OT AUSTRALIA WA
Australian Association of Occupational Therapists WA (Inc)

8th May 2008

The Principal Research Officer
Education and Health Standing Committee
Legislative Assembly
Parliament House
Perth WA 6000

Re: Inquiry into the General Health Screening of Children at Pre-Primary and Primary School Level

Dear Committee Members,

Thank you for the opportunity to provide a response.

SUBMISSON FROM THE ASSOCIATION OF OCCUPATIONAL THERAPISTS WA

Since the late 1990's Child Development Services around the world have responded to the Early Brain Development evidence, which requires that health, social and education services should identify children as young as possible in order to attain the most effective intervention outcomes. This also requires engaging families in a family partnership model of care, and providing parenting education and support.

Assessment and intervention for young children with identified developmental difficulties is provided by Occupational Therapists (OT) in WA through a range of service providers including the:

- Dept of Health Child Development Services, Child and Adolescent Community Health (CAHS) and WA Country Health Services (WACHS).
- Private Practitioners specialising in services for children, and
- NGO's such as the Speech and Hearing Centre, Wembley

Some private practitioners are registered to provide the 5 Allied Health sessions available through the Enhanced Primary Care (GP) Medicare items.

Occupational Therapy services available through funded providers of the Disability Services Commission, available for children eligible for DSC registration, are not discussed in this submission.

Assessment (Appropriate Service)

Occupational Therapists assess children identified with developmental concerns in areas of occupational performance that include:

- Play & playskills (includes disordered play such as repetitive play etc)
- Fine motor skills: including: cutting, drawing, pre–writing, letter formation writing skills & pencil control
- Hand preference and /or dominance development and bilateral coordination

- Co-ordination delay/disorder: may include difficulty with strength, endurance, stability and/or joint laxity.
- Motor planning (praxis) and organisation of the motor task, sequencing etc.
- Sensory Processing Disorder and self regulation.
- Activities of daily living : feeding , toileting, dressing etc
- Visual Perception: visual discrimination , visual memory, form constancy, which impact in learning etc
- Attention/ Concentration
- Specific Learning Difficulties of which any of the above contribute to the difficulty

Behavioural problems in very young children are frequently a response to their experiences of failure, challenges and frustration in any of the above listed domains of development, which may be further contributed to with a co-existing language & speech delay or specific learning difficulties.

Access to appropriate services for children identified with motor-skill difficulties

Evidence provided by Canadian and USA research & studies demonstrates that Family Relationships and Parenting Capacity have profound impact on children's emotional well being. The evidence also informs us that emotional well being and resilience is also an indicator for good social, developmental and educational outcomes. Improving family functioning and providing "best environments" such as quality child care and pre school programs in The Early Years positively affects the child's potential and ability to learn. (Early Years ref Fraser Mustard. Re-thinking the Brain ref Rima Shore)

The Occupational Therapist's assessment will make reference to all developmental and educational concerns the child may be experiencing, as well as family functioning, as appropriate. Within a family partnership model of care this provides the family with information to assist and support their child's play, therapy & education goals, daily living skills, and social behaviour.

For effective outcomes to therapy, Occupational Therapists recommend that assessment and intervention for children is best provided in their normal environment (ref: Fraser Mustard) as this informs a more accurate assessment through the observation of the child in his/her natural context (home, child care, playgroup,) and facilitates setting accurate intervention goals through multi-disciplinary collaboration (parents, child care staff, teachers and therapists)

Pre- primary and primary school age children experiencing specific learning and motor difficulties should have access to Occupational Therapy services in the classroom environment. This will achieve more effective outcomes through using the child's natural learning environment and providing a team approach to intervention (therapist, teacher and parent)

Currently Dept of Health Occupational Therapists working in Child Development Centres across the metropolitan area are not resourced to provide this service in schools. OTs and teachers establish contact through written and telephone consultation and liaison. Where there are serious and complex concerns, Dept of Health OT services may be able to provide one school visit for the purpose of a teacher and family case conference.

Recommendation: School based Occupational Therapy services are more effective for better educational outcomes for children aged 5 – 12 years who have been identified as having sensory motor delays contributing to learning difficulties. These services need to be Government funded on top of existing Child Development Services (DoH) by either the DoH or DEET.

Adequacy and Access to services

Occupational Therapists and all the Child Development Service clinical staff are currently unable to provide timely early intervention due to waitlists. Services prioritise Early Intervention evidence based) and this can mean that some school aged children receive little or no direct therapy. Families and teachers may be able to avail of a consultation service but this is not adequate for children with complex developmental, learning and behavioural challenges. The waitlists and unmet need for therapy provision is due to lack of any workforce growth over the last 10-15 years in the context of not only a large increase of referrals but also the increase of the developmental and social complexity of those referrals (eg Autism , Family Dysfunction, Population growth 0-5 yrs and Engaging CALD and Aboriginal families)

Due to the developmental continuum of young children with developmental and learning difficulties, these children require ongoing services over many years. This in itself means that Therapists carry “active” caseloads of hundreds of children each, who require ongoing reviews and support as well as trying to manage new referrals.

Specifically Occupational Therapists would like to highlight the following areas of limitation within the CACH Child Development Services (CDS)

The CDS cannot continue with its burden of unmet need without allowing the “true“ waitlists to emerge – (ie: listing children as they are referred and not allocating resources “managing the waitlists” eg Parent Advise Clinics, Teacher Education groups etc)
If this was to occur children would wait up to 2 years for some services and 12 months would be commonplace for most Allied Health including Occupational Therapy

CDS already provides a consultation and liaison service only for primary school aged children due to lack of staff positions.

There is also a lack of workforce with appropriate cultural identity (CALD and Aboriginal Health Workers) who can appropriately engage families who are difficult to reach. These families are referred to CDS as the child has been identified by child care staff, kindergarten teacher, Child Health Nurse or AMS but don’t attend appointments. The child’s developmental needs are unmet.

All families are encouraged to access the Enhanced Primary Care Medicare 5 Allied Health sessions through their GP while they wait for public services. All families with private cover are encouraged to use this, but for services such as OT and Speech Therapy the rebate finishes after $600 approx combined ie. $300 each service if the child needs both, which only provides a few sessions. Children with complex difficulties who require multi-disciplinary and ongoing team management require CDS services.

Implications for unmet need and inadequate services

Continuing to accept all referrals that fit the CDS intake criteria may mean that the ‘evidence of best practice’ would be to stop providing any service for school aged children, rather than continuing with unreasonable waitlists and minimal (?non effective) intervention services. This would have major implications re restricted access and inequity of services for families.

Unmet need is further increased by the ineffective use of clinicians and therapy assistant’s time doing administrative duties - due to lack of admin staff positions.

There have been no categories of developmental problems that we have been able to 'exit' from the CDS service criteria.

Assessment Waitlists in months for Priority Children eg: 0-5 yrs
Occupational Therapy is 3 - 12 months. Differences in waitlist times are due to service sites having different numbers of Occupational Therapists, demographics in the catchments and different service priorities.

The Play and Learning (PAL) Home Visiting Service is for complex children & families (supports families as a "first in" service)and is the "fast response" service with a waitlist of 2 - 6 months. Occupational Therapists are located within this trans-disciplinary program.

In summary Occupational Therapists working in the Child Development Services of CAHS across metropolitan WA, provide Assessment and Intervention services for children which are based on international standards of practice for Developmental Paediatric OT.

With reference to the Terms of Reference for this Committee the services provided by OT are most appropriate for children of pre- primary and primary age with identified motor difficulties.

Following 15 years of no increase in staff resourcing and years of utilising innovative waitlist management strategies to try to manage waitlists as best as possible, the unmet need for therapy service provision can no longer be absorbed eg. providing parent education sessions without assessing the child, providing consultation and liaison services only, therapy in groups only etc

Operating true waitlists would not allow Child Development Services to provide any early intervention as children could wait well over 12 months to be assessed.

Evidence based practice would suggest it may be better to provide no service at all than one that is so diluted that it is ineffective.

The Dept of Health OT services are not adequate due to lack of staff resources (FTE) to meet the demand made of the Child Development Services of metropolitan WA. Real waitlists (not those "managed" through other tactics of family engagement with the service) of over 12months are not acceptable to staff or the community. Staff morale in these services is low amongst highly skilled and experienced therapists and staff retention occurs out of a commitment to the children. We cannot "expect" this of younger therapists entering the DoH services and they will not stay under such pressures.

Children of school age would receive more effective therapy with better learning outcomes if the therapy services were provided in the normal learning environment in collaboration with the teacher, classroom routines and other educational support services. Children are now withdrawn from school to travel to a therapy service and frequently miss important classroom learning opportunities for those who are already experiencing learning and behavioural challenges.

Please contact me for further clarification.

Developmental Paediatric Special Interest Group
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