The Australian Medical Association (WA) is Western Australia's peak medical representative body representing medical practitioners' professional interests.

We represent the views of WA's medical profession to the government and community and seek the resolution of major social and community health issues from a moral, ethical and medical perspective with the interests of the patients and the people at the core of our engagement.

In the spirit of reconciliation, the AMA (WA) acknowledges the Traditional Custodians of country throughout Australia and their connections to land, sea and community. We pay our respect to their elders past and present and extend that respect to all Aboriginal and Torres Strait Islander peoples today.

The AMA (WA) welcomes the establishment of a Select Committee to examine child development services in Western Australia.

We would like to acknowledge the dedicated, hard working staff in WA's child development services, who continue to provide excellent healthcare and support to patients and their families while facing insurmountable challenges including severe service funding shortages, excessive workloads that continue to grow, and workforce shortages.

Engagement with our members, including survey responses point to services that are not inefficient, but are completely overwhelmed, suffering from severe under resourcing which has resulted in:

- limited service capacity;
- preventable barriers to accessing care including unacceptable patient waiting times and regional; and
- an overstretched, burnt-out workforce.

These issues obviously have a detrimental impact on patients and their families, and the AMA (WA) believes that Select Committee recommendations should aim to dismantle barriers to access to care and improve service capacity in WA.

The AMA (WA) also stresses the importance of government and health system intervention to bolster and support the expansion of child development services workforce and training opportunities in Western Australia. Limited training opportunities and a service that is plagued by systemic workforce shortages, does not present an attractive or sustainable training pipeline for those interested starting a career in child development services, nor does make WA an attractive place to relocate.

The AMA (WA) conducted a survey of all members, with specific invitations sent to paediatricians, general practitioners and psychiatrists, to respond to questions on WA's public child development services. The survey received over 100 responses in a short period of time, with responses received from a range of medical specialty groups and from doctors who currently provide public child development services, and those who don't, but have an interest or experience in WA public child development services.

A selection of practitioners' views in relation to the following questions, are provided from page 6 onwards.

- What are the key changes that need to be made to improve public child development services in WA?
- In terms of general practice, what can be implemented to support child development services in WA?
- What should be done to support specialist medical colleges, universities and other training bodies in establishing sufficient workforce pathways?

The AMA (WA) presents the results of our survey to the Select Committee.

AMA (WA) – WA Parliament Select Committee Inquiry into Child Development Services Survey

- All survey questions were optional.
- Not all respondents answered all survey questions.
- n = 117
- Minimum question response n = 112

In your experience, currently how long (months) do public patients need to wait to access child development services in WA?

Respondent Group	Average Number of Months
All Respondents	**30 months**
Only General Practitioners	**30 months**
Only Paediatricians & Child Health Specialists	**31 months**
Only Psychiatrists	**39 months**
Only Drs that provide public CD services	**24 months**

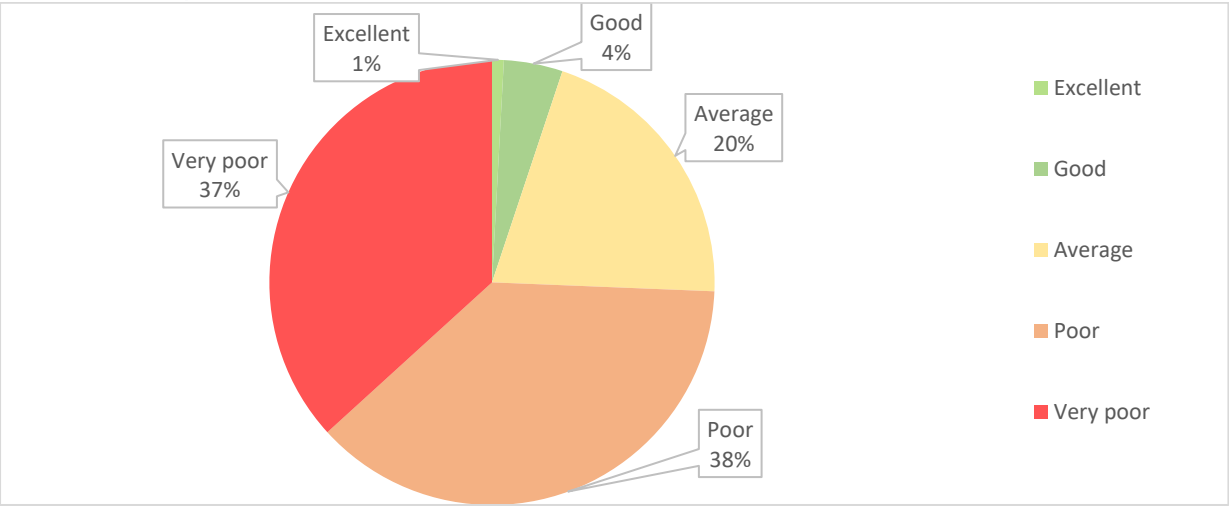
Observations

These responses are subjective and based on a practitioners' individual experience. WA's Child Development Service and medical colleges will be able to report comprehensibly on wait times and how these compare with the clinically recommended time for first specialist outpatient appointment.

The AMA (WA) understands that current wait times exceed clinically recommended wait times. Service provision must be funded to support demand, this includes enabling multidisciplinary teams of health professionals to provide child development services by creating sustainable and supportive working and learning environments, that are appropriately staffed to provide the required service.

The AMA (WA) also suggests the Select Committee consider other factors that may influence current wait times, including patients who would otherwise seek treatment in WA's public services, seeking treatment elsewhere due to lack of public service capacity.

Overall, how would you rate the WA Govt/WA Health's management of public child development services in WA?



AMA WESTERN AUSTRALIA

Overall, how would you rate the WA Govt/WA Health's management of public child development services in WA? (cont. d)

Respondent Group	'Poor' or 'Very Poor' Rating
All Respondents	**74 percent**
Only General Practitioners	**76 percent**
Only Paediatricians & Child Health Specialists	**67 percent**
Only Psychiatrists	**87 percent**
Only Drs that provide public CD services	**67 percent**

In relation to public child development services, how would you rate WA's performance / management of the following issues:

	Excellent	Good	Average	Poor	Very poor
Service funding	3%	3%	14%	40%	40%
Current public clinical governance structures	3%	9%	37%	30%	21%
Medical FTE (Senior Doctor)	4%	4%	10%	43%	37%
Medical FTE (DiT/Trainees)	6%	3%	19%	41%	30%
Allied Health FTE	4%	8%	16%	43%	29%
Availability of aboriginal health services	4%	7%	20%	32%	37%
Availability of community support services	3%	3%	16%	38%	38%
Linkage with primary care	4%	5%	24%	31%	36%
Availability of private child development services	5%	6%	13%	36%	41%

How would you describe workforce planning relating to child development services in WA:

	Excellent	Good	Average	Poor	Very poor
Medical training positions	0%	3%	18%	39%	41%
Consultant FTE	0%	2%	12%	45%	41%
Allied Health FTE	1%	3%	20%	48%	28%

In relation to public child development services in WA, how would you rate:

	Excellent	Good	Average	Poor	Very poor
Current availability of services (metro)	0%	0%	14%	42%	44%
Current availability of services (regional)	0%	1%	8%	27%	64%
Staffing numbers - medical practitioners	0%	1%	8%	41%	50%
Staffing numbers - allied health services	1%	3%	15%	46%	35%
Culturally appropriate services	1%	3%	30%	33%	34%

Observations:

WA's management of specialist medical practitioner FTE, service funding, availability of community support services and availability of private CDS services are all rated as 'Poor' or 'Very Poor" by more than 75 percent of survey respondents.

The AMA (WA) recommends the Select Committee consider how each of these factors can be addressed to support increased service capacity and to create an attractive working environment in WA public services for health professionals.

Workforce planning is critical to ensuring service capacity is sufficient to meet service deliver, training requirements and population changes. The AMA (WA) recommends that specific workforce planning is conducted in relation to child development services. This should include consideration of medical practitioner training requirements. Child development services are delivered by multidisciplinary teams, so workforce planning and forecasts must consider allied health professionals and primary care providers.

The concerning ratings relating to 'availability of services' in metropolitan areas are unsurprisingly eclipsed by the assessment of service availability in regional WA. Intermediate measures to support to service delivery in regional WA should be considered, this includes further incentivising regional work and supporting sustainable upskilling of health professionals in regional WA.

The AMA (WA) notes that availability of specialist medical practitioner FTE and doctors in training FTE is determined by a number of factors, including system-wide factors such as WA Health's reputation as an employer in WA, Australia and internationally. Employee management, working conditions and salaries all play role in attracting staff to WA Health.

The AMA (WA) does not believe WA Health is currently an employer of choice, and we continue to report high levels of dissatisfaction among WA Health doctors, breaches of basic industrial entitlements and working conditions that are driving our medical professionals interstate, overseas or into alternative careers.

What are the key changes that need to be made to improve public child development services in WA?

109 comments received.

The AMA (WA) notes that a large number of responses highlighted the lack of required service funding, the need to urgently increase FTE and commitment to support the current workforce through further engagement and resource provision.

Develop a State-wide plan based on strong governance, that includes a robust framework for care delivery.

Provide necessary resource – both facilities and staffing - in both urban and rural/remote settings.

Establish strong working links with other services related to the child development.

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Waitlists for public health services are generally poor, not just for CDS. The health system needs to address what is driving dramatic increases in referrals. Specifically, in the area of child development work there are important upstream factors, including: parental difficulties; mental health difficulties; increasing cost of living; demand driven by schools who will only respond to the needs of a child if certain developmental diagnoses are made.

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Consideration needs to be made of factors external to child health which significantly impact on child development waitlists. Many of the behavioural and developmental issues seen in children could be improved or prevented prior to school entry, if parents have better access to parent supports, parent training & mental health supports.

Once children enter school, the education department places a significant strain on child development services, requiring certain diagnosis. Rather than assigning funding based on diagnoses, if the education department moved to a functional model for funding this would reduce pressure on CDS services.

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More prevention services and funding are essential to prevention of child development problems. This should include implementing programs and active support for breastfeeding; teaching parents how to optimise infant speech and language development; preventing Foetal Alcohol Spectrum Disorders (a completely preventable condition which is a large contributor to our child developmental disorder burden), by providing meaningful, accessible drug and alcohol services to women of childbearing age; and providing extra support and education to pregnant women.

There is a looming crisis of literacy and social skills due to screen use by babies, toddlers and children. We need high profile public health messages and community education.

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Urgently invest in modern, evidence-based, accessible ADHD and dyslexia care. Don't separate it from education - at the same time, roll out education to the teacher workforce to correctly identify and refer, and also to provide appropriate teaching accommodations for young people who have ADHD and dyslexia. Speech and language disorders are often missed and diagnosed late - this is another huge area which needs organised care provision with proactive screening and modern, evidence-based care.

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Reduce the amount of Griffiths assessments that take time and use other less labour-intensive measures Use GP and nurse practitioners within the service. Outsource work to the private sector with support, as this sector is much more efficient.

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Shifting Department of Education's focus away from diagnosis-based funding to needs based funding, as there is a huge push for autism diagnoses from schools to ensure they receive funding for students with challenges

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Use more screening tools and Telehealth to ensure high risk children are identified early.

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Existing services are not inefficient, they are simply grossly under-resourced.

Dyslexia is essentially not diagnosed or treated in public health in WA, yet our prison population is mostly comprised of people who cannot read. Budgets need to more than double in order to have a chance at making a difference. But you will more than recoup the costs in reduced prison population and reduced school behaviour problems / reduced school dropout and increased productive workforce.

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It must be recognised that children and adolescents who have autism and probably also those who have ADHD, show a higher proportion of young people who identify as trans or gender-diverse, and a higher proportion of young people who identify as gay, lesbian, bisexual. pansexual or other non-heterosexual orientation.

Child development services need to be "Full Rainbow", welcoming and validating diversity of gender and sexuality, not pathologising it.

The government and WA Health must strengthen services to support Aboriginal health and there are a number of large refugee communities and recent migrant communities, that services must be designed and funded to support, including recruiting community workers from specific ethnic and language groups.

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Regional public CDS need additional separate funding for developmental services.

Currently most regional developmental services are low on staff & rely on staff that also do acute paeds/ contribute to the on-call roster. More staff need to be trained and attracted to work in regional/ rural areas. This means making housing easy to access (that's child/pet/life friendly) and ensuring that pay matches the responsibility.

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Consideration could also be given to changing the model of care within CDS so that children rotate through annually to CDS, with their GP primarily in charge of their ongoing care.

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Lack ability to manage lower-level mental health concerns that coexist (yet impact on dev) and many fall well below CAMHS threshold and/or cannot afford private psych (even if GP CMHP activated due to gap payments being unaffordable). Increased psych access important.

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Better links to primary health care and education, with better early identification intervention and support before a child's symptoms get to a paediatrician.

Better services to direct families to for parenting support and access to psychology services. Links to and collaboration with psychiatry.

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Change the funding structure from block funding to funding based per capita with weighting for social disadvantage.

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As a medical practitioner that sees young adults presenting to EDs with severe emotion dysregulation in the context of undiagnosed ADHD / ASD, I can vouch for the urgent need for timely intervention across the infant, child and adolescent setting. Otherwise, we spend millions reactively providing inpatient care to young people with neurodevelopmental vulnerability misdiagnosed with emotionally unstable personality disorder, and lose many to suicide.

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More medical workforce to meet current demands. We will have to recruit from overseas to grow the workforce.

The answer is not to cut corners and continually limit the scope of the service, by spreading workforce. The service needs more doctors, with time and resources to do work properly to provide a good standard of care.

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Medical leadership in key decision-making roles is vital. Digital transformation of services. Access to funding for nurse support position to assist paediatric consultations and to provide nurse led assessment with Consultant oversight. Improved EMR systems. Use of dashboards and online progress reporting and medication monitoring.

Online referral system. Improved psychosocial supports. Better communication between health and NDIS services.

Case coordination support for Paediatricians and other medical practitioners for complex NDIS clients.

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Increase Consultant Paediatrician FTE immediately. Increase medical trainee numbers as soon as possible. Include medical leadership in decision-making about medical problems including trainees and consultant FTE.

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Aboriginal health CDS are a critical component of culturally secure and appropriate service provision.

There is almost no awareness of the needs and high developmental burden in families from culturally and ethnolinguistically diverse backgrounds, especially those with limited English backgrounds or refugee backgrounds.

The services are not trauma-informed nor do they have sufficient wrap around health disciplines to support inter-related socioeconomic determinants of health (SW, psych, transport, interpreters etc) that impact on development and therapy engagement.

There is an urgent need to specifically develop child development services for CALD patients and ATSI families, with the wrap around care and integration with tertiary specialists (RHS and Koorliny Moort)

There is also lack of synergy between allied health waitlists (ST/OT/PT) and paediatric waitlists – patients can wait 12-18 months between accessing one discipline, even though the other is clearly needed.

Poor integration and assistance with NDIS transitioning, especially for CALD and ATSI families mean many get lost and end up with suboptimal plans, further disadvantaging these children.

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Services need to be more widely available in rural areas. Currently there is only one clinic every so often for child development, so in South West WA everyone goes privately (even with wait times over a year).

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Schools to be part of the solution – teachers should receive education on child development issues and referral pathways.

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Increase medical training position availability and opportunities. There must be better regional and culturally appropriate services, developed with community and stakeholder involvement.

There is a need for better collaboration with education and disability sectors, and for a collaborative service provision with Child and Adolescent Psychiatry colleagues.

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Need for Consultant psychiatry funding in Child Development Service to manage complex cases and improve infant mental health support capacity

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Fund more WACHS Child Development Services Centres so that they can perform autism assessment, which can only be done in limited CDC or via Department of Communities in regional areas.

Improvement in FTE of Paediatric Consultants and Paediatric Trainees in order to increase number of developmental clinics

We need to address physical number of clinic rooms available.

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Paediatric trained allied health positions are very hard to find. Assistance with initial postgraduate training and completion of educational psychology masters for candidates would increase available staff.

Further developmental paediatrics (medical) training positions, which support part time trainees.

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Current demand is for ASD and ADHD assessments and ongoing management. The services have evolved to manage a vast array of many formidable developmental and some mental health disorders. In Victoria, these conditions (ADHD and ASD) are managed in well-resourced child and adolescent psychiatry services and with case managers.

WA workforce shortages span both paediatric and psychiatry services.

In terms of general practice, what can be implemented to support child development services in WA?

101 comments received. The below comments only represent those provided by general practitioners.

The AMA (WA) believes that further engagement with relevant medical colleges (RACGP, ACRRM, RACP and RANZCP) would be critical prior to implementing alternative clinical/referral pathways and training programs.

It is not the role of general practitioners to provide specialist paediatric, child psychiatry, speech therapy, occupational therapy or child psychology services.

There are opportunities for increased linkage with GPs for ongoing management, eg co-prescribing for stimulants.

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WA Health and WA government need to remain mindful of how general practice is funded. A lot of GPs take a financial hit when providing additional support to families in difficulty, especially given the medicare freeze.

GPs are very willing to support services, but there must also be appropriate funding and support for private general practice for this.

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More referral opportunities and funding an MBS item number for GP child development consultations.

This will allow greater access to initial assessments and enable remuneration for the work.

Clinical education for GPs in child development specifically, so they can then access the item number.

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Supporting a certificate in developmental paediatrics to allow some GP's prescribing rights.

Project Echo: https://www.childrens.health.qld.gov.au/chq/health-professionals/integrated-care/project-echo/ Allowing GPs to diagnose and treat ADHD

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Addition of GPs with a Special Interest in Child Development into public assessment and treatment services may improve wait times and improve the coordination between tertiary and primary care.

Full State funding for Advanced Skill training in paediatrics, concentrating on developmental paediatrics, to develop a skilled regional and rural Rural Generalist/Rural GP workforce to work within a multidisciplinary team.

Introduce case management, similar to the nurse navigator services interstate.

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Better training and improve payments to private general practitioners who have the ability to spend the time needed with these families.

Endorse GP training programmes to enable diagnosis/child assessment with support from paediatric specialists to improve diagnosis waiting times.

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Access to timely advice /support from Paediatricians while patients wait to be seen by CDS. Early access to Allied Health to begin assessment rather than waiting for Paediatrician.

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Provide training for GPs in child development and then fund and appropriately remunerate positions for GPs in the area.

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Streamlined referral pathways, guides to support pre-referral workup to save time.

More timely patient access to allied health assessments, with patient-support funding provided if certain criteria me.

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General practitioners can and should be familiar with both screening tools for developmental delay and assessment tools for provisional diagnosis of developmental and behavioural problems.

There could be supported co-prescribe stimulant therapy where appropriate.

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GP's ability to have higher training in developmental paediatrics if they wish to (funded training).

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GPs with special training under support of paediatrician could potentially take on part of the patient load in terms of diagnosis and prescribing.

The lack of clear referral pathways for allied health etc, could be addressed by an overarching guideline / pathway

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Co-prescriber rights, support so GPs can provide increased pre-assessment recommendations (eg completing the appropriate questionnaires prior to appointments, recommended pathology), increased integration and utilisation of community child health nurses.

What should be done to support specialist medical colleges, universities and other training bodies in establishing sufficient workforce pathways?

96 comments received.

The AMA (WA) notes that WA Health doctors in training morale is low, and DiTs continue to report high levels of burnout, work stress, underpayment and excessive additional hours.

These issues will also play a role in attracting and retaining trainees in WA, in addition to specific child development services commentary, outlined below.

Increase exposure to community paediatrics throughout training as a positive experience. This will require supporting a service that is not constantly overworked. Paediatric trainees see WA's developmental paediatricians working in understaffed environments and really struggling with the resources available, which does not encourage them to join the specialty.

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Train more developmental paediatricians and encourage specialist to come from overseas. Stop expecting these to work in a overwhelming environment with high workload. Make it attractive as a specialty.

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Child development work is probably seen as a bit of a slog, not as attractive as other procedural specialties in terms of financial reimbursement and professional kudos.

Improving the image, providing those working in the area with a functional workload and work/life balance and making it clear it is such important part of paediatrics.

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A paediatric training pathway that runs across the state should be implemented, it should include all the peripheral hospitals and paediatric services including CDS in that planning.

Currently paediatric training is a PCH centric model, with very little involvement from external paediatric sites, unlike interstate training pathways.

Currently at PCH, it feels that use of registrar staff is a convenience / service-based model with training as an after-thought. I understand that the hospital has critical staffing issues, but staff retention is better when staff are happier and for registrars where training is central to their circumstances thinking about this and how it can be done better is part of the solution.

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Specialty training needs to be more family friendly.

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Part time opportunities, (and not just job share opportunities).

All available advanced trainee positions are full time. More supervised training and education opportunities are needed.

Much of the experience appears to be “teach yourself”, based on trainee feedback.

Both general paediatrics and developmental paediatrics advanced training requires developmental training positions to fulfil requirements. As a result there are many more juniors than jobs available, but not all are then working in developmental paediatrics once qualified.

Possibly direct pathways for those interested in developmental paediatrics alone to streamline fulfilment of RACP requirements and fellowship.

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More streamlined training pathway and a clear role to Consultant jobs. Meeting training requirements is hard and requires completion of many additional requirements, which the trainee is expected to complete their own time and at their own expense, for example a Masters of public health.

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Ensure that medical students have training placements in child development services and in child and adolescent mental health.

There should be academic chairs of developmental paediatrics and active local research focusing on prevention.

WA and WA Telethon Kids Institute have one of the strongest international teams in autism research - this should be celebrated, showcased, publicised, and the research potential in public child development clinics should be maximised, with research built into everyday care, which improves standards and holds teams to best practice

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Increased awareness of importance of funding workforce capacity and allow part-time employment and training.

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Sub-specialist training for paediatric trainees and increased prevocational training rotations and exposure to child development services.

Guaranteed spots for Griffiths Developmental Assessment Course, Bailey’s training, ADOS-2 training.

WA Health needs to treat its paediatric trainee registrars better.

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The RACP Community Child Health training path makes it particularly difficult to have regional or rural positions counted towards training, as developmental work in regional areas often requires you to do acute medicine too, they will not accredit 6-month positions for CCH training.

This reduces the chance of attracting CCH dual trainees into regional/rural positions.

In WA in particular there are a very limited number of positions available to complete CCH training which delays trainees in completing the 3 years of training.