Submission to the Inquiry into child development services from Occupational Therapist in Western Australia

This is a joint submission from the Developmental Occupational Therapy Association of Western Australia [DOT(WA)] and the Western Australian Occupational Therapy Association (WAOTA), two peak bodies who represent occupational therapists working in Western Australia.

DOT(WA) is a voluntary organisation that provides support to occupational therapists who work with children within Western Australia. Currently, there are 166 members of this association.

WAOTA is the state association supporting Western Australian registered occupational therapists, occupational therapy support staff and students. There are currently 713 members of WAOTA, which includes therapists working across the lifespan.

In October, 2022, DOT(WA) and WAOTA developed an survey (designed for purpose in Qualtrics) and distributed the survey online to members of both associations. The survey questions addressed each of the terms of reference as set out by the Select Committee into child development services. The survey remained open for 10 days and a total of 48 responses were received, including a mix of DOT(WA) and WAOTA members. In addition to the survey responses, the deputy chair of DOT(WA) received individual email and face-to-face communications from three occupational therapists regarding child development services in Western Australia. The submission below is a compilation of survey responses and individual communications.

In response to each of the terms of reference, DOT(WA) and WAOTA submit the following on behalf of Western Australian occupational therapists:

The role of child development services on a child's overall development, health and wellbeing

Child development services play a crucial role in the development, health and wellbeing of children. As occupational therapists, we are particularly concerned with a child's participation in activities of daily living, play, education, rest and sleep and social participation. We view participation as essential to the health and wellbeing of all children, and we work collaboratively with families to develop goals targeted at meaningful participation.

Occupational therapists maintain that occupational performance is optimised when children's environments (social and physical) and skills (motor, sensory, cognitive, emotional, and social skills) meet the demands of the activity. Therefore, child development services must consider the person, their environment, and their occupations in order to adequately support children with developmental concerns.

Occupational therapists value strengths-based services and as such, we feel that an essential role of child development services is **EARLY IDENTIFICATION** of children's strengths and areas of difficulty and very importantly, **TIMELY DIAGNOSIS** where applicable. Early identification of specific challenges and the provision of appropriate diagnoses can help families to access appropriate services to minimise the impact of development delays upon children's occupational performance, health and wellbeing. Targeted, early intervention services can assist children to develop skills, and families to develop strategies to maximise participation across all daily activities. Child health nurse developmental reviews play an essential role in early identification and are particularly crucial around the 8–9-month mark where nurses can identify (among other things) delayed motor or language skills, difficulties in vision or hearing and early signs of neurodevelopmental conditions.

If children present with significant difficulties or diagnoses that are likely to be enduring and cause permanent and significant disability, child development services play an essential role in **REFERRAL TO APPROPRIATE SERVICES**. Services such as the NDIS can be extremely difficult for families to access and therefore, it is essential that referral includes some support of families until the point of access to other services.

A primary role of child development services is to **PROVIDE MEDICAL AND THERAPEUTIC SERVICES TO CHILDREN WITHOUT SIGNIFICANT AND ENDURING DISABILITIES,** i.e. children who are not eligible for disability services. It is these children who often 'fall through the gaps' and although they may not meet criteria for significant and permanent disability, they can have significant impairment in their occupational performance across a range of activities.

It is essential that child development services **PROVIDE TARGETED EARLY INTERVENTION** which is proven to have the greatest impact upon children's occupational performance and ultimately their health and wellbeing. Whilst the evidence for best practice in specific interventions can be mixed, it is very well documented that early intervention has greater impact on development and without it, the incidence of mental/physical health concerns is significantly increases and school performance and participation in sports and recreational activities are decreased. Moreover, within some specific neurodevelopmental disorders, the risk of criminality in later life is significantly increased.

Occupational therapists value the contribution of other medical and allied health staff and as such, we feel that **COLLABORATIVE TEAMWORK** is another essential role of child development services. Importantly, occupational therapists consider the child and family to be the key members of the child development team. To **WORK IN PARTNERSHIP WITH FAMILIES**, child development services must ensure they prioritise child and family goals and provide flexible services which includes information sharing among all members of the team.

How child development services are delivered in both metropolitan and regional Western Australia

Currently, we believe that **CHILD DEVELOPMENT SERVICES IN BOTH METROPOLITAN AND REGIONAL WESTERN AUSTRALIA ARE IN CRISIS** and children and families are currently not receiving adequate service to maximise children's occupational performance, health and wellbeing. We understand that referrals to public child development services have increased exponentially, whilst staffing in both allied health and medical services has had minimal to no increase.

PUBLIC AND PRIVATE WAITLISTS FOR MEDICAL AND ALLIED HEALTH SERVICES APPEAR TO BE AT AN ALL-TIME HIGH and this does not enable the early identification of developmental concerns, timely diagnosis, or referral to disability services such as the NDIS. Child health nurse resources appear to be reduced and as a result, children can go many years before developmental concerns are identified.

At this time, **ACCESS TO CHILD DEVELOPMENT SERVICES IS NOT EQUITABLE** and children from higher socio-economic backgrounds are more likely to receive services. Wait times and limited occasions of service in public services have meant that many families do not have access to services for many years and often seek therapy from private providers in the interim. However, current rebates from Medicare GP complex care plans and private health insurance schemes are very low and as such, even families who are eligible for a GP complex care plans or those with private health insurance are often unable to afford private occupational therapy services.

Furthermore, families who are fortunate enough to be able to afford the expense of private therapy are also unable to access child development services. This is due to private providers currently have long waitlists and in many metropolitan areas, private therapists have closed their books to new referrals, further limiting access to required services.

In the past, most private occupational therapists in Western Australia provided the bulk of their services to children with developmental concerns that were not likely to cause significant permanent disability. Children with significant developmental delays largely received services from organisations funded by the Disability Services Commission (DSC). However, since the introduction of the NDIS, the caseloads of private practitioners have undergone significant change. Currently, private occupational therapy practitioners provide services to children with a much wider range of abilities, and this has lead to significant waitlists in private practice.

REFERRAL, AND SUBSEQUENT ACCEPTANCE TO THE NDIS IS A LONG AND PROTRACTED PROCESS which impacts public services provision. Children who are eligible for NDIS can remain in public services such as Early Intervention services at Perth Children's Hospital or Child Development Services for extended periods of time, adding to the long public wait times for services.

Long waitlists/private services that are closed to new referrals are not specific to the field of occupational therapy and we find that our medical and allied health colleagues face these same issues. In particular, **ACCESS TO PAEDIATRICIANS (PUBLIC OR PRIVATE) IS EXTREMELY DIFFICULT** and can take many years. Often, occupational therapists and other health professionals identify specific concerns that require timely review by a qualified medical practitioner, however, such services are not available. In some instances, families have been told that Autism assessment will take 3 years in the public system, which is clearly inadequate. The protracted wait times for diagnoses have a deleterious effect on children's self-esteem and performance at home, school and the community due to their needs being poorly understood. Furthermore prior to diagnosis the children do not qualify for the appropriate support in the aforementioned environments.

In the private system, occupational therapists can often find themselves working as a sole practitioner with a child and their family, who cannot afford or cannot find availability for other allied health services. This means that **INTERDISCIPLINARY COLLABORATIVE PRACTICE IS NOT POSSIBLE** in the current Western Australian child development services. Such collaboration also appears limited in the public services where children are often seen by one health professional in isolation. The goals of the child/family and the child's level of need do not appear to impact the number of occasions of service in the public system, or the access to a full team of professionals.

The pressure on public services appears to have changed the level and type of assessment and interventions provided. In our experience (and as reported by parents at times), assessments and interventions can be very prescriptive and inflexible, meaning that a focus on the unique goals of each child and **FAMILY CENTRED PRACTICE IS NOT ACHIEVED**. In many instances, **BEST PRACTICE INTERVENTIONS CANNOT BE IMPLEMENTED** due to the limited occasions of service that are allocated to individual children.

Currently public child development services tend to be inaccessible to families from culturally and socio-economically diverse backgrounds. The services that are currently provided publicly do not allow for flexibility for families according to cultural needs. Furthermore, appointment times can be inflexible and families who rely on both parents to work, or families of working single parents often miss appointments due to work commitments. As a result, families can easily miss appointments and such non-attendance typically results in discharge from services.

THE DIFFICULTIES SEEN IN METROPOLITAN WESTERN AUSTRALIA ARE MAGNIFIED IN RURAL AND REMOTE AREAS. Some occupational therapists report that it can be "impossible to get a diagnosis," let alone a timely diagnosis in regional Western Australia. The Northwest services were highlighted as particular areas of concern where therapists employed within the public system cover a very wide range of services and child development services are seen as low priority. There are very poor levels of allied health and medical professionals servicing these areas.

In the experience of our members, there are also significant gaps in services to children affected by family domestic violence and for refugees. Children from these backgrounds already face significant challenges which place them at risk. Additional developmental issues can compound these difficulties if they are not addressed adequately by child development services.

The role of specialist medical colleges, universities and other training bodies in establishing sufficient workforce pathways

We believe that it is the role of tertiary education facilities to **ENSURE QUALITY EDUCATION OF MEDICAL AND ALLIED HEALTH PROFESSIONALS** that highlights the importance of early intervention and strength-based, family centred services.

With many small, private practices providing child development services to children with significant and enduring disabilities and to those without, the current occupational therapy workforce is lacking in numbers consisting of many inexperienced therapists and few senior practitioners. **GREATER NUMBERS OF OCCUPATIONAL THERAPY GRADUATES ARE REQUIRED** and new, innovative **POST GRADUATE OPPORTUNITIES SHOULD PROVIDE PRACTICAL, CLINICALLY RELEVANT EDUCATION** to ensure ongoing development of this very young, inexperienced workforce. Supervision of the junior workforce may require unique models of services provision that ideally include dual input from universities AND practitioners.

Essential student placement experiences are currently in short supply as the inexperienced work force are not necessarily equipped for student supervision. Furthermore, due to the shortage of occupational therapist in Western Australia, providers are more likely to provide placements to students in their graduating year, in the knowledge that these students will soon be potential employees.

Some of the Western Australian universities **PROVIDE STUDENT CLINICS** which offer child development services to children who are currently not eligible for services elsewhere, or who are waiting for public child development services. These clinics play an important role in educating the future workforce and in providing services for children with developmental concerns. We feel that there is great potential for student clinics (across a range of medical and allied health disciplines) to **WORK COLLABORATIVELY WITH WESTERN AUSTRALIAN PUBLIC SERVICES** to provide increased quality services and greater frequency of service to children with developmental concerns. Whilst students cannot replace professionals, there is the potential for students to supplement occasions of service and dedicated, structured programmes that are jointly managed by Health Department and universities could potentially address some of the current gaps in child development services in Western Australia. With input from quality, experienced clinicians, these clinics could equip medical and allied health students with the necessary skills to enhance child development services (public and private) as new graduates. Additional FTE within the early intervention services at Perth Children's Hospital and in Child Development Services could be used to develop new models of intervention utilising students.

In regional Western Australia, the number of student placements are minimal. It is assumed that these placements are costly and can be difficult to arrange, particularly in terms of accommodation and supervision. However, initiatives in collaborative clinics run jointly by university and health collaboration would likely benefit children and families in rural and remote Western Australia.

How to increase engagement with, and collaboration between, government and nongovernment child development services including Aboriginal Community Controlled Organisations

In the past, block funding by the DSC allowed for large, interdisciplinary teams to work collaboratively with families, the child and other relevant agencies. However, it has been our experience that collaboration across agencies in Western Australia is currently very poor. This appears due (in part) to:

- Territory guarding - as funding can often be unstable and agencies tend to work in opposition, vying for funding, rather than collaborating with one another. Improved collaboration is required between government services and non-government organisations; and
- Limited occasions of service – in both public and private services have meant that clinicians tend to use available therapy time for direct service or parent education/coaching, which leaves little time for collaboration within and between agencies.

It is unlikely that 1:1 therapy will generalise, or result in significant, functional outcomes if clinicians do not have sufficient time to collaborate with other members of the child's team – especially their family.

The feedback from members of DOT(WA) and WAOTA suggests that engagement with Aboriginal people and organisations is very poor in Western Australian child development services. Improvements might be achieved by:

- Education of local, Aboriginal people as therapy assistants to improve engagement with Aboriginal children and families;
- Greater flexibility in services, to allow true family centred practice across all cultures;
- Improved communication with consumers, particularly as the current paperwork and systems are not accessible to all cultures;
- Additional scholarships for indigenous students to study medical and allied health;
- Collaboration with Aboriginal organisations to develop (for example) culturally appropriate resources, screening tools and interventions.

How child development service models and programs outside of Western Australia could be applied in Western Australia.

The Western Australian department of education appears to have very little connection with child development services, apart from limited psychological services. In the UK, and in some other Australian states, the education department employs allied health professionals alongside school psychologists. Such a structure provides a unique opportunity for screening and early intervention, and it can enhance early identification of developmental difficulties as well as improve social and academic outcomes for children. Ecological interventions have the greatest impact on child development and greater school-based services would enhance collaboration and information sharing between health and education specialists.

Western Australia is clearly unique due to our geographical size, with many rural and remote areas that are currently underserviced. **A JOINT EDUCATION AND HEALTH SERVICE MODEL** could have a significant impact on child development services in regional Western Australia. Here, Aboriginal staff liaison officers could work alongside families and medical/allied health/education staff to ensure culturally relevant ecological and family centred practice.

Child and Parent Centres (CPCs) within schools offer an excellent way for child development services to engage with the community, supporting families and schools. However, currently the services that are offered as part of the Western Australian CPCs is limited to speech pathology services. There is potential for **CHILD AND PARENT CENTRES TO ACCOMMODATE A GREATER RANGE OF HEALTH PROFESSIONALS** and the scope of services could include capacity building in the local community e.g. allied health led sessions within established playgroups and pre-kindy programmes. Within the CPCs, education for families and triage of referrals to child development services could potentially reduce waitlists in both public and private child development services.

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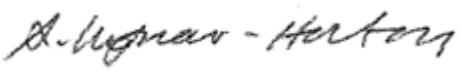

Sally Wojnar-Horton
On behalf of WAOTA
11/11/2022

Inquiry into Child Development Services

Submission number: P00080

Submission received: 14 Nov 2022

Organisation name: Developmental OT Association WA and WA Occupational Therapy Association

Position: Administrator

Title:

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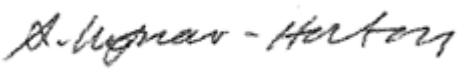

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