Submission No 49

IMPROVING ACCESS TO EARLY CHILDHOOD HEALTH AND DEVELOPMENT CHECKS

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BARRIERS AFFECTING ACCESS

There are multiple barriers to parents accessing routine health and developmental checks. These include

1) ***Workforce shortages****: GP's, Paediatricians, Child Psychiatrists, Speech Pathologists, Occupational Therapists, Psychologists, etc. In addition there is maldistribution of all health professionals, with increasing occurrence at the MMM Rating rises.*

2) ***Access to publically funded health services*** *of all type within a reasonable time frame. In my area(Woolgoolga, 2456) referrals to the Coffs Harbour Health Campus Paediatric Service for children with ADHD and ASD are specifically declined. Waiting Times for Paediatric*

Outpatient Speech Pathology and OT are 12-18 months at last count.

3) ***Lack of awareness*** *in many health professionals of the key features of some conditions affecting normal childhood development. The best example here is ADHD(Attention Deficit Hyperactivity Disorder). Its incidence of 5-10% makes it a relatively common condition, with lifelong impacts on the individual and their family.*

4) ***Access to stimulant medication*** *for children who are experiencing significant negative impacts from ADHD and associated comorbidities is further impaired by the opaque regulatory processes of NSW Health*

CHANGES NEEDED

1) ***Targeted recruitment of Health Professionals*** *to identified areas of greatest need. This could occur in a coordinated manner by NSW Health or via an agency already active in the area such as the NSW Rural Doctors Network Ltd.*

   Reinstatement of a specific Medicare Item Number *to cover GP Screening of 4 year old children prior to school entry. Much of this work could be done by*

Practice Nurses, who already undertake such activities as Health Assessments for Over 75's, etc.

2) ***LHD's(Local Health Districts) should be instructed to prioritise access to all necessary childhood services for financially disadvantaged children and their families****. Referrals of these patients by GP's to Staff Specialist Paediatricians in all Base Hospitals should be accepted and screened by an appropriately trained health professional.*
Paediatric Outpatient Appointments in all larger hospitals should be available in a similar way.

GP's should be allowed to refer directly to Child Development Units *at the three Paediatric Teaching Hospitals in NSW(SCH, Westmead and John Hunter). At present those units will only accept referrals from a Paediatrician.*

Access to the Royal Far West Children's Child Development Scheme at Manly *should be enhanced for eligible children(geographical limitations exist).*

Integrated service models *should be developed in all regions, which should include GP's. Their involvement could be funded by existing Medicare Case Conference Item Numbers, as well as Mental Health and Care Plan Item Numbers. Better communication between health and education providers for children and adolescents*

should be encouraged by the development of innovative models of care such as that at Eden High School on the Far South Coast.

3) ***Health and Educational Curricula*** *should be updated regularly to ensure that future graduates receive appropriate training for the conditions that they will be expected to diagnose and treat. I recognise that the NSW Parliament has no direct jurisdiction in such matters, but it is critical that its workforce is better equipped to manage all the common conditions that will be encountered, such as ADHD and its many comorbidities.*

   I have been involved in Medical Education at both undergraduate and postgraduate level for many years. I have identified many gaps in the already crowded curricula. I have interviewed three recent graduates of Paediatric Training regarding their experiences. Only one had any significant exposure to Paediatric Developmental issues. That was obtained at Royal Far West at Manly, and only after I had encouraged her to seek a six month term there as a Registrar to broaden her training. Thus, it is possible for "newly minted" Paediatricians to commence independent practice with limited awareness of common conditions such as ADHD.

Training opportunities for GP's *working with neurodiverse children could be created in Paediatric Outpatient settings. The GP's could be upskilled, and then take over the management of the less complex patients, thereby reducing access block to Paediatricians generally. This is completely consistent with the Recommendations of the Henry Report.*

4) ***GP Prescribing of Stimulants*** *for children significantly impaired by ADHD.*
Until very recently, with one exception, only Paediatricians, Psychiatrists or Neurologists could prescribe stimulants for children in NSW. Within the last 12 months NSW Health has introduced "Shared Prescribing of Stimulants" for GP's working under the direction of a Paediatrician in a stable patient. That is a step in the right direction, but on its own will not solve the severe access issue identified in the Henry Report.
The exception that I refer to is the category of ***ODP(Other Designated Prescriber).*** *I have been working as one of those since 1995. I am able to assess a child or adolescent as having ADHD with significant impairment, and initiate a "Trial of Stimulants", provided no contraindications exist, and appropriate consent is given.*

I have been attempting to make contact with other ODP's in NSW who are effectively my peer group in the

medical community. NSW Health(PSU) have not been forthcoming in providing information to me, despite the obvious potential benefits of us supporting each other, arranging educational activities, etc. As best I can determine, there are no more than ten. ***The approval of additional ODP's by NSW Health is recommended strongly****. It is a option that is available immediately to address "access block".*

I'm also aware of a number of GP's who have applied to obtain ODP status in the past 12 months and been rejected. These are GP's with a significant relevant case load who have undertaken additional study and training in this clinical area. Considerable effort has gone into education and training for GP's in recent years, both for Child and Adult ADHD.

The RACGP established a Special Interest Group in "ADHD, ASD and Neurodiversity" *within its Faculty of Special Interests in 2021. I am, and remain, its Inaugural Chair. We have been very active in identifying GP's with an interest in this area, and arranging educational events, and now have about 1500 members nationally.*

If a patient with ADHD proves to be complex, I will refer as will any other GP. However, I then encounter the system-wide problem of poor access to Paediatricians. Creative ways have to be found at

times. I have previously participated in Telehealth Trials with Royal Far West as one way to obtain needed expert care. I have long ago recognised my limitations, but sometimes am thrust into difficult clinical situations when no access can be obtained despite my best efforts to achieve that.

Currently I am prescribing stimulants for approximately 150 children and adolescents aged 4-18. I am 70 years of age, now working part time since a Triple Bypass in January of this year, and insertion subsequently of a cardiac pacemaker. I enjoy working with this group of patients due to the great results than can often be obtained. However, if I wasn't able to keep working, the local Paediatric resources couldn't manage half the demand, assuming that their parents/carers could afford the significant fees required.

There are many misconceptions about stimulants, *both within health and the wider community. Fears of addiction are misplaced. Any medication can be abused or misused, but there is no evidence that stimulants are a particular problem.*
However, because they are classed as "S8 Medications, ie Drugs of Addiction", there are significant regulatory requirements in prescribing.

A very simple way to fix that problem would be to reclassify them as "S4 Medications", requiring only a prescription by a doctor.

***Additional safeguards** to ensure appropriate prescribing are already in place, chiefly "SAFESCRIPTS NSW" allowing real time monitoring of prescribing and dispensing. Additionally, PBS requirements for certain stimulants to meet particular criteria will limit inappropriate prescribing.*

***Fears of "diversion"** are similarly overstated. No evidence exists to show that it is a significant problem.*

It is relevant to note that other drugs with stimulant activity such as caffeine, nicotine,phentermine, etc are far more readily available in the community.

***GP Prescribing of other restricted drugs** such as Clozapine(for Schizophrenia), Methadone, etc is well established in the NSW health system. The potential dangers of those, and other medications, significantly exceed those of stimulants. All medications, from Aspirin and Paracetamol upwards, have the potential to cause harm, but little concern is often raised about their use. The degree of regulation of any medication should be proportionate to its potential for harm, if misused. I cannot see that principle as being applied to stimulant medication in Australia, with the sole*

exception of ***Queensland, where GP's are now able to initiate stimulants for children with ADHD.***

KEY AUSTRALIAN INFORMATION SOURCES

2019 Deloitte's Report: Annual Cost to Australia of ADHD is $20 billion
https://aadpa.com.au/wp-content/uploads/2019/07/The-social-and-economic-costs-of-ADHD-in-Australia-AADPA-Press-Release-28-July-2019.pdf

2022 Australian Evidence-Based Clinical Practice Guideline for Attention Deficit Hyperactivity Disorder(ADHD)
https://adhdguideline.aadpa.com.au/about/recommendations-summary/

2023 Senate Inquiry into ADHD Report
https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/ADHD/Report/List_of_recommendations

2024 AADPA Prescribing Guideline(releasing Spring, 2024)