality and reliability of diagnosis). A nationwide, Commonwealth government funded, ASD diagnostic service would also support equal access for all Australians, ideally coordinating screening, diagnosis, professional training and post diagnosis support (compare state-wide ASD diagnostic service recommended in the Victorian Parliament in Final Report to the Inquiry on services for people with autism, recommendation 3.7 - 3.8).	
	ID375		As discussed below, functional and needs assessments should be separately funded under the NDIS.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Accreditation and Regulation • Practice points for clinical, research and policy settings
	ID376		Diagnostic evaluations must be reliable and consistent across and within Tier 1 and 2. The ongoing monitoring and evaluation of ASD assessment quality should be prioritised	Thank you for this comment.

			going forward, with Commonwealth funding to audit and evaluate ASD assessments.	
	ID377		Autistic females - Drawing on the discussion above regarding the assessment of ASD in females under 'Initiating an ASD assessment', we recommend that this chapter highlight the importance of diagnosticians taking into account the different presentation of ASD in females when undertaking an ASD assessment, particularly the potential for women and girls to mask their autistic characteristics. It should also highlight the limitations of ASD assessment criteria in identifying ASD in women and girls. The latest revision of the criteria for diagnosing ASD in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), is accompanied by a statement that girls with autism might not be diagnosed due to gender differences, and that 'girls without accompanying intellectual impairments or language delays may go unrecognized, perhaps because of subtler manifestations of social and communication difficulties'. At the very least, this statement should be quoted in the guideline. However, studies to date have failed to find that the application of the DSM-5 criteria identifies autistic females any more (or less) reliability than DSM-4 (see Haney J 2015. Autism, Females, and the DSM-5: Gender Bias in Autism Diagnosis. October 2015. Social Work in Mental health. Available online via https://www.researchgate.net/publication/283467413_Autism_Females_and_the_DSM-5_Gender_Bias_in_Autism_Diagnosis)	A table outlining behavioural features that may be more common in females with ASD who have an average or high IQ (compared to males with ASD with average or high IQ) has been added to the Important Considerations – Gender section.
	ID378		Amaze supports the approach outlined in the draft guideline for functional and support needs assessments to be undertaken by prescribed professionals, with prescribed high-	Thank you for this information. This revised Structure of the Assessment Process addresses this issue, by recommending that the comprehensive functional and needs assessment is conducted by clinicians. For further information, please refer

			level skills and expertise, in parallel with diagnostic evaluations. In the context of the NDIS, we have been concerned about the conduct of functional and needs assessments by planners that are inexperienced in the application of these tools and fail to understand matters that may confound a participant's responses. Autistic people can often have difficulty processing the meaning or intent of questions in assessment tools and can struggle to provide a fully informed or accurate response in high pressured situations, such as a planning meeting. Accessibility and reliability - The sustainability, feasibility and reliability of the approach outlined under the draft guideline to functional and needs assessments, and indeed meeting support needs under the NDIS, will be reliant on ALL consumers being able to access a functional and support needs assessment. To ensure reliable functional and support needs assessments are available to the NDIS, it should fully fund the costs of these assessments. As discussed above, the government should conduct a cost-benefit analysis of Medicare funding all or a more significant proportion of diagnosis costs. Recommendation: • Functional and support needs assessments should be funded by the NDIS.	to the ‘Overview of Major Amendments’ chapter under the heading: • Structure of the Assessment Process Please also note that the revised Guideline includes a recommendation regarding costs for ASD assessments. Please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Practice points for clinical, research and policy settings
	ID379		Functional Assessment Tools - We appreciate the value of valid, reliable, accurate and efficient functional assessment tools capable of measuring levels of functioning in people diagnosed with ASD. We also welcome the recommendation that a Functional Assessment should determine the individual's activity related and character strengths. However, we are concerned that the draft identifies functional assessment tools [such as Paediatric Evaluation of Disability Inventory - Computer Adaptive Test ('PEDI-CAT') for children, adolescent and young adults, and the World Health Organization Disability Assessment Schedule 2.0 (WHODAS)	Recommendations relating to specific instruments that measure functioning have been removed from the Guideline, and information about resources will instead be located on the Guideline webpage to enable updates to occur more readily.

			for all ages] as tools with a strong evidence-base for use with autistic people. There is evidence that commonly used functional assessment tools, including the PEDI-CAT and WHODAS may not be providing a valid, reliable or accurate measure of the nature, frequency and intensity of young autistic children's diverse support needs (particularly between the ages of 0 to 5) and indeed, may be providing a barrier to young autistic children accessing the levels and types of early intervention they require, via the NDIS Early Childhood Early Intervention ('ECEI') pathway (see Coster W et al 2016. Evaluating the appropriateness of a new computer-administered measure of adaptive function for children and youth with autism spectrum disorders. Autism. Vol. 20(1), 14 - 25; Kao YC et al 2012. Comparing the functional performance of children and youth with autism, developmental disabilities, and without disabilities using the revised Paediatric Evaluation of Disability Inventory (PEDI) Item Banks. Am J Occupational Therapy. 2012; 66(5): 607 - 616). As recognised by the Productivity Commission in its NDIS Costs Position Paper 2017, the current application of these tools by the NDIA in its functional and support needs assessment may be skewing the NDIA's data and wrongly suggesting that 40% of children entering the scheme do not have substantial functional deficits relative to their peers. If PEDI-CAT continues to be a recommended functional assessment tool, in order to mitigate against the tool's flaws in making a functional assessment in young autistic children, research suggests that the PEDI-CAT, modified for autism spectrum disorder 'PEDI-CAT (ASD)', is likely to be a more efficient and sound assessment tool for this group (ibid). The PEDI-CAT (ASD) is yet to be validated, however, particularly in the Australian population. We therefore urge you to highlight that no single functional assessment tool is currently capable of capturing the range of difficulties that young autistic children can present with now,	

			or in the future, and thus caution should be taken with use of any assessment tool to measure support needs. The mandatory use and identification of a functional assessment tool in the draft ASD Functional and Support Needs Assessment template (pg.5) should also be reviewed. If the requirement to use and identify a specific tool remains, we would urge the inclusion in the template of a further comments or considerations sections to capture any functional or support needs the identified tool may have missed, misrepresented or inadequately prioritised. Recommendation: • If PEDI-CAT is to be highlighted as a preferred assessment tool, the guideline should instead encourage the use of the PEDI-CAT (ASD) to measure the adaptive behaviours and functional needs of all young children, particularly those aged 0-7.	
	ID380		Amaze welcomes the direction contained in this chapter of how ASD assessment findings should be shared with consumers and others. This will ensure that consumers and where relevant, their families and caregivers are consistently provided with a detailed/transparent assessment and that assessment is delivered in a timely manner and an appropriate, sensitive, understandable and meaningful way for consumers. To ensure that assessments are being shared in accordance with the draft guideline, ongoing funding to survey the experiences of consumers and their families/carers will be essential.	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Implementation and Evaluation of the Guideline
	ID381		Amaze supports the identification of 'Important Considerations' in Chapter 12 of the draft guideline, with respect to age, gender, gender diversity, intellectual disability,	Please refer to the responses to similar comments made by this respondent.

			CALD communities, regional or remote locations and co-occurring conditions. To date, adults, women, trans or gender diverse people, CALD communities and people in remote locations have historically been underrepresented in the data of ASD diagnosis and often their differing support needs (particularly based on gender and age) have not been met. There have also been significant misunderstandings/lack of knowledge among health professionals about when/how intellectual disability and/or mental health conditions may be differentiated or co-occur/overlap with ASD. However, we are concerned that the overview of each Important Consideration provided in Chapter 12 will not be adequate of itself to inform professionals involved in diagnostic evaluations or FSNAs of these issues. Specific training and expertise in each of these areas should be required, and be a pre-requisite to all prescribed professions undertaking ASD diagnosis and FSNAs. This will be key to reliable diagnostic evaluations and FSNAs that consumers, their families/carers and the NDIA can have confidence in. - Autistic women. As discussed above, we are particularly concerned that the discussion and recommendation on gender may not be adequate to capture the different needs of females in diagnostic evaluation and functional and support needs assessment. Historically, there has been a systemic failure to identify and diagnose autistic females, predominantly due to a prevailing lack of knowledge across sectors of the differences in how ASD presents in females compared to males, as well as historic gender biases in ASD screening and diagnostic tools. Due to these failures, many autistic females are not receiving the supports and services they need throughout their lifetime and are at increased risk of misdiagnosis, abuse, financial hardship and social isolation.	

			The draft guideline should aim to rectify these failures and ensure that all professionals involved in the diagnostic, and functional needs assessments understand the differing presentation of autism in autistic females, and the limitations of screening and assessment tools for autistic females. The guideline should include more detail from Evidence Table 66 about the different presentation of autism in females compared to males. It is recognised in Evidence Table 66 that females tend to have: fewer restrictive and repetitive behaviours; lower parent rating of social skills (this may reflect higher social expectations for girls); less inappropriate special interests (horses, dolls or pop stars) and play topics therefore seeming less impaired; higher incidence of disordered eating; less aggressive/hyperactive behaviours; and masking of impairment through imitation. It also recognises that females tend to have better: imaginative play; attention; concentration; coping; adaptation; compensation skills; play skills; theory of mind; language/communication; executive function; females may show more of a desire to have friends and fit in with their peer group than males, and may mask social play deficits by imitating their typically developing peers; and females who have difficulty maintaining eye contact and seem to be socially withdrawn may be thought to be 'shy' rather than having a symptom of autism. At the very least, these characteristics of autistic females should be highlighted in the guideline itself. As discussed above, the tendency of women to mask their autism characteristics during ASD assessments, as well as day to day life, must be highlighted throughout the draft guideline. The draft guideline should also highlight the importance of gender being taken into account when assessing functional and support needs. For example, the barriers to, and development of, communication and social skills in autistic females can be very different to that of autistic males, with significant implications for the subsequent design and implementation of intervention programs (see Autism Program at Yale, 'Initiative for Girls and Women with Autism Spectrum	

			Disorder. Yale School of Medicine, available at https://medicine.yale.edu/childstudy/autism/clinical_services/initiative/).	
	ID382		Co-occurring conditions - We welcome the guidance on co-occurring conditions and the recommendation that Diagnosticians must be highly familiar with the full range of conditions that commonly co-occur with ASD. However, as discussed above, we are concerned that the allied health professions identified as eligible to the perform the role of a Diagnostician may not have adequate knowledge of these co-occurring conditions. Indeed, for all professions eligible to be Diagnosticians, this recommendation would need to be supported with professional training as there is currently a general lack of knowledge among these professionals regarding ASD and these co-occurring conditions, particularly commonly occurring mental health conditions (see for example, recommendation of the Victorian Parliament in its Final Report to its Inquiry into services for people with ASD, recommendation 8.4). While some resources are available online to help assist mental health and mainstream healthcare professionals working with autistic people, they can be difficult to find, and quality assess, and/or are not widely publicised or targeted across mainstream health and healthcare professionals. Further, it should also be highlighted in the guideline that not all autistic people will recognise that they are experiencing a mental health condition or feel conformable disclosing their mental health condition to healthcare or other professionals (see Crane L et al 2017. Know your normal - Mental health in young autistic adults. Ambitious about Autism and Centre for Research in Autism and Education, UCL Institute of Education, UK, June 2017. Available at https://www.ambitiousaboutautism.org.uk/the-research) Historically there has been a lack of coordination and collaboration across the disability, mainstream health and	Please refer to the responses to similar comments made by this respondent.

			other sectors. We therefore welcome the recommendation that if a particular Diagnostician does not have the clinical qualifications or expertise to adequately evaluate a potential co-occurring condition for a given individual, then that individual should be referred to a professional who does have the expertise. However, for this to be sustainable it will need to be accompanied by better integration of government services for people with ASD and co-occurring conditions to ensure they have the capacity required to support autistic people (see for example, recommendation by the Victorian Parliament in its Inquiry into services for people with ASD - Final Report, see recommendations 8.5 and 2.2). A co-ordinated approach to training and professional development of mainstream healthcare providers (in the relationship between ASD and co-occurring conditions such as mental health) will also be required if the holistic needs of autistic people are to be met in a meaningful way.	
	ID383		Recommendations: The guideline should outline a prescribed level of training in the identified 'Important Considerations' as a prerequisite for all professionals to diagnose ASD and conduct FSNAs.	The revised Guideline has an additional recommendation that all members of the ASD assessment team have training and expertise in the “impact of other important considerations, such as intellectual and / or communication capacity, culturally and linguistically diverse background and regional or remote location on the ASD assessment.”
	ID384		The different presentation of ASD in autistic women compared to autistic men, as identified in Evidence Table 66, should be highlighted in the guideline itself.	A table has been added to the Gender section that outlines behavioural features that may be more common in females with ASD who have an average or high IQ compared to males with ASD with average or high IQ.
	ID385		The guideline should highlight the importance of all professionals involved in an ASD assessment considering whether the consumer may be masking their autistic characteristics during ASD assessments and/or in their daily life.	Text was added to the topic of ASD signs and/or symptoms under the Stage 2 and 3 Information Collection section to consider:

				“that the client may mask these during an ASD assessment and/or daily life)”
	ID386		The guideline should recommend that all professionals take gender into account when assessing ASD characteristics and functional and support needs.	Text was added to the Stage1, 2 and 3 Information Collection section: “Taking into consideration all relevant Important Consideration”.
	ID387		The guideline should highlight that not all autistic people will recognise that they are experiencing a mental health condition or feel conformable disclosing their mental health condition to diagnosticians.	Text was added to the Stage 1 Information Collection section: “It is important to consider that not all will recognise or feel conformable disclosing other medical conditions, particularly relating to mental health”
	ID388		9.4 & 9.5 Amaze supports the two-tiered approach to diagnostic evaluation outlined in the draft guideline. We agree that a simplified assessment process (Tier 1) is required in cases where an ASD diagnosis can be confirmed or ruled-out with certainty. We also agree that a diagnostic evaluation incorporating a multidisciplinary assessment team (Tier 2) is required in cases where an ASD diagnosis cannot be confirmed or ruled-out with certainty.	Thank you for the comment. No amendment is required in response to this comment.
Fay Whitehead [101]	ID389	Individual - Lived experience	I am pleased to see the inclusion of Pathological Demand Avoidance. My daughter has struggled to raise her child who has been diagnosed with ASD and described by professionals as having PDA. She has followed the same path as so many parents who I am aware of who have struggled their children's behaviour and experienced bewilderment, frustration, despair, accidental hearing about PDA from a friend who has recognised the symptoms as fitting their child, their 'light bulb moment' and immense relief of at last finding a diagnosis that fits. This was followed by a subsequent change in her parenting methods to accommodate her child’s needs. Also,	Thank you for the comment. No amendment is required in response to this comment.

			most importantly, she was able to join a PDA support network of parents, who have been on the same journey and who help each other. The notable and sad aspect of this frequently traumatic journey is the absence of professional knowledge, understanding and diagnosis and hence the need for PDA to be included in this important document.	
Anonymous [102]	ID390	Individual - Lived experience	It is important that the criteria for Pathological Demand Avoidance are included within the document as well because many cases are missed because people are considered to be too social to be autistic. Many with PDA don't have a speech delay and have reasonable eye contact. Unfortunately, their oppositional behaviours can distract from their autistic traits and be considered behavioural rather than rooted in anxiety. This is grossly unfair on parents who have tried absolutely everything to help their children.	Thank you for the comment. No amendment is required in response to this comment.
Royal Children's Hospital [103]	ID391	Organisation – Professional experience	In relation to the report template it appears to include a lot of detail and some repetition. Many families find long reports overwhelming and some experience difficulty reading and comprehending the report. This is something we are particularly mindful of when we see CALD families or parents who may have their own history of learning difficulties.	Thank you for this comment. The revised templates have been simplified to address this important issue.
	ID392		We feel concerned about diagnostic clinicians taking on the role of functional assessment. While some functional assessment is an important part of diagnosis we feel that the extent of the functional assessment outlined in the report proforma is in excess of what can be reasonably accomplished within a diagnostic assessment. Spending additional time conducting an assessment will mean that we can see fewer clients and will add to our already lengthy waiting time. We also do not believe this is the best approach for children and families. Children develop so quickly that functional assessment needs to be conducted in	The structure described in the revised Guideline incorporates considerably more flexibility than the structure described in the original version. Please note that there is no requirement for the diagnostic clinician to be the clinician undertaking the functional assessment. For a description of the changes in this revised version, please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Structure of the Assessment Process • Professional Roles

			an ongoing way and is ideally conducted by the treating professional. Further, given that families already can find the diagnostic process overwhelming it would seem more reasonable to briefly assess a child's functioning as part of the diagnostic assessment allowing the treating professionals to assess the child's functioning as part of treatment evaluation and planning.	
	ID393		Another concern is that there is not a Tier 3 in the model presented. This is problematic in that it provides no clear option for children who might be difficult to diagnose in Tier 2. It also does not recognise that there are tertiary assessment services, such as our team, which are multidisciplinary and employ experienced clinicians for the purpose of completing comprehensive assessments. Here in Victoria we have tertiary assessment services in each of our CAMHS teams and the RCH also has another tertiary level assessment team in the Department of Developmental Medicine. Considering the role of these services and how they might play a role in supporting families who have not been able to be diagnosed in Tier 2 and in providing second options will be important.	Tertiary assessment services for individuals with complex neurodevelopmental disorders are not available in every Australian state. For this reason, a reference to these services was not included in the main figure describing the assessment model in the revised guideline. However, the following text has now been included in the revised draft (Section 10.1): “In some Australian states, tertiary services are available for the assessment of individuals with complex neurodevelopmental disorders. If these services are available, then it is recommended that clients are referred to these services if a consensus decision cannot be achieved at Stage 3.”
	ID394		Although the guidelines speak to the importance of clinical judgement they remain very prescriptive which to some extent devalues the role of clinical judgment. We would suggest that clinicians be encouraged to use their judgment around assessment tools, informants, and the like, with the awareness that what constitutes an appropriate assessment will vary from child to child. Given the varied presentations of ASD being able to adjust and adapt the assessment you are doing is essential. Finally, we see assessments as being therapeutic rather than simply as an information gathering exercise or a hurdle to accessing funding. Ensuring that the focus remains on	Thank you for this feedback. The revised Guideline provides significantly more flexibility for individual clinician choice. For further information about this, please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Use of ‘Standardised’ Instruments

			individual children and their families and enables clinicians to tailor an assessment to them is essential.	
	ID395		The role of the coordinator was unclear. Who will undertake this role and how will they manage these time requirements? There is no clarity about who will follow up with the family post diagnosis. Our research has shown that parents value this and would like to have more of this.	Thank you for this feedback. The revised Guideline provides significantly more flexibility for individual clinician choice. For further information about this, please refer to the 'Overview of Major Amendments' chapter under the heading: • Coordinator
	ID396		In Table 7, it would be helpful to add Paediatricians under trauma and Speech Therapists under behaviour and mental health.	Thank you for this comment. Based on feedback received, this table has been omitted from the revision Guideline, and the information included in the table has been incorporated in other sections of the document.
	ID397		Our concerns relate primarily to how clinicians involved in Tier 2 assessments can initiate further assessment for complex presentations.	Tertiary assessment services for individuals with complex neurodevelopmental disorders are not available in every Australian state. For this reason, a reference to these services was not included in the main figure describing the assessment model in the revised guideline. However, the following text has now been included in the revised draft (Section 10.1): "In some Australian states, tertiary services are available for the assessment of individuals with complex neurodevelopmental disorders. If these services are available, then it is recommended that clients are referred to these services if a consensus decision cannot be achieved at Stage 3."
	ID398		We think it is important to clarify that having direct observation of the child in two different settings is often not necessary and that the common practice of obtaining information from those settings and visiting if further information is needed is sufficient.	Thank you for this feedback. Based on the considerable feedback received regarding the need for flexibility in the assessment model, we have used the following wording: (Section 10.1)

				"It is recommended that the Consensus Team Diagnostic Evaluation involve the collection of information about the individual's participation in all relevant community settings. This information may be obtained through communication with the client and/or other professionals but direct observations by member(s) of the ASD assessment team within some of these community settings may also be helpful."
	ID399		The ADOS is a helpful tool, however it is not a standardised measure in the way that we typically think of standardisation. It has no normative data and it would be preferable to not refer to it as a standardised tool.	Thank you for this comment. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Use of 'Standardised' Instruments
	ID400		We feel it is important to include the term pragmatic language in brackets on Table 8, particularly given that the research often refers to pragmatic language rather than social communication	Pragmatic language has been added as a type of specialist assessment under the social interaction and/or communication domain(s).
	ID401		It is important to note Language Disorder as a differential in Table 16	Language disorder has been listed in the new table on possible differential or co-occurring diagnoses.
	ID402		The CARS is listed as an assessment tool. However, we feel that only the CARS 2 should be listed in terms of promoting the use of current tools	Recommendations relating to specific instruments that measure functioning have been removed from the Guideline, and information about resources will instead be located on the Guideline webpage to enable updates to occur more readily.
	ID403		The ADI-R is not a practical measure to use, given the extensive amount of time it takes to administer and that it often fails to detect the high functioning children. It would be helpful to emphasise the role of a good developmental history rather than the use of the ADI-R	Recommendations relating to specific instruments that measure functioning have been removed from the Guideline, and information about resources will instead be located on the Guideline webpage to enable updates to occur more readily.

	ID404		It's great that there is some recognition of the need to think further about CALD clients. Often, we lack good normative information about what is typical, particularly in some cultures. We do however feel that it is important to prioritise the experience of the family rather than making assumptions about what their experience or perception might be and perhaps this could be emphasised	Thank you for this feedback.
Beth Mozolic-Staunton [104]	ID405	Individual - Lived and professional experience (F,PR,PD,PS)	Overall, I think the guideline is well structured, comprehensive and takes a holistic and strengths-based approach to the assessment and diagnosis of autism spectrum disorders. I think the scope of practice of Occupational Therapists is well recognized and supported within the guidelines. I think the implementation of this guideline will improve rates of early detection and facilitate access to quality services and supports for children and families.	Thank you for the comment. No amendment is required in response to this comment.
	ID406		I need to make you aware that Adele Suda left her position at Southern Cross University suddenly in early 2017. As I was a colleague working in ASD research at the same university, Adele passed my name along to Kiah to take up the role on the committee. I was then contacted by Susanne Nelson, with whom I worked extensively to develop the guidelines on behalf of Occupational Therapy throughout 2017. Adele Suda did not contribute at all to this process, did not clearly communicate a handover of her commitments related to development of the guidelines to myself, Kiah or Susanne and should not be named as a contributor.	Clarification was added to the Guideline and Technical Report that Ms Adele Suda discontinued her involvement in the Steering Committee, and was replaced by Ms Susanne Nelson.
	ID407		I support/endorse the feedback provided by Occupational Therapy Australia. In particular, I do not support the requirement for Occupational Therapists in the role of diagnostician to be registered with the Better Access to Mental Health program (6.4.1). I agree that the most experienced occupational therapists who are likely to take up	Please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Qualifications for occupational therapists

			a leadership role as diagnosticians for our profession will be from paediatric and developmental health backgrounds. I would support collaboration and referral to a mental health professional within the multidisciplinary team approach (which may or may not be an OT) as appropriate to the situation. I also strongly agree that Occupational Therapists should not be subject to requirements that are more onerous that those required for our colleagues in Speech Pathology and Psychology. A strength of these guidelines is the recognition of equivalence of expertise across disciplines of professionals who have expertise in this area of practice.	
	ID408		I would also like to add in Table 4, that the Social Attention and Communication Surveillance tool (SACS-R) should be added as a commonly used screening tool by parents and carers (including nurses and early childhood education professionals). This tool has been developed in the Australian context and robust psychometric properties have been demonstrated in several studies (Barbaro et al, 2010, 2011, 2013). The SACS-R is currently being implemented across Australia and while it is relatively new, it should be included in this best practice guideline.	Recommendations relating to specific instruments that measure functioning have been removed from the Guideline, and information about resources will instead be located on the Guideline webpage to enable updates to occur more readily.
	ID409		Table 7: I think that Occupational Therapists should be included as diagnosticians and informants for behavioural concerns (Behavioural concerns that may include - compulsive behaviours, tic disorders, selective mutism, excessive challenging behaviour and/or tantrums) as this is explicitly included in the undergraduate degree for OT. I also agree with other comments about OT being included in the section on sleep.	Thank you for this comment. Based on feedback received, this table has been omitted from the revision Guideline, and the information included in the table has been incorporated in other sections of the document.
	ID410	Organisation -	Green font is very hard to read.	The green font will be changed in the final guideline.

Occupational Therapy Australia [105]	ID411	Professional experience	4.1 Occupational Therapy Australia supports the principle of the approach to ASD diagnosis being both individual and family centred. 4.2 Occupational Therapy Australia support the use of a holistic approach to assessment, which takes into account the unique strengths of a person, their physical and mental performance components, and their environment, at a minimum. The WHO ICF is a good framework to apply to ensure this, and fits well within most professional philosophies, occupational therapy included. 4.3 Occupational Therapy Australia supports a focus on strengths within the assessment. 4.4 Occupational Therapy Australia supports the use of the best available evidence at all times in clinical practice, and the guideline expresses well the challenge of applying evidence to subjective clinical judgement, and agrees with the guideline's statement that this is ethical practice.	Thank you for these comments.
	ID412		5.1 Occupational Therapy Australia supports the need for a comprehensive ASD assessment to include both a diagnostic evaluation and an assessment of functional and support needs. 5.2 Occupational Therapy Australia supports the recommendation for a central coordinating person when multiple professionals are involved in a comprehensive assessment process.	Thank you for this feedback.
	ID413		6.1 Occupational Therapy Australia supports the principle that the consumer is an essential participant and provider of critical information in the ASD assessment process.	Thank you for these comments. Please note that, based on considerable feedback, amendments have been made to the Referral for an Assessment of ASD Concerns and Coordinator sections of the Guideline. For further information,

			6.2 Occupational Therapy Australia support the notion that a Referral for an Assessment of ASD Concerns could be from a range of backgrounds and includes consumers and professionals. If a professional, Occupational Therapy Australia concurs that there should be a solid understanding of ASD precipitating the referral. 6.3 Occupational Therapy Australia is supportive of the role of the coordinator (see item 5.2 above), and welcomes the statement that a coordinating person may be from an allied health background, and supports the requirement for them to have specific expertise as detailed in item 6.3.2.	please refer to the 'Overview of Major Amendments' chapter under the headings: • Referral for an Assessment of ASD Concerns • Coordinator
	ID414		6.4 Occupational Therapy Australia welcome the recommendation that a diagnostician in ASD comes from a specific professional background, and has additional knowledge and expertise in the area of ASD.	Thank you for this feedback.
	ID415		Occupational Therapy Australia particularly welcomes the inclusion of registered occupational therapists, and who have the additionally required knowledge and expertise as able to complete a diagnostic evaluation. However, there was concern amongst the OT community of expert practitioners in paediatrics that the additional requirement of BAMHS registration may not appropriate to all practitioners, due to its focus on mental health rather than ASD specifically. Occupational Therapy Australia note however that there are no other similar accredited programmes available at this current time that would be a better fit, so can understand why this criterion was included in the guideline as it as a way of ensuring 'Best practice'. The diagnostician role is to be considered an advanced practice role, so ideally requires some accreditation ASD presents with so many secondary mental health symptomatology and vice versa, some mental health	This recommendation in the original version of the Guideline was based on a previous submission to the Executive Committee from Occupational Therapy Australia. This has now been amended in the revised version of the Guideline.

			disorders mimic symptoms of ASD, it's important OTs have this understanding and knowledge. However, the current BAMHS accreditation programme is not a good fit for OTs working with younger children particularly as it does not focus well on these issues, and OTs in the early intervention sector will not necessarily have built up the skill level required to achieve BAMHS accreditation, so the committee may wish to look further into this issue. We note that other health professions are not required to undertake this kind of certification in order to act as diagnosticians, according to the guideline.	
	ID416		6.4.2 Occupational Therapy Australia are pleased to see the comprehensive and rigorous list of additional knowledge and expertise that would be required for a professional to be a diagnostician. Table 3. Occupational Therapy Australia recommend reviewing this list to include additional information, as the role of occupational therapists goes beyond comprehensive assessment and sensory work. In fact, Occupational Therapy Australia have concerns about the inclusion of 'sensory assessments' here, as within the profession there has been considerable discussion about the use of sensory models and approaches in isolation from an occupational approach (considered to be best practice in Occupational Therapy Australia's Guide to Good Practice with Children and Young People). We would like to see the wording 'sensory assessment' in table 3 altered to 'sensory contribution'.	This description has been expanded to: “Allied health practitioners who have skills and expertise in the assessment and treatment of personal, activity and environmental factors to assist meaningful participation in activities and life roles across the lifespan, along with skills and expertise in sensory and motor systems.”
	ID417		6.5 Occupational Therapy Australia welcomes the inclusion of registered occupational therapists as functional and support needs assessors, and again welcomes the additionally required knowledge and expertise that would be required for a professional to take on this role.	Thank you for this feedback. Based on feedback received, the specified role of ‘functional and support needs assessor’ has been omitted from the revised Guideline. However, the Guideline still emphasises the importance of comprehensive needs assessment as forming the foundation of an ASD

				assessment. For further information, please refer to the ‘Overview of Major Amendments’ chapter under the headings: • Structure of the Assessment Process • Professional Roles
	ID418		6.6 Occupational Therapy Australia welcomes the inclusion of the role of Professional Informant, which occupational therapists who do not complete the roles of diagnostic evaluation or functional and support needs assessor may take on, and concurs with the need for professional informants to have and maintain current knowledge and experience in the area.	Thank you for this feedback. Based on feedback received, the specified role of ‘professional informant’ has been omitted from the revised Guideline. However, the Guideline still emphasises the importance of collecting information from a variety of sources, and from individuals who observe the client in community settings. For further information, please refer to the ‘Overview of Major Amendments’ chapter under the headings: • Structure of the Assessment Process • Professional Roles
	ID419		For Tier 1 level assessments, Occupational Therapy Australia recommend that it may be prudent to suggest that 2 Professional Informants are involved, one of whom explores other medical explanations for the presenting symptoms	Thank you for this comment. We believe that the revised structure addresses this concern. For further information, please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Structure of the Assessment Process • Professional Roles
	ID420		7.1 Occupational Therapy Australia support the need for comprehensive assessment to be carried out in a range of environments. It is worth commenting that for this to happen, assessors will need to have this recognised by funding bodies in order to ensure adequate travel and time is reimbursed.	Thank you for this information. A recommendation regarding this point has been added to the revised Guideline. Please refer to the ‘Overview of Major Amendments’ chapter under the following heading: • Practice points for clinical, research and policy settings

	ID421		7.2 Occupational Therapy Australia agrees that it is not vital for assessment to take place in a clinic setting, and that in fact comprehensive assessment can take pace in a range of settings, with function in a community environment being particularly crucial to comprehensive assessment findings (7.2.2) 7.2.3 Occupational Therapy Australia welcomes the inclusion of telehealth within the assessment protocol in order to increase access to services for people from rural and remote settings, with the use of a Professional Informant.	Thank you for this feedback. These elements have been retained in the revised Guideline.
	ID422		Occupational Therapy Australia supports the use of developmental screening tools prior to referral for an ASD assessment, and that this referral is based on clinical reasoning and judgement, and this rationale is included in referral documentation. Occupational Therapy Australia welcomes the additional factors to consider when making a referral in Table 5, with the caveats expressed below the table.	This table has been omitted from the revised version of the Guideline. For further information, please refer to the 'Overview of Major Amendments' chapter under the heading: • Referral for an Assessment of ASD Concerns
	ID423		Occupational Therapy Australia welcomes the potential for occupational therapists to act as either diagnostician or professional informant, depending on the situation, and welcomes the use of intact settings for assessment as well as a range of sources of information (9.4.2 and 9.4.3). It is the view of Occupational Therapy Australia that the draft guideline provides a clear outline as to a best practice assessment process, with shared responsibility amongst professionals for making a diagnosis depending on the situation. Occupational Therapy Australia are happy with the areas outlined for particular occupational therapy involvement, but caution against the use of the word 'specialist' as our regulator (AHPRA) has some issues with the use of this word - the word specialist is used through section 9 quite liberally, at times related to occupational therapy. We would suggest replacing this with 'expert' or 'experienced'.	Thank you for these comments. Based on extensive feedback, the structure of, and Professional Roles within, the assessment process has been revised. For further information, please refer to the 'Overview of Major Amendments' chapter of this document. The revised Guideline includes a recommendation that Occupational Therapists are able to form part of the consensus team for diagnosis (Stage 3). The term 'specialist' has been deleted or replaced, unless it is part of a specific definition (e.g. specialist registration with the Medical Board of Australia).

	ID424		Occupational Therapy Australia recommend that the COPM - Canadian Occupational Performance Measure assessment tool be added to the list of available tools.	Recommendations relating to specific instruments that measure functioning have been removed from the Guideline, and information about resources will instead be located on the Guideline webpage to enable updates to occur more readily.
	ID425		It is the view of Occupational Therapy Australia that the draft guideline provides a clear outline as to a best practice assessment process, including the communication of results.	Thank you for this feedback.
	ID426		Occupational Therapy Australia particularly welcomes the inclusion of these important considerations in the draft guideline.	Thank you for the comment. No amendment is required in response to this comment.
Anonymous [106]	ID427	Individual - Professional experience (PD)	Just a point on the recommendation in 6.4.1 Professional Discipline. The recommendation is for 'Speech pathologists who are a Certified Practicing Member of Speech Pathology Australia are eligible to be a Diagnostician.' This recommendation is inconsistent with NSW health, NDIS and HCWA funding service provider requirements. In NSW, the main employer of SPs involved in ASD diagnosis require is NSW Health. SPs employed by NSW Health are not required to be members of SPA nor Certified Practising Speech Pathologist (CPSP) of SPA, rather eligible to join SPA. To be an NDIS provider requirement is to be a SPA member (but not CPSP). HCWA funding required SPs to be a 'Practising Member' of Speech Pathology Australia and not CPSP (although the preferred standard for SPs was to be CPSP).	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Qualifications for speech pathologists
	ID428	Organisation -	The inclusion of applying strengths-focussed, and family/individual centred principles in regard to the	Thank you for the comment. No amendment is required in response to this comment.

Diverse Minds Psychology Clinic [107]		Professional experience	assessment process was considered as a valuable aspect of the guidelines.	
	ID429		It was suggested that for a Tier one assessment, that the diagnostician role should be limited to Consensus Based Recommendation (CBR) level 1, given the requirement at this level in relation to the diagnostic team is a minimum of one diagnostician and one professional informant. The only exception to this would be a psychiatrist with specific ASD experience and training. It was considered that currently there does not seem to be enough strong evidence to support the capacity of CBR 2, 3, and 4 level clinicians to be responsible for providing an ASD diagnosis in a Tier 1 assessment (Sections 3.4.4, and 6.4). Importantly, the Tier 1 diagnostician could not be reasonably expected to make certain a conclusion as to the presence or absence of symptoms or conditions for which they have not received specialist training in. This is important when being aware of the possible differential diagnoses or alternative explanations that may appear to be ASD (e.g. other mental health related explanations).	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Professional Roles • Structure of the Assessment Process
	ID430		With respect to the professional discipline required for the Coordinator Role (Section 6.3.1) it was suggested that it would be difficult for an administrator to fulfil the tasks of the role, particularly in respect to explaining the ASD assessment process. It was indicated that only those with clinical expertise would have sufficient training to be able to inform the client of the process to the extent that they can provide informed consent as to do or not do the assessment	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Coordinator Role
	ID431		In relation to expertise in ASD, it was also mentioned that experience and competency in this area, are not always indicated by professional title alone and that there needs to be consideration of experience, years of practice, settings of	The Guideline recommends that all clinicians involved in the assessment process has 'relevant training and expertise'. The training and expertise is defined on page 24 of the Guideline, and includes expert knowledge and experience in typical

			practice, and training when considering professional contribution to assessment of ASD	development in the age range in which the clinician' practices'.
	ID432		The two-tiered approach to assessment to support efficient, valid, and timely assessments, both in complex and straight-forward presentations of ASD. The clear descriptions of 'the basics' of what should be included for an ASD assessment. This was considered as very useful for clinicians with limited experience with ASD populations, to enable capacity building in ASD assessment at a time when there is an increased demand for this service.	Thank you for this feedback.
	ID433		In relation to Tier 2 diagnostic evaluation, specifically with respect to the assessment of general function or adaptive behaviour difficulties, it was suggested that limiting diagnostician role to a registered psychologist with a clinical speciality may be excessive, particularly given that many registered psychologists without clinical specialty working in the disability field, often as behaviour support practitioners, have extensive experience in the process of functional assessment. As such, this could limit the efficacy and timeliness of an ASD assessment. Perhaps, the competency required for this component of a Tier 2 assessment could be adapted to include registered psychologist with recognised training (such as Institute for Applied Behaviour Analysis (IABA) Training) and experience in assessing function and adaptive behaviours).	Please refer to the 'Overview of Major Amendments' chapter under the heading: • Qualifications for Psychologists
	ID434		The inclusion of functional and support needs assessment, in particular, reference to tools and activity areas to review in such an assessment, as well as clarifying the scope of a support needs assessment which will assist in ensuring an efficient and timely assessment process.	Thank you for this comment.

The Australian Autism Alliance [108]	ID435	Organisation - Professional experience	The Guideline is comprehensive. However, there is significant potential difficulty in implementation in a manner that meets the needs of clinician and diagnosticians. A clear implementation and communication plan will be the required next step to ensure effective engagement of various professionals and the development of resources and information that is clearly and easily understood. This is particularly critical given that a majority of diagnoses tend to occur in private practice.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Implementation and Evaluation of the GuidelinePractice points for clinical, research and policy settings
	ID436		We support the four principles identified in the Guideline. We would also add: • Accessible for all irrespective of race, age, ethnicity, socio-economic background, age, geographical location etc • Timely - wait times need to be no longer than three months • Affordable - across the lifespan. Either government funding to increase assessment service options needs to be extended or the current age limit and rebate amount for Medicare assessment items needs to be lifted • Alignment with other assessment processes (Education, NDIS, Health, Centrelink etc) with a view to reduce duplication • Benchmark standards for education and training of diagnosticians, especially those undertaking Tier 1 assessments • Sensitivity do the different presentations need to be considered (e.g., adults, females)	The revised Guideline has added 'equity' (dot point #1 in comment) and 'lifespan perspective' (dot point #2 in comment) as guiding principles, as well as a recommendation regarding the ideal maximum wait times (Section 6.3). The other recommendations have been incorporated as future recommendations. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Practice points for clinical, research and policy settings
	ID437		Completing a functional and support needs assessment is important to identify the person's support needs in addition to the diagnostic evaluation. Therefore, we consider this to be an important inclusion in the Guideline and note that there is	Thank you for this comment. We have highlighted this potential issue in the future recommendations section. Please refer to the 'Overview of Major Amendments' chapter under the heading:

			some flexibility whereby the functional assessment can be completed subsequent to the diagnostic assessment. As above, completing this kind of assessment will utilise additional time and resource thereby increasing costs and waitlists as outlined for Tier 2 assessments described above.	• Practice points for clinical, research and policy settings
	ID438		Comments on Tier 1 The Guideline states that 'A Tier 1 Diagnostic Evaluation recognises that there are a proportion of individuals whose presentation is sufficiently clear that a diagnostic decision can be reliably made with certainty by a limited number of experienced members of a multidisciplinary assessment team' (p. 35). The two-tier process is clearly aimed at avoiding 'over-assessing' of individuals who clearly meet criteria for autism and to have some flexibility (e.g., in the case of adults). This is preferable compared to prescribing multi-disciplinary assessments for everyone regardless of age or presentation. The failure to include at least one standardised ASD diagnostic tool as is the case for Tier 2 is an omission. The guidelines are set out such that everyone begins at a Tier 1 level and only progresses to Tier 2 if the diagnostician is of the opinion that this is necessary. At this stage there are no clear ways of verifying the skill set of a Tier 1 diagnostician other than the description in the guidelines. The inclusion of at least one standardised assessment at Tier 1 would at least be one way of ensuring some level of expertise and awareness of autism assessment tools at this level.	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Use of ‘Standardised’ Instruments
	ID439		There have been concerns raised regarding the validity of OTs and Speech Pathologists being sole diagnosticians. Clearly, there need to be benchmark standards for education and training of diagnosticians (and these are included in the	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading:

			Guideline). What the Guideline seems to lack is a recommendation regarding appropriate quality control mechanisms to ensure consistency in practice, process and pricing across the spectrum and across the lifespan. There is no monitoring mechanism for the level of training nor the validity of diagnostic evaluation. As an example, in South Australia, all diagnoses are verified by an expert panel to ensure diagnostic integrity. Comments on Tier 2 -Tier 2 requires observation in two or more settings. This will be problematic for families living outside of metropolitan areas and will also result in significant additional cost for any families who opt to pay privately for an assessment due to unacceptably long waitlists for publicly funded assessments. If this requirement remains it will be very important to advocate for increased Government funding for assessment services via Medicare rebate which has not changed since HCWA was introduced in 2008 and through increased funding for government assessment centres. The two-tier process potentially creates a financial barrier whereby individuals needing to undertake the entire assessment process are required to pay more. Both Tier 1 and Tier 2 require that a medical evaluation be completed prior to assessment. For most young children who have developmental delays a comprehensive medical evaluation is critical prior to or as part of an autism assessment. Many older children and adults who present for assessment have been reviewed by doctors many times in the past and a requirement that they seek out further medical assessment prior to the autism diagnosis in these cases is probably unnecessary. However, it is noted that the guidelines provide a medical evaluation form which can be easily completed by a GP therefore this aspect of the guidelines is not one that we have a particular concern as there is some flexibility allowed for cases as described.	• Structure of the Assessment Process • Professional Roles • Accreditation and Regulation • Practice points for clinical, research and policy settings

Association for Behaviour Analysis Australia [109]	ID440	Organisation - Professional experience	3.4.3 The Association for Behaviour Analysis Australia (ABA Australia) would like to be part of future steering committees in relation to concerns and issues for children and adults with an Autism Spectrum Disorder and their families and caregivers. In this case, ABA Australia would like to offer comments in relation to the Draft Guidelines for ASD diagnosis in Australia.	Thank you for providing feedback. Membership of the Steering Committee was finalised within the first month of this project, and there is currently no scope to increase membership of this Committee.
	ID441		6.4.1 It is concerning that Occupational Therapists and Speech Therapists have been included as primary diagnosticians rather than in a diagnostic supporting role. This will increase the likelihood of diagnostic error or possible over diagnosis given the lack of specialization offered within these professionals training courses. Additionally, a speech therapist and an occupational therapist may not understand the complexity of possible differential diagnosis options. It widens the possibility that an Allied Health provider may provide a diagnosis for an individual to access funding and in turn that individual may then use that funding within the same Allied Health provider's service, this is setting up multiple opportunities for conflicts of interest. Psychologists are the only Allied Health professionals trained specifically in using the DSM/ICD diagnostic manuals.	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Professional Roles • Structure of the Assessment Process
	ID442		6.5.1/6.5.2 Functional and Support Needs Assessors. Board Certified Behaviour Analysts (BCBA) have a Masters level education in either Psychology, Applied Behaviour Analysis, and/or Special Education. They have completed a 1500-hour supervised placement and passed an internationally certified exam. The majority of a BCBA's clients have an ASD. By the time a BCBA has reached certification level they are as equally qualified, if not more qualified, as an Allied Health professional in supporting a person with an ASD. A BCBA has extensive experience in collecting information from parents, caregivers, education staff and other Allied Health professionals, identifying functional capacity, determining level of support needs, referring Consumers to supports, and	Please note that the revised Guideline incorporates substantial changes to the Structure of the Assessment Process and associated Professional Roles . For further information, please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Professional Roles • Structure of the Assessment Process If a BCBA also meets the requirements outlined in Section 4.2 (e.g., a psychologist registered with AHPRA), there is no

			sharing assessment findings with Consumers; all of these points are part of a BCBA's course work for certification. A BCBA has an extensive knowledge and expertise in ASD. Currently in Australia as part of treatment, BCBA's run functional and support assessments to design an individual's treatment plan and review an individual's treatment progress. It would be relevant and applicable to add a Board-Certified Behaviour Analyst (BCBA) to the list of professionals that are eligible to be a Functional and Support Needs Assessor. 6.6.1/6.6.2 Further to the points above a Board-Certified Behaviour Analyst (BCBA) should be added to the list of Professional Informants. A BCBA has a 5-year + degree with relevant Masters level course work, plus hands on experience with clients with an ASD. A BCBA is experienced with child development via their Masters degrees in either Psychology, Applied Behaviour Analysis, or Special Education.	preclusion from these professionals being incorporated into the assessment process at Stage 1 or Stage 3.
	ID443		10.3 as stated above i6.5.1/6.5.2 Functional and Support Needs Assessors. Board Certified Behaviour Analysts (BCBA) have a Masters level education in either Psychology, Applied Behaviour Analysis, and/or Special Education. They have completed a 1500-hour supervised placement and passed an internationally certified exam. The majority of a BCBA's clients have an ASD. By the time a BCBA has reached certification level they are as equally qualified, if not more qualified, as an Allied Health professional in supporting a person with an ASD. A BCBA has extensive experience in collecting information from parents, caregivers, education staff and other Allied Health professionals, identifying functional capacity, determining level of support needs, referring Consumers to supports, and sharing assessment findings with Consumers; all of these points are part of a BCBA's course work for certification. A BCBA has an extensive knowledge and expertise in ASD. Currently in Australia as part of treatment, BCBA's run functional and support assessments to design an individual's treatment plan and review an individual's treatment progress. It would be relevant and applicable to add	Please see response above.

			a Board-Certified Behaviour Analyst (BCBA) to the list of professionals that are eligible to be a Functional and Support Needs Assessor. 6.6.1/6.6.2 Further to the points above a Board-Certified Behaviour Analyst (BCBA) should be added to the list of Professional Informants. A BCBA has a 5-year + degree with relevant Masters level course work, plus hands on experience with clients with an ASD. A BCBA is experienced with child development via their Masters degrees in either Psychology, Applied Behaviour Analysis, or Special Education. It would be relevant and applicable to add a Board-Certified Behaviour Analyst (BCBA) to the list of professionals that are eligible to be a Functional and Support Needs Assessor. Limiting Functional and Support Needs assessors and Professional Informants to currently recognized Allied Health professionals and or Medical Professionals may limit the treatment options that ASD diagnosed are exposed to and possibly bias treatment options to Speech Therapists, Occupational Therapists, and Psychologists only. Board Certified Behaviour Analysts (BCBA) are exceptionally trained and experienced in supporting people with an ASD from early intervention through to adulthood. By excluding BCBA's from being part of the diagnostic process as Support Needs Assessors and Professional Informants you are essentially limiting people with ASD from accessing evidence-based treatment options. People with ASD deserve the right to understand all the evidence-based treatment options available to them and to make an informed choice as to which treatment option they would like to undertake. As expressed above, BCBA's have extensive training and experience in providing functional and support needs assessments, and linking clients to evidence-based treatment options. Information about the individual's interaction between their function and environment within all relevant community settings may be obtained through a combination of:	

			• Direct observation of the individual in natural environments; • Review of video recordings of the individual in natural environments; and/or • Verbal or written report (including file review) from the Professional Informant(s) BCBA's undertake each of these points with their clients on a regular basis and are well placed to provide information as a professional informant supporting functional needs in the client's natural environment. The Functional and Support Needs Assessor can provide guidance on the type of supports that will assist the individual and/or their caregivers to address these prioritized support needs and goals through overcoming limitations / barriers and optimizing strengths / facilitators. Where required to access a service, the Functional and Support Needs Assessor can make a referral to appropriate service providers to ensure these supports are implemented. It is imperative that BCBA's are represented as strongly as currently recognized Allied Health practitioners. BCBA's primary client group are people with ASD, their training and experience is evidence-based and recognized as gold standard treatment in the USA, Canada, New Zealand, and Ireland.	
	ID444		9.5.2 in table 7, examples of professional informants Board Certified Behaviour Analysts (BCBA) should be added to the sections 'Behavioural concerns that may include -compulsive behaviours, tic disorders, selective mutism, excessive challenging behaviour and/or tantrums' and 'General function or adaptive behaviour difficulties in one or more activity area that enables an individual to fully participate in life (e.g., self-care, play, school, employment or community safety)'. Both areas are areas where BCBA professionals specialise and have extensive training and experience.	Thank you for this comment. Based on feedback received, this table has been omitted from the revision Guideline, and the information included in the table has been incorporated in other sections of the document.

Deakin Child Study Centre, Deakin University [111]	ID446	Organisation - Professional experience	We have provided the general comment above after considering all of the information provided by the Autism CRC for community comment.	Thank you for providing feedback.
	ID447		The assessment and diagnosis of Autism Spectrum Disorder (ASD) can be a challenging task given the variable presentation of individuals presenting with autistic symptoms and that many other developmental, psychiatric and medical problems can overlap with, or cause, these presentations. Guidelines for the assessment of ASD need to be evidenced based, practical to implement within clinical practice, and affordable, accessible and in the best interests of families and individuals. We have the following major concerns with the proposed guideline from the Autism CRC: We feel the guidelines are too prescriptive, formulaic and restrictive and lack a broad developmental focus. These guidelines will likely result in high cost to consumers and a lack of consideration of other diagnoses or reasons that an individual might present with autistic like symptoms. This will potentially result in misdiagnosis and some individuals (most likely those most vulnerable in our society) missing out on a diagnosis due to the complex and burdensome nature of the diagnostic process	Thank you for providing this feedback. The assessment model has been revised substantially to provide additional flexibility, and a Emphasis on the Importance of Functional Abilities in Referral for Supports. For a summary of the changes, the ‘Overview of Major Amendments’ chapter.
	ID448		While we believe the guidelines are generally too prescriptive they also overlook the major tenant of autism guidelines worldwide and current Australian best practice by use of Tier 1 diagnosis by Speech Pathologists, Occupational Therapists and Psychologists without the requirement of a medical practitioner (paediatrician/psychiatrist). Tier 1 diagnoses by one diagnostician will be highly problematic in that an individual presenting as 'sufficiently clear' as having ASD may actually have a different underlying cause for their apparent autistic symptoms. A medical assessment should always be required to exclude other possible underlying causes. While	Thank you for the comment. A medical evaluation was a requirement of every diagnostic assessment in the previous draft of the Guideline This element has been retained in the revised Guideline.

			the purpose of the Tier system may have been to increase access to ASD assessments it will likely have the repercussions of misdiagnosis and increased ASD prevalence in Australia.	
	ID449		There is a lack of consideration for what families and individuals need from a diagnosis and the diagnostic process. For example, the inclusion of diagnostic criteria in reports may not be very helpful for most families/individuals with ASD. The diagnostic criteria are for professionals and not lay people, hence these may be misinterpreted by families/individuals resulting in conflict re the findings. While this may be of significant research value to tick which specific symptoms are/are not met these could do harm to the experience of families/individuals. Including this information is contrary to what is specified in the guidelines about a report: 'Worded in language suitable for a layperson audience (i.e. jargon is either excluded or clearly defined)'	Evidence from the extensive consultation undertaken as part of the development of this Guideline indicated that consumers (parents and autistic individuals) had a strong desire for greater transparency regarding the ASD diagnostic process, including the diagnostic criteria relevant to their child/themselves. For this reason, this element has been retained in the revised draft.
	ID450		There is a general lack of consideration of adult ASD assessments - this includes a lack of focus on differential ASD diagnoses in adults (for example Personality Disorders, Eating Disorders);	The table describing potentially differential diagnoses and comorbid conditions included a range of diagnoses and alternative clinical explanations more relevant to adults, including personality disorders. Eating disorders were not included in this table in the original Guideline, and has been included in the revised Guideline.
	ID451		[There is a general lack of…] inappropriate report templates for adults, and a lack of guidelines for adult tools to assist in the diagnosis of ASD, and lack of research evidence for the use the ADOS in adults (particularly those without intellectual impairment).	Thank you for this feedback. Recommendations relating to specific instruments that measure functioning have been removed from the Guideline, and information about resources will instead be located on the Guideline webpage to enable updates to occur more readily

	ID452		It would be inappropriate and potentially damaging for adult clients to view them in any setting other than the clinic, yet this is a rule of Tier 2 assessment.	Thank you for this comment. Based on the considerable feedback received regarding the need for flexibility in the assessment model, we have used the following wording: (p.51): "It is recommended that the Consensus Team Diagnostic Evaluation involve the collection of information about the individual's participation in all relevant community settings. This information may be obtained through communication with the client and/or other professionals but direct observations by member(s) of the ASD assessment team within some of these community settings may also be helpful."
	ID453		While these guidelines might appeal to researchers for fidelity of diagnosis of research participants, we feel they are inappropriately detailed and burdensome for Referral for an Assessment of ASD Concernss, clinicians, families and individuals with ASD. These guidelines are written more as rules than guidelines which are too rigid and will be difficult for clinicians to implement. For example, statements such as 'should' and 'must' are not guidelines but are rules.	Consistent feedback from consumers and the clinical community indicated a strong desire for guidelines that provided a consistent framework through which ASD behaviours can be appraised. The aim was to produce a Guideline that describes a process that is both flexible enough to be tailored to an individual's behavioural presentation, but also ensure that a comprehensive assessment is conducted with all individuals to guide their future clinical management. We note that the use of 'should' is standard practice in clinical practice Guidelines, including for other complex neurodevelopmental conditions. Please see here for a document outlining clinical practice points for the diagnosis, assessment and management of ADHD.: https://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/mh26_adhd_cpp_2012_120903.pdf We agree that flexibility is key component of the clinical management of children and adults with neurodevelopmental conditions, and have omitted the use of the prescriptive term 'must' in the document. The revised structure of the Guideline also provides substantially more flexibility for the assessment to be tailored to the individual being assessed as well as to the large range of settings and services in which assessments

				take place. For further information on this, please refer to the 'Overview of Major Amendments' chapter under the heading: • Structure of the Assessment Process
	ID454		While access to services are based on a diagnosis rather than a functional impairment there will be significant discrimination for service access based on diagnosis. Many will miss out on the services they need, particularly the underprivileged and vulnerable members of society who do not have the social and economic capacity to understand and navigate the complex system that has been established to access services. Prevalence rates will increase when a specific diagnosis permits funding for service provision - as seen with the rapid ASD prevalence rise in Australia since the introduction of Helping Children with Autism Package which necessitated an ASD diagnosis to access early intervention services. Instead of the focus on diagnosis, funding agencies should refocus on the tenant of early intervention - that children who are not functioning and participating in life and society are given service access to improve their developmental trajectories - rather than the insistence of an early label which can have lifelong implications for the child and their family. The focus should be on 'what is happening for this child' and 'how can we help them?', rather than 'do they have autism?	Thank you for this comment. The revised structure provides far greater emphasis on the importance of a comprehensive functional and needs assessment in providing the foundation for a diagnostic evaluation. For further information on the specific amendments, please refer to the 'Overview of Major Amendments' chapter under the heading: • Structure of the Assessment Process
The Australian Psychological Society [112]	ID455	Organisation - Professional experience	The APS acknowledges the challenges for community members seeking diagnostic assessments for ASD and the complexity of assessment issues confronting clinicians undertaking such assessments. The Society therefore applauds the decision to develop national guidelines for the assessment of ASD. However, the APS has serious concerns about many aspects of the draft Guideline and in its current form, cannot endorse the document. The APS would be	Thank you for this feedback.

			pleased to work collaboratively with Autism CRC to address the weaknesses in the draft Guidelines. In summary, the APS is eager for national guidelines for the diagnosis of ASD to be available in Australia but cannot support the draft document in its current format. The APS would be pleased to be part of a working group to assist Autism CRC to revise the document.	
	ID456		6.3 Coordinator Role -The draft Guideline states that one person should be assigned to coordinate the assessment process; this would be very difficult when multiple private practitioners are involved in the diagnostic process. Moreover, some of the state tasks are unrealistic such as 'ensuring all documents are completed and shared in a timely fashion.' Private practitioners are extremely variable in terms of their timelines regarding reports. There would need to be specific instructions related to what is meant by a 'timely fashion'. In brief, appointing a separate coordinator or expecting a diagnostician in private practice to take on this role in addition to their assessment work is likely to add significant cost to the family. The situation in the public health sector is different, where funds are provided for administrative staff to perform this role, although this support is minimal in many school environments. The APS acknowledges that in the case of a Tier 1 assessment, the diagnostician would be the one to coordinate all the information collected as part of their assessment, so it would be appropriate for them to act as a coordinator. However, in the case of Tier 2 assessment, particularly with multiple organisations involved, rather than there being one coordinator, it should be the responsibility of each clinician/diagnostician to advise the family regarding the process for their part of the assessment and how it fits in the overall picture for an ASD diagnosis. If multiple assessments are occurring at the same time, it would be preferable for the client to consent for clinicians to be in contact by phone or	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Coordinator Role Please also note that the revised Guideline includes a recommendation regarding costs for ASD assessments. Please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Practice points for clinical, research and policy settings

			email to discuss their diagnostic impression of the client. Each diagnostician should also provide feedback for their part of the assessment. Families should have the opportunity to speak to each diagnostician during or following feedback regarding the results if they have questions.	
	ID457		6.3.2 ASD Specific Expertise - It is appropriate that the Guidelines make explicit reference to competency and currency of practice. The APS recommends that the Guidelines make more explicit the need for diagnosticians and functional and support needs assessors to undertake specific formal training programs, as well as ongoing learning to ensure currency of practice. The draft Guidelines (section 6.4.2, p. 16-18) propose that occupational therapists and speech pathologists should be able to individually and independently diagnose ASD (if they think this is clear and they have extra training in ASD assessment). This represents a major departure from international standards. Conducting an assessment for ASD involves not just having skills in ASD but involves the consideration of the individual's presentation, one of which might be ASD. It is critical to be aware of typical human development and what other disorders or conditions that might better account for an individual's presentation (e.g., ADHD, anxiety disorders, behaviour disorders, intellectual disability, medical conditions or developmental conditions (see Table 15). It is the overall developmental picture of the child that has resulted in paediatricians and psychologists being considered as the main professional groups able to make diagnostic conclusions. The above skill set is part of the basic training and daily work of paediatricians and psychologists who work with children and young people. These skills do not form part of the training or daily work of speech pathologists or occupational therapists. The APS does not recommend that such professionals take up roles as primary diagnosticians	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Professional Roles • Structure of the Assessment Process • Accreditation and Regulation • Practice points for clinical, research and policy settings

			with ASD, although their inclusion and expertise is invaluable as part of the multidisciplinary diagnostic team.	
	ID458		The draft guidelines state that diagnosticians must demonstrate 'at least four years full time equivalent of postgraduate experience that is directly relevant to ASD Diagnostic Evaluations, obtained through university qualifications, formal training programs and/or formally supervised work experience' (p.17). The APS has several concerns with this requirement. The requirement for four years 'postgraduate experience' obtained through 'university qualifications, formal training programs and/or formally supervised work experience' is extremely unclear. The APS recommends the term 'postgraduate' be removed for greater clarity. Moreover, most clinicians will not only be seeing and diagnosing people with ASD, but also seeing other clients. Four years full time equivalent of ASD diagnostic specific training is not realistic and has the potential to exclude many highly experienced clinicians. Assessment skills in relation to differential diagnosis are in fact likely to be enhanced in clinicians who are seeing a range of clients and are familiar with a broader view of human development. Expecting this extremely high level of specific experience is also likely to limit the number of clinicians able to complete diagnostic assessment, consequently increasing wait times for families for assessment. The APS therefore recommends this requirement be urgently re-visited; it is recommended that a more suitable criteria be implemented such as: two-years full-time equivalent ASD diagnostic-specific training and/or experience. This is also the maximum length of time stipulated by the Psychology Board of Australia to gain an area of practice endorsement as an indicator of advanced practice skills/training in a specific area. The requirement for psychologists to have an area of practice endorsement.	This requirement has been omitted from the revised Guideline. For a rationale, please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Duration of ASD-specific Expertise

	ID459		The draft Guideline makes several distinctions between registered psychologists and registered psychologists who hold an area of practice endorsement. It is important to note that many psychologists have high levels of expertise in specific areas of practice but do not hold an area of practice endorsement. All psychologists must 'only provide psychological services within the boundaries of their professional competence' (APS Code of Ethics, 2007, Standard B.1.2). The current draft Guideline therefore has the potential to exclude highly skilled psychologists from exercising their professional competence in relation to ASD with concomitant impact on access to services in the community. The APS raises the following specific issues with the draft Guideline: • Table 3 (p.18): The current document implies that psychologists who are diagnosticians must hold an area of practice endorsement. It is not clear to the APS why psychologists (6 years minimum trained) are required to have an area of practice endorsement when the other allied health professions (speech pathologist and occupational therapist) only require the minimum standard (4 years minimum). It is recommended that reference to psychologists with area of practice endorsement (i.e., Clinical, Clinical Neuropsychologist, Educational and Developmental) be removed and reference be made to 'psychologists who hold general registration with the Psychology Board of Australia'. • The statement on the training of registered psychologists is incorrect (p.18). A minimum six-year sequence of education and training in psychology is required for an individual to become eligible for registration as a psychologist in Australia. Additional information can be obtained from the APS at:	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Professional Roles • Qualifications for Psychologists

			https://www.psychology.org.au/studentHQ/studying/study-pathways/).	
	ID460		- Table 7 (p.42): It is not clear why some diagnostic areas are specified as suitable for registered psychologists, but some require a psychologist with an area of practice endorsement (clinical or educational and developmental). As stated above, the APS recommends reference to psychologists with endorsement be removed from the draft Guideline and reference be made to 'psychologists who hold general registration with the Psychology Board of Australia'	This table has been omitted from the revised version of the Guideline. Please refer to the 'Overview of Major Amendments' chapter under the heading: - Professional Roles - Qualifications for Psychologists
	ID461		8.1 Recognition of signs and symptoms of ASD (section 8.1.2) The APS recommends that the following is added to Table 5 (p.29): 'Family member diagnosed with ASD or suspected of having ASD (e.g., an adult who has not undergone formal assessment).'	This table has been omitted from the revised version of the Guideline. For further information, please refer to the 'Overview of Major Amendments' chapter under the heading: - Referral for an Assessment of ASD Concerns
	ID462		Acting on a referral for an ASD Assessment (section 8.3) appears to assume that all parts of the assessment are occurring in one place and are being coordinated by one person which may not be feasible, particularly in a Tier 2 assessment where multiple private clinicians from different work settings and different locations are involved. The APS recommends that this section be revised and clarified in respect to location of the assessment process.	The 'Referral for an Assessment of ASD Concerns' section of the Guideline has been substantially revised. For further information, please refer to the 'Overview of Major Amendments' chapter under the heading: - Referral for an Assessment of ASD Concerns
	ID463		9.5.3 Moreover, most of the tools to assess cognitive and intellectual functioning are restricted to individuals with the appropriate training/qualification. The terms of service of these psychometric tools clearly indicate that they have restricted usage. For example, access to intelligence tests is only available to professions classified as 'User Level C', that is, registered psychologists. The APS recommends that the	Recommendations relating to specific instruments that measure functioning have been removed from the Guideline, and information about resources will instead be located on the Guideline webpage to enable updates to occur more readily.

			diagnosticians listed for undertaking cognitive and intellectual functioning be limited to psychologists.	
	ID464		8. Information Collection-Standardised ASD Diagnostic Tool (section 9.5.3) The APS strongly recommends the Diagnostic Interview for Social Communication Disorders (DISCO) is added to the list of instruments for the diagnosis of ASD. The DISCO has more diagnostic accuracy than many of the measures currently included in the list on page 45 of the draft Guidelines. For further information, please see the Cardiff University Wales Autism Research Centre website for research literature on the DISCO. Additionally, the DISCO now has a DSM-5 algorithm that can be used by clinicians.	Recommendations relating to specific instruments that measure functioning have been removed from the Guideline, and information about resources will instead be located on the Guideline webpage to enable updates to occur more readily
	ID465		The APS has particular concerns about the use of the ADOS-2 (Module 4). The ability of this tool to discriminate between ASD and other presentations is currently not supported in the assessment of adults with average and above average intelligence, and is even more problematic for females who have learned reciprocal conversation and gestures. Thus, it is recommended that Module 4, if used at all with adults, should only be used in conjunction with other assessment tools.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Use of 'Standardised' Instruments
	ID466		6.5 Functional and Support Needs Assessment Given current time frames for the ASD assessment process, it may not be possible or even desirable for the functional assessment to be conducted at the time of outcome of the ASD assessment process. The additional time and cost to conduct a comprehensive assessment in this area will make this unachievable for many families. It is often a requirement for a functional assessment to occur when an application for funding support is being undertaken. A diagnosis of ASD does not ensure eligibility for funding which is often primarily based on the individual's level of functioning. It may be preferable therefore, to have a functional assessment occur at a later stage which would also eliminate the possibility of duplicating	The feedback received during the consultation period highlighted the importance of every individual receiving a functional assessment, either prior to a diagnostic assessment or during this process. Due to this strong feedback, the revised structure has a functional assessment forming the foundation step of the assessment. Please note that the revised Guideline includes a recommendation regarding costs for ASD assessments. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Practice points for clinical, research and policy settings

			costs should an independent assessment for funding be necessary.	
	ID467		The APS recommends that establishing a realistic time frame when the functional assessment is to be undertaken, such as within a 12-month period following diagnosis, would be beneficial. The Guideline also needs to make explicit that a functional assessment is necessary for clients who do not receive a diagnosis of ASD but clearly have difficulties and need support.	Please refer to the response to comment.
	ID468		9.4 Diagnostic Evaluation Structure The APS is concerned that the draft Guidelines are recommending a less rigorous approach to diagnosis than is currently the case in Australia. Given the two-tier approach proposed in the document, the APS recommends that diagnostic reports must include a justification for the choice of a Tier 1 or Tier 2 approach. Additional concerns are outlined below. A tier 1 Diagnostic Evaluation allows for one diagnostician to make a decision with input from a different professional discipline. Theoretically, aside from the requirement for a medical evaluation (not diagnosis), this allows for an occupational therapist to make a decision about an autism diagnosis with input from a Professional Informant, for example, a school teacher. This means that a diagnostic decision could be made without input from a speech pathologist (communication deficits as per DSM-5 and ICD-10), or a psychologist (exclusion of other reasons for clinically significant impairments). This situation will not align with the criteria for funding in many school systems as it will not include a multidisciplinary diagnosis (i.e., paediatrician, psychologist, and speech pathologist). The APS strongly recommends that the Guidelines explicitly state that a paediatrician or psychologist must be part of the diagnostic evaluation (either as the diagnostician or informant).	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Professional Roles • Structure of the Assessment Process • Progression from Stage 2 to Stage 3

	ID469		As outlined, there is currently no requirement for a Tier 1 diagnostic evaluation to include any formal standardised assessment tools. While the use of reliable, valid tools is a useful adjunct to assessment, the final decision must rest with the clinician. The training of psychologists and paediatricians equips them to complete a global developmental assessment and use clinical judgement for a diagnosis for ASD. The DSM-5 diagnostic criteria for ASD require that 'symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning'. For symptoms to be clinically significant suggests that these must be observed by a suitably qualified clinician following a careful history and diagnostic evaluation. While the use of reliable and valid assessment tools may aid in diagnosis, the identification of clinically significant symptoms requires considerable clinical expertise beyond psychometric assessments. The APS therefore recommends that Tier 1 assessments include use of reliable and valid standardised assessment tools where necessary, but that suitable training for clinicians must also be emphasised. This will ensure that assessments are rigorous and based on sound clinical decision making.	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Use of ‘Standardised’ Instruments
	ID470		The APS strongly recommends that the Guidelines explicitly state that if there are issues related to differential diagnosis, that the client is immediately referred to Tier 2.	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Progression from Stage 2 to Stage 3
	ID471		The APS is concerned that the two-tier system is a less rigorous diagnostic process than current procedures, particularly in South Australia where two professionals are required to complete a diagnosis. It is not clear to the APS that the approach proposed in the draft Guidelines will ensure that community members will be able to continue to access	Thank you for these comments. A major challenge in public policy is how to strike the best balance between assessment accessibility and assessment rigour for all Australians. Following the extensive consultation, we believe that the revised Guideline document achieves this balance substantially better than the original draft. The ‘Overview of Major Amendments’ chapter.

			robust assessments and that the proposed approach may actually lead to a reduction in standards across Australia	
	ID472		9.5 7. Professional discipline specialists for co-occurring concerns (section 9.5) Table 7 (p.43) of the draft Guidelines lists paediatricians and psychiatrists as diagnosticians for cognitive and intellectual functioning. While paediatricians and psychiatrists may undertake a general medical assessment of a child to obtain a basic impression of the child's functioning, they do not undertake robust psychometric testing of cognitive and intellectual functioning	Thank you for this comment. Based on feedback received, this table has been omitted from the revision Guideline, and the information included in the table has been incorporated in other sections of the document.
Anonymous [113]	ID473	Individual - Professional experience (PR,PD,PS)	I reviewed the guidelines in conjunction with the members of my OT team within the Child Development Service. While I am responding as an individual, the comments were agreed upon by all occupational therapists in our team.	Thank you for providing feedback. No amendment is required in response to this comment.
	ID474		Our concern is the recommendation for who can contribute or complete a diagnostic evaluation is only for OTs who are registered with BAHMS and have the additionally required knowledge and expertise. In our current practice as OTs within a Child Development Service (part of a state-wide health service), a significant part of our caseload is the contribution to assessment of children where there is a question about an ASD diagnosis. There are multiple entry points into our service including individual clinics, multidisciplinary clinics, ASD specific clinics, FASD clinic. Children in any of these clinics may undergo assessment for ASD. The OTs have an equal diagnostic role to psychology and speech pathology within our service. We contribute to the assessment process via parent interview and history taking, developmental assessment, ADOS, home and school visits, sensory assessments, motor assessments, play and interaction assessments. We do not provide intervention	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Qualifications for occupational therapists

			to children diagnosed with ASD as they are access services through HCWA. As therapists employed in a child health service we are not BAMHS registered. We are registered with AHPRA. Our expertise is in differential diagnosis of children who present with delays or concerns related to their development. If only BAMHS registered therapists are approved to be diagnostic clinicians, would this mean we are no longer approved to part of the diagnostic process for children presenting to our health service? If this is the case: 1. The role of OT within our service would be greatly diminished. 2. We fear these risks undermine the perception of other disciplines about OT capacity to contribute to any diagnosis related to a child's overall development. 3. We would no longer have an equal diagnostic role within our service to our allied health colleagues. We do find it curious that OT's are the only discipline that must be registered with BAHMS to be eligible to be a diagnostician, especially when SLP are not even required to have national registration with AHPRA. In our experience within our region, being registered to provide services via BAHMS is not a guarantee of a therapist's knowledge of child development, particularly early child development. Many therapists who work in Child Youth Mental Health Services can have a general mental health clinician role and this may not include developmental assessment. We have experience of children referred to our child development service for assessment and diagnostic clarification before they are accepted into mental health services. Our concerns are regarding the role of OT within public health services.	

Child Development Service, Community Services Directorate, ACT Government [114]	ID475	Organisation - Professional experience	Diagnosticians - ASD specific expertise Pg. 17 Clarification is sought regarding the requirement to have obtained: • 4 years fulltime equivalent of post graduate experience that is directly relevant to ASD Diagnostic evaluations obtained through university qualifications, formal training programs and or formally supervised work experience. How realistic is it that professionals can develop 4 years fulltime post graduate experience directly relevant to ASD diagnostic evaluations? • Most professionals do not solely work full time in one area of practice • Would experience in ASD intervention be considered to be equally valued? Most psychologists, speech pathologists, occupational therapists would be unlikely to have been able to obtain 4 years full time diagnostic experience. Traditionally speech pathologist and occupational therapists would be more likely to have been involved in providing therapeutic intervention to individuals diagnosed with ASD • How likely is it that professionals will spend 4 years full time plus in one area of practice? Health professionals frequently change jobs or areas of practice because they want to develop new skills and professional experiences across their career • Traditionally health professionals are more likely to be female, possibly resulting in higher rates of part-time employment whereby achieving 4 years full-time would take many more years to achieve. • How can services succession plan to ensure they have clinicians who can develop the ASD specific expertise? Based on the guidelines they possibly can only be involved in the role of a professional informant and not involved in administering standardised ASD assessments or direct interviewing? • The majority of professionals who most likely meet these criteria now would be psychologists and possibly	Please note that the requirement for ‘4 years’ experience’ has been omitted from the revised Guideline. For a rationale, please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Duration of ASD-specific Expertise

			paediatricians (but again most would work across a range of medical/ developmental presentations rather than just ASD) how can we ensure speech pathologists and occupational therapists are able to develop this skill set? • What do professional associations and AHPRA think about giving delegation to an Occupational Therapist and Speech Pathologist to be able diagnose ASD? And would this diagnosis be accepted if the diagnosed individual moved internationally? What is considered recent experience and how and to who do you prove that you have maintained your skills? And if you haven't what would you need to do to demonstrate you have regained the required expertise? Suggestions for Alternative Measures for achieving ASD expertise: • Number of hours and or number of assessments completed with supervision from a diagnostician. • Competency standards that can be clearly achieved and demonstrated e.g. skills in administering standardised ASD assessment tools • Demonstrated understanding of the criteria and the ability to document • Understanding of differentials and co morbidities • Number of ASD Assessments performed • Experience across abroad range of presentations of ASD (Young children, female, older children, adolescents	
	ID476		How will the community and services know that someone has the skill set to be a diagnostician? • How will Referral for an Assessment of ASD Concerns (GP and professional informants) and diagnosticians know that someone meets the ASD specific expertise and can be referred to for a Tier 1 and Tier 2 ASD assessment?	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Accreditation and Regulation • Practice points for clinical, research and policy settings

			- Will professionals need to provide evidence that they have obtained the ASD specific expertise and if so to who? - Will there be a list of Australia wide practitioners who meet this ASD specific expertise level?	
	ID477		Professional Informant Comments - As the majority of children who are referred for ASD assessment who are under 5 years of age, the criteria of a professional informant would most likely exclude early childhood educators or child care workers due to the possible lack of a 4-year degree	The requirement of a ‘4-year degree’ has been omitted in the revised Guideline, and the list of ‘other professionals’ who may be consulted during the ASD assessment process includes childcare workers.
	ID478		- Our services MD ASD assessment pathway always includes an observation of the child in a functional environment e.g. school, childcare, or home (either by a speech pathologist or occupational therapist) and discussion with the educator regarding their observations, concerns and participation (activity and social). We find this to be a critical component of all ASD assessments, this also allows for a pathway that would allow a SP/OT to develop components of the skilled expertise required to become a diagnostician	Thank you for providing feedback. No amendment is required in response to this comment.
	ID479		Our service stipulates that only a paediatrician or psychiatrist can refer in for an ASD assessment. In doing this it allows our service to have the required medical evaluation and any other possible reasons for the child's presentation ruled out before commencing the ASD assessment process. Allowing a professional informant or a GP to be able to refer will increase the ability to access an ASD assessment in a quicker time frame as most paediatrician's frequently have long waiting periods, and the cost of a private paediatrician may be cost prohibitive for some families. Benefits of a paediatrician referral include the screening out of other possible reasons for the child's presentation resulting in	Thank you for this information.

			no need to refer on for ASD assessment. Greater skill and expertise in being able to identify the signs and symptoms associated with ASD to indicate the need for a referral, and also providing (possibly if they meet the Diagnostician criteria) the second Diagnostician required if the assessment progresses to a Tier 2 assessment. Our government funded service currently employs psychologists, occupational therapists and speech pathologists in the MD ASD assessment team. We believe that all of our psychologists would meet the diagnostician criteria, and possibly 1 of our Speech pathologists and 1 of our Occupational therapists. If our OT/ SP were unable to meet these criteria, or they left the service, we would need to engage a paediatrician to be able to find a 2nd diagnostician - this would most likely stall the assessment process due to possible waiting times or if referred to a private paediatrician costs may be prohibitive for the family. There is also the potential for an increase in the number of ASD referrals due to the ability to self-refer via a GP or professional informant, thereby increasing waiting times for assessment significantly. From our own data, approximately 40% of our referrals (all coming via a paediatrician) do not receive a diagnosis of ASD highlighting the importance of differentials in the assessment process for young children. The screening tools suggested for developmental assessment prior to considering an ASD referral included self-report and clinician administered tools.	
	ID480		Were ASD specific screeners also considered prior to a referral? e.g. ASD detect App, SACS?	Recommendations relating to specific instruments that measure functioning have been removed from the Guideline, and information about resources will instead be located on the Guideline webpage to enable updates to occur more readily.

	ID481		Currently our Team uses the DSM-V criteria and in using this provides a point in time severity rating to indicate functional impact and level of need. Specific recommendations are also provided within the report with appropriate referral and linkages and then the client is discharged. The addition of the Functional and support needs assessment in the way described would add a significant amount of time to the assessment process which our service is not currently funded to add in addition, and if we were required to do this with the current resources - would likely lead to increased waiting times for assessment services. We would not see a role for our service in repeating and reviewing this as our service function is primarily assessment, referral and linkage. What role does the NDIA have in funding a functional and supports needs assessment and repeating this when required for the purposes of ensuring those who are eligible for the scheme have a funded support package that meets their goals? The cost for a family to organise this assessment on a repeated basis privately would be significant and cost prohibitive. The idea of completing the Functional and Support needs assessment concurrently rather than waiting for the diagnostic outcome or alternate diagnosis, would be challenging if it was not the diagnostician - some of the tools you have referred to for use, appear to be diagnosis specific e.g. ICF core sets for ASD), also any referral's or linkages would need to take into account the diagnosis as a factor.	Thank you for this helpful information. These comments are addressed in the 'Overview of Major Amendments' chapter of this document.
	ID482		Tier 1 feedback - Having access to the medical evaluation as part of the referral was thought to be preferable rather than having to refer for this information once the assessment has commenced.	We believe that the revised structure addresses this comment. For further information, please refer to the 'Overview of Major Amendments' chapter under the heading: • Structure of the Assessment Process

	ID483		It would be useful to specify some of the situations where a Tier 2 assessment should be considered as routine rather than commencing with a Tier 1 assessment e.g. • The child is over 6 years of age • Has any type of complexity in their developmental history • Has any previous diagnoses or psycho pathology (e.g. ADHD, Anxiety, trauma history) • Has any history of complex medical conditions	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Progression from Stage 2 to Stage 3
	ID484		A tier 1 assessment that may only involve an OT or speech pathologist as the diagnostician, relies on them having the clinical expertise to be able to consider diagnosis's outside of their discipline in order to recognise the need to refer on to a Tier 2 diagnostician e.g. Mental Health/Attachment/anxiety/OCD etc. In these instances, potentially having a psychologist or paediatrician as the professional information would safe guard against this issue.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Professional Roles • Structure of the Assessment Process
	ID485		Tier 2 Feedback - If the referral indicates that the child is clearly going to be a Tier 2 assessment there would be time efficiencies in being able to bring the team together and to book consecutive appointments with known availability in the first instance. As mentioned before possible guidelines for this may include: • The child is over 6 years of age • Has any type of complexity in their developmental history • Has any previous diagnoses or psycho pathology (e.g. ADHD, Anxiety, trauma history) • Has any history of complex medical conditions The issue of having timely access to the required Tier 2 team could significantly delay the assessment process if not organised in a more upfront way e.g. waiting times to see a second diagnostician and professional informant. There may	Thank you for these helpful comments.

			be challenges/ delays in the coordination of the report when two diagnosticians are involved.	
Anonymous [116]	ID486	Individual - Professional experience (PD,PS)	The guideline has a specific focus on 'community settings' (e.g., pages 24-25), which is understandable. However, there are individuals in institutional settings (e.g., prisons, forensic mental health hospitals) who would also meet the diagnostic criteria for ASD, if they were given the opportunity for a comprehensive assessment. Of note, the existing literature suggests that ASD is under-diagnosed in prison settings and clinically, we do see a number of prisoners with strong ASD features who were never diagnosed previously, at times due to difficulty assessing them properly in the community. For example, many prisoners might have led a chaotic lifestyle in the community and some may even spend the vast majority of their life in custody. For these people, their time in custody may actually present a golden opportunity for a comprehensive mental health/diagnostic/functional assessment, as easy access to substances may be less likely and prison environment tends to be more structured. I wondered whether some considerations can be made for people in institutional settings (rather than having a focus purely on community settings), especially for those people who may not have the opportunity to spend much time in the normal 'community' settings?	‘Prison’ and ‘forensic mental health hospital’ have been added as examples of a ‘community setting’, as they fit within the definition in the Guideline of “familiar environments where the individual being assessed for ASD undertakes one or more of their usual activities.”
	ID487		Page 41 of the guideline (9.5.2) states that direct observations must occur in at least two settings, where at least one is a community setting. Does this mean that Tier 2 diagnostic assessment cannot happen for people who are placed in institutional settings (e.g., prisons, forensic mental health hospital)? For some prisoners/forensic patients, they may stay in institutions for a significant length of time. When their mental state is stable and when they are well engaged in mental health treatment, being in an institution probably	As indicated above, examples of institutional settings have been added to the section on community settings. We have also included greater flexibility in the number of settings, using the following wording (Section 10.3): “It is recommended that the Consensus Team Diagnostic Evaluation involve the collection of information about the individual’s participation in all relevant community settings. This information may be obtained through communication with the client and/or other professionals but direct observations by

			shouldn't preclude them from accessing Tier 2 diagnostic assessment.	member(s) of the ASD assessment team within some of these community settings is suggested when possible.”
	ID488		Page 64 of the guideline (12.2) provides information about guardianship legislation and 'substitute decision maker'. Although this could be useful information in some cases, it may be important to highlight that a guardianship order should always be used as a 'last resort' (once all other less restrictive options have been tried and failed). For example, the concept of 'supportive decision making' has become better recognised in the last couple of years since some legislative change in Victoria (http://www.publicadvocate.vic.gov.au/power-of-attorney/supportive-attorney-appointments). This may be a particular important point to make, given that all individuals with ASD will have their unique strengths and they may still be able to provide informed consent, with some support from people of their own choice (without the need to have a substitute decision maker).	Thank you for this information. We feel that it is most appropriate to not be prescriptive about this point, but rather highlight the different states legislative acts to facilitate decision making at the level of the individual clinician. No changes have been made to the Guideline in response to this point.
	ID489		The draft guideline is thoughtful and provides informative details particularly for assessment of ASD in younger populations. I work with people in an adult custodial environment, and I wondered whether some considerations could be made about prisoners' and forensic patients' need for ASD assessment and interventions that are appropriate for this unique setting.	As indicated above, examples of institutional settings have been added to the section on community settings. In addition, the phrase “clinical management” has been expanded to “referral to service providers” to more broadly encompass support services within a wide variety of sectors.
Anonymous [117]	ID490	Individual - Lived experience (F,C)	As a parent of an autistic child my feelings are that this nationwide guide is imperative and a great step forward for the standard of diagnosis. Thank you and well done.	Thank you for the comment. No amendment is required in response to this comment.
	ID491		There needs to be another case study added of female aged 8-10 years old. Educated in mainstream schooling with normal to high IQ. Camouflaging her difficulties at school and showing traits at home plus anxiety, defiance, aggression,	Thank you for this feedback. An additional case study has been added.

			sleep difficulties and avoidance. If this isn't added then a vital example of many girls, including my own, will be overlooked. This case study would provide vital assistance in helping girls get diagnosed at a younger age, so they can get the support they need. Until the DSM 5 changes to reflect female traits of autism then this example is imperative to be included in this guideline.	
Anonymous [118]	ID492	Individual - Professional experience (PD,PS)	Case Study 2: Much of the information provided appears irrelevant (e.g. heart rate) or non-specific such that it is unclear why a diagnosis was made.	This information has now been omitted.
	ID493		RE: ASD Diagnostic Evaluation Report Template DSM-5. pp.6-7. Diagnostic assessment tools and lists of reported and observed behaviours do not diagnose someone with Autism Spectrum Disorder, clinicians with expertise that weigh up an interpret the available evidence make the diagnosis. Therefore, it is important that under each criterion the clinical decision making is also made explicit, i.e. that a summary of why each criterion was judged to be met, or not, is provided. E.g. Criterion A1 was met due to the nature, pervasiveness, functional impact, course, duration of X, Y, Z.	The report templates in the original version of the guideline incorporated sections that encouraged diagnosticians to record the information that is requested in this comment. These sections have been retained in the revised Guideline.
	ID494		The foreword to the document clearly outlines the key issues with current diagnostic practices. I wholeheartedly agree with the general ideas of the proposal that the assessment should be comprehensive, involve consideration of multiple sources of information, be done by people with professional expertise and that consistency across these factors nationwide would be beneficial. I think these general ideas are also captured well throughout the guideline.	Thank you for this feedback.

	ID495		The referral factors (p. 29, Table 5) could be made clearer if it is to be used for referring professionals who may not have specialist knowledge of autism spectrum disorder: 1. Including 'more severe signs and symptoms' as a referral factor could reduce appropriate referrals depending on the potential Referral for an Assessment of ASD Concerns's interpretation of severe e.g. does this mean more obvious, marked or 'Kanner type' symptoms? What would be the guidelines in identifying whether these signs and symptoms met the chosen definition of severe? In my opinion, the functional impact and/or distress caused by signs and symptoms captured in the 'impact factor' described later in Table 5 is more in keeping with severity, especially how it is conceptualised within the DSM-5 criteria as degree of support required.	This table has been omitted from the revised version of the Guideline. For further information, please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Referral for an Assessment of ASD Concerns
	ID496		2. I am unsure why 'a history of developmental regression' is listed as a referral factor as this is not a characteristic feature of ASD (at least as defined by the DSM-5).	This table has been omitted from the revised version of the Guideline. For further information, please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Referral for an Assessment of ASD Concerns
	ID497		3. Individuals with hearing impairments may also have co-occurring ASD. Rewording the 'testing of hearing' referral factor to read that 'hearing impairments have been ruled out as the primary factor for communication impairments and, yet these impairments persist,' would help reflect this more clearly.	The table of additional factors to consider in determining whether to refer for an ASD assessment has been omitted from the revised Guideline. The Medical Evaluation involves testing hearing status, hearing assessment (e.g. screening test or full auditory evaluation) was provided as an example of further assessment at Stage 3, and hearing impairment has been listed in the new table on possible differential or co-occurring diagnoses.

	ID498		9.4.2 The account of the tier based assessment system would benefit from further clarification about recommendations for information gathering and the qualifications of specialists assessing co-occurring concerns: 1. I acknowledge that observations are important to a comprehensive assessment. However, recommending observations across two different settings at Tier 2 (p. 41) may not be possible in some circumstances e.g. if lacking consent or assessing an adult who may not wish to be observed at their workplace or home. In these instances, could observation in one setting e.g. a clinic, be supplemented with information from another reporter from a different setting e.g. the individual's spouse, employer, health practitioner such as a psychologist, psychiatrist, support worker etc.?	Thank you for this feedback. Based on the considerable feedback received regarding the need for flexibility in the assessment model, we have used the following wording (Section 10.3): "It is recommended that the Consensus Team Diagnostic Evaluation involve the collection of information about the individual's participation in all relevant community settings. This information may be obtained through communication with the client and/or other professionals but direct observations by member(s) of the ASD assessment team within some of these community settings may also be helpful."
	ID499		9.5.3 3. Standardised assessment tools can assist health professionals in informing their clinical decision to reach a diagnostic outcome. I do however have concerns about the lack of evidence supporting the recommended tool (p.44-45) for some populations. The evidence for the use of the ADOS with adults is inconsistent i.e. it routinely performs above or below adequate levels for sensitivity and specificity depending on the study. Indeed, the NICE guidelines for adult ASD assessments stipulate that no standardised diagnostic tools can be recommended for adults as none have emerged with any consistency as having adequate sensitivity and specificity in this population. The NICE instead opted to suggest that clinicians consider using a range of standardised tools, being mindful of their limitations, with adults. Of these tools, the ADOS does not have the strongest psychometric data. Instead, the RAADS/RAADS-R/RAADS-14 performs most consistently in the recommended range for sensitivity and specificity, with adequate inter-reliability and, good agreement with other measures of ASD. I strongly suggest	Recommendations relating to specific instruments that measure functioning have been removed from the Guideline, and information about resources will instead be located on the Guideline webpage to enable updates to occur more readily.

			acknowledging that while the ADOS is consistently recommended by systematic reviews for its use in children etc, it has not been recommended for adults and does not consistently perform with adequate sensitivity and specificity in this population. It might be advisable to adopt a stance similar to the NICE and suggest considering the use of the RAADS-R as of the available tools for adults, it most consistently performs with adequate sensitivity and specificity.	
	ID500		It may also be worth considering removing the ASDI from the list of tools with emerging or consistent evidence as it does not assess Criterion B4 as per DSM-5, and there is only one research paper to date, the original publication in 2001.	Recommendations relating to specific instruments that measure functioning have been removed from the Guideline, and information about resources will instead be located on the Guideline webpage to enable updates to occur more readily.
	ID501		In general, I have concerns about the Tiered model and the practicality (coordination, time, financial and resource costs) of conducting a thorough ASD assessment whilst also identifying other diagnoses.	Thank you for this feedback. For a description of the revised structure, the ‘Overview of Major Amendments’ chapter.
	ID502		I agree that to assess co-occurring concerns (p. 42, Table 7), health professionals must have sufficient training, supervision and experience. However, I note that in a number of cases reference is made to the specific types of psychologists (e.g. clinical, educational and developmental) performing assessments of co-occurring issues. These psychologists, in addition to a postgraduate qualification in clinical or educational and developmental psychology which allows them to identify as a general psychologist, have then completed 1-2 year 'registrar programs' to be endorsed as specialists in clinical or educational and developmental psychology. Registrar programs are designed to develop competencies in a range of areas including assessment, often with a particular focus on the selection and administration of assessment tools and familiarity with a range of disorders. Whether an individual's endorsement program specifically covers training in the assessment of sensory processing, trauma or	Please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Qualifications for Psychologists

			deprivation, adaptive behaviour, sleep difficulties, intellectual and cognitive assessments and literacy issues will however vary. I believe the intent in noting these specialties in this Table was to highlight that psychologists who have undergone adequate supervision and further training in the area of these co-occurring issues should complete these assessments. Given that endorsement as a clinical or educational and developmental psychologist may not necessarily equate to expertise in assessing these specific areas but rather that this develops through specific training, supervision and experience which may also be achieved by psychologists without these endorsements, I suggest removing the specialties / endorsements. Perhaps a blanket statement that psychologists who have developed appropriate expertise, defined in a similar manner to the requirements for diagnosticians on pages 16-17 would suffice?	
Dr Jane Son [119]	ID503	Individual - Professional experience (PD)	I acknowledge that ASD is a growing issue in our society, and that we need to respond accordingly. However, there are many more children and adults in our society with other neurodevelopmental disorders, that do not get the attention and support that they deserve. There aren't national guidelines for diagnostic and functional evaluation of these disorders. These people may have significant functional impairments, but are limited in their ability to access funding and support in an increasingly diagnosis driven system. We would suggest that a guideline be developed in general for neurodevelopmental disorders.	Thank you for these comments. One of the aims of the revised structure is to highlight the importance of all individuals with neurodevelopmental difficulties, and to provide them prompt clinical management no matter their ultimate diagnosis. For a description of the revised structure, please refer to the 'Overview of Major Amendments' chapter under the heading: • Structure of the Assessment Process
	ID504		Firstly, thank you for the Autism CRC's work and dedication in developing this comprehensive guideline. Particularly the inclusion of Autistic individuals and parents and caregivers of Autistic children is noted and celebrated. The guiding principles of ASD assessment being individual and family centred is strongly supported. This acknowledges that the ASD assessment process can differ case by case, and there needs to be flexibility. Acknowledging that this is complex and	Thank you for the comment. No amendment is required in response to this comment.

			has attempted to be addressed in the guideline to promote equity in accessing ASD assessments around Australia, as a developmental paediatrician working in a public multidisciplinary diagnostic and assessment service, and also in practice, I would like to raise the following concerns, which are shared by a number of my paediatric and allied health colleagues at the Kogarah Developmental Assessment Service.	
	ID505		Tier 1 assessments- only trained diagnosticians experienced in child development, and able to distinguish between ASD and other developmental disorders that can present similar to ASD (e.g. Fragile X, Attachment/ Trauma disorders, impact of psychosocial factors, intellectual disabilities etc.) should be able to conduct single diagnostician assessments. Our understanding is that some allied health clinicians are not specifically trained in this manner, and in other developmental disorders (e.g. ADHD) are not able to make formal diagnosis.	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Professional Roles • Structure of the Assessment Process
	ID506		We note that a 'medical assessment' by a General Practitioner (GP) is a requirement in Tier 1 assessments if medical practitioner is not directly involved in assessment, but again, GPs are not specifically trained to diagnostically differentiate and evaluate neurodevelopmental disorders. As quoted from the guidelines, 'we reiterate the importance of tailoring the process to meet the needs of the individual consumer, including considering the broader neurodevelopmental features and environmental context of the individual'	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Structure of the Assessment Process • Professional Roles
	ID507		Tier 2 assessments - We support the concept of Tier 2 assessments for more complex or unclear cases, and liken them to the assessments currently provided by NSW Diagnostic and Assessment teams. However not all the children that we see currently require a 'Tier 2' level of service as defined by the guideline, and we reserve Tier 2 level assessments (two diagnosticians, with two professional	Thank you for this feedback. The revised Guideline has sought to provide greater flexibility in the assessment model in order to be feasible for the full range of clinical services. For further information the ‘Overview of Major Amendments’ chapter.

			informants AND including direct observations in two or more settings) for only a small number of children that we see and deem require this level of assessment. Currently the multi-disciplinary diagnostic assessment services are limited in their capacity to conduct such comprehensive assessments, and we are concerned that with the new guideline that we would get increasing referrals for Tier 2 assessments that may not be necessary and would place increased pressure on an already strained public health system. The ability for private practices to conduct Tier 2 level assessments is limited to non-existent from our current understanding.	
	ID508		Tier 1.5 assessments - If current recommendations for Tier 1 and Tier 2 were to remain the same, we would suggest that an intermediate level between Tier 1 (e.g. potentially a single allied health diagnostician) and Tier 2 (e.g. resource intensive public multidisciplinary assessment service) be included within the guidelines.	We believe that the added flexibility included in the revised Guideline addresses this comment.
	ID509		9.4.1 & 9.5.1 Regarding professional experience and title of diagnosticians- we support that clinicians involved in diagnostic and functional evaluations of children with ASD should have the relevant training and experience to do so. We also acknowledge that there are professionals currently operating outside those cited in the guidelines, and who are competent in evaluating children with ASD. These include (though not limited to) social workers, career medical officers and educators, who work within the multidisciplinary assessment teams. Although listed as able to be professional informants, some of these individuals are very skilled diagnosticians and their contribution to assessments must be acknowledged.	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Qualifications for medical practitioners

Anonymous [120]	ID510	Individual - Lived experience (CDE)	As a parent struggling to identify and care for a child with extra needs, I would appreciate more information added about PDA. Information from The National Autistic Society about PDA would be valuable to add to this guide. Thank you.	Please refer to the 'Overview of Major Amendments' chapter under the following heading: • Pathological Demand Avoidance
Australian Psychological Society College of Educational & Developmental Psychologists (APS CEDP) [121]	ID511	Organisation - Professional experience	6. ASD assessment roles - terminology - In relation to Section 6.1, the suggested terminology for individuals being assessed for ASD and any caregiver(s) or support people participating in the process is a consumer. We recommend that individuals being assessed for ASD be referred to as clients, or individuals seeking assessment. The use of consumer suggests a business/economic/purchaser relationship, and is not consistent with the language used in developmental psychology, nor the collaborative, participant relationships between professionals and those who consult them, which are helpful to positive outcomes from diagnostic procedures.	Please refer to the 'Overview of Major Amendments' chapter under the following heading: • Consumer
	ID512		We are pleased to see the inclusion of person-centred, strengths and functional assessment focused approach to Autism Spectrum Disorder (hereafter referred as ASD) assessment, which is consistent with the framework in which educational and developmental psychologists practice. We would like to draw your attention to the following areas of the draft which are pertinent to the members of the Australian Psychological Society College of Educational & Developmental Psychologists (CEDP).	Thank you for this comment.
	ID513		1. Training and key skills areas for diagnosticians - In relation to p.17. CBR-1 (psychologist) diagnosticians are required to have 'Demonstrating at least four years full time equivalent of postgraduate experience that is directly relevant to ASD Diagnostic Evaluations, obtained through university qualifications, formal training programs and/or formally	This requirement has been omitted from the revised Guideline. For a rationale, please refer to the 'Overview of Major Amendments' chapter under the heading: • Duration of ASD-specific Expertise

			supervised work experience'. The term 'postgraduate experience' is unclear, and it may be best replaced with 'post registration'. This should include provisional registration, given psychologists in training have the opportunity to gain considerable experience under supervision by appropriately trained psychologists during their practicum/internship. The stipulation of four years' full time equivalent work experience is unnecessarily onerous, given psychologists can achieve an area of practice endorsement as an indicator of advanced skills in the two years following a Masters training pathway (6 years total) or 18 months following a combined Masters/PhD training pathway. An arbitrary length of time is not necessarily indicative of the degree of competence of the individual diagnostician.	
	ID514		2. Professional discipline specialists for co-occurring concerns. In relation to Table 7, page 42. We note with concern the over emphasis on Clinical Psychologists and lack of equal representation on the training and skills of Educational and Developmental Psychology in relation to all aspects from diagnosis, contexts evaluation, and intervention. Thus, the rationale for a psychologist with clinical endorsement in the areas of literacy, trauma, sleep, and adaptive behaviour assessment is neither clear nor justified. In the following list of co-occurring concerns, a psychologist does not need to have clinical endorsement to be able to provide expertise: • Sensory processing deficits • Cognitive and intellectual functioning • Trauma or deprivation • Literacy and learning issues • Adaptive behaviour difficulties • Sleep difficulties We therefore recommend the term 'clinical psychologist' is removed from Table 7 and 'registered psychologist' inserted	Please refer to the 'Overview of Major Amendments' chapter under the heading: • Professional Roles • Qualifications for Psychologists

			instead. In recommending an inclusive approach here for registered psychologists and provisional psychologists working under supervision (both hereafter referred as psychologists), we suggest the guidelines highlight the role of competence as opposed to defining discipline specialists based on specific titles within the profession. It is the ethical responsibility of the individual psychologist to ensure they do not practice outside the scope of their skills and training, as is the case for all other professions. It seems remiss given the focus on competencies in practitioner training internationally that these guidelines refer only once to the term competent ‘. To make best use of the guideline, it is essential that clinicians familiarise themselves with the content enclosed in this document, and ensure that the requisite professional training is achieved and maintained in order to competently deliver these clinical services...' (p.8) In the pursuit of best practice, the guidelines should highlight the role of both initial training and supervision to gain competence, but also the role of continuing professional development in maintaining competence over time.	
	ID515		3. ASD Specific Expertise, 6.4.2 (p. 16-18). In relation to: 'In addition to belonging to an eligible professional discipline (with associated specialist skillsets, Table 3), diagnosticians must also have current expert knowledge and experience in a wide range of areas that are relevant to all stages of a Diagnostic Evaluation for ASD.' We recommend that a diagnosis of ASD is undertaken as part of a multidisciplinary team of appropriate professionals, at minimum including support from both a paediatrician and psychologist. We do not recommend that speech pathologists and occupational therapists are able to individually and independently diagnose ASD, but acknowledge they are an important aspect of a multidisciplinary team when their skills are relevant to understanding the client's presentation. Table 14 and 15 describe the differential diagnostic considerations required for	Please refer to the ‘Overview of Major Amendments’ chapter under the following heading: • Structure of the Assessment Process • Professional Roles

			an ASD diagnosis, and it is important to note that speech pathologists and occupational therapists do not have the training and competence to assess for these conditions (unless dual qualified in psychology). It is relevant to note here that funding applications in schools may require diagnostic support statements from a paediatrician, psychologist, and speech pathologist to be eligible for ASD funding support. This may cause confusion for families, particularly if practitioners consulted after the initial (singular disciplinary) diagnosis do not agree with the multidisciplinary consensus. There is a concern that the three disciplines model (paediatric, psychology, and speech pathology) is being threatened, which may prevent or reduce the opportunity for individuals to obtain a comprehensive understanding of their strengths and needs, their learning styles, the interplay between their ASD, other disabilities and social-emotional development. This model is consistent with best practice internationally, and any deviation from best practice is unlikely to provide positive outcomes for individuals seeking assessment for ASD.	
	ID516		4. Professional discipline specialists for co-occurring concerns. In relation to Table 7. p.43. which lists paediatricians and psychiatrists as diagnosticians for cognitive and intellectual functioning. It is important to note that assessment tools for cognitive and intellectual functioning are restricted tools. Publishers restrict these tools to practitioners who are psychologists. Therefore, it is neither appropriate nor legal for paediatricians and psychiatrists to act as diagnosticians for cognitive and intellectual functioning based on the use of standardised tests of this kind (unless they hold dual qualifications). We therefore recommend that this table be corrected to reflect psychologists as diagnosticians for cognitive and intellectual functioning.	Thank you for this comment. Based on feedback received, this table has been omitted from the revision Guideline, and the information included in the table has been incorporated in other sections of the document.

	ID517		We are concerned that some settings may provide a lack of face-to-face experience for diagnosticians from a diagnostic and differential diagnosis perspective. In addition, the draft guidelines leave open the possibility of professionals not having sufficient information to recognise the existence of dual diagnoses and/ or the need for differential diagnosis (e.g. in relation to ASD, ADHD, FASD, DTD, ID etc.) without additional guidelines about individual contextual circumstances.	The revised Guideline places significantly greater emphasis in this regard. For example, the Guideline recommends progression to a Stage 3 assessment if co-occurring psychopathologies are suspected. Please refer to the 'Overview of Major Amendments' chapter under the headings: • Progression from Stage 2 to Stage 3
	ID518		In relation to Section 5.1 which outlines the purpose and content of a functional and support needs assessment. We recommend a functional and support needs assessment consider the opportunities and experiences which have advantaged or disadvantaged people and influenced their functional skills attainments prior to assessment.	The following text has been added to the introduction to the Comprehensive Needs Assessment: "The Comprehensive Needs Assessment provides an opportunity to consider the opportunities and experiences that have advantaged or disadvantaged the client and influenced their functioning and development prior to the ASD assessment".
	ID519		In relation to section 11.1 communication Style (p. 56) - The guidelines focus on the technical aspects of a diagnosis, but are relatively silent on best practice in diagnostic communication. For example, the guidelines do not include reference to the tone of the communication. An individual's perceptions of the diagnosis may be distressing, or an opportunity to understand their differences. Whilst prior conceptions about terminology heavily influences response to diagnosis, the manner in which diagnosis is conveyed also profoundly influences the way in which people understand their diagnoses. Recommendations about creating an opportunity for clients and their supporters to consider the implications of a diagnosis and to seek further consultation to discuss these implications with diagnosticians would be helpful.	The following statement was added to the Communication Style section: "facilitated by a tone that encourages understanding and acceptance" The following suggestion was added to the Content of Communication section: "This meeting creates an additional opportunity to assist the client to understand and consider the implications of the diagnostic outcome. Along with sharing information with the client, the ASD assessment team can encourage the client to ask questions and facilitate discussion regarding how the diagnostic outcome may impact on relationships, roles and eligibility for services / funding. This may include developing

			There is insufficient reflection on discussion about diagnosis with the client and how they will use diagnostic information. Diagnostic information is of value to individuals and the people who support them when it is understood, when they have thought about how to use it, when they have plans for alternative explanations for those who they encounter briefly etc. When a diagnosis is conveyed to parents it is imperative that specific plans for diagnostic disclosure with their children are developed. Overall, the guidelines do not draw professionals' attention to the impact of relationships and context, learning opportunities and experiences on individuals' presentations, and implications of these influences from a diagnostic perspective. The silence on interpersonal interactions/ transactions is concerning.	plans for using the diagnostic information and preparing for diagnostic disclosure.” We would welcome further feedback regarding this point.
Flinders Medical Centre [122]	ID520	Organisation - Professional experience	Clear guidelines for the diagnostic evaluation of children in whom ASD is possible are needed in Australia, and this document is welcomed.	Thank you for this feedback.
	ID521		It is essential that clinicians undertaking ASD diagnostic assessments have adequate training. This document states: 'Demonstrating at least four years fulltime equivalent of postgraduate experience that is directly relevant to ASD Diagnostic Evaluations, obtained through university qualifications, formal training programs and/or formally supervised work experience.' It is felt that few clinicians currently undertaking ASD assessments would fulfil this requirement, and it is unclear how they would do so, given the scarcity of appropriate university qualifications, formal training programs and placements offering formally supervised work experience. The time and cost involved would also make this pathway prohibitive for many clinicians already working in the area, or for those looking to do so. This requirement would have a significant impact on the numbers of clinicians able to undertake ASD assessments, particularly in regional areas,	This requirement has been omitted from the revised Guideline. For a rationale, please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Duration of ASD-specific Expertise

			and therefore waiting times for children and families for assessment.	
	ID522		In addition, it is unclear from the document who will be responsible for determining whether clinicians have appropriate expertise to operate as an ASD diagnostician.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Accreditation and Regulation • Practice points for clinical, research and policy settings
	ID523		The use of Telehealth settings in exceptional circumstances is supported. It is suggested that a professional be present with the consumer during the telehealth process, to provide support.	Thank you for this feedback. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Telehealth
	ID524		While it is recognised that the diagnosis of ASD is clearer in some children than others (often in younger children displaying more significant signs), which children can be assessed using the Tier 1 model may not be clear at the outset of the assessment process. In addition, whether a child can be categorised as clearly meeting criteria is likely to differ between assessors. For instance, a child considered straightforward by one clinician may be considered more complex by another more aware of underlying psychosocial issues in the family. Further guidance regarding which children can be assessed via a Tier 1 approach, and therefore by one diagnostician only, would be helpful. In particular, considering the child's age is likely to be useful, as children over the age of 4 or 5 years would rarely fall into this category.	This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Progression from Stage 2 to Stage 3

	ID525		It is suggested that medical history and examination that occur as part of a Tier 1 assessment should be undertaken by a paediatrician. It is likely that these children will show more significant features and have coexisting issues such as developmental delay and intellectual disability, and therefore will be more likely to have an associated or underlying medical condition or comorbidity requiring investigation.	Thank you for this comment, which is addressed by the revised structure. Please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Structure of the Assessment Process
	ID526		It is not clear from the document whether a cognitive/developmental assessment and/or adaptive functioning assessment and/or speech and language assessment should occur as part of a Tier 1 process to inform diagnostic formulation. It is suggested that these assessments should be recommended for this group to inform the diagnostic process, rather than afterwards.	Thank you for this comment. The revised structure provides far greater emphasis on the importance of a comprehensive functional and needs assessment in providing the foundation for a diagnostic evaluation. Please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Structure of the Assessment Process
	ID527		The inclusion of an option to review an individual after a specified timeframe after targeted interventions are implemented if diagnostic consensus is not achieved is supported	Thank you for this feedback.
	ID528		The complexities of assessing individuals with CALD and Aboriginal backgrounds is well outlined in this document. It is suggested that the particular issues involved in the assessment of children in Out of Home Care, with the associated difficulty in obtaining a reliable history and the likely contribution of exposure to developmental trauma, also be included.	Out of Home Care Providers have been added as an information source in the tables for preschool and school-aged children. The revised Guideline also lists an exposure to psychosocial risk and/or trauma as a factor that may indicate a need for a Stage 3 assessment.
Anonymous [124]	ID529	Organisation - Professional experience	Thank you for forwarding the Autism Spectrum Disorder National guideline to [Name] for comment.	Thank you for the comment. No amendment is required in response to this comment.

		(PD, PS)	The National Guideline has been reviewed by the [Organisation]. The Paediatrics network supports the document and the process used to develop it. Members of the Intellectual Disability (ID) Health Network were aware of the opportunity to provide feedback directly to the website and have been reminded again to do so as a result of your email. The National Guidelines covers an area of particular interest to many of the ID members both as clinicians and as carers. [Name] and [Name are members] of the ID Network's Executive and are also members of the National Guideline's Steering Committee. This National Guideline (autism spectrum disorder), funded by the NDIA, makes an important recommendation that 'a minimum national standard for ASD diagnosis across Australia would improve diagnostic practices and consistency across the country, and ensure that future diagnostic assessments are in keeping with best practice guidelines'. With the roll-out of the National Disability Insurance Scheme, a national approach to diagnosis has become imperative. The approach taken by the guidelines has the support of the Network in principle, with detailed feedback being given directly by its members to the website.	
The Australian Clinical Psychology Association [125]	ID530	Organisation - Professional experience	**Summary of the ACPA position** Overall, ACPA believes that the draft Australian guidelines provide a very thorough and evidence based approach to the assessment of Autism Spectrum Disorder (ASD). The guidelines clearly aim to strike a balance between ensuring a more standardised and comprehensive approach to assessment whilst meeting consumers' needs for an efficient assessment that can expedite access to relevant intervention. We think the guidelines provide a level of rigour and	Thank you, we greatly appreciate the helpful feedback provided. Please note that the Structure of the Assessment Process has been substantially revised. For further information, please refer to the 'Overview of Major Amendments' chapter under the following heading

			standardisation that will prove beneficial in changing the landscape of ASD assessment moving forward. Our submission covers several recommendations for adjustment all outlined in detail with related evidence.	
	ID531		However, in the main, ACPA strongly believes: 1. The role of Diagnostician needs to be further restricted to Paediatricians, Psychiatrists and Master's level (or above) qualified Clinical Psychologists, Clinical Neuropsychologists, and Education and Developmental Psychologists.	The revised Guideline incorporates this change. Please refer to the 'Overview of Major Amendments' chapter under the following heading: - Professional Roles
	ID532		**2.** Further flexibility needs to be incorporated into the proposed tiered model and reduced stringency regarding the number of professionals required in Tier 2 as well as the timing of specific assessments, such as medical evaluations and the Functional and Support Needs assessment.	Thank you for this feedback. We believe that the revised structure addresses this comment by incorporating a greater degree of flexibility. Please refer to the 'Overview of Major Amendments' chapter under the heading: - Structure of the Assessment Process - Professional Roles
	ID533		**Strengths** - ACPA praises the attempt to provide templates that offer a standardised approach to collating the information from assessments and ensuring that this information is clear for both families and professionals. - ACPA particularly likes the clear sections showing the relevant symptoms with evidence to support each symptom. We believe this will make it easier for families to understand the rationale behind a child's diagnosis, which can contribute to reducing stress in families at a typically difficult time.	Thank you for this feedback.

	ID534		**Recommendations** • Given that all guidelines from the Anglosphere and the draft Australian guidelines use the term ASD we would argue that all report templates offer this as a single diagnostic term rather than creating separate templates for diagnosing Asperger's Disorder or Pervasive Developmental Disorder – Not Otherwise Specified (PDD-NOS). • ACPA understands that, unlike DSM V, ICD-10 still uses the terms Asperger's Disorder, and PDD. However, as noted in the current draft Australian guidelines, it seems that ICD-11 will bring language into alignment with DSM V functional assessment. Moreover, ICD-10 itself notes that terms like Asperger's Disorder are of "uncertain nosological validity" (http://apps.who.int/classifications/icd10/browse/2016/en#/F80-F89 • Using separate terms might create further confusion. Furthermore, non-published clinical evidence seems to indicate that the major government funded services (e.g. the NDIA) are most interested in a DSM V based diagnosis of ASD with severity levels specified as opposed to determining funds on the basis of other diagnostic terms (e.g.https://www.ndis.gov.au/people-withdisability/access-requirements/completing-your-access-request-form/evidence-of-disability).	The Guideline has been updated to refer to ICD-11 diagnostic criteria, hence ICD-10 terms have been removed from the report templates.
	ID535		**ASSESSMENT SCOPE (Section 4 of guidelines)** **Strengths** • ACPA agrees that the most helpful form of assessment is one that covers both diagnosis and a Functional and Support Needs assessment. The guidelines provide a good rationale for the importance of building a meaningful profile of the individual, which can better inform	Considerable feedback was received during the consultation period that a comprehensive functional and needs assessment is important in providing the foundation for a diagnostic evaluation of neurodevelopmental disorders. Based on this feedback, the structure of the assessment model has been revised. For further information, please refer to the 'Overview of Major Amendments' chapter under the headings: • Structure of the revised assessment

			intervention rather than simply answering the question of the presence or absence of ASD. **Recommendations** - ACPA recommends that the guidelines allow flexibility in the timing of the diagnostic assessment and the Functional and Support Needs assessment. They often do occur in parallel as recommended in the current Australian draft. However, our clinical experience is that they can occur at separate times to each other e.g. Functional and Support Needs assessment occur separately before or after the ASD diagnostic evaluation. This is also consistent with other international guidelines e.g. those from Missouri (2010) which encourage flexibility in the timing of these separate evaluations to reduce the stress and burden for families as well as expedite access to intervention.	- Professional Roles Please note that the revised Guideline includes a recommendation that individuals are referred for further supports based on the initial evaluation of functional abilities and support needs.
	ID536		However, in the main, ACPA strongly believes: - The role of Diagnostician needs to be further restricted to Paediatricians, Psychiatrists and Master's level (or above) qualified Clinical Psychologists, Clinical Neuropsychologists, and Education and Developmental Psychologists.	Thank you for this comment. This amendment has been made in the revised Guideline. Please refer to the 'Overview of Major Amendments' chapter under the heading: - Professional Roles - Structure of the Assessment Process
	ID537		**Strengths** - The extent of the role of the Diagnostician is clearly defined and seems to align well with international guidelines (e.g. Nachshen, et al 2008). - ACPA applauds the dual criteria established in the current draft indicating that Diagnosticians are both qualified in a professional discipline and have demonstrated knowledge and expertise in ASD. - ACPA further agrees with the suggested outline as to what constitutes "ASD specific expertise" as noted in	Thank you for this feedback. Responses to these concerns are provided next to similar comments made by this respondent.

			section 6.4.2. of the draft. Specifically, we believe that some degree of stringency is required to ensure that a solid understanding of ASD is established based on a mix of clinical experience, supervised work, and continuing professional development/ training. **Concerns** • ACPA strongly disagrees with the suggestions in section 6.4.1. regarding which professionals are eligible to be considered “Diagnosticians”. • Specifically, we would argue that Speech Pathologists and Occupational Therapists are ineligible to be considered as “Diagnosticians”. • We would also argue that generalist Psychologists i.e. those without a Master’s level (or above) qualification in either Clinical Psychology, Clinical Neuropsychology, or Education and Developmental Psychology are ineligible to be considered as “Diagnosticians”. • The above concerns are dealt with separately below:	
	ID538		**Evidence for concerns** ***Speech Pathologists and Occupational Therapists*** • After reviewing various international guidelines directly (e.g. Missouri Department of Mental Health, 2010; Nachshen et al. 2008; NIHCE, 2011), as well as articles reviewing international guidelines (e.g. Penner et al. 2017), ACPA can find no evidence of any recommendation that suggests Speech Pathologists or Occupational Therapists operate as independent Diagnosticians. Rather, these allied health professionals are mentioned in the context of contributing to a multidisciplinary assessment only. • Interestingly, the American Occupational Therapy Association guideline itself does not recommend	Thank you for this comment. This amendment has been made in the revised Guideline. Please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Professional Roles • Structure of the Assessment Process

			participation of Occupational Therapists in all diagnostic assessments for ASD (Tomchek and Case-Smith, 2009). • The current draft Australian guidelines (Whitehouse et al. 2017) cite the Missouri Department of Mental Health (2010) guidelines as evidence toward inclusion of Speech Pathologists and Occupational Therapists as independent Diagnosticians. ACPA would argue that this is somewhat misleading. The Missouri Department of Mental Health Guidelines (2010) indicate that a “licensed health professional” can diagnose ASD, without further specifying the type of professional. However, closer examination of other documents released by the same Department of Mental Health on the topic of Autism Services indicates that Physicians (Paediatricians, Psychiatrists, Neurologists), Clinical Psychologists, and Neuropsychologists are the only health professionals listed as Diagnosticians (Missouri Department of Mental Health, 2015). As such, the Missouri Autism Guidelines (2010) do not provide evidence for the inclusion of Speech Pathologists and Occupational Therapists as sole Diagnosticians. • In some guidelines (e.g. Nachshen et al. 2007) the training of Speech Pathologists and Occupational Therapists is explicitly considered insufficient for ASD diagnosis. • Whilst Speech Pathologists and Occupational Therapists offer invaluable contributions to components of ASD assessment and intervention, ACPA would argue that their professional training is insufficient for eligibility as a Diagnostician, particularly in the area of differential diagnosis. • Differential diagnosis is considered as being of prime importance across all international guidelines in the Anglosphere (e.g. Missouri Department of Mental Health, 2010; NICE, 2011). • There are many factors that can account for symptomology other than ASD and an appropriate assessment involves considering developmental,	

			neurodevelopmental, mental health, psychiatric, intellectual, cognitive, complex trauma, behavioural, social, or environmental (family) factors that could better account for symptoms, plus assessing for the comorbid conditions common in ASD presentations. With most cases requiring in-depth assessment by multiple professionals, it is essential that Diagnosticians are highly trained, experienced, and competent at diagnosing ASD, plus ruling out competing diagnoses that may account for the symptoms presenting (e.g. Global Developmental Delay, hearing problems, complex trauma, psychiatric conditions etc). • The Australian draft guidelines highlight the need for sound differential diagnosis at all tiers of the proposed diagnostic evaluation model (Whitehouse et al. 2017). • The lists of ASD expertise required for Diagnosticians (6.4.2.) vs Functional and Support Needs Assessors (6.5.2) can also be distinguished from each other based on the skills required in differential diagnosis and understanding of common co-morbid conditions for Diagnosticians, but not for Functional and Support Needs assessors (Whitehouse et al. 2017). Clearly skills in differential diagnosis are viewed as critical to sound diagnostic practice within the proposed Australian guidelines, just as they are internationally. • ACPA would argue that the only professionals suitably qualified in differential diagnosis of the full range of relevant Diagnostic and Statistical Manual of Mental Disorders, Edition 5 (DSM V) conditions are Paediatricians, Psychiatrists, Clinical Psychologists Clinical Neuropsychologists, and Education and Developmental Psychologists. Differential diagnosis of all relevant DSM V conditions and understanding of related comorbidities is covered in depth in post-graduate training of the above noted professionals. This also forms part of their daily work in conducting assessments for a range of developmental and psychiatric/mental health disorders.	

			• Some of the highest levels of comorbidity between ASD and other DSM V conditions are observed in AD/HD (up to 40%; Zeiner, Gievik, & Weidle, 2011), anxiety disorders (up to 80%; Siminoff et al. 2008) and depression (up to 38 %; Magnuson & Constantino, 2011). Speech Pathologists and Occupational Therapists are not trained to assess and diagnose these kinds of conditions and, as such, ACPA would argue that distinguishing between these conditions and ASD is not their core skill set. • This is further substantiated by exploring the key areas covered in the professional training of Speech Pathologists and Occupational Therapists. For example, a listing of subjects covered in the Speech Pathology degree at University of Sydney highlights that interpretation of the full range of DSM V conditions is not a core focus (http://sydney.edu.au/courses/uos-landing.html/content/courses/courses/uc/bachelor-of-applied-science-speech-pathology.html). • ACPA again notes the indispensable contribution of Speech Pathologists and Occupational Therapists to other aspects of ASD assessment and intervention. However, we would strongly suggest that including only Paediatricians, Psychiatrists and Clinical Psychologists, Clinical Neuropsychologists, or Education and Development Psychologists as Diagnosticians is the best way to avoid further variation across clinicians in assessment approaches and related outcomes.	
	ID539		***Generalist vs Endorsed (Specialised) Psychologists*** • Table 3 of the draft guidelines (Whitehouse et al. 2017) suggest all types of Psychologists (generalist and endorsed) be considered Diagnosticians. However, standards of training vary greatly between generalist Psychologists and Psychologists with endorsement in a relevant specialised area (e.g. Clinical Psychologists, Clinical Neuropsychologists, Education and	Thank you for this comment. This amendment has been made in the revised Guideline. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Qualifications for Psychologists

			Developmental Psychologists) in the same way that the training of a General Practitioner (GP) is vastly different to that of a specialist Paediatrician. • In the Anglosphere countries where guidelines for ASD diagnosis have been developed there is accredited post-graduate professional training for all psychologists. For example, as a minimum, New Zealand requires a two-year Master's degree; the United Kingdom requires a two-year Master's degree for some areas of specialisation in psychology, but a three-year Doctoral degree for clinical psychology; the USA and most Canadian Provinces require a four-year Doctoral degree, plus an Internship year of supervised practice for registration or licensure as a professional Psychologist. These countries do not allow the practice of psychology by those who have undertaken only an undergraduate degree in the science of psychology. The Psychology Board is aware that the standards for registration as a generalist Psychologist fall behind those of other comparable jurisdictions. Consequently, it plans to retire this model. • Given that generalist Psychologists are not able to be trained in any comparable manner via an unaccredited supervision pathway, it follows that all Psychologists are not capable of conducting the same work. • There is a common thread across all reviewed international guidelines that diagnostic assessments should involve family interviews, direct clinical observations, the potential for multi-setting observations, familiarity (if not formal training with) specialist diagnostic assessment tools and sound skills in differential diagnosis (e.g. Missouri Department of Mental Health, 2015; Nachshen et al. 2008). • As such, ACPA would argue strongly that registered generalist Psychologists are not sufficiently qualified to diagnose ASD despite being able to assist with other aspects of the assessment e. g. Functional and Support Needs assessments.	

	ID540		**Recommendations** • Physicians (Paediatricians, Psychiatrists, Neurologists), Clinical Psychologists, Clinical Neuropsychologists, and Education and Developmental Psychologists (i.e. with a minimum of Master's level Psychology Degree) are the only professionals considered as Diagnosticians. • Speech Pathologists, Occupational Therapists and generalist Psychologists are considered as Functional and Support Needs assessors	Please see responses to similar comments made by this respondent.
	ID541		**Strengths** • Use of peer-reviewed, evidence-based review and uniform diagnostic criteria in the form of the DSM V and International Statistical Classification of Diseases 10th (ICD-10) diagnostic criteria for ASD. • The compromise suggested by Autism Cooperative Research Centre (Autism CRC) of minimising the number of Diagnosticians, particularly for non-complex cases at Tier 1. This would presumably improve the assessment experience for consumers and carers, plus reduce the cost to consumers and institutions. • The recommendation to include multiple sources of information to make a differential diagnosis, including gathering information from multiple sources and across settings. This is consistent with the diagnostic criteria for ASD being evident in multiple settings. • The recommendation for the assessment of complex cases to include multiple Diagnosticians to improve differential diagnosis. • The allowance by the guidelines to include video recordings and video conferencing especially for remote and rural populations. This would improve accessibility to diagnostic services for consumers in remote or rural	Thank you for this feedback. Please see responses to similar comments made by this respondent.

			settings, or those who have other issues that impact on attending clinic settings for the purposes of assessment. **Concerns** • ACPA would suggest that the current proposed guidelines might be too stringent in two areas (with evidence discussed separately further below): • The requirement for all cases to proceed through the Tier 1 assessment process. • The requirement that all cases which are unable to be determined at Tier 1 should go on to have a multidisciplinary assessment that must involve at least 2 Diagnosticians and 2 professional informants. • As described in the earlier section of this submission on Assessment Roles, ACPA does not endorse the inclusion of Speech Pathologists, Occupational Therapists, and generalist Psychologists as Diagnosticians because of lack of sufficient training in differential diagnosis. Evidence relating to this concern was presented in earlier sections of this submission. • The use of Clinical Psychologists is not mentioned in Table 7's list of professionals suitable for conducting assessment of feeding difficulties. Clinical Psychologists are well equipped to help in the assessment of feeding difficulties including sensory, mental health, social and environmental (including family) factors to impair feeding and eating issues (e.g. Silverman and Tarbell, 2009). • Although noted in the list of possible standardised tools for ASD assessment, the value of the combined use of the ADOS/ADOS-2 and the ADI-R if using standardised assessments for ASD is not highlighted enough. Evidence is discussed separately below. • From the language used in the current draft guidelines it seems that medical evaluations are required during diagnostic evaluation rather than being able to be conducted before, during or after an individual has been given an ASD diagnosis. There is discrepancy across the	

			guidelines from the other countries in the Anglosphere on this point. For example, the NICE (2011) guidelines argue for medical evaluation during the ASD diagnostic evaluation (which is understandable given that the same guidelines also adopt a multidisciplinary team for all ASD assessments which include a Paediatrician or Psychiatrist in the core team). Alternatively, both the guidelines from the University of Connecticut (2013) and those from Missouri (2010) suggest that medical evaluations can occur separately to the ASD evaluation. ACPA would argue that given the documented stress on families from protracted assessments and the need to expedite access to intervention (Reed & Osborne, 2012; McMorris, 2013) a medical evaluation, is essential, but more flexibility should be allowed such that they can occur before, during or after the specific ASD evaluation, rather than only during the ASD assessment.	
	ID542		**Evidence** ***The Stringency of the proposed Australian Tiered Model Approach*** • While there is currently insufficient evidence for the most accurate and helpful assessment process (Penner et al. 2017) a Tiered approach to assessment (as conducted in Missouri and elsewhere) may be beneficial if appropriately undertaken. The guidelines note literature indicating that decreasing wait times for a complete assessment, plus using the minimum number of professionals involved, is likely to decrease stress and increase satisfaction for Consumers and Carers (Moh & Magiati, 2012; Reed & Osburne, 2012; Rogers et al. 2016; Rutherford, et al. 2016). It is also acknowledged in the literature that timely assessments are important for accessing early treatment (Canadian Best Practice Guidelines, 2008) and increasing the efficacy of treatment (Reed & Osburne, 2012). Non-published clinical evidence from ACPA members would	In the revised Guideline, ‘tiers’ of assessment have been renamed ‘stages’. This amendment has been made to make it clearer that the Guideline describes a progressive approach to neurodevelopmental and behavioural assessment that is based on the need and clinical complexity of the individual being assessed. The intention of the model is not to repeat assessments from Stage 2 to 3, but to conduct further assessments on an individual (if required) to facilitate differential diagnosis. For further information, please refer to the ‘Overview of Major Amendments’ chapter under the headings: • Professional Roles • Structure of the Assessment Process We believe that the revised Guideline provides the flexibility requested in this comment.

			confer with this proposition. The guidelines also recommend against repeating assessments across Tier 1 and Tier 2, which is to be praised. • Evidence Table 37 (Whitehouse et al. 2017) indicates that there is a great diversity of views amongst professionals, consumers, and the literature about the best structure for Autism assessments. Initially the consultation process conducted by Autism CRC indicated that Tier 1 should be reserved for the most clear or severe presentations. Such presentations may be more easily assessed by an experienced Diagnostician. Preliminary results from the Commissions consultation process indicated that only 10% of cases would fall into this category. The recommendation that all cases pass through Tier 1 before Tier 2 was developed in Round 2 of the Delphi Surveys. However, no clear rationale is given for this change. • Non-published clinical experience of ACPA members working in this area is that referral between professionals, Tiers, or Services often involves some level of repetition of the assessment and certainly an additional wait time for the consumer. Having up to 90% of cases pass through a Tier 1 assessment before a Tier 2 assessment would inadvertently increase wait time for a complete assessment to be conducted. This could well lead to a waste of the consumers' and Diagnosticians' resources and time, increase stress and dissatisfaction for families, lead to a longer wait for treatment and possibly decrease the effectiveness of treatment. Many cases would clearly be complex at the point of referral to experienced and trained Diagnosticians or Professional Informants. Given the lack of consensus or rigorous evidence base, complex referrals could proceed directly to another Tier (e.g. Multidisciplinary assessment). This would save time and resources for Diagnosticians, consumers and their carers, reduce stress and dissatisfaction for families, and allow families to access treatment faster. • Non-published clinical experiences from ACPA members working in this area indicate that at times one experienced	

			Diagnostician can be just as effective as a multidisciplinary team, even when cases are complex. • Moreover, the recent Penner et al. (2017) review article demonstrates that despite multiple recommendations for multidisciplinary team assessment, there is little to no accompanying empirical evidence suggesting that it is a more accurate process than that of an experienced and well trained solo clinician. • ACPA is mindful of the importance of striking a balance between a sound assessment where differential diagnosis is carried out thoroughly, and the needs of families to gain access to critical intervention (often at a critical age in the case of early intervention). As such, we would argue that the Missouri (2010) guidelines offer a model that seems to strike that balance well whereby the use of standardised measures and involvement of other professionals is flexible rather than a requirement and one experienced lead clinician has the ability to determine whether or not a case is obvious and can be assessed with diagnosis made immediately or whether the case is more complex and requires further input from both standardised assessments and other professionals. In that model there is also flexibility as to how many professionals are called upon at each stage rather than a prescribed number as in the current draft guidelines. This already seems to be a model adopted by the National Disability Insurance Agency (NDIA) where the need for evidence for an ASD diagnosis can be satisfied on the basis of an assessment from either a multidisciplinary team or single Diagnostician (Paediatrician, Psychiatrist of Clinical Psychologist (e.g.https://www.ndis.gov.au/people-withdisability/access-requirements/completing-your-access-request-form/evidence-of-disability). ACPA strongly believes: • Further flexibility needs to be incorporated into the proposed tiered model and reduced stringency regarding	

			the number of professionals required in Tier 2 as well as the timing of specific assessments, such as medical evaluations and the Functional and Support Needs assessment.	
	ID543		The combined use of The Autism Diagnostic Observation Schedule (ADOS) and The Autism Diagnostic Interview-Revised (ADI-R) as diagnostic assessment tools. • ACPA would like to acknowledge that the Clinical Psychologist leading ACPA submission is an accredited ADOS and ADI-R trainer in case there is any perceived conflict of interest. However, it is our view that this has no bearing on presenting evidence regarding the statistical properties of these standardised tools as cited in several research studies independent of the above noted clinician. • In the current draft Australian guidelines, the ADI-R is listed along with other instruments as having “emerging” or “inconsistent” evidence (p. 45 Whitehouse et al. 2017). However, a study by Corsello et al. (2007) found that the ADI-R has excellent sensitivity (.90) in distinguishing children with ASD from those who do not have ASD, although the specificity was lower (.54) in distinguishing these two groups. ACPA would suggest that it is likely that the ADI-R will continue to have strong reliability and validity when used for DSM V criteria, although revised algorithms might be needed (e.g. LeCouteur, James, Hammal, & McConachie, 2013). • Similarly, the combined use of the ADOS/ADOS-2 and ADI-R are listed in the same section • under “emerging or inconsistent evidence” (Whitehouse et al. 2017). • ACPA would argue that studies have shown that using the Autism Diagnostic and Observation Schedule (ADOS) and the Autism Diagnostic Interview – Revised (ADI-R) in combination provide the greatest sensitivity and specificity compared with other assessment tools and as such this	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Use of ‘Standardised’ Instruments

			should be highlighted accordingly within the current guidelines. The benefits of combined use of the two tools has been demonstrated for past versions of DSM criteria e.g. DSM-IV-TR (e.g. Risi et al. 2006), as well as replicated in preliminary examinations of current DSM V criteria (Mazefsky, McPartland, Gastgeb, & Minshew; 2013). Indeed, the review conducted by Falkmer et al. (2013), which was cited in the draft Australian guidelines, also indicated that the ADI-R and ADOS stood out with the largest evidence base and highest sensitivity and specificity, when combined. • ACPA acknowledges and agrees with suggestions in other guidelines from the Anglosphere that use of standardised assessment tools should not replace sound clinical judgement and experience (e.g. Ministries of Health and Education, New Zealand, 2016; University of Connecticut School of Medicine and Dentistry, 2013). Moreover, ACPA also believes that data obtained from standardized instruments are most valuable when they are interpreted in the context of the overall evaluation by an experienced clinician. • ACPA does not wish to imply that all diagnostic assessments need to include the ADOS and the ADI-R. • Rather, ACPA would simply suggest that the two tools are not only listed together in the draft guidelines, but also more is said to highlight that, relative to other assessment tools, the combined use of the two measures renders better assessment outcomes. • ACPA suggests that the ADOS and ADI-R are listed together as examples of diagnostic assessment tools and that their value when used in combination is better highlighted.	
	ID544		Recommendations • In line with the Missouri Autism Guidelines Initiative (2010), ACPA proposes a less stringent model that that	Thank you for this feedback. We believe that the revised structure provides a greater degree of flexibility for clinicians, while maintaining assessment rigor. For more information

			proposed by the current draft Australian guidelines. Consistent with the Missouri Guidelines (2010), ACPA endorses the following approach: • Tier 1: The lead diagnostic clinician determines that he or she can independently make a diagnosis or rule out an ASD based on clinical judgment. The lead clinician must come from those trained to complete a thorough differential diagnosis: Paediatrician, Psychiatrist, and at least Master's level qualified Clinical Psychologist, Clinical Neuropsychologist, or Education and Developmental Psychologist. • Tier 2: The lead diagnostic clinician may determine that input from additional sources is needed to determine whether an ASD diagnosis is warranted, particularly when an individual has a more subtle or complex presentation. At this stage, consultation with at least one other professional and/or use of standardized diagnostic assessment tools like the ADOS and ADI-R can aid diagnostic decision making by supplying another viewpoint or additional information based on another professional's expertise, if needed. • Tier 3: The lead diagnostic clinician determines where other professionals from other disciplines are needed to inform clinical judgment about whether an ASD diagnosis is warranted. Such professionals might work within the same setting as the lead Diagnostician or be affiliated with other organisations/workplaces. No specific number of professionals is specified but rather this is based on the judgement of the experienced lead clinician.	about the revised model, please refer to the 'Overview of Major Amendments' chapter under the headings: • Professional Roles • Structure of the Assessment Process
	ID545		• ACPA suggests that Clinical Psychologists are added to Table 7's list of professionals suitable for conducting assessment of feeding difficulties.	The revised version of the Guideline has removed Table 7. For further information, please refer to the 'Overview of Major Amendments' chapter under the headings: • Qualifications for Psychologists

	ID546		- Whilst ACPA would argue that medical evaluations are critical to an overall evaluation, we would recommend that more flexibility be allowed for such that they can be conducted before, during or after an ASD specific assessment.	Please refer to the ‘Overview of Major Amendments’ chapter under the heading: - Structure of the Assessment Process
	ID547		- In the Assessment Role section of this submission, ACPA has already recommended that Paediatricians, Psychiatrists and Clinical Psychologists, Clinical Neuropsychologists, or Education and Development Psychologists (with at least Master’s level training) are considered the appropriate professionals to act as Diagnosticians for the purposes of the ASD diagnostic evaluation	Please see responses to similar comments made by this respondent.
	ID548		**Strengths** - Over all, ACPA believes this section of the guidelines has been very well thought through and developed. - The guidelines also seem to suggest that it is up to the relevant professional to set specific goals. The Functional and Support Needs assessment might indicate that a certain type of professional assessment is needed (e.g. speech assessment) but the speech therapist is given the flexibility to further identifying and prioritise specific goals for intervention. This flexibility is helpful as ACPA would argue that the relevant professionals are well able to determine their own intervention goals in collaboration with their clients.	Thank you for this feedback
	ID549		**Concerns** - From the language used in the current draft guidelines it is unclear to ACPA whether or not Functional and Support Needs assessments *must* occur at any point during the ASD diagnostic evaluation or whether they can be	Please see responses to similar comments made by this respondent.

			conducted before, during or after an individual has been given an ASD diagnosis. There are clear similarities between what appears to be unanimous agreement across guidelines from the other countries in the Anglosphere (e.g. NICE, 2011; Nachshen et al. 2008) and suggestions within the peer reviewed literature regarding the stress on families from protracted assessments and the need to expedite access to intervention (Reed & Osborne, 2012; McMorris, 2013; Mitchell & Holdt, 2014). Therefore, ACPA would argue that a Functional and Support Needs assessment, although helpful, could occur with more flexibility before, during or after an ASD diagnosis is given, rather than only during the ASD assessment (in parallel). **Recommendations:** • Although helpful to an evaluation (and often conducted in parallel), ACPA would recommend more flexibility in allowing for Functional and Support Needs assessments to occur before, during or after an ASD diagnosis is given, rather than in parallel only.	
	ID550		**Strengths:** • ACPA thinks that the suggestion that the support needs assessment should identify whether the client needs to maintain current supports, increase supports, or have further supports added is praiseworthy.	Thank you for this feedback.
	ID551		**Recommendations:** • ACPA would suggest that under 10.3.3. developmental assessments, such as the Griffiths Scales of Child Development, Third Edition (Green et al. 2015) or the Bayley Scales of Infant and Toddler Development, Third Edition (Bayley, 2005), be recognised in the list of standardised assessments for the purposes of gaining a	Recommendations relating to specific instruments that measure functioning have been removed from the Guideline, and information about resources will instead be located on the Guideline webpage to enable updates to occur more readily.

			comprehensive picture of the functional abilities of the individual. These assessments provide descriptive information about the individual's functional strengths and challenges, a total score to describe the individual's overall functional/ developmental status, are norm-referenced with percentile rankings and sub-scores for different activities or activity areas thus providing a detailed profile of functional/ developmental strengths and weaknesses. They also provide profiles that align with the WHO activity areas listed on page 50 of the guidelines. As such, if a professional has already conducted one of these developmental assessments, there would be no further need to “double up” with other functional assessments like the Adaptive Behavior Assessment System (ABAS) or the Vineland Adaptive Behavior Scales.	
	ID552		**Recommendations:** • ACPA is also aware of a Queensland-based group that has developed ASD specific resources (card-sorting tool) to identifying needs. The goal setting tool is still under development, but may prove to be useful as the evidence base develops. It is available for review on the Autism Queensland website: https://autismqld.com.au/page/the-family-goal-setting-tool-fgst (contact person is vicki.tomkins@autismqld.com.au. As ACPA understand it, this project seems to be a joint venture between Autism CRC, Autism Queensland and the University of Queensland. Again, these tools are not necessary, but may be helpful if listed as options to assist in identifying and prioritising needs in a visual way so that the client is better included in the process.	Recommendations relating to specific instruments that measure functioning have been removed from the Guideline, and information about resources will instead be located on the Guideline webpage to enable updates to occur more readily.
	ID553		**Strengths:** • ACPA believes that the guidelines present a very thorough overview of the diverse range of disorders and	Noonan’s syndrome has been added as a co-occurring condition in the Web Resources.

			challenges that can present as either co morbid to ASD or for consideration in discerning differential diagnosis. **Recommendations:** • ACPA would recommend including Noonan's Syndrome as a genetic condition to include in Table 14	
	ID554		REFERENCES Bayley, N. (2005). Bayley Scales of Infant and Toddler Development®, Third Edition (Bayley-III®). USA. Pearson. Corsello, C. Hus, V. Pickles, A. Risi, S. Cook, E. H. Leventhal, B. L. & Lord, C. (2007). Between a ROC and a hard place: Decision making and making decisions about using the SCQ. Journal of Child Psychology and Psychiatry, 48, 932–940. Falkmer, T. et al. (2013). Diagnostic procedures in autism spectrum disorders: A systematic literature review. European Child & Adolescent Psychiatry, 22, 329-340. Filipek, P. et al. (2000). Practice parameter: Screening and diagnosis of autism. Report of the quality standards subcommittee of the American Academy of Neurology and the Child Neurology Society. Neurology, 55, 468-479. Green E. et al. (2015). Griffiths III: Griffiths Scales of Child Development (3rd Edition). Oxford. UK. Hogrefe Ltd. LeCouteur, L. James, P. Hammal, D. & McConachie, H. (2013). New ADI-R algorithms for children and young people with ASD: Implications for DSM V. Symposium presented at the International Meeting for Autism Research, San Sebastian, Spain.	No amendments are required in response to this comment.

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Australian Medical Association Manual Submission [126]	ID555	Organisation - Professional experience	Thank you for providing the Australian Medical Association (AMA) with an opportunity to provide written comment on the draft version of the diagnostic process for children, adolescents and adults referred for assessment of autism spectrum disorder in Australia: A national guideline. In response to growing concern the AMA developed its own position statement on Autism Spectrum Disorder (ASD) in 2016, which contained calls for the development of appropriate clinical guidance for general practitioners (copy attached to submission). The work of the Autism Cooperative Research Centre (CRC), and the members of the Steering Committee, to develop such guidance is welcomed.	Thank you for providing feedback.

	ID556		Further, the proposed two-tier approach to diagnostic assessment will feasibly reduce the time it takes for children with a typical ASD presentation to receive a diagnosis. Children with complex presentations will undergo more comprehensive diagnostic assessments, but given the variety of symptoms and presentations this is likely to be beneficial. A survey conducted by Autism Awareness Australia showed that over thirty per cent of families impacted by ASD had waited over one year for the diagnosis and twenty percent had waited for two years. This is not ideal, and the AMA supports efforts to reduce this wait time. It will be important to monitor the impact that the two-tier system has on the time it takes for families with typical and atypical presentations to receive a diagnosis.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Emphasis on the Importance of Functional Abilities in Referral for Supports • Structure of the Assessment Process
	ID557		As part of initiating an ASD assessment, the draft guidelines strongly encourage the administration of standardised developmental screening measures, three of which are highlighted to be used by professionals such as general practitioners. The cost of purchasing the complete package of resources relating to each of these screening tools is over $1,000. This cost may be prohibitive for some of the designated 'Referral for an Assessment of ASD Concernss' including general practitioners.	Recommendations relating to specific instruments that measure functioning have been removed from the Guideline, and information about resources will instead be located on the Guideline webpage to enable updates to occur more readily. The cost of assessments will be one factor (along with psychometric properties) in determining recommended tools.
	ID558		General practitioners play an important role in providing referrals for the diagnostic assessment. The AMA has received reports that some diagnosticians require a standardised report from a child's school, or teacher, to be completed and provided as part of the referral documents. While there is no doubt that this sort of report provides unique insights, it is important to recognise that general practitioners have no real ability to compel a school, or a teacher, to provide such documentation. While the AMA does recognise the importance of the health and education sectors working together on ASD, it is important to acknowledge practical	Thank you for this comment. This issue is out of scope of the project terms of reference, and so no amendment has been made. However, it may be helpful to note that upon receipt of a referral (such as from a general practitioner), the Guideline recommends "a nominated clinician (or their delegate) from the ASD assessment team … collates existing documents that may assist with the assessment (e.g. previously administered

			limitations such as this. General practitioners cannot be responsible for the conduct of certain teachers and schools. The draft Guidelines do not provide any practical advice about how to resolve such concerns. A small section containing suggestions on improving engagement between health and education professionals, and how to approach any related problems, may be a beneficial inclusion.	client questionnaires, reports from treating clinicians, school records)."
	ID559		It is vitally important that these guidelines are complemented by an appropriately funded dissemination strategy. All too often guidelines and other clinically relevant materials are uploaded to the internet and there is no meaningful effort to alert the relevant professional groups to the material. Specifically, it is worth alerting all Primary Health Networks of the Guidelines and working towards having the document included in their Health Pathways web portals which support the work of clinicians.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Implementation and Evaluation of the Guideline • Practice points for clinical, research and policy settings
	ID560		It would also be appropriate for the Guidelines to be complemented by targets for diagnosis timeframes, for example 70 per cent of children receiving a diagnosis within 4 months of initial presentation with concerns. While such targets may not be achievable initially, ongoing monitoring will provide a clear picture of progress and will unify all relevant professionals to work towards the same goal. It is also worth highlighting the importance of monitoring progress in those with a diagnosis of ASD. This involves base line measurements and then ongoing assessments, but it would help quantify the effectiveness of various interventions, for individuals, but also collectively. Such activities provide important insights, but are also time consuming and would require dedicated funding.	Thank you for this comment. This issue is out of scope of this project, and so no amendment has been made. However, please note that the revised Guideline includes recommendations for future research and policy. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Practice points for clinical, research and policy settings
	ID561		In summary, the AMA would like to reiterate the need to recognise the practical realities of the health and education sectors working together. Doctors and teachers are not able	Please see responses to similar comments made by this respondent.

			to compel each other to complete reports on materials that accompany referrals. The draft Guidelines must recognise this. While it is important to use well validated developmental screening measures, it is also important to recognise that in some instances the costs may be prohibitive.	
	ID562		Finally, the AMA would like to reiterate its appreciation to the Autism CRC and the members of the Steering Committee for their work on these Guidelines. In 2016 the AMA voiced concern about the lack of clinical guidance on ASD and we are pleased to see that such material will soon be available. We would welcome advice around the projected release date of the guidelines so that we can alert AMA members to this important resource.	Thank you for this information.
NSW Government Health - Central Coast Local Health District (Child & Family Health Developmental Assessment Team) [127]	ID563	Organisation - Professional experience	It is difficult for a single clinician from any discipline to fulfil all the roles needed for diagnostic evaluation and functional and support needs assessment. Allied Health assessment is an integral part of assessing functional and support needs and planning intervention.	Thank you for this feedback. The revised structure provides greater clarity regarding Professional Roles, including the importance of allied health assessment. For further information, please refer to the 'Overview of Major Amendments' chapter under the heading: • Professional Roles • Structure of the Assessment Process
	ID564		**Item 6.3- Co-ordinator** Given the clinical complexities of this role, we recommend that a co-ordinator needs to have a clinical background rather than an administrative background.	Thank you for this feedback. The revised structure provides greater clarity regarding Professional Roles, including the importance of allied health assessment. For further information, please refer to the 'Overview of Major Amendments' chapter under the heading: • Coordinator Role

	ID565		**Item 6.4 – Diagnostician** In our service and others in NSW, many developmental assessments including autism-specific assessments are provided by Career Medical Officers/Senior Medical Officers who would meet the "current expert knowledge and experience" as per Item 6.4.2. Within our service, CMOs have 20 years or more experience of assessing and supporting children's behavioural and developmental needs. A large proportion of our work relates to ASD assessment. *We strongly suggest that there should be provision for CMOs working within diagnostic and assessment services to be included as an appropriate diagnostician for both Tier 1 and 2 assessments.*	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Qualifications for medical practitioners • Duration of ASD-specific Expertise
	ID566		Many of our general paediatricians in the community are very competent in diagnosing 'frank' ASD, yet they do not have the 'ASD specific expertise' as outlined in Item 6.4.2. We recommend that general paediatricians be considered as sole diagnosticians in Tier 1" without ASD specific expertise" where the diagnosis is evident.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Qualifications for medical practitioner • Duration of ASD-specific Expertise
	ID567		We are concerned, particularly in the context of NDIS and private EI and therapy services shifting to more of a business/marketing model, that having a single allied health professional in Tier 1 opens up a Pandora's box for potential conflict of interest downstream in the delivery of support and intervention.	Text has been added to the Comprehensive Needs Assessment - Decision Making and Outcome section to suggest that conflict of interest be managed at the point of referral to service providers through members of the ASD assessment team. Please refer to the 'Overview of Major Amendments' chapter under the following heading: • Conflicts of interest

			We recommend that safeguards are established to ensure the diagnostic process remains independent and that ongoing monitoring for potential conflicts of interest is implemented.	
	ID568		Item 10 - Functional and Support Needs Assessment: We agree this is a necessary part of the evaluation of a child with possible ASD, but recommend it should be regarded separately to the diagnostic evaluation, and may take place after the initial diagnostic evaluation is completed.	Please also refer to the ‘Overview of Major Amendments’ chapter under the following headings: • Emphasis on the Importance of Functional Abilities in Referral for Supports • Cost implications of the assessment model recommended in the Guideline
	ID569		Once again, in non-urban and regional areas, awaiting an assessment from allied health services could potentially delay the process of accessing early intervention services in a timely manner.	Thank you for this feedback. The revised Guideline provides greater flexibility in terms of professionals able to undertake a Stage 1 assessment, particularly in terms of medical practitioners.
	ID570		**Item 9.4 - Tier 1 Diagnostic Evaluation:** ***We recommend that a paediatrician, CMO, or GP with Disability specialist training be the minimum requirement for the diagnostic process.*** It is important that differential diagnoses are excluded, and co-occurring conditions considered given the complex presentations of the children we see. There is potential for these to be missed by a clinician who does not have the skills or expertise to adequately assess the medical and health issues in those with developmental concerns where ASD is a possible explanation for the child’s difficulties. Comorbid conditions like anxiety and ADHD influence a child’s presentation and functioning socially, emotionally, and academically so these children need a thorough work-up. Within our service, we see a proportion of children from vulnerable backgrounds, including those in out-of-home care	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Professional Roles • Structure of the Assessment Process

			arrangements, with complex family and social circumstances. Many present with attachment issues, which often overlap with ASD presentations. Many of them are assessed by our multidisciplinary team, which has the skillset and expertise to tease out the needs of these children.	
	ID571		**Items 9.4 and 9.5- Tier 1 & 2 Diagnostic Evaluation:** ***We recommend that a developmental/cognitive assessment should be a mandatory part of the diagnostic process in both tiers, which addresses one of the 'specifiers' in the DSM-5 diagnostic criteria for ASD.*** Within our service, we undertake formal developmental assessments using the Griffiths III and/ or our psychologists undertake cognitive testing. We rely on these to help us understand a child's skills profile- their strengths and areas of challenges, which informs intervention and therapy strategies and approaches; and to allow direct observation of a child's social communication and interaction skills, their play and behaviour. It is an invaluable part of our diagnostic and assessment process.	Thank you for this comment. The revised structure provides far greater emphasis on the importance of a comprehensive functional and needs assessment in providing the foundation for a diagnostic evaluation. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Structure of the Assessment Process
	ID572		For Tier 2 diagnosis in children under school age, we recommend that a diagnostic evaluation can be completed by two medical professionals (Paediatricians/Career Medical Officers/GP's with Disability specialist training) who have the relevant skills to assess for both ASD and global developmental delay, i.e. without an additional diagnostician from a different professional discipline or specialty. Subsequently, allied health therapists can be involved for the functional and support needs assessment. Paediatricians, CMOs, and GPs with disability specialist training with "current expert knowledge and experience" as per Item 6.4.2 have a wide knowledge and holistic approach across the domains of paediatric medicine, and development	The revised structure provides greater flexibility that will enables the scenario described here. For further information of the revised structure, please refer to the 'Overview of Major Amendments' chapter under the headings: • Professional Roles • Qualifications for medical practitioners

			and behaviour, which often includes the ability to administer formal developmental assessments. Unfortunately, due to resource restrictions in the public setting, our allied health colleagues have long waiting lists for initial assessment, which then further delays diagnosis. This means that it will be mostly impossible to complete a full evaluation of a child within the recommended 3-month period. This is particularly an issue in low socio-economic areas- such as our own	
Manual Submission [128]	ID573	Organisation - Professional experience	I am writing to you in my position as Coordinator of the [Title] Course at [Organisation]. The submission is supported by my experience as a provider of ASD diagnostic and intervention services in the Northern Territory. Since first commencing in Darwin in 2013 I have been very dismayed by the extremely low level of specialist services in NT and Darwin. Over the past five years I have been directly involved in the provision of ASD diagnostic services to close to 200 children, teenagers and adults in Darwin. This has involved working in collaboration with Paediatricians, Psychiatrists, Speech Pathologists, NT Education, Autism NT and Autism SA. This has been a humbling experience but one which has also allowed me to see the direct benefits of considered skilled diagnosis of ASD, or other neurodevelopmental disorder for these individuals and their families. I have read the draft guidelines and congratulate your group for the well-considered and excellent document. One of the issues which has been apparent in NT has been that diagnosis and treatment without solid guidelines with minimum standards has resulted in the provision of many, very expensive, but inferior assessments. Individuals with little or no knowledge and no ongoing training have misdiagnosed many in NT. Shortage of specialists has encouraged	Thank you for these helpful comments. The Guideline has been developed with a specific eye to the issues of accessibility to clinical services in rural and remote regions. We believe that the revised structure provides even greater flexibility that help ensure ready access to services to all Australians regardless of geographic location. For further information on the revised structure, please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Structure of assessment process Please also note that the revised Guideline includes ‘equity’ as a guiding principle (Section 2.5).

			diagnosis or rejection of diagnosis, based on assessments as brief as 15 minutes. [Organisation] ASD assessments have provided assessments based on WAADF guidelines and have resulted in a raising of standards which is encouraging. The assessments are heavily subsided by the University. There are very few private psychology assessors in Darwin - to my knowledge only two in the past eighteen months who are past students of the [Organisation] [Course]. I encourage you to think about how to ensure provision of like with like assessments and interventions for all Australians. Rural and remote areas and small cities including a capital city such as Darwin, have very limited specialist resources, and a heavy weighting towards junior providers with high turnover. The report recommends defined Diagnosticians and Professional Officers which will work well in bigger cities but how can we get this expertise into these rural and remote areas and small cities and towns? How can we network to bring experienced Diagnosticians from other parts of Australia into these communities? How can we streamline diagnosis and then the service provision required? How can we effectively use tele video and other resources? I fear that we will end up with a good system in the major capital cities and an inferior or non-existent system in the rest of Australia. This will be especially problematic for indigenous Australians.	
	ID574		I am also concerned that in the areas of the report requiring specialist levels of skill/qualification such as Table 7 page 42-3 that you have not recommended registered psychologist (clinical speciality) in the area of mental health and psychiatric concerns. It is vital that in these areas the professional has the skills. These are provided routinely in the specialist qualifications provided in the Master of Psychology programmes. When making diagnostic determinations we must demand qualifications which enable informed decisions. The report required clinical speciality for Trauma and	Please refer to the 'Overview of Major Amendments' chapter under the heading: • Qualifications for Psychologists

			Deprivation and it does not make sense to not also extend this to mental health and psychiatric concerns.	
Manual Submission [129]	ID575	Individual - Lived experience (C,F)	I respectfully request an extension of 3 months to allow community and professionals an appropriate amount of time to prepare submissions. The Guideline, technical report and evidence table contains an overwhelming amount of material. The Guideline contains ambiguity in many areas which have potential for significant impact on service delivery. Disambiguating the guideline in the context of case law pertaining to the Disability Discrimination Act and NDIS communiques, requires the marshalling of a large volume of further information - all of which takes time and resource. The consultation period September 7th to October 19th does not permit those working voluntarily and without technical and administrative support, reasonable time to read, digest and respond to the proposed guideline. Furthermore, the CRC did not invite Applied Behavior Analysis Australia, (ABAA, a group representing credentialed ABA practitioners in Australia) to participate in the community consultation for the guideline. Credentialed practitioners from the field of ABA were not involved in the preparation of the Guideline. The process of dissemination to ABAA by word of mouth, was much slower than the process for the groups who were formally invited by the CRC. This had the effect of reducing the time for ABA professionals to respond. In the interest of developing a Guideline that protects and promotes the welfare of all people with autism, I	Thank you for this feedback. Unfortunately, we were unable to provide an extension to the timeline of the feedback period, but greatly appreciate the comments you have provided here. We note that our extensive, nationwide consultation included feedback from many ABA service provider organisations and clinicians. The feedback received has been very helpful in generating the revised Guideline.

			hope that CRC will grant this request for an extension of the public consultation period.	
	ID576		What follows is a very limited response, it does not contain many significant concerns due to lack of time to respond. 1. The title of the guideline “The diagnostic process for children, adolescents and adults referred for assessment of autism spectrum disorder in Australia: National guideline” is inaccurate. In addition to diagnostician, the guideline creates the role “Functional Needs Assessor” (FNA) and a “Functional and Supports Needs Assessment” (page 20). The guideline also describes a Functional and Support Needs Assessment is a parallel assessment to diagnostic assessment that identifies support needs, establishes goals and links to the most appropriate support services (p48) This is of concern because the guideline goes beyond diagnosis into assessment of needs, referral to interventions and ongoing evaluation of interventions. Experts in need-assessment and intervention from the field of applied behavior analysis, i.e. Board-Certified Behavior Analysts, who should be concerned about this guideline, would not even know to comment if they are not diagnosticians, because the title suggests that the guideline is not relevant to their scope of practice.	The title of the Guideline has been changed to: “*A national guideline for the assessment and diagnosis of autism spectrum disorders in Australia*”
	ID577		2. The Functional Needs Assessor must be licensed to administer standardized tests, and this is of concern because it rules out many BCBAs from assessing needs (p22).	Please note that the revised Guideline incorporates substantial changes to the Structure of the Assessment Process and associated Professional Roles . For further information, please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Professional Roles • Structure of the Assessment Process

				If a BCBA also meets the requirements outlined in Section 7.1 (e.g., a psychologist registered with AHPRA), there is no preclusion from these professionals being incorporated into the assessment process at Stage 1 or Stage 3.
	ID578		3. The list of professional informants does not mention BCBA or behavior analysis, (p22). This is of concern because diagnosticians and parents need to know that BCBAs can help children with autism and that credentialing of behavior analysts is an important consumer and human rights protection.	Board Certified Behaviour Analysts have been added to the list of other professionals who can provide information to support the ASD assessment.
	ID579		4. The only permitted assessment tools in Functional and Support Needs Assessment are standardized tests (p50). This is of concern because the terminology “functional” and “assessment” may cause consumers to assume that their child is receiving a functional behavior assessment. There is a lot of confusing jargon for parents to learn quickly when their child has ASD, anything that can be done to avoid confusion is helpful. Furthermore, the exclusive use of standardized tests to identify treatment goals, falls outside the requirements of the NDIS Communiques and restricts the rights of people with disability as described by World Health Organization and UN charters. It is desirable that treatment and support goals, and the methods to identify the goals, are aligned with the rights of people with disability. NDIS Communiques, WHO resolutions and UN charters do not require individuals with autism to accomplish statistically significant gains in behavior of significance to populations, in order to access habilitative and rehabilitative treatment for behavior that is socially significant	Recommendations relating to specific instruments that measure functioning have been removed from the Guideline, and information about resources will instead be located on the Guideline webpage to enable updates to occur more readily.

			to an individual’s quality of life and increases independence at home and in the community. There are norm referenced criterion based tests (such as the VB MAPP and Essential for Living) that do a better job of identifying many socially significant treatment goals than standardized tests. The NDIS communiques, WHO resolutions and UN charters do not preclude their use. Public and private funding agencies outside Australia, permit the use of norm referenced criterion referenced tests to identify treatment goals for people with autism.	
	ID580		5. The evaluation of ongoing functional status and support needs is done by repeating the Functional and Support Needs Assessment i.e. using standardized tests. The guideline proposes that standardized tests are used to estimate potential for increased functioning if additional supports were provided. This raises a scientific and ethical red flag because use of standardized tests is not evidence based practice., without directly observed and graphed data, well defined behavior, written behavior plans, checks for treatment fidelity and explicit programming for skill generalization. In the absence of program evaluation and evidence based practices, it is unethical to conduct standardized tests on a child for the purpose of predicting their potential, (p54). Human rights experts might have concerns about this too and the CRC should consult with that sector before finalising the guideline and submitting it for publication. There are also concerns for older clients for whom statistically significant changes in a standardized test are unlikely, but who have potential for behavior change of social significance as measured by graphed data over time for well-defined behaviour. This is especially relevant for clients with severe problem behavior managed by restrictive practices or involuntary sterilization.	We have been unable to identify evidence to support the statement: “*This raises a scientific and ethical red flag because use of standardized tests is not evidence based practice, without directly observed and graphed data, well defined behavior, written behavior plans, checks for treatment fidelity and explicit programming for skill generalization.’* The Guideline relates to the holistic evaluation of an individual presenting for an assessment that may lead to a diagnosis of ASD. This comment appears to be referring to treatment monitoring, which is a critical part of clinical management, but an aspect of clinical practice that is outside of the scope of the terms of reference for this project.

	ID581		3. The list of professional informants does not mention BCBA or behavior analysis, (p22). This is of concern because diagnosticians and parents need to know that BCBAs can help children with autism and that credentialing of behavior analysts is an important consumer and human rights protection.	Please refer to the response to comment above.
	ID582		4. The only permitted assessment tools in Functional and Support Needs Assessment are standardized tests (p50). This is of concern because the terminology "functional" and "assessment" may cause consumers to assume that their child is receiving a functional behavior assessment. There is a lot of confusing jargon for parents to learn quickly when their child has ASD, anything that can be done to avoid confusion is helpful. Furthermore, the exclusive use of standardized tests to identify treatment goals, falls outside the requirements of the NDIS Communiques and restricts the rights of people with disability as described by World Health Organization and UN charters. It is desirable that treatment and support goals, and the methods to identify the goals, are aligned with the rights of people with disability. NDIS Communiques, WHO resolutions and UN charters do not require individuals with autism to accomplish statistically significant gains in behavior of significance to populations, in order to access habilitative and rehabilitative treatment for behavior that is socially significant to an individual's quality of life and increases independence at home and in the community. There are norm referenced criterion based tests (such as the VB MAPP and Essential for Living) that do a better job of identifying many socially significant treatment goals than standardized tests. The NDIS communiques, WHO resolutions and UN charters do not preclude their use. Public and private funding agencies outside Australia, permit the use of norm referenced criterion referenced tests to identify treatment goals for people with autism.	The name of this part of the ASD assessment has been changed to 'Comprehensive Needs Assessment', which includes a 'Functioning Assessment'. It was considered essential to maintain this reference to functioning, as it is a core concept within the ICF and underpinning the assessment principles. Recommendations relating to specific instruments that measure functioning have been removed from the Guideline, and information about resources will instead be located on the Guideline webpage to enable updates to occur more readily.

Dieticians Association of Australia (DAA) [130]	ID583	Organisation - Professional experience	**Recommendations** DAA recommends the following: That the word 'Dietitian' be changed to 'Accredited Practising Dietitian (APD)', throughout the guidelines.	Accredited practising dietitian has now been used throughout the Guideline.
	ID584		APDs valuable Professional Informants on nutrition-related behaviours of concern for ASD Assessments, and during the Functional and Support Needs Assessment.	Thank you for this comment. Based on feedback received, this table has been omitted from the revision Guideline, and the information included in the table has been incorporated in other sections of the document.
	ID585		The Coordinator should ensure they are familiar with the definition and role of an APD, and understand that APDs work across a range of settings.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Coordinator Role
	ID586		The following changes be made to *table 7.* (p42-44): **Physical and Sensory** Column *Co-occurring Concerns*, Row *2* - include 'food allergies and intolerances' with gastrointestinal difficulties.	Thank you for this comment. Based on feedback received, this table has been omitted from the revision Guideline, and the information included in the table has been incorporated in other sections of the document.
	ID587		Column *Example of Additional Professional Informant,* Row *8* - include APD for *Sensory processing differences, such as hypersensitivity or hyposensitivity*	Thank you for this comment. Based on feedback received, this table has been omitted from the revision Guideline, and the information included in the table has been incorporated in other sections of the document.
	ID588		**Mental and Social**	Thank you for this comment. Based on feedback received, this table has been omitted from the revision Guideline, and

			Column *Example of Additional Professional Informant,* Row *8* - Include APD under for *Attention Difficulties and/or Hyperactivity*.	the information included in the table has been incorporated in other sections of the document.
	ID589		**Functional** Column *Co-occurring concerns*, Row *2*, *'Feeding issues, such as food selectivity, diet concerns or meal time challenges'* should be reworded to '*Food-related behaviours of concern, such as sensory issues, food refusal and selectivity, or mealtime challenges'*.	Thank you for this comment. Based on feedback received, this table has been omitted from the revision Guideline, and the information included in the table has been incorporated in other sections of the document.
	ID590		DAA recommends APDs be included in the list of professionals who may observe the child in home or outside settings (Table 10. under column *Considerations*, for Aspect: *Information and Collection*, p 59.)	The professionals listed here are provided as examples (e.g., '…such as…'), and is not intended as an exhaustive list. For this reason, we have not added APDs into this list.
	ID591		**Physical and Sensory (p. 42, row 2)** As part of gastrointestinal difficulties, APDs do assess Consumers with ASD for food allergies and intolerances, and are skilled at guiding Consumers and their carers through processes such as elimination diets to ensure diet quality is maintained. There is a growing body of evidence linking feeding difficulties and ASD [1], including sensory issues to food smell, taste, and textures [2]. APDs should be considered key Professional Informants in assessing these issues. **Mental and Social (p. 43, row 4)** An APD should be considered a Professional Informant for *Attention Difficulties and/or Hyperactivity*, particularly if concerning behaviour occurs around meal times [3,4]. It is also important to make sure Consumers diets are adequate to	Thank you for this comment. Based on feedback received, this table has been omitted from the revision Guideline, and the information included in the table has been incorporated in other sections of the document.

rule out nutritional deficiencies as a cause of any concerning behaviours. Consumers with ASD have been found to have higher rates of certain nutrient deficiencies/imbalances (including calcium and protein) [1,2,5]. It is therefore important that an APD be involved to conduct a thorough assessment of the Consumers diet [1].

Functional (p.44, row 2)

The changes to the wording for the *Co-occurring Concerns* column, under ‘Functional’ are recommended to better encompass terminology used in the guiding documents used by APDs working with Autism, and the literature [1,6,7]

Communication during an ASD Assessment

DAA supports that professionals be sensitive to the cognitive/intellectual abilities and verbal language level of the Consumer. This includes those of Culturally and Linguistically Diverse (CALD) Backgrounds (including Aboriginal peoples).

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	ID592		**ASD Assessment Guiding Principles** DAA supports the purpose of the guidelines, and that they should be individual and family-centred, strengths focused, evidence based and follow a holistic framework.	Thank you for this comment.
	ID593		**ASD Assessment Roles** DAA supports the roles outlined and described in the guidelines for the assessment team – Consumer, Referral for an Assessment of ASD Concerns, Coordinator, Diagnostician/s, Functional Needs Assessor/s, Professional informant/s. DAA agrees that the ASD assessment process should be coordinated by a central contact person, or Coordinator. The Coordinator should have comprehensive knowledge of ASD and the Professional Informants contributing to team care.	Thank you for this feedback.

			DAA supports APDs as Professional Informants for both Tier 1 and Tier 2, and Functional and Support Needs ASD Assessments.	
	ID594		**ASD Assessment Settings** DAA agrees that environment can influence behaviour, therefore collecting assessment information from a variety of settings is important. APDs, as Professional Informants, are well placed to consult with Consumers in the clinical setting (i.e. allied health clinics, Medical Centres) and in the community (i.e. home visits), to assess meal times. With Consumer/carer consent, this may be recorded or photographed for documentation purposes and to provide visual evidence of nutrition-related signs, symptoms and/or behaviours of concern to the Coordinator. APDs can also use telehealth (e.g. telephone, video conferencing) for consulting with those clients in which access or transportation is a barrier to a face-to-face assessment.	Thank you for this comment. Based on feedback received, this table has been omitted from the revision Guideline, and the information included in the table has been incorporated in other sections of the document.
	ID595		**Communication during an ASD Assessment** DAA supports that professionals be sensitive to the cognitive/intellectual abilities and verbal language level of the Consumer. This includes those of Culturally and Linguistically Diverse (CALD) Backgrounds (including Aboriginal peoples).	Thank you for this feedback.
Officer of Director-General ACT Government Health [131]	ID596	Organisation - Professional experience	ACT Health feedback on the draft publication 'the diagnostic process for children, adolescents and adults referred for assessment of autism spectrum disorder in Australia: National guideline'. The feedback that I have received from the Community of Paediatricians of ACT Health is that the document does not fully	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the headings: • Emphasis on the Importance of Functional Abilities in Referral for Supports • Structure of the Assessment Process

			address the issue that disability and educational support funding is still allocated for certain diagnoses, but not others, regardless of an individual child's level of functional impairment. It was suggested that further concentration and elaboration is undertaken on Section 10 of the document - establishing a standardised evaluation of an individual's functional capacity and support needs, and allocating resources accordingly, regardless of their underlying diagnosis. It has long been the case that children with ADHD, Specific Reading Disorder (dyslexia) and Borderline Intellectual Impairment are denied support funding in both Disability and Education fields, whilst Autism automatically brings with it support funding, regardless of an individual's language, cognitive or academic capacity. The Community Paediatricians felt that this underlies the markedly increased rates of autism diagnosis over the past 10 years with the perception that families and schools now look to autism as an explanation for any child's struggles with learning, behavioural or emotional difficulties, because it is the surest means of securing support for that child. Thank you for the opportunity for ACT Health to provide feedback on this National Guideline.	
Djerriwarrh Health Service (group of respondents) [132]	ID597	Organisation - Professional experience	We have several concerns related to the proposed model for diagnostic evaluation. 1. Training and Accreditation of Diagnosticians. If the diagnosis of ASD is to retain clinical relevance it is essential that those tasked with the ability to make the diagnosis are properly accredited and trained in best practice. This must be an open and objective process. It must also take into consideration the possible differential diagnoses, (which	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the headings: • Accreditation and Regulation • Practice points for clinical, research and policy settings

			is highlighted in the discussion paper,) and presumes the diagnostic skill to do so. Sadly, in our experience, in practice this is often not the case. Unless these issues are addressed with a robust accreditation process for diagnosticians it is our belief that the diagnosis will be "dumbed down" to little more than a synonym for Global Developmental Delay. As a contrast, it takes 12 months accredited training to train a paediatrician in something formulaic as Allergy, yet in something as complicated as Autism Assessment, we will allow any paediatrician or allied health professional to self-declare their competence. Your guidelines include no description of an accreditation process for diagnosticians. Who assesses the assessors? This is critical if this is to be a valid process. We must have some form of recognised training/accreditation from a recognised program/multi-disciplinary team. The proposed training you have outlined for diagnosticians is open to subjectivity and we are concerned that with subjective training guidelines and no regulatory process the quality of diagnosticians will vary and may be substandard. This is dire when the proposal is that one clinician, without accreditation, can make a diagnosis. Within current practice, requiring a multidisciplinary team, there is some quality control over diagnostician expertise as a consensus between three practitioners must be reached. Your proposed guideline removes this quality control and hence it would seem that rigorous accreditation is essential.	
	ID598		4. Compatibility with funding criteria The Education Department in Victoria will not currently accept a Tier 1 diagnosis as part of their 'Program for Students with Disabilities'. They require a multidisciplinary assessment comprising of a speech pathologist, psychologist, and paediatrician/psychiatrist. This will deny any children access to integration funding and enrolment in specialised education facilities. E.g. Western Autistic School.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Implementation and Evaluation of the Guideline • Practice points for clinical, research and policy settings

			The tier process may be used by NDIS as a cut off for support. Additionally, within the public health sector making changes such as this impact on funding from the Department of Health as the service delivery model is affected. Existing funding arrangement may not necessarily cover major adaptations to the model such as the proposed two-tier system. This is likely to create downstream problems in terms of funding public services and have flow-on-effects into other areas of public health care. It is critically important that the assessment for autism can continue within this sector and does not become available only within the private sector to those who can pay. We are optimistic that national guidelines can be developed and agree that a standardised empirically-sound model for assessing autism should be used across all assessments providers in Australia in order to provide thorough, accurate and most importantly assessments which are useful for the individuals and their families involved. We look forward to seeing the revised guidelines	
	ID599		5. A Move Away from Standardised Instruments. Diagnosticians are discouraged from using any standardised autism-specific tests or developmental/language/cognitive tests within the Tier 1 assessment. This seems concerning as it would make autism assessment less consistent and recommendations based on more subjective information. Specifically, for this population of children standardised assessments can often reveal strengths that should be recognised and utilised in future supports and treatments are often not obvious on informal observation.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Use of 'Standardised' Instruments
	ID600		2. The Two-Tier Model	We appreciate these helpful comments. In light of this and other feedback, the revised Guideline has been amended. For

			Multidisciplinary assessment continues to be recommended by many as optimal for making a diagnosis of autism spectrum disorder (e.g. NICE Guidelines 2011, American Academy of Child and Adolescent Psychiatry Committee on Quality Issues 2014, New Zealand Autism Spectrum Disorder Guideline 2016). Whilst we accept than an experiences clinician is able to make a diagnosis in a clearly autistic child, this is only the beginning of a process that will need to involve many health professionals. The emphasis however must be placed on experience and accreditation of a sole clinician and how that is determined. This in our view is critical and the core of a two-tier process is to have any validity. Evidence table 37 states that the steering committee recommended that a tiered system be "… informed by sound empirical evidence, that operationalisation of the guideline is sufficiently detailed and clear to promote consistent application, and that the mechanisms for the objective oversight of the system are included" (page 134, Evidence Tables). This seems a fair and important recommendation which does not appear to have been addressed, empirical evidence eon the efficacy of a single clinician diagnosis is not established and studies which have measured stress and parent satisfaction (as cited in the scholarly literature on page 132) do not produce results which say anything regarding diagnostic accuracy. The evidence tables refer to any assumption that only a small number (10%) (e.g. workshop participant comments on page 135 of the Evidence Tables), will involve a Tier 1 process, when in fact the pressure will be on all practitioners to use this as "fast track" diagnostic process for the majority of assessments. While the guidelines state "diagnostic certainty" must be reached there is no description of what exactly this means, it is likely that what is "certainly autistic "to one practitioner may not necessarily be so to another.	further information, please refer to the 'Overview of Major Amendments' chapter under the heading: • Structure of the Assessment Process

			Additionally, the recommendation that a Tier 2 Assessment must involve face-to-face observation in two or more setting will be time and resource intensive and is unnecessary if clinicians are skilled in undertaking history taking and clinical observation. Perhaps in a small number of children this may be necessary, however it is unlikely to be necessary in the “90% of children who are optimistically being assumed to be suitable for Tier 2. As well as presumably the most efficient way to undertake a Tier 1 diagnostic assessment and functional needs and support assessment is that the information from the diagnostic assessment informs the functional needs and support assessment (e.g. X child has the following deficits in social reciprocity ...and therefore the following functional supports are recommended…). However, there seems to be a mismatch between the information required to undertake a thorough and useful functional needs assessment and what would be required at a minimum for a Tier 1 evaluation (i.e. no standardised assessment results). The issues with the current systems (e.g. long waiting times, having to see multiple clinicians separately, etc.…) certainly will not be resolved if consumers are required to undertake a diagnostic assessment and then need to be referred to a separate functional and support needs assessment. Other concerns we hold regarding the potential short-comings of a two-tiered system appear to be well articulate in the workshop comments of evidence Table 37, however disappointingly these do not seem to be addressed in your proposed model.	
	ID601		3. Use of a GP as a Professional Informant. It is not appropriate for a GP to provide medical component of an allied health assessment; they lack the diagnostic skill or training and we believe would be appropriately reluctant to do so. Further they will be put under pressure to “rubber stamp”	We appreciate these helpful comments. We believe that the revised draft addresses this comment. For further information, please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Structure of the Assessment Process

			the diagnosis of others. Additionally, encouraging use of a GP, rather than building a paediatrician/child psychiatrist into the model as the central health professional may discourage families from linking in with paediatricians/child psychiatrists. The role of a paediatrician (or child psychiatrist) is crucial for a child with ASD, during the assessment phase and then following up the child through their development. In the rapidly developing field that is autism, primarily, paediatricians that possess the specialty knowledge to make a thorough differential diagnosis and answer parents questions and concerns. Importantly, paediatricians themselves do not typically provide autism interventions enabling them to be a relatively less biased source of information about treatments and prognosis for a child. Furthermore, it is wholly appropriate for a paediatrician to follow up a child over the entire span of their childhood and adolescence, no other discipline listed in the proposed diagnosticians list would have any reasonable justification for doing this. Any model should encourage parents to use a paediatrician as this central practitioner for the child's development, not create a situation where children are potentially never seen or assessed by a paediatrician.	• Professional Roles
Manual Submission [133]	ID602	Individual - Lived experience	I am a parent of a 35yr old daughter with ASD and many other issues, who was not diagnosed till she was 19+yrs of age. Certainly not through lack of taking her to Specialist from kindergarten. Everyone making me feel that it was my fault or bad parenting I am a full-time carer of her son since he was 20 months. I feel I am going down that same track. He has been diagnosed by 3 psychologists as PDA (pathological demand avoidance) and yet here in Australia we do not recognize this. WHY? Their father/grandfather in his words believes he is Asperger. He has cousins that have autistic children and go to special schools. Due to my grandson passing these ridiculous one-sided tests we are told he does not qualify for ASD diagnosis. I have been saying he is on the spectrum since he was 2- 1/2yr old. I feel whoever	Please refer to the 'Overview of Major Amendments' chapter under the following heading: • Pathological Demand Avoidance

			write these guide lines Do Not Have Personal Experience of Living with these Children and Should be Listening to what Parents are Saying. These specialists say, "We are Listening to the parents" very few, believe me. My question is Why Isn't PDA in these Diagnostic Diagnosis with ASD " If you were to google Pathological Demand Avoidance it comes up, that it is on the Autism Spectrum Disorder. Why do we have to go down this track again with non-believers? I would appreciate a reply.	
Australian Association of Developmental Disability Medicine (AADDMM) [134]	ID603	Organisation - Professional experience	AADDM supports elements of the guidelines, bot holds significant concerns about important aspects. Key elements of the guideline we support include: • The importance of function and support needs for people diagnosed with autism spectrum disorder (ASD) • Recognition of the importance of the person and the family's experience of the assessment process and the need to be supported through it • The pragmatic 2-tiered approach to diagnosing ASD, • The importance of working collaboratively across disciplines	Thank you, we greatly appreciate the feedback provided.
	ID604		However, AADDM holds significant concerns in relation to several important professional and service implications of these Guidelines. The draft guidelines introduce a range of complex and intricate new requirements for involved professionals and the diagnostic process which will be unlikely to address inconsistencies in current approaches to diagnosis and will introduce new issues with uncertain impact. Furthermore, the resource implications of these guidelines can be expected to be substantial, and warrants serious consideration. This must include all aspects of proposed modifications to service delivery, training and monitoring.	Thank you for these comments. We believe that the substantial revisions to the Guideline address these concerns. The 'Overview of Major Amendments' chapter.

	ID605		AADDM acknowledges that the diagnosis of Autism Spectrum Disorder (AS) is important for understanding the types of interventions that may be helpful for the person, however, a precise categorical diagnostic approach for ASD may not be feasible for a particular individual given inherent complexities of the condition. We strongly support a diagnostic formulation that focusses on developmental/functional skills as the foundation an ensures that appropriate support and intervention are provided to the person, and their family, irrespective of the specific diagnosis. These are not clearly apparent in these Guidelines. We believe that some of the recommendations are unlikely to be workable or in the best interests of the person suspected to have ASD. We strongly recommend that the inclusion of speech therapists and occupational therapists as diagnostics be reviewed. AADDM recognises their important to the diagnostic process and to intervention, but contends that diagnosis requires extensive professional training to integrate a complex array of health and other clinical information. For this reason, AADDM does not support speech therapists and occupational therapists being a sole/primary diagnostician.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Emphasis on the Importance of Functional Abilities in Referral for Supports • Professional Roles • Structure of the Assessment Process
	ID606		We also recommend that: ASD specific diagnostic processes are effectively integrated into existing services, especially those for detecting and diagnosing developmental delay/disability.	We believe the structure of the revised Guideline addresses this helpful comment. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Referral for an Assessment of ASD Concerns • Coordinator • Structure of the of the assessment process
	ID607		Irrespective of the outcome of an ASD diagnostic assessment the goal is to provide assistance to the person and their family in relation to their concerns.	Thank you for this comment. We believe that the revised Guideline is compatible with this comment, particularly the emphasis of referring of individuals (at each stage) based on functional abilities and support needs. Please refer to the 'Overview of Major Amendments' chapter under the heading:

				• Emphasis on the Importance of Functional Abilities in Referral for Supports
	ID608		Guiding principles should include a statement that diagnosis should consider issues from a lifespan perspective.	Thank you for this comment. 'Lifespan perspective' has been added as a guiding principle in the revised Guideline. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Guiding principles
	ID609		The extensive requirements for ASD training is not feasible for most medical specialists, e.g. paediatricians and psychiatrists.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Duration of ASD-specific Expertise
	ID610		Specific recommendations in relation to allied health professionals such as psychologists must be line with APS and psychology college recommendations.	Please refer to the 'Overview of Major Amendments' chapter under the heading: • Qualifications for Psychologists
	ID611		Significant costs are likely to be incurred by families in order to meet the assessment/diagnosis requirements and this need to be considered and acknowledged.	Thank you for these comments. A major challenge in public policy is how to strike the best balance between assessment rigour and affordability. Following the extensive consultation, we believe that the revised Guideline document achieves this balance as much as possible. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Cost Implications of the Recommended Assessment Model Please also note that the revised Guideline includes a recommendation regarding costs for ASD assessments.

				Please refer to the 'Overview of Major Amendments' chapter under the heading: • Practice points for clinical, research and policy settings
Manual Submission [135]	ID612	Individual	Dear Colleagues *Re: National Guideline for Autism Diagnosis* Thank you for the opportunity to review *The Diagnostic Process for Children, Adolescents and Adults referred for assessment of Autism Spectrum Disorder in Australia: A National Guideline*. The Guideline is thorough and comprehensive and underscores the multi-disciplinary roles in diagnosis. It was reassuring to find that the Guideline states what our local Paediatricians require from our private allied health professionals prior to them seeing a child regarding ASD. With reference to the Guideline and following a brief discussion with psychologists developing expertise in ASD: • There is no business case to be an allied-health diagnostician in a private, Medicare funded practice in a regional, low SES area • There is a business case to provide Early Intervention Services to children with ASD which is funded through NDIS • Psychologists competent and confident to assess and work with people with ASD in a regional setting are booked months in advance • Training costs to maintain ASD diagnostic expertise is beyond an individual's CPD funding allocation • Training staff to maintain ASD expertise does not guarantee a return on investment as there is a turnover in staff in regional areas	Thank you for this very helpful feedback.

			• Costs associated with keeping up-to-date, training and purchasing of psychometric tests required for diagnostic purposes is prohibitive. Thank you for your good work, I look forward to the final National Guideline.	
Manual Submission [136]	ID613	Individual	The proposed national guidelines for ASD assessments would have some impact on diagnostic practices with SA. **Feedback** Firstly, I would like to commend the efforts of the working group who have written the proposed guidelines. I support the notion that there should be consistency in diagnostic assessment processes and reporting processes across the country, to ensure equitable assessments which are transferable from state to state. Listed below are a range of general comments in relation to the proposed guidelines in no particular order: • There are many aspects of the proposed guidelines that I like. Providing proformas and templates for reports is seen to be a positive step in standardising processes at a national level. Including information and examples in the report clearly outlining how the clinician reached the conclusion that the individual is/is not living with ASD is very important. • Expansion and prioritisation of the recommendations is felt to be helpful for families, particularly when discussing priorities for funding with NDIS planners. I particularly liked the question regarding "barriers to accessing services".	Thank you for this helpful feedback.

	ID614		I am curious as to how compliance to the new guidelines would be monitored. For example, will there be a register of experienced ASD clinicians? Will report quality be monitored?	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Accreditation and Regulation • Practice points for clinical, research and policy settings
	ID615		I imagine that there might be a need for discussion with other bodies, such as the state/territory department for education, Catholic Education System and Independent Schools Association. This would ensure that the education system accepted the proposed changes and enabled all children with a diagnosis of ASD to access appropriate supports at school.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Implementation and Evaluation of the Guideline • Practice points for clinical, research and policy settings
	ID616		In general, I support the idea of a functional assessment in association with an assessment for ASD. I note the suggestion of repeated functional assessments, and wonder how often these would be required and who might be expected to provide them. I feel some concern as to whether paediatric referrals/workload would increase as a result of this requirement.	Thank you for this comment. No amendment is required.
	ID617		I am a Speech Pathologist from South Australia working solely in the area of diagnostic assessments for Autism Spectrum Disorder (ASD), both individually and as part of a multidisciplinary team. I have been working in this area for about 15 years. Historically, Autism SA was the peak body and only place in South Australia where a recognised Autism Spectrum Disorder (ASD) assessment was undertaken (until 2000). The diagnostic team determined that, consistent with world's best practice, two professionals (some combination of a paediatrician, psychiatrist, speech pathologist, psychologist) would undertake an assessment either independently or	Thank you for this information.

			together to confirm the diagnosis. Standards regarding the assessment report were also stipulated that required the diagnosticians to address all of the criteria of the diagnostic statistical manual (DSM) and demonstrate how the individual met the criteria. Assessment using the CARS was also required. Individuals who had been diagnosed with ASD were able to be registered with Autism SA and receive support and advice from Autism SA staff and programmes. Registration with Autism SA was also required by the education sector (Catholic, Independent and DECD) for children and young people to obtain funded support at preschool and/or school. With the changes related to the NDIS registration with Autism SA is no longer required, and NDIS accepts one diagnostician completing an assessment for ASD. The education sector, however, continues to require that the assessment be undertaken by 2 recognised diagnosticians and that the report is comprehensive. Autism SA has maintained an oversight role of clinicians in SA who had the knowledge, experience and skills to be an “accredited diagnosticians”. Clinicians have been required to undertake training and then be “assessed” by the Autism SA diagnostic team to achieve accreditation status. It is not clear where why/how Autism SA has retained this authority.	
	ID618		A focus on the strengths of the person being assessed is considered useful and positive.	Thank you for the comment. No amendment is required in response to this comment.
	ID619		I fully support the inclusion of Occupational Therapists as diagnosticians. I question the need for OTs to be registered for Mental Health Care Plans, particularly within the public health system. Some demonstration of knowledge, experience and skill might be more relevant.	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Qualifications for occupational therapists

	ID620		Similarly, I question the need for Speech Pathologists to be members of Speech Pathology Australia. While this might be appropriate in private practice (where membership of Speech Pathology Australia means that families can access Medicare rebates), this does not seem necessary in all situations e.g. in the public health sector (perhaps ‘eligible for membership of Speech Pathology Australia’ might be more appropriate).	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Qualifications for speech pathologists
	ID621		I support the idea that diagnosticians should have specific experience and training in ASD. I have some concern as to whether four years of experience in this area is realistic, and concern as to whether this may limit the number of practitioners who are able to work in the area of diagnosis.	Please note that the requirement for ‘4 years’ experience’ has been omitted from the revised Guideline. For a rationale, please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Duration of ASD-specific Expertise
	ID622		In addition to experience in ASD, I would like to stress the importance of practitioners having experience in typical development. I have been involved in the training of other diagnosticians, and note that a number of trainees have found it difficult to identify children with ASD as they have limited experience with children who are developing typically.	The importance of professionals having an understanding of typical development was highlighted in the previous version of the Guideline, and has been retained in the revised version.
	ID623		I can foresee that in some cases, it may be hard to establish professional informants, particularly for those children who are not yet in formal educational settings, and for those children who may be schooled at home.	Thank you for this feedback.
	ID624		The use of tele-health facilities was considered a useful addition for families in rural and remote areas, although some consideration may be needed in relation to how this can be used effectively and successfully.	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Telehealth

	ID625		I support the idea that different types (or 'tiers') of assessment may be appropriate for different children/adults. I am somewhat confused as to which individuals would require a Tier 1 assessment and which individuals would require a Tier 2 assessment. A person whose assessment may be considered very straightforward to one assessor (and could therefore be considered a Tier 1 assessment) may not be considered as straightforward to another assessor (and could therefore be considered a Tier 2 assessment).	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Progression from Stage 2 to 3
	ID626		Perhaps there is scope for a third tier, which could be used for the assessment of very complex individuals. For such a complex child, a visit to a community setting would be appropriate.	Tertiary assessment services for individuals with complex neurodevelopmental disorders are not available in every Australian state. For this reason, a reference to these services was not included in the main figure describing the assessment model in the revised guideline. However, the following text has now been included in the revised draft (Section 10.1): "In some Australian states, tertiary services are available for the assessment of individuals with complex neurodevelopmental disorders. If these services are available, then it is recommended that clients are referred to these services if a consensus decision cannot be achieved at Stage 3."
	ID627		In relation to assessments that may be considered Tier 2, I agree it is important to gather information from a number of possible settings (e.g. home and school/child care). In my private work, I would find it unwieldy and possibly unnecessary to observe children in two settings. Instead, I would suggest that if diagnostic certainty has not been established following a comprehensive Tier 2 assessment, then a visit to a second location would be indicated (rather than insisting an observation in a second environment is essential in all Tier 2 assessment processes). This is consistent with our team's current practice. Further to this, I note that for private practitioners, insisting on observations	Thank you for this feedback. Based on the considerable feedback received regarding the need for flexibility in the assessment model, we have used the following wording (Section 10.3): "It is recommended that the Consensus Team Diagnostic Evaluation involve the collection of information about the individual's participation in all relevant community settings. This information may be obtained through communication with the client and/or other professionals but direct observations by

			being provided from two settings would add to the cost of the assessment process, and possibly make assessments unaffordable for many families.	member(s) of the ASD assessment team within some of these community settings may also be helpful.”
	ID628		It was felt that the diagnosis of Reactive Attachment Disorder should be added to the list of possible differential diagnoses.	Reactive Attachment Disorder was included in the original version of the Guidelines, and this has been retained for this revised version.
Autism Asperger’s Advocacy Australia (A4) [137]	ID629	Organisation - Professional experience	Thank you for the opportunity to comment on your proposed guidelines from ASD diagnosis in Australia. The following comments are meant to be constructive. I apologise that I had insufficient time to prepare this response properly. I reject the claim of “considerable variability between states in diagnostic practices”. Essentially, there are numerous national diagnostic requirement: the HCWA requirements were national and are being replaced by national access conditions for the NDIS. Carer Allowance (child) is national. I acknowledge that state and territory education systems have different diagnostic requirement ... but few of them treat similar assessments consistently, so it's not a state issue anyway. The bigger problem is the variable and inadequate training given to people performing diagnoses. The education process is failing. In many instances, interpretations of the diagnostic criteria are far too variable. My quick reading of the guidelines did not help me see these issues recognised and addressed.	Thank you for this feedback. No amendments are required in response to this comment.
	ID630		There needs to be much more clarity about the severity levels in a DSM-5 diagnosis. There also needs to be a strong	Text was added to the Stage 2 and 3 Decision Making and Outcome sections:

			emphasis in any diagnostic report that the DSM-5 is very clear that severity levels are not to be used for resource allocation.	"…with a decision of current severity level if DSM-5 criteria are utilised" Text was added to the Content of Communication section: "Evidence that supports the current severity level (if DSM-5 criteria are utilised)"
	ID631		The draft guidelines place substantial emphasis on making an assessment and providing treatment/therapy recommendations. I think this very wrong. People who diagnose ASD should focus on diagnosis, especially the ability to differentiate multiple diagnoses. The draft guidelines seem focused on ASD, but it should focus on distinguishing ASD from other complex combination of diagnoses. Any effort put into recommendations for treatment is pointless: it waste time and money. Most recommendation given with a diagnosis will be ignored in early intervention. Early intervention clinicians, if they are any good, will make their own detailed assessments of the individual child and develop a much more detailed program. They will adapt the individual program quickly to the child's changing needs. Rather than doing an assessment, it would be much more useful to refer the family to impartial Autism Advisors (if they still existed). Now, families should be told that best practice EI options and given contact information for clinicians offering those options. The clinicians should be prepared to engage in intake processes with families of newly diagnosed children.	Thank you for this feedback. The revised structure provides much greater focus on differential diagnosis by recommending: 1. An initial comprehensive needs assessment; 2. The amendment of professions to those who have received formal training on differential diagnosis across the full range of neurodevelopmental disorders; and 3. A greater focus on differential diagnosis at both Stage 2 and Stage 3. The Guideline does not ask clinical clinicians to define treatment targets, but rather to identify the support needs of an individual (i.e., the outcome of the comprehensive functional and needs assessment). There is considerable empirical evidence supporting the importance of this aspect of the assessment process, and this was further endorsed by feedback received during the consultation period.
	ID632		I approve of the proposed 2 Tier model. There is no need for an extensive/excessive diagnostic process when a diagnosis is obvious. My main concern would be that some other comorbid conditions may not be recognised if ASD diagnosis is too quick.	Thank you for this comment. A specific section on possible differential and co-morbid diagnoses is included in the revised Guideline. We also believe that the revised structure further emphasises the importance of clinicians assessing the full range of possible explanations for a child's behaviour. Please

				refer to the ‘Overview of Major Amendments’ chapter under the heading: • Structure of the Assessment Process
	ID633		The commentary does not appear to recognise/appreciate that currently most diagnoses of ASD in Australia are made after the person reaches 9 years of age. One of the primary and more strongly emphasised goals of the guidelines should be to reduce substantially the typical age of ASD diagnoses.	We agree that the empirical evidence is clear about the importance of an early diagnosis in promoting earlier access to intervention and promoting better outcomes. However, this issue was not in the scope of the project terms of reference, and so no amendment has been made in response to this comment.
Yellow Ladybugs [138]	ID634	Organisation - Professional experience	We note that the case studies conducted in the development of the draft guidelines do not include a case study involving a younger female, without developmental delay or presenting with anxiety/depressed, when ASD is an underlying reason. We consider there would be real value to the guidelines process in including a new case study of this nature.	Thank you for this feedback. An additional case study has been added
	ID635		Yellow Ladybugs welcomes the draft guideline document, and supports the view that there is a need for a consistent process across Australia for how an individual is assessed for a diagnosis of autism spectrum disorder (ASD). We have a particular interest in ensuring that females undergoing an ASD assessment benefit from this consistent process and our response to the draft guideline focuses on this particular issue. While we are generally supportive of the proposal for a consistent assessment process, and we welcome the references to gender differences in the presentation of the draft guidelines document, we consider that there remain two limitations to improving assessment processes for females. Firstly, the diagnostic criteria used to assess ASD continues to favour male presentation and diagnosis of ASD. Secondly, although the draft guidelines state that diagnosticians will be	Thank you for this very important information. An examination of the DSM5 and ICD10/11 diagnostic criteria was not within the project terms of reference, which we have highlighted on page 9 of the revised Guideline. However, an aim of the Guideline was to provide overarching guidance on a process for collecting the optimal level of information that may inform an ASD diagnosis for all individuals. This includes females with ASD, who may present very differently to males with ASD. These sections remain in the revised Guideline.

			required to have expertise in understanding gender differences, it is unclear how this will be achieved, and in our view, the assessment process will still largely be reliant on individual practitioners who may or may not have a sufficient level of understanding of how females with ASD can present. Our overarching concern is therefore that unless the diagnostic criteria is actually adjusted for the more subtle presentation in females, and unless diagnosing professionals have a significantly better understanding of the female presentation, the process set out in the draft guidelines will actually continue to discriminate against females by forcing them through the Tier 2 diagnostic process, costing them more time and money than for males.	
	ID636		In general, we support the idea of further research into females with autism, the development of more appropriate screening and assessment tools for females, and the creation of a comprehensive evidence-base to guide best-practice approaches. Females with autism will benefit socially, emotionally and economically from improved ASD detection, assessment and recognition. We are grateful for the opportunity to comment on this process and we welcome the opportunity to work directly with Autism CRC in addressing the issues we have identified, and in finalising the draft guidelines.	Thank you for this comment. No amendments are required in response to this comment.
	ID637		We support the recommendation made in the draft guidelines that ASD assessments be conducted in various natural settings, such as child's home or school or childcare setting. We believe that that will be great benefit in doing this in both the Tier 1 and Tier 2 assessment processes.	Thank you for the comment. No amendment is required in response to this comment.
	ID638		The instruments for screening developmental delays filled by either parent or professional to warrant further investigation. We would be interested in further research on how sensitive	Recommendations relating to specific instruments that measure functioning have been removed from the Guideline,

			these screening tools are for screening girls from birth to 7 years old, without any significant developmental delays. Screening tools can be a critical first step in triggering a timely pathway for an ASD diagnosis. As with the diagnostic tools themselves, we are concerned that these screening mechanisms may not always pick up ASD signs in young girls. Developmental delays in girls may not always be obvious, and may be missed by parents (especially if this is their first child) or by health professionals with little experience of females with ASD (Table 4, [18, 19, 21]). We agree with the draft guidelines that screening tools should not be used in isolation to determine a referral. We have further questions about the sensitivity of these screening tools in flagging girls with or without delays. Parents within our community have noted that their daughters 'passed' screening tools listed in the guidelines document. We encourage further research into the accuracy of these screening instruments for girls. Given that females are routinely diagnosed later than males, there is considerable value in looking more closely at this early screening tools as a means of flagging girls and triggering an assessment process.	and information about resources will instead be located on the Guideline webpage to enable updates to occur more readily.
	ID639		We support the finding in Evidence Table 64, particularly [1] and [2]. With respect, to the tables 10, 11 and 12 listing 'additional signs and symptoms', we note that this information could be more comprehensive and provide information more tailored to females (i.e. girls, being 'shy', or overreacting to situations. Also, further examples of stimming such as hair twirling.	A table has been added to the Important Considerations - Gender section that outlines behavioural features that may be more common in females. This includes reference to being shy and hair twirling.
	ID640		In considering females between 6-16 years, where a female is socially motivated, we would like to see more information on the impact of mimicking and use of camouflage skills, and a greater understanding of how these skills result in females not	A table has been added to the Important Considerations - Gender section that outlines behavioural features that may be

			getting flagged, as they are not presenting with stereotypical ASD behaviours.	more common in females. This includes reference mimicking and use of camouflage.
	ID641		With regard to the list of factors for adults undergoing an ASD diagnosis (Evidence Table 41), we suggest an additional trigger is mothers are prompted to seek a diagnosis once their daughter has been diagnosed. This is a common path to diagnosis for women, and generally is reliant on the involvement of a diagnostician who is an expert on ASD for women. This is particularly the case if the mother has a mild presentation, that does not fit neatly with the ASD assessment criteria (i.e., makes eye contact, is empathetic, socially and financially successful and/or presenting as depressed and highly anxious).	The section outlining factors to consider in determining whether to refer for an ASD assessment has been deleted from the Guideline, as this was deemed beyond the scope of the current project. Subsequently, it was not possible to address this request.
	ID642		There is a growing consensus among professionals and the autistic community in general that ASD females are currently misdiagnosed, under-diagnosed or missed all together. As noted in Evidence Table 4 [1] of the proposed guidelines a correct diagnosis is the catalyst for a positive change and increased understanding of needs, for the suspected ASD female and her family. There is therefore a genuine need to improve the diagnostic processes for females with suspected ASD. We welcome the recognition that the ASD assessment process must follow and evidence based approach in order to reach a streamlined, accurate and ethical diagnosis. We question whether the review of the evidence-base has gone deep enough, however, when it comes to better processes for diagnosing females. Specifically, we are concerned that two barriers will remain which will continue to make it more difficult for females to be diagnosed: 1. The inherent male-bias of the international diagnostic manuals, such as the DSM-V	Thank you for these helpful comments. Please refer to the responses to similar comments made by this respondent.

			2. The continued reliance on practitioners, who may also have a lack of understanding or bias against the female presentation of ASD	
	ID643		**1. Effectiveness of International Diagnostic Criteria (e.g. DSM-V) in Assessing Females** We note that although the purpose of this process was not to review the international diagnostic criteria (e.g. DSM-V), which are used in the diagnostic process, significant questions remain about whether these criteria have the degree of sensitivity needed to pick up a more subtle female presentation of ASD. We therefore make the point that an improved and more consistent national assessment process may still be hindered by the limitations of the diagnostic manuals which guide the assessment process.	An examination of the DSM5 and ICD10/11 diagnostic criteria was not within the project terms of reference, which we have highlighted on page 9 of the revised Guideline. No amendments have been made in response to this comment.
	ID644		**2. Reliance on Individual Practitioners in Assessing Females** We welcome the requirement for Diagnosticians to have current expert knowledge and experience in a range of areas, including 'ASD symptom presentation among male, female and where applicable, gender diverse individuals'. We seek more information, and preferably direct input, into how this level of expertise is going to be achieved in a consistent manner. Our concern is that the accuracy of the assessment process for females is still largely dependent on individual diagnosing practitioners, who may or may not understand the difference between male and female presentations of ASD. We are aware that there are currently many practitioners who have an inherent or stated bias against how ASD manifests in females. We question how the proposed guidelines might effectively address this, given the potential negative impact on females undergoing the assessment process, at both the proposed Tier 1 and Tier 2 processes. We consider that the proposed guidelines have the potential to result in a more	Thank you for highlighting these very important issues. The aim of the Guideline was to provide overarching guidance on a process for collecting the optimal level of information that may inform an ASD diagnosis for all individuals. As reported, there is now good evidence that females with ASD may present very differently to males with ASD, and it is critical that clinicians have an understanding of this important point. In order, to assist clinicians with this knowledge, the revised Guideline includes multiple sections in which potential differences in ASD presentation between males and females has been highlighted. These include a table that has been added to the 'Important Considerations – Gender' section that outlines behavioural features that may be more common in females.

			accurate and timely diagnosis process for females, where the assessment tools are applied appropriately by diagnosticians who have the skills and level of experience to make an accurate clinical judgement. As noted above, we would welcome direct input into the development of a finalised set of guidelines which more effectively address our concerns stated above. **Comments on Evidence Base (Evidence Table 4)** Our views are also supported by the research presented in Evidence Table 4, including that psychologists to be vigilant in addressing the needs of a suspected ASD female to avoid inappropriate referrals, missed diagnoses or misdiagnosis. Also, the need for an educational campaign with focus on gender presentation differences and characteristics. And lastly, the need to use quantitative research to devise ‘best practice guidelines’ for diagnosing females with ASD. We would welcome further research on the current diagnostic experience and how this might be used to develop evidence to inform best practice guidelines. The findings from research are consistent with previous research which confirms that girls are generally diagnosed with ASD at a later age then boys and that there are significant negative implications in this. It also notes the considerable risk of initial misdiagnosis or missed diagnosis for females, resulting in receiving lack of services and supports. Thus, there is a considerable responsibility on professionals to pay closer attention to issues that surround ASD females and to ensure a timely and accurate diagnosis. CBR-1 states the process of undertaking an assessment must follow an evidence-based approach. We suggest that it is important to look more closely at this evidence base and to start addressing some of the generalisations about ASD that do not necessarily fit the presentation of ASD females, and which have resulted in the current unequal diagnosis ratio for females (with or without an	

			intellectual disability) to their male counterparts. Key points are as follows: • The undertaking of an assessment, is informed by the best evidence-base available. Evidence Table 4[1] implies the diagnostic criteria is gender biased and does not take gender differences, particularly in relation to sociability into account. The research study also notes that the evidence-base which informs the range of assessment tools utilised by professionals is based mostly on male samples. • Consistent with CBR-1 and Evidence Table 4, we seek clarification of the best-evidence base available for diagnosing females suspected with ASD. We note Evidence Table 4[1] refers to a study [Lai et al (p. 55, 2001)] which reveals diagnostic tools are not sensitive enough in identifying adult women with ASD a finding supported by other researchers. • To illustrate these concerns, we refer to an overseas study detailed in Evidence Table 4[1] where the participants were girls aged 11-17 years old, with average intelligence, diagnosed by a comprehensive multi-disciplinary assessment team. The use of an assessment team did not create a protective barrier against a bias in the diagnostic process, and the study suggests that clinicians are less likely to diagnose females, than males with ASD, *even when they are similarly impaired*. The participants were diagnosed using DSM-5 or ICD-10 criteria, in accordance with best practice guidelines, and consistent with the international standards also used in Australia. Given these findings, we have questions about whether or not these same best practice guidelines, as set out in the draft guidelines.	
	ID645		**Yellow Ladybugs Comment:**	Thank you for these helpful comments. No amendments are required in response to these comments.

			We strongly support this recommendation and the supporting information provided in Evidence Table 66. For many parents looking to initiate an ASD assessment for their daughter, the first contact with a professional can be the barrier to further pursuing or exploring their concerns. Parents and caregivers often have their initial concerns dismissed, and miss the opportunity for early detection of ASD in their daughter. Typically, it is only when more significant issues present during primary school or adolescence, that girls ‘may’ be flagged - correctly. We strongly believe that behavioural presentations of ASD related to gender need to extend to other health and education professionals, not only those involved in an ASD assessment as stated in the recommendation. Key comments are as follows: • Multi-sector health professionals including GPs, and maternal and child health nurses, will have some involvement with a child prior to starting school. Young children also come into regular contact with educational and early childhood specialists, including in supported playgroups, kindergartens and childcare settings. Greater awareness of the female presentation of ASD in these settings could result in better processes for girls with ASD to be flagged before starting school, and to receive better support and access to therapy services at this critical early stage in their development. • The developmental screening tools used in routine pre-school check-ups or when there has been concerns raised, do not appear to have the sensitivity to flag ASD girls, particularly, when there is no obvious developmental delay. This can result in missed referrals for a diagnosis. Parents themselves may not be aware of the way ASD can present in girls, or alternatively, they may have raised concerns, but the person administering and scoring the developmental screening tools, does not have the necessary awareness or expertise. The use of early years screening tools requires greater research and education	

			of the assessor need to be addressed for a timely diagnosis.	
	ID646		• We seek further information, in relation to the proposed guidelines, about to achieve a sufficient level of training for all diagnosing professionals, to ensure recognition and understanding of the ways autism manifests in females, in any development/age in their lives. We are especially concerned about this given the lack of research and limited number of recognised experts in ASD in females in Australia. • Furthermore, we would like to understand how this training is to be monitored to ensure diagnosing professionals have obtained the relevant skill sets, even if they are eligible to a professional discipline [i.e. 6.4.1. & 6.4.2]? This is critical ensure a clinician's competency during the diagnostic process, especially in the case of less 'severe' ASD presentations. • We wonder whether a standard or threshold needs to be created, to call a leading diagnostician 'an expert' or 'competent enough' to diagnose females? Especially in complex cases or where the female being assessed has presenting comorbidities?	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Accreditation and Regulation • Practice points for clinical, research and policy settings
	ID647		• More generally, we support the idea of further research into females with autism, the development of more appropriate screening and assessment tools for females, and the creation of the best available evidence-base to guide best-practice approaches. Females with autism will benefit socially, emotionally and economically from improved ASD detection, assessment and recognition.	Thank you for this comment.
Mindful [139]	ID648	Organisation -	General Comments It is appreciated the guidelines support a flexible and strength-based approach to assessment and includes	Thank you for the comment. No amendment is required in response to this comment.

		Professional experience	acknowledgement of the functional needs of the child/young person/adult.	
	ID649		It is important the guidelines distinguish between clinical diagnosis and ‘educational diagnosis for funding purposes’.	The Guideline was developed to guide clinical assessments for ASD, and are not aware of what is meant by the term “educational diagnosis for funding purposes’. For this reason, no amendments have been made in response to this comment.
	ID650		It may also be helpful in the forward to address the issue of context (urban, rural and remote) and inherent challenges of providing an ASD assessment being dependent on attracting and maintaining a suitably trained expert workforce in rural and remote areas.	The following text has been added to the Foreword: “The geographical location, in particular the urban, regional or remote context, also has implications on attracting and maintaining a suitably trained expert workforce.”
	ID651		The guide could articulate the role of professional associations in ‘assuring Speech Pathologists as Diagnosticians and Professional Informants are competent and there is a mechanism for assuring this is maintained.	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Accreditation and Regulation • Practice points for clinical, research and policy settings
	ID652		Hearing and vision assessment should be included in all assessments. Audiologists, Optometrists / Ophthalmologists could be added here.	Audiologists, ophthalmologists and optometrists are included in the list of other professionals who can provide information to support the ASD assessment. The Medical Evaluation involves testing hearing and vision status, hearing assessment (e.g. screening test or full auditory evaluation) and vision assessment (e.g. screening test, sight test or full ophthalmologist evaluation) were provided as examples of further assessment at Stage 3, and hearing and vision impairments have been listed in the new table on possible differential or co-occurring diagnoses.

	ID653		*Coordinator:* The Coordinator Role is clearly defined but should additionally include following up the family post-diagnosis. For many clients it is unclear who might take this role on particularly in the private sector. It is also important for families that there is streamlining of information sharing so families are not required to share their stories over and over.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Coordinator Role
	ID654		Table 3 Speech Pathologists have expertise in oral and written language, swallowing and feeding and play. OT's have expertise in sensory and motor skills assessment.	Speech pathologist's expertise was expanded to include: "along with oral language, written language, swallowing, feeding and play." Occupational therapist's expertise was expanded to include: "expertise in sensory and motor systems."
	ID655		*ASD specific expertise*: We fully support that ASD diagnosis should be undertaken by expert and experienced clinicians however we are concerned about the practicalities of monitoring clinician skills in a meaningful way. Even for professional bodies to establishing effective credentialing will be a difficult challenge.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Accreditation and Regulation • Practice points for clinical, research and policy settings
	ID656		Peer mentoring could be more clearly defined	The different types of peer learning (observation, supervision and mentoring) have now been defined in the Guideline.
	ID657		"Clinical reasoning in weighing evidence integrating findings, reaching assessment conclusions and making diagnostic decisions" should acknowledge a bio-psycho-social framework.	The Guiding Principles - Holistic Framework section suggests using the current version of the International Classification of Functioning, Disability and Health as a biopsychosocial framework throughout the ASD assessment. This is reiterated in the Decision Making and Outcome sections for each stage.

	ID658		6.5.2 ASD specific expertise Identifying family strengths and vulnerabilities (carer coping; siblings with developmental challenges; family violence). Global delay and intellectual disability could be added to this list.	Clinicians who undertake Functional Assessments are now recommended to have relevant training and expertise in: “Evaluating the abilities, challenges, strengths, environmental context and support needs of individuals with ASD and other neurodevelopmental disorders (along with those of their caregivers and support people).”
	ID659		6.6.2 It would be helpful to at this point to note that professional informants also should have some mechanism of integrating their observations and assessment ideally through a meeting or by phone.	The Guideline has included the broad term “liaise” to refer to interactions with other professionals, and this would include meetings, telephone calls, emails and formal reports.
	ID660		Table 4 Add Developmental Behaviour Checklist (DBC)	Recommendations relating to specific instruments that measure functioning have been removed from the Guideline, and information about resources will instead be located on the Guideline webpage to enable updates to occur more readily.
	ID661		Table 5 Add Siblings with ASD	This table has been omitted from the revised version of the Guideline. For further information, please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Referral for an Assessment of ASD Concerns
	ID662		Table 6 Add DSM V Specifiers (e.g. with/without language impairment; with/without Cognitive impairment…	A description of the specifiers has been added in the section introducing the DSM-5 criteria. The Stage 2 and Stage 3 Decision Making and Outcome sections have been edited to include “a decision of specifiers if DSM-5 criteria are utilised.”

				In addition, the Content of Communication section has been modified to include the requirement to share “Evidence that supports specifiers (if DSM-5 criteria are utilised).”
	ID663		Table 7 Gut difficulties - add Gastro-intestinal specialists Hearing difficulties - add ENT Executive functioning and memory difficulties: Add Neuro-psychologists Mental Health (include selective mutism)- add speech pathologists Behaviour – add speech pathologist Trauma- Paediatricians	Thank you for this comment. Based on feedback received, this table has been omitted from the revision Guideline, and the information included in the table has been incorporated in other sections of the document.
	ID664		Table 8 Possible differentials: co-morbid ADHD could be added	We believe this comment may relate to Table 14 rather than Table 8. ADHD was in the original version of this Guideline, and has been retained in the Web Resources.
	ID665		**Chapter 5 & Chapter 10 Functional Needs Assessment** *Functional Needs Assessor:* We agree that ASD diagnostic assessment include some functional assessment. However, the depth described in the document is more than what can be done in an ASD assessment and will only create longer waiting times. A thorough functional assessment should be carried out by treating clinicians as it will inform treatment and should be revisited regularly, as for particular children, as their functional needs will change with their development. To the extent that functional assessment is described it the guideline we feel strongly that it does not fall within a usual	Please refer to the ‘Overview of Major Amendments’ chapter under the following headings: • Emphasis on the Importance of Functional Abilities in Referral for Supports. • Structure of the Assessment Process • Practice points for clinical, research and policy settings

			ASD assessment and should be considered as a separate assessment.	
	ID666		**Chapter 11: Sharing ASD Findings** We are concerned about the assessment templates. These seem overly long and too prescriptive and will increase the time assessments take to complete. Guidelines for report writing may be more helpful than templates.	The ASD assessment report templates are an optional resource available for clinicians to use at their own discretion. This has been clarified in the Guideline.
	ID667		Table 16 Add Language Disorder as a differential	We believe this comment may relate to Table 15 in the original draft Guideline rather than Table 16. Language Disorder was in the original version of this Guideline, and has been retained in the Web Resources.
	ID668		*Tier 1:* While a flexible model is supported there is concern that a diagnosis from only one diagnostician is not sufficient and reports from two informants from two different settings would ensure information about the child's presentation in different contexts is considered. Ideally Tier 1 assessments should always include a communication assessment, given DSM V Criteria A relates to Communication, and a language specifier is part of the diagnosis. Alternatively, to identify speech & language or cognitive impairment referrals to these professions should be recommended after a tier 1 assessment.	Thank you for this comment. The revised structure provides far greater emphasis on the importance of a comprehensive functional and needs assessment in providing the foundation for a diagnostic evaluation. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Structure of the Assessment Process • Emphasis on the Importance of Functional Abilities in Referral for Supports
	ID669		The experience of mental health ASD diagnosticians working with young adults is that there is little availability of assessment availability even at a tier 1 level for adults, and usually only have access to assessment if they have significant comorbid mental health issues.	Thank you for this information. No amendments are required.

	ID670		*Tier 2:* There is also concerned at the Tier 2 level if diagnosis is unclear, that to keep reassessing by the same team may not always be appropriate. We would suggest where diagnosis is unclear the client should be referred to at Tier3 service (an experienced multidisciplinary team) for assessment. *Tier 3:* In Victoria there is a network of Tertiary CAMHS/CYMHS ASD teams who provide assessment of complex clients. In other some states there are similar tertiary services. It is important these teams are used effectively in the new guidelines to provide support Tier 1 & 2 services and families who need clarification regarding diagnosis or second opinion. These existing team are made up of very experienced clinicians and these skills should be acknowledged and utilized within the proposed framework.	Tertiary assessment services for individuals with complex neurodevelopmental disorders are not available in every Australian state. For this reason, a reference to these services was not included in the main figure describing the assessment model in the revised guideline. However, the following text has now been included in the revised draft (Section 10.1): “In some Australian states, tertiary services are available for the assessment of individuals with complex neurodevelopmental disorders. If these services are available, then it is recommended that clients are referred to these services if a consensus decision cannot be achieved at Stage 3.”
	ID671		Role of Interpreters: the role of interpreter needs to be clearly stated in all levels of assessment including Tier 1 & 2	The role of interpreters was included in the original version of this Guideline, and has been retained in the revised version.
Neurodevelopmental and Behavioural Paediatric Society of Australasia [140]	ID672	Organisation - Professional experience	• We support the need for greater national consistency and accuracy in diagnostic and functional needs assessment of neurodevelopmental and behavioural conditions, including ASD. We welcome the guiding principles that have been developed for the draft guideline. However, the NBPSA cannot support the draft guideline in its current form. We are concerned that implementation of the current draft guideline recommendations will lead to greater variation in diagnostic outcomes and higher exposure to risk. • Although outside the scope of guideline development, we are particularly concerned about the implications of these guidelines in the current Australian context, where ASD diagnosis is used as a criterion for eligibility for funding and support for health, education and disability services. NBPSA strongly supports access to support based on	Thank you for this detailed and helpful feedback. Please refer to the responses to similar comments made by this respondent.

			function and support needs, rather than access based on specific diagnostic labels such as ASD. • Key concerns arising from our review of the draft guideline include the following: • The presumption that ruling in or ruling out a diagnosis of ASD is the primary outcome for a child who has been referred for assessment due to complex developmental and behavioural concerns. • The evidence, as presented, is insufficient to justify a number of recommendations which could, if executed, have major impacts on diagnostic process and accuracy. Such recommendations require a high level of evidence or a clear, accepted rationale of risks, benefits and cost, neither of which are provided. • The two-tier structure as proposed will increase diagnostic error and may further overload existing assessment services. While we support a staged approach to neurodevelopmental and behavioural assessment, based on individual need and complexity, further consultation and consideration is required. • The recommendations do not take in to account existing services and ‘pathways to care’ and may place additional pressure on families and carers to pursue assessments outside existing publicly funded arrangements, as well as making implementation difficult and expensive. • Although the importance of subgroups is recognised in the guideline, there is no adaptation to the diagnostic pathways to cater to the very different diagnostic processes required for children and youth, given the careful consideration that is needed when making a diagnosis that is likely to change their self-perception and the way others interact with them, during their formative years. • The methodology adopted departs significantly from the NHMRC guidance on national guideline • development. We draw attention to the methodological concerns in this response and will provide more detail in a	

			specific response to the Technical Paper and the Evidence Tables under separate correspondences.	
	ID673		As noted in the Technical Paper, the paucity of evidence in this area led to development of a unique methodology for evaluating and applying available evidence. We have identified significant concerns with the approach devised and strongly suggest that the methodology be independently reviewed. We will provide more detail in a separate submission on the Technical Report and Evidence Tables to assist your consideration of this issue.	Thank you for this feedback. As part of the Guideline development process, the methodology was revised by a specialist reviewer nominated by the National Health and Medical Health Research Council. This reviewer provided very favourable reviews of the methodology. Further methodological reviews will be undertaken by the NHMRC in early 2018.
	ID674		We support the need to improve the consistency and accuracy of assessment of neurodevelopmental and behavioural conditions, particularly in relation to the diagnosis of ASD, in Australia. We are pleased to see that the complexity and variability of clinical presentations that may give rise to concerns about ASD are recognised. As a constructed diagnostic group, rather than a biological diagnosis, many of the signs and symptoms associated with ASD can also be associated with other neurodevelopmental and behavioural conditions that are differential diagnoses to, or co-morbid with, ASD. The diagnosis of ASD requires an assessment of behaviour in the context of environment, involves a subjective element and carries with it a degree of inherent uncertainty. For many individuals, the diagnosis and functional needs may not remain stable over time and this must be considered within the broader guideline development. For these reasons, we do not support the approach that diagnostic accuracy and consistency can be improved through a specific ASD diagnostic pathway. Such an approach is inconsistent with the principles underpinning the draft guidelines. The diagnostic pathway should remain part of a neurodevelopmental and behavioural assessment process to	Thank you for this very helpful feedback. We believe the structure of the revised Guideline addresses this helpful comment. Please refer to the 'Overview of Major Amendments' chapter under the headings • Structure of the Assessment Process • Emphasis on the Importance of Functional Abilities in Referral for Supports

			ensure the diagnostic decision is well informed and that the risks of an incorrect decision are properly considered. We agree with including a greater emphasis on function and care needs and a focus on both strengths and deficits. Requiring diagnostic certainty for ASD is not an appropriate or equitable criterion for gaining access to support and care services. **Recommendation:** The diagnostic pathway for all children presenting with developmental and behavioural concerns should be through a comprehensive developmental assessment which includes an assessment of both functional and support needs, in order to determine the most appropriate diagnosis, or diagnoses, when sufficient clarity is achieved. **Recommendation:** Criteria for determining access to support services should be based on an assessment of functional needs rather than a specific diagnosis.	
	ID675		3.3 Diagnostic criteria for ASD With ICD-11 due to be released in 2018, the NBPSA believe that these draft guidelines should reference the beta version of ICD-11 in this section and then update the document upon their release. Recommendation: Reference to the diagnostic criteria should be to the ‘most current versions’ of the DSM and ICD diagnostic criteria, rather than specific versions of these documents.	The Guideline has been edited so that the diagnostic criteria is consistently referred to as the current version of the DSM or ICD. The table outlining the diagnostic criteria for each of these manuals now focuses on DSM-5 and ICD-11 beta.

	ID676		3.4 Scope of the guideline development process The NBPSA supports the contributions consumers, and professionals outside of the health sector, make in the development of draft guidelines. However, although the draft guidelines promote the principle of evidence-based research informing diagnostic assessments and clinical decision making, we have identified a number of issues with the methodology set out in the Technical Report and the evidence presented in the Evidence Tables that creates an internal inconsistency between this principle and the recommendations as written. Recommendation: That the original NHMRC categories be applied to the evidence tables in the interests of transparency and consistency with the nationally recommended protocol for Guideline Development. That an independent review be arranged with the NHMRC as soon as possible and prior to further development of the guidelines so that any methodological changes that may be needed can inform future considerations. We are compiling further analysis for the Technical Report and Evidence Tables and this will be provided separately.	Thank you for this feedback. As part of the Guideline development process, the methodology was revised by a specialist reviewer nominated by the National Health and Medical Health Research Council. This reviewer provided very favourable reviews of the methodology (see recommendations at the end of this document). Further methodological reviews will be undertaken by the NHMRC in early 2018.
	ID677		**3.2 Definition of ASD** The NBPSA support the definition set out. However, the definition is not consistently applied throughout the document. For example, the assertion in Table 10 that "ASD can be reliably and validly diagnosed at 2 years" does not apply to children who do not develop ASD signs and symptoms until later in their life. ASD covers a broad spectrum of presentations and severity and it is unrealistic to imply that	This statement has been changed to allow variation in the development of ASD signs and symptoms: "There is now robust empirical evidence that, for a small proportion of children, ASD can be reliably and validly diagnosed at 2 years of age by an experienced clinician, and that this diagnosis is relatively stable over time."

			ASD can always be reliably diagnosed (or ruled out) at such an early age.	
	ID678		**Chapter 4. ASD Assessment Guiding Principles** The NBPSA supports the guiding principles set out. *Recommendation:* The NBPSA recommends consideration of an additional guiding principle: that access to supports and services should be triggered by a formal assessment of function and needs that demonstrates functional impairment, not by a diagnosis of ASD, a syndrome that, by definition, covers a wide range of functioning, ability, disability and support needs. Our reasoning for making this recommendation is that a number of children whose presentation may be considered as being within the boundaries of the autism spectrum will require very little or no support over that provided by their families and existing community or educational resources. On the other hand, children with significant and urgent needs for support and treatment services may not meet diagnostic criteria for ASD at the time of assessment but may do so later in their development. A child’s needs, not the presence of a diagnostic label, must be used to determine eligibility and prioritisation of access to intervention and support services.	Thank you. This has been added to the ‘holistic framework’ guiding principle. Please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Guiding principles
	ID679		The opening sentence in section 4.1 would be better expressed in the following terms: “*This principle is based around the key concept that the primary **sources of** information required during and assessment of ASD are the individuals undergoing assessment and their family and carers.”*	This sentence has been changed to: “This principle is based around the key concept that the primary sources of information required during an assessment of ASD are the individual undergoing assessment and their family members (most notably, caregivers and support people).”

	ID680		**5.1 Content of an ASD assessment** *Recommendation*: The NBPSA supports assessment of function and support needs as one component of a broader, comprehensive neurodevelopmental and behavioural assessment that also considers clinical investigations, possible differential diagnoses, co-morbidities and other biopsychosocial influences on behaviour and development. Functional and needs assessment should occur prior to, or early in, the diagnostic process. The results of the functional and needs assessment should inform the priority and type of early intervention and support services, regardless of whether a diagnosis is able to be made. The results of the baseline assessment and the concept of assessing response to intervention over time can also provide information that is important in the formulation of a valid, reliable diagnosis. Methods used to assess for function must be tailored to the age and capabilities of the child. (An example of the response to intervention concept is provided at the end of our comments on Section 9.3)	Thank you for this very helpful feedback. We believe the structure of the revised Guideline addresses this helpful comment. Please refer to the 'Overview of Major Amendments' chapter under the headings: • Structure of the Assessment Process • Emphasis on the Importance of Functional Abilities in Referral for Supports
	ID681		**5.2 Co-ordination of an ASD assessment** The NBPSA supports the need for a well-coordinated assessment process, with good connections and communication between all professionals involved, particularly for those requiring more complex and comprehensive assessment. Developmental assessment can be complicated and stressful for children and carers. It is important that the coordination function and the advice and support is clinically informed.	Thank you for this comment. No amendments are required.

	ID682		**Chapter 6. ASD Assessment Roles** 6.2 Referral for an Assessment of ASD Concerns Consumers and education professionals provide essential information for functional and diagnostic assessment but do not have the relevant expertise to refer children directly for clinical assessments as many of the features that might suggest ASD may in fact be attributable to, or co-morbid with, other disorders; alternatively, they may be present for other reasons (e.g. developmental trauma). *Recommendation:* Referral and assessment of children for neurodevelopmental or behavioural concerns, including concerns about ASD, must be carried out within existing health system referral processes, rather than creating unnecessary parallel processes that duplicate existing structures and focus on one diagnosis. Referral for a neurodevelopmental and behavioural assessment must come from a child's primary care provider. Direct access to primary health care providers is readily available to parents or individuals who are concerned about ASD. Education and health professionals who are not involved in neurodevelopmental care but have concerns can advise families to seek assistance from a primary health care provider. Without a primary health care professional as the primary Referral for an Assessment of ASD Concerns, secondary and tertiary services are at great risk of becoming overwhelmed by the additional demand for these services through an increase in self-referrals or referrals from allied health and other staff working in the education sector. Also, primary health care professionals (e.g. maternal and child health nurses) can assist with access to existing funded	Thank you for this feedback. The revised Guideline has been revised to state that referral is to be made by an individual's primary health care provider. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Referral for an Assessment of ASD Concerns

			services that are relevant, including state funded community child health (staffed by allied health professionals who are child experts) and state and federally funded early intervention services (staffed by allied health professionals and learning experts). Existing Medicare funding mechanisms for important components of further assessment and access to intervention require involvement of a paediatrician or psychiatrist, following referral from a general practitioner. To make recommendations that do not enable access to existing services and funding will potentially deprive families of assessments and interventions, unless another funding stream for these actions is identified.	
	ID683		**6.3 Coordinator** The NBPSA supports the provision of well-coordinated care. <u>The coordination function should remain the responsibility of the lead clinician</u>. This does not prevent a clinician choosing to delegate some coordination activities to an administrative resource or the use of technology to provide practical assistance and information.	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Coordinator Role
	ID684		The NBPSA does not support broadening the professional groups who can act as primary diagnosticians under the current accreditation and training arrangements. Doing so will increase, rather than reduce, the range and variability in ASD diagnosis nationally and increase the risks to groups such as children and young people, especially pre-schoolers and those who do not communicate. The level of evidence presented is insufficient to support broadening current arrangements, particularly recommendations supported by CB2 and CB3 ratings.	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Professional Roles • Structure of the Assessment Process

			The roles and responsibilities of a diagnostician are not adequately described or explained. For example, the professional responsibilities (including adequate professional indemnity cover) associated with a diagnosis made by a single clinician are considerable. Requirements include a detailed knowledge of normal and abnormal development, a wide range of other neurodevelopmental and behavioural conditions, including genetic disorders, as well as other mental health and physical considerations and the ability to assess family environmental factors. There are considerable risks in both making and excluding an ASD diagnosis. For the child, risks include over and under-diagnosis with potential for missed causes and comorbidities and subsequent incorrect treatment and management planning. Children, in particular, may be significantly disadvantaged or put at risk by an inaccurate diagnostic decision. For the family, risks include wrong information about their child or young person's problems, the likely causes and how to best decide on appropriate interventions. For the community, risk include misallocation of resources for assessments and intervention. *Recommendation:* A diagnostician with the capacity to diagnose without the support of a multidisciplinary team must be a suitably credentialed medical practitioner with relevant advanced training in the field of developmental-behavioural paediatrics. We strongly recommend that for preschool or young people who are not communicating, a paediatrician with relevant advanced training in the field of developmental-behavioural paediatrics should be the only suitable diagnostician. All diagnosticians without the support of a multidisciplinary team must have: • broad biopsychosocial assessment capacity;	

			• extensive clinical training and experience across the range of disorders of development, learning, behaviour and mood; • extensive experience in the assessment and clinical care of children with these concerns across the age range; and, • specific skills and expertise in ASD.	
	ID685		These specific skills and expertise in ASD must be regulated and a suitable credentialing process needs to be established and monitored. An algorithm for the development of this process should be able to be developed but the current draft guidelines do not provide sufficient details to allow for this.	This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Accreditation and Regulation • Practice points for clinical, research and policy settings
	ID686		The draft guidelines exclude a sizeable group of highly skilled and experienced Senior Career Medical Officers (SCMOs) and Senior Child Health Medical Officers who are working in the public sector as key diagnosticians within multidisciplinary teams.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Qualifications for medical practitioners
	ID687		*Recommendation:* The NBPSA strongly recommends that the relevant professional colleges and associations must be consulted on the roles, responsibilities, qualifications, experience and training appropriate to their discipline in relation to both Tier 1 and Tier 2 roles and responsibilities as diagnosticians and informants. Existing international guidelines do not attempt a process of evidence evaluation for ascribing diagnostician roles. Roles are assigned on the basis of legislation or the training and skills required to perform a role.	Thank you for this feedback.

	ID688		Social workers and registered nurses would be valuable additions to the list of proposed professional informants.	Social workers have been added to allied health processions involved in Stage 1 of the assessment protocol.
	ID689		**Chapter 7. ASD Assessment Settings** We support the principle of direct observation of the patient: in the clinical setting, by the diagnostician, and in a community setting, by a professional informant with allied health qualifications and appropriate experience and accreditation in neurodevelopmental and behavioural assessment. In regional and remote areas, however, distance and workforce limitations may render such a requirement impractical or impossible to implement. The use of telehealth in these circumstances requires further consideration. The risks from over and under diagnosis outlined in Section 6.4 must be considered and elevated when the diagnostician does not have face-to-face access to the person being assessed. Health services, disability service providers and education all face similar challenges in delivering services in remote and hard to reach communities. *Recommendation:* Specific guidance should be developed for the use of telehealth in neurodevelopmental and behavioural assessments that includes: managing the expectation for clinical diagnosis when adequate clinical observations are not available, support for local clinicians and focusing on functional and support needs assessment and access to appropriate services. That, as a part of introducing any new national guidelines, additional work be undertaken across the health, disability and	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Telehealth

			education sectors to develop specific considerations for rural and remote implementation, including sharing of communications, training and support intrastate.	
	ID690		*Recommendation:* Referral for a neurodevelopmental and behavioural assessment and consideration of a possible ASD diagnosis must come from a consumer's primary care provider. Without a primary care provider as the primary Referral for an Assessment of ASD Concerns, secondary and tertiary services may be overwhelmed by the additional demand for these services through an increase in self-referrals or referrals from allied health professionals who do not work in neurodevelopment and employees working in the education sector. Under current Medicare arrangements, a referral is required to trigger the MBS payment system for specialist consultations.	The revised Guideline has been revised to state that referral is to be made by an individual's primary health care provider. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Referral for an Assessment of ASD Concerns
	ID691		The factors listed in Table 5 only slightly increase the risk of ASD at most. If all children displaying these symptoms were referred for an ASD assessment, the waiting lists would significantly increase and a lot of anxiety, particularly for parents and their children, would be created unnecessarily. *Recommendation:* That Table 5 be omitted and that the clinical expertise and judgement of the primary care provider determines the need for a referral.	This table has been omitted from the revised version of the Guideline. For further information, please refer to the 'Overview of Major Amendments' chapter under the heading: • Referral for an Assessment of ASD Concerns
	ID692		The title of this section is misleading as it presumes that diagnosis of ASD is the only possible conclusion for a child	Please also note that the revised Guideline provides additional content that addresses this issue. For example, in

			who has been referred for a comprehensive neurodevelopmental and behavioural assessment. *Recommendation:* That the terminology used in this title and throughout the draft guideline be changed to more accurately reflect the assessment process. For example, “making a referral for a complex developmental assessment” would provide a more accurate description of the process that is undertaken.	the section “Content of an ASD assessment” the following text has been added (Section 3.1): “The Diagnostic Evaluation seeks to answer the questions: “*Does the individual meet criteria for a clinical diagnosis, such as ASD?*” and “*If the individual does not meet criteria for a clinical diagnosis, are there other considerations that explain the presentation?”*
	ID693		The two-tier structure as proposed will increase diagnostic error and may further overload existing assessment services. While we support a staged approach to neurodevelopmental and behavioural assessment, based on individual need and complexity, further consultation and consideration is required.	We believe that the revised structure addresses this comment by describing a progressive approach to neurodevelopmental and behavioural assessment that is based on individual need and complexity. Please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Structure of the Assessment Process.
	ID694		**9.1 Purpose** The neurodevelopmental and behavioural assessment can be a long process because of significant variance in clinical presentations and reasons for initiating the referral. The NBPSA recommends that the draft guidelines clearly describe the potential risks of diagnosis, the risks associated with misdiagnosis, the risk of missing other diagnoses, and the risks from over diagnosis. For example, the risk of missing an associated Intellectual Disability or diagnosis of Fragile X syndrome goes beyond the child, extending to future pregnancy decisions for the family, including female siblings. In some circumstances, individuals and their families may not want, or choose not to associate with, a diagnostic label of	The Stage 1, 2 and 3 Decision Making and Outcome sections include the following statement: “In cases where the ASD Assessment identifies support needs, there is immediate linkage to appropriate supports based on functional abilities/impairments and needs, without the requirement for a clinical diagnosis of ASD.”

			ASD. This will impact the services they choose on the path to understanding their strengths, difficulties and needs. *commendation:* When individuals display needs that require intervention, or have functional deficits, and choose not to identify as having been diagnosed with ASD, these families or individuals should not be disadvantaged, through denial or reduction in service, by this choice. The draft guidelines must provide clarification of this to support clinicians and families in these circumstances.	
	ID695		**9.2 Diagnostic evaluation** We welcome the inclusion of the beta ICD-11 diagnostic criteria into these draft guidelines. As the ICD-11 criteria have been stated by the authors to have a "strong focus on assessing functional impairment", we believe that this should be further iterated in Table 6.	Further information has been provided on the table outlining the ICD-11 beta criteria, in particular the specifiers for co-occurring conditions and a description of the functional impact.
	ID696		**9.3 Diagnostic Evaluation Structure** While we are familiar with tiered approaches to health and disability care, the evidence presented in the Evidence Tables on this matter is not sufficient to support this approach for ASD diagnosis. The concept of a two-tier approach to diagnosis requires further consideration. The NBPSA supports a staged and progressive approach to neurodevelopmental and behavioural assessment, based on individual need and complexity. However, any approach must be structured to ensure known risk factors for an inaccurate diagnosis are excluded and that appropriate care is taken for those in vulnerable	Thank you for this feedback. The revised structure provides much greater focus on differential diagnosis by recommending: 1. An initial comprehensive functional and needs assessment; 2. The amendment of professions to those who have received formal training on differential diagnosis across the full range of neurodevelopmental disorders; and 3. A greater focus on differential diagnosis at both Stage 2 and Stage 3. Tertiary assessment services for individuals with complex neurodevelopmental disorders are not available in every Australian state. For this reason, a reference to these services was not included in the main figure describing the assessment

			circumstances or where an incorrect decision may have substantial adverse consequences in later life. *Recommendation:* That further expert consultation be undertaken on the utility of a tiered assessment approach within existing care delivery models, including consideration of primary, secondary and tertiary care delivery components.	model in the revised guideline. However, the following text has now been included in the revised draft (Section 10.1): "In some Australian states, tertiary services are available for the assessment of individuals with complex neurodevelopmental disorders. If these services are available, then it is recommended that clients are referred to these services if a consensus decision cannot be achieved at Stage 3."
	ID697		Figure 4 represents only a small portion of the journey that many individuals will take when pursuing a diagnostic evaluation for neurodevelopmental and behavioural conditions, including ASD. Many children who are referred for a Tier 2 assessment will not have an ASD diagnosis, even after assessments have been completed by the multidisciplinary team. *Recommendation:* That Figure 4., and associated narrative, be extended to include ongoing diagnostic uncertainty, and also to illustrate the link to access to early intervention services. The function and needs of the child should be the primary consideration when determining referral to additional support and services, including early intervention. A link to re-evaluation of the patient after an initial diagnosis should also be included into the flowchart. If functional and needs assessment is completed early, as described above, there are many potential positive flow-on effects for the child and family, and for streamlining the diagnostic process. For example, if a child aged 3 presents with little connection with peers, limited communication, has a preference for routines and does not like loud noises and, following a	Thank you. We believe the structure of the revised Guideline (and associated figure) addresses this helpful comment. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Structure of the proposed assessment.

			functional and needs assessment, is found to have sufficient difficulties to warrant referral to an early intervention service. That service would develop a program to cater to the child's learning, functional and support needs and appropriate strategies to improve communication. If the early intervention providers do not see a response to their interventions and identify a severity and breadth of difficulties that warrant further neurodevelopmental and physical assessment, they will refer to a paediatrician. The paediatrician will then have important information about the strengths, difficulties and needs of the child and family at the time they are seen, as well as information about whether there has been a response to intervention. This will assist a timely decision about whether further investigation and assessment, beyond the ongoing monitoring provided during early intervention, is needed or not. If further assessment is needed, a professional informant has been established, some relevant information is already available and can guide the most efficient assessment pathway.	
	ID698		**9.5.3 Information Collection – Standardised ASD Diagnostic Tool** There is insufficient evidence upon which to base a recommendation that an ASD specific diagnostic tool be included as part of an assessment for children and young people presenting with neurodevelopmental differences of the types seen in ASD. There does not seem to be consistency at level 1 when reading the extracts provided in evidence table 47 from draft guidelines, the Delphi or the scientific committee to include the current wording of this recommendation. *Recommendation:* The decision about whether an ASD specific diagnostic tool is used should be left to the discretion of the diagnostician until there is a higher level of evidence to support inclusion, or	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Use of 'Standardised' Instruments

			strong consensus that this would add value to all assessments.	
	ID699		**Chapter 10. Functional and Support Needs** The NBPSA strongly supports the value and necessity of the functional and support needs assessment. *Recommendation:* That the functional and support needs assessment be completed prior to, or concurrently with, the diagnostic assessment process. The outcome of the functional and support needs assessment should be used to determine, or assist in the determination of: • whether pursuit of a diagnostic assessment is necessary or warranted; and, • the patient's access to support through the NDIS including access to early intervention services.	Thank you for this comment. The revised structure provides far greater emphasis on the importance of a comprehensive functional and needs assessment in providing the foundation for a diagnostic evaluation. The 'Overview of Major Amendments' chapter, under the heading • Emphasis on the Importance of Functional Abilities in Referral for Supports
	ID700		*Recommendation:* Given the NBPSA recommendations on diagnostic assessment, the professional qualifications skills, training and experience required for functional and support needs assessment will need to be more clearly described. While some elements of this assessment can be carried out by paediatricians, the allied health professions and others have access to a greater array of tools and practical opportunities for undertaking functional and support needs assessment. There is additional complexity in assessing function in pre-schoolers and those who are unable to communicate. The NBPSA would welcome the opportunity to contribute to	Thank you for this feedback. We believe that the revised Guideline more clearly describes the training and expertise required for each professional. We have also added the recommendation regarding the development of competencies for professionals. The 'Overview of Major Amendments' chapter, under the heading: • Practice points for clinical, research and policy settings We would welcome feedback about further recommendations that may be important for young children and those who are unable to communicate.

			development of recommendations for assessment in these two groups.	
	ID701		The use of standardised assessment tools is supported, with the caveat that a more detailed review will be needed to decide appropriateness and validity in pre-schoolers and individuals who do not communicate.	This table has been omitted from the revised version of the Guideline. For further information, please refer to the 'Overview of Major Amendments' chapter under the heading: • Use of standardised assessments
	ID702		*Recommendation:* That only a medical professional with expertise in the diagnosis of ASD and other neurodevelopmental conditions should be performing in the role of a single diagnostician. (See also our comments at Section 6.4)	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Professional Roles • Structure of the Assessment Process
	ID703		The diagnostic process should not consider ASD alone, but the wide range of differential diagnoses and cooccurring conditions to minimise the likelihood of misdiagnosis or over diagnosis. The diagnostician should work with a professional informant, from a different professional discipline or specialty, also having input into the process. The exact role of that person should not be so prescribed as to create unnecessary barriers to pursuing a diagnosis, particularly for families in rural and remote areas.	Thank you for this feedback. The revised Guideline provides significantly more flexibility for individual clinician choice. For further information about this, please refer to the 'Overview of Major Amendments' chapter under the heading: • Structure of the proposed assessment • Emphasis on the Importance of Functional Abilities in Referral for Supports
	ID704		The NBPSA strongly supports the concept of monitoring response to intervention, as outlined in the example above at the end of Section 9.3. This is not considered in the current diagnostic outcomes provided within the document. *Recommendation:* That the draft guideline is updated to reflect the inclusion of response to early intervention, regardless of the diagnostic	The revised Guideline includes a recommendation regarding ongoing monitoring of functional abilities and support need (Section 7.5).

			outcome. For example, a young child who meets ASD criteria may be re-assessed after a period of appropriate and targeted intervention to determine future support requirements.	
	ID705		We agree that “the Functional and Support Needs Assessment process should be repeated throughout the individual’s life to ensure that changes to functional status and support needs are identified and acted upon in a timely manner.” *Recommendation:* As stated in previous sections, funding should be based on the needs of the child, in accordance with the guiding principle of individual and family-centred care. A child who does not receive a diagnosis of ASD or any other neurodevelopmental condition should be provided with the required support as established through the completion of the functional and support needs assessment. A child with an ASD diagnosis should have interventions and services tailored to their needs.	Thank you for this comment. The revised structure provides far greater emphasis on the importance of a comprehensive functional and needs assessment in providing the foundation for a diagnostic evaluation. The ‘Overview of Major Amendments’ chapter, under the heading • Emphasis on the Importance of Functional Abilities in Referral for Supports
	ID706		*Recommendation:* A comprehensive formulation should be developed, including details and outcomes of the diagnostic process and the results of the functional and support needs assessment. This can then be used for multiple purposes, including development of a child and family centred management plan and determination of the level of support.	This information was recommended in the original version of this Guideline, and has been retained in the revised version.
	ID707		**9.5 Tier 2 diagnosis** Many people who enter the diagnostic pathway for a neurodevelopmental condition, including exploration of the likelihood of ASD, are likely to be part of a multidisciplinary assessment process. We agree with the draft guidelines	Thank you for this comment. The terminology of this section has been changed to:

			stance that "[if] consensus on a diagnostic decision was not achieved among the diagnosticians following an extensive Tier 2 diagnostic evaluation, the diagnostic decision should be deferred until re-assessment after a specified period of time." When this situation arises, the necessary supports, in line with assessed functional needs, must still be provided. Tier 2 diagnostic processes set out in the draft guidelines, however, provide three narrow diagnostic outcomes for individuals completing the assessment that do not accurately represent clinical reality. *Recommendations:* That the potential diagnostic outcomes should be broadened, in line with our recommendation in 9.4, to include the diagnosis, or further evaluation, of other neurodevelopmental disorders.	"A Stage 3 Consensus Team Diagnostic Evaluation will result in one of the following three outcomes: 1. Consensus was reached that the individual does not meet criteria for a clinical diagnosis; 2. Consensus was reached that the individual does meet criteria for a clinical diagnosis, with a decision of specifiers and current severity level if DSM-5 criteria are utilised; or 3. Consensus was not reached in relation to whether the individual meets criteria for a clinical diagnosis, and the individual is recommended for re-assessment at a later timepoint."
	ID708		That assessment includes direct observation of the individual in two or more settings, where at least one is a community setting. However, while the diagnostician should make the observation in the clinical setting, an allied health professional with relevant skills in ASD assessment would usually be better placed to complete these observations in the community setting. Families and education staff often do not have specialist-level training in broad developmental norms and disorders in children. Observations from skilled allied health professionals are essential and reduce over-reporting and over-interpreting of behavioural problems as ASD symptoms. If the diagnostician were to complete these observations, the duration, expense and waiting lists for assessment would significantly increase and this provides no benefit to the child or the wider health and disability system.	Thank you for this feedback. Based on the considerable feedback received regarding the need for flexibility in the assessment model, we have used the following wording (Section 10.3): "It is recommended that the Consensus Team Diagnostic Evaluation involve the collection of information about the individual's participation in all relevant community settings. This information may be obtained through communication with the client and/or other professionals but direct observations by member(s) of the ASD assessment team within some of these community settings may also be helpful."

	ID709		Alternative pathways must be developed for patients living in rural and remote location to ensure these patients and their families are not disadvantaged by their geographic location and limited access to clinicians with the required skills and expertise. (See also the comments at Section 7. Assessment Settings)	Please refer to the ‘Overview of Major Amendments’ chapter under the following headings: • Telehealth
	ID710		Information from early intervention services will provide valuable information for the multidisciplinary assessment through multiple engagements with skilled observers in a child’s usual settings.	Early intervention service providers have been added to the list of other professionals who may provide information to support the ASD assessment.
	ID711		The draft guidelines fail to mention other key parts of diagnostic assessment including targeted physical examination and the appropriate investigations (such as genetic testing) required to detect co-existing and/or differential diagnoses.	Further medical investigations, such as genetic testing, may be arranged during any stage of the ASD assessment if indicated to detect co-occurring and/or differential diagnosis. This has been stated in Table 7 of the revised Guideline.
	ID712		The statement in Table 10, may be misinterpreted and fails to account for the complex and often prolonged process to pursuing a diagnosis of ASD: “there is now robust empirical evidence that ASD can be reliably and validly diagnosed at 2 years of age by an experienced clinician, and that this diagnosis is relatively stable over time.” In its present form, we have concerns with this statement. *Recommendation:* The commentary in chapter 3, section 2 is much clearer and should be replicated in this section to prevent any misinterpretation.	This statement has been changed to allow variation in the development of ASD signs and symptoms: “There is now robust empirical evidence that, for a small proportion of children, ASD can be reliably and validly diagnosed at 2 years of age by an experienced clinician, and that this diagnosis is relatively stable over time.”

	ID713		Specific consideration should be given to the assessment of function and needs for preschool children and individuals who do not communicate. This is because: 1. all facets of ability, symptoms and function are being assessed using behaviour; and, 2. preschool children and individuals who do not communicate are more reliant on their parents or carers to function. As such, specific consideration of how to assess function and needs is warranted in these two groups. The NBPSA would like to contribute to the formulation of appropriate assessment for these two groups.	Please see responses to similar comments made by this respondent.
	ID714		Medical professionals with additional training in the assessment, diagnosis and treatment of conditions present in the adolescent and young adult (AYA) population can diagnose patients to the age of 25 years. The draft guidelines should reflect this.	The upper age limit for paediatricians and child and adolescent psychiatrists has been increased to 25 years.
	ID715		We strongly support the statement that “all professionals involved in an ASD assessment with an individual from a different racial or ethnic background, including Aboriginal peoples, should first obtain a good understanding about the cultural factors relevant to the individual and their caregivers that may guide or influence the ASD assessment process.”	Thank you for this feedback.
	ID716		The inclusion of Table 14 provides no assistance to a clinician who is supporting a patient through the assessment and diagnostic pathway for a neurodevelopmental condition, with little rationale being provided for the inclusion of some conditions and exclusion of others.	The three tables in the Differential Diagnosis and Co-occurring Conditions section have been condensed, so that other potential clinical explanations are included for all conditions. All conditions were retained, as other submissions commented that this information was helpful.

			Recommendation: That Tables 14 and 15 in this section are reconfigured to describe the differential diagnoses and co-occurring phenotypes, as per the current contents of Table 15, and the most common aetiologies only.	
The Royal Children's Hospital Melbourne (RCH) (group submission: Psychologists, Speech Pathologists, Paediatricians, Occupational Therapists, Psychiatrists, ASD Service Coordinators) [142]	ID717	Organisation – Professional experience	General Comments 1. The RCH has developed this response following agreement amongst clinicians and researchers affiliated with the hospital, following two face-to-face consultation sessions. 2. The RCH welcomes the notion of a national diagnostic guideline for ASD that is evidence-based and promotes equitable and timely access to diagnosis, as appropriate to the context of age, developmental stage and local health and developmental service provision.	Thank you for this information and feedback.
	ID718		1. Concerns exist regarding how this guideline and its implementation would be monitored by all relevant bodies, professions, consumer groups and the NDIS. Suggestions regarding accreditation processes, if required, whilst recognising relevant conflicts of interest, would be welcomed.	Please refer to the 'Overview of Major Amendments' chapter under the following headings: • Accreditation and Regulation • Conflicts of interest • Practice points for clinical, research and policy settings
	ID719		2. The process for declaring and managing conflict of interest at Steering Committee level and with respect to professional training and the diagnostician/treatment interface should be clarified.	A transparent process of declaration and management of conflicts of interest was established as part of the Steering Committee Terms of Reference (contained in the Technical Report).
	ID720		3. The RCH suggests that the evidence-base, and integration of evidence to formulate this guideline be reviewed by an additional external international body/professional prior	A methodological review by a NHMRC-nominated reviewer has already been completed. The independent reviewer provided very favourable reviews of the methodology, including an endorsement of the process to develop new

				category descriptors given the current state of the empirical evidence in this area. Further methodological reviews will be undertaken by the NHMRC in early 2018.
	ID721		Chapter 12: The funding implications of the tiered model and the functional assessment have not been addressed and require clarification in relation to existing funding systems such as the Medicare Benefit Schedule.	Please refer to the 'Overview of Major Amendments' chapter under the following headings: • Emphasis on the Importance of Functional Abilities in Referral for Supports • Structure of the Assessment Process • Cost implications of the assessment model recommended in the Guideline • Practice points for clinical, research and policy settings
	ID722		1. The Coordinator Role is both clinically important and administratively demanding. A multidisciplinary team should have both administrative and clinical coordination support. Clinical expertise (medical or allied health) is required from point of referral triage onwards and an administrator-only model would not be sufficient to complete this role, as described in its entirety. In general, position descriptions of administrative staff specifically exclude clinical competencies.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Coordinator Role
	ID723		2. The descriptions of professional disciplines at 6.4.1 do not reflect current or appropriate registration requirements. Most health professionals in Australia are registered with, and regulated by AHPRA, or alternatively with professional associations where registration is not mandated. Registration of medical specialists requires Fellowship of the RACP or other specialist Colleges, or their international equivalent. The latter is critical in recognising the role that international medical graduates play in Australia. The same is true of other health professions. Many psychologists who meet all other expertise requirements are registered with other bodies, and do not have college	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the headings: • Qualifications for medical practitioners • Qualifications for Psychologists • Qualifications for occupational therapists

			registration. Occupational therapists working in early years developmental assessment services would not deem it necessary, nor beneficial to be registered with the Better Access to Mental Health Programme. We welcome levels of expertise being specified for each discipline, however there is some over-specification, which will exclude relevant and experienced clinicians. For example, we understand that many experienced and expert speech pathologists are not members of Speech Pathology Australia as it is not a registered health profession in Australia.	
	ID724		3. Neurologists are generally not involved in ASD in assessment in Victoria, and possibly around most of Australia. The RCH would welcome reconsideration of the appropriateness of their listing as a diagnostician.	Given the important role that neurologists play in the diagnosis of ASD internationally, the decision was made to retain neurologists as an eligible medical practitioner to administer all stages of an ASD assessment, as long as they meet the relevant training and expertise requirements specified in the Guideline.
	ID725		Section 8.1.2 The RCH agrees with referral not just being dependent on outcomes of screening measures. Surveillance, parent concern, and clinical reasoning are also relevant to the decision-making process, and should be flexible.	Thank you for this feedback.
	ID726		Vision and hearing assessment in children with possible ASD is recommended and should be initiated at the time of the referral for ASD assessment if not already completed	Audiologists, ophthalmologists and optometrists are included in the list of other professionals who can provide information to support the ASD assessment. The Medical Evaluation involves testing hearing and vision status, hearing assessment (e.g. screening test or full auditory evaluation) and vision assessment (e.g. screening test, sight test or full ophthalmologist evaluation) were provided as examples of further assessment at Stage 3, and hearing and vision impairments have been listed in the new table on possible differential or co-occurring diagnoses.

	ID727		We welcome the notion of direct assessment in various settings where possible, but for some teams this is not possible. We agree that information from these settings is a mandatory part of Tier 1 or Tier 2 assessment. Methods used to collect this information should be dependent on clinical judgement and the service setting of the professional/s involved in assessment.	Thank you for this feedback. Based on the considerable feedback received regarding the need for flexibility in the assessment model, we have used the following wording (Section 10.1): “It is recommended that the Consensus Team Diagnostic Evaluation involve the collection of information about the individual’s participation in all relevant community settings. This information may be obtained through communication with the client and/or other professionals but direct observations by member(s) of the ASD assessment team within some of these community settings may also be helpful.”
	ID728		Telehealth could be utilised as required for informant or history taking aspects of assessment. For direct clinical aspects of assessment, this should only be adopted for outer rural and remote postcodes, where no other option is available to diagnosticians and families.	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Telehealth
	ID729		The RCH welcomes the recognition of this key aspect of assessment in relation to any diagnostic process. Function and support needs should drive resource allocation in any service or model of care, as opposed to a specific diagnosis. A strength-based and functional approach is essential for all who seek to provide important information about an individual’s profile and/or need for specific services.	Thank you for this feedback. No amendments are required in response to this comment.
	ID730		The guidelines should acknowledge the wide variability in alignment with the requirements of current state and territory health and education departments –raising eligibility issues for funding and service provision.	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Implementation and Evaluation of the Guideline Practice points for clinical, research and policy settings

	ID731		The RCH proposes that one time point for function and support assessment is insufficient in young developing children. A snapshot approach is not appropriate in the early years due to the potential for rapid change in development and needs. It is important that this is highlighted in Chapter 10 as well as Chapter 12.	The Guideline recommends “that the Comprehensive Needs Assessment is repeated throughout the individual’s life to ensure that changes to functional status and support needs are identified and acted upon in a timely manner. Further assessment is to be conducted as required by clinicians engaging with the client at the particular time.”
	ID732		The RCH has concerns about the fit of this aspect of assessment within the overall diagnostic process. Confusion was noted in relation to whether this happens before, during or after diagnostic assessment, and what impact that would have on the other diagnostic processes, and clinical resourcing at a tier 1 or tier 2 level. Clarification would strengthen the feasibility and appropriateness of this recommendation	Thank you for this comment. The revised structure provides greater emphasis on the importance of a comprehensive functional and needs assessment in providing the foundation for a diagnostic evaluation. For further information about this, please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Structure of the Assessment Process
	ID733		It is not clear whether this is a general or ASD-specific functional assessment. There are tools suggested but no overarching principles of the purpose and importance of tools, and their evidence base in different age ranges. There is concern around the appropriateness of some tools for young children with ASD e.g. the PEDICAT, and the WHO-DAS 2.0. The absence of other tools worth considering was noted, for example interview-based tools such as the Canadian Occupational Performance Measure ICF Core sets for ASD are difficult to review, as they are not yet published.	Thank you for this comment. The revised structure provides greater emphasis on the importance of a comprehensive functional and needs assessment in providing the foundation for a diagnostic evaluation. For further information about this, please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Structure of the Assessment Process Given the ASD core sets are not yet publicly available, the revised Guideline has omitted reference to these. These may be included in future revisions of the Guideline.
	ID734		The RCH acknowledges that there are some children who, based on presentation, do not require a full multidisciplinary team assessment to obtain a diagnosis of ASD. There is still some concern however, that Tier 1 processes, as currently	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading:

			stated in the guideline, will place notable burden on the system and increase the risk of misdiagnosis. Tier 1 also does not fit with international guidelines. There are a number of considerations that the RCH feels should be in place if Tier 1 was to continue as recommended. These are as follows: - The RCH agrees that diagnosticians under Tier 1 should be defined differently than in Tier 2. In particular, specific training and experience to ensure diagnosis of medical conditions, developmental and mental health comorbidities, intellectual capacity, and other significant issues should be considered. This overall capability is unlikely in allied health professions unless their training and experience are at a very high level. Many general practitioners are also unlikely to be able to provide all the medical expertise required in this scenario. - The risks of allied health staff making Tier 1 diagnoses, without medical review by an experienced practitioner, needs to be specified. Different professions will need to acknowledge the impact on professional responsibility and scope. - The RCH does not believe that Tier 1 expansion of diagnosticians will address the widespread problem of service access for children. It is more likely to overload the system and may not be robust enough to ensure diagnostic rigour, causing downstream issues in relation to pressure on Tier 2 services to review diagnoses whether positive or negative.	• Professional Roles • Structure of the Assessment Process
	ID735		- More structure and rigour are required around the assessment process at Tier 1. The RCH suggests two informants from two different settings, as opposed to one informant, should be the absolute minimum required for the single diagnostician to draw his or her conclusions. This will ensure adequate information is collected and	Thank you for this comment. The revised Guideline highlights the importance of collecting information through a variety of means (direct observation, parent/caregiver report, file review, other professional report) and sources (parent/caregiver, other professionals) at each assessment stage.

			evaluated. It is difficult to determine how DSM 5 criteria would be satisfied under Tier 1 as it stands currently.	
	ID736		Chapter 11: There is a concern that the suggested paperwork will become a key requirement of assessment. Some forms present as cumbersome and may not be appropriate for timely assessment communication. Further guidance in this area would be welcome. In particular, the diagnostic reporting template is very detailed and long, taking considerable time to complete especially in a Tier 1 assessment setting. There needs to be clarity about its intended use. Recommendations about principles of good documentation and reporting may be more appropriate.	The ASD assessment report templates are an optional resource available for clinicians to use at their own discretion. This has been clarified in the Guideline.
	ID737		**Tier 2 Assessment (Section 9.5)** 1. The RCH broadly welcomes the defining of Tier 2 assessment processes, diagnosticians, and informant specifications. 2. The RCH wants to ensure that the list of diagnostic tools does not include any screening tools. The RCH would welcome a listing of principles of tools, with appropriate examples, rather than tool prescription at any point along the guideline, or at any tier of assessment.	Thank you for this comment. Recommendations relating to specific instruments that measure functioning have been removed from the Guideline, and information about resources will instead be located on the Guideline webpage to enable updates to occur more readily.
	ID738		Section 12.1: The diagnostic difficulties in children aged around age 2 years should be communicated to families if they are going through the diagnostic process. Some children around this age will require surveillance over time as their development unfolds.	This statement has been changed to allow variation in the development of ASD signs and symptoms: “There is now robust empirical evidence that, for a small proportion of children, ASD can be reliably and validly diagnosed at 2 years of age by an experienced clinician, and that this diagnosis is relatively stable over time.”

	ID739		Interpreters must be available for all parts of the process when working with children/families from culturally and linguistically diverse backgrounds; in the document interpreters are not mentioned until the section on communication	The role of interpreters was included in the original version of this Guideline under the section Culturally and Linguistically Diverse Backgrounds (Section 12.4), which we believe is the most appropriate section for this information. This has been retained in the revised version of the Guideline. However, the Instructions for Using this Guideline now includes advice to refer to the Important Considerations sections, such as culturally and linguistically diverse backgrounds, when relevant.
	ID740		Section 12.6.2: 1. Pathological Demand Avoidance in not recognised as a specific condition in Australia and should not be listed as a comorbidity.	Please refer to the 'Overview of Major Amendments' chapter under the heading: • Professional Roles
	ID741		2. Language Disorder and Developmental Coordination Disorder prevalence should be listed in Table 16 given high prevalence rates	Language Disorder and Developmental Coordination Disorder are both listed in table of co-occurring and differential diagnosis.
Children's Health Queensland Hospital and Health Service (Medical Director Child Development Program, Developmental-Behavioural Paediatrician, Director Child	ID742	Organisation – Professional experience	A life course, or developmental approach to assessment is also appropriate, recognising that different approaches are needed at different phases of development. **The Diagnostic process** • This proposed model essentially defines a list or screening algorithm via a decision tree but reduces the contextual decision-making process- e.g. a child with a severe receptive language disorder and anxiety may get a diagnosis on these grounds and thus be "prescribed" the wrong therapeutic interventions. • It is agreed that the diagnostician needs appropriate expertise in diagnosis of ASD. This must include the biological underpinnings of this disorder.	Thank you very much for these very helpful comments. Many of these comments have been addressed through the revised structure of the Guideline. For a fuller description, please refer to the 'Overview of Major Amendments' chapter. Please also refer to the responses below.

Development Program) [143]			• The diagnostician must also have specialist training in all aspects of child development and paediatric medicine, using a biopsychosocial approach. This is because the presentation is an undifferentiated one at the start of the patient journey (or should be, to avoid bias), and critically, the clinician must be able to recognise other aspects of the diagnostic formulation and differential diagnosis. • We believe the assessment process has two phases- Data gathering including biopsychosocial assessment, and diagnostic formulation • Biopsychosocial assessment- the ecological framework for this is not well emphasised in the diagnostic section. (The new paper- the First 1000 days comprehensively covers this) • Diagnostic formulation- this process is not well described in the proposed guideline. • This process is well described by O'Keeffe and Mc Cauley (2012) Nurcombe (2008). The formulation process ensures that the biopsychosocial framework is considered for each child prior to arriving at a categorical diagnosis. History, examination, and assessment are required. • ASD is a spectrum disorder and as such there is inherent uncertainty about the diagnostic cut off point. This spectrum disorder is more suited to a process of diagnostic formulation than a binary format. • Diagnosis is a complex process, typically learned over many years. The algorithms presented on pages 40 and 41 may be acceptable for case validation in a retrospective fashion, but are not sufficient to meet the needs of a prospective diagnostic reasoning process in a clinical setting. In all medical reasoning, the testing of multiple hypotheses is critical to medical decision making and this isn't evident in this process. • The experienced diagnostician uses a variety of methods to arrive at a diagnosis, including personal experience, published experience and the attributes of the patient in order to make a decision. Most experienced clinicians employ hypothesis testing to support diagnosis. Typically,	

and wide number of hypotheses may be possible at the start of the process and these are gradually refined as the assessment process continues. The diagnostician must be aware of possible cognitive errors or biases in the diagnostic process. Reference: Sox, Higgins, Owens. (2013) The focus on ASD as the sole purpose of the consultation leads to the probability of cognitive bias, as there is only one hypothesis being tested in this proposed process.

The clinician

- The process of diagnostic reasoning complements assessment, and requires a particular skill-set in hypothesis testing. (See comments on hypothesis testing). In assessing children with ASD features, the diagnostician must take into account the biological aspects of the presentation. Some disorders have medical treatments for specific underlying disorders that might present with ASD features. Biological therapies will be more, not less likely to be available in the future. Only specialist physicians are trained to consider the biological aspects (genomics/ neurology/ epilepsy/ syndromic presentations/ metabolic/ reactive attachment disorder etc) of a presentation. Competency in all aspects of an evaluation of a child with possible autism are necessary to make a differential diagnosis. This is the primary consideration rather than being a diagnostician for ASD only.
- Please note the expertise of specifically trained Developmental Paediatricians particularly in tier 2 table 3 p 18 is not incorporated at all.

Retrospective validation vs prospective guidance- Clarity of purpose

- This document’s stated purpose is to “support clinicians who undertake diagnostic assessments that may result in

			an ASD diagnosis. …provides a framework that enables an effective and efficient appraisal of these behaviours.” • We are concerned that the proposed model does not function as an effective clinical pathway to manage an undifferentiated presentation of neurodevelopmental disability which may include ASD features. It appears to be more suited to use as a retrospective tool to determine the validity - to see if an ASD assessment is valid and sufficient to access funding, rather than a document which will help a clinician to determine what is an appropriate assessment for an undifferentiated presentation. • Clarity of purpose is important here. This may be very useful as a decision-making tool for making an assessment about the validity of the diagnostic process, but requires changes to function as a working clinical pathway which meets the needs of our clients and families. **Populations** • The document does not take a population health view of screening and assessment services for developmentally vulnerable and at-risk children. • It does not consider the preventative or other opportunities afforded by screening and functional assessment of this population • The population of children eventually diagnosed with ASD exists within a population of similarly vulnerable children with alternative diagnoses. Any model needs to take into account the undifferentiated developmental issues that present to clinicians- they may have alternative diagnoses or indeed no diagnosis. • Clinicians are responsible for the assessment and support of the referred population, and diagnostic systems must be valid for this entire referred population.	

	ID743		**Strengths** 1. ASD Assessment Guiding Principles (p11) The assessment principles of holistic framework, strengths focussed are appropriate. As part of a holistic approach, an ecological model of development could also be considered. This document also considers a transdisciplinary approach. (Suggested reference - Act Now- Principles and Practice) https://www.childrens.health.qld.gov.au/wpcontent/ uploads/PDF/qcycn/child-development.pdf p42	Thank you for this comment.
	ID744		**Concerns** Guiding Principles • The heading ASD Assessment guiding principles could be more broadly considered under the heading Developmental Assessment Guiding Principles, as the diagnosis is not predetermined at the point of referral, and children with many different diagnostic outcomes will be determined. There are several possible diagnoses at this point.	Thank you for this comment, with which we agree. To emphasise this point, we have added the following statement in the 'Scope of the Guideline' section (Section 1.2): "It is critical that an ASD assessment takes place in the context of a broader neurodevelopmental and behavioural assessment. Where possible, this Guideline describes an assessment process that is applicable for individuals presenting with signs or symptoms of a broad range of neurodevelopmental conditions. However, to meet the defined objectives of the project, this Guideline retains a focus on applying this process to the context of individuals presenting with signs or symptoms characteristic of ASD." The main figure describing the assessment model has also used broad terminology (i.e., no specific reference to ASD above other neurodevelopmental disorders). Nevertheless, given the objectives of the project, and the focus of the research effort underpinning the content of the Guideline, it was decided not to change the title of the Guiding Principles section.

	ID745		Concerns ASD Assessment Scope - "A functional and Support Needs Assessment aims to explore the question" What are the strengths and challenges which inform future management?" This is an important part of the assessment process. In some cases, it may be more appropriate to explore this in detail prior to definitive diagnosis- a response to intervention approach. This type of approach is gaining in acceptance, but not discussed here.	Thank you for this comment. The revised structure provides far greater emphasis on the importance of a comprehensive functional and needs assessment in providing the foundation for a diagnostic evaluation. For a fuller description of this, please refer to the 'Overview of Major Amendments' chapter under the heading: - Structure of the Assessment Process
	ID746		**The Clinician:** - The process of diagnostic reasoning complements assessment, and requires a particular skill-set in hypothesis testing. (See comments on hypothesis testing). In assessing children with ASD features, the diagnostician must take into account the biological aspects of the presentation. Some disorders have medical treatments for specific underlying disorders that might present with ASD features. Biological therapies will be more, not less likely to be available in the future. Only specialist physicians are trained to consider the biological aspects (genomics/ neurology/ epilepsy/ syndromic presentations/ metabolic/ reactive attachment disorder etc) of a presentation. Competency in all aspects of an evaluation of a child with possible autism are necessary to make a differential diagnosis. This is the primary consideration rather than being a diagnostician for ASD only.	Thanks for these comments. We believe the structure of the revised Guideline addresses this helpful comment. Please refer to the 'Overview of Major Amendments' chapter under the headings: - Professional Roles - Structure of the Assessment Process
	ID747		Strengths	Thank you for his comment. No amendment is required.

			2. ASD Assessment Roles 6.3 • Making explicit the role of the coordinator or case manager is useful in providing an integrated approach for children and families.	
	ID748		**The Diagnostic process** • It is agreed that the diagnostician needs appropriate expertise in diagnosis of ASD. This must include the biological underpinnings of this disorder. • The diagnostician must also have specialist training in all aspects of child development and paediatric medicine, using a biopsychosocial approach. This is because the presentation is an undifferentiated one at the start of the patient journey (or should be, to avoid bias), and critically, the clinician must be able to recognise other aspects of the diagnostic formulation and differential diagnosis.	Please see responses to similar comments made by this respondent.
	ID749		Strengths 4. Functional and support needs assessment p49 • We agree that the functional needs of the child are a paramount consideration. We would also agree with this process being important at any time during the evaluation. We would consider this information as part of the diagnostic formulation and then again when we plan and set goals with consumers.	Thank you for this feedback.
	ID750		Strengths 3. Table 9 “The functional assessment should determine the individual’s activity related to character strengths” p52 This is articulated	Thank you for this feedback. The revised Guideline makes explicit that findings from the Comprehensive Needs Assessment (Stage 1) are to be used to inform the diagnostic formulation in Stages 2 and 3.

			well. This information may also be integrated into the diagnostic formulation, so that the assessment and diagnostic process includes the strengths and difficulties together in a balanced formulation.	
	ID751		Early diagnosis of functional limitations and early intervention should be the primary drivers of assessment in the early years. There’s evidence that diagnosis can be made reliably at two, but in some children a better outcome may be to implement functional supports and defer diagnosis. This is the essence of a Response to Intervention (RTI) approach. A presentation at an early age may be undifferentiated, and may become clearer in time. The first two sentences in Table 10 (in the signs and symptoms section) are potentially misleading. They suggest that diagnosing every case of ASD should be our goal by age 2. We believe that early identification of functional disability or developmental risk is paramount for early intervention. Further that categorical diagnosis should be reserved for those children where there is clear and sufficient differentiation to provide such diagnosis at this age. Once the child has an identity as a child with ASD it is in our experience almost very difficult to “remove” this diagnosis. We remain concerned that a child with an ASD diagnosis will be forever identified as such and indeed this may be detrimental to some in terms of self-identity. The diagnostic stability studies that suggest that reliable and stable diagnosis by two years may be appropriately referring to the severe end of the ASD spectrum not those with less severe presentations. The statement from point 3.2 about features “often being present before three years, but may also first become apparent during the school years or later in life” is much more appropriately applied to a variety of presentations and should be replicated here, at the expense of the current introduction.	This statement has been changed to allow variation in the development of ASD signs and symptoms: “There is now robust empirical evidence that, for a small proportion of children, ASD can be reliably and validly diagnosed at 2 years of age by an experienced clinician, and that this diagnosis is relatively stable over time.”

Manual Submission [144]	ID752	Organisation – Professional experience	The draft examines the life span in its scope. We consider that the discussion of the diagnosis of the assessment and treatment of adults in the report contains an inherent miscommunication. This is an assumption that adult individuals will only seek assessment for ASD because they have a need for intervention. The reality is that many adults have lived their lives with a knowledge that they are different to the majority of their peers but not understanding why. Many of these adults are functioning members of society who require no intervention. We understand that the focus of the report is on those adults who do or will need services. We think it important for the report to acknowledge that there are individuals who will seek diagnosis to understand themselves. The implication in reading the report is that all ASD adults will need services. We think it important for the report to acknowledge that a majority of adults with adult ASD do not need services. We also believe that in the future the percentage of adults who will require disability services will be reduced from present levels. This is because children and teenagers are now receiving services which will moderate the problems experienced by the adults they grow into. In contrast adults today have faced discrimination and lack of understanding of their difference to the majority population with negative interactions and blaming for their struggles. We encourage the authors to acknowledge that many if not most adults with ASD may want a diagnosis but not require specific disability services. Those adults who do require services as adults are well discussed in the report.	The following text was added to the table summarising additional considerations for older adolescents and adults: “It is also important to recognize that some adolescents or adults may be interested in seeking an ASD diagnosis, but may not be interested in being referred to service providers to meet support needs.”
	ID753		Table 7 (page 42) Professional Discipline specialists for co-occurring concerns observed during ASD assessments. The particular section is on page 43, Mental and Social in the section Mental Health or Psychiatric concerns. We respectfully recommend most strongly that the psychologist category for	Thank you for this comment. Based on feedback received, this table has been omitted from the revision Guideline, and the information included in the table has been incorporated in other sections of the document.

			this section needs to be Registered Psychologist (clinical speciality) as is identified later for the section on Trauma and Deprivation. The section Mental Health and Psychiatric concerns requires the psychologist to have higher level understanding of mental health and psychiatric concerns than is provided for in the training of general registered psychologists. Clinical Psychologist spend two full time academic years studying these issues and learning about diagnosis and treatment at University and then undergoing supervised practice. It is important when teasing apart co-occurring disorders and concerns to have this level of knowledge and experience. We thus recommend that this section be changed to Registered Psychologist (clinical speciality).	
	ID754		3. Our main concern is in the area of funding for the ASD assessments - diagnosis and reviews for intervention. The report identifies a complex diagnostic model which is very good. We consider that the categories of Diagnostician and Professional Officer are well described and include reasonable strategies for defining their knowledge and experience. We consider that this will work well in the major Australian Capital cities but that there will be special issues in smaller cities and Darwin and rural and remote regions of all states and territories. The present reality is that individuals seeking diagnosis and intervention in rural and remote regions and smaller cities (including Darwin) receive in the majority of cases services which are in very limited supply - often no supply. The specialised professionals are often junior and there are very long waiting times. Services are very expensive if available and there is often no quality control. These guidelines will provide a benchmark for those services but without an injection of special funding will not be available because the required specialists will not be available.	Thank you for this feedback. We believe the structure of the revised Guideline addresses this helpful comment. In particular, the revised version of the Guideline keeps the rigour of the original version, but provides a simplified structure that is likely more accessible for different population groups across Australia. Please refer to the 'Overview of Major Amendments' chapter under the headings: • Structure of revised assessment process • Cost Implications of the Recommended Assessment Model

			The report has included recognition of the potential role of tele video resources which will greatly assist in areas where there is good internet network availability. I think the report needs to acknowledge the need for ALL Australians to be eligible for these new levels of training and experience in the assessors and not to water down requirements in these communities - which is what happens now. All Australians should have access to standardised levels of assessment and intervention. This will inevitably include both tele video and directly provided services and assessment. Thought needs to be given to how this can occur so as to avoid repetition of the current situation of much higher quality services in dense cities and very poor services or no services in rural and remote and small cities.	
	ID755		3. Our main concern is in the area of funding for the ASD assessments - diagnosis and reviews for intervention. The report identifies a complex diagnostic model which is very good. We consider that the categories of Diagnostician and Professional Officer are well described and include reasonable strategies for defining their knowledge and experience. We consider that this will work well in the major Australian Capital cities but that there will be special issues in smaller cities and Darwin and rural and remote regions of all states and territories. The present reality is that individuals seeking diagnosis and intervention in rural and remote regions and smaller cities (including Darwin) receive in the majority of cases services which are in very limited supply - often no supply. The specialised professionals are often junior and there are very long waiting times. Services are very expensive if available and there is often no quality control. These guidelines will provide a benchmark for those services but without an injection of special funding will not be available because the required specialists will not be available. The report has included recognition of the potential role of tele video resources which will greatly assist in areas where there	Thank you for these helpful comments. The Guideline has been developed with a specific eye to the issues of accessibility to clinical services in rural and remote regions. We believe that the revised structure provides even greater flexibility that help ensure ready access to services to all Australians regardless of geographic location. For further information on the revised structure, please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Structure of the Assessment Process Please also note that the revised Guideline includes ‘equity’ as a guiding principle (Section 2.5).

			is good internet network availability. I think the report needs to acknowledge the need for ALL Australians to be eligible for these new levels of training and experience in the assessors and not to water down requirements in these communities - which is what happens now. All Australians should have access to standardised levels of assessment and intervention. This will inevitably include both tele video and directly provided services and assessment. Thought needs to be given to how this can occur so as to avoid repetition of the current situation of much higher quality services in dense cities and very poor services or no services in rural and remote and small cities	
Manual Submission [145]	ID756	Individual - Professional experience (PD)	The emotional, social, academic, physical and financial burden of autism is enormous; not only to the individual with autism, but to family and those involved with the diagnostic and ongoing management of this neurodevelopmental disorder. The rising number of autism diagnoses and associated real, potential and future unrealised costs warrant tight scrutiny of the diagnostic process for this neurodevelopmental disorder. New National draft guidelines for autism propose a research and evidenced based structure of diagnostic tiers. This utilizes the clinical expertise of the stakeholders – paediatricians, psychiatrists, neurologists and clinical psychologists, speech pathologists and occupational therapists. A rigorous and potentially time intensive process provides a standardised ‘best practice’ diagnostic platform to give accurate diagnoses with comprehensive follow-up and an inclusive management style for families with a child diagnosed with autism. A detailed functional assessment, combined with a formal developmental (intellectual) screen by the paediatrician in the role of a diagnostician is described in the accompanying	Thank you for this very helpful feedback. We greatly appreciate the comments. We believe the structure of the revised Guideline addresses the issues raised here regarding flexibility, cost burden, and clinician resourcing. The ‘Overview of Major Amendments’ chapter.

			National guideline case studies. Specifically, the requirement for a paediatrician to conduct a formal developmental screen to exclude an intellectual disability and a ‘prescribed’ functional assessment, the PEDI-CAT, is outlined in the Tier 1, Case study 1, where autism has been diagnosed. Evidence based medicine and ‘gold standards’ are the ideals to which medical professionals aspire. But, the diagnostic process has to also be realistic, achievable and sustainable. It has to work within current workplace limitations. This includes prompt access to paediatricians, neurologists and psychiatrists within the private sector. Without scrupulous attention to ‘manpower’ issues, and consideration of the variability in clinical experience, particularly in relation to accredited paediatric developmental screening, the proposed draft guidelines will be difficult to implement. The requirement that paediatricians maintain and update their skills with peer review and possible future re-accreditation is threatening and expensive. Within the private sector it will force many experienced clinicians to opt out from the diagnostic process. The risk of these guidelines, should they be implemented unchanged, is that they will create an escalation of waiting times, far greater than currently exist. The number of clinical hours dedicated to a diagnosis will be difficult to accommodate in most private clinical practices and result in prohibitive costs for many patients. Dedicated private ‘testing’ centres will come at a high financial cost for families. Indirectly, if realised, some of this will be borne by Government funding such as Medicare. Given these concerns and reservations about the roll out of this proposal in current form, I give a clinical perspective as a practising paediatrician in private practice in Western Australia. My reflections are likely to reflect those of other States within Australia.	

			Comments for reflection I acknowledge the time, expertise and consideration that has resulted in a substantial document pertaining to autism guidelines in Australia. This proposed document aims to increase the specificity of the clinical diagnosis and to reduce bias and subjectivity. It removes the pressure that can be exerted by school, families and health carers to diagnose autism from ‘soft’ criteria so that specialized early childhood interventions can be used quickly and effectively to optimise a child’s development and to change their developmental trajectory. There is also recognition that the NDIS which funded this project, whilst not influencing the study, will be the financial ‘beneficiary’ of an initial slow down and overall reduction in autism diagnoses. Whether this will be sustained is uncertain. However, the diagnostic process must not overlook the problems of children who may not meet the diagnostic criteria of autism, but effectively present with the same and at times greater needs due to complex co-morbidity. The frustration vented by the parents of children who fall across the broad spectrum of autism will be widespread and problematic. Parents will face increased costs associated with multidisciplinary teams and medical specialists adhering to specified autism guidelines. The waiting times to be seen for an autism assessment in tertiary centres will likely become unmanageable and threaten a political backlash. The bureaucracy to perfect a ‘template’ for autism diagnosis risks increased waiting times and fee hikes within the private and public sectors. It promotes a culture for big commercial clinics to be created and charge high fees for autism assessments. There will be competition between State services with families crossing borders to seek the cheapest assessments.	

			The transfer of autism and possible autism diagnoses from private diagnosticians, including paediatricians, neurologists and psychiatrists will handball parent funded assessments to government health funded resources. There will be lobbying and incentive for new Medicare items to be made available for: general practitioners, paediatricians, psychiatrists, clinical psychologists, speech pathologists and occupational therapists. This will be to cover the costs of case conferencing, paediatricians seeing parents without children and teleconferencing, phone consultations and the provision of written reports. The government will be forced to fund new tertiary centres for autism assessments or to significantly increase funding to existing child development services within the public sector. This will include additional money for information and ongoing educational sessions for professionals so that they retain their autism diagnostic skills. There will be commercial incentive for large companies to 'buy' doctors and to run large autism diagnostic clinics. Families will likely face fees of thousands of dollars. Those families that can't afford inflated private fees will struggle to accept exponential waiting times.	
	ID757		Although strongly evidenced based this draft document is not 'practically' geared. It has an academic and idealistic mantra. That isn't a bad thing, but it is not easily translated into 'hands on' medicine in a busy, stressful and changing world. It won't result in the earlier or necessarily better diagnosis of autism. Or, provide for those children who have functional needs, but not a diagnosis of autism. We live in a world with flaws; where children grow up quickly. There is a narrow window of opportunity to diagnose and help children with autism. This is during early childhood. We already grieve the lost time for delayed autism diagnoses. Symptoms are often seen before the age of two years but is	Thank you for this very helpful feedback. We greatly appreciate the comments. We believe the structure of the revised Guideline addresses the issues raised here regarding flexibility, cost burden, and clinician resourcing. The 'Overview of Major Amendments' chapter.

			usual for children to be diagnosed later at 3 to 5 years. Children with autism will have to wait even later for a diagnosis under new and expensive guidelines. The rigid tone of this draft document will lengthen the time between presentation, diagnosis and intervention for autism. There is insufficient flexibility to be workable within a reasonable cost framework as proposed. **Financial** ‘Private medicine’ is unfairly portrayed as being made up of greedy doctors with self-interest. In the world of paediatric medicine this is not the case. Many private paediatricians assess complex children with only small financial returns after paying the costs of their private practice. Private sector salaries are much lower than within the public sector for non-procedural private paediatricians, many of whom work part-time. Paediatricians generally are very compassionate and kind people and often minimise the costs for their patients. A family whose child is referred to a private paediatrician with concerns of autism will be assessed and expect to pay an out of pocket fee which varies in the vicinity of $100 to $350. This is after assistance from an applicable Medicare item payment. The gap is less if the family have already reached the Medicare safety net. Under the draft guidelines the paediatrician as the primary diagnostician is expected to provide a minimum of four comprehensive clinical assessments within a three-month period. Practically, these would need to be around an hour in duration and include face-to -face consultation with the parents only, a consultation which is not covered by a Medicare item number.	

			Having worked in the private sector I would anticipate a minimum commitment of around five hours and a resultant fee to the family of $1500 to $2000, but with potential for wide variation. This would preclude many families from seeking a private assessment. The families would still have to pay the fee of other Referral for an Assessment of ASD Concernss, informers and diagnosticians. They may also incur pathology and radiology fees as part of the diagnostic process. A multidisciplinary assessment could extend to $5000 to $7000 dollars. This is significantly more than current costs. **Manpower** The private sector absorbs an unrealised amount of clinical work associated with neurodevelopmental trauma. This includes autism and comorbidity: ADHD, anxiety, depression, school non-attendance and anxiety. What is not understood is the rapidly changing demographics of this group of workers. Many experienced clinicians are in their twilight years. Increasingly, child psychiatrists are leaving the private sector. Not all of them feel 'comfortable' about seeing children with autism. Adolescent and adult psychiatrists often have strict intake criteria dictated by their expertise, conflicts of interest and limited booking capacity. This can prevent a young person with autism from being seen by them. Neurologists don't often participate in the diagnostic process as they are time poor and epilepsy weighted. But, they continue to see the complexity of autism. They manage the conditions which link with autism such as genetic conditions, seizures and structural brain anomalies. A limited number of experienced clinicians see a large number of children and assist in the diagnostic process for autism. Their waiting times are quite long, often three to nine months or more. States other than Western Australia describe similar scenarios.	

			There is little flexibility in scheduling to accommodate the proposed time intensive and frequent assessments for autism within private practice. Whereas this time may be required by a paediatric registrar or doctor with little prior exposure to autism, it may not be necessary to a clinician who has ten, twenty or thirty years of working in the area of autism. They are usually capable to make concurrent clinical evaluations within the time frame of one to three hours, usually spread over two appointments. **Rigidity** The directive for a private paediatrician, psychiatrist or neurologist to use a specific formal developmental screening tool such as the Mullens Scale of Early Learning to determine whether a child has a language and social lag disproportionate to their fine and gross motor development is officious and hostile. This screening tool takes about thirty to sixty minutes to administer. It is unfamiliar to most Western Australian doctors. Formal developmental screens shouldn't negate the value of careful clinical observation and an experienced doctor's judgement of whether a child is vulnerable to have significant developmental delay. A formal developmental screen by the managing doctor or other diagnostician, or more objective psychometric testing by a psychologist can be done at another time. In Western Australia the Griffiths Scales of Child Development 3rd edition would be the preferred screening tool, taught to paediatricians who work in tertiary developmental centres. Some private paediatricians can use this tool or will have to update their skills to administer this test. But, it is costly for paediatricians to self-fund at around $5000 for course enrolment, completion and purchase of a registered Griffiths 111 developmental kit. If eligible to update online, the cost of	

			this new kit and registration of its use for private paediatricians is about $3,300. Most private paediatricians have insufficient time to use this screening tool within their practice as it takes around sixty to ninety minutes to complete and additional time to write a clinical report. The cost of this test will further increase the financial burden on families. Additional administration costs, including requests for secretarial assistance outside of their ‘routine’ job criteria in private practice are ‘unpaid’ in contrast to the public sector. The developmental screening tools for ‘professionals’ as listed on pages 28 and 29 of the draft guidelines are unfamiliar to most WA paediatricians, psychiatrists and neurologists, so are unhelpful. Most paediatricians, psychiatrists and neurologists don’t use the formal functional assessment tool, PEDI_CAT (The Paediatric Evaluation of Disability Inventory). This is a computer adaptive test which can be used to examine the domains of daily activities, mobility and social and cognitive skills. Private clinicians won’t be able to easily accommodate this additional assessment tool in their practice. They are already busy with clinical caseloads and are likely to opt out of autism assessments. This will have a flow on effect within the private sector to speech pathologists and clinical psychologists. The intent under the guidelines for the listed diagnosticians to perform formal screening to exclude intellectual disability and functional assessments as part of the autism diagnostic process means that private medical diagnosticians such as paediatricians, neurologists and psychiatrists won’t be able to participate in initial autism assessments. Their caseload will have to be absorbed through the public system. This means extra government money, rather that parent payment contributions. Government services will have to pay private	

allied health professionals for contract services to limit blow outs in waiting times for autism assessments.

It is not always appropriate to perform formal developmental screening or to organise psychometric testing concurrently with a clinical assessment for autism. A clinical vulnerability can be noted, and formal documentation done at another time. Parents can also be overwhelmed if told within a short time frame that their child has autism with the additional burden of an intellectual disability.

In anticipation of new National Autism Guidelines there has already been pressure on private paediatricians in Western Australia to comply with directives as part of independent and non-affiliated large multi-disciplinary autism ‘testing’ services.

I cite a practical example to illustrate this point. I recently received a promotional request to provide a comprehensive paediatric referral to a Perth Autism Diagnostic clinic in September 2017. I was asked to include:

- ‘A medical history, including prenatal, perinatal and family history and past/current health conditions.
- A general physical examination
- Exclusion of other conditions
- Where the child is aged 6 years or under, an assessment of the child’s development (including their intellectual ability) i.e. the Griffiths Scales of Mental Development’

The Griffiths Scales of Mental Development is now obsolete for formal documentation purposes as it has been replaced by the new Griffiths 111 screening tool. To my knowledge there are only a couple of paediatricians within the private sector in Western Australia who have purchased this kit for their practice.

It is offensive for experienced paediatricians to be told what a comprehensive paediatric assessment for autism involves. It’s what they have been doing competently and professionally for many years. In private practice we have choice. This includes the possibility of referring to the government sector all children vulnerable or with possible or definite autism.

This may appear a hostile response, but it is a likely one from many private paediatricians, given the inflexibility of the proposed autism diagnostic process. This is not helpful for the children who have significant impairments in the domains of language, social skills, communication and associated behavioural and adaptive difficulties.

Of greater concern, it will delay therapeutic interventions for children with autism and deprive those with ongoing significant functional impairments who don’t fully meet autism criteria.

RECOMMENDATIONS

Western Australia has always aspired to meet the ‘gold standard; for autism diagnosis. It has been a leader in liaising and sharing information to improve the National approach to autism spectrum disorders, one that is consistent and reliable. The draft guidelines for autism seek a system that is sensitive and specific to avoid blanket and inappropriate labels being applied to children with social and language delay due to other problems such as complex ADHD, anxiety, reactive attachment disorders and developmental trauma.

But, a rigid and dictatorial guideline excludes the flexibility necessary to make the guidelines workable, cost effective and sustainable. They could exclude experienced clinicians from easily participating in their implementation. They will also ostracize many child psychiatrists and neurologists. Those in solo or small private practices, will have to fund these time intensive assessments from their business profits or not do autism assessments at all. Private business costs are as high as 50-70% of income earned.

			Parents can’t afford the cost of formal developmental screening tests for their children on top of several diagnostic clinical appointments. To participate in the autism diagnostic assessments as proposed under new National guidelines risks the financial viability of running a private practice. Additional Medicare Items will have to be offered. At present, under a specific developmental item number for paediatricians there is a Medicare contribution of around $250. In private paediatric practice this supplements a fee for a thorough consultation of 60 to 90 minutes of the paediatrician’s time and expertise and a further ‘unpaid’ component for administration. This includes dictation, consultation with teachers and allied health if required and follow-up phone calls. To comply with new autism guidelines requires a further four or five sessions. This would be provided at a substantial financial Government cost. An autism ‘rebate’ under Medicare would have to be around $1000 to $1500 to assist families and to make it financially viable for paediatricians in private practice to offer autism assessments as currently described. These guidelines can still be modified to accommodate levels of excellence. Core criteria and documentation can be considered with more complex assessment requested with a tertiary panel or professional when a diagnosis is not affirmed. This could be provided by the primary diagnostician, or if they are not able to complete a satisfactory functional or developmental screening assessment, with assistance by another diagnostician. This would provide greater inclusivity for the parents and health care professionals who currently make up the autism workforce. Within the private sector, a paediatric assessment would realistically involve the acceptance of a referral from a general practitioner when a child has neurodevelopmental problems. These may not be due to autism, but irrespective, that child would benefit from a clinical opinion made by an experienced	

			paediatrician. They can suggest appropriate intervention with a speech pathologist, physiotherapist, occupational therapist or clinical psychologist as determined by the child's presentation. The diagnosis is not the priority at this early time. It is changing the developmental trajectory of the child who shows a lag in their social, emotional, physical or academic development. The practice's secretary already has a defined role with limits set around patient care to minimize medico-legal risk to the practice. It is added burden and one that is not paid, for a private secretary to assume a co-ordinator role in autism assessments. This includes them seeking informed consent and chasing up and chelating patient records. With privacy laws it is also increasingly difficult for a private practitioner to request records from the public system. That request has to made by the patient or their guardian or custodial parent. The paediatrician's job is to take a full medical and social history and to include family history and notation of family stressors. The paediatrician observes the child throughout the consultation, takes the opportunity where appropriate to examine the child, to try and engage in play and to ask some screening clinical questions to determine developmental or social and language vulnerability. Ideally the paediatrician has some one on one interaction with the child, with their consent and that of the parent or legal custodian. This is age and stage dependent. Referral for further medical assessment is determined by the clinical presentation and the lag from the time of initial referral to first consultation. This can be six to nine months within the private sector and is usually longer in the public health system. Referral may be: medical (genetics, endocrine, gastroenterology, neurology or psychiatry), surgical (ENT) or to pathology and radiology for targeted investigations. If autism is considered a realistic differential diagnosis, at the time of an initial appointment, generally sixty to ninety minutes	

			within the private sector, a formal appraisal using internationally recognised criteria for autism is made. In Western Australia most, private clinicians use the Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM -5). Most parents attend a paediatric appointment well informed and ask, ‘Has my child got autism?’. They have already had family, dentists, school teachers, therapists and other doctors and parents raise this concern with them. If an experienced paediatrician conducts a clinical assessment and their written correspondence indicates that autism is likely, they should be able to forward their opinion to a central referral service for diagnostic consideration. That body can then request reports from private speech pathology, clinical psychology and supplemental informant material from school. Or, if a family can’t afford a private assessment with clinical psychology or speech pathology they can be placed on a tertiary assessment wait list. If the patient has been referred to a paediatrician and then seen by another diagnostician, both reports can be reviewed by a governing body. If the paediatrician hasn’t been able to do the Mullens or other formal screening test, or PEDI-Cat functional assessment, these or similar can be sourced by an appropriate service provider within the private or public system. If, however, there is sufficient initial information to meet the baseline requirements of an autism assessment, the child is accepted to receive therapy and funding. As there is a delay in both the private and public sectors for therapy to commence there is time to complete any extra assessments. But, if a child is 3 years of age and is non-verbal, hand-leading, stimming, gaze avoidant and lining up all the toys in your office they need therapy, not more assessment. **CONCLUSION**	

			I respect the expertise and consideration given over a twelve-month period by a panel of accomplished diagnosticians, researchers and educators to formulate a proposal to make autism assessment evidence based, sensitive and accurate. It is my responsibility to challenge the draft guidelines for autism as an experienced clinician within the private sector who has seen thousands of children with complex neurodevelopmental problems. I advocate for all children who present within the autism spectrum. They must have early access to high standard clinical assessment and intervention to address their complex needs. It is important that in the effort to reach our gold standard for autism diagnosis that we haven't raised the bar so high that we will never reach it, or grasp it too late! The guidelines as proposed could exclude experienced clinicians such as myself and similar peers from contributing to the autism process. This will place an unenviable burden on the resources of the public sector and on government monetary resources. The guidelines need to be more flexible. Tier the criteria to those which 'must', should' and 'ideally' be met rather than tier the diagnostic process with complexity. There is also concern within the private sector from paediatricians and families about the anticipated burden of bureaucracy from the pending National Disability Insurance Scheme. If paediatricians are expected to complete and provide comprehensive and extensive documentation additional to their clinical opinion for funding purposes at the completion of their diagnostic assessments, they are unlikely to be willing participants in diagnostic autism assessments. Templates can't simplify this arduous task.	

	ID758		**My clinical experience** I am an accredited medical practitioner, registered with the Australian Health Practitioner Regulation Agency and a fellow of the Royal Australasian College of Physicians – Paediatric and Child Health Division. I qualified as a paediatrician prior to the division of advanced paediatric training into specific categories. But, my advanced training included a twelve-month placement at the State Child Development Centre in Perth, a recognised centre of excellence. My mentor was Professor Trevor Parry, eminent developmental paediatrician. I was also the Chief registrar at Princess Margaret Hospital, a tertiary children's hospital in Western Australia. I don't meet the strict requirements for a primary diagnostician (paediatrician) as outlined on page 18 of the draft guidelines for: 'The diagnostic process for children, adolescents and adults referred for assessment of autism spectrum disorders.' This states that a paediatrician during their training has to have completed a '3-year advanced training program in one of the paediatric divisions through the Royal Australian College of physicians'. These divisions were set up after I completed my training and was registered as a paediatrician by the RACP. To 'formally' qualify as a diagnostician a 'grandfather' clause needs to be included in the guidelines. To omit this clause would significantly decrease the available workforce for autism assessments. For the last twenty years I have been in private paediatric practice in Perth. My accumulative caseload as a clinical paediatrician totals around 30,000 children. In private practice I care for children with complex neurodevelopmental disorders. They include: autism, attention deficit hyperactivity disorder (ADHD), specific learning disorders, eating disorders, developmental trauma, separation anxiety, attachment disorders, social phobias and selective mutism, school non-attendance, depression, self-harm and suicidal ideation.	The revisions to the Guideline have broadened the skills and expertise for medical practitioners. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Qualifications for medical practitioners

			My clinical practice is similar to many private paediatricians who have been ‘forced’ to take on a skewed psychiatric caseload because of the complexity of the co-morbidities of neurodevelopmental disorders, including autism. The current acute shortage of child psychiatrists within the public and private sectors in Western Australia has recently been reported in the media. It has a significant impact on the mental distress seen by community paediatricians. I have experience and an understanding of the emotional and social vicarious load of these conditions on families and the detrimental impact they have on vulnerable children. Unless there are more child psychiatrists, it is unlikely that those still practising will be available as diagnosticians for autism. The same limitations apply for paediatric neurologists. From a clinical perspective, at least in Western Australia, common knowledge is that at least five child psychiatrists in private practice have withdrawn services, plan retirement or have relocated within the last six months. These are the ‘manpower’ realities that will reduce the pool of available autism diagnosticians. As paediatric registrars aren’t ‘qualified’ to do autism assessments, the number of actively working paediatricians needs to be carefully assessed. Private practice hours in paediatrics tend to be restricted due to the demographic of the workforce. Increasingly sole or small private practices struggle to be financially sustainable ‘businesses’.	

	ID759		Tier the criteria to those which ‘must’, should’ and ‘ideally’ be met rather than tier the diagnostic process with complexity.	Thank you for this comment. The revised Guideline provides clarification that the Guideline represents a consistent, yet flexible, structure for the assessment of children, adolescents and adults for a diagnosis of ASD. While individual clinicians, organisations or jurisdictions may place additional recommendations on top of those presented in the document, we recommend that this document represents a minimum standard to which the clinical community aspires.
Manual Submission [146]	ID760	Organisation – Professional experience	This document details the [Organisation] response to The Diagnostic process for children, adolescents and adults referred for assessment of Autism Spectrum Disorder in Australia: A national guideline. Published by the Autism CRC with financial support from the NDIA. This response is a consensus document summarising the concerns of the Diagnostic and Assessment Teams at [Organisation]. It includes the views of a diverse range of professionals who are expert in the diagnosis and assessment of children presenting with developmental and behavioural symptoms. Our teams include Paediatricians, Neuropsychologists, Clinical Psychologists, Speech Pathologists, Occupational Therapists, Social workers and Clinical Nurse consultants. [Organisation] acknowledge the extensive work undertaken to produce the guidelines and the opportunity to provide feedback. We are concerned about the short timeframe and believe this will limit the careful consideration and broader	Thank you very much for these important comments. We believe that the structure of the revised Guideline addresses this comment. Please refer to the ‘Overview of Major Amendments’ chapter under the headings: • Structure of the Assessment Process • Emphasis on the Importance of Functional Abilities in Referral for Supports

			feedback from the full range of stakeholders, which needs to be encompassed into any final guidelines. [Organisation] acknowledge and support the underpinning motivation for the guidelines; to provide the community with greater equity in access to a rigorous and comprehensive assessment, transparency in the diagnostic and decision-making process, and confidence in the accuracy and reliability of the diagnostic decision. Whilst [Organisation] agree with underlying principles, we have significant concerns about the impact of the draft guidelines upon children and adolescents presenting with symptoms suggestive of Autism Spectrum Disorder. Our overriding concern is that the guidelines, whose focus is to establish if an individual does or does not meet diagnostic criteria for ASD, will produce a limited review of the child and their family. Children who present with developmental or behavioural symptoms do so secondary to a very broad range of aetiologia’s which will not be identified if the focus is reduced to a binary decision of ASD or not. Assessments of neurodevelopment and behavioural symptoms should sit within a framework of universal developmental surveillance, screening and assessment and encompass a detailed review of the child’s development and skills, medical and family history and psychosocial assessment.	
	ID761		The guidelines are very detailed, and we want to highlight particular areas of concern rather than present a full list of our concerns. **Conflicts of interests** [Organisation] is very concerned about a number of conflict of interests which will arise from implementation of these guidelines. Firstly, the role of allied health diagnosticians who will then provide intervention and therapy: In all but large urban areas, there is a paucity of allied health providers. It is unlikely a family will be able to access two different professionals the	We believe that the revised structure of the Guideline addresses this comment. Please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Structure of the Assessment Process • Professional Roles • Conflicts of interest The project was supported by funding from the National Disability Insurance Agency (NDIA). However, the views of the NDIA did not influence the document. Importantly, there is no

			first for the diagnostic process, functional assessment and support needs assessment and a second as the provider of the recommended intervention. This establishes a clear conflict of interests for those professionals. The role of the NDIA as funder and arbiter of the diagnostic process also presents a conflict of interest	suggestion that that the NDIA is ‘the arbiter of the diagnostic process’.
	ID762		**Workforce** We agree all those engaged in the diagnosis and assessment should have expertise in child development and behaviour along with specific ASD training. However, the training requirements listed in the guidelines will reduce rather than increase access to a diagnostic assessment. As an example, the guidelines list the requirements for Paediatricians to be considered diagnosticians. Even those who train specifically in Community Child Health will not meet the requirement when they reach Fellowship. General Paediatricians do not receive this level of specific ASD training, and those who subsequently reach this threshold are unlikely to meet the continuing professional development requirements to maintain their status as diagnosticians. Private Paediatricians provide the majority of what could be considered Tier 1 diagnosis and they will no longer be able to do so under these guidelines. This moves the diagnostic process from a child centred process to a diagnosis and diagnostician centred process. Paediatricians and paediatric neurologists undergo intensive training over a period of 4-6 years, exclusively in child health, development and behavior. This training includes the ability to identify developmental disorders which include autism spectrum disorder. There appears to be limited rationale to further restrict these specialists in their ability to recognise and diagnose ASD according to the DSM 5 Criteria.	The revisions to the Guideline have broadened the skills and expertise for medical practitioners. Please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Qualifications for medical practitioners

	ID763		The guidelines have expanded the number of professions who can serve as diagnosticians but opportunities to gain the required training and continuing professional development are not currently available. Therefore, limiting access to diagnostic review and assessment rather than expanding it.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Professional Roles • Structure of the Assessment Process
	ID764		The guidelines include a new role called a Care Coordinator to support families through the diagnostic process. This role is poorly defined and does not currently exist, as a specific individual, within private or public providers. The role of Coordinator or Linker around diagnosis is a feature of Non-Governmental Organisations and has been part of the move towards National Disability Insurance Scheme. Therefore, it does not sit within the diagnostic process currently. This shift will have significant workforce and resourcing implications for diagnosticians and assessment services.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Coordinator Role
	ID765		The role of informer to the diagnostician is defined and will also have resource implications. The requirement for tertiary qualifications in all informers will exclude the valuable role of early education providers who are currently essential in the diagnostic process and sit outside of health (public and private). This guideline will require additional allied health input from health services.	Based on feedback received, the specified role of 'professional informant' has been omitted from the revised Guideline. However, the Guideline still emphasises the importance of collecting information from a variety of sources, and from individuals who observe the client in community settings.
	ID766		An adaptive function assessment using a standardised assessment tools is a critical element of the diagnostic assessment and required as part of DSM 5 criteria. It is standard care that following diagnosis families are provided with specific and individualized recommendations with regard to intervention and support. The guidelines discuss Functional Assessment and Support Needs Assessment which are the remit of treating allied health professionals and sit outside the diagnostic process. The planning process for NDIS packages and the individual treatment plans developed by allied health professionals should remain outside of the diagnostic process.	Thank you for this comment. Significant feedback was received that highlighted the importance of a comprehensive functional and needs assessment in providing the foundation for a diagnostic evaluation. For this reason, the revised structure places a comprehensive functional and needs assessment at as Stage 1 in the assessment process. For further information about the rationale, please refer to the 'Overview of Major Amendments' chapter under the heading: • Structure of the Assessment Process

	ID767		[Organisation] is concerned that a Tiered system will reduce the equity and quality of assessment rather than enhance them. ASD diagnosis needs to sit within a comprehensive review of the child's development, health, and family. All children with ASD are complex, though the diagnosis may be less subtle in some, the need for a full review of aetiology, cognitive ability, co-morbidity and family and community factors remains essential for all. The use of allied health professionals with support from a General Practitioner will not provide this comprehensive review. The absence of a developmental or cognitive assessment as part of the proposed ASD assessment is not in keeping with national or international best practice guidelines and highlights the deficits in the model. A multidisciplinary assessment (which may occur in a single or several locations over a reasonable period of time) remains the gold standard for the assessment of ASD as this provides for a full assessment and an accurate and comprehensive review of the individual.	Thank you for this feedback. We believe that the revised structure addresses this comment by placing a greater emphasis on the importance of a comprehensive functional and needs assessment (including allied health and medical practitioner) in providing the foundation for a diagnostic evaluation. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Structure of the Assessment Process • Emphasis on the Importance of Functional Abilities in Referral for Supports
	ID768		**Other** The rational of requiring a declaration to be signed by Diagnosticians stating they have adhered to this guideline is unique to these guidelines and is considered inappropriate.	This statement has been omitted from the revised template.
Anonymous[147]	ID769	Organisation – Professional experience	[Organisation] is strongly supportive of implementing nationally consistent diagnostic criteria for ASD and believe that this will significantly increase equity across Australia and minimise the challenges that people with ASD experience when moving between states. General feedback: • It may be useful to explain the process before the roles so that the role requirements are read in context. • A careful review of the document is still required to ensure "identity first" terminology throughout as there are still	Thank you for this feedback. 'Autistic individual' is first-person language, as opposed to person-first language (e.g., 'individual with autism'). The rationale for this language is included in the Foreword.

			multiple instances where this is not used (e.g. p.2 refers to “autistic individuals”).	
	ID770		Section 6.3 Coordinator - Nursing is not currently mentioned as a potential discipline for this role. [Organisation] would suggest that appropriately experienced nurses can fulfil this role highly effective (as currently occurs within [Organisation]).	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: - Coordinator Role Please also note that nursing staff with selected qualifications and expertise have been added as professionals able to undertake Stage 1 assessments.
	ID771		The issue of defining expert knowledge and experience for Diagnosticians is seen as an appropriate step given the complex nature of ASD. However, the guidelines do not propose how this would/could be monitored or audited. Historically, most agencies (particularly non-government) have struggled to recruit clinicians with suitable experience in child development and ASD to provide ASD assessments within current requirements.	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: - Accreditation and Regulation - Practice points for clinical, research and policy settings
	ID772		The requirement for Speech Pathologists to be Certified Practicing Members of Speech Pathology Australia to be Diagnosticians is problematic for the public sector in Western Australia where employment requirements are eligibility for practicing membership, rather than actually having it. Ongoing membership of a professional organisation is also difficult to monitor over time, and it is suggested that this be reviewed to align with employment requirements.	Please refer to the ‘Overview of Major Amendments’ chapter under the heading: - Qualifications for speech pathologists

	ID773		Whilst [Organisation] Occupational Therapists (OTs) are not currently involved in the diagnostic process, it is suggested that the proposed requirement for registration with both the Occupational Therapy Board of Australia and the Better Access to Mental Health program poses considerable barriers to any future involvement. Public sector OTs are not listed with Better Access to Mental Health so perhaps public sector employees could be exempt from this additional requirement.	Please refer to the 'Overview of Major Amendments' chapter under the heading: • Qualifications for occupational therapists
	ID774		The required qualifications/experience levels for diagnosticians such as "*4 years full time equivalent of postgraduate experience that is directly relevant to ASD diagnostic evaluations obtained through university qualifications, formal training, program and/or formally supervised work experience*" may need further clarification as it may not be consistently interpreted. It is also suggested that this may not be feasible and there are concerns that this may limit workforce capacity to the point where the growing demand for assessment is unable to be met.	Please note that the requirement for '4 years' experience' has been omitted from the revised Guideline. For a rationale, please refer to the 'Overview of Major Amendments' chapter under the heading: • Duration of ASD-specific Expertise
	ID775		The tiered approach is strongly supported by [Organisation] as it will facilitate shorter waiting times for clients with a "frank presentation" and allow resources to be directed to those who require a more thorough assessment process. [Organisation] is also supportive of the proposal that the particular discipline/s involved in the process can vary according to clinical presentation. This will ensure clients receive a thorough and appropriate assessment and supports sustainable resource allocation given growing demand.	Thank you for this feedback.
	ID776		The guidelines present an option to use the diagnostic criteria of either DSM-5 or ICD11 (to be released) – this could lead to confusion and variation in diagnosis. Perhaps agreement on one of these diagnostic criteria sets could be reached with	The extensive feedback obtained during the consultation phase of this project indicated a strong preference for flexibility in which diagnostic criteria diagnosticians apply. For

			consideration given to alignment with recommended standardised tools.	this reason, both DSM5 and ICD11 (to be released) have been retained in the revised Guideline.
	ID777		Section 10. Functional and Support Needs Assessment - [Organisation] strongly supports this concept however would express some concerns about embedding this within the ASD assessment process. - Functional and Supports Needs Assessment is ongoing as needs often change significantly over time. - It is suggested that this may be better embedded within the National Disability Insurance Scheme (NDIS) for the following reasons: • There is significant overlap between this and the NDIS planning process. It could be argued that an assessment of support needs should be embedded within the process that allocates support to meet those needs, rather than being conducted in isolation. • This may also provide a platform for a more clinically focused NDIS planning process for clients with ASD (and potentially be expanded in the future to other clients with complex presentations). • Embedding this within NDIS enables these assessments to occur regularly/as needed. • Incorporating this into NDIS aligns with the nationally agreed separation of roles between Health (as diagnosticians) and NDIS (who are responsible for further assessment to determine support needs) as per the bilateral schedule.	Thank you for this comment. Significant feedback was received that highlighted the importance of a comprehensive functional and needs assessment in providing the foundation for a diagnostic evaluation. For this reason, the revised structure places a comprehensive functional and needs assessment at as Stage 1 in the assessment process. For further information about the rationale, please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Structure of the Assessment Process
West Australian Autism Diagnostician Forum	ID778	Organisation – Professional experience	WAADF would like to acknowledge: • The efforts that went into putting the guidelines together and the scale of the work achieved • The breadth of consumer and professional contributions	Thank you for the helpful feedback. We appreciate you taking the time to provide this.

(WAADF) [148]			• The focus on the person-centred and strength-based approach to assessment, placing individual, families and carers at the centre of the process. • The consideration of the multiple options of observation and service provision. • The consideration of rural and remote settings in terms of assessment accessibility • The recognition that one size “does not fit all” in terms of ASD assessment, and that multiple pathways need consideration • The recognition of a need for balance between obtaining significant quality information for accurate diagnosis, whilst avoiding overly complex, time consuming and expensive assessment processes, especially with frank autistic presentations. • The recognition of the need to differentiate female presentations that may be more subtle and/or vary from more typical male presentations	
	ID779		• While we can see merit in a national set of guidelines, there is concern that in WA there has been much work, and considerable success, in establishing consistent diagnostic standards, and that national guidelines may erode those. We are concerned with the potential of such a document becoming a required protocol for service provision.	Thank you for this very helpful feedback. We believe the structure of the revised Guideline addresses this helpful comment. Please refer to the ‘Overview of Major Amendments’ chapter under the headings: • Implementation and Evaluation of the Guideline
	ID780		• We are also concerned about the suggestion of a formal declaration/certificate at the conclusion of a report about having used these guidelines, replacing considered practice, with potential for misuse.	This statement has been omitted from the revised template.

	ID781		• It is acknowledged as above, that more efficient processes are required. • It is acknowledged that with the growth in diagnosis, the interface between assessment and service provision has changed markedly, so that the people conducting assessments are often no longer those providing services. That is uses of assessment have changed. Thus, it is appropriate to review and adjust roles of assessors. However, there is concern that while simplifying processes, ensuring safeguards exist to accurate diagnosis is also important. • We feel that diagnosis currently acts as a gateway for access to services. Could there be room for the tier one assessment to be a pathway for a provisional diagnosis facilitating access to tailored services? We are wary of a tier one diagnosis being a final diagnosis. We recommend putting functional support needs assessment at the beginning of the process when a child is identified as having developmental differences. The aim would be that the outcomes of the functional needs assessment will result in preliminary intervention with the at-risk child. This could then better inform the necessity of a formal multidisciplinary assessment.	Thank you for this very helpful feedback. We believe the structure of the revised Guideline addresses this helpful comment. The 'Overview of Major Amendments' chapter. Please note that the revised guideline recommends referrals for intervention supports at Stage 1, which is prior to the undertaking of an ASD diagnostic evaluation.
	ID782		• We consider that there is an overarching principle that autism diagnosis is part of the intervention process, and that diagnosticians should be skilled and even contemporaneously involved in both.	The revised Guideline did not make this a requirement of the assessment process. However, we note that the revised structure provides greater flexibility for this to occur.
	ID783		• The foundation of assessment of the DSM-5 diagnostic criteria is in reference to what would be usual for a person of that age and general developmental level. It is therefore essential that there is either a developmental assessment or cognitive assessment. This need not be formal. There	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading:

			may be sufficient evidence of cognitive functioning within the normal range, particularly in the case of older children and adults, with academic and vocational histories. Where younger children cannot be formally assessed, assessment according to observations of behaviours and capabilities allows developmental estimates by those trained in this area.	• Structure of the Assessment Process
	ID784		We seek clear distinction between processes for children and adults, with greater recognition of the possibility of more subtle presentations and different pathways and appropriate assessment processes for adults.	The overarching assessment model described in the revised Guideline is the same for children, adolescents and adults. However, we note that the structure the revised model provides greater flexibility in tailoring the assessment processes to individuals of different ages. The Instructions for Using this Guideline include advice to refer to the Important Considerations sections, such as age, when relevant. The table summarising additional considerations for older adolescents and adults now includes “a more subtle presentation or masking strategies.”
	ID785		Finally, given the comprehensiveness of the document, an index would be handy.	The document has been substantially reduced in length, which we believe circumvents the requirement for an index.
	ID786		*Coordinator:* We agree in principle that a coordinator would be very useful but it may not be achievable across settings. If there is not a coordinator, the diagnostician needs to explain, and assist the family from assessment to diagnostic finalisation and connection to services as appropriate. It is queried whether the Coordinator is a new label for the autism advisor or key worker?	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Coordinator Role

	ID787		*Diagnostician*. We acknowledge the difficulty in determining competency of diagnosticians, and the attempts made in the guidelines to set some clear standards e.g. with recommending 4 years post graduate ASD experience. 6.4.2 Ideally in the longer term there would be competency criterion referenced assessment of diagnosticians, and some means of ensuring maintenance of competencies through practices such as reliability checking between diagnosticians to prevent drift. More guidance here would be welcomed.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Accreditation and Regulation • Practice points for clinical, research and policy settings
	ID788		*Occupational Therapists (OTs)*. While there is no doubt that some OTs have gained relevant experience in the ASD area and make valuable contributions, it is not thought that the core areas of OT (according to the description of the discipline provided in the guidelines) overlap sufficiently with the core diagnostic features of ASD: communication and socialisation and behavioural difficulty assessed against global cognitive developmental functioning, to make an appropriately informed diagnosis. This may be rectified if OTs had additional training in these areas, but the current requirements as per guidelines are not considered adequate. Additionally, a diagnosis of Autism requires a breadth of knowledge in terms of possible differential or comorbid diagnoses. Occupational Therapist are not considered as having the necessary training to make these diagnostic decisions.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Professional Roles • Structure of the Assessment Process
	ID789		*Professional informants.* We seek further clarification regarding the exact role of the professional informant, suggesting that they are seen as providing information in response to diagnostician's questions, rather than providing a diagnostic opinion. Responsibility in the diagnostic decision lies within the diagnostician. It may need acknowledgement that for some adults, it would be difficult to find any professional informants to meet the assessment requirements of either Tier 1 or Tier 2, and other non-professional informants may be sought, but again not always available.	Based on feedback received, the specified role of 'professional informant' has been omitted from the revised Guideline. However, the Guideline still emphasises the importance of collecting information from a variety of sources, and from individuals who observe the client in community settings.

	ID790		*Tier 1.* We are concerned about safeguards to accurate diagnosis free from self-interest when just one diagnostician makes the diagnosis, without some other review process. If moving away from a multidisciplinary team, which has previously been the gold standard, could evidence in settings including Australia, for the reliability of single diagnosticians be cited, rather than relying upon consensus opinion.	The Guideline has been developed to optimise equity of access to diagnostic services for all Australians, regardless of age, gender, cultural background, socioeconomic status, or geographical, as well as to ensure fit with the broadest possible range of existing clinical health systems. We would like to emphasise that the Guideline does not preclude jurisdictions placing additional recommendations on top of those presented in the document.
	ID791		*Tier 1.* While there is a requirement for a medical evaluation, it is not specified that this is done by a paediatrician. We believe that the need for differential diagnosis and assessment of other associated medical issues can only be carried out by a paediatrician or medical person with additional training and qualification in this area. In adults without developmental disability it is thought that it is essential to have a psychiatric opinion re mental health issues that are differential diagnostic explanations or comorbid.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the headings: • Professional Roles • Structure of the Assessment Process
	ID792		We are also concerned about the suggestion of a formal declaration/certificate at the conclusion of a report about having used these guidelines, replacing considered practice, with potential for misuse.	This statement has been omitted from the revised template
Royal Australian and New Zealand College of Psychiatrists [149]	ID793	Organisation – Professional experience	In June 2017, the RANZCP was invited to provide feedback during the development of the guideline regarding the role that psychiatrists have in the diagnosis, assessment, management and prevention of ASD, and the RANZCP is pleased to see its feedback has informed the guideline. The RANZCP recognises the importance of adopting a consistent process in the assessment of autism spectrum disorder (ASD) and supports the development of the guideline to ensure that there is consistency in diagnostic practices and service provision across Australia. The RANZCP believes that	We greatly appreciate the feedback provided.

			a national guideline for ASD Diagnosis will be a valuable resource to support clinicians and reduce diagnostic variation. The RANZCP recognises the considerable work involved in the development of the draft guideline and it particularly welcomes the guideline's recognition that the ASD assessment process should follow an individual and family-centred approach. However, the RANZCP has significant concerns about aspects of the guideline and has suggested revisions in our attached submission. The RANZCP recommends that this feedback is addressed in the guideline's post-consultation revision process to ensure that the final guideline provides an accurate reflection of the current evidence as well as a meaningful resource to ASD clinicians.	
	ID794		The RANZCP also recommends …. the inclusion of forensic implications for young people with ASD be considered	Thank you for this comment. We agree that forensic issues are highly relevant to the clinical management of young people with ASD, but are currently unsure about how these may be included in this diagnostic guideline. We would be very pleased to receive additional guidance from RANZCP relating to this issue.
	ID795		Under the CSR on page 9, the RANZCP suggests the following revision to the text to ensure the consideration to the individual's family during the assessment process. '*The ASD assessment process should follow* a *strengths-focused approach, in which identifying the strengths, skills, interests, resources and support systems of the individual and their families are recognised as being just as important* as *identifying limitations*'.	The recommendation now states: "It is recommended that the ASD assessment process follow a strengths-focused approach, in which identifying the strengths, skills, interests, resources and support systems of the individual, and their caregiver(s) or support people, is recognised as being as important as identifying limitations."
	ID796		The RANZCP notes that the guideline uses a 'modified approach' to the National Health and Medical Research Council (NHMRC) grading system was used to assess the strength of the evidence. The RANZCP recommends that	Thank you for this feedback. As part of the Guideline development process, the methodology was revised by a specialist reviewer nominated by the National Health and Medical Health Research Council. This reviewer provided

			further clarification is included in the guideline to clearly explain how the ratings differed from the standard GRADE approach employed by the NHMRC.	very favourable reviews of the methodology (see recommendations at the end of this document). Further methodological reviews will be undertaken by the NHMRC in early 2018.
	ID797		There is a typo on page 10, the text should read 'the individual *'who'* presents for assessment and not the individual *'that'* presents for assessment.	This typo has been amended.
	ID798		The RANZCP suggests the following revision to line 5 to ensure consideration in an ASD assessment to potential communication deficits *'however, every individual being assessed will also have* a *range of behavioural, communication and cognitive strengths.'* The RANZCP also suggests that *'temperament'* should be included in this section as it can also be an·· important consideration in an ASD assessment.	This statement has been amended to: “every individual being assessed will also have a range of personality, behavioural, communication and cognitive strengths”
	ID799		The RANZCP recommends the consideration of comorbid diagnoses. A proposed revision could be as follows: *'However, it is critical for the future clinical management of the individual being assessed to not just understand the presence or absence of ASD diagnostic behaviours and/or comorbid diagnoses'.*	This phrase has been amended to: “…not just understand the presence or absence of clinical diagnoses”.
	ID800		The RANZCP recommends clarification on the role and responsibilities of the Coordinator Role and the differences between this and the roles of a traditional key worker/case manager role.	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading:

			The RANZCP also suggests that this section includes a recommendation that best practice should be to minimise handovers in care from the intake to the assessment process.	• Coordinator Role
	ID801		The RANZCP also recommends that the guidelines are revised to address the inclusion of audiologists, optometrists and ophthalmologists earlier in the guideline than their current positions due to the importance of contextualising each assessment to vision and hearing adequacy to ensure an appropriate diagnosis.	Audiologists, ophthalmologists and optometrists are on the list of other professionals who can provide information to support the ASD assessment, which is earlier in the Guideline compared to the original draft.
	ID802		The RANZCP is concerned that the wide range of professional disciplines listed as Diagnosticians for ASD may result in the potential for an ASD diagnosis to be made without input from an appropriately trained and experienced medical practitioner. The RANZCP believes that this is at odds with both international diagnostic guidelines as well as current clinical practice, where only certain medical specialists such as paediatricians, psychiatrists and neurologists can make a standalone ASD diagnosis. The RANZCP recommends that a medical practitioner is always involved in ASD diagnosis. This medical knowledge is particularly important in differentiating ASD from other conditions that can present similarly, in the selection of medication to treat challenging behaviours and management of comorbidities associated with ASD	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Professional Roles • Structure of the Assessment Process
	ID803		The RANZCP recommends the wording *'completing* a *Referral Form'* is revised to allow for flexibility in referrals, some of which undertaken using methods other than a Referral Form.	This has been amended to "providing a written referral" to provide greater flexibility.

	ID804		The RANZCP believes that the expectation that one individual takes an ongoing responsibility for each case may be unrealistic in many settings and suggests further clarification is provided about the expectations and/or specific evidence base to support these recommendations. The RANZCP recommend that all sections of the guideline which refer to the Coordinator Role are revised with this consideration in mind.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Coordinator Role
	ID805		The RANZCP recommends that while all qualified psychiatrists have the training to undertake ASD diagnosis, assessment should ideally be undertaken by psychiatrists with suitable additional training to undertake ASD assessments in both children and adults (e.g. the RANZCP Certification of Advanced Training in Child and Adolescent Psychiatry) and/or additional training in ASD assessments (e.g. Autism Diagnostic Interview, Autism Diagnostic Observation Schedule or positions in specific services for adults with neurodevelopmental disabilities). The RANZCP suggests the inclusion of explicit recommendations regarding clinical flags to facilitate appropriate referrals to psychiatrists for people with complex presentations. Psychiatrists often deal with complex clinical cases and play important leadership roles in cases involving multidisciplinary care. Psychiatrists play an essential role in the identification, assessment, intervention and care of children and adults with ASD and physical, behavioural and mental health comorbidities. Psychiatric knowledge is particularly important in differentiating ASD from other conditions that can present similarly, in the selection of medication to	The revised Guideline includes a recommendation regarding the additional skills and expertise for psychiatrists to conduct ASD assessments. The Guideline also includes recommendations regarding professional bodies developing competency-based training programs for professionals involved in the ASD assessment process. Please refer to the 'Overview of Major Amendments' chapter under the following heading: • Accreditation and Regulation • Practice points for clinical, research and policy settings The Executive Committee would welcome feedback from RANZCP regarding clinical flags that may facilitate a referral for to psychiatrists for individuals with complex presentations.

			treat challenging behaviours and management of comorbidities associated with ASD.	
	ID806		The RANZCP suggests that the title of Table 3, page 18 is revised where it states that Diagnosticians *'have acquired and demonstrated competency in the skills described in 6.4'* as currently it may read that clear competencies and skills have been determined. The RANZCP believe that much of what is described in Section 6.4 is knowledge or experience and not competencies or skills.	This has been amended to: "…also have relevant training and expertise"
	ID807		Another recommended revision in this table is the rewording on the years that individuals may assess child and adolescent psychiatrists many of whom now see young people up to 25 years of age, not 17 as listed in the table.	The upper age limit for child and adolescent psychiatrists has been increased to 25 years.
	ID808		The RANZCP believes that the requirements of the consensus based recommendation (CBR) on page 17 that diagnosticians must demonstrate *'at least four years fulltime equivalent of postgraduate experience that is directly relevant to ASD Diagnostic Evaluations, obtained through university qualifications, formal training programs and/or formally supervised work experience'* will disqualify potential expertise currently working in this area. It is suggested by the RANZCP that it would be better to outline the specific ASD training needed rather that a suggested timeframe.	Please note that the requirement for '4 years' experience' has been omitted from the revised Guideline. For a rationale, please refer to the 'Overview of Major Amendments' chapter under the heading: • Duration of ASD-specific Expertise
	ID809		There is a minor typo, 'aother'='other' in 'Professional Informants are responsible for providing clinical and other information about the individual being assessed'	This typo has been amended.

	ID810		The RANZCP suggests that the listing 'Suitable professional disciplines' is reworded as certain terms are not widely used as a professional discipline, e.g. 'General practice', 'Dietetic' and 'Indigenous community health'. The RANZCP also suggests that this section promotes more of a 'collaborative approach' of assessment between the disciplines, involving information sharing and outcome planning rather than a 'silo' process.	The list of other professionals has been written in terms of the job title. A statement has also been included regarding the importance of a collaborative approach between disciplines in the ASD assessment process.
	ID811		The RANZCP suggests that this section includes mention to possibility of family/home based assessment settings. The complexity of an assessment varies, and it should be individually tailored to the diagnostic necessity.	The Guideline recommends that Stage 1, 2 and 3 assessments are able to take place in a community setting, such as the home.
	ID812		*The RANZCP suggests adding an additional benefit of a clinic setting with the improved cross collaboration of differing professional disciplines when they are in the same setting.*	The advantages of a clinic setting were expanded to include: "Improved cross collaboration of differing professional disciplines when they are in the same setting."
	ID813		The statement on page 31 that 'a *Consumer is able to self-refer for an ASD assessment, and may proceed directly with* a *referral through their General Practitioner'* requires further clarity as it appears contradictory for some Diagnostician categories e.g. certain medical specialists require a referral from a GP as opposed to a consumer self-referral for reimbursement from Medicare. *The RANZCP also suggests that this section includes a statement that the referral should been discussed with individual/family, as appropriate to gain their consent.*	Additional text was added to the referral process: "It is recommended that a referral for an ASD Assessment is initiated by a primary health care provider. The professional discipline of this individual may differ between private and public health care settings, but may need to meet specific professional requirements (e.g., be a general practitioner) to meet certain funding prerequisites." "It is recommended that the primary health care provider discusses their recommendation to initiate a referral for an ASD assessment with the client, and obtains their consent to proceed."
	ID814		The RANZCP suggests the following revisions to Table 5. *1.* Under the list entitled *'Presence of any of the following*	This table has been omitted from the revised version of the Guideline. For further information, please refer to the 'Overview of Major Amendments' chapter under the heading:

			we/l-established risk factors': a. inclusion of other risk factors such as a family history of ASD b. inclusion of substance toxicity during pregnancy (e.g. alcohol, sodium valproate) alongside *'Birth complications associated with ischemia or hypoxia'* 2. Under *'Factors',* the inclusion of *'testing for vision'* alongside testing for hearing.	• Referral for an Assessment of ASD Concerns
	ID815		The RANZCP welcomes the CBR 1 that states that a *'Functional and Support Needs Assessment is* a *core component of an* ASD *assessment'.* However, the RANZCP recommends that this is further emphasised here as necessary for both a Tier 1 and a Tier 2 assessment.	Thank you for this comment. The revised structure provides far greater emphasis on the importance of a comprehensive functional and needs assessment in providing the foundation for a diagnostic evaluation. For further information about this, please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Structure of the Assessment Process • Emphasis on the Importance of Functional Abilities in Referral for Supports
	ID816		The RANZCP believes that the expectation of the Tier 1 Diagnostician to be able to screen and interpret medical, psychiatric and behavioural information, make decisions about the appropriateness of further investigations and to perform a *'Medical evaluation of the individual being assessed for ASD, consisting of neurological and physical history and examination to assess whether there are medical causes and/or associations with the behavioural presentation of the individual'* is outside the professional scope of practice of non-medically trained professionals. This is further	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Professional Roles • Structure of the Assessment Process

			reinforced by the lists of differential diagnoses in Tables 14 and 15, many of which require specific medical diagnostic training to be appropriately identified.	
	ID817		The RANZCP recommends that a clear definition of what is meant by a 'Tier 1' and 'Tier 2' Diagnostician' is included at their first mention in the guideline. The RANZCP believes that clarification is needed to ensure that the assessment pathways for an individual and/or their families will result in equivalent assessments for strengths/functional needs whether in a Tier 1 or a Tier 2 pathway.	We believe the structure of the revised Guideline addresses this helpful comment. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Professional Roles
	ID818		The RANZCP suggests further clarification is provided in the recommendations regarding suitable timeframes for completion of a multidisciplinary assessment. For example, the recommendation that a Tier 2 Diagnostic Evaluation be conducted by at least two Diagnosticians, with input from at least two Professional Informants. The RANZCP is concerned that if there are delays in accessing multiple diagnosticians due to waitlists, costs, access in rural areas etc. this will likely lead to diagnostic delay and disadvantage those in both rural areas and who rely on the public health system.	The Guideline suggests that the ASD assessment would ideally commence within three months of referral, and the findings would ideally be shared within three months of the first assessment appointment.
	ID819		The RANZCP recommends the inclusion of the Developmental Behaviour Checklist (Einfeld and Tonge, 2002) to the sections on both screening for ASD and for co-occurring concerns. This important instrument has a sensitive and specific ASD screening module and Australian has been developed with Australian norms.	Recommendations relating to specific instruments that measure functioning have been removed from the Guideline, and information about resources will instead be located on the Guideline webpage to enable updates to occur more readily.
	ID820		The RANZCP also recommends the inclusion of an explicit recommendation that expertise in the assessment of global delay or ID is required at all	Thank you for this helpful comment. The revised Guideline includes the recommendation that all individuals involved in

			levels of the diagnosis formulation and not just the developmental level of the individual.	the ASD assessment process have expertise in a number of areas, including the following: • Typical and atypical development across the age range assessed in their practice • Presentation of the signs and/or symptoms of ASD and other neurodevelopmental disorders across all developmental stages in which they practice • Presentation of symptoms of ASD and other neurodevelopmental disorders; neurodevelopmental disorders among male, female, and where applicable, gender diverse individuals • Impact of other important considerations, such as intellectual and / or communication capacity, culturally and linguistically diverse background and regional or remote location on the ASD assessment
	ID821		The RANZCP notes the inclusion of the draft ICD-11 diagnostic criteria in Table 6. However only DSM-5 and ICD-10 are included in the CBR for ASD specific expertise in section 6.4.2. The RANZCP suggests that revisions are made to either include or remove ICD-11 from both sections to ensure continuity in the guideline recommendations.	The Guideline has been edited so that the diagnostic criteria is consistently referred to as the current version of the DSM or ICD. The table outlining the diagnostic criteria for each of these manuals now focuses on DSM-5 and ICD-11 beta.
	ID822		The RANZCP also recommends the inclusion in Table 6 of the DSM-5 criteria which can specify whether or not there is intellectual and/or language impairment with a severity analysis protocol.	A description of the specifiers has been added in the section introducing the DSM-5 criteria. The Stage 2 and Stage 3 Decision Making and Outcome sections have been edited to include “a decision of specifiers if DSM-5 criteria are utilised.” In addition, the Content of Communication section has been modified to include the requirement to share “Evidence that supports specifiers (if DSM-5 criteria are utilised).”

	ID823		The RANZCP suggests more information is provided here about the process for readying parents/other family members for an ASD diagnosis and where stress, environmental and relationship factors may impact diagnostic complexity, even in cases where a diagnosis seems clear.	The following has been added to the Content of Communication section: "This meeting creates an additional opportunity to assist the client to understand and consider the implications of the diagnostic outcome. Along with sharing information with the client, the ASD assessment team can encourage the client to ask questions and facilitate discussion regarding how the diagnostic outcome may impact on relationships, roles and eligibility for services / funding. This may include developing plans for using the diagnostic information and preparing for diagnostic disclosure."
	ID824		The RANZCP recognises the degree of flexibility facilitated by the guideline's two-tiered approach to ASD diagnosis. However, categorical diagnostic decisions are not always appropriate for ASD, as diagnostic boundaries are not always clear in developmental syndromes. The RANZCP recommends that this section and the two diagnostic algorithms (pages 39-40) are further expanded to clarify the process when an individual does not meet the criteria for ASD but who has similar support needs.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments'chapter. In particular, the revised Guideline recommends immediate referral for intervention and support services as soon as functional impairment and support needs is identified in Stage 1 (please see Figure 2. The revised Guideline also provides a specific recommendation that if diagnostic certainty is unable to be made following a Stage 3 assessment, then the Diagnostician provides a recommendation for a re-assessment at a later date.
	ID825		The RANZCP would also welcome clarification on the impact of diagnostic processes on funding mechanisms as it is concerned that an arbitrary diagnostic boundary does not address the complexities of an individuals need	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the headings: • Emphasis on the Importance of Functional Abilities in Referral for Supports
	ID826		The RANZCP recommend the inclusion of both 'Educational History' and 'Transcultural sensitivity' as a consideration.	Educational history has been added to the 'Information Collection' section. Transcultural sensitivity is referred to in the Important Considerations section.

	ID827		The RANZCP also suggests the revision of the CBR wording on page 38 'If appropriate based on age and communication abilities' as it currently lacks clarity in the context of the whole recommendation.	Restructuring the recommendation has allowed the removal of the phrase “‘appropriate based on age and communication abilities” (referring specifically to interview with the individual undergoing assessment), it now states: “Interview with the client” and “Observation of the individual undergoing assessment”
	ID828		The RANZCP recommends the following inclusions for Table 7: • 'Gastroenterologist' for gastrointestinal difficulties • 'Neuropsychology' for cognitive assessment • 'Special Education Teachers' for literacy • 'Lived Experience Consultant' as an overall inclusion of their role in addressing family support and advocacy	Thank you for this comment. Based on feedback received, this table has been omitted from the revision Guideline, and the information included in the table has been incorporated in other sections of the document.
	ID829		The RANZCP recommends that revision of the wording 'emerging and/or inconsistent' in the sentence 'there is emerging and/or inconsistent evidence that the following instruments may have adequate diagnostic accuracy for ASD (among specific populations)'. The RANZCP suggests that this list is separated into emerging evidence and inconsistent evidence to ensure the reader is aware of the evidence for each instrument.	Recommendations relating to specific instruments that measure functioning have been removed from the Guideline, and information about resources will instead be located on the Guideline webpage to enable updates to occur more readily.
	ID830		The RANZCP also recommends that the standard and high functioning versions of the CARS2 are mentioned in this section.	Recommendations relating to specific instruments that measure functioning have been removed from the Guideline, and information about resources will instead be located on the Guideline webpage to enable updates to occur more readily.

	ID831		The RANZCP suggests the following inclusions to Table 8: 'psychiatric' and 'neurological' under 'Type of specialist assessment' for the repetitive behaviour domain to exclude other psychiatric causes of repetitive behaviours	Additional rows were added to the repetitive patterns of behaviour, interests, or activities domain section of the table on Possible assessment choice for a Stage 3 Consensus Team Diagnostic Evaluation covering both psychiatric assessment and neurological assessment.
	ID832		The RANZCP suggests the following inclusions to Table 8: 'co-morbid ADHD' under 'Possible differential or co-occurring diagnosis'	Attention deficit hyperactivity disorder has been listed in the new table on possible differential or co-occurring diagnoses.
	ID833		The RANZCP recommends that the guideline includes further detail at the beginning of this section, regarding the need to seek consent of the person being assessed, as appropriate, considering age and/or ability. The RANZCP also believes that consideration to the consent issues for children and adolescents, and those with Intellectual Disabilities should be included in the earlier sections on assessment. These may include, but are not limited to consideration that communication levels of the individual during the assessment e.g. whether the person is a symbolic communicator or not.	Added recommendation that all members of the ASD assessment team have training and expertise in the “impact of other important considerations, such as intellectual and / or communication capacity, culturally, linguistically and/or socio-economically diverse background and regional or remote location on the ASD assessment.”
	ID834		The RANZCP recommends the inclusion of *'discussion of diagnostic specific funding and services'* in the CBR	“Available funding and services” were added to the list of topics to communicate to the client at the conclusion of the ASD assessment.
	ID835		The RANZCP welcomes the addition of this section to note the differing needs of specific populations with ASD including children and adults. The RANZCP recommends that the section on diagnosing ASD in adulthood is expanded to note	The following text was added to the table summarising additional considerations for older adolescents and adults:

			the key role which psychiatrists play in this space where further complexities occur. The RANZCP notes that many adults may not have access to the list of suitably qualified diagnosticians noted in Section 6.4 (e.g. paediatrician, child and adolescent psychiatrist) and this may negatively impact the rates of adults being appropriately diagnosed.	"Although adolescents and younger adults may continue to be assessed by a paediatrician or child and adolescent psychiatrist, adults above the age of 25 years will be restricted in the clinicians who can conduct an ASD assessment. A wide range of clinicians may be available to conduct a Stage 1 or 3 assessment, however an adult psychiatrist, clinical psychologist or a medical practitioner meeting the specified requirements may be more appropriate for a Stage 2 assessment."
	ID836		The RANZCP also suggests that guidance is provided on the use of screening tools with adults.	Recommendations relating to specific instruments that measure functioning have been removed from the Guideline, and information about resources will instead be located on the Guideline webpage to enable updates to occur more readily.
	ID837		The RANZCP welcomes the inclusion of intellectual disability (ID) as a critical consideration in the diagnosis of ASD. However, the RANZCP recommends that given the strong association between ASD and ID, that ID be introduced earlier than Section 12 of the guideline and that competencies for assessment of people with ID are included in Section 6.3.2 ASD Specific Expertise. An example of current competencies in this area include the University of New South Wales' Intellectual Disability Mental Health Core Competency Framework: A Manual for Mental Health Professionals	The revised Guideline has included a further recommendation that all members of the ASD assessment team have training and expertise in: "Presentation of symptoms of … other neurodevelopmental disorders" "Impact of other important considerations, such as intellectual and / or communication capacity, culturally, linguistically and/or socio-economically diverse background and regional or remote location on the ASD assessment." This is introduced early in the Guideline (Section 4.2).
	ID838		The RANZCP also recommends the inclusion of an explicit recommendation that expertise in the assessment of global delay or ID is required at all levels of the diagnosis formulation and not just the developmental level of the individual.	Please refer to the responses to similar comments made by this respondent.

	ID839		Section 12.3 Gender The RANZCP believes that this section may benefit from the inclusion that the functional needs assessment may require a focus on the sexual vulnerability of females with ASD.	A table has been added to the Important Considerations – Gender section, outlining characteristics more common in females. The item "potentially increased sexual vulnerability" has been added to this table.
	ID840		The RANZCP suggests the specific inclusion of Schizotypal Disorder in children, as it is an important differential or co-morbid diagnosis to be considered.	Schizotypal disorder has been listed in the new table on possible differential or co-occurring diagnoses.
Women's and Children's Health Network - SA Health [150]	ID841	Individual	Currently in SA all children and adolescents see two diagnosticians for the assessment of ASD. The proposed guidelines recommend a change to a two-tiered system. This is for children whose presentation is sufficiently clear that a diagnostic decision can be reliably made (either yes or no) by one clinician with input from at least one professional informant from a different professional discipline or specialty a. One diagnostician b. File review c. Interview with caregiver d. Interaction/observation with individual e. Discussion/information sourced from a professional informant f. Functional and support needs assessment g. Medical evaluation **1. Determining Tier 1 and Tier 2 status** It is recognized that the diagnosis of ASD is clearer in some children than others (often in younger children displaying more significant signs), and that determining which children can be assessed using the Tier 1 model may not be clear at the outset of the assessment process. In addition, whether a	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the headings: • Structure of the Assessment Process • Progression from Stage 2 to 3

			child can be assessed as clearly meeting criteria is likely to differ between assessors. For instance, a child considered straightforward by one clinician may be considered more complex by another more aware of underlying psychosocial issues in the family. Further criteria regarding which children would be suitable for assessment via a Tier 1 approach, and therefore by one diagnostician only, would be helpful. In particular, considering the child's age is likely to be useful, as children over the age of 4 or 5 years would rarely fall into this category.	
	ID842		2. **The introduction of a Medical evaluation** (Tier 1 and 2 assessment requirement) It is suggested that medical history and examination that occur as part of a Tier 1 assessment should be undertaken by a paediatrician (rather than a GP). It is likely that these children will show more significant features and have coexisting issues such as developmental delay and intellectual disability, and therefore will be more likely to have an associated or underlying medical condition or comorbidity requiring investigation. Some individuals diagnosed with ASD do not currently see a medical professional during the diagnosis process. These individuals are assessed by a speech pathologist and psychologist. Within South Australia, Autism SA does not employ paediatricians, and the need for medical evaluation for these children would potentially increase referrals to SA Health Child Development Units and Paediatric Outpatient Clinics. In an environment where public health services are commissioned on an annual basis, planning and resourcing such impacts would need to be considered in advance of such a change in practice or service delivery.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Structure of the Assessment Process • Professional Roles
	ID843		3. **The addition of Occupational Therapists to the diagnostic disciplines**	Please refer to the 'Overview of Major Amendments' chapter under the heading:

			Current ASD diagnosticians include speech pathologists, psychologists, paediatricians and psychiatrists. The proposed inclusion of occupational therapy (OT) as a diagnostic discipline requires the OT to be registered with the Better Access to Mental Health (BAMH) programme to be eligible for diagnostic status. OTs employed in the public health sector are not able to be registered with Medicare or to charge for services, therefore their inclusion as a diagnostic discipline does not increase flexibility or change current practices across SA Health ASD diagnostic services.	• Qualifications for occupational therapists
	ID844		**4. Information must be provided about the individual's participation in at least two relevant community settings** Information is typically sought from others as part of an ASD assessment in SA. For children who do not attend any out of home care, education or community based activities, the requirement to source information from at least two relevant community based settings may be difficult to obtain.	Thank you for this feedback. Based on the considerable feedback received regarding the need for flexibility in the assessment model, we have used the following wording (Section 10.3): "It is recommended that the Consensus Team Diagnostic Evaluation involve the collection of information about the individual's participation in all relevant community settings. This information may be obtained through communication with the client and/or other professionals but direct observations by member(s) of the ASD assessment team within some of these community settings may also be helpful."
	ID845		**5. Requirement for a functional and support needs assessment (Tier 1 and Tier 2 assessment)** It is understood that the intention of sourcing this additional information is to guide the future provision of supports to assist the individual as a core component of an ASD assessment.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Cost implications of the assessment model recommended in the Guideline

			The completion of a functional needs assessment will add significant time to ASD assessments. The resourcing impacts of this change in practice for South Australia may be marginally offset by the new requirement for one clinician only for a Tier One assessment, however quantification of the impact would be necessary to consider viability of implementation. Within the private sector, this additional component of the assessment (regardless of Tier type) is likely to add significant time and therefore cost of service provision to consumers. The potential consequences or risks of this change may therefore: • Create disincentive for some private practitioners to undertake ASD assessments as they become financially unviable; • Increase the cost of private assessments to consumers as the cost of additional assessment is passed on, making such assessments unaffordable for many families; • Transition demand for increased services to the public sector, as families seek affordable public options or have access to fewer private assessment service options. In an environment where meeting public sector demand is challenging, this could represent significant risk.	Please note that the revised Guideline also includes a recommendation regarding costs for ASD assessments. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Practice points for clinical, research and policy settings
	ID846		**6. Single diagnostician assessments** It would be helpful to further understand the interface with the education sector for children who are subject to a Tier 1 assessment. In particular, clarification of how a Tier 1 assessment and diagnosis will be recognised in order for those individuals to be eligible for funded support at schools (public and private).	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Implementation and Evaluation of the Guideline • Practice points for clinical, research and policy settings

	ID847		**TIER 2 DIAGNOSTIC EVALUATION** The proposed components of the Tier 2 evaluation are largely consistent with current practice in South Australia, i.e. • Two clinicians • File review • Interview with caregiver • Interaction/observation with individual in two or more settings with at least one of the settings being in the community • Discussion/information sourced from at least two professional informants • Functional and support needs assessment • Medical evaluation The proposed interaction/observation with the individual in two or more settings, with at least one being a community setting is however a change to current practice.	Thank you for this very helpful information.
	ID848		**1. Community setting assessment (observation in two or more settings, with one being a community setting)** • The vast majority of ASD assessments completed by SA Health staff occur in the clinical setting. Detailed information, both written and oral feedback, regarding the individual's presentation and functioning in other settings, such as home and community, is sought to fully inform the assessment. • Whilst child care/preschool/school visits are undertaken, they are only undertaken where the clinicians have not been able to reach a conclusion. The proposed requirement for a community based assessment in two or more settings as a compulsory part of a Tier 2 evaluation would increase complexity related to	Thank you for this feedback. Based on the considerable feedback received regarding the need for flexibility in the assessment model, we have used the following wording (Section 10.3): "It is recommended that the Consensus Team Diagnostic Evaluation involve the collection of information about the individual's participation in all relevant community settings. This information may be obtained through communication with the client and/or other professionals but direct observations by member(s) of the ASD assessment team within some of these community settings may also be helpful."

			coordinating and liaising with schools to arrange a community visit. There are clear implications arising from this change related to additional time to undertake visits, and without an expansion in resourcing to absorb this, would potentially increase waiting times for assessments.	
	ID849		**Other Impacts of the proposed Guidelines for SA Health** **1. Diagnostician's experience** The proposal states diagnosticians must demonstrate at least four years' fulltime equivalent of postgraduate experience directly relevant to ASD diagnostic evaluations, obtained through university qualifications, formal training programmes and/or formally supervised work experience. It is unclear how such experience will be defined or measured, and there is a risk that private practitioners may be unable to demonstrate such experience outside of undertaking formal training or obtaining university qualifications. This may potentially reduce the pool of private practice diagnosticians, which in turn will transition increased demand and referrals to public services. It would be helpful for public jurisdictions to understand if there is an expectation that tertiary paediatric health services will provide specialised clinical training to facilitate this outcome. Clarification regarding the nature, funding and period of clinical supervision would be important to determine the viability of this. e.g. If staff need to demonstrate four years' experience with an ASD diagnostic service to become recognised diagnosticians, this would mean that each Tier 2 assessment would in fact require 3 clinicians (2 diagnosticians and the trainee) and funding arrangements would need to be made to accommodate this OR wait times for assessments will increase.	Please note that the requirement for '4 years' experience' has been omitted from the revised Guideline. For a rationale, please refer to the 'Overview of Major Amendments' chapter under the heading: • Duration of ASD-specific Expertise

	ID850		**2. Profession of the diagnostician** It is proposed that the assessing diagnostician must be a different profession from the Referral for an Assessment of ASD Concerns. Many of the children referred to health services are referred by a paediatrician. This will mean that only allied health diagnosticians will be eligible to assess the individual. Assessment times available with this combination of staff are limited, resulting in likely increased wait times.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Referral for an Assessment of ASD Concerns
	ID851		**3. Review of functional and support needs assessment** It is proposed that "The Functional and Support Needs Assessment process should be repeated throughout the individual's life to ensure that changes to functional status and support needs are identified and acted upon in a timely manner". It is not clear who will be responsible for completing such ongoing review of functional and support needs assessments and no suggested time period or frequency for repeat assessments has been indicated. This would be an important part of understanding the intended change in practice. The practical implication of such a change would require increased resourcing to respond to increased service response. It is likely that most jurisdictions would not have the capacity to flex service availability to undertake the additional activity of these reviews without it being commissioned as new activity by their State Health Department. It is assumed in any case, that this would be the role of the NDIS funded service providers and the child's paediatrician to undertake these.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Structure of the Assessment Process

	ID852		The use of Telehealth settings in exceptional circumstances is supported. It is suggested that a professional be present with the consumer during the telehealth process, to provide support.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Telehealth
	ID853		The complexities of assessing individuals from CALD and Aboriginal backgrounds are well outlined in the document. It is suggested that the particular issues involved in the assessment of children in Out of Home Care, with the associated difficulty in obtaining a reliable history and the likely contribution of exposure to developmental trauma, also be included.	Out of Home Care Providers have been added as an information source in the tables for preschool and school-aged children. The revised Guideline also lists an exposure to psychosocial risk and/or trauma as a factor that may indicate a need for a Stage 3 assessment.
Manual Submission [151]	ID854	Organisation – Professional experience	**Overall comment** We appreciate the amount of research and consideration that has gone into this document; it is very detailed, although we did not really find it suggested anything all that new to diagnosticians in Western Australia, especially when compared to that which had already been documented by The Western Australian Autism Diagnosticians Forum years ago (Glasson et al, 2008, updated by Campbell et al 2014, and what the NICE guidelines stipulate. There are some positives in terms of processes being officiated as part of a guideline around the country and the incorporation of the functional assessment, but we question the tiered system to diagnosis as it actually goes against the suggested gold standard, which the UK and various US states, with some exceptions (Minnesota), attempt to adhere to in terms of multi-disciplinary assessment.	Thank you for this comment and for providing feedback.
	ID855		A "tiered" system to diagnosis • This would be a positive for families in the sense that time to final diagnosis would be reduced in some cases - as	Thank you for this feedback.

			would costs - meaning earlier access to intervention services for some. • It is also a positive for families living in some rural areas in terms of access to assessment; however, we fear that quality and usefulness of the assessment reduces if only one clinician is involved.	
	ID856		The suggestion that a "tier 1" assessment be conducted on children who are "obviously" on the Autism Spectrum raises the question of "obvious to whom?" This recommendation relies entirely on the level of training, experience, and the nature of the experience the 'tier one diagnostician' has had with Autism Spectrum Disorder. It is a fundamentally flawed system whereby the person making the decision that a child is Tier 1 is also the person who takes on the responsibility of diagnosing that child.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Progression from Stage 2 to Stage 3
	ID857		We have concerns about removing the speech pathology component from the Tier 1 assessment. Autism Spectrum Disorder is a social communication disorder and in order to assess whether a child fits the social communication criteria, a very strong and in-depth knowledge of language development, and how typically developing children use language at each age and stage is critical. We have concerns about children being labelled as having Autism Spectrum Disorder who, in fact, are presenting with other speech and language difficulties such as childhood apraxia of speech or severe developmental language disorder. By assuming that a child is a straightforward case and therefore can be assessed by only one professional, you are assuming that this professional is able to differentially diagnose these conditions, which is not necessarily the case. Presumably the children who are "obviously autistic" would be the more severe presentations, these are the children who need the most support in the beginning in terms of therapy,	We believe the structure of the revised Guideline addresses these comments. Please refer to the 'Overview of Major Amendments' chapter under the headings: • Structure of the Assessment Process • Professional Roles • Progression from Stage 2 to 3

			and parent support and training. Intervention planning should involve multiple disciplines.	
	ID858		The functional assessment at a tiered 1 level seemingly could be done by a parent, teacher or a general practitioner, as they are considered to be "professional informants", or the identified diagnostician who could be either a paediatrician, psychiatrist, neurologist, psychologist, speech pathologist, or occupational therapist. Based on what is required for a functional assessment, according to section 10.3.3 on information collection, the person undertaking the functional assessment would be reviewing reports, conducting direct interviews, observing the individual, communicating with other professional informants, and conducting standardised assessment tools. We query how all these individuals listed can access and administer the functional assessment standardised tools suggested, and whether all of these individuals would be in a reasonable position to make an adequate assessment to determine the specific supports that are needed that will invariably govern the treatment.	We believe the structure of the revised Guideline addresses this comment. Please refer to the 'Overview of Major Amendments' chapter under the headings: • Structure of the Assessment Process • Professional Roles
	ID859		The incidence of the comorbidity of mental health disorders is high in the Autism Spectrum Disorder population, with the DSM citing 70% suffering from one mental health issue at some point in their lives, and 45% suffering from two or more. This would require involvement of a psychologist or a psychiatrist, both for adequate differential or comorbid diagnosis and evidence-based treatment.	We believe the structure of the revised Guideline addresses this comment. The 'Overview of Major Amendments' chapter.
	ID860		We agree fully with the statement in the WAADF response regarding provisional diagnosis. We feel that diagnosis is currently a gatekeeper for access to services. Could there be room for the tier 1 assessment to be a pathway for a provisional diagnosis facilitating access to tailored services	Thank you for this very helpful feedback. We believe the structure of the revised Guideline addresses this helpful comment. Please refer to the 'Overview of Major Amendments' chapter under the heading:

			with the intention for review of the diagnosis after further multidisciplinary assessment has been conducted?	• Emphasis on the Importance of Functional Abilities in Referral for Supports
	ID861		We would like to suggest that a "brief practical diagnostic map" may be useful, for clinicians, given the volume of written information in this document.	A figure titled “Schematic representation of ASD assessment process” has been added to the Content of an ASD Assessment section.
	ID862		For all of us at [Organisation], who have had the pleasure and privilege of assessing and working with children on the autism spectrum and their families, we know too well the individuality of each of their presentations and familial contexts. It is for this reason that we feel quite strongly about the necessity of maintaining a multidisciplinary approach to assessment. While there is merit in the stated drawbacks of wait-list times for numerous professionals, as well as cost and length of the assessment process, we believe a multidisciplinary approach lends itself to a far more person-centred and strength-based approach, which ensures the family and child are supported in the best possible way at the beginning of a difficult journey	Thank you for this feedback. We believe the structure of the revised Guideline addresses this comment. The ‘Overview of Major Amendments’ chapter.
	ID863		*Functional Assessment* • The focus on functional assessment is important and a welcome addition. There is plenty of research that indicates adaptive skills in childhood and adolescence are a more reliable predictor of independence in adulthood for an individual with Autism Spectrum Disorder, than IQ alone. There is merit in ensuring that these functional assessments are carried out for all children who go through the diagnostic process, especially in terms of determining a baseline for the service provider/clinicians who will be providing intervention to the child.	Thank you for this feedback. We believe the structure of the revised Guideline addresses this comment. The ‘Overview of Major Amendments’ chapter.

			• However, the guidelines must be clearer in determining who conducts a functional assessment, and in what circumstance. • We would like to add that functional assessment should be an on-going aspect of developing and refining an individualised intervention for each person diagnosed with Autism Spectrum Disorder, not something that is just assessed by one over-seeing "diagnostician".	
	ID864		We question the inclusion of occupational therapists as diagnosticians, especially the reference to considering occupational therapists as being clinically competent in completing tier 1 diagnostic assessments. Section 6.4.2. point 4, 5, 6, and 7 indicates that the diagnostician must have knowledge of symptoms associated with comorbid and differential diagnosis, current international Autism Spectrum Disorder diagnostic criteria in the DSM 5 and/or /CD 10, administering Autism Spectrum Disorder specific diagnostic assessments with all training qualifications and prerequisites met, and administering other standardised assessments within a diagnostic evaluation with those prerequisites met. To date, occupational therapists have primarily been seen as valuable in the treatment planning for managing motor-based issues and specific sensory issues for children with Autism Spectrum Disorder. However, they do not have clinical training or expertise in social communication, speech and language development, nor mental health or management of behavioural issues. They cannot purchase or administer cognitive or psychological standardised tools used by psychologists nor standardised speech and language assessments used by speech and language therapists. We would be concerned to find out there were occupational therapists currently acting in this role as they do not have the required training in their university programmes, nor is it part	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Professional Roles • Structure of the Assessment Process

			of their traditionally defined role to conduct any of the formally mentioned tasks, thus bringing ethical practice into question. While there are occupational therapists who claim to "specialise" in mental health, this is not near the level of training that a registered or clinical psychologist has in the area.	
	ID865		We note that the ADOS and ADI-Rare paired together in the guidelines rather than individually. Our question is, would the ADOS be sufficient in its own right as an Autism Spectrum Disorder diagnostic tool used in conjunction with a developmental clinical interview based on the DSM 5 criteria for Autism, which to our knowledge is what most experienced clinicians specialising in this area use (Aiello et al, 2017; Hathorn et al, 2014; Skellern et al, 2005; Randall et al, 2015; Rogers et al, 2016 & Ward et al, 2016), rather than using the ADOS and the ADI-R in conjunction. Section 9.5.3, states it should involve the administration of at least one standardised Autism Spectrum Disorder diagnostic tool. Whilst we recognise that as ideal, we do not think this should be mandated, as the research has indicated that these tools are no more reliable than specialised clinical judgement (Falkmer et al, 2013). • There is no mention of other standardised measures or tools which have been found to have adequate reliability and validity and are more commonly used within psychological practice when ruling out differential diagnoses or considering co-occurring conditions. (e.g. Beck Inventories, Strengths and Difficulties Questionnaire, DASS, Child Behaviour Checklist, and a standard mental state exam). • We are unsure about the overall mention of this	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Use of 'Standardised' Instruments

			list of "standardised assessment tools". Given the variation in presentation of individuals on the spectrum, we question the idea of a completely standardised assessment process for each person and do not believe this is person-centred or strengths-based. We believe the choice of tools should be at the discretion of the experienced clinicians that are involved with the assessment process, this of course would be best delivered within the context of multidisciplinary assessment.	
	ID866		The strong focus on differential and comorbid diagnosis is excellent and very important. Parents at this very early stage of their journey are looking for guidance to help with decision-making for possible interventions. Providing a differential diagnosis in the absence of Autism Spectrum Disorder, or a comorbid diagnosis when Autism Spectrum Disorder is present, is an important initial aspect of evidence-based intervention planning. The question of which clinician(s) are in a more clinically informed position to make these diagnostic decisions is unclear. As mentioned previously, adequate differential assessment and consideration of comorbid conditions would be inadequately done by a sole clinician. We think it is important to consider the lens through which each clinician views presenting issues, and that this lens is invariably one of the factors which will affect "tier 1" diagnosticians in deciding whether a child is "obviously" autistic or not. This would then affect the quality of the differential and comorbid diagnostic considerations.	Thank you for this helpful feedback. We believe the structure of the revised Guideline addresses this helpful comment. The 'Overview of Major Amendments' chapter.
	ID867		Should we still be advocating that parents are still able to access the support of an Autism Advisory service, as an	The Guideline makes recommendations for immediate referral for support services if/when functional impairment is identified.

			independent body that could act to link parents in with reputable services in the community, so parents could make a well-informed decision about what is the best fit for them?	It is the discretion of the individual clinician (or clinical team) as to where clients are referred to, noting that the Guideline makes recommendations regarding managing conflicts of interest (Section 7.4).
	ID868		Section 11.1 - There is no clear definition of which member of the diagnostic team should be providing the formal feedback session. We are of the understanding from your document, that the person conducting the functional assessment may not have been part of the original diagnostic team. The question remains, who is the best person to provide feedback? The functional assessment should really be driving the intervention; is that of higher priority to discuss with the individual and the caregiver, than the diagnosis itself? To us, it makes more sense that the person conducting the functional assessment is one of the members of the diagnostic team. We feel quite strongly, based on our experience, that not all medical practitioners will be as well versed on best practice treatment methods for individuals with Autism Spectrum Disorder, or as aware of all of the agencies and programs available in the community. Often, psychologists can be better able to provide all this information given that their training is centred around a scientist-practitioner model and that they should have a broader knowledge of evidence-based psychosocial/emotional/behavioural practices.	Additional clarification was added under the Communication Style section: “It is recommended that findings from the ASD assessment be communicated by at least one member of the Consensus Diagnosis Team to the client …”
	ID869		We were of the understanding that the purpose of the NDIS was for individuals to make their own decision about priorities and goals, and up until this point, we have experienced that some planners have not been open to receiving formal recommendations set by trained professionals. We welcome, in section 11.2, the suggestion that highest priority support needs of the individual and related goals are being set by the trained professional	Thank you for this feedback.

	ID870		The consultation process has been time restricted and made difficult by the manner in which the CRC has segmented the documents and the requirement to request documents via a separated portal. This process will have deterred some contributors and for others, will have presented a barrier to access due to the variability of ICT skills and willingness to disclose personal information to the CRC. In the first instance, I would like to propose that your presentation and dissemination of the information has been less than optimal. In the spirit of openness with your effort to encourage community engagement, I look forward to the CRC publishing all the submissions.	We thank you for providing feedback. All submissions will be made public. We note an extensive consultation was undertaken as part of this project. Information about this was provided in the original Guideline, and has been retained in the revised version.
	ID871		In responding to the draft guidelines, it appears the CRC has proposed that the existing diagnostic process is fundamentally flawed. I respectfully ask the CRC to provide evidence for this. That the medical paediatric and psychiatric clinical specialists require additional diagnosticians in the form of allied health professionals. Again, I ask the CRC to provide evidence for this. In relation to the notion there is diagnostic variability at a national level, I ask the CRC to provide this evidence. If there is diagnostic variability, this will be an artefact of access in metropolitan, rural and remote Australia. With regard to the technical tables, I have significant concerns about the implementation of the model. There is a lack of coordinated processes, a significant cost burden and the question whether and how these proposed changes would bring “value for money”.	Thank you for these comments. The rationale for the development of these guidelines was provided in the original Guideline, and has been retained in the revised version.
	ID872		The model is onerous and from a costing perspective will add a significant financial strain to the existing burgeoning welfare bill.	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading. • Cost implications of the assessment model recommended in the Guideline • Practice points for clinical, research and policy settings

	ID873		The existing system is adequately structured. The utilisation and coordination of the existing community health and medical services would propose a cost and time efficient model. The child and maternal health services (birth to 3.5yr), the Medicare PIP and the PNIP facilities which are already in situ with in accredited general practices and the Aboriginal Torres Strait Island health initiatives, can be easily tasked to provide comprehensive screening, data management and sharing within the medical online systems to optimise the diagnostic process. This existing system, together with paediatric and psychiatric specialists is a more robust system to address the diagnostic need of the ASD community including remote communities. The current funding within the Medicare system provides value without incurring huge financial blowouts that will result from the proposed changes. In addition, we can easily build within the nursing PNIP and medical sector, a thorough and integrated system to help streamline diagnostic services and integrate the allied health assessments in a cost effective and efficient diagnostic national service. This is easily accomplished given the platform for this integrated system is currently in situ, the My Health Record.	We believe that the revised assessment structure addresses these concerns. Please refer to the ‘Overview of Major Amendments’ chapter of this document.
	ID874		Finally, as part of the diagnostic process, individuals with autism and their families has the right to impartial, informed information about evidence based interventions and supports. This is the responsibility of the paediatric medical specialists.	Thank you for this comment. Additional content was added to the Content of Communication section: “The ASD assessment team play an important role in educating the client about strategies to identify and critique evidence based interventions.”
	ID875		In conclusion, the guidelines are not persuasive and lack empirical evidence for the need for change. I would encourage the Autism CRC to look closer at integrating and strengthening the multidisciplinary approach where the medical specialists are central and responsible for diagnosis and the psychology, speech and language pathology allied	Thank you for providing this feedback.

			health contribute additional assessments where additional clinical information is required to support the diagnosis as set out in the DSM-5.	
Manual Submission [152]	ID876	Not stated	I requested additional time to allow for a detailed response to the draft document. Had this additional time been granted, a fully scoped, modelled and costed comparison of the 2 models would have been presented.	Unfortunately, an extension of the timeline was unable to be provided, but greatly appreciate the comments you have provided here.
	ID877		There are concerns with tasking allied professionals with the responsibility of diagnosis given that the three disciplines: psychology, speech and language pathology and occupational therapy are not trained in the science of diagnosis and their training is of a generalist nature. The added issue is with the responsibility for diagnosis. There are professional, ethical and legal considerations, particularly where early diagnosis and intervention for autism has lifelong consequences. The allied health professionals will be exposed to significant risk of litigation should they get the diagnosis incorrect or delay diagnosis and where associated medical co morbidity is missed. Allied health professionals are not trained or part of the rigorous standards and specialist training (18 years of medical training up to 9 years of paediatric specialist training) the specialist general practitioners, paediatric and psychiatric specialists undertake. In contrast the CRC is prepared to accept allied health professionals to undertake specialist training via peer mentoring. I find this unacceptable and disturbing that CRC is prepared to trivialise the seriousness of diagnosis of autism and associated co morbidities.	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Professional Roles • Structure of the Assessment Process
	ID878		The draft diagnostic guidelines have over reached the diagnosis scoping. The inclusions of support assessments have no relevance to diagnosis. The intervention and support service provider undertake these assessments at intake. This is part of the personalised service plan. Support and functional assessments (Not to be confused with Functional	This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading. • Emphasis on the Importance of Functional Abilities in Referral for Supports • Structure of the Assessment Process

			Behaviour Assessment) prior to this are unnecessary and not part of the diagnostic criteria set out in the DSM--5.	• Cost implications of the assessment model recommended in the Guideline
Government of Western Australia: Department of Communities (Previously Disability Services Commission until 1 July 2017) [153]	ID879	Organisation – Professional experience	The most pressing issue with the draft guideline appears to be the lack of protections for consumers against the provision of a misdiagnosis as a consequence of a Tier 1 assessment. The content of a Tier 1 assessment represents a substantial step away from what is currently considered internationally as best practice in the diagnosis of Autism Spectrum Disorder. The very report referenced in the foreword of the draft guideline, to justify the development of national guidelines, indicates that international best practice for the diagnostic assessment for ASD, "should consist of a full medical evaluation, developmental or cognitive assessment, an assessment of language and adaptive skills and incorporate standardised measures of ASD symptomology"1 (pg. 15), a standard that a Tier 1 assessment (as proposed in the guidelines) is unlikely to meet. The limited rigour of the Tier 1 evaluation is so problematic because it is highly unlikely that the ascription of a diagnostic outcome through a Tier 1 assessment will be reserved for those individuals for whom the authors may well intend it. This is because there is a lack of objective guidance for diagnosticians regarding when a Tier 1 assessment should be considered sufficiently robust to deliver an accurate outcome. The threshold of "diagnostic certainty" proposed by the authors, gatekeeping the transition between a Tier 1 and Tier 2 assessment, is entirely subjective and completely contingent upon the competence and clinical ethics of each individual diagnostician. Unfortunately, it is likely to see less competent diagnosticians misdiagnose as a consequence of a lack of insight into their own limitations, and diagnosticians who may be influenced by pragmatic, but diagnostically irrelevant factors, will not be able to be held accountable by their peers. These difficulties in the essential architecture of the system	Thank you for this very helpful feedback. We believe the structure of the revised Guideline addresses these helpful comments. Please refer to the 'Overview of Major Amendments' chapter under the headings: • Structure of the revised assessment • Professional Roles

			lead Communities to be concerned that the practice the guideline will support will be a marked step away from established best practice standards in ASD diagnosis and will unduly expose individuals to the risk of negative outcomes as a consequence of misdiagnosis. In our previous submission we urged the authors that, "if a tiered system is to be established... that this is informed by sound empirical evidence, that the operationalisation of the guidelines is sufficiently detailed and clear to promote consistent application, and that mechanisms for the objective oversight of the system are included". Having reviewed the draft guideline and accompanying technical report and tables of evidence it appears clear that there is insufficient or inadequate operationalisation in key areas of the draft guideline to ensure that accuracy is maintained in the diagnostic assessment process. Communities urges substantial modifications to the draft guidelines prior to suggested implementation to prioritise the accuracy of the diagnostic outcome for the benefit of individuals and the integrity and utility of the diagnosis into the future. Please find expanded and additional feedback below provided	
	ID880		It may be appropriate to acknowledge the authors of the Missouri guideline who pioneered a tiered approach to the diagnosis of ASD and which has obviously greatly informed the architecture of the Australian draft guidelines.	Thank you for this comment. The development of the has been directly informed by extensive consultation with a range individuals, organisations, and professional association. We have been very careful to acknowledge all of these parties as appropriate.
	ID881		Clarity is requested regarding the intention of the Guideline in relation to current established best practice. It is noted that the draft guideline could be intended as a minimum national standard rather than a best practice guideline as reference is made to this in the foreword. Clarity is required as to whether the authors intend that the draft guidelines meet international	This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Consistent and Flexible Structure • Implementation and Evaluation of the Guideline

			best practice standards? Further, do the authors expect clinicians who practice with standards substantially in excess of the minimum standard articulated in the draft guideline to reduce the fidelity of their assessments to comply with the minimum standards proposed? Are clinicians encouraged to, where possible, exceed these standards and pursue international best practice standards? The forward urges national consistency in the diagnosis of ASD but does not establish that the value of this consistency outweighs the cost of lowering standards in some jurisdictions. The very marginal benefits for consistency across states are likely to be grossly outstripped by the potential for increases in misdiagnosis associated with a move away from what is considered international best practice. Whilst an author of the draft guidelines has stated publicly that people moving between states are placed in a position where they need to get another ASD diagnostic assessment to access services, this is inaccurate in the context of Western Australia and the context of access to disability related supports and services. Differences in standards across states are managed administratively through portability arrangements that ensure an individual accessing services on the basis of ASD in another jurisdiction can continue to access supports in WA without additional assessment requirements. This is not a cost of inconsistency across states and territories. The forward's focus on consistency across states neglects the central imperative of an ASD diagnostic assessment, that the right diagnostic outcome is achieved in order to best understand the individual. Rather than being motivated by consistency across states more emphasis in the draft guideline is needed on promoting consistently high standards for ASD diagnosis in jurisdictions where there are weak standards.	

	ID882		**3. Overview** We query whether recommendations based on a CBR of 4, or even 3, should be included in the guidelines given that there is such poor consensus and limited support for them.	The revised Guideline no longer contains any consensus based recommendations with a grade of 4. Several consensus based recommendations with a grade of 3 were retained as there was compelling reasons supplied by numerous experts, however these recommendations have clear caveats to mitigate potential risk resulting from uncertainty.
	ID883		**4.1 Individual and Family Centred and 4.3 Strengths Focused** We recognise that the guiding principles of being individual and family centred and strengths focused may be an ideal and something to work towards in practice however it should be acknowledged that current best practice tools do not support this (e.g. ADOS and ADI-R). To be strengths focused a diagnostician also has to know the individual well and have completed a comprehensive assessment, which is difficult to achieve if the diagnostician is completing a Tier 1 assessment only. There are also only very limited examples throughout the guidelines of how to do this in practice. The case study examples provided in the guideline appear to meet only a very basic level of a strengths focused approach and individual and family centred practice. Is it the intention of the authors that the examples demonstrate the degree of expected application of the above principles?	Thank you for this feedback. We believe the structure of the revised Guideline addresses this comment. Please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Use of ‘Standardised’ Instruments. Further case studies will be added to the web resources over time to facilitate the implementation phase.

	ID884		4.4 Evidence Based In reference to the recommendation which references evidence table 4 it states that an ASD assessment should be "... based on a review of the best available research evidence" pg. 11. We recognise that there needs to be a sound research base and reiterate that tenants of good clinical practice should be encouraged as well. Where a clinician or service provider considers that the evidence base would indicate a higher level of rigour in assessments than is recommended in the guideline does the principle of evidence based outweigh the specific operationalisations described in other sections of the draft guideline?	The 'Overview of Major Amendments' chapter: • Consistent and Flexible Structure
	ID885		Please clarify the intended breadth of the term clinical management ("What are the key strengths and challenges that inform future clinical management?" pg. 12). Does this refer to medical management or how broadly is it to be applied. Functional assessment is often considered not to inform clinical management (i.e. diseases, disorders or impairments in the ICF framework) but the provision of supports to assist functioning (more often categorised at the level of activity limitations and participation restrictions in the ICF framework).	The term "clinical management" has been amended to the broader term "service delivery" throughout the Guideline.
	ID886		**6.2 Referral for an Assessment of ASD Concerns** There is limited guidance provided for Referral for an Assessment of ASD Concernss. Whilst it's noted that they do not need any specific professional background it is unrealistic to expect that should the Referral for an Assessment of ASD Concerns also be a consumer that they would have the requisite knowledge and skills required noted under 6.2, e.g. knowledge of typical development and signs and symptoms of ASD. Is it the intention of the authors that consumers be exempted from these recommendations?	This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Referral for an Assessment of ASD Concerns

	ID887		Evidence Table 38 appears to indicate that the professional informant is to have a quasi-diagnostician role as it is suggested as a compromise between a single or multiple diagnostician's being involved at Tier 1. If the professional informant's role in the diagnostic assessment is the provision of information regarding an individual in the context of their own sphere of competence, then they do not represent the additional diagnostic opinion which Table 38 appears to be suggesting they are intended to provide. If the intention is that the professional informant is to provide a diagnostic opinion, then it is likely that the majority of individuals represented within the professional informant category would not reasonably be expected to have the knowledge or experience or competence to do so. Substantial clarification and reconsideration regarding this role is required.	Based on feedback received, the specified role of ‘professional informant’ has been omitted from the revised Guideline. However, the Guideline still emphasises the importance of collecting information from a variety of sources, and from individuals who observe the client in community settings.
	ID888		The likelihood of misdiagnosis due to insufficiently competent diagnosticians is only increased by the breadth of professional backgrounds endorsed to be assessors and the ambiguity of the guidelines for the training and experience of these potential diagnosticians. The insufficient clarity will impact on a prospective diagnostician's ability to self-assess their experience, and their peers' and regulators' ability to hold individual diagnosticians accountable for their self-assessed competence.	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Professional Roles • Structure of the Assessment Process
	ID889		**6.4 Diagnostician** There are a number of issues which need to be considered regarding the suggestions for diagnosticians. A wide breadth of professional backgrounds have been included, such as occupational therapists and neurologists. It is noted that exceptionally poor agreement was achieved regarding the role of both Neurologists and Occupational Therapists as diagnosticians (CBR-3).	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Professional Roles • Structure of the Assessment Process

			It is not clear as to why individuals with professional backgrounds with such low levels of evidence supporting their role as a diagnostician have been recommended as diagnosticians let alone endorsed to be the only diagnostician involved in an ASD assessment. The tables of evidence appear to contraindicate the outcome described in the guideline. For example, in the case of Occupational Therapists, evidence table 14 the author's summary of the evidence states "... lack of agreement in relation to this being as a single Diagnostician." Similarly, evidence table 11 (for Neurologists) states, "Limited published and community consultation evidence support that neurologists are suitably qualified to conduct ASD diagnostic evaluations, with some community consultation evidence specifically stating they are not appropriately skilled in Australia". The recommendation provided by the authors in this case appear in contrast to their own evaluation of the evidence available. The inclusion of a wide range of diagnostician backgrounds - each endorsed to give a diagnosis of ASD at Tier 1 on the basis of their own perception of certainty (which is vulnerable to their own insight into their limitations of practice; clinicians who don't know what they don't know) is likely to contribute to an increase in the rate of misdiagnosis. The breadth of assessors able to diagnose at Tier 1 appears in contradiction to the intention of 9.4 which states that, "... a diagnostic decision can be reliably made with certainty by a limited number of experienced members of a multidisciplinary team...". The document appears to be internally inconsistent in this matter.	
	ID890		**6.4.2 ASD Specific Expertise** It is unclear how the standards of expertise for diagnosticians will be overseen and enforced, and without this the standards may be ineffective in ensuring that the knowledge and	Please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Accreditation and Regulation

			experience intended by the authors will be present in some diagnosticians. The learning approaches described and required for diagnosticians to comply with are insufficiently operationalised (i.e. "directly relevant to ASD diagnostic evaluations") to ensure individual diagnosticians are able to reliably self-- assess their compliance with the guidelines	• Practice points for clinical, research and policy settings
	ID891		**6.6 Professional Informant** Clarity is required regarding the intended role of the professional informant. The draft guideline appears to confuse the role of diagnostician and informant. An informant is primarily a source of information regarding an individual. Their qualifications and experience in relation to the diagnostic question is secondary to their familiarity with the individual and their expertise in their own area of practice. Unless it is the intention that the responsibility for diagnostic decision making is shared with the professional informant there is no need to evaluate the professional's training and experience in ASD as the information provided by any informant should be interpreted by the diagnostician to inform the diagnostic question. The professional informant should not be placed in a position where their opinion on the diagnostic question is more important than the information they are able to provide regarding the individual.	Based on feedback received, the specified role of ‘professional informant’ has been omitted from the revised Guideline. However, the Guideline still emphasises the importance of collecting information from a variety of sources, and from individuals who observe the client in community settings.
	ID892		**6.6.2 Professional Informants ASD specific expertise** Please clarify the inconsistency regarding the qualifications or experience required to be a professional informant. In section 6.6.2 it suggests that informants may obtain or maintain their ASD knowledge and experience in range of ways, including but not limited to a university qualification. However, the CBR	Please refer to the responses to similar comments made by this respondent.

			for that section, which references evidence table 27, suggests that the informant should have a 4-year full- time equivalent degree. If it is the latter it is considered that those involved with young children who may have considerable knowledge about the child's behaviour and also about typical development and atypical development in young children, such as education assistants in schools and childcare carers, would not be able to be professional informants.	
	ID893		**7.2.3 Telehealth Setting** It is noted that observations across multiple settings is essential in order to complete a comprehensive ASD assessment. However, attention should be drawn to the recommendations regarding a telehealth setting. Clarity is required regarding what is considered to be exceptional circumstances that justify the use of telehealth. There is some ambiguity to the guideline such that it could be interpreted that all individuals who live in rural or remote areas can be assessed by telehealth methods. Communities is committed to principles of substantive equity as they apply to individuals in rural and remote areas. Communities provides publicly funded assessments in rural and remote areas, expending substantial resources ensuring that individuals in rural and remote areas have access to high quality diagnostic assessment services within the same timeframe as individuals in metropolitan areas. If assessments by diagnosticians are completed via telehealth only, this will be a marked step away from best practice standards and likely contribute to misdiagnosis. If telehealth is implemented broadly then it is likely to lead to a disproportionate rate of misdiagnosis for individuals in rural and remote areas, contributing by way of the implementation of inappropriate interventions specified by the inaccurate diagnosis, to poorer long-term outcomes for individuals in regional and remote locations. Until such time as diagnostic protocols reach a well-	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Telehealth

			established level of evidence for application in telehealth settings, the core components of an ASD assessment should follow international best practice standards which do not endorse this guideline. The evidence provided to support this recommendation is very weak.	
	ID894		**Recognition of Signs and Symptoms of ASD** Clarification is required regarding the responsibilities when the consumer is the Referral for an Assessment of ASD Concerns. The recommendation on pg. 30, which references evidence table 33, only provides information about how a professional Referral for an Assessment of ASD Concerns should weigh up the referral information using their clinical judgement. It is unclear what process is expected of a consumer as they are unlikely to have clinical judgement to rely on.	This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Referral for an Assessment of ASD Concerns
	ID895		A tension exists between the DSM-5 and the requirement expected of the Tier 1 assessment. It is hard to see how a Tier 1 assessment will provide sufficient evidence to meet the DSM-5 requirements including severity levels and specifiers. The lack of a need for assessments for cognition and language at Tier 1 may undermine a diagnostician's ability to comprehensively rate the DSM-5 criteria.	Thank you for this very helpful feedback. We believe the structure of the revised Guideline addresses this helpful comment. Please refer to the 'Overview of Major Amendments' chapter under the headings: • Structure of the Assessment Process
	ID896		**9.3 Diagnostic Evaluation Structure** There is no objective guidance as to when an individual is likely to need a Tier 2 assessment. What characteristics of the consumer or the context should indicate further assessment are absent from the guideline. Instead the guideline suggests that diagnostic certainty should be achieved and if this is achieved by a diagnostician at Tier 1 then, regardless of the complexity of the diagnostic	Please refer to the 'Overview of Major Amendments' chapter under the heading: • Progression from Stage 2 to Stage 3

			decision, no further assessment is needed. The lack of objective guidance regarding when an individual is suitable for a Tier 1 assessment is one of the most pressing weaknesses of the guideline as it neglects that the very clinicians who lack insight into their own shortcomings are the very same that require the support of a multidisciplinary team to arrive at an accurate diagnostic outcome. For example, a diagnostician with limited insight into the range of potential differential diagnoses that may generate the expression of ASD-like features in an individual may be less likely to continue to a more comprehensive assessment instead erroneously attributing the features to an ASD and making a diagnosis of such at Tier 1 without the supports of additional diagnosticians. Further, the subjective nature of the standard for diagnostic outcome at Tier 1 "diagnostic certainly" is likely to have differential effects on clinicians with varying levels of competence, and conscientiousness leading to outcomes in the opposite direction to those intended by the authors regarding the use of clinical resources. For example, upon reflection on the suggested criterion of "diagnostic certainty" a conscientious diagnostician may find themselves proceeding to a Tier 2 assessment for more assessments than may be required, leading to the undesirable outcome of increases in clinical time allocation and costs for individuals with obvious presentations of ASD. More objective guidance regarding the applicability of each tier of assessment, ideally based on a level of evidence that exceeds consensus opinion, is needed.	
	ID897		**9.4.1 Professional Involvement** The recommendation that a single diagnostician in conjunction with a "Professional Informant" is sufficient for the diagnosis of ASD appears to be poorly supported by the evidence provided and summarised in evidence table 38. It is unclear if any	Thank you for this feedback. We believe the structure of the revised Guideline addresses this comment. Please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Structure of the Assessment Process

			systematic consultation was made regarding the concept of a professional informant as it appears conceptually challenging to understand how the opinion of an individual without sufficient knowledge, understanding and experience of ASD to be a diagnostician is considered to hold a casting vote in the ascription of a diagnosis of ASD. No evidence is provided regarding even the opinion of the steering committee or the participants in the Delphi survey regarding the effectiveness of this individual in increasing the accuracy of the diagnosis or the inclusion of this individual as a central construct in the guideline. The novelty and lack of evidence regarding the professional informant's efficacy in supporting accurate diagnosis contraindicate the role as a suitable solution to the disagreement between endorsing a single diagnostician or multiple diagnosticians. It is unlikely that mandated inclusion of a single professional informant is likely to be effective in protecting against the misuse of the Tier 1 pathway.	
	ID898		9**.4.3 Information Collection** Clarity is required regarding the intention of the authors in relation to whether a diagnostician will interact with or observe the consumer. The formatting and grammar of the recommendation contributes to ambiguity on this important matter.	The means for information collection in Stage 2 and 3 (i.e. the diagnostic evaluation stages) are now presented as a list with the term “and”, indicating all means are required. This includes “observation of the individual undergoing assessment” at both stages.
	ID899		**9.4.4. Diagnostic Decision Making** Clarification is required regarding "Figure 5: Diagnostic Algorithm for DSM-5". Is it the intention of the authors that a bottom up (Autism-by-numbers) approach to diagnosis be endorsed as part of the 'guideline' as appears to be indicated if diagnosticians follow the procedure documented in the DSM-5 'algorithm' supplied? If so what evidence	Based on feedback received, Figures 5 and 6 have been omitted from the revised Guideline.

			is there to recommend this approach particularly in the light that this kind of "mechanistic" or "cookbook" approach to diagnosis is specifically cautioned against (see DSM-IV-TR® "Use of Clinical Judgement" xxxii). Figure 5 inaccurately reflects the content of the DSM-5 Criteria in a number of ways. In relation to DSM-5 criterion D, Figure 5 prompts the diagnostician to question if there is significant social, occupational or other impairment. However, the DSM-5 requires that the symptoms of ASD cause the functional impairments rather than these simply co-occurring. In relation to DSM-5 criterion E, Figure 5 asks if the symptoms are best explained by ASD. This misrepresents the DSM-5, which requires that the symptoms are not accounted for by Intellectual Disability or Global Developmental Delay.	
	ID900		Figure 5 makes no reference to severity levels or specifiers mandated by DSM-5. Is it the intention of the authors that these are not addressed in the process?	Thank you for this comment, and we apologise for this omission. Severity levels and specifiers have been added to the revised Guideline.
	ID901		**10. Functional and Support Needs** Whilst it is agreed that considering functioning is important within an ASD assessment this is required of any diagnostician in rating criterion D of the DSM-5. The inclusion of a specific functional and supports needs assessment does not further inform the diagnostic question of whether the individual has ASD. As stated above this diagnostic question should remain central to the diagnostic guidelines. The functional and support needs assessment is likely to be resource intensive and may encroach upon the role of other stakeholders that already provide this service and have the expertise in doing so, such as Autism Advisors, intervention providers, Planners and Local Coordinators. It adds a resource burden to the assessor at the time of the diagnostic	Please refer to the ‘Overview of Major Amendments’ chapter under the following heading: • Structure of the Assessment Process Please also note that the revised Guideline includes a recommendation regarding costs for ASD assessments. Please refer to the ‘Overview of Major Amendments’ chapter under the heading: • Practice points for clinical, research and policy settings

			evaluation and mandates an impractical level of follow up for diagnosticians by way of repeated regular functional assessments. There is no guidance regarding the frequency of the repeated functional assessment and no guidance as to how this clinician interfaces with intervention providers who may be in the best place to complete this assessment in the future. Additionally, for how long should a functional and supports needs assessor be involved if a consumer is found not to have an ASD. The lack of guidance could see a support needs assessment completed regularly for an individual where there is no rationale or organisational mandate to have continued involvement with the consumer. It will possibly lead to greater cost for individuals who are self-funding an ASD assessment.	
	ID902		The independence of the functional and support needs assessment from the diagnostic assessment in relation to the assessors and the time at which it is completed described in the guideline raises the question as to its inclusion as a core component of a diagnostic assessment guideline for ASD.	Please refer to the 'Overview of Major Amendments' chapter under the following heading: • Structure of the Assessment Process
	ID903		**10.3.3 Information Collection** Clarity is sought on the following: • How information is suggested to be collected regarding functional abilities given the "and/or" wording.	The term "and/or" was replaced with "and" for the means for data collection at all stages, with the terms "as required" and "if applicable" added specific means if they are not necessary in all cases.
	ID904		• How the ICF Core Sets for ASD are expected to be used given that they do not provide a normative reference, but simply condense the list of applicable ICF codes into those most relevant to an individual with ASD. It is also somewhat concerning that this is being recommended as a tool, yet they have not yet been released. Preliminary	Given the ASD core sets are not yet publicly available, the revised Guideline has omitted reference to these. These are likely to be included in future revisions of the Guideline. Recommendations relating to specific instruments that measure functioning have been removed from the Guideline, and information about resources will instead be located on the Guideline webpage to enable updates to occur more readily.

			information regarding their use also suggests that they are quite time-consuming.	
	ID905		• Whether the primary recommended tool should be the WHO-DAS 2.0. According to the tool's manual "WHODAS 2.0 has basically been developed for adult populations.... at present, we cannot recommend its use in subjects below the age of 18 years". We query whether this should remain the primary recommended tool given that the vast majority of individuals being assessed for ASD will be children.	Recommendations relating to specific instruments that measure functioning have been removed from the Guideline, and information about resources will instead be located on the Guideline webpage to enable updates to occur more readily.
	ID906		• If the functional and supports needs assessment is expected to be completed regardless of if the child receives a diagnosis of ASD or not?	Yes, the revised Guideline describes a process in which the comprehensive functional and support needs assessment is to be conducted for every individual. Please refer to the ‘Overview of Major Amendments’ chapter under the following heading: • Structure of the Assessment Process
	ID907		**11.2 Content of Communication** A declaration of compliance with these guidelines, which are at times internally inconsistent and insufficiently operationalised, may be worse than not having one as it affords pragmatic clinician's acting outside the bounds of their genuine scope of competence a defence against their poor clinical practice.	This statement has been omitted from the revised template.
	ID908		**12.1 Age** Please clarify: Whether it's expected that children are to be compared to typically developing peers of the same age or compared to	It has been clarified throughout the Guideline that children being assessed are being compared to both children of the same chronological age, as well as children of the same developmental age

			peers of the same cognitive or developmental level. Contradictory statements in regard to this are provided throughout this section.	
	ID909		Is it expected that only the frequency and variety of behaviours are considered (i.e. "... reduction in the frequency and variety of a particular behaviour...." Table 10, pg. 58). Surely the important concept here is the quality of the behaviours, which is not included.	These tables are provided as a guide for key behaviours, and not an exhaustive list. We have now clarified the intent of these tables in Section 12.1.
	ID910		The inclusion of Pathological Demand Avoidance as a recognised subtype of ASD. It appears that is only recognised in the UK and it is not recognised as a disorder in the DSM-5. As such, it is questionable whether this be included in the guidelines and if included is that providing tacit endorsement of its inclusion into the autism spectrum in Australia. If it is intended that this is included in ASD diagnosis in Australia, then can some evidence of this constructs validity be provided?	Please refer to the ‘Overview of Major Amendments’ chapter under the following heading: • Pathological Demand Avoidance
	ID911		What is meant by the statement "... to provide an adequate evaluation of mental health functioning" (Table 12, pg. 63). Caution is required in suggesting that is provided without clarifying who has the clinical skills and abilities to complete this such that the evaluation is useful.	This sentence was amended to provide greater clarity and guidance: “It is critical that if mental health symptomatology are present, these are evaluated by a clinician with expertise is diagnosing mental health conditions, such as a psychiatrist or clinical psychologist.”
	ID912		As noted under the telehealth section the expectations of good practice need to apply to regional and remote locations. It should be reiterated here that it should not be acceptable that the diagnostic outcomes be compromised for people	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Telehealth

			living in rural and remote areas by way of less well validated diagnostic protocols.	
	ID913		There are considerable concerns around Table 14. There appear to be a number of errors, most notable of which are Rett syndrome and Down syndrome not being listed as potential differential diagnoses.	We believe this comment may be in error. Rett and Down Syndrome were listed in Table 14 of the original version of the Guideline, and these have been retained in the Web Resources.
	ID914		Furthermore, only formal diagnoses of other disorders are listed. This seems to oversimplify the complex issue of differential diagnosis as in many cases, particularly with young children, they may not have been diagnosed with a disorder as yet. This is likely because they do not meet diagnostic criteria due to their age, or, arguably, they should not be diagnosed at a young age. Diagnosticians that do not have the necessary expertise in a range of differential concerns may then use this table and consider that because a child does not have a formal diagnosis that the concern is not present without having the awareness that the concern may still exist. It is important that before a diagnosis is formalised that if the diagnostician does not have the expertise to adequately give a differential diagnosis then further clinical expertise needs to be sought. It's not clear from the guidelines that this is to be completed prior to finalising the diagnostic assessment.	We believe that the revised structure addresses this concern. Please refer to the 'Overview of Major Amendments' chapter under the following heading: • Structure of the Assessment Process
	ID915		**8.3 Making and Acting on Referral for an ASD Assessment** Clarity is required as to the process by which referrals will be screened, who will complete this and the oversight of the acceptance of referrals. It is stated that the assessment coordinator receipts the referral and there is reference to them checking it for completeness. However, clarification is sought	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the headings: • Referral for an Assessment of ASD Concerns • Coordinator

			as to whether the referrals are expected to be reviewed to determine if there is justification for an assessment to occur. It appears there is no role of screening of referrals and no indication of who would take responsibility for this. If we assume that the assessment coordinator would screen the referrals this is further complicated if an administrator has taken the role of the assessment coordinator. There is significant concern that an administrator does not have the clinical prerequisite skills to review a referral and thus it is not within the scope of their role to be able to determine if an assessment should go ahead. Furthermore, if as stipulated any individual or family can self-refer and in this case the assessment Coordinator Role is also filled by an administrator this could lead to many people going to Tier 1 assessment when this is not warranted as there is insufficient screening of the referral. This could lead to an inefficient use of clinical time and higher chance of false positive assessment outcome/misdiagnosis.	
	ID916		15 ***Case Studies*** Tier 1 Diagnostic Evaluation (ASD Diagnosed) Clarification as to whether it's expected that Tier 1 assessments are completed across two sessions with the diagnostician as the case study would suggest. Attending two sessions places additional burden on the family or individual being assessed (e.g. if they are required to pay for two sessions with a diagnostician who is a private practitioner, travel time etc). Furthermore, in this case of a "frank presentation" the assessment process is not tailored to this individual as has been stated is the intention behind a Tier 1 assessment. In fact, the burden placed on the family in attendance at these assessment sessions does not differ greatly from what is occurring in more rigorous assessments such as those currently in place in WA or compared to a Tier 2	New case studies have been generated based on the revised Guideline.

			assessment where individuals would have to be seen over two sessions. Clarity is also required as to what constitutes a community setting. In this case the mother provided information about the individual at home which was considered community setting 1. The mother also provided information about what has been reported to her about the individual's behaviour at day-care, which formed community setting 2. Please clarify if it is the intention that information from a community setting can be provided by second-hand report of the consumer, their parents and carers. We urge that caution be exercised in seeking information from only one person in regard to two community settings and particularly when they are only providing second-hand reporting of one of the settings. Tier 2 ASD Diagnostic Evaluation (ASD Diagnosed) Please clarify regarding the role of the professional informant 1 in this case. The case study suggests that the GP professional informant provided a report to the diagnosticians regarding the individual's health. It is unclear if the assessors also sought information about the individual's behaviour relevant to the symptoms of ASD from the GP and whether the diagnosticians spoke to the GP directly or only reviewed written information. Is it the intention of the authors that the professional informant does not provide information specifically related to ASD symptomatology to assist the diagnostician in the rating of the diagnostic criteria?	
	ID917		Evidence Tables It remains unclear how the varying 'evidence' is combined to create the summary of evidence and then the recommendations. At times there is a disconnect between the evidence and the recommendations (see above feedback	The Evidence Review section of the Guideline, and the Technical Report, have been amended to make this process clearer.

			regarding Neurologists and Occupational Therapists as diagnosticians). The lack of transparency regarding the methodology leading to the proposal of each consensus based recommendation erodes confidence in the draft guideline. There is no complete or systematic accounting for the evidence from the systematic review, the viewpoint survey or the Delphi survey. Information from the submission and workshops are hard to interpret because it is unclear what proportion of views are represented by each comment. This undermines a readers' attempts to independently interpret the evidence provided for the draft guideline.	
	ID918		**Report Templates** Review of the ASD Diagnostic report template was hampered as some information was not made available for evaluation due to the format of the document i.e. (it listed "Select" or "Choose and item" in some cases yet there is no information about what items are in these lists). On page 8 there is a section outlining the identified strengths of the individual being assessed with the suggestion that this aligns with a strengths-focused approach. We express concern that a list of a few identified strengths is considered in line with a global strengths based approach to assessment and clarification is sought as to whether and how the strengths based approach is to be evident in other sections of the diagnostic report. Clarity is also sought as to why the support needs table is repeated in the report template.	The report templates have been adjusted to align with the revised Guideline, and these suggestions have been incorporated.
	ID919		By identifying that the intended evaluation of the guideline will assess the accuracy of the diagnoses ascribed under the guideline, the authors identify that there is likely an impact on diagnostic accuracy. Why has a guideline with potentially	The Guideline has been developed to optimise equity of access to diagnostic services for all Australians, regardless of age, gender, cultural background, socioeconomic status, or geographical, as well as to ensure fit with the broadest

			substantial negative impacts on diagnostic accuracy been proposed without there being sufficient confidence/assurances provided prior to the release that it will not have deleterious impacts on accuracy? Whilst it is clear that the authors intend to begin a program of research to evaluate the guideline, the impartiality of the evaluation of the guidelines may be jeopardised if members of the same organisations who constructed the guideline take the lead role in evaluating its performance. It is noted that no service providers based in Western Australia were included on the steering committee. The technical report does not provide results for the systematic review of literature, the viewpoint survey or the Delphi Survey in any systematic way. Whilst some results are provided in the Tables of Evidence there is insufficient information for an independent reader to form an informed view of the whole of the results and subsequent recommendations. Clarity is requested regarding the intention of the column titled, "Systematic Review" in "Appendix A - included Studies". Is it a summary of the results found or reference to the most salient features of the study? Was only a single theme examined from each reference? If it is a reference to the key areas of study or the salient features of the results, then there are concerns that it has missed important other findings described. For example, Taylor, 2016 has been categorised under the, "Time Factors" label however this paper comments far more broadly than on time factors. This paper identifies important considerations for the architects of a draft guideline. It identifies that clinicians often don't meet international best practice. That diagnosticians will diagnose ASD even when the criteria are not met (often for the sake of acquiring additional resources for the consumer albeit without regard to the accuracy of the diagnosis). It describes higher rates of diagnosis and lower rates of multidisciplinary teams in the private sector. It also does not	possible range of existing clinical health systems. We would like to emphasise that the Guideline does not preclude jurisdictions placing additional recommendations on top of those presented in the document.

			demonstrate that states with higher standards for ASD diagnosis have higher waitlists for assessment or are diagnosing ASD later. In relation to this matter, Bent and colleagues review of the national Helping Children with Autism (HCWA) data appear to demonstrate that WA has the lowest age at diagnosis of ASD compared to other states and territories2. Appendix A does not provide confidence that the breadth of findings available in each study have been comprehensively addressed.	
	ID920		Clarification is required regarding the responsibilities of the Research Executive.	The Research Executive Committee Terms of Reference are contained in the Technical Report.
	ID921		The Technical Report indicates that one of the primary responsibilities of the research executive is to "Ensure the development of the guideline is consistent with best practice". Clarity is required as to whether "best practice" in this context relates to the guideline development process or the content of the proposed guidelines. If indeed the requirement for best practice is related to the content, then it is either by its own admission (in the case that further clarification identifies that the guideline is a minimum standard) or objectively (when compared to best practice guidelines) not in line with current conceptualisations of best practice.	This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Consistent and Flexible Structure
Manual Submission [154]	ID922	Organisation – Professional experience	Key elements of the *guideline* we support include: 1. Recognition of the importance of examining function and support needs for people diagnosed with autism spectrum disorder (ASD). Two of the most important predictors of outcome are language use/competence and cognitive abilities. Understanding a person's abilities informs intervention, behaviour assessment/management and parenting, amongst other things;	We greatly appreciate this helpful feedback.

			2. Recognition of the importance of the person and the family's experience of the assessment process and the need to be supported through it; 3. The pragmatic two-tiered approach to diagnosing ASD, with a more extensive diagnostic assessment and experienced multidisciplinary team provided for those whose diagnosis is more complex; 4. Recognition that strengths and areas of difficulty can lead to a more nuanced conversation about the future and how to support the person being diagnosed with ASD; and 5. The importance of working collaboratively across disciplines. We acknowledge that variations are likely to exist in approaches to the diagnosis of ASD across Australia, and that there is inequitable distribution of valuable resources for diagnosis and intervention. We support the development of a national minimal standard for diagnosis of ASD that is embedded in a developmental, family-centred, lifespan and ecological approach.	
	ID923		Areas about which we have concerns include: These *draft guidelines* go beyond a minimum standard by introducing a range of complex and intricate new requirements for involved professionals and the diagnostic process. As a result, we are concerned that the *draft guidelines* will be unlikely to address inconsistencies in current approaches to diagnosis and will introduce new issues with uncertain impact. This raises the possibility that if implemented in their current form, the *draft guidelines* may lead to further variation in practice and add to the confusion in the field of ASD diagnosis and intervention. Furthermore, the resource implications of these *draft*	Thank you for these comments. Our responses are present in response to comments below

			guidelines can be expected to be substantial, and warrants serious consideration. This includes aspects of proposed modifications to service delivery, training and monitoring. It contains a large number of qualifications and specifications that have the potential to significantly adversely affect waiting times and current diagnostic services. Overall, the *draft guidelines* are very detailed and complex to read, and so an easy read format or summary that captures key points should be considered. It is also important that any guideline recommendation can be meaningfully included within local procedures and policies.	
	ID924		**Autism Spectrum Disorder is a neurodevelopmental disorder** ASD is a neurodevelopmental disorder with reported prevalence of over one in one hundred children. Though some aspects of ASD have been well characterised, there remains much about the causes, developmental trajectory over time, variation in presentation from one person to another, between genders and over the lifespan and effective intervention and treatment that are yet to be fully elucidated. Adding to the complexity of diagnosis and intervention is the common co-occurrence of other conditions, such as cognitive impairment, which may have more impact on development and achievements than ASD itself. Presentations and trajectories of neurodevelopmental disorders in the very early childhood years can be difficult to accurately characterise. The nature of the intervention best suited for the child's needs are not consistently informed by diagnosis alone, but by a range of factors including family and cultural issues, general development and additional health concerns. These factors have resulted in a rigid categorical approach to diagnosis of ASD being less than helpful in some cases, and a growing preference towards a more extensive diagnostic formulation that captures a range of salient issues. It also implies that exclusion of an ASD diagnosis at one point in time may need	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Guiding principles • Structure of the Assessment Process

			to be revisited if concerns remain or increase. This must be clearly articulated in the *draft guidelines*.	
	ID925		We strongly support a diagnostic formulation that focuses on developmental and functional skills and ensures that appropriate support and intervention are provided to the person, and their family, irrespective of the specific diagnosis. This approach is not clearly apparent in the *draft guidelines*. Whilst the diagnosis of ASD can provide useful information about the types of interventions and likely causes of difficulties that may be helpful for the person, a precise categorical diagnostic approach for ASD may not be feasible or necessary for a particular individual.	Thank you for this comment. The revised structure provides far greater emphasis on the importance of a comprehensive functional and needs assessment in providing the foundation for a diagnostic evaluation. For further information, please refer to the 'Overview of Major Amendments' chapter under the heading: • Emphasis on the Importance of Functional Abilities in Referral for Supports • Structure of the Assessment Process
	ID926		This is an important clinical guideline for children and young people presenting with developmental concerns that may be part of an ASD, and as such careful and systematic analysis of the literature is vital. We hold concerns about the strength of the evidence base, its interpretation and the use of a modified approach to the NHMRC guidelines approach that is not well defined.	Thank you for this feedback. As part of the Guideline development process, the methodology was revised by a specialist reviewer nominated by the National Health and Medical Health Research Council. This reviewer provided favourable reviews of the methodology (see recommendations at the end of this document). Further methodological reviews will be undertaken by the NHMRC in early 2018.
	ID927		Other specific changes that could improve this section include: • An adjustment to the use of the term "identity first" (i.e. autistic people), as it is at odds with the preference of parents and professionals in the disability and childhood sector, where great efforts are made to acknowledge the personhood first and foremost; and	Thank you for this comment. The use of identity first language in the Guideline was based on feedback from the autistic community and other stakeholders. Nevertheless, it is critical that individual practitioners use their judgment as to the most appropriate language for their clients and patients. This has now been emphasised with the following statement on page 8: "We note that identity-first language (e.g. autistic children and adults) is the preferred language of many people on the autism spectrum and their parents {Kenny, 2016). We therefore use this terminology to describe the children and families in this guideline. However, it is recognised that practitioners may have their own preferences in terms of terminology, such as "person with autism", and that personal

				judgment is used as to the most appropriate language in their clinical practice.”
	ID928		• Despite an exhaustive clinical assessment, the diagnostic process may still not achieve a reliable diagnosis. Clinical observation, potentially involving repeated assessments, over time, may be a valuable mechanism for determining whether the person has ASD. Alternatively, reliably characterising the range of strengths and difficulties across developmental domains, including social/emotional domain and behaviour, may be a pragmatic interim approach to facilitate intervention and treatment. The draft guidelines should address these issues	Thank you for this feedback. We believe that the revised structure addresses this comment – in particular, the recommendation for an initial comprehensive functional and support needs assessment and the immediate referral for further supports. For further information, please refer to the ‘Overview of Major Amendments’ chapter under the headings: • Emphasis on the Importance of Functional Abilities in Referral for Supports • Structure of the Assessment Process
	ID929		Removing the term” consumer.” Although it is commonly used in health services, it implies a commercial relationship between the service provider and the person to whom care and services are provided. We believe that the relationship between a health professional and person with ASD and their family goes further than this, and recommend that another term is substituted;	This term has now been adjusted to ‘client’. Please refer to the ‘Overview of Major Amendments’ chapter under the following heading: • Consumer
	ID930		• Adjusting the approach to strengths and resilience factors, which warrants expansion to more fully capture aspects within the child, family and community that can enhance developmental outcomes, wellbeing and community participation. These factors can be important strengths that build resilience for the person and their family.	Given that the community consultation activities focused on the construct of strengths, the principle has not been renamed to include resilience factors. However, the additional text was added to the description of a strengths-focused approach: “It is acknowledged that these strengths and resources help facilitate resilience among the individual and their caregiver(s) or support people, both during the ASD assessment and when they progress to the service delivery phase.”
	ID931		**ASD Assessment Guiding Principles** Guiding principles are an important opportunity to outline how this *draft guideline* will enhance the current diagnostic	Thank you for this comment. ‘Lifespan perspective’ has been added as a guiding principle in the revised Guideline. This

			process. ASD specific diagnostic processes ought to be included in existing services, especially in those for detecting and diagnosing developmental delay/disability, rather than representing a separate diagnostic stream. We recognise that resource enhancement may be required. Irrespective of the outcome of an ASD diagnostic assessment, the goal is to provide assistance to the person and their family in relation to their concerns. Therefore, a lifespan perspective should be a key element of the diagnostic process, given the long-term implications of a diagnosis of ASD.	comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Guiding principles
	ID932		**ASD Assessment Roles** We believe that the diagnosis of ASD should be made by an appropriately trained medical practitioner, such as a paediatrician, psychiatrist or a neurologist. This reflects current practice and key international guidelines such as UK National Institute for Health and Care Excellence (NICE) Guidelines for ASD diagnosis. We recognise the importance of multidisciplinary teams that include speech pathologists and clinical/educational psychologists among others, in the diagnosis of ASD. However key elements of establishing an ASD diagnosis can only be delivered by a suitably trained medical practitioner. These include integration of clinical signs and symptoms, careful consideration of alternative possible diagnoses and detection of important contributing health conditions. The case to expand the role of diagnosis of ASD beyond these groups has not been established in the draft guidelines. We fully support involvement of other professionals such as speech pathologists and occupational therapists in the diagnosis of ASD through providing assessment and recommendations in specific areas of development/abilities.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Professional Roles • Structure of the Assessment Process

	ID933		Involving general practitioners (GP) in the diagnostic referral process maintains their engagement in the health and wellbeing of the child and family and enables other important issues to be addressed. Continuing professional and resource development supports the responsiveness and value of these referral systems for the person with a potential ASD diagnosis and for their family.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Referral for an Assessment of ASD Concerns
	ID934		Other specific changes that could improve this section include: Replace terms such as "functional and support needs assessor" and "professional informant" that are introduced in the draft guidelines. They are without precedent in child development practice, and as such risk significant confusion in the sector and for families. An alternative would be the use of less specific terms such as "clinician who assesses…"	Based on feedback received, the specified role of 'professional informant' has been omitted from the revised Guideline. However, the Guideline still emphasises the importance of collecting information from a variety of sources, and from individuals who observe the client in community settings.
	ID935		Review the Consensus Based Recommendation (CBR) rating for the different medical professions listed (neurologists, psychiatrists and paediatricians). The ratings are potentially inadequate, as there is great variability within these groups regarding their expertise in diagnosing ASD. It is reasonable to say that within these professions where the specialist does not have the expertise required for ASD diagnosis they ought to refer to another specialist who can. This is in line with the best-practice approach for a range of health conditions.	The Guideline outlines the qualification, training and expertise of all clinicians involved in the ASD assessment. Furthermore, the Guideline retains the recommendation that: "If a particular clinician does not have the clinical qualifications or expertise to adequately evaluate a potential differential diagnosis and/or co-occurring condition for a given individual, then it is suggested that the individual be referred to a clinician who does have this expertise."
	ID936		Noting that rather than all individuals having to have all the expertise specified in S 6.5.2, this expertise needs to be present in the team.	There was consistent and strong support from a broad range of stakeholders for recommendations that outline the required qualification, training and expertise of all clinicians involved in the ASD assessment, hence this has been retained in the Guideline. It is expected that clinicians would have varied expertise beyond these recommendations, and these

				additional areas of expertise may be balanced across the team.
	ID937		Ensure the guidelines are not overly prescriptive in relation to which endorsements should be considered appropriate to address specific areas of concern. In particular, the omission of clinical neuropsychology in evaluating a neurodevelopmental disorder is potentially problematic.	Based on feedback received, Table 7 has been omitted from the revised Guideline. For further information regarding psychologist qualifications, please refer to the 'Overview of Major Amendments' chapter, under the heading: • Qualifications for Psychologists
	ID938		Conducting further consultation with professional colleges on the importance of ASD specific expertise and determining appropriate additional training requirements.	The key professional colleges relevant to ASD assessment are represented on the Steering Committee, and these organisations have been invited to provide further feedback on the revised Guideline. This will provide an opportunity to make further contributions in relation to training and expertise requirements.
	ID939		Recognise that coordination and continuity of care is important, and is primarily a clinical role rather than administrative. Funding should be identified for this important role.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Coordinator Role
	ID940		Reviewing those professions approved to diagnose ASD. Internationally, occupational therapists and speech pathologists are not considered qualified to make definitive diagnosis of ASD and the case for doing so in Australia has not been established. Their inclusion may lead to further diagnostic variability and a potentially increased rate of ASD diagnosis. The evidence table demonstrates the importance of occupational therapists and speech pathologists to the diagnostic process, but does not establish the case that their	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Professional Roles • Structure of the Assessment Process

			training and expertise equips them for the primary role of ASD diagnosis.	
	ID941		Avoid requiring an additional four years of ASD specific training, which is unworkable and would preclude most paediatricians from involvement in the diagnosis of ASD. Paediatricians are already extensively trained in a range of relevant childhood and neurodevelopmental conditions as well as the integration of a range of clinically relevant information and diagnoses.	Thank you for this feedback. This requirement for '4 years' experience' has been omitted from the revised Guideline. For a rationale, please refer to the 'Overview of Major Amendments' chapter under the heading: • Duration of ASD-specific Expertise
	ID942		Adjust listed age ranges in recognition that paediatricians and adolescent medicine physicians can treat/manage young people up to 25 years, beyond the 17 years noted in the draft Guideline (Table 3).	The upper age limit for paediatricians has been increased to 25 years.
	ID943		Review training requirements for registered psychologists. Psychologists on diagnostic teams may not have areas of practice endorsements and yet have been providing an excellent service within multidisciplinary teams. To remove these psychologists from the diagnostician list (where 2 diagnosticians are required for Tier 2) may exacerbate waiting times in existing diagnostic services. Guidance from relevant psychology colleges should be sought in relation to these professional standards and practice issues.	Please refer to the 'Overview of Major Amendments' chapter under the heading: • Qualifications for Psychologists
	ID944		Review the role of informants. They should not be required to have ASD specific expertise, yet can offer valuable insights into a child's function. Suggesting that they must have a 4-year university degree and specific ASD expertise is unhelpful.	Based on feedback received, the specified role of 'professional informant' has been omitted from the revised Guideline. However, the Guideline still emphasises the importance of collecting information from a variety of sources, and from individuals who observe the client in community settings.

	ID945		**ASD Assessment settings** Changes that should be considered in this section include: • Removing the requirement that a waiting area forms part of a clinic space. While all contact with a person suspect of having ASD provides insight into their reactions to different environments and other people, this is overly prescriptive	The definition of a clinic setting has been amended by removing reference to the waiting area.
	ID946		Changes that should be considered in this section include: • Reviewing the use of telehealth for diagnosis of ASD. Telehealth may provide a useful adjunct to face to face consultation. Quality of service should not be compromised for children who live away from tertiary centres, but this medium provides an opportunity to address inequity in services due to rurality. Telehealth has a role to play to supplement other models of care, but should not be relied upon as the sole medium by which to make a diagnosis	Thank you for this comment. The revised Guideline has provided clearer recommendations around the use of telehealth. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Telehealth
	ID947		Other specific changes that could improve this section include: • Greater acknowledgement of existing early childhood development surveillance programs and primary health care services. These services provide vitally important mechanisms for developmental concerns to be raised, detected and then linkages with diagnostic and intervention services to be made.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Referral for an Assessment of ASD Concerns

	ID948		**Initiating an ASD assessment** As above, it is important that referral to a diagnostician come from a patient's primary health care professional. We acknowledge that screening for ASD behaviours as part of primary child health care is recommended in some jurisdictions (American Academy of Paediatrics for example) Within Australia, screening tools are part of developmental surveillance programs, and these programs specifically articulate what to do if concerns are raised. Currently, ASD screening tools are not used consistently in Australia and their role has not yet been established. Screening has the potential to do harm as well as good, and careful consideration of any screening programme would need to be undertaken before widespread recommendations could be made.	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Referral for an Assessment of ASD Concerns
	ID949		Other changes that should be considered in this section include: • Recognising that evaluation of general developmental/cognitive/adaptive abilities must occur prior to establishing a diagnosis of ASD. This may involve formal developmental assessment and is in line with DSM 5 requirements to consider alternative diagnoses that better explain the presenting concerns	This is incorporated into the revised Guideline. For further information, please refer to the 'Overview of Major Amendments' chapter under the heading: • Structure of the revised assessment process
	ID950		• Removing the Denver screen as it has poor validity	Recommendations relating to specific instruments that measure functioning have been removed from the Guideline, and information about resources will instead be located on the Guideline webpage to enable updates to occur more readily.
	ID951		• Reviewing the statement that hearing loss must be ruled out. We agree that hearing must be considered prior to diagnosing ASD, and suggest that testing for Auditory Processing disorders(APD) are part of this assessment, but recognise that hearing loss/APD and ASD can occur together	Auditory processing disorder has been listed in the new table on possible differential or co-occurring diagnoses (along with hearing impairment).

	ID952		- Clarifying who is intended to use Table 5 (page 30)	This table has been omitted from the revised version of the Guideline. For further information, please refer to the ‘Overview of Major Amendments’ chapter, under the heading: - Referral for an Assessment of ASD Concerns
	ID953		- The inclusion of a statement that referrals for ASD assessment where ASD is unlikely to be the primary cause of a child’s difficulties can place pressure on the ability of health services to provide access to interventions for children who do have ASD, and can contribute to patient anxiety	Please refer to the ‘Overview of Major Amendments’ chapter, under the heading: - Referral for an Assessment of ASD Concerns
	ID954		**Diagnostic Evaluation** We recognise that establishing a diagnosis of ASD can provide valuable information to assist with intervention and answer important questions other professionals, the person or their family may have. Timely access to diagnosis and intervention is important. Other changes that should be considered in this section include: - A clear definition of ‘Tier 1’ and ‘Tier 2’ should appear alongside their first mention in the Guideline - Noting that Tier 1 diagnostic evaluation can be undertaken by paediatricians or child psychiatrists - Making reference to the need for medical evaluation, including physical health assessment, which must be conducted as part of the diagnostic process by a medical specialist who understands the context, what is being	These comments have been incorporated into the revised Guideline. Please refer to the ‘Overview of Major Amendments’ chapter under the heading” - Structure of the Assessment Process - Progression from Tier 1 to Tier 2

			looked for and what is relevant	
	ID955		- Changing specific editions of diagnostic criteria (e.g. DSM 5 and ICD-10) to the 'current edition of relevant diagnostic criteria' and acknowledge that as new editions are developed, clinical practice may change in response to emerging approaches. This improves the longevity of Guidelines and ensures that re-establishing the diagnosis is not required on release of a new edition	This adjustment has been made to in the revised Guideline. The Guideline has been edited so that the diagnostic criteria is consistently referred to as the current version of the DSM or ICD.
	ID956		- Removing the requirement that a Tier 2 assessment must include ADOS and replacing it with a statement that an ASD specific tool may be used as part of Tier 2 assessment	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: - Use of 'Standardised' Instruments
	ID957		- Reviewing the evidence around the value of diagnostic tools. The choice to use a diagnostic tool must be undertaken by the involved clinician. Additionally, the guidelines should recommend present evidence around a range of relevant tools to assist decision by clinicians and include the developmental behavioural checklist (DBC), an Australian tool that has been shown to have value in the diagnosis of ASD	Recommendations relating to specific instruments that measure functioning have been removed from the Guideline, and information about resources will instead be located on the Guideline webpage to enable updates to occur more readily.
	ID958		- Moving intellectual disability from medical history to developmental history (section **9.4.3**)	The reference to intellectual impairment has been moved from medical history to developmental history.
	ID959		- Noting that the listings of potential coexisting conditions in sections 8/9 are incomplete and easily misunderstood. Identifying these conditions relies on the training and judgement of experienced clinicians	Thank you for this comment. The three tables in the Differential Diagnosis and Co-occurring Conditions section have been combined, and additional conditions have been added in response to various submissions, resulting in a more complete list. Members of the Consensus Diagnosis Team are expected to have knowledge in relation to these conditions,

				and this table serves as a prompt to the range of conditions that may have overlapping presentations with ASD.
	ID960		• Reviewing Table 7 for its utility and completeness, and clarifying its role. It is important that this is not implemented in a prescriptive way. For example, speech pathologists are listed next to hearing problems, but not other professionals trained to identify these concerns. Paediatricians and GPs should be expected to conduct an oral health check as part of their clinical work	Thank you for this comment. Based on feedback received, this table has been omitted from the revision Guideline, and the information included in the table has been incorporated in other sections of the document.
	ID961		• Clarifying some elements of this guideline in relation to DSM 5. For example, Diagnostic algorithm Table 5 implies a rigid approach to diagnosis at Tier 1 or referral to Tier 2 based on the number of symptom categories. DSM 5 does not require a prescribed number of criteria to be met	Based on feedback received, Figures 5 and 6 have been omitted from the revised Guideline.
	ID962		• Noting that speech and language assessment should occur for all children diagnosed with ASD	The importance of a language assessment is recognised in the Guideline in two ways: 1. The Guideline recommends that Stage 1 assessment covers a broad range of developmental and functional domains, including language. 2. The Guideline further recommends that professionals with expertise in certain assessment domains are consulted. e.g., speech and language (speech pathologist).
	ID963		• Recommending discourage use of level of ASD arising from DSM 5 to describe degree of support needs	The Guideline recommends DSM-5 severity levels be assessed and reported in relation to the diagnostic evaluation. The DSM-5 severity levels are not included in the comprehensive needs assessment, where support needs are identified.

	ID964		**Functional and support needs assessment** Assessing functional and support needs is a valuable component of the diagnostic process that can inform intervention, future development and learning. Consideration of these skills must occur prior to establishing a diagnosis of ASD, even if formal assessment occurs when the child is older. Functional and support needs are likely to change through the lifespan, so we recommend specifying that this assessment may need repeating when appropriate. A specific recommendation that developmental/cognitive assessments must be made should be included. These are important and valuable tools that provide valuable information on adaptive/functional/cognitive /developmental skills and may also facilitate demonstration of behaviours characteristic of ASD.	Thank you for this comment. This comment is addressed in the ‘Overview of Major Amendments’ chapter under the heading: • Emphasis on the Importance of Functional Abilities in Referral for Supports • Structure of the revised assessment Please note that the Guideline recommends that standardised developmental assessments are at least attempted during the Stage 1 Comprehensive Needs Assessment.
	ID965		Other changes that should be considered in this section include: • The emphasis on ICF Core sets for ASD is premature as they have not yet been released, nor tested for feasibility, acceptability and value in Australia. They may prove to be helpful and acceptable in due course	Given the ASD core sets are not yet publicly available, the revised Guideline has omitted reference to these. These are likely to be included in future revisions of the Guideline. \Recommendations relating to specific instruments that measure functioning have been removed from the Guideline, and information about resources will instead be located on the Guideline webpage to enable updates to occur more readily.
	ID966		• Qualifying the categories listed under functional assessment tool according to the age of the person being assessed as the functional and support needs section is not tailored for young children where a substantial proportion of diagnoses will be made	Recommendations relating to specific instruments that measure functioning have been removed from the Guideline, and information about resources will instead be located on the Guideline webpage to enable updates to occur more readily. In the case of young children, a standardised developmental assessment may provide relevant information on the child’s functioning, and information about these instruments will also be located on the Guideline webpage.

	ID967		• Noting that reporting of the results of an adaptive behaviour tool must be consistent with professional guidelines and practice. Reporting of specific scores is discouraged, unless the audience understands the limitations of specific scores	The Guideline highlights the importance of explaining findings in a way that is meaningful to the client, as illustrated in the Content of Communication section with: “It is recommended that findings from the ASD assessment be communicated … to the client in a comprehensive and understandable way” “Assessments conducted, including the name of instrument, what it measures, the administering professional, and the findings and their implications”
	ID968		• Re-examining the PEDICAT and Character Strength tools, as they have substantial limitations and should not be supported in this context	Recommendations relating to specific instruments that measure functioning have been removed from the Guideline, and information about resources will instead be located on the Guideline webpage to enable updates to occur more readily.
	ID969		Key elements of the *guideline* we support include: 4. Recognition that strengths and areas of difficulty can lead to a more nuanced conversation about the future and how to support the person being diagnosed with ASD; and	Thank you for this feedback.
	ID970		**Sharing ASD assessment findings** It is important that outcomes from the diagnostic process should be communicated with relevant stakeholders including the person, family, Referral for an Assessment of ASD Concerns and other professionals. This section should outline the need to obtain consent from the consumer or their family to share assessment findings with other clinicians and health services.	Additional text has been added to the Communication Style section: “It is recommended that findings from the ASD assessment only be shared with relevant stakeholders, such as the Referral for an Assessment of ASD Concerns, caregivers / support people, service providers or funding agencies, with the expressed consent of the client.”

	ID971		Importantly, some children will have the right to have a say in how their information is shared, depending on a number of factors that inform their competence. Table 11 incorrectly implies that children 16 years and under do not have a role in determining how their information is shared. The Gillick principles (or similar) should be used to determine the competence of a child to have input in to (or make) these decisions.	The following information has been added to the tables describing additional considerations for school aged children and older adolescents and adults: “It is recognised that as older children and adolescents mature, their capacity and motivation to make health related choices develops. It is suggested that the level of information provided and involvement in decision-making processes increase alongside this maturation. This may involve obtaining consent from both the child and parent for adolescents aged 12 – 17 years, and in some circumstances an adolescent aged at least 14 years may be considered capable of participating in an ASD assessment without their parent’s consent. Guidance is available from the principle of ‘Gillick competence’, legislative requirements and the United Nations Convention on the Rights of the Child.”
	ID972		Other changes that should be considered in this section include: • Discouraging the use of the telephone in reporting assessments	The section on telehealth emphasises that the use of telehealth as the predominant medium for conducting an ASD assessment is restricted to exceptional circumstance, such as when conducting a face-to-face assessment in a clinic or community setting would be very difficult. Examples include when a client lives in a regional or remote location without access to ASD assessment services, or other significant travel restrictions prevent a face-to-face assessment occurring (such as challenges relating to sensory or anxiety symptoms). If telehealth is used as the predominant medium for conducting part of an ASD assessment or to share the ASD assessment findings, it is recommended that a local clinician (or other professional with relevant expertise) is physically present with the client during the telehealth meetings. Please note that the Telehealth section includes the recommendations that there is to be at least one face-to-face assessment performed and a member of the ASD assessment team.

	ID973		• Clarifying why a 3-month period for provision of report is supported as the professional standards require a shorter timeframe;	The Guideline suggests that the findings would ideally be shared within three months of the first assessment appointment. Clinicians should meet existing professional standards if they suggest a shorter time frame.
	ID974		• Revisit the appropriateness of defining the style of reports in this draft guideline (e.g., technical/plain English). Both may be appropriate, depending on the circumstances and professional practices;	The Guideline makes recommendations for the report that will be provided to the client, hence layperson language has been suggested. Clinicians may prepare more technical reports in addition to the client report, that is tailored to the intended audience.
	ID975		• Noting that reporting should also include language and cognitive/functional levels and associated medical conditions	The Content of Communication section has been expanded, hence language, cognitive and functional levels would be included, as would associated medical conditions: • Evidence that supports the current severity level and specifiers (if DSM-5 criteria are utilised) • Current developmental status / level of functioning across multiple domains and potential level of functioning with supports • Co-occurring conditions identified, diagnosed or requiring further investigation
	ID976		• It is inappropriate to require a declaration by the professional to declare that the ASD diagnosis was conducted according to these *draft guidelines*.	This statement has been omitted from the revised template
	ID977		We are concerned that Tier 2 assessments have too many specifications. Not all children referred to Tier 2 require specific ASD assessment via tools such as and Autism Diagnostic Observation Schedule (ADOS), or need direct observations outside of the clinic. Reports from informants may provide sufficient information. The decision to conduct a	Thank you for this comment. This comment is addressed in the 'Overview of Major Amendments' chapter under the heading: • Use of 'Standardised' Instruments

			specific assessment must be a clinical decision.	
	ID978		**Important considerations** We are fully supportive of the intent in the sentence “all professionals involved in an ASD assessment with an individual from a different racial or ethnic background, including Aboriginal peoples, should first obtain a good understanding about the cultural factors relevant to the individual and their caregivers that may guide or influence the ASD assessment process (section 12.4).” We would suggest the changes outlined in the paragraph below: *“All professionals involved in an ASD assessment with an individual* ***from a cultural background other than their own*** *should obtain a good understanding of the cultural factors relevant to the individual and their caregivers that may guide or influence the ASD assessment process.”* These considerations also influence the approach taken to intervention and therapy.	This recommendation has been rephrased on the basis of other feedback received, and this has removed the phrase that was of concern in this submission. This sentence now reads: “It is recommended that all members of the ASD assessment team consider the individual’s racial or ethnic background, including Aboriginal peoples, and how cultural factors relevant to the individual and their caregiver(s) may guide or influence the ASD assessment process.”
	ID979		Other changes that should be considered in this section include: • Noting that “there is now robust empirical evidence that ASD can be reliably and validly diagnosed at 2 years of age by an experienced clinician” refers to ASD that is relatively severe or where the child also has significant developmental delay. Milder cases may not become apparent until later. Given that ASD is a spectrum that involves all levels of severity, many children will not be diagnosed before they are 3 years old	This statement has been changed to allow variation in the development of ASD signs and symptoms: “There is now robust empirical evidence that, for a small proportion of children, ASD can be reliably and validly diagnosed at 2 years of age by an experienced clinician, and that this diagnosis is relatively stable over time.”
	ID980		• Changing the last line of the first paragraph on page 64 which mentions ‘autistic children with ASD	This typo has been amended.

	ID981		Other changes that should be considered in this section include: • Noting that in section 12.1 (see pages 63-64) the document states that consent / confidentiality from the age of 18 years. This is not in keeping with practice where consent (with assessment of capacity to) and confidentiality are important even before the age of 18 years	The following information has been added to the tables describing additional considerations for school aged children and older adolescents and adults: “It is recognised that as older children and adolescents mature, their capacity and motivation to make health related choices develops. It is suggested that the level of information provided and involvement in decision-making processes increase alongside this maturation. This may involve obtaining consent from both the child and parent for adolescents aged 12 – 17 years, and in some circumstances an adolescent aged at least 14 years may be considered capable of participating in an ASD assessment without their parent’s consent. Guidance is available from the principle of ‘Gillick competence’, legislative requirements and the United Nations Convention on the Rights of the Child.”
	ID982		Other changes that should be considered in this section include: • Including further information on behaviour and emotion. Challenging behaviour is in important predictor of outcomes and this must be considered as part of diagnostic formulation. Given the high prevalence of intellectual disability (ID) in people with ASD, it is imperative that the Guidelines include the recommendation that ID be considered for people diagnosed with ASD specifically where there are cognitive concerns	Thank you for this feedback. This information is included in the recommendations made by the Guideline. The Stage 1 assessment recommends an investigation of developmental and functional abilities/impairments within the cognitive domain, along with the inclusion of a standardised assessment of intellectual abilities (if able to be conducted). Stage 3 involves more in-depth assessment of areas where there are indications that challenges may be present. In the table suggesting possible assessments to conduct during Stage 3, the following is included: “Behavioural assessment (e.g. challenging behaviour which falls outside the range of expected age-appropriate behaviour).”

				"Cognitive and/or neurodevelopmental assessment (e.g. intelligence, learning capability, visual perception, memory, executive functioning)" Intellectual impairment is also included in the list of potential co-occurring and/or differential diagnosis.
	ID983		This may involve an individual experienced clinician, such as paediatrician or child psychiatrist, establishing a diagnosis and delivering initial case coordination, or a multidisciplinary team if the presentation or comorbidities are complex. We support a comprehensive diagnostic formulation that captures development/cognitive/adaptive abilities, specific diagnoses, additional health conditions and contributing conditions. Underlying issues such as genetic health issues, relevant social, family and community issues and strengths and weaknesses should also be included. Further consultation is needed on how these tiered assessments are intended to work.	We believe that the revised structure addresses this comment by describing a progressive approach to neurodevelopmental and behavioural assessment that is based on individual need and complexity. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Structure of the Assessment Process
Manual Submission [155]	ID984	Organisation – Professional experience	Dear Dr Evans, RE: SUBMISSION TO THE "NATIONAL GUIDELINE ON THE DIAGNOSIS OF AUTISM SPECTRUM DISORDER. (ASD) IN AUSTRALIA" PROJECT Thank you for the opportunity to make a submission on the Draft National Guidelines on "The diagnostic process for children, adolescents and adults referred for assessment of autism spectrum disorder in Australia" produced by the Autism Cooperative Research Centre. We are experts in law, health, disability discrimination and inequality, and members of the [description] area of [department and organisation]. Our current research is on 'The Legal Regulation of Behaviour as a Disability', an [project type and number] that provides a	We believe that the revised structure addresses this comment. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Emphasis on the Importance of Functional Abilities in Referral for Supports

			comprehensive analysis of the legal issues raised by the expansion of the category of disability to include people with what has come to be called "challenging behaviour". Through the project, we are exploring how laws, regulations and policies respond to individuals with challenging behaviour, including people with autism spectrum disorder ("ASD"). Our work aims to ensure laws which regulate people with challenging behaviour (both punitive and protective) maximise their social participation, including access to justice, by taking full account of the goals of equality and social inclusion. A significant component of our research concerns the various legal definitions of disability, including the way that these intersect with a diagnosis of disability. Our submission primarily concerns the potential indirect impact on people with ASD traits of a single diagnostic process. Human rights and equality concerns with a single diagnostic process for ASD We believe that a single diagnostic process for ASD, while it may be beneficial for service provision and in other contexts, could also have the unintended consequence of undermining people's enjoyment of their legal rights, including under disability discrimination law. This is because our research has shown that people can mistake a diagnosis (or lack of a diagnosis) in one context for the existence (or lack of) a disability in another context. This can potentially stop people accessing rights or benefits that require meeting a definition of disability, but do not necessarily require a diagnosis. Our primary concern is that where a person has been diagnosed as not meeting diagnostic criteria for ASD, they may then assume that they do not have a disability in other contexts, including legal and human rights contexts. We understand that your Guideline is being developed to serve specific clinical and service provision needs and does not set out to engage in any way with law or human rights. However, given that people with ASD are vulnerable to discrimination	

			and human rights abuses, we believe that it is imperative to consider the indirect impact of this Guideline on disability rights. In Australian federal anti-discrimination law, disability is defined broadly. Section 4 of the Disability Discrimination Act 1992 (Cth) sets out a definition that is designed to be inclusive and not create unnecessary hurdles to accessing human rights protections. From a legal or regulatory perspective, in some respects it is beneficial to be diagnosed with a disability, since (along with access to medical and psychological treatments) this can directly bring a person within the protective zone of disability discrimination law. This potential access to legal protection, however, comes at a cost, because it requires the person to take on a stigmatised social identity as 'disabled', whether or not the person identifies with that label, and to accept their status as presumptively outside the mainstream. For children with ASD, this concern is greater because their identities are in development and adult decisions made on their behalf will impact them in ways they may not yet understand. Parents, in fact, sometimes choose not to have their child with ASD traits formally diagnosed, in order to avoid a stigmatising label. Additionally, the child's challenges may not require clinical treatment, as some parents find that non-medical treatments, such as clear routines or time spent in low stress environments, work best for their child. Where a child or adult either does not have a diagnosis, or fails to meet a clinical threshold for diagnosis, the absence of these does not mean that they are able to function in environments that are discriminatory or poorly accommodate their needs. We submit that the absence of a diagnosis should not impact their status as 'disabled' for the purpose of enjoying their legal rights to non-discrimination. The Committee on the Rights of Persons with Disabilities has	

			made it very clear in their recent General Comment on Education that diagnosis should not be a threshold for enjoyment of disability rights: Provision of reasonable accommodation may not be conditional on a medical diagnosis of impairment and should be based instead on the evaluation of social barriers to education. (Committee on the Rights of Persons with Disabilities, General comment No. 4 Article 24: Right to inclusive education UN Doc CRPD/C/GC/4 (Adopted 24 August 2016), para 29.) In other words, the focus should be on whether a person can in fact access education (or other area of public life), not on their medical status. We recommend an inclusion in the Guideline that clarifies that the lack of a diagnosis does not necessarily mean that the individual may not have a disability in other contexts. We believe that it is important in order for people to have full access to their legal and human rights.	
	ID985		As part of the ASD specific expertise of diagnosticians and functional and support needs assessors we suggest including after "ASD symptom presentation among male, female, and where applicable, gender diverse individuals", and individuals from culturally, linguistically and socio-economically diverse backgrounds".	Added recommendation that all members of the ASD assessment team have training and expertise in: "Impact of other important considerations, such as intellectual and / or communication capacity, culturally, linguistically and/or socio-economically diverse background and regional or remote location on the ASD assessment."
	ID986		Further, our research has raised a concern that gender stereotypes work their way into otherwise seemingly objective ways of defining and understanding a disability. So, when comparisons are made with peers of the same age, gender and cognitive ability, stereotypes of gendered social behaviour should be carefully critiqued. For instance, where there is gender non-conformity it may be something that is entirely	Thank you for providing this information.

			appropriate although in comparison with other children of the same sex is unusual. For further reference on some of the issues raised in this submission, see Karen O'Connell, 'Should we take the 'disability' out of discrimination laws? Students with challenging behaviour and the definition of disability' (2017, forthcoming) 35 (2) Law in Context.	
Manual Submission [156]	ID987	Individual	I am really pleased with the work that has been done and agree with all that have been raised. My only comments are that: I know that my skill, expertise, experience and qualifications are unique - I do not hold psychology quals, however, I am often the first point of contact for many young adults/ adults that I believe are AS. I would like a formal checklist or reporting format that I could refer to a psych (I have not been wrong yet in 30 years once formal diagnosis has been done)	Thank you for this comment. No amendments have been made in response to this comment.
	ID988		As well as the 'professionals' having a standard, we need the systems to accept a standard diagnosis e.g., Centerlink, NDIS, criminal justice, Dept of Education system Once you have achieved acceptance of the professional standards, how can this be built into training for existing and undergrad psychologist and psychiatrist?	Thank you for this comment. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Accreditation and Regulation • Practice points for clinical, research and policy settings
Manual Submission [157]	ID989	Individual	I just wanted to let you know how impressed I am with the approach that has been taken. Working predominantly with children living in remote Aboriginal communities in WA, it has been an ongoing frustration to me that children who quite obviously have ASD with severe impairment need to wait for a diagnostic team from Perth to formalise the diagnosis. It also concerns me that	Thank you for this helpful feedback.

			under current processes these complex cross-cultural developmental diagnoses are being made by fly-in fly-out teams who have expertise in autism but may have had little or no previous exposure to families living in remote Aboriginal communities and therefore little understanding of the expected norms for this population or how to engage appropriately with these children, and who have an extremely limited timeframe within which to complete the diagnostic process. The result is an over-reliance on standardised diagnostic tests that have limited validity in this population, and de-valuing of the expertise that can be provided by local professionals who have expertise in the normal development and behaviour of children in this cultural context. I'm so pleased to see the two-tier model for assessment, which would allow for a formalised diagnosis to be made in many cases by a regionally-based diagnostician who has familiarity with remote Aboriginal communities, in association with a professional informant who has expertise in local cultural and developmental standards. I'm also pleased to note the emphasis given to taking care in diagnosis in cross-cultural settings and particularly in Aboriginal people. What would be great to see along with this change in requirements for the diagnostic process would be more accessible training materials for regional/remote professionals to develop and maintain skills in diagnosis, management and support of people with autism. I look forward to the release of the final version.	
Manual Submission [158]	ID990	Individual	Consideration of inappropriateness of the diagnosis – if a practitioner does not agree with the diagnosis of Autism given to a child previously (e.g. new information regarding differential diagnosis has come to light or the symptoms no longer exist), there needs to be a mechanism whereby the diagnosis can be withdrawn. This could be an assessment similar to one conducted for giving the diagnosis and conducted by the registering agency.	Thank you for this comment. The was out of the scope of the Guideline objectives, and so no amendment has been made.

			I hope I am not too late in making these suggestions and you are able to incorporate these into the final guidelines.	
	ID991		I would like to add a couple of things to the draft guidelines: 1) Addition of a phrase for overseas trained physicians who for a significant proportion of the workforce – Table 3 mentions for training for Paediatricians: Successfully completed a medical degree accredited by the Australian Medical Council and at least one intern year. Successfully completed a further 3-year basic training in paediatrics and child health and 3-year advanced training program in one of the paediatrics divisions through the Royal Australian College of Physicians. 2) Could this phrase be added "or established to have fully comparable training by the Royal College of Physicians.	We believe that the requirements for medical practitioners included in the revised Guideline addresses this comment. Please refer to the 'Overview of Major Amendments' chapter under the heading: • Qualifications for medical practitioners
Manual Submission [159]	ID992	Organisation – Professional experience	The [Organisation] commends Cooperative Research Centre for Living with Autism (Autism CRC) on the development of these comprehensive guidelines. We acknowledge the importance of establishing clear criteria for the diagnosis and management of Autism Spectrum Disorder (ASD) and believe the draft guidelines capture the primary domains of care provision to individuals with ASD in the general practice setting. However, we believe the document could be improved to further recognise the important role of GPs in facilitating early diagnosis and we provide the following comments.	Thank you, we greatly appreciate you providing this feedback.
	ID993		**Section 6 – ASD Assessment Roles** The [Organisation] welcomes the recognition of the role of GPs in ASD assessment, more specifically in care coordination (item 6.3) and in the provision of information to	Thank you for this feedback

			support the Diagnostic and Functional and Support Needs Assessment (item 6.6).	
	ID994		**GPs' role in early identification and care coordination** Given that GPs are clinical leaders in primary care, the [Organisation] is of the view that the Autism Spectrum Disorder Guidelines can better delineate the important role of GP in early diagnosis and management of individuals living with ASD. GPs are in a unique position as healthcare providers for both the individual living with ASD and their family/carers. GPs work across the entire age range, are accessible and closer to home compared to specialist services. As health professionals with regular contact with children and their families, GPs are well placed to notice abnormalities or delays in a child's development that could indicate ASD. Considering that early diagnosis and intervention can have a significant effect on the long-term health and psycho-social outcomes for those living with ASD, section 6 of the guidelines should emphasise the key role GPs play in facilitating early diagnosis. Reference should also be made to how other professionals in the multidisciplinary care team, including allied health and medical specialists, can work closely with GPs to maximise healthcare outcomes.	Thank you for this comment. The revised Guideline includes information in section 6.1 regarding the pivotal role that GPs (and other primary health care providers play in the early identification of individuals with neurodevelopmental disorders.
	ID995		**Item 6.4 – Diagnostician** **GPs as diagnosticians** The guidelines identify the following professionals in the role of diagnostician: paediatricians, psychiatrists, neurologists, registered psychologists, speech pathologists and	Please refer to the 'Overview of Major Amendments' chapter under the heading: • Medical practitioner.

			occupational therapists. As GPs are not included in this list, it suggests GPs don't have a role in management and that GPs have a peripheral role in the multidisciplinary team. While most GPs are likely to operate at the level of professional informant and coordinator, some have the skills, knowledge and desire to be involved as diagnostician. GPs plan an important role in coordinating care through an interdisciplinary team and treating children's associated conditions, including sleep disturbances, gastrointestinal problems, anxiety, and hyperactivity. Diagnostics is a process and general practice is the only medical professionals seeing patients over time. No other specially can offer that. For a disorder that has such a broad range of possible functional impacts, the [Organisation] believe it is important to recognise the role of GPs as diagnosticians.	Under this definition, a GP may be able to play a diagnostic role in ASD if they have acquired the stated expertise and skills.
	ID996		Furthermore, the [Organisation] believes consideration should be given to education targeting GPs and GP registrars in the identification of early signs of ASD.	Thank you for this feedback. This issue is out of scope of the project terms of reference, and so no amendment has been made. However, please note that the Guideline includes recommendations regarding the development of training programs. Please refer to the 'Overview of Major Amendments' chapter under the following heading: • Practice points for clinical, research and policy settings
Manual Submission [160]	ID997	Organisation – Professional experience	OT Australia Better Access to Mental Healthcare OT applicants (page 11, ASD not an eligible diagnosis for BHMH). https://www.otaus.com.au/about/better-access-to-mental-health/application-process -see '2' for details.	Please refer to the 'Overview of Major Amendments' chapter under the heading: • Qualifications for occupational therapists

	ID998		Victorian Department of Education and Training Program for Students with Disabilities (PSD). Specifically, page 15 and page 22. To be eligible for funding through PSD, you must have a letter from a Paediatrician, Speech and Psych at a minimum.	Please refer to the ‘Overview of Major Amendments’ chapter under the headings: • Consistent and Flexible Structure • Implementation and Evaluation of the Guideline
	ID999		Trauma wasn’t listed in the guide as a co-morbidity. Just curious regarding other clinicians’ viewpoint on trauma and ASD as its quite the focus in the region I work – not so much elsewhere.	Wording has been modified to ensure clinicians are guided to consider current or previous exposure to personal or familial trauma and/or psychosocial risk, and if present, progress to a Stage 3 Consensus Team Diagnostic Evaluation.
Audiology Australia [161]	ID1000	Organisation – Professional experience	We congratulate the Autism CRC on the development of the Guideline. Audiology Australia strongly supports the development and implementation of a consistent, national approach to streamline the diagnosis of Autism Spectrum Disorder (ASD). We also endorse the Guideline’s principles, which focus on individual, family-centered, holistic and evidence based care.	Thank you for this feedback.
	ID1001		However, as determining auditory function is a fundamental, necessary step in diagnosing and providing interventions for ASD, Audiology Australia suggests that the Guideline would benefit from greater emphasis on the significance of hearing impairment in the context of autism. For example, we consider that the Guideline could provide more detail about the importance of a comprehensive audiological assessment as part of best practice for the development of an ASD diagnosis. While Table 8 refers to the need for a screening test or a full auditory evaluation, there is no reference or information elsewhere in the Guideline as to why such an assessment is important. For instance, some indices for ASD may include delayed or atypical language, which are also signs of possible hearing loss. Moreover, undiagnosed comorbid hearing impairment, if left untreated,	Audiologists are included in the list of other professionals who can provide information to support the ASD assessment. The Medical Evaluation involves testing hearing and vision status, hearing assessment (e.g. screening test or full auditory evaluation) and vision assessment (e.g. screening test, sight test or full ophthalmologist evaluation) were provided as examples of further assessment at Stage 3, and hearing and vision impairments have been listed in the new table on possible differential or co-occurring diagnoses.

			may reduce the benefit that the child with ASD gains from the relevant early intervention therapies. We also note that hearing loss and associated disorders are not specifically listed as one of the important elements to take into account when considering the prospect of ASD diagnosis for different age groups (0-5 years, 6-16 years, 17 years or older) in Tables 10, 11 or 12. Of particular relevance would be the elevated incidence of temporary middle ear related hearing loss in children of preschool age and its potential impact on a variety of other behaviours and assessments; and auditory processing disorders that may impact classroom learning and behaviour. Audiology Australia would also like to suggest that the Guideline highlights the role that audiologists have in diagnosing (or ruling out) hearing loss in children, particularly those difficult-to-test children suspected of having a diagnosis of ASD and, consequently, audiologists' important role as part of the interdisciplinary health team. For instance, while the Guideline identifies audiologists as a Professional Informant in Table 7, Audiology Australia requests that audiologists be included in the list of Professional Informants at 6.6 of the Guideline. We also suggest adding 'audiologist' as a Professional Informant under the 'Functional' category of 'Communication and language difficulties such as potential speech delay or language delay / disorder and stuttering' as some of these issues may occur as a result of hearing difficulties. We also recommend adding Otolaryngologist (Ear Nose and Throat (ENT) specialist) to 6.6 of the Guideline as those children who are found to have middle ear pathology may be recommended to consult with an ENT for treatment of comorbid middle ear problems before having their hearing retested by an audiologist.	
	ID1002		Another important factor is that - just as a speech pathologist can only diagnose ASD with sufficient training and experience	The Guideline has recommendations regarding the skills and expertise of professionals involved in the ASD assessment

			- a child with suspected ASD should be assessed by an audiologist who specialises in assessing children. We believe that this should be referred to in the Guideline.	process, which would include audiologists who form part of the assessment team.
	ID1003		In consultation with our expert members who specialise in paediatric audiology, Audiology Australia would also like to make some best practice recommendations in regards to behavioural hearing assessments for children who do have or may be suspected of having an ASD diagnosis as set out below. We particularly wish to emphasise the importance of testing the hearing of children suspected of ASD aged under 5 years and – in terms of best practice – if possible referring these children for behavioural hearing assessments before the age of 2½ years. This gives the paediatric audiologist the best chance of successfully assessing hearing using conventional behavioural techniques. As a minimum test battery, we would recommend (in no particular order): • Otoscopy • Tympanometry • Otoacoustic Emissions • Auditory Processing Disorder assessments • **B**ehavioural hearing assessment – Visual Reinforcement Orientation Audiometry (VROA) is most likely to be most effective particularly if conducted before the child is 2 to 2½ years old. We recommend that this test is conducted by experienced paediatric audiologists in an appropriately sound treated environment. Ideally the procedure should involve two paediatric audiologists due to the built-in checks for bias which are missing when one audiologist performs VROA. The question being asked as part of this process is essentially: 'Is there a hearing loss sufficient to account for the	Thank you for this comment. This issue is out of scope of the project terms of reference, and so no amendment has been made. However, we note that we have made recommendations regarding professional bodies developing competency-based training programs for professionals involved in the ASD assessment process. Please refer to the 'Overview of Major Amendments' chapter under the following heading: • Accreditation and Regulation • Practice points for clinical, research and policy settings

			child's communication delays?' Audiologists endeavour to answer that question first for VROA before doing any objective tests since these may frighten children with ASD, making further assessment difficult.	
	ID1004		We also note that children being considered for an ASD diagnosis are often challenging to assess using conventional techniques. This may lead some medical practitioners to wait until the child is older before referring them for a hearing assessment in the belief that they will be able to cope better at that age. However, Audiology Australia strongly recommends that the initial hearing test not be delayed. Situations may occur where there are 6-year-old children with severe ASD who are too old for VROA and not ready to wear headphones or do play audiometry. In these circumstances, sedating the child for an objective assessment by a hospital audiologist undertaking an Auditory Brainstem Response test may be the only available option. If clinicians are unable to obtain a result at the first hearing assessment, they will not test a child over and over as this is clearly counterproductive. Clinicians can evaluate the information that they have been able to gather and make appropriate decisions and recommendations. A recommendation may be that the doctor directs the child into 6 months of speech therapy and – following this time – that the child have another hearing assessment. Waiting for this period for another hearing assessment will generally not present a problem so long as the ASD diagnosis process for the relevant child is not delayed on the basis of the (currently) incomplete hearing assessment.	Thank you for this comment. It is beyond the scope of the Guideline to provide specific recommendations regarding audiological testing. However, we note that we have made recommendations regarding professional bodies developing competency-based training programs for professionals involved in the ASD assessment process. Please refer to the 'Overview of Major Amendments' chapter under the following heading: • Accreditation and Regulation • Practice points for clinical, research and policy settings
	ID1005		Audiology Australia further recommends that the Guideline specify the importance of evaluating children who may be suspected as having an ASD diagnosis for Auditory	Auditory Processing Disorder has been included in the list of co-occurring/differential conditions (web resources).

			Processing Disorder (APD). It is important to distinguish between APD and ASD. APD is an auditory disorder that impacts how sounds are processed and understood. It is not the result of a global condition such as ASD; rather, APD and ASD are two separate conditions. That being said, some of the behaviours of children with ASD and APD may appear very similar, such as difficulty understanding speech in noisy environments, following directions and behaving as if a hearing loss is present. In some circumstances, APD may also co-exist with ASD or other disorders. In these cases, careful assessment can assist in making an accurate diagnosis. A multidisciplinary team approach is crucial to fully assess and understand the problems exhibited by children who may have ASD and/or APD. The audiologist will play an important role in this process, determining the type of auditory condition a child may exhibit and recommending appropriate individual management and treatment activities.	
	ID1006		Audiology Australia further recommends that headphones should only be introduced if a parent is completely confident that their child will accept the headphones and will tolerate sound coming through them. In a recent example, Audiology Australia members had a parent of a child indicate that their child ‘wears headphones all the time at home’ but the child became very distressed on the first presentation of a sound through the headphones. Only subsequently did the parent advise that their child ‘uses the headphones at home to block out all the sounds’.	Thank you for this comment. This issue is out of scope of the project terms of reference, and so no amendment has been made.
	ID1007		Finally, we recommend that parents should be encouraged to inform the audiology clinic when booking the appointment that their child is suspected of or undergoing assessment for ASD to ensure that the child is booked into an appointment with appropriately skilled staff. We also recommend that parents be encouraged to book an appointment at a time most suited to the child and inform the clinic ahead of time of any special	Thank you for this comment. This issue is out of scope of the project terms of reference, and so no amendment has been made.

			needs their child has - for instance, that their child is frightened of soft toys or has a strong interest in doors.	

A = Autistic individual; AR = Academic Researcher in ASD; C = Caregiver to an autistic individual, CDE = Carer of an individual who is currently, or considering, undergoing a diagnostic assessment for autism; F = Family member of an autistic individual; I = Individual who is currently, or considering, undergoing a diagnostic assessment for autism; O = Advocacy or service provider organisation; P = Partner of an individual with a suspected ASD; PD = Professional conducts Diagnostic Evaluations for autism; PR = Professional who refers individuals to Diagnostic Evaluations for autism; PS = Professional who provides services to autistic individuals or their carers/ families; Spouse of an autistic individual.

5. Appendix A: List of Respondents Providing Feedback and Corresponding Identity Number

Respondent ID	Organisation Details
1	Individual submission
2	Individual submission
3	Individual submission
4	Individual submission
5	Individual submission
6	Individual submission
7	Individual submission
8	Individual submission
9	Individual submission
10	Individual submission
11	Individual submission
12	Individual submission
13	Individual submission
14	Individual submission
15	Individual submission
16	Individual submission
17	Individual submission

18	Individual submission
19	Individual submission
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28	Individual submission
29	Individual submission
30	Individual submission
31	Individual submission
32	Individual submission
33	Individual submission
34	Individual submission
35	Individual submission
36	Individual submission
37	Individual submission
38	Individual submission

39	Individual submission
40	Individual submission
41	Individual submission
42	Individual submission
43	Individual submission
44	Individual submission
45	Individual submission
46	Individual submission
47	Individual submission
48	Individual submission
49	Autism Queensland
50	Individual submission
51	Individual submission
52	Department for Education and Child Development - South Australia
53	Individual submission
54	Individual submission
55	Noah's Ark Inc.
56	Individual submission
57	Individual submission
58	Individual submission
59	Individual submission

60	Individual submission
61	Individual submission
62	Individual submission
63	Individual submission
64	Individual submission
65	Individual submission
66	Forrest Parade School
67	Individual submission
68	Individual submission
69	Individual submission
70	Individual submission
71	Individual submission
72	Individual submission
73	Individual submission
74	Individual submission
75	Individual submission
76	Individual submission
77	Individual submission
78	Individual submission
79	Individual submission
80	Individual submission

81	Autism Association of Western Australia
82	Speech Pathology Australia
83	University of Western Australia
84	Individual submission
85	Individual submission
86	Individual submission
87	Individual submission
88	Individual submission
89	Individual submission
90	Individual submission
91	Tasmanian Autism Diagnostic Service
92	Individual submission
93	Individual submission
94	Individual submission
95	St Giles Society
96	Individual submission
97	Individual submission
98	Australian Association of Social Workers
99	Queensland Child and Youth Clinical Network (QCYCN) - Child Development Subnetwork (CDSN)
100	Amaze
101	Individual submission

102	Individual submission
103	Royal Children's Hospital (Team Coordinator)
104	Individual submission
105	Occupational Therapy Australia
106	Individual submission
107	Diverse Minds Psychology Clinic
108	The Australian Autism Alliance
109	Association for Behaviour Analysis Australia
110	No submission
111	Deakin Child Study Centre, Deakin University
112	The Australian Psychological Society
113	Individual submission
114	Child Development Service, Community Services Directorate, ACT Government
115	No submission
116	Individual submission
117	Individual submission
118	Individual submission
119	Individual submission
120	Individual submission
121	Australian Psychological Society College of Educational & Developmental Psychologists
122	Flinders Medical Centre

123	No submission
124	Anonymous Organisation
125	The Australian Clinical Psychology Association
126	Australian Medical Association
127	NSW Government Health - Central Coast Local Health District (Child & Family Health Developmental Assessment Team)
128	Manual Organisation Submission *
129	Individual submission
130	Dieticians Association of Australia
131	Officer of Director-General ACT Government Health
132	Djerriwarrh Health Service (group of respondents)
133	Individual submission
134	Australian Association of Developmental Disability Medicine
135	Individual submission
136	Individual submission
137	Autism Asperger’s Advocacy Australia (A4)
138	Yellow Ladybugs
139	Mindful
140	Neurodevelopmental and Behavioural Paediatric Society of Australasia
142	The Royal Children’s Hospital Melbourne (group submission: Psychologists, Speech pathologists, Paediatricians, Occupational Therapists, Psychiatrists, ASD Service Coordinators)

143	Children’s Health Queensland Hospital and Health Service (Medical Director Child Development Program, Developmental-Behavioural Paediatrician, Director Child Development Program)
144	Manual Organisation Submission *
145	Individual submission
146	Manual Organisation Submission *
147	Anonymous Organisation
148	Western Australian Autism Diagnostician Forum
149	Royal Australian and New Zealand College of Psychiatrists
150	Women’s and Children’s Health Network - SA Health
151	Manual Organisation Submission *
152	Individual submission
153	Government of Western Australia: Department of Communities (Previously Disability Services Commission until 1 July 2017)
154	Manual Organisation Submission *
155	Manual Organisation Submission *
156	Individual submission
157	Individual submission
158	Individual submission
159	Manual Organisation Submission *
160	Manual Organisation Submission *
161	Audiology Australia

Anonymous Organisation * refers to an organisation who made an online submission and did not select the option for their name to be published alongside your submission in the supporting documents for the Final Guideline.

Manual Organisation Submission * refers to an organisation who did not use the online submission process, and has not since provided consent for the name of their organisation to be published alongside your submission in the supporting documents for the Final Guideline.

Please note that the names of these organisations were included for the confidential methodological, content and NHMRC reviews to allow the reviewers to consider the breadth of feedback provided on the Guideline. These organisations represent a wide range of government departments, private providers, universities, advocacy groups and associations / colleges at a state and national level.