41ST PARLIAMENT

Interim Report

SELECT COMMITTEE INTO CHILD DEVELOPMENT SERVICES

Child development services in Western Australia: Valuing our children and their needs

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Presented by
Hon Dr Sally Talbot MLC (Chair)

November 2023

Select Committee into Child Development Services

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ISBN 978-1-925580-92-1

Government response

This report is subject to Standing Order 191(1):

> Where a report recommends action by, or seeks a response from, the Government, the responsible Minister or Leader of the House shall provide its response to the Council within not more than 2 months or at the earliest opportunity after that time if the Council is adjourned or in recess.

The two-month period commences on the date of tabling.

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EXECUTIVE SUMMARY

1 The Select Committee into Child Development Services (Committee) was established in August 2022 against the background of widely-acknowledged unacceptably long waiting times and gaps in the provision of child development services provided by the State's public health system, and to some extent, in the private sector as well.

2 The Committee has been tasked with inquiring into and reporting on these considerations:

(a) the role of child development services on a child's overall development, health and wellbeing;

(b) the delivery of child development services in both metropolitan and regional Western Australia, including paediatric and allied health services;

(c) the role of specialist medical colleges, universities and other training bodies in establishing sufficient workforce pathways;

(d) opportunities to increase engagement in the primary care sector, including improved collaboration across both government and non-government child development services, including Aboriginal community-controlled organisations; and

(e) other government child development service models and programs operating outside of Western Australia and the applicability of those programs to the state.

This interim report deals mainly with considerations (a) and (b).

3 'Child development' is a term used to describe a child's progressive acquisition of skills and abilities as they grow, and the functional application of these skills and abilities in everyday life. Children are expected to acquire certain communication, physical, cognitive and social-emotional skills and abilities by a particular age range. It is important for children to meet these milestones within a reasonable timeframe because earlier skills and abilities will lay the foundation for more sophisticated ones.

4 'Child development services' are the interventions that can be provided to a child showing signs of developmental delay to ensure they develop as well as possible. Such services can include:

- the screening for, and identification of, potential issues
- assessments of a child's development, including diagnostic assessment
- therapy for the child and/or their family
- the provision of strategies and supports for the child, their family and other networks, such as their school.

These interventions can be delivered by a range of providers in various settings.

5 It is well established and universally accepted that child development services are most effective when they are provided early (preferably within the first 1,000 days from conception) and/or in a timely manner (that is, as soon as practicable after an issue has been identified).

6 The inquiry is focused on secondary and tertiary-level child development services delivered by the public health system, referred to in this interim report as 'CDS'. CDS are offered by either the metropolitan Child and Adolescent Health Service or the WA Country Health Service, through allied health professionals, nurses, paediatricians and other health workers.

CDS sit within a larger system of child development services offered by a range of providers, including other government agencies, the private sector and non-government sector.

7 This inquiry is the latest in a long line of reviews into, and related to, CDS. Many of the issues raised in the evidence presented to this inquiry are not new, except for the more recent and significant effects of the National Disability Insurance Scheme and the COVID-19 pandemic. A significant part of this evidence has conveyed a strong sense of frustration from everyone involved in, or working alongside, the CDS system. In particular, parents and caregivers of children referred to child development services are increasingly concerned about the effects of long waiting times on their children's health and wellbeing.

8 The Committee received evidence through WA Health that once children and families are seen, they are generally satisfied with the services provided. The Committee found that this was corroborated by other witnesses. The deficiencies and issues impacting satisfaction levels, however, relate to the timeliness of the interventions and services, the continuity, duration and availability of care, as well as navigation of the system.

9 The often excessive waiting times encountered by families in the CDS system are inconsistent with the principle of early and timely intervention. This report highlights the very real impacts of excessive waiting times on children, families and their wider networks, as well as on CDS practitioners.

10 The inquiry has also considered the evidence demonstrating a second, equally problematic, issue. Due to resourcing constraints, and the importance placed on providing interventions in the early years of life, the Child and Adolescent Health Service prioritises its allied health services for children who are aged under seven years. This often leaves its paediatricians to manage older children with little or no allied health practitioner support. The Child and Adolescent Health Service acknowledges this gap in its services.

11 This interim report discusses several causes of service deficiency in the CDS system, with a particular focus on what can be done 'now for now' to address them. The final report will concentrate on other strategies to be implemented 'now for later' to ensure that CDS is accessible and sustainable into the future.

12 In this report, the Committee concludes that, without additional funding, significant reductions in unacceptable waiting times and an expansion of CDS provision, particularly to children aged seven years and older, are unlikely. Therefore, a majority of the Committee, comprising Hons Dr Sally Talbot and Samantha Rowe MLCs, recommends that the State Government immediately consider providing the funding increase required to reduce unacceptable waiting times and expand CDS provision.

13 A minority of the Committee, compromising Hon Donna Faragher MLC, is of the strong view that the need to reduce unacceptably long waiting times and expand provision of CDS, particularly to children aged seven years and older, is urgent. Therefore, the Member recommends that a substantial funding increase be provided immediately, and no later than the 2024-25 State Budget.

14 Based on the findings in this report and the evidence received, all Members are of the opinion that if the State Government provides the funding increase required, it can be confident that waiting times will reduce and the provision of CDS can be expanded.

15 The Committee stresses that the recommendations made in this interim report and the recommendations that will be made in the final report are of equal weight. The Committee expects that if the recommendations in this report about changes to be made 'now for now' are implemented, the two CDS providers will undertake concurrent planning to address the issues to be raised in the Committee's final report about changes to be made 'now for later'. In the Committee's view, implementing these measures will go a long way to reducing the

burden of developmental delay on children and families and help ensure that the development, health and wellbeing of Western Australian children meets the expectations of our community.

Findings and recommendations

Findings and recommendations are grouped as they appear in the text at the page number indicated:

FINDING 1 Page 52

In relation to the Child and Adolescent Health Service–Child Development Service:

- it is not meeting its self-imposed target median waiting time of six months or less
- median waiting times for most services are increasing, meaning that services are not meeting demand.

FINDING 2 Page 53

Although the WA Country Health Service–Child Development Service does not have target median waiting times, the median waiting times for most services are increasing, meaning that services are not meeting demand.

FINDING 3 Page 57

Long waiting times for child development services can result in problems becoming more serious and difficult to address, not only for children but for their families, their schools and treating practitioners.

FINDING 4 Page 58

The waiting times for services delivered by the Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service are unacceptably long.

FINDING 5 Page 61

Child and Adolescent Health Service–Child Development Service's resourcing constraints result in what much of the evidence identifies as a serious deficit of services to children aged seven years and older who have been identified as requiring developmental assessment, intervention and support.

FINDING 6 Page 68

Since the end of 2022, the Child and Adolescent Health Service's Community Health service area has been successful in reducing its staff vacancy rates.

FINDING 7 Page 76

Without additional funding for the Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service, significant reductions in waiting times and expansion of service provision, particularly to children aged seven years and older, are unlikely.

FINDING 8 Page 76

Since its last major uplift in 2010-11 to 2014-15, state government funding for child development services delivered by the Child and Adolescent Health Service–Child Development Service has not been commensurate with demand for these services.

FINDING 9 Page 76

Since its last major uplift in 2010-11 to 2013-14, state government funding for child development services delivered by the WA Country Health Service–Child Development Service has not been commensurate with demand for these services.

FINDING 10 Page 79

With additional funding for permanent positions, the Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service will be able to increase their respective workforces.

FINDING 11 Page 79

The Child and Adolescent Health Service–Child Development Service has a proven record of effectively utilising funding uplifts to reduce waiting times for its services.

FINDING 12 Page 81

The assumptions underpinning the Child and Adolescent Health Service–Child Development Service's 2023-24 State Budget funding submission are sound.

RECOMMENDATION 1 Page 81

The child development services provided by the Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service continue to be free and publicly funded.

RECOMMENDATION 2 Page 81

The State Government immediately consider providing the Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service the funding increase required to:

a) recruit more clinical staff

b) recruit more non-clinical staff

c) expand and improve building and information technology facilities,

in order to reduce unacceptable waiting times and expand the provision of services, particularly to children aged seven years and older.

RECOMMENDATION 3 Page 83

The State Government monitor the effectiveness of its funding of the Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service against the length of the median waiting times (to ensure that the waiting times are reduced and maintained at an acceptable level) using a framework based on existing data collection systems and a measure of community health needs.

Minority recommendations

The recommendation of a minority of the Committee, comprising Hon Donna Faragher MLC, appears in the text at the page number indicated:

Minority Recommendation **Page 82**

The State Government immediately provide the Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service the substantial funding increase required to:

a) recruit more clinical staff

b) recruit more non-clinical staff

c) expand and improve building and information technology facilities,

in order to reduce the unacceptably long waiting times and expand the provision of services, particularly to children aged seven years and older, and that this funding increase be provided no later than the 2024-25 State Budget.

CHAPTER 1
Introduction

Purpose of this report

1.1 This inquiry was established in August 2022 against the background of unacceptably long waiting times, which had been widely acknowledged, and gaps in the provision of public and, in some cases, private child development services in Western Australia.

1.2 Unless otherwise indicated, the term 'CDS' refers to specialised child development services provided by the State's public health system. That is the focus of this inquiry (Inquiry).[1] The two providers within the CDS system are the Child and Adolescent Health Service (CAHS-CDS) in the Perth metropolitan area and the WA Country Health Service (WACHS-CDS) in regional areas.

1.3 At the outset, the Select Committee into Child Development Services (Committee) wishes to establish clearly how this report is to be read. Standing Orders for the Legislative Council do not allow for a select committee to table a final report in two parts, with the second part tabled at a later date. Presentation of a final report effectively brings a select committee inquiry to a close. However, during the process of deliberating and collecting evidence for this inquiry, the Committee decided that, in order to have maximum effect, its report should be structured in two parts. The Committee's thinking was guided by evidence received throughout the inquiry.

1.4 In particular, Dr Yvonne Anderson, a paediatrician working across Curtin University, the Telethon Kids Institute and the Child and Adolescent Health Service, captures the rationale for this approach in the following extract of evidence:

> when considering the terms of reference for the inquiry, I do believe that there is a conflation of two issues in relation to child development services. There is the immediate issue of the waitlists, and then there is the need to pause to reflect on how we want our services to be for children in the future. What do we want for our children? What do we need to do now for now, and now for later? …
>
> I believe there is one reasonably clear-cut decision in this inquiry and the complexity of this complex, wicked problem. Either we choose to adequately fund services for early intervention and prevention that support the development of a child, or we do not. Either we choose to value children and our future generations' needs, or we do not. In terms of the waitlist, this should not be a can that we are prepared to continue to kick down the road. We know how to be agile in health. We have undertaken rapid trans-sectoral responses before, and we should be prepared to take on a rapid response to this immediate problem. Addressing the waitlists with an immediate response means we can spend more time reflecting on how we want to contemporise our health services into the future.[2]

1.5 Adopting Dr Anderson's words, the Committee is presenting this interim report in order to address and make recommendations about what can be done now to reduce unacceptable waiting times and expand CDS provision (the 'now for now'). The final report will consider and make recommendations on other strategies to improve the accessibility and sustainability of CDS (the 'now for later'). The Committee stresses that the recommendations

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1 Refer to paragraphs 3.14 to 3.16 of this report.

2 Dr Y Anderson, Associate Professor, Community Child Health, Curtin University, [*transcript of evidence*], *Legislative Council,* 12 May 2023, p 4.

made in this report and the recommendations that will be made in the final report are of equal weight.

1.6 In addressing the 'now for now', this interim report presents what a majority of the Committee, comprising Hons Dr Sally Talbot and Samantha Rowe MLCs, views as compelling evidence for the State Government to immediately consider providing the funding increase required to reduce unacceptable waiting times and expand CDS provision, by implementing the changes and innovations identified as priorities by CDS providers.

1.7 A minority of the Committee, comprising Hon Donna Faragher MLC, is of the strong view that this interim report presents compelling evidence for the State Government to immediately provide the substantial funding increase required to reduce the unacceptably long waiting times and expand CDS provision. Furthermore, it is the Member's view that this funding increase should be provided no later than the 2024-25 State Budget.

1.8 This report also:

- introduces the general concept of child development and explains why child development services have a vital role to play in children's overall development, health and wellbeing
- provides the background and context in which this report (the 'now for now') and the final report (the 'now for later') can be viewed
- reflects the evidence that has been gathered to date.

Committee establishment

1.9 On 16 August 2022, a petition supporting the establishment of the Inquiry was tabled in the Legislative Council.[3] It was signed by 3,750 people over a three-week period.[4]

1.10 On 31 August 2022, the Legislative Council established the Inquiry and the Committee to conduct it.[5] The Committee is to inquire into and report on these considerations:

(a) the role of child development services on a child's overall development, health and wellbeing;

(b) the delivery of child development services in both metropolitan and regional Western Australia, including paediatric and allied health services;

(c) the role of specialist medical colleges, universities and other training bodies in establishing sufficient workforce pathways;

(d) opportunities to increase engagement in the primary care sector, including improved collaboration across both government and non-government child development services, including Aboriginal community-controlled organisations; and

(e) other government child development service models and programs operating outside of Western Australia and the applicability of those programs to the state.[6]

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3 Petition 63 from J Matthewson, tabled by Hon Donna Faragher MLC on 16 August 2022.

4 Legislative Council, *Debates*, 2022, p 3,914.

5 Legislative Council, *Debates*, 2022, pp 3,912–3,921. The original motion was moved by Hon Donna Faragher MLC.

6 Term of reference 2: The Committee's full terms of reference appear on the inside back cover of this interim report.

1.11 The Committee was to report no later than 31 August 2023 – 12 months after the Committee's establishment.[7] On 18 May 2023 however, at the Committee's request, the Legislative Council granted an extension of the reporting deadline to 31 December 2023.[8]

1.12 This interim report deals mainly with considerations (a) and (b).

Conduct of the inquiry

1.13 The Committee has obtained evidence from a range of stakeholders, including:

- parents and guardians
- providers of child development services (such as allied health professionals, medical practitioners and/or their various employing organisations, both government and non-government)
- peak bodies and other non-government organisations
- other stakeholders.

1.14 Appendix 1 contains a list of the submissions received and details of the public hearings, travel and site visits conducted by the Committee to date. The Committee's webpage also provides links to public submissions, transcripts of evidence and other information published by the Committee for this inquiry.[9]

Written submissions

1.15 The Committee has received 89 submissions for the inquiry. It called for submissions by:

- issuing a media release on Thursday 1 September 2022
- publishing an advertisement in *The West Australian* on Saturday 10 September 2022
- posting on social media.

Hearings

1.16 The Committee has held 42 hearings, seven of which were held in private. The majority of the hearings were held in Perth, with some witnesses appearing through a video link. A number of hearings and meetings were also held in regional and remote areas of the state, and these are discussed at paragraphs 1.18 and 1.19.

Private evidence

1.17 Private evidence used in this report is anonymised, except for some evidence provided by the Child and Adolescent Health Service (CAHS) in a private hearing. In the case of the latter, the Committee has not used evidence that the CAHS requested remain confidential.

Travel and site visits

1.18 From 3 to 4 April 2023, the Committee travelled to Bunbury and Albany to hear from parents, allied health professionals, the South West Aboriginal Medical Service, the Community Kindergartens Association and the Isolated Children's and Parents Association.

1.19 From 30 April to 2 May 2023, the Committee travelled to the Kimberley (Broome, Bidyadanga and Derby) to hear from parents, the Kimberley Aboriginal Medical Services, WA Country

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7 Term of reference 3.

8 Legislative Council, *Debates*, 2023, pp 2,459 and 2,481.

9 While the Committee is operating, its webpage may be accessed via Current Parliamentary committees. After the Committee has tabled its final report and dissolved, its webpage may be accessed via Past committees.

Health Service (Kimberley) and Derby Aboriginal Health Service. The Committee also had an informal discussion with the Bidyadanga Aboriginal Community (La Grange).

1.20 On 7 August 2023, the Committee visited the Child and Parent Centre Arbor Grove, Midland Child Development Service (both locations) and Bentley Child Development Service.

1.21 The Committee thanks all interested parties who have participated in the inquiry to date.

Figure 1. *Child and Parent Centre Arbor Grove – Committee Members with centre staff, Anglicare WA staff and the Arbor Grove Primary School principal*

[Source: Committee site visit, 7 August 2023.]

Figure 2. *Midland Child Development Service, Sayer Street – Committee Members with Child and Adolescent Health Service staff*

[Source: Committee site visit, 7 August 2023.]

CHAPTER 2
Child development and early intervention

Chapter summary

2.1 This chapter provides a general introduction to child development and the issues that give rise to the need for child development services. It examines:

- how children develop
- developmental delay and neurodevelopmental disorders
- the prevalence of developmental disorders
- the importance of early intervention
- interventions and treatment that can improve outcomes for children.

Child development

2.2 Children develop a range of skills and abilities as they grow. The term child development relates to the acquisition of these skills and their functional application in everyday life.[10]

2.3 The progressive development of essential abilities (such as sitting, eating, making sounds) form the basis of milestones that can assist in tracking a child's development.[11] These skills and abilities can be grouped according to the following general attributes or 'domains of development':

- speech, language and communication
- physical fitness, fine and gross motor coordination
- cognitive growth
- social-emotional competency.[12]

2.4 Dr Elizabeth Green, a recently retired paediatrician, explained why meeting milestones within these developmental domains is important for a growing child:

> A child has to meet these milestones within a reasonable timeframe to learn, socialise and gain emotional resilience and robust mental health as a young person.[13]

2.5 Early skills lay the foundation for others, as the Minderoo Foundation said:

> I think the principal point is that brain architecture and skills are built in a hierarchical bottom-up sequence. The foundational skills then beget later skills. If the foundations are not in place, then that which follows proves harder and harder to build on.[14]

2.6 There are periods in childhood that are characterised by significant development. Notably, the period from conception into early childhood (the first thousand days) is when

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10 Submission 77 from WA Health, 9 November 2022, p 11.

11 Healthdirect, Developmental milestones in babies and children | healthdirect, accessed 24 August 2023.

12 Submission 50 from Dr E Green, paediatrician, 24 October 2022, p 4.

13 Submission 50, p 4.

14 Hon J Weatherill, Director, Thrive by Five, Minderoo Foundation, [*transcript of evidence*], *Legislative Council,* 9 February 2023, p 2.

developmental plasticity – our ability to adapt to our physical and social environment – is at its peak.[15]

> While most systems mature in utero, brain development occurs mostly in the first two years after birth and is strongly shaped by a child's social and physical experiences. This is a form of developmental plasticity, known as neuroplasticity, and refers to the biological capacity of the central nervous system to change structurally and functionally in response to experience, and adapt to the environment.[16]

2.7 Thus, a combination of genetics and environmental factors shape the developing brain and influence the course of a child's development.[17] Early childhood experiences are a crucial element in this process.[18] The Minderoo Foundation explained:

> The other critical thing in all of this is that that whole brain architecture occurs in the context of a brain which is informed by its surrounding environment, which is fundamentally established through relationships. Nurturing and responsive relationships build healthy brain architecture and provide the strong foundation for learning, behaviour and health. The relationship the young child has with their caregiver influences those neural circuits.[19]

2.8 While the first thousand days is undoubtedly critical, significant opportunity to influence a child's development continues throughout early childhood:

> Beyond the first thousand days, the second thousand days of a child's life continue to provide a significant opportunity to promote optimal development, recognise risk/issues and prevent and reduce adverse outcomes, with dramatic brain development continuing to occur throughout the first five postnatal years. As well as critical periods for development, there are sensitive developmental stages when key skills are easier for children and young people to acquire, although developmental plasticity does allow some latitude and the possibility of catching up a little later.[20]

Developmental delay and neurodevelopmental disorders

2.9 While children typically develop at a similar rate, some children will be slower to reach milestones in one or more developmental domains.[21] A developmental delay might be temporary or it can be persistent and related to more serious conditions or disorders such as

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15 Dr T Moore, N Arefadib, Dr A Deery, S West, *The First Thousand Days: An Evidence Paper*, Centre for Community Child Health (CCH), Murdoch Children's Research Institute, Victoria, 2017, Centre for Community Child Health : Strong Foundations: Getting it Right in the First 1000 Days (rch.org.au), accessed 30 August 2023, p 5.

16 CCH, *The First Thousand Days: An Evidence Paper*, p 12.

17 Submission 77 from WA Health, 9 November 2022, p 11.

18 Submission 77, p 11.

19 Hon J Weatherill, Director, Thrive by Five, Minderoo Foundation, [*transcript of evidence*], *Legislative Council,* 9 February 2023, p 2.

20 Submission 77 from WA Health, 9 November 2022, p 11.

21 'Generic terms such as developmental 'concerns' or 'problems' might indicate awareness that a child has developmental needs without specifying the cause, severity or prognosis. A 'global developmental delay' is the term used when many areas of development are slow to develop.' Queensland Health, *Child development in Queensland Hospital and Health Services – 2 Act now for kids 2morrow: 2021 to 2030*, Queensland Health, Queensland Government, 2021, accessed 30 August 2023, p 11.

cerebral palsy, autism spectrum disorder (ASD), intellectual disability or sensory impairment (including vision or hearing impairment).[22]

Neurodevelopmental disorders

2.10 An impairment to the nervous system during early brain development can result in a range of neurodevelopmental disorders. Intellectual disability, motor disability (such as cerebral palsy), learning disabilities (such as dyslexia), ASD and attention deficit hyperactivity disorder (ADHD) are some examples.[23]

2.11 Neurodevelopmental disorders frequently co-occur. Children with ASD, for example, often also have intellectual developmental disorder and many children with ADHD also have a specific learning disorder.[24] Children with developmental disorders are also five times more likely to experience mental health problems.[25]

2.12 Neurodevelopmental disorders can be difficult to diagnose because the symptoms are not necessarily unique to a single diagnosis. Consequently, diagnosis will often rely upon consideration of a child's functional presentation as well as behavioural observations from their caregiver.[26]

2.13 The DSM-5[27] defines neurodevelopmental disorders as:

> a group of conditions with onset in the developmental period. The disorders typically manifest early in development, often before the child enters grade school, and are characterized by developmental deficits that produce impairments of personal, social, academic, or occupational functioning. The range of developmental deficits varies from very specific limitations of learning or control of executive functions to global impairments of social skills or intelligence. The neurodevelopmental disorders frequently co-occur …[28]

2.14 The categories of neurodevelopmental disorders listed in the DSM-5 are provided in Table 1 on page 8.

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22 The term 'developmental delay' is generally only used by professionals until the cause of the delay is identified. The Sydney Children's Hospitals Network, *Developmental delay and intellectual disability | Sydney Children's Hospitals Network (nsw.gov.au)*, accessed 28 August 2023.

23 Murdoch Children's Research Institute, *Neurodevelopment - Murdoch Children's Research Institute (mcri.edu.au)*, accessed 29 August 2023.

24 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, (5th edn), American Psychiatric Association, Arlington, VA, 2013, p 31.

25 Submission 77 from WA Health, 9 November 2022, p 12.

26 Queensland Health, *Child development in Queensland Hospital and Health Services – 2 Act now for kids 2morrow: 2021 to 2030*, Queensland Health, Queensland Government, 2021, accessed 30 August 2023, p 11.

27 The DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, 5th edition) and the ICD-11 (International Classification of Diseases 11th Revision) are the two main diagnostic classification systems adopted by the Royal Australian and New Zealand College of Psychiatrists. See Diagnostic manuals | RANZCP (accessed 13 September 2023).

28 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, (5th edn), American Psychiatric Association, Arlington, VA, 2013, p 31.

Table 1. *Categories of neurodevelopmental disorders (DSM-5)*

Category	Characterised by		Functional impairment
Intellectual Disability (Intellectual developmental disorder)	Deficits in logical thinking, problem solving, planning, judgment and academic learning.		Failure to meet standards of personal independence at home or in the community. Difficulties with communicating and participating in social environments.
Autism spectrum disorders (autism)	Deficits in social communication and interaction. Repetitive patterns of behaviour, interests or activities.		Difficulties developing, maintaining or understanding relationships. Difficulties learning through social interaction or in social settings. Interference with eating and sleeping.
Attention deficit/hyperactivity disorders (ADHD)	Short attention span, disorganisation, fidgeting or inability to stay seated.		Reduced quality of social, academic or occupational functioning.
Specific learning disorder	Deficits in processing information efficiently and accurately.		Difficulties with learning academic skills in reading, writing and/or maths.
Communication disorders	Language disorder	Difficulties with speaking, writing or sign language.	Limitations in effective communication, interfering with social participation, academic achievement and/or occupational performance.
	Speech sound disorder	Difficulty communicating verbally.	
	Social (pragmatic) communication disorder	Persistent and frequent stuttering.	
	Childhood-onset fluency disorder	Difficulties in the social use of verbal and nonverbal communication.	
Neurodevelopmental motor disorders	Developmental coordination disorder	Clumsiness, slowness and limited ability to perform tasks which require motor skills.	Interferes with activities of daily living appropriate to age such as self-care and self-maintenance. Negatively impacts academic productivity, leisure and play.
	Stereotypic movement disorder	Repetitive hand flapping, body rocking, head banging, self biting or hitting.	Interferes with social, academic or other activities.
	Tic disorders	Repetitive and sudden motor or vocal tics.	Individuals with severe symptoms may experience disruption in daily activities resulting in social isolation, interpersonal conflict and an inability to work or go to school.

Category	Characterised by		Functional impairment
Other Neurodevelopmental Disorders	For example, neurodevelopmental disorder associated with prenatal alcohol exposure.	A range of developmental disabilities.	Impairment in social, occupational or other important areas of functioning.

[Source: American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, (5th edn).]

Prevalence and quantifying need

Inadequacy of scientific literature

2.15 The prevalence of neurodevelopmental disorders is difficult to determine. Prevalence studies within Australia and elsewhere have adopted different methodologies, with very few studies based on direct examination and assessment of individuals.[29]

2.16 Moreover, the rate of co-existence between disorders, as well as the complexity and co-morbidities of individual disorders is often overlooked in the literature[30] despite knowledge that these overlaps are common:

> Clinical experience leads us to believe that it is rare for a single NDD [neurodevelopmental disorder] to occur in isolation; rather, there is overlap between different disorders … and with other psychiatric psychopathologies …[31]

Referrals to child development services

2.17 Acknowledging the inadequacy of prevalence data, WA Health submitted that there has been a 42.7% increase in children referred to CAHS–CDS by an external source in the 10 years since 2012-13. This has been accompanied by an increase in the proportion of children with issues in three or more developmental areas.[32]

Australian Early Development Census

2.18 The Australian Early Development Census (AEDC) is a nationwide data collection of early childhood development completed by schoolteachers in a child's first year of full-time school. Conducted every three years, the AEDC provides a snapshot of children's development in Australia. The most recent data collection was in 2021.[33]

2.19 Teachers respond to questions across five domains. These are:

- physical health and wellbeing
- social competence

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29 Submission 77 from WA Health, 9 November 2022, p 28; and L Frances, J Quintero, A Fernandez et al., 'Current state of knowledge on the prevalence of neurodevelopmental disorders in childhood according to the DSM-5: a systematic review in accordance with the PRISMA criteria', *Child Adolesc Psychiatry Ment Health*, 2022, 16 (27): p 2, doi.org/10.1186/s13034-022-00462-1, accessed 5 September 2023.

30 Frances et al., 'Current state of knowledge on the prevalence of neurodevelopmental disorders in childhood according to the DSM-5: a systematic review in accordance with the PRISMA criteria', p 13.

31 Frances et al., 'Current state of knowledge on the prevalence of neurodevelopmental disorders in childhood according to the DSM-5: a systematic review in accordance with the PRISMA criteria', p 2.

32 Submission 77 from WA Health, 9 November 2022, p 28. WA Health did not provide a corresponding figure for WACH–CDS.

33 Nationally, 305,015 children in their first year of full-time school participated in the 2021 AEDC, equating to 95.5% of eligible children: Australian Early Development Census (AEDC), *Australian Early Development Census National Report 2021*, Australian Government, 2021 AEDC National Report, accessed 24 August 2023, p 68.

- emotional maturity
- language and cognitive skills (school-based)
- communication skills and general knowledge.[34]

2.20 Children are assessed on each domain as either:

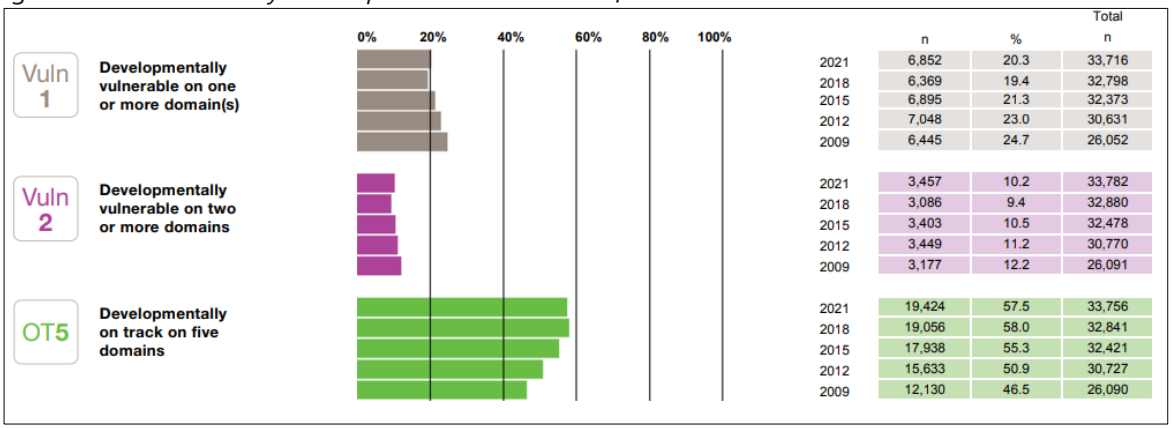
- developmentally on track (developing well)
- developmentally at risk (facing challenges in some aspects of their development)
- developmentally vulnerable (facing some significant challenges in their development).[35]

2.21 The 2021 results in Western Australia show that:

- 20.3% (6,852 children) were identified as developmentally vulnerable across one or more domain(s)
- 10.2% (3,457 children) were identified as vulnerable across two or more domains
- 57.5% (19,424 children) were developmentally on track across five domains.[36]

2.22 Figure 3 shows that, from 2009 to 2018, the percentage of developmentally vulnerable children progressively decreased, but in 2021, that vulnerability increased slightly.

Figure 3. *Australian Early Development Census trends for Western Australia 2009 to 2021*



	Vuln 1 n	Vuln 1 %	Vuln 2 n	Vuln 2 %	OT5 n	OT5 %	Total n
2021	6,852	20.3	3,457	10.2	19,424	57.5	33,756
2018	6,369	19.4	3,086	9.4	19,056	58.0	32,841
2015	6,895	21.3	3,403	10.5	17,938	55.3	32,421
2012	7,048	23.0	3,449	11.2	15,633	50.9	30,727
2009	6,445	24.7	3,177	12.2	12,130	46.5	26,090

[Source: AEDC, *Australian Early Development Census National Report 2021*, Australian Government, p 58.]

Vulnerable groups

2.23 As discussed earlier in this chapter, a combination of genetics and environmental factors influence a child's development. Social and economic disadvantage is a significant risk factor that coincides with developmental vulnerability:

> Discrepancies between children that are based upon avoidable differences in social and economic circumstances are evident as early as 9 months of age in a range of domains, and they grow larger over time.[37]

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34 AEDC, *Australian Early Development Census National Report 2021*, Australian Government, 2021 AEDC National Report, accessed 24 August 2023, p 9.

35 AEDC, 2021 AEDC National Report, p 9.

36 AEDC, 2021 AEDC National Report, p 58.

37 T Moore, M McDonald, L Carlon, K O'Rourke, 'Early childhood development and the social determinants of health inequities', *Health Promotion International*, 2015, 30 (suppl_2): p ii103, doi.org/10.1093/heapro/dav031, accessed 5 September 2023.

2.24 Evidence from the latest AEDC report shows 'persistent equity gaps in children's development'. In particular, continued disadvantage occurs among Aboriginal and Torres Strait Islander children, children living in regional and remote areas, those in socio-economically disadvantaged communities and families whose first language is not English.[38]

Early intervention

2.25 Neuroscience tells us that early childhood is 'a crucial window of opportunity for having a positive impact on future development'.[39] The benefits of intervening when children are young and developmentally most responsive is indisputable, as Professor Catherine Elliott from the Telethon Kids Institute stated:

> the evidence is overwhelming that the years from zero to five are vital for a child's development. What that essentially means is that the earlier we can assess and provide support to children who are developing differently, the better.[40]

A recurring theme in the evidence

2.26 The importance of early intervention is a dominant theme in evidence received by the Committee. For example, Professor Andrew Whitehouse from the Telethon Kids Institute asserted that:

> early intervention is absolutely key. It is a truism; it is not even up for debate anymore.[41]

2.27 Catholic Education Western Australia emphasised the link between early development and learning:

> The importance of early, authentic, and sustained intervention with younger children – including from birth – is paramount. This imperative is strongly evidence-based, not only as a community health issue, but also as a student learning issue. The link between early years development and learning is well established.[42]

2.28 Dr Elizabeth Green expressed a sense of collective responsibility for providing timely support to children who need it:

> No-one can dispute the importance of early child development, nor excuse the detrimental impact the failure to act and intervene early for all children causes. Especially in those who are vulnerable because of social circumstance or childhood trauma due to emotional, physical or sexual abuse.[43]

Intervening early: a broader concept

2.29 Early intervention does not relate solely to the first five years of life. It also means timely intervention when issues arise, regardless of a child's age.

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38 AEDC, *Australian Early Development Census National Report 2021*, Australian Government, 2021 AEDC National Report, accessed 24 August 2023, pp 5 and 29–42.

39 Submission 77 from WA Health, 9 November 2022, p 5.

40 Prof C Elliott, Director of Research, Telethon Kids Institute, [*transcript of evidence*], *Legislative Council,* 9 February 2023, p 2.

41 Prof A Whitehouse, Bennett Professor of Autism Research, Telethon Kids Institute, [*transcript of evidence*], *Legislative Council,* 9 February 2023, p 4.

42 Submission 37 from Catholic Education Western Australia Ltd (CEWA), 24 October 2022, p 1.

43 Submission 50 from Dr E Green, paediatrician, 24 October 2022, p 4.

2.30 WA Health explained:

> early intervention itself is a much broader concept. That is about intervening early when a concern is identified … so being able [to] intervene early when issues are identified at whatever point they are in their course of life. In my mind anyway, thinking about it as early childhood intervention and early intervention as a broader concept is quite helpful.[44]

2.31 The Telethon Kids Institute similarly expressed the view that early intervention should be part of a 'life span approach':

> We know that investment in early childhood drives success in school and life. It is also important to note, though, that children will often require support across their childhood, and early intervention treatment needs to be taken in the context of a life span approach.[45]

2.32 In this context, there are key transition points in a young person's life that have the potential to influence future development:

> Commencing childcare, starting school and transitioning to high school are all key transition points. Adolescence is a vital time for development. What happens during this 'window of vulnerability' when biological and psychosocial changes are occurring, has the potential to have a long-term effect on health outcomes.[46]

2.33 The provision of appropriate and timely support is therefore essential. According to WA Health:

> sensitive developmental stages and transition points in the lives of children and young people … provide key opportunities to support their development and promote positive outcomes. Strong preventative measures and early intervention when needed is vital.[47]

The cost of not intervening early

2.34 Early intervention to support optimal child development is more effective than a delayed response. It is also prudent for other reasons.[48] Evidence shows that failure to intervene has significant costs. For example:

- Failure to provide timely care can result in 'prolonged and escalating problems for children and their families'.[49]
- Not addressing speech and language difficulties before the age of three years can affect vocabulary development and subsequent communication, learning and self-regulation skills.[50]

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44 A Turnell, Acting Director, Clinical Services, Child Development Service, Child and Adolescent Health Service (CAHS), [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 11.

45 Prof C Elliott, Director of Research, Telethon Kids Institute, [*transcript of evidence*], *Legislative Council,* 9 February 2023, p 2.

46 Submission 77 from WA Health, 9 November 2022, p 11.

47 Submission 77, p 5.

48 Submission 77, p 13.

49 Dr A Leech, General Practitioner, Royal Australian College of General Practitioners, [*transcript of evidence*], *Legislative Council,* 17 May 2023, pp 1–2.

50 Dr E Green, Paediatrician, Southern Paediatrics, [*transcript of evidence*], *Legislative Council,* 17 February 2023, p 2.

- Individuals with poor speech, language and communication skills have an increased risk of contact with the criminal justice system.[51]
- There is a link between poor self-regulation in the early school years and later problems such as unemployment, behavioural and mental health issues, and alcohol and substance abuse.[52]
- Australia spends $15.2 billion annually on health, mental health, justice and other services in response to issues experienced by children and young people.[53]

Interventions and treatments

2.35 Intervention and treatment will depend on the nature and cause of the developmental delay.

2.36 In some cases, there will be a clear treatment pathway for an easily diagnosed functional impairment, while complex neurodevelopmental disorders may require treatment from multiple disciplines.[54]

2.37 Behavioural therapies to develop the skills associated with the functional impairment are the most common intervention.[55] For example, communication difficulties can improve through speech therapy, while managing self-care or improving fine motor skills will benefit from occupational therapy.[56]

2.38 Evidence shows that the use of medication has had mixed success in treating neurodevelopmental disorders (for example ASD and intellectual disability), although it has been shown to be effective in reducing the symptoms of ADHD.[57]

Enhancing protective factors to improve developmental outcomes

2.39 A developmental disorder can be acquired or have biological roots. However, the functional outcome for a child – the extent to which their everyday functioning is impaired – can be influenced by a range of factors.[58]

2.40 Risk factors, such as disadvantage and trauma, are circumstances that cause stress and increase the likelihood of adverse health outcomes. Protective factors, on the other hand, can moderate risk and promote well-being. Positive and supportive relationships (particularly with parents/caregivers), family stability, health and nutrition all serve to support child development:

> Parents are the most powerful influence on a child's life. The importance of a nurturing, secure and stimulating parent-child relationship on a child's brain

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51 Submission 77 from WA Health, 9 November 2022, p 13.

52 Submission 77, p 13.

53 Submission 77, p 13.

54 Submission 77, p 32.

55 Prof A Whitehouse and Prof A Bennett, *Background Paper 6B: Neurodevelopmental disorders*, National Mental Health Research Strategy, National Mental Health Commission, Australian Government, accessed 30 August 2023, p 2.

56 Submission 77 from WA Health, 9 November 2022, pp 51-53.

57 Prof A Whitehouse and Prof A Bennett, *Background Paper 6B: Neurodevelopmental disorders*, National Mental Health Research Strategy, National Mental Health Commission, Australian Government, accessed 30 August 2023, p 2.

58 Queensland Health, *Child development in Queensland Hospital and Health Services – 2 Act now for kids 2morrow: 2021 to 2030*, Queensland Health, Queensland Government, 2021, accessed 30 August 2023, p 11.

development, general development, health and wellbeing cannot be over-emphasised.[59]

2.41 Harvard University's Center on the Developing Child has developed three principles to improve outcomes for children and families:

- Support responsive relationships that promote healthy brain development, support well-being and develop resilience against challenging experiences that can cause toxic stress.
- Strengthen core skills related to executive functioning and self-regulation (such as planning, focus, self-control, awareness and flexibility) that are needed to manage life, work and relationships.
- Reduce sources of stress that can trigger a stress response in children or affect the ability of parents to protect and support them.[60]

2.42 These principles help to explain why, in general, child development services are not simply confined to therapeutic services. Services such as parent workshops aim to enhance the protective factors in a child's life by providing parents with the skills and knowledge to support their child's development.[61]

[59] Submission 77 from WA Health, 9 November 2022, p 12.

[60] Center on the Developing Child at Harvard University, *Three Principles to Improve Outcomes for Children and Families*, 2021, accessed 13 September 2023.

[61] Submission 77 from WA Health, 9 November 2022, p 31.

CHAPTER 3
Child development services in Western Australia

Chapter summary

3.1 This chapter provides the Western Australian context for child development services. It discusses:

- what child development services are and why they have a vital role to play in children's overall development, health and wellbeing
- how, and which parts of, the Western Australian public health system delivers child development services
- who else provides child development services in this state and how they interact with the parts of the Western Australian public health system that deliver child development services.

What are child development services?

3.2 As a general concept, child development services are the interventions that can be provided to a child to ensure they develop as well as possible. Such services can include:

- the screening for, and identification of, potential issues
- assessments of a child's development, including diagnostic assessment
- therapy for the child and/or their family
- the provision of strategies and supports for the child, their family and other networks, such as their school.

3.3 The principal role of child development services is to:

> support children to achieve optimal developmental, health (including mental health) and wellbeing outcomes.[62]

The importance of child development services

3.4 For the reasons discussed in Chapter 2, child development services can be crucial to a child's overall development, health and wellbeing. When such services are provided at the right time and in the right way, to a child who requires the services, they can change the path of that child's life. This is a truism that underpins the Inquiry and, in the Committee's opinion, is undeniable. Here is a selection of evidence submitted to the Committee in this regard:

- 'Child Development Service(s) play a key role in providing early intervention services for children with developmental delay. Early intervention can change a child's developmental trajectory, reducing the risk of further psychosocial and health issues, and their associated economic and social consequences.'[63]
- 'The provision of linked and comprehensive child development services are crucial to a child's overall development, health and wellbeing, with research demonstrating that early assessment, intervention and targeted support has a lifelong and positive impact on

[62] Submission 74 from Australian Psychological Society, 8 November 2022, p 4.

[63] Submission 16 from Neurosciences Unit, North Metropolitan Health Service – Mental Health, Public Health and Dental Services, 19 October 2022, p 1.

outcomes for the mental health, education and social engagement of the child and their family (parents and siblings), and for the community more generally.'[64]

- 'Child development services are critical services for the development of children in Western Australia. They are the first [health] services that most parents and children have contact with [after children are first born into a family], and have a vital role in providing advice and support to families, identifying children that may have developmental delays, and intervention early in the trajectory of developmental problems that can manifest later in the lifecycle.'[65]
- 'Research shows that child development services … are critical to child development.'[66]

Focus on child development services provided by Western Australian public health system

3.5 For the purposes of the Inquiry, the Committee, submitters and witnesses have focused on child development services provided by the State's public health system. The child development services provided by other government agencies and the private and non-government sectors are discussed at paragraphs 3.79 to 3.124.

Levels of healthcare services

3.6 Child development services offered in Western Australia fall within a spectrum of primary, secondary, tertiary and, occasionally, quaternary levels of healthcare.[67]

Primary

3.7 Primary healthcare refers to:

> typically the first contact an individual with a health concern has with the health system. Primary health care covers health care that is not related to a hospital visit, including health promotion, prevention, early intervention, treatment of acute conditions, and management of chronic conditions.[68]

3.8 Another way of understanding what is meant by primary healthcare is that a person can generally access it without the need for a referral from another health professional. Examples of primary healthcare providers are general practitioners (GPs), dentists, pharmacists, optometrists and other allied health practitioners operating directly within the community.

3.9 In the context of child development services provided by the Western Australian public health system, primary healthcare services are also known as 'community health services' for children. Primary healthcare providers include child health nurses and school health nurses, who are collectively known as 'community health nurses'.

> Community [child] health nursing services include the universal offer of child health assessments, screening, immunisation, support and parenting advice to the families of every child born in WA. [School health nursing services] … for school aged children include health and development screening on school entry, targeted

64 Submission 23 from College of Educational and Developmental Psychologists (Australian Psychological Society, WA Branch), 22 October 2022, p 2.

65 Submission 41 from Minderoo Foundation, 24 October 2022, p 2.

66 Submission 85 from Telethon Kids Institute, 18 November 2022, p 2.

67 For example, refer to Appendix 2 of this report for a description of the primary, secondary and tertiary levels of healthcare offered by CAHS–CDS.

68 Australian Institute of Health and Welfare (AIHW), *Primary Health Care*, AIHW, Australian Government, 2023, accessed 21 August 2023.

> screening and assessments, support: for student health care planning and the provision of the school-based immunisation program …[69]

3.10 Aboriginal health workers who support service engagement, parent education and health service navigation for Aboriginal families, are also primary healthcare providers.[70] In addition, primary care is provided by Aboriginal Health Practitioners who are registered with the Aboriginal and Torres Strait Islander Health Practice Board of Australia and would usually have completed a Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care Practice. They are primarily employed in Aboriginal community controlled health organisations and provide a range of clinical services dependent on their training, experience and clinical setting.[71]

Secondary

3.11 Secondary healthcare refers to:

> medical care provided by a specialist or facility upon referral by a primary care physician.[72]

3.12 In Western Australia, secondary-level child development services provided by the public health system include:

> a range of assessment, early intervention and treatment services to children with developmental delay or difficulty that impact on function, participation and/or parent-child relationship. Services are provided [by] a multidisciplinary team of allied health professionals and paediatricians.[73]

Tertiary and quaternary

3.13 Tertiary healthcare is provided by specialists, hospitals and palliative care services,[74] while quaternary healthcare is described as:

> an extension of tertiary care in reference to advanced levels of medicine which are highly specialised and not widely accessed. Experimental medicine and some types of uncommon diagnostic or surgical procedures are considered quaternary care.[75]

Focus on secondary and tertiary child development services

3.14 In the Western Australian public health system, child development services are delivered by:

- CAHS, principally through two teams known as Community Health Nursing (primary-level healthcare) and the Child Development Service (mainly secondary-level, but including tertiary-level healthcare)[76]

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69 Tabled Paper 4, *Memorandum of understanding: Community-based child and adolescent health services*, 2021, tabled by CAHS and WACHS during hearing held 28 November 2022, p 1, clause 1.1.

70 Submission 77 from WA Health, 9 November 2022, p 6.

71 Submission 77, p 83 and Department of Training and Workforce Development, *Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care Practice*, Jobs & Skills WA, 2023, accessed 1 September 2023.

72 AIHW, *Australia's Health 2016*, AIHW, Australian Government, 2016, accessed 21 August 2023, Chapter 2, p 4.

73 Tabled Paper 4, *Memorandum of understanding: Community-based child and adolescent health services*, 2021, tabled by CAHS and WACHS during hearing held 28 November 2022, p 1, clause 1.1

74 AIHW, *Review and evaluation of Australian information about primary health care*, AIHW, Australian Government, 2008, accessed 21 August 2023, p 2.

75 NSW Ministry of Health (NSW Health), *Annual report 2015-16*, NSW Health, New South Wales Government, 2016, accessed 21 August 2023, p 271.

76 See also, paragraphs 3.25 to 3.27 of this report.

- the WA Country Health Service (WACHS), through its Population Health service area[77] (primary, secondary and tertiary-level healthcare).[78]

3.15 CAHS–CDS acknowledged that, during the Inquiry, there has been some conflation of the primary, secondary and tertiary child development services that are provided by the public health system:

> It comes back to that definition as to the inquiry being about child development services broadly versus the Child Development Service as a referral-based service largely. There has been some uncertainty at times about what we provide because … [evidence has been given about] … child health and community health nursing, which is appropriate because development is a processing that should be from the normal right through to concerns around development.[79]

While strictly speaking, community health nursing does not fall within CDS, the Committee notes that CAHS–CDS works collaboratively with other CAHS services, including Community Health Nursing. This is discussed in later parts of this report (see paragraphs 3.26 and 3.74).

3.16 For the purposes of the Inquiry, the Committee focused on the secondary and tertiary-levels of child development services provided by CAHS–CDS and WACHS–CDS (CDS).

Overview of Western Australian public health system

3.17 In Western Australia, the public health system (known as WA Health) is comprised of:

- the Department of Health (DOH)
- seven board-governed health service providers:
  - North Metropolitan Health Service
  - South Metropolitan Health Service
  - East Metropolitan Health Service
  - CAHS
  - WACHS
  - Health Support Services
  - PathWest Laboratory Medicine WA[80]
- the Quadriplegic Centre, a chief executive-governed health service provider[81]
- contracted entities, to the extent that they provide health services to the State.[82]

3.18 The director general of DOH is the system manager for WA Health, responsible for providing:

> stewardship, strategic leadership and direction and to allocate resources for the provision of public health services in the State.[83]

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77 Tabled Paper 4, *Memorandum of understanding: Community-based child and adolescent health services*, 2021, tabled by CAHS and WACHS during hearing held 28 November 2022, pp 1–2, clause 1.2.

78 See paragraph 3.52 of this report.

79 Child Development Service, CAHS, [*private transcript of evidence*], *Legislative Council,* 25 July 2023, p 5.

80 *Health Services Act 2016* s 32; and *Health Services (Health Service Provider) Order 2016.*

81 *Health Services Act 2016* ss 32 and 251; and *Health Services (Quadriplegic Centre) Order 2018*.

82 *Health Services Act 2016* s 19(1).

83 *Health Services Act 2016* s 19(1A).

3.19 Through service agreements between the director general and each health service provider:

> Health Service Providers agree to meet the service obligations and performance requirements as detailed in the Service Agreement. The Department CEO [director general], as System Manager, agrees to provide the funding and other support services as outlined in the Service Agreements.[84]

3.20 For each health service provider, the governing body (the board or the chief executive) also serves as the employing authority for the provider's employees.[85]

Child and Adolescent Health Service – metropolitan area

3.21 CAHS is the health service provider that delivers child development services (at the primary, secondary and tertiary levels) in the Perth metropolitan area and is the largest single provider of CDS (secondary and some tertiary-level child development services) in the State.[86] It is also the State's only dedicated health service for infants, children and young people.[87]

Structure

3.22 CAHS consists of four service areas:

- Neonatology
- Community Health
- Child and Adolescent Mental Health Services (CAMHS)
- Perth Children's Hospital (PCH).

3.23 CDS are offered within the Community Health service area by the Child Development Service (referred to in this report as CAHS–CDS). Community Health also includes Community Health Nursing (child health, school health and immunisation services), the Aboriginal Health Team and the Refugee Health Team (see Figure 4 on page 20).

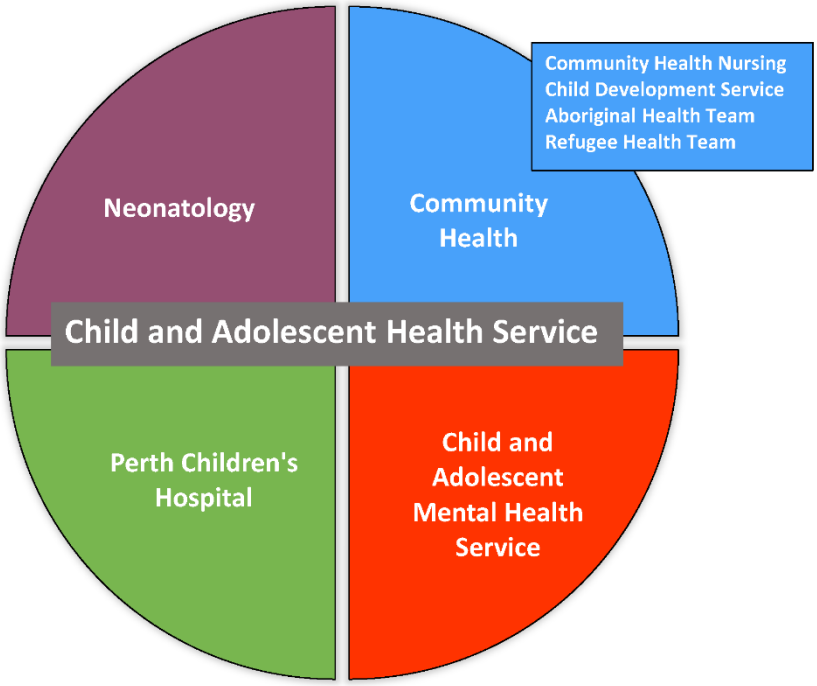
84 Department of Health (DOH), *Service agreements and deeds of amendment (abridged)*, DOH, 2023, accessed 13 November 2023.

85 The exception to this is that the director general of DOH is the employing authority of a health service provider's chief executive: *Health Services Act 2016* s 103.

86 Submission 77 from WA Health, 9 November 2022, p 5.

87 CAHS, *2021-2022 Annual report*, CAHS, October 2022, accessed 28 February 2023, p 11.

Figure 4. *Child and Adolescent Health Service – service areas*



[Source: Produced by the Committee based on submission 77 from WA Health, 9 November 2022, p 15.]

Overview of child development services

3.24 CAHS–CDS first formed into a single metropolitan provider in 2007.[88] It is the only such model in Australia:

> where both assessment and intervention services are provided by a multidisciplinary team of paediatricians and allied health clinicians under the one service umbrella. In other states and territories, services are dispersed across different organisations, organisational divisions and/or local government areas, and diagnostic, medical and intervention services are often separated. Eligibility for services and the range of allied health services offered also varies nationally.[89]

3.25 Its core business falls under secondary healthcare – that is, a referral of some form is required, meaning that the referrer, who may be a primary healthcare provider, or another person has already identified the presence of a possible developmental delay or difficulty.

> We are designed as a service for children where there are some developmental concerns that have been identified or flagged, or perhaps even further that there is a fairly clear question mark over a particular diagnosis, which is quite different to a primary healthcare service that exists to support the entire population and general development no matter which family you are or what situation you are in. So when we talk about something like assessment, that is a natural kind of first step with a

88 Submission 77 from WA Health, 9 November 2022, p 26.

89 Submission 77, p 85. Refer to Appendix 3 of this report for copies of letters from health ministers in other Australian jurisdictions to the Committee regarding their waiting times for child development services. The letters illustrate the general lack of a single service provider, which affects the collection of data.

child coming into a secondary service because there is already something that has been identified that we are trying to support.[90]

3.26 As shown in Appendix 2, there are also primary and tertiary aspects to the CAHS–CDS services. However, CAHS–CDS services are distinct from the primary healthcare services offered by Community Health Nursing, such as child health nursing, school health nursing and immunisation services. This contrasts with the more integrated WACHS structure, as discussed later in this report (see paragraph 3.52).

3.27 CAHS–CDS provides limited quaternary healthcare when its developmental paediatricians provide specialist child development advice to CAMHS and inpatient services at PCH, both of which provide mainly tertiary healthcare.[91]

3.28 CAHS–CDS's core services are delivered from 18 CDS locations across the metropolitan area.[92] However, it is noted that some individual services are provided in numerous other settings.

Disciplines

3.29 CAHS–CDS provides the following discipline-specific services:

- allied health services:
  - audiology
  - clinical psychology
  - occupational therapy
  - physiotherapy
  - social work
  - speech pathology
- nursing – delivered by clinical nurse specialists
- developmental paediatrics.

Each of these services is described in the WA Health submission.[93]

3.30 Allied health assistants also work within CAHS–CDS,[94] to support the delivery of allied health services; for example, by helping to plan and run therapy sessions.

Eligibility and referral

3.31 A child is eligible for CAHS–CDS services if they:

- are under the age of 16 years at the time of referral[95]

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90 A Turnell, Acting Director, Clinical Services, Child Development Service, CAHS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 11.

91 Child Development Service, CAHS, [*private transcript of evidence*], *Legislative Council,* 25 July 2023, pp 6 and 7.

92 CAHS, *Centre locations,* CAHS, 2023, accessed 23 August 2023.

93 Submission 77 from WA Health, 9 November 2022, pp 50–54.

94 Allied Health Assistants would have completed a Certificate III or Certificate IV in Allied Health Assistance: Submission 77 from WA Health, 9 November 2022, pp 46 and 72.

95 This ensures that 'there is a window of time in which to provide assessment and transition services before the child turns 18 years of age': Tabled Paper 2, *Inquiry into child development services: Potential questions*, tabled by CAHS during hearing held 28 November 2022, p 2.

- hold an appropriate Medicare card
- live in the Perth metropolitan area.[96]

3.32 The Committee was advised by CAHS–CDS that children who are accepted into its care at ages younger than 16 years would continue to be assisted until they turn 18 years old. Children aged 16 and 17 years at the time of referral to CAHS–CDS are re-referred to an appropriate adult service, which may include a WA Health service.[97]

3.33 In addition to the eligibility criteria listed in paragraph 3.31, CAHS–CDS and the child's parents or legal guardians must determine collaboratively whether CAHS–CDS services will be suitable for the child. Generally, CAHS–CDS services are considered appropriate when:

- the client presents with developmental delay or difficulties impacting on function, participation and/or parent-child relationship that is not the result of general medical, surgical or acute conditions or injuries
- the client is medically fit enough to safely participate in any physically challenging intervention in a community setting (e.g. physiotherapy)
- parents have previously accessed universal services for support regarding typical childhood concerns including nutrition, mealtimes, sleeping, toileting, behaviour, play and parent-child relationships
- the client is not receiving services from another government funded agency that they may be entitled to. Note that children receiving NDIS [National Disability Insurance Scheme] funded services are still able to access CDS diagnostic services and specialist paediatric medical services.[98]

3.34 CAHS–CDS does not provide:

- mental health (only) services
- general medical, surgical or acute services
- rehabilitation services
- emergency or crisis services
- services to children whose skills are within a developmentally normal range.[99]

3.35 CAHS–CDS has an open referral system, meaning referrals may be made by anyone, including parents or legal guardians, GPs, child health nurses, school health nurses, teachers and other professionals. However, all referrals require parental or guardian consent.[100] A dedicated referral form is available on the CAHS–CDS website[101] and may be filled out either electronically or in hard copy. The form can then be e-mailed, faxed or posted.

3.36 Currently, the dedicated referral form is non-mandatory, so the Centralised Intake Team will accept referrals in other formats, despite the fact that this creates an administrative burden. CAHS–CDS is investigating the option of an online referral platform.[102]

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96 Submission 77 from WA Health, 9 November 2022, p 26.

97 S Kiely, Executive Director, Community Health, CAHS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 5.

98 Submission 77 from WA Health, 9 November 2022, pp 26–27.

99 CAHS, *Child Development Service*, CAHS, 2023, accessed 27 October 2023.

100 Submission 77 from WA Health, 9 November 2022, p 27; and CAHS, *Eligibility and referrals*, CAHS, 2023, accessed 23 August 2023.

101 CAHS, *Eligibility and referrals*, CAHS, 2023, accessed 23 August 2023.

102 Submission 77 from WA Health, 9 November 2022, p 27.

3.37 CAHS–CDS advised that GP referrals have increased since 2012, 'particularly for children aged 7 years or older with the referral reason [being] related attention and concentration.'[103]

3.38 In 2021-22, there were 33,701 referrals to CAHS–CDS. Most referrals (55% or 18,428) came from allied health professionals, both within and external to the service (refer to Table 2). Other sources of referrals included schools (18% or 5,928), Community Health Nurses (15% or 4,979) and GPs and other doctors (10% or 3,327). Parents made only 3% (977) of the referrals.

Table 2. *Referrals to Child and Adolescent Health Service – Child Development Service in 2021-22*

Referral source	**Number of referrals**
Allied health (internal and external)	18,428
Community health nursing	4,979
Parent	977
GP/doctor	3,327
School	5,928
Child protection	62
Total*	**33,701**

* The total number of referrals related to 19,765 unique children.

[Source: Dr DJ Russell-Weisz, Director General, DOH, Answer to question on notice 12 asked at hearing held 28 November 2022, dated 20 December 2022, p 6.]

3.39 CAHS–CDS has a Centralised Intake Team,[104] including a triage process that involves a clinical nurse specialist assessing which clinical discipline is most aligned to the primary concern(s) noted in the referral.[105]

3.40 CAHS–CDS advised the Committee of recent trends in the relative mix of ages at which children are referred to it:

> the data we have pulled for the last 10 years [2012-13 to 2021-22] shows that the **number** of children aged zero to four that have been referred has increased. It is the **proportion** of children aged zero to four that has decreased, and obviously "proportion" is a relative term. We have seen increases across the last 10 years in the number of children referred and increases in all the numbers of children, but the increases have been higher in school-aged children, and particularly for children aged over eight, there has been a very large percentage increase in the numbers of children.[106] (emphasis added)

3.41 The four to eight years age group has consistently been the largest proportion of referrals since 2012-13 and its proportion is steadily increasing (50% in 2012-13 to 54% in 2021-22). The proportion of the eight years and older age group has also increased markedly over the last 10 years – doubling from 7% in 2012-13 to 14% in 2021-22. Figure 5 on page 24

[103] Submission 77 from WA Health, 9 November 2022, p 27.

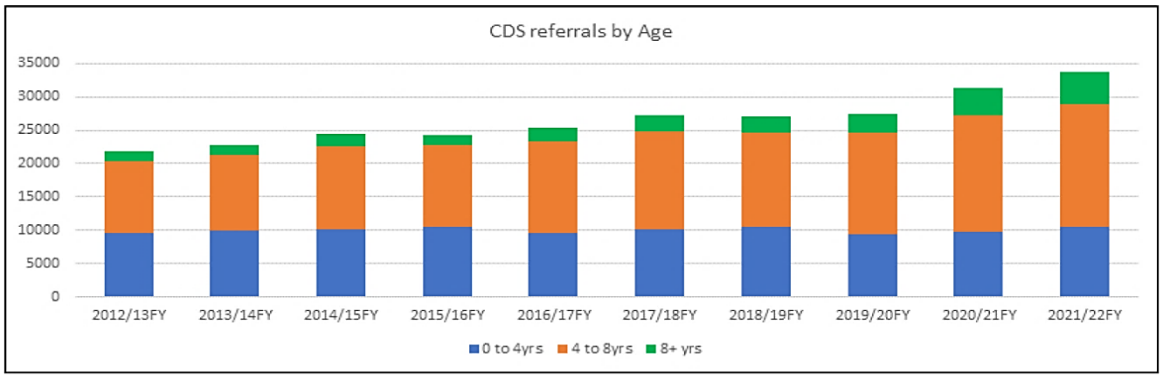
[104] Submission 77, p 27.

[105] Tabled Paper 2, *Inquiry into child development services: Potential questions*, tabled by CAHS during hearing held 28 November 2022, pp 2–3 and 19.

[106] S Kiely, Executive Director, Community Health, CAHS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 7.

illustrates the changes in the relative proportions of referral-age groups.[107] This is further discussed at paragraph 4.32.

Figure 5. *Child and Adolescent Health Service – Child Development Service referrals received, by age*



[Source: Tabled Paper 1 tabled by CAHS and WACHS during hearing held 26 April 2023, p 1.]

Service options

3.42 CAHS–CDS delivers its services in a variety of ways, including the provision of:

- activity ideas and resources for home, school or day-care
- parent workshops
- individual or group therapy appointments
- information on community programs
- referrals to other services.[108]

3.43 These service options are not mutually exclusive. The combination of service options accessed, and the disciplines involved, in a child's service plan are discussed at a service planning appointment, which should occur within 8 weeks after a referral.[109]

> Essentially, with every client we would consider what the family's goals and priorities are, what the evidence base is for the areas of concern that they have, and what our service capacity is. All of those things will feed into making a decision and planning for that family as to what services would work the best for them. … those service types are not mutually exclusive. For instance, a family after a service planning appointment may access a parent information workshop while they are waiting for their assessment. Once they have been assessed, they may then access a group program and they may go on to access an individual therapy as well.[110]

Service guidelines

3.44 Each of the disciplines working within CAHS–CDS follows service guidelines that:

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107 Tabled Paper 1 tabled by CAHS and WACHS during hearing held 26 April 2023, p 1.

108 CAHS, *Child Development Service*, CAHS, 2023, accessed 22 August 2023.

109 CAHS, *Child Development Service*.

110 A Turnell, Acting Director, Clinical Services, Child Development Service, CAHS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 7.

> give them some parameters to work with in terms of the services that they have available to offer to those families, but we also have the ability for clinicians to make exceptions to those service guidelines as well when needed.[111]

3.45 The guidelines all have a similar format but provide assessment and intervention pathways that are specific to each specialty. These pathways are based on the child's presentation, the family's concerns for the child, the severity of those concerns and the child's age.[112] Each guideline also:

- explicitly states that clinicians are supported in considering clinically appropriate and reasonable variations from the guidelines in order to meet the child's and their family's needs
- set outs a procedure that must be adhered to when considering such variations.[113]

3.46 While the Committee has decided to abide by WA Health's request not to publish the service guidelines, it is satisfied that they provide clinicians with adequate information about treatment pathways and procedures.

WA Country Health Service – regional areas

3.47 Geographically, WACHS is the largest regional health service in Australia, covering nearly 2.5 million square kilometres (see Figure 6 on page 26). It provides services to over 500,000 residents, approximately 11% of whom identify as Aboriginal.[114] WACHS operates across seven regions:

- WACHS–Kimberley
- WACHS–Pilbara
- WACHS–Midwest
- WACHS–Wheatbelt
- WACHS–Goldfields
- WACHS – South West
- WACHS – Great Southern.

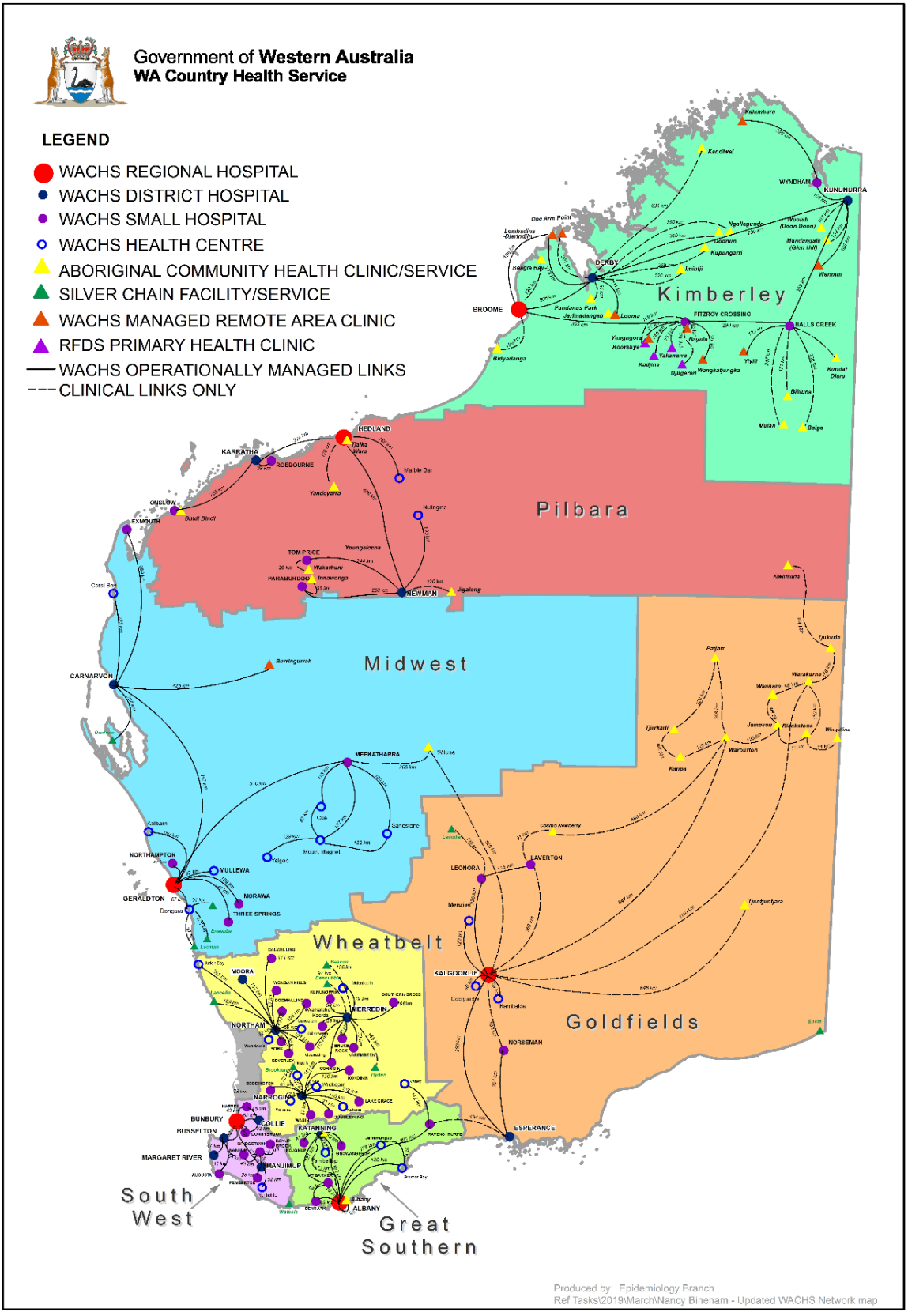
111 A Turnell, Acting Director, Clinical Services, Child Development Service, CAHS, [*transcript of evidence*], *Legislative Council*, 28 November 2022, p 9.

112 A Turnell, [*transcript of evidence*], 28 November 2022, pp 8–9.

113 Service guidelines provided by Dr DJ Russell-Weisz, Director General, DOH, Answer to question on notice 2 asked at hearing held 28 November 2022, dated 20 December 2022.

114 Submission 77 from WA Health, 9 November 2022, p 8.

Figure 6. *Map of WA Country Health Service regions*



[Source: WACHS, *Overview*, WACHS, 2023, accessed 23 August 2023.]

Structure

3.48 As a whole, WACHS provides the following health services: emergency and hospital; population and public healthcare; Aboriginal health; mental health; drug and alcohol; child, community and school healthcare; and residential and community aged care.[115] However, the combination of services offered in each of the seven regions varies according to the local conditions, such as the available service facilities and workforce, catchment demographics, past and expected service utilisation, availability of alternative service providers and community infrastructure.[116]

3.49 Unlike CAHS, WACHS does not have one team that is dedicated to providing CDS. Instead, CDS and all other health services are delivered under seven service umbrellas designated by the WACHS regions. That is, each WACHS region has its own mix of clinicians providing CDS:

> WACHS CDS has a limited number of dedicated child development teams and health professionals, with the majority needing to provide services across the life span and across multiple health programs including inpatients, acute, subacute and outpatient.
>
> …
>
> Between regions there is variance in the mix of professions engaged in CDS, as well as the percentage of staff resource allocated to CDS. CDS staff have varying degrees of experience in the developmental space. WACHS CDS supports upskilling clinicians by self-directed learning modules, communities of practice and expert consultation pathways.[117]

3.50 CDS are provided under a 'hub and spoke' model, with the hubs feeding out services to the spokes as necessary. There are 21 hubs, each of which is situated at a hospital[118] – six at regional health campuses and 15 at district health campuses.[119] (See Figure 6 on page 26.)

3.51 The larger the health campus, the greater the likelihood that a dedicated multidisciplinary CDS team is present locally. Remote and/or smaller regional communities are more likely to rely on clinicians who either travel to them or deliver telehealth services, often from a hub. WA Health provided this description of the CDS that a child and their family may expect to receive in regional Western Australia, depending on their location:

- No physical or permanent local service
    - Services are provided by visiting clinician and/or by telehealth services from the hub. For example, allied health staff drive over four hours from Albany to Ravensthorpe a few times a year (when there are sufficient number of children requiring assessment or treatment). Ongoing support may be provided by a local primary health care provider or other relevant community agency (e.g. Remote area nurse or school).
- Small hospital/primary health care centre
    - Regular visiting and/or telehealth services are provided from the local hub … [responsible for] … service planning. Support is provided by local

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115 WA Country Health Service (WACHS), *Annual report 2021-2022*, WACHS, 2022, accessed 24 August 2023, p 13.

116 Submission 77 from WA Health, 9 November 2022, p 61.

117 Submission 77, p 67.

118 Submission 77, p 61; and L Pereira, Manager, Child Development Service, WACHS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 26.

119 WACHS, *Overview*, WACHS, 2023, accessed 23 August 2023.

primary health care providers (e.g. GP, community nurse, school, day care).

- Integrated District Health Service
    - [Services are provided by] … a small multidisciplinary CDS team, who also work as generalists across the life span and multiple program areas, including inpatient and outpatient services (e.g. at multipurpose sites). This team also provide visiting or telehealth services to smaller catchment communities. There may be local access to paediatricians within the region who regularly attend the service. Visiting and/or telehealth services are often provided by professionals who do not live locally e.g. audiology, psychology.
- Regional Resource Centre
    - [Centres have] … an onsite expanded multidisciplinary CDS team, with dedicated/designated CDS team members. Specialist clinics/services are offered with access to paediatricians at the service hub and visiting and/or telehealth services may still be required [to] be provided by professionals who do not live locally e.g. audiology, psychology. This dedicated CDS team provides a regional wide service (beyond the immediate catchment) and provides region wide clinical and professional support and advice.[120]

Overview of services

3.52 While the CDS provided by WACHS are secondary and tertiary healthcare services, they are integrated with child health services and school health services, which are primary healthcare services.[121] This contrasts with the more segregated CAHS structure.[122]

3.53 The term 'WACHS–CDS' is used in this interim report to refer to the teams within WACHS that provide CDS across the seven WACHS regions.

Disciplines

3.54 As noted earlier,[123] most WACHS–CDS clinicians are required to work as generalists (as opposed to specialists in child development), across the lifespan of their patients and in multiple health programs, including in-patient, acute, sub-acute and out-patient care.[124]

3.55 WACHS–CDS provides the following discipline-specific services:

- allied health services:
    - audiology
    - psychology
    - occupational therapy
    - physiotherapy
    - social work

120 Submission 77 from WA Health, 9 November 2022, pp 61–62.

121 WACHS, *Healthy Country Kids,* WACHS, 2023, accessed 25 August 2023.

122 See paragraphs 3.25 to 3.27 of this report.

123 Refer to paragraph 3.49 of this report.

124 L Pereira, Manager, Child Development Service, WACHS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 24.

    - speech pathology
    - dietetics
    - podiatry
- nursing – delivered by community nurses
- paediatrics[125]

3.56 Allied health assistants[126] and Aboriginal health workers[127] also work within WACHS–CDS.[128]

Eligibility and referral

3.57 To be eligible for WACHS–CDS services, children residing in regional Western Australia need to present with, or be at risk of, a developmental delay that is affecting their functions.[129] For example, they may have difficulty with eating, hearing, talking, understanding, moving, hand skills and social or play skills.[130] Children are eligible until they turn 18 years old, although WACHS–CDS advises referrers to lodge the referral before the child reaches 16 years of age.[131]

3.58 Examples of services that are out of scope include:

- education based services in the absence of an underlying developmental delay or disability (for example, literacy, handwriting)
- diagnostic assessment of ASD – this service is delivered in partnership with the Department of Communities (see paragraphs 3.108 to 3.109)
- assessment and diagnosis of dyslexia, dysgraphia or auditory processing
- acute mental health issues
- psycho-social services in the absence of existing or risk of health issue, developmental delay or disability.[132]

3.59 Anyone can refer a child to WACHS–CDS. However, referrals from someone other than the child's parent or legal guardian will require the parent or legal guardian's consent. A dedicated referral form is available on the WACHS–CDS website[133] and may be filled out either electronically or in hard copy. The form can then be e-mailed, faxed or posted.

3.60 In 2021-22, the top five sources of referrals to WACHS–CDS were the Department of Education (25% of referrals or 3,148), allied health professionals (21% or 2,623), nurses (20% or 2,518), GPs (10% or 1,264) and a family member or friend (7% or 907). A full list of the referral sources appears in Table 3 on page 30.

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125 WACHS, *Child development services*, WACHS, 2022, accessed 23 August 2023. See also, Submission 77 from WA Health, 9 November 2022, p 61.

126 Refer to paragraph 3.30 of this report.

127 Refer to paragraph 3.10 of this report.

128 Submission 77 from WA Health, 9 November 2022, p 61.

129 L Pereira, Manager, Child Development Service, WACHS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, pp 5–6.

130 WACHS, *Child development services*, WACHS, 2022, accessed 25 August 2023.

131 L Pereira, Manager, Child Development Service, WACHS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 5.

132 Tabled Paper 5, *Health Country Kids Program: Child development service framework*, tabled by WACHS during hearing held 28 November 2022, pp 12–13.

133 WACHS, *Child development services*, WACHS, 2022, accessed 25 August 2023.

3.61 As WACHS–CDS does not have a centralised intake team, the WACHS region that receives a referral will proceed with the initial intake call.[134]

Table 3. *Referrals to allied health disciplines in WA Country Health Service – Child Development Services in 2021-22*

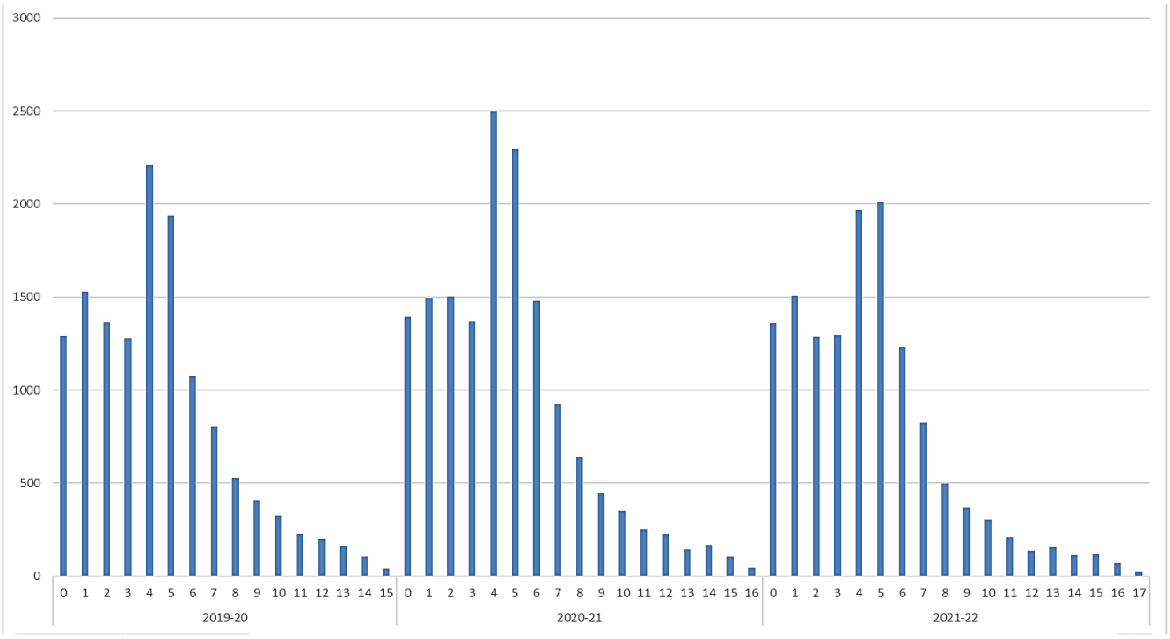
Referral source	**Number of referrals**
Allied health professional	2,623
Another institution	35
Clinician	97
Community	374
Education department	3,148
Emergency department	35
Family or friend	907
General practitioner	1,264
Government agency	15
Inpatient ward	36
Medical practititioner	398
Mental health clinic or team	16
Non-government organisation	17
Not specified	3
Nurse	2,518
Nurse practitioner	73
Other	112
Other hospital	155
Other professional	286
Other service	62
Outpatient department this hospital	126
Private referral	4
Same consultant	1
Self	115
Specialist rooms	332
Unknown	5
Total	**12,757**

[Source: Dr DJ Russell-Weisz, Director General, DOH, Answer to question on notice 12 asked at hearing held 28 November 2022, dated 20 December 2022, pp 6–7.]

[134] L Pereira, Manager, Child Development Service, WACHS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 6.

3.62 Data submitted by WACHS–CDS indicate that the majority of referrals it received in the three years from 2019-20 to 2021-22 were for children aged four and five years (see Figure 7). However, WACHS–CDS noted that the data was unlikely to be complete, given that different systems are used to enter referrals. It also stressed that referrals to individual disciplines occurs at different ages.[135]

Figure 7. *WA Country Health Service – Child Development Service referrals received, by age*



[Source: Tabled Paper 1 tabled by CAHS and WACHS during hearing held 26 April 2023, p 2]

3.63 Based on the above figures, children in the zero to eight age group were the subject of more than 80% of the referrals to WACHS–CDS.

Service options

3.64 WACHS–CDS works to support children and their families by providing:

- strategies to strengthen skills in everyday activities
- parent information workshops
- individual or group therapy appointments
- information on community programs
- referrals to other services.[136]

3.65 These service options are discussed with families and a service plan is developed during the initial intake call. The families are then streamed into the services that they think best suit their needs.[137]

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135 Tabled Paper 1 tabled by CAHS and WACHS during hearing held 26 April 2023, pp 1–2.

136 L Pereira, Manager, Child Development Service, WACHS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 6; and WACHS, *Child development service information for referrers*, WACHS, accessed 25 August 2023, p 2.

137 L Pereira, [*transcript of evidence*], 28 November 2022, p 6.

Service guidelines

3.66 The *Health Country Kids Program: Child development service framework* was released in January 2017. The framework:

> aims to ensure the consistent operations of WACHS[–CDS] by providing overarching principles, service standards and strategies to guide flexible and responsive service planning, delivery and evaluation in line with best practice.[138]

3.67 One of the objectives of the framework is to support clinicians by providing service practice guidelines and targeted education and training.[139]

Memorandum of understanding between Child and Adolescent Health Service and WA Country Health Service

3.68 As the two providers of CDS in this State, CAHS and WACHS signed a memorandum of understanding in November 2022 that outlines their shared roles and responsibilities[140] in delivering these services.

3.69 For example, under the heading 'Transfer of clients', the memorandum acknowledges that:

> When families move between metropolitan and regional services it is important to ensure an equitable and streamlined transfer to ensure continuity of care.[141]

When a client is referred to either CAHS or WACHS but has not yet commenced services upon their transfer to the other agency, the initial date of referral 'is maintained'. For clients who are receiving services when they are transferred, a clinical handover must be completed in accordance with the WA Health Clinical Handover policy.[142]

3.70 The memorandum will be current for five years.[143]

Partnerships in delivering child development services

Workforce

3.71 CAHS–CDS prefers to provide its services through a directly employed workforce.[144] In contrast, WACHS–CDS often relies on contracted workers to deliver its services. Outsourcing may occur when there is an employee shortage in a particular region or discipline.

3.72 As an example of discipline shortages, WACHS–CDS across all regions is experiencing difficulties in recruiting and retaining audiologists and clinical psychologists. These difficulties are overcome by entering into contracts with preferred providers:

> **Ms MILLER**: … For both of those health professional groups, we actually have a statewide contract that we go out to procurement. We organise a preferred provider list and they are supplied to all the regions. The regions then have

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138 Submission 77 from WA Health, 9 November 2022, p 61.

139 Tabled Paper 5, *Health Country Kids Program: Child development service framework*, tabled by WACHS during hearing held 28 November 2022, p 9.

140 In the areas of service delivery, the Triple P – Positive Parenting Program, education and training, service reporting and research.

141 Tabled Paper 4, *Memorandum of understanding: Community-based child and adolescent health services*, 2021, tabled by CAHS and WACHS during hearing held 28 November 2022, p 4, clause 4.1.3.

142 *Memorandum of understanding: Community-based child and adolescent health services*, 2021, p 4, clause 4.1.3.

143 *Memorandum of understanding: Community-based child and adolescent health services*, 2021, p 2, clause 1.3.

144 Dr DJ Russell-Weisz, Director General, DOH, Answer to question on notice 13 asked at hearing held 28 November 2022, dated 20 December 2022, p 7.

> buckets of money that they can then contact those preferred providers and contract them in to provide the service.
>
> **Hon DONNA FARAGHER**: Okay, and those services would be within that region?
>
> **Ms MILLER**: They are not necessarily located in the region, but they will travel to that region and provide a certain amount of visits per year.[145]

3.73 The Earbus Foundation of Western Australia is currently one of the organisations contracted to provide audiology services to WACH–CDS.[146]

Service partners

3.74 CAHS–CDS submitted that it:

> works collaboratively with other CAHS services, including Community Health Nursing [within the same Community Health service area as CAHS–CDS], the Child and Adolescent Mental Health Service and Perth Children's Hospital, as well as the broader government and non-government sectors to promote the best outcomes for children, young people and their families.[147]

3.75 Similarly, WACHS–CDS acknowledges that its services are complemented, extended and enabled by partnerships with other service providers and organisations, across the public, private and non-government sectors. Some of these 'service partners' are healthcare providers in their own right (primary, secondary and tertiary level), some provide occasions and/or facilities for CAHS–CDS and WACHS–CDS to engage with families and some provide funding and other collaborative opportunities. Many of these service partners are common to both agencies, and include, but are not limited to:

- Aboriginal health providers – such as Aboriginal medical services and Aboriginal community controlled health services
- child care centres
- child and parent centres – provided by the Department of Education in partnership with non-government organisations
- Early Years networks – supported by the Department of Communities
- hospitals
- mental health services – including those provided by CAMHS and community based organisations
- the National Disability Insurance Scheme (NDIS)[148]
- other state government agencies – particularly, the Department of Education and Department of Communities[149]
- parenting support services
- private philanthropic organisations

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145 Hon D Faragher MLC, Deputy Chair, and K Miller, Director, Population Health, WACHS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, pp 15–16.

146 Earbus Foundation of Western Australia (Earbus), *2022 Annual report*, Earbus, 2022, accessed 17 October 2023, p 12. For more information about Earbus, refer to paragraph 3.86 of this report.

147 Submission 77 from WA Health, 9 November 2022, p 5.

148 Refer to paragraphs 3.111 to 3.124 of this report.

149 Refer to paragraphs 3.87 to 3.110 of this report.

- playgroups
- primary healthcare providers – such as GPs, community health nurses and Aboriginal health workers[150]
- private allied health providers and medical specialists
- schools, both public and private.

3.76 Some of the work that CAHS–CDS and/or WACHS–CDS have done with these service partners is outlined in the WA Health submission[151] and WACHS's *Health Country Kids Program: Child development service framework*.[152]

3.77 Notwithstanding WA Health's stated acknowledgement of the importance of partnerships, the Committee notes the Sustainable Health Review's message that, both internally and externally, WA Health must work in a more coordinated and integrated manner and this was reflected in some of the evidence presented to the Committee (see paragraphs 5.5 to 5.6) The Review panel made the following comment in the context of discussing its recommendation 8,[153] which relates to giving children the best start in life:

> Delivering services during the first 1,000 days of life must begin with better coordination and integration of health and other services that contribute to a child's wellbeing. Health must actively partner with the many other stakeholders working in areas such as housing, child protection, disability services and education.[154]

Other child development services available in Western Australia

3.78 As discussed early in this chapter,[155] the Committee has focused on child development services provided by the State's public health system. The specific focus has been on secondary and tertiary-level child development services provided by CAHS–CDS and WACHS–CDS (CDS). However, there are other providers that also deliver child development services, some of which are listed at paragraph 3.75. The following paragraphs discuss a small but notable selection of these providers which have been referred to in the evidence provided to the Committee.

Private sector

3.79 Private sector providers are the main alternative source of secondary and tertiary-level child development services. Providers include both individual practitioners and multidisciplinary teams of allied health practitioners, nurse practitioners, paediatricians and psychiatrists.

3.80 Inquiry evidence suggests that these private sector providers are also overwhelmed by the demand for their services. Submitters and witnesses have advised that many providers

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150 Although in the case of WACHS, community health nurses and Aboriginal health workers are integrated with the WACHS–CDS teams.

151 Submission 77 from WA Health, 9 November 2022, pp 77–84.

152 Tabled Paper 5, *Health Country Kids Program: Child development service framework*, tabled by WACHS during hearing held 28 November 2022, pp 21–23.

153 'Health actively partner in a whole-of-government approach to supporting children and families in getting the best start in life to become physically and mentally healthy adults.'

154 DOH, *Sustainable Health Review Final report to the Western Australian Government*, DOH, 2019, accessed 29 August 2023, p 69.

155 Paragraph 3.5 of this report.

operating privately in Western Australia, particularly paediatricians, are no longer accepting new patients[156] – this is known colloquially as 'closing their books'.

3.81 Accessing private services does not preclude a child from being eligible for CAHS–CDS and WACHS–CDS services.[157] Therefore, children can potentially appear on multiple waitlists for services from the same discipline (for example, physiotherapy).

Non-government sector

3.82 Aboriginal community controlled health organisations (ACCHOs) operate health services which offer culturally appropriate and responsive primary healthcare[158] to members of their communities, including children and young people. These services are financed mainly by state and commonwealth government grants and, to a lesser extent, Medicare income, other funding partnerships and NDIS income.[159]

3.83 Some ACCHOs are able to put their funding towards employing or contracting allied health professionals or medical specialists who may provide secondary and/or tertiary-level child development services.[160] Clinicians may also work voluntarily in that area[161] or run occasional visiting clinics.[162] However, the Committee understands that ACCHOs typically refer their clients to CAHS–CDS or WACHS–CDS when such services are needed.[163]

3.84 Other not-for-profit centres and organisations, like CliniKids (operated by the Telethon Kids Institute)[164] and Telethon Speech and Hearing,[165] also provide secondary-level child development services. Both CliniKids and Telethon Speech and Hearing are fee-for-service providers and therefore not universally available, although Medicare, NDIS funds and/or

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156 For example, Submission 9 from private citizen, 26 September 2022, p 1; Submission 42 from private citizen, 24 October 2022, p 1; Submission 80 from Developmental Occupational Therapy Association WA and WA Occupational Therapy Association, 14 November 2022, p 3; and S Dowden, Paediatric Nurse Practitioner/Director, NursePrac Australia/Just Kids Health Clinic, [*transcript of evidence*], *Legislative Council,* 20 February 2023, p 11.

157 CAHS, *Eligibility and referrals*, CAHS, 2023, accessed 31 August 2023; and WACHS, *Child development services*, WACHS, 2022, accessed 31 August 2023.

158 Through Aboriginal health practitioners, Aboriginal health workers, nurses (including child health nurses), GPs, support workers and other professionals: for example, Kimberley Aboriginal Medical Services (KAMS), *Our member services*, KAMS, 2023, accessed 30 August 2023; Derbarl Yerrigan Health Service, (DYHS), *Annual report 2021-22*, DYHS, 2022, accessed 30 August 2023, p 6; and South West Aboriginal Medical Service (SWAMS), *Health*, SWAMS, 2023, accessed 30 August 2023.

159 For example, DYHS, *Annual financial report for the year ended 30 June 2022*, DYHS, 2022, accessed 30 August 2023, p 13; and SWAMS, *Annual Report 2021-2022*, SWAMS, 2022, accessed 30 August 2023, pp 32–33.

160 For example, in 2021-22, DYHS had a general and developmental paediatrician embedded within its Maternal and Child Health Team: DYHS, *Annual report 2021-22*, DYHS, 2022, accessed 30 August 2023, pp 17 and 28.

161 For example, in 2021-22, a paediatrician volunteered her paediatric services at DYHS: DYHS, *Annual report 2021-22*, DYHS, 2022, accessed 30 August 2023, p 17.

162 For example, in 2021-22, the SWAMS Maternal and Child Health Team hosted four paediatrician clinics and four ear, nose and throat clinics: SWAMS, *Annual Report 2021-2022*, SWAMS, 2022, accessed 30 August 2023, p 25. WACHS paediatricians visit the Derby Aboriginal Health Service: Dr A Fleming, Senior Medical Officer, Derby Aboriginal Health Service, [*transcript of evidence*], *Legislative Council,* 2 May 2023 p 4.

163 For example, J Ingrey, Maternal Child Health Coordinator, SWAMS, [*transcript of evidence*], *Legislative Council,* 3 April 2023, p 2; and Dr A Fleming, Senior Medical Officer, Derby Aboriginal Health Service, [*transcript of evidence*], *Legislative Council,* 2 May 2023 pp 3–4.

164 CliniKids provides a clinical service for children with developmental delay and/or an autism spectrum disorder diagnosis and their families: CliniKids, *About us*, Telethon Kids Institute, 2023, accessed 8 September 2023.

165 Telethon Speech and Hearing operates an independent speech and language school for children aged 4 and 5 years and also offers allied healthcare, early intervention programs supports and mainstream school support programs: Telethon Speech and Hearing, *Annual report 2022*, 2022, accessed 31 August 2023, p 4; and M Fitzpatrick, Chief Executive Officer, Telethon Speech and Hearing, [*transcript of evidence*], *Legislative Council,* 17 May 2023, p 2.

private health insurance rebates may help to cover their fees. Both organisations also receive funding from local, state and/or commonwealth governments and philanthropic partners.[166]

3.85 Ability WA is a not-for-profit disability service provider that offers a free,[167] secondary-level healthcare service known as the In-home Baby Intervention Service, or IBIS. IBIS is available to children aged 0 to 2 years who have been identified by a medical professional as being at risk of neurodevelopmental disability.[168] IBIS is:

> a family-centered program which fosters babies' development, well-being and participation within everyday routines. Our highly skilled therapists provide quality, on-time therapy supports in the child's natural environment – which is usually in their home. We honour family strengths, facilitate service navigation, and provide specialized therapeutic equipment through our ECI [early childhood intervention] Equipment Library.[169]

3.86 The Earbus Foundation of Western Australia is a children's charity that offers the following secondary-level child development services:

- The Hear Today Clinic: a fee-for-service clinic in Perth that provides diagnostic hearing assessments[170] and a referral pathway, if necessary.[171] It is aimed mainly at children, although adults are also accepted.[172]
- The Earbus Program: an outreach service that works to reduce the incidence of middle ear disease in Aboriginal and at-risk children around the State. The program has six mobile ear health clinics that travel to the Goldfields, Esperance-Norseman, Pilbara East, Pilbara Central, Pilbara South, Peel, the South West and the Perth metropolitan area. These mobile clinics offer comprehensive ear screening, surveillance and treatment (a mixture of primary and secondary-level healthcare) provided by GPs, audiologists and ear, nose and throat specialists.[173]

Department of Education

3.87 Schools provide students who have special educational needs due to various reasons, including developmental delay or a learning disability, with various supports to help optimise their learning. Schools also facilitate the provision of primary-level child development services; for example, by hosting school health nurses employed by CAHS and WACHS.

Education support schools and centres

3.88 Within the State's public education system, children who have extra educational needs may attend either a mainstream school or an 'education support school'.

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166 Telethon Speech and Hearing, *Annual report 2022*, 2022, accessed 31 August 2023, p 29; and M Fitzpatrick, Chief Executive Officer, Telethon Speech and Hearing, [*transcript of evidence*], *Legislative Council,* 17 May 2023, pp 2–3; CliniKids, *Frequently asked questions*, Telethon Kids Institute, 2023, accessed 8 September 2023; and Telethon Kids Institute, *Annual report 2022*, 2022, accessed 8 September 2023, pp 27 and 35

167 It is funded by Telethon and other fundraising activities conducted by Ability WA: Letter from J Thomson, Chief Executive Officer, Ability WA, 17 July 2023, p 1.

168 Letter from J Thomson, Chief Executive Officer, Ability WA, 12 May 2023, p 1; and Ability WA, *Early intervention – IBIS*, Ability WA, 2021, accessed 21 July 2023.

169 Letter from J Thomson, Chief Executive Officer, Ability WA, 17 July 2023, p 1.

170 Earbus, *What you need to know*, Hear Today, accessed 17 October 2023.

171 Earbus, *Next steps after diagnosis*, Hear Today, accessed 17 October 2023.

172 Earbus, *Specialists in testing kids hearing*, Hear Today, accessed 17 October 2023.

173 Earbus, *Earbus program*, Earbus, accessed 17 October 2023.

3.89 Education support schools are separate primary and/or secondary schools with on-site access to multi-disciplinary teams, including nursing and therapy staff. They have specialist facilities like therapy rooms, swimming pools and accessible playgrounds. They also offer early intervention programs, specialist programs for children with ASD and other specific needs, smaller class sizes and specially trained teachers and education assistants.[174]

3.90 Children needing educational support whose families opt to enrol them in a mainstream school can still obtain assistance through either additional school funding (see paragraphs 3.92 to 3.98) or attending a co-located 'education support centre'.

3.91 Education support centres offer similar benefits to education support schools but they are located alongside mainstream primary and secondary schools. Children attending these centres receive individualised programs delivered by specialist staff and therapy services provided by external organisations while still interacting and participating in programs with their mainstream school peers.[175]

Mainstream schools – Planning and additional funding

3.92 Mainstream schools with students who require additional learning supports, whatever they may be, have a duty to plan for and provide those supports:

> the school is obligated to plan, to implement, to consult with parents to provide access to specialist services where they align with educational costs. It is an obligation irrespective of whether you have … diagnoses. So long as you are at an educational risk.[176]

3.93 For example, the school may, with family input, prepare an 'individual education plan' that addresses the child's academic and personal needs. All school staff must adhere to the plan.[177] As part of that plan:

> We might have a literacy intervention. They might come out for a second-dose literacy intervention if they are not getting their sounds or they need extra practice with phonemic awareness. An education assistant might take a few children out and give them a second dose. That might be on a regular basis. It just depends on what their skill need is …[178]

3.94 The individual education plan also influences the amount of funding received by the school from the Department of Education (DOE) because students with additional teaching and learning needs will attract additional funds known as an 'education adjustment allocation'. According to the DOE, the education adjustment allocation will 'typically' support students with 'learning disabilities or imputed disability such as dyspraxia, dyslexia and … [ADHD]'.[179]

3.95 The school has discretion over how an education adjustment allocation will be spent, although the school should be guided by the student's individual education plan.[180] For example, an education adjustment allocation may be used to facilitate:

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174 Department of Education (DOE), *Education support centres and schools*, DOE, accessed 31 August 2023.

175 DOE, *Education support centres and schools*; and DOE, *Children with special educational needs*, DOE, accessed 31 August 2023.

176 S Percival, Director, Disability and Inclusion, DOE, [*transcript of evidence*], *Legislative Council,* 2 March 2023, p 29.

177 DOE, *Children with special educational needs*, DOE, accessed 31 August 2023.

178 L O'Donovan, Principal, Wattleup East Primary School, [*transcript of evidence*], *Legislative Council,* 2 March 2023, p 17.

179 DOE, *Children with special educational needs*, DOE, accessed 31 August 2023.

180 Developmental Disability WA, *What funding support is available at your local school?*, Developmental Disability WA, 2023, accessed 1 September 2023.

- teacher observation and judgment
- personalised learning and support planning
- designing learning opportunities for whole school implementation
- supporting classroom teachers to attend collaborative meetings or professional learning to build teacher capacity.[181]

3.96 Where the learning needs of a student are more acute, the school may also apply to the DOE for an 'individual disability allocation'. If successful, the additional funding is paid to the school directly. There are seven levels of additional funding available[182] and the amount allocated will correspond with the amount of support and adjustments required by the student.[183] Again, the school has discretion over how the allocation will be spent. A Perth school listed the following examples of how an individual disability allocation may be used:

- training and development activities
- additional teacher time
- educational assistant time
- teacher release
- targeted resources/programs
- program co-ordination time
- Social and Emotional Well-being support by Student Services Team.[184]

3.97 Students are only eligible for an individual disability allocation if they have a diagnosis for one (or more) of eight categories of disability:

- ASD
- deaf and hard of hearing
- global developmental delay
- intellectual disability
- physical disability
- severe medical health condition
- severe mental disorder
- vision impairment.[185]

This is the stage when CAHS–CDS or WACHS–CDS, or some other secondary and tertiary-level child development service provider, can become involved, for the purposes of providing a diagnosis. Ultimately, the student's parents will determine where the referral for an assessment and diagnosis will be directed.

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181 DOE, *Children with special educational needs*, DOE, accessed 31 August 2023.

182 Developmental Disability WA, *What funding support is available at your local school?*, Developmental Disability WA, 2023, accessed 1 September 2023.

183 DOE, *Children with special educational needs*, DOE, accessed 31 August 2023.

184 Applecross Senior High School, *Guidelines for individual disability allocation*, 2023, accessed 1 September 2023.

185 S Percival, Director, Disability and Inclusion, DOE, [*transcript of evidence*], *Legislative Council,* 2 March 2023, p 29; and Applecross Senior High School, *Guidelines for individual disability allocation*, 2023, accessed 1 September 2023.

3.98 Teachers and/or students may also obtain specialist services from Schools of Special Education Needs (see paragraph 3.99), the Statewide School Psychology Service (see paragraphs 3.100 to 3.101) and language development centres (see paragraphs 3.102 to 3.107).

Schools of Special Education Needs

3.99 These schools can provide support and services for teachers and students, depending on the type of special education need. The schools offer services across four areas of need:

- behaviour and engagement – the service recipients are students with extreme, complex and challenging behaviours
- disability – the service recipients are the teachers of students with a disability. The services may include visits from consulting teachers or the provision of specialist equipment
- medical and mental health – the service recipients are students whose medical or mental health prevents them from attending school. The specialist teachers can teach the students in a hospital or at home
- sensory (vision and hearing) – the service recipients are students who are vision and/or hearing impaired. The specialist teachers deliver one-to-one, direct teaching and provide access to specialist equipment.[186]

School psychologists

3.100 The DOE Statewide School Psychology Service provides psychological assessment, intervention and consultation in the three areas of behaviour, learning and mental health and wellbeing. These services are available to every public school in the State[187] and can be provided to individual children, groups or at a whole-of-school level.[188]

> Many people have a conception of what psychologists do and that they would be providing some sort of medical based model, but psychologists in schools … get to work with the context that children are in every day and support change within that context. There is direct service to children, indirect service that supports teaching, planning with staff and working with school systems to make changes that are going to make schools more effective for students.[189]

3.101 In 2022, an average of 412.7 full-time equivalent school psychologists supported public schools through the Statewide School Psychology Service.[190]

Language development centres

3.102 The DOE's Statewide Speech and Language Service provides services and support to students with speech and language difficulties through two methods:

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186 DOE, *Children with special educational needs*, DOE, accessed 31 August 2023.

187 L Lucas, Director, Student Engagement and Wellbeing, DOE, [*transcript of evidence*], *Legislative Council,* 2 March 2023, p 26.

188 DOE, *Children with special educational needs*, DOE, accessed 31 August 2023.

189 L Lucas, Director, Student Engagement and Wellbeing, DOE, [*transcript of evidence*], *Legislative Council,* 2 March 2023, p 27.

190 DOE, *Annual report 2022-23*, DOE, 2023, accessed 2 November 2023, p 36.

- the operation of five language development centres (LDCs), each of which has a campus located across a mainstream primary school in the Perth metropolitan area[191]
- the provision of an outreach service to other mainstream primary schools.

3.103 LDCs provide specialised language support for students with a primary diagnosis of a developmental language disorder. They support students from Kindergarten to either Year 2 or 3, depending on the centre, and offer small class sizes and a multi-disciplinary team.[192]

3.104 Students attending a LDC which is co-located with a mainstream school participate in the full mainstream curriculum. However:

> the curriculum and the activities they participate in have been supported and designed in collaboration with both teachers and speech pathologists in order to optimise the delivery of that curriculum. The design of those activities is for children with language disorders to participate so that they can make the most of those learning opportunities while also receiving support for their communication needs.[193]

3.105 The LDC teams work directly with the students attending LDCs, in a whole class setting, in small groups and/or one-on-one instruction, depending on the students' needs.[194]

3.106 LDCs also provide an outreach service to mainstream public primary schools with which they are not already affiliated. Each LDC is responsible for its own service regions; for example, the South East LDC supports schools in the south metropolitan and Goldfields regions. The aim of the outreach service is the:

> capacity building of teachers and support staff through professional learning and consultations which promote the use of evidence-based practices in oral language.[195]

It should be noted that the outreach service does not provide direct, face-to-face support to students.

3.107 Generally, schools must elect to receive services and commit to ongoing learning, via a request for service.[196]

Department of Communities

3.108 Evidence from CAHS and WACHS indicated that allied health professionals employed by the Department of Communities (DOC), in the Neurodevelopmental Disability Assessment Service,[197] have developed a proficiency in ASD diagnosis, which is utilised by both CAHS–CDS and WACHS–CDS.

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191 The Fremantle Language Development Centre; North East Metropolitan Language Development Centre; Peel Language Development School; South East Metropolitan Language Development Centre; and West Coast Language Development Centre: DOE, *Language development schools and centres*, DOE, accessed 1 September 2023.

192 DOE, *Language development schools and centres*, DOE, accessed 1 September 2023.

193 Dr R Wells, Policy and Advocacy Executive, WA Branch, Speech Pathology Australia, [*transcript of evidence*], *Legislative Council,* 12 December 2022, p 8.

194 Dr R Wells, [*transcript of evidence*], p 8; and R Simpson, Oral language consultant, Tracks to Literacy, [*transcript of evidence*], *Legislative Council,* 17 February 2023, p 6.

195 South East Language Development Centre (SELDC), *Outreach service*, SELDC, 2023, accessed 1 September 2023.

196 For example, SELDC, *Outreach service*; and West Coast Language Development Centre (WCLDC), *Summary of services*, WCLDC, 2023, accessed 1 September 2023.

197 This service provides 'comprehensive multidisciplinary neurodevelopmental assessments, determining if children meet criteria for diagnoses such as Autism Spectrum Disorder and Intellectual Disability. The service promotes

3.109 WACHS–CDS paediatricians routinely partner with DOC allied health practitioners to complete ASD diagnoses:

> we partner with DOC–Department of Communities–to support our diagnostic process. Our paediatricians provide the medical component of the assessment and then a referral is made by the paediatrician if they feel that there is enough there to warrant an assessment to the Department of Communities, who provide the allied health component of the assessment. At the moment, WACHS is working closely with the Department of Communities to try and tease out a process and make this as clean and smooth as we possibly can.[198]

3.110 Similarly, CAHS–CDS paediatricians will sometimes refer their clients to the DOC when they have already diagnosed global developmental delay and there is clear evidence of ASD:

> It is notable that the [CAHS] Child Development Service also sometimes will send our own children through to the Department of Communities disability services, particularly children where they may have seen the paediatrician early on and the child has got clear evidence of global delay plus autism spectrum, and we have done the assessment for global delay and we know that they would access NDIS services but we also believe they are on the autism spectrum. We have addressed criteria somewhat. We may well not refer to our team but ask the Department of Communities to do that. There is a significant proportion of our children that did and still go through that pathway as well.[199]

NDIS funding and services

3.111 The NDIS is implemented by the National Disability Insurance Agency (NDIA). The scheme:

> provides funding to eligible people with disability to gain more time with family and friends, greater independence, access to new skills, jobs, or volunteering in their community, and an improved quality of life.[200]

3.112 At December 2022, the NDIS supported over 500,000 Australians, approximately 80,000 of whom were children with developmental delay.[201] The full roll-out of the NDIS in Western Australia commenced in 2018.[202] At 30 June 2023, 52,451 people in Western Australia were participating in the scheme.[203]

Eligibility

3.113 To be eligible for NDIS funding, a person must:

- be an Australian resident who is living in Australia
- be aged under 65 years at the time they apply to access the scheme

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informed decision making about, and linkages to, the most appropriate supports and services for the individual': Department of Communities (DOC), *Annual report 2019-20*, DOC, 2020, accessed 14 September 2023, p 45.

198 L Pereira, Manager, Child Development Service, WACHS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 45.

199 Dr B Jongeling, Medical Head of Department, Child Development Service, CAHS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 41.

200 National Disability Insurance Agency (NDIA), *What is the NDIS?*, National Disability Insurance Scheme (NDIS), 2022, accessed 4 September 2023.

201 NDIA, *What is the NDIS?*

202 Submission 77 from WA Health, 9 November 2022, p 26.

203 NDIA, *Western Australia*, NDIS, 2023, accessed 4 September 2023.

- demonstrate they have a permanent disability that affects their everyday life.[204] However, a child with development delay or difficulty does not need to meet this eligibility criterion if they are under the age of six years and their family wishes to access services under the NDIS's Early Childhood Approach (see paragraphs 3.122 to 3.124).[205]

3.114 A person will meet the disability requirements if they have evidence of all of the following:

- Their disability is caused by an impairment.
- Their impairment is likely to be permanent.
- Their permanent impairment substantially reduces their functional capacity to undertake one or more of the following activities: moving around, communicating, socialising, learning, or undertaking self-care or self-management tasks.
- Their permanent impairment affects their ability to work, study or take part in social life.
- They are likely to need NDIS support for their whole life.[206]

3.115 The NDIA has published the following three lists of conditions:

- List A – conditions that are likely to meet the disability requirements
- List B – conditions that are likely to result in a permanent impairment
- List C – Western Australian-based disability supports that may already meet most of the NDIS eligibility criteria.

3.116 List A conditions include:

- ASD – diagnosed at a severity of either level two (requiring substantial support) or level three (requiring very substantial support)
- intellectual disability – diagnosed and assessed as moderate, severe or profound
- cerebral palsy – diagnosed and assessed as severe
- a list of genetic conditions that consistently result in permanent and severe intellectual and physical impairments
- spinal cord or brain injury resulting in paraplegia, quadriplegia or tetraplegia
- hemiplegia where there is severe or total loss of strength and movement in the affected limbs
- permanent blindness in both eyes, diagnosed and assessed at certain severities
- permanent bilateral hearing loss of more than 90 decibels in the better ear
- deaf-blindness confirmed by an ophthalmologist and audiologist and assessed as resulting in permanent and severe to total impairment of visual function and hearing
- amputation or congenital absence of two limbs.[207]

3.117 List B conditions include:

- a list of conditions primarily resulting in intellectual or learning impairment, such as:

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204 NDIA, *A GP & health professional's guide to the NDIS*, NDIA, Australian Government, 2020, accessed 4 September 2023, p 1; and NDIA, *Am I eligible?*, NDIS, 2023, accessed 4 September 2023.

205 NDIA, *The early childhood approach for children younger than 9*, NDIS, 2023, accessed 4 September 2023.

206 NDIA, *Do you meet the disability requirements?*, NDIS, 2022, accessed 4 September 2023.

207 NDIA, *List A: Conditions that are likely to meet the disability requirements*, NDIS, 2022, accessed 4 September 2023.

- pervasive developmental disorders, such as ASD, not meeting severity criteria in List A or List C[208]
- intellectual disability
- Asperger syndrome
- atypical ASD
- childhood ASD
- a list of chromosomal abnormalities resulting in permanent impairment and not specified on List A

- a list of conditions primarily resulting in neurological impairment – for example, Alzheimer's disease, Parkinson's disease and vascular dementia
- a list of conditions resulting in physical impairment – for example, amputation, juvenile arthritis, rheumatoid arthritis and cerebral palsy not meeting the severity criteria on List A
- a list of conditions resulting in sensory and/or speech impairment
- a list of conditions resulting in multiple types of impairment – for example, foetal alcohol spectrum disorder and spina bifida.[209]

3.118 The Committee notes that ADHD is not explicitly mentioned in either List A or B (see discussion at paragraph 4.34).

Funding for supports, not diagnosis

3.119 The NDIS was designed to complement, not replace, other government services and supports available to people with a disability. This includes services and supports for which the State Government is responsible, such as those provided under the health and education systems. For example, the NDIS will fund:

- home modifications, personal care and development of skills to help a person become more independent
- allied health and other therapy needed because of a person's disability, including occupational therapy, speech therapy or physiotherapy
- prosthetics and artificial limbs (but surgery remains the responsibility of the health system)
- assistive technology (aids and equipment), such as wheelchairs, adjustable beds or hearing aids related to a person's disability
- therapeutic and behavioural supports for people with psychosocial disability,

but it will not fund:

- diagnosis and assessment of health conditions, including mental health conditions and disabilities
- medication, general medical and dental services and treatment, specialist services, hospital care, surgery and rehabilitation

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208 People who are already receiving a Western Australian-based disability support that appears in List C may already meet most of the NDIS eligibility criteria and therefore, receive faster access to the scheme: NDIA, *List C: What if you're receiving disability support in Western Australia?*, NDIS, 2022, accessed 17 October 2023.

209 NDIA, *List B: Conditions that are likely to result in a permanent impairment*, NDIS, 2022, accessed 4 September 2023.

- clinical care for mental health conditions
- palliative care, geriatric and psychogeriatric services
- sub-acute, rehabilitation and post-acute care including treatment of wounds by a nurse, except under interim arrangements for eligible participants
- planning and preparation for a patient to return home after a hospital stay
- general hearing and vision services not related to a person's disability (for example, prescription glasses).[210]

3.120 In the metropolitan area, NDIS local area coordinators[211] and the NDIS-provider market[212] are well established. CAHS–CDS's role with respect to the NDIS is to assist children (and their families) wishing to access the scheme by completing diagnostic assessments that will become part of the supporting information for applications.[213]

3.121 In regional Western Australia, the NDIS only has a presence in three of the seven WACHS regions – the Great Southern, the inner Wheatbelt and the South West.[214] In those three regions, WACHS–CDS's role with respect to the NDIS is similar to that of CAHS–CDS; that is, to complete and provide the diagnostic assessments supporting an application. However, as the NDIS-provider market in the regions is still developing, WACHS–CDS is often still the main, if not the only, provider of secondary-level child development services in many regional and remote areas.[215]

Early Childhood Approach

3.122 Currently, the NDIS's Early Childhood Approach offers:

- children under six years of age with developmental delay[216] or developmental concern[217]
- children under nine years of age with a disability,

a suite of supports known as 'early connections'.[218] Prior to 1 July 2023, children had to be under the age of seven years to be eligible for these supports.[219]

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210 NDIA, *A GP & health professional's guide to the NDIS*, NDIA, Australian Government, 2020, accessed 4 September 2023, p 2.

211 Local area coordinators are the main contact points for the NDIS. In the Perth metropolitan area, the local area coordinators are Mission Australia (central north, north east and south east metropolitan regions) and APM Communities (central south, north and south metropolitan regions): NDIA, *Western Australia*, NDIS, 2023, accessed 4 September 2023.

212 These tend to be private-sector providers.

213 Submission 77 from WA Health, 9 November 2022, p 79.

214 APM Communities is the local area coordinators in these three regions: NDIA, *Western Australia*, NDIS, 2023, accessed 4 September 2023.

215 Submission 77 from WA Health, 9 November 2022, p 79.

216 'It means a child finds it much harder to do everyday things that other children their age can do, for example dress themselves, talk or walk. A child with developmental delay needs lots of extra help to do everyday things compared to children of the same age': NDIA, *Developmental delay and the early childhood approach*, NDIS, 2023, accessed 4 September 2023. There are set criteria for assessing a child as having developmental delay: NDIA, *Early childhood approach*, NDIA, Australian Government, 2023, accessed 4 September 2023, p 4.

217 A term used to describe 'delay or delays in a child's development, below what is expected for their age, where they do not fully meet the developmental delay definition under the NDIS Act [*National Disability Insurance Scheme Act 2013* (Cth)]': NDIA, *What types of early connection are available?*, NDIS, 2022, accessed 4 September 2023.

218 NDIA, *Early childhood approach*, NDIS, 2023, accessed 4 September 2023.

219 NDIA, *Early childhood approach*; and Submission 77 from WA Health, 9 November 2022, p 79.

3.123 Children younger than six years who have a developmental delay or concern are not required to have a diagnosis before being eligible for early connections.[220] Early connections are time-limited interventions[221] and can take the form of:

- connections with mainstream and community services – for example, childcare and playgroups, child health nurses, GPs and family support services
- connections to practical information that is relevant to a child's development – for example, practical advice on typical child development topics, and helpful strategies to include in a child's daily routine
- connections with other families with similar experiences
- connections with early supports – these are designed to build parent and child capacity and to promote everyday learning in their home and other environments
- assistance with applying for NDIS funding.[222]

3.124 Early connections are delivered by the NDIS's early childhood partners. Wanslea Family Services is the early childhood partner in the Perth metropolitan area and the Great Southern, inner Wheatbelt and South West regions.[223] Currently, there are no early childhood partners in other regional areas, although:

- there are plans to establish a partner in the greater Geraldton area
- in all regions, the NDIA has contracted ACCHOs to deliver NDIS connection and access supports to their respective communities.

Despite these initiatives, WA Health submitted that there is still great reliance on WACHS–CDS to assist regional residents with NDIS access and navigation.[224]

220 NDIA, *The early childhood approach for children younger than 9*, NDIS, 2023, accessed 4 September 2023.

221 Submission 77 from WA Health, 9 November 2022, p 79.

222 NDIA, *What types of early connection are available?*, NDIS, 2022, accessed 4 September 2023.

223 NDIA, *Western Australia*, NDIS, 2023, accessed 4 September 2023.

224 Submission 77 from WA Health, 9 November 2022, p 80.

CHAPTER 4
Assessment of child development service delivery

Chapter summary

4.1 This chapter provides an assessment of how well child development services are being delivered by the Western Australian public health system, by:

- giving a snapshot of previous inquiries relating to these issues
- presenting an overview of the issues identified by this Inquiry
- identifying how the issues raised by this Inquiry are manifesting within CAHS–CDS and WACHS–CDS
- considering some of the suspected causes of service deficiency
- discussing the causes of service deficiency that CDS providers have identified as prime concerns
- making findings and recommendations.

Previous inquiries

4.2 The late Professor Trevor Parry AM, developmental paediatrician, established the State Child Development Centre in the mid-1970s. The centre developed a multidisciplinary team model of treatment that continues in all CDS centres today.[225] CAHS–CDS has existed in its current form since 2007, when it became a single metropolitan provider.[226]

4.3 Over time, there have been several reviews and parliamentary inquiries relating (directly or indirectly) to the provision of child development services in Western Australia, including those outlined in Table 4 on page 47.

4.4 An examination of past inquiries reveals the repeated identification of the same issues. Essentially, long-standing deficiencies in planning and the funding of child development services has, and continues to have, an impact on service delivery, equity and performance.

> This is a long standing issue of concern, highlighted by both the major parties when in opposition, but which neither has adequately addressed when in government. As a member of the Legislative Council between 2010 and 2013 I was part of that cycle of failure.[227]

4.5 Many of the lessons and recommendations of previous inquiries remain relevant today. Dr Bret Hart, in his submission to this inquiry, pointed out that the series of past inquiries has not prevented the need for this one. Nor is it clear why:

> Had the recommendations been implemented they are likely to have increased the adequacy of CDS. In reviewing material which is in the public domain it was impossible to determine who was responsible for and reasons behind ignoring, dismissing or refusing to act on the recommendations.[228]

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225 Commissioner for Children and Young People (CCYP), *Professor Trevor Parry AM*, CCYP, accessed 24 October 2023.

226 Submission 77 from WA Health, 9 November 2022, p 26.

227 Submission 17 from L Savage, 20 October 2022, p 1.

228 Submission 15 from Dr B Hart, medical practitioner, 18 October 2022, p 31.

Table 4. *Previous inquiries relating to child development services*

Date	Inquiry
2006	**Health Reform Implementation Taskforce, *Future Directions for Western Australian Child Development Services*** Issues identified by the Taskforce include: lengthy waitlists for most disciplines; eligibility restrictions based on age used to manage limited resources; inadequate staff; increased workload due to increasing numbers of complex cases; a limited capacity to deliver community based services; resource constraints affecting service delivery; fragmented and inconsistent services; significant constraints to effective planning due to the absence of a central data base; a significant difference between regional and metropolitan services; and poor integration and coordination with other health and social services.
2009	**Community Development and Justice Committee, *Inquiry into the Adequacy of Services to Meet the Developmental Needs of Western Australia's Children*** The Committee found that Western Australia did not have an integrated policy framework for early childhood. Services are fragmented. There is a lack of coordination and collaboration within government and with the non-government sector. There are significant access and resourcing issues (including a per capita reduction in allied health service resourcing) which have led to a narrowing of eligibility criteria.
2009	**Education and Health Standing Committee, *Healthy Child - Healthy State: Improving Western Australia's Child Health Screening Programs*** The Committee made recommendations for the Government to address inadequate staffing and long waiting times (which could be up to 18 months for both an initial assessment and for treatment). Recommendations were also made to increase the number of school and child health nurses; improve data information systems and data sharing, and achieve greater collaboration between the Departments of Health and Education.
2010	**Education and Health Standing Committee, *Invest Now or Pay Later: Securing the Future of Western Australia's Children*** The Chair's Foreword expressed the hope that the report would 'act as a catalyst to the Government to stop the neglect of children's health in their early years'. She reproached the Government for the growing number of children waiting for child development services and progressively longer waiting times. Staffing shortages and insufficient funding were affecting frontline services. Families suffered financial and emotional strain due to the lack of available public services.
2010	**Education and Health Standing Committee, *Destined to Fail: Western Australia's Health System*, Volume 2 – Community Health Sector** The Committee found that a dedicated Ministerial portfolio for early childhood education and development in other Australian jurisdictions had produced benefits for children and their families. It was recommended that a Minister for early childhood services be established in Western Australia. The Committee also recommended a whole of government approach toward child health issues and the establishment of a Children's Services Coordination Board with membership (at senior executive level) from government departments.

Date	Inquiry
2010	**Western Australian Auditor General's Report, *Universal Child Health Checks*** The Auditor General found that funding for child health services had not been a focus of health resourcing and that funding had not kept up with demand. Many children were missing important health checks, resulting in delays in detecting developmental problems and providing intervention. WA Health was not using its resources efficiently and improvements were needed in relation to facilities, information technology and administrative support for child health nurses.
2011	**Commissioner for Children and Young People Western Australia, *Report of the Inquiry into the mental health and wellbeing of children and young people in Western Australia*** CDS support the healthy development of children, which in turn, has a positive impact on mental health outcomes. However, the report notes that many years of underinvestment has left the CDS providers struggling to provide services to children who most need them and that opportunities for early and effective intervention are being lost.
2014	**Western Australian Auditor General's Report, *Universal Child Health Checks Follow-up*** The number of child health checks delivered by WA Health had increased but capacity had not increased sufficiently. Delivery had not kept pace with demand, targets were not being met and children were still missing out. The Auditor General's findings in 2010 regarding resource inefficiencies remained true. Service flexibility and access needed to be improved.
2019	**DOH, Sustainable Health Review** Health care (and associated funding) must be defined more broadly than the existing focus on acute hospital care. Health and social care services are interdependent and effective partnerships within and outside government are essential. Key recommendations included: transformational reform of the mental health system, a whole-of-government focus on supporting early childhood development and wellbeing; investment in digital technology including electronic medical records, workforce reform and adopting a culture that supports innovation.

Overview of evidence

4.6 When the State Child Development Centre was established in the mid 1970s, it was widely regarded as an example of world-leading best practice in service delivery and planning:

> It was innovative in its time ... It was a multidisciplinary assessment pathway that engaged allied health, paediatrics, nursing support–engaged within schools with community nursing and child health nursing. It introduced new developmental assessments that are standardised in Griffith[s[229]] pathways, and of its time, was the first in Australia, actually, to do that.[230]

[229] The Griffiths Scales of Child Development is a test of child development and dates back to 1954. The third and latest edition of the test ('Griffiths III') was published in 2016: JH Cronje, EM Green & LA Stroud, 'Stability reliability of the Griffiths Scales of Child Development (3rd edition)', *Psychology*, 2022, 13(3):353–360, doi: 10.4236/psych.2022.133022.

[230] Dr B Jongeling, Medical Head of Department, Child Development Service, CAHS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 9.

4.7 In the case of CAHS–CDS, the Committee has received evidence that practitioners want to work for this service, which, despite the disruption to the health workforce caused by COVID-19, has not experienced the kind of employee unavailability suffered by other health service providers (see paragraph 4.45).

4.8 Since CAHS–CDS formed into a single metropolitan provider in 2007, it has been held in high regard, both nationally and internationally.[231] The Committee has received evidence through WA Health that once children and families are seen, they are generally satisfied with the services provided and the Committee found that this was corroborated by other witnesses. However, the Committee also received evidence of deficiencies and issues that impact satisfaction levels, including the timeliness of the interventions and services, the continuity, duration and availability of care, as well as navigation of the system.

4.9 It is clear to all involved that both CAHS–CDS and WACHS–CDS are overwhelmed and no longer able to meet the demand for most services adequately. It was also recognised by witnesses who are child development professionals that these challenges are not unique to Western Australia. Dr Helen (Honey) Heussler, a developmental and behavioural paediatrician and the medical director of Child and Youth Community Services within Children's Health Queensland, stated:

> I understand that [what] child development services in WA are going through seem to be fairly universal both nationally and internationally at the moment. I think we are all grappling with the challenges that that poses for the population.[232]

4.10 Dr Yvonne Anderson, a paediatrician working across Curtin University, the Telethon Kids Institute and the Community Health service area within CAHS, expressed the view that:

> [CAHS–CDS] … has been the envy of many paediatricians and clinicians out of state since its inception, yet multiple factors have contributed to an inability for the service to meet demand. This issue is not specific to Western Australia. The swirl of the societal upstream determinants of health are impacting the ability of general broad child health services across Australasia to meet that demand.[233]

4.11 Dr Bradley Jongeling, Paediatric Head of Department at CAHS–CDS, suggested that:

> it is not a WA issue. It is not even an Australian issue; it is a worldwide issue. All places in the world are dealing with this increased complexity and increased referral numbers.[234]

4.12 Although the discussion in this chapter will include criticism of CAHS–CDS and WACHS–CDS, the Committee emphasises that this criticism is directed at the CDS system and does not extend to clinical and non-clinical staff. The Committee commends the dedication and efforts of every member of staff working to support children and their families.

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231 Dr Y Anderson, Associate Professor, Community Child Health, Curtin University, [*transcript of evidence*], *Legislative Council,* 12 May 2023, p 2; Private citizen, paediatrician, [*private transcript of evidence*], p 2; and Submission 77 from WA Health, 9 November 2022, p 85.

232 Dr H Heussler, Medical Director, Child and Youth Community Services, Children's Health Queensland, [*transcript of evidence*], *Legislative Council,* 26 July 2023, p 1.

233 Dr Y Anderson, Associate Professor, Community Child Health, Curtin University, [*transcript of evidence*], *Legislative Council,* 12 May 2023, p 2.

234 Dr B Jongeling, Medical Head of Department, Child Development Service, CAHS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 10.

How are the issues manifesting?

4.13 A range of issues, many of which are identified by WA Health, are resulting in excessive waiting times and limited service provision.

Excessive waiting times

4.14 The excessive waiting times for children to be assessed and treated by CAHS–CDS and WACHS–CDS was the most common concern voiced by submitters and witnesses. In the data which follows (paragraphs 4.16 to 4.25) it should be noted that the figures refer to median waiting times, meaning that in individual cases, waiting times may be longer or shorter. It is also worth noting that both CAHS–CDS and WACHS–CDS indicated that in some less complex cases, children can be assessed and treated very quickly[235] and/or very early in their lives.[236]

4.15 Ironically, it is the unique structure of CAHS–CDS, as a single provider of CDS in the metropolitan area, that allows it to produce data (using Community Health's Child Development Information System (CDIS)), such as waiting times, readily.[237] In the case of WACHS–CDS, while data is not as readily and consistently obtained from each of the regions, it is, nonetheless, able to produce detailed information about waiting times across the disciplines.

Child and Adolescent Health Service – Child Development Service

4.16 CAHS–CDS has set itself a target of six months or below for median waiting times.[238]

Children of all ages (zero to 17 years)

4.17 The annual median waiting times for each CAHS–CDS discipline from 2017-18 to 2021-22 for children of all ages are provided in Figure 8 on page 51. The times vary according to the discipline but for all the disciplines, other than audiology and physiotherapy, the median waiting times have increased steadily, and, by 2021-22, have exceeded the 6-month maximum set by CAHS. For example, the median waiting time for paediatrics in 2021-22 was approximately 15 months. The impact of such a delay on a child's development is potentially very significant. As one speech pathologist stated:

> children and families often face long waiting lists and do not get the support they need in a timely manner, for them to be able to take part in their worlds and communities safely and effectively. This is especially true in the case of young children – a 9 month waiting list for example in the life of a 3 year old is … [approximately] … 25% of that child's life that they are left waiting for essential support.[239]

4.18 The longest median waiting times since 2017-18 have consistently related to paediatricians. They rose from just over 11 months in 2017-18 to just under 15 months in 2021-22.

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235 For example, when a child is referred only for a hearing assessment with an audiologist: A Turnell, Acting Director, Clinical Services, Child Development Service, CAHS, and L Pereira, Manager, Child Development Service, WACHS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 10.

236 For example, an infant who presents with torticollis or plagiocephaly is often directed straight to a physiotherapy assessment rather than a service planning appointment: A Turnell and L Pereira, [*transcript of evidence*], 28 November 2022, p 10; and S Kiely, Executive Director, Community Health, CAHS, [*transcript of evidence],* *Legislative Council,* 26 April 2023, p 12.

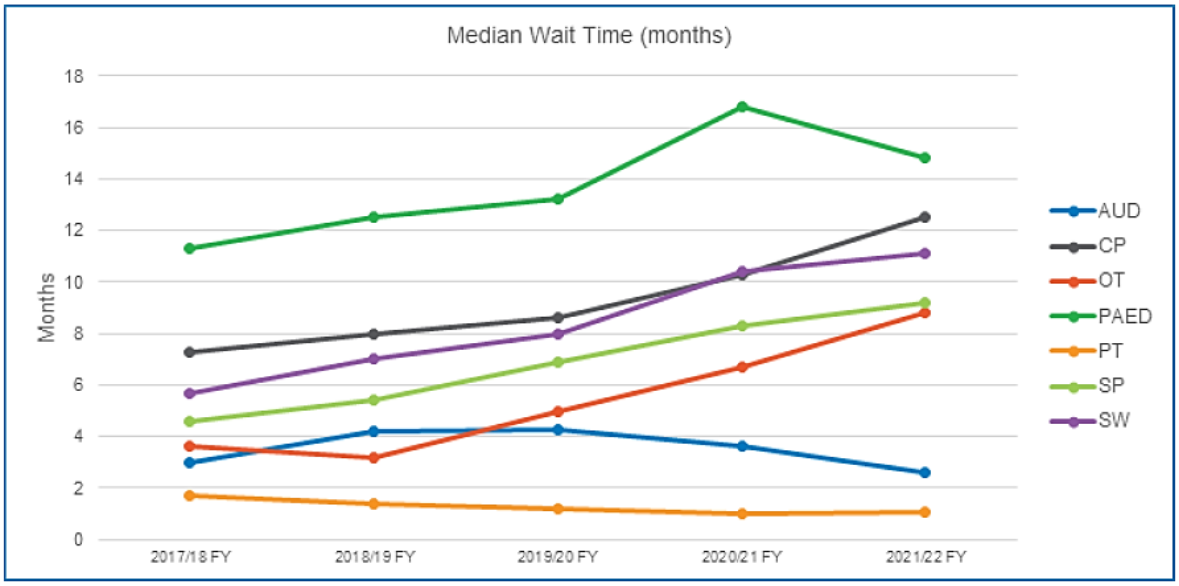
237 Submission 77 from WA Health, 9 November 2022, p 85. See also, footnote 89 of this report.

238 Letter from V Jovanovic, Chief Executive, CAHS, 28 June 2023, p 2.

239 Submission 55 from private citizen, speech pathologist, 24 October 2022, p 2.

4.19 By its own admission, the waiting times at CAHS–CDS are of 'significant concern' to staff and clients.[240]

Figure 8. *Child and Adolescent Health Service – Child Development Service: Annual median waiting times for each discipline (children aged zero to 17 years)*



Legend: Audiology (AUD), Clinical Psychology (CP), Occupational Therapy (OT), Paediatrics (PAED), Physiotherapy (PT)**, Social Work (SW), Speech Pathology (SP).

[Source: Submission 77 from WA Health, 9 November 2022, p 48.]

Primary school aged children (five to 11 years)

4.20 With respect to primary school aged children, Table 5 shows the median waiting times for six of the CAHS–CDS disciplines at a point in time. Other than audiology, all the disciplines have median waiting times of more than 6 months.

Table 5. *Child and Adolescent Health Service – Child Development Service: Median waiting times for each discipline at a point in time (children aged five to 11 years)*

Date	Discipline	Months
16 Feb 2023	Paediatrics	17.8
21 Feb 2023	Speech pathology	12.2
16 Mar 2023	Clinical psychology	17
23 Mar 2023	Occupational therapy	11.3
14 Jun 2023	Audiology	3.5
10 Aug 2023	Physiotherapy	9.3

[Source: Answers to questions without notice 77, 106, 251, 325, 628 and 817, Legislative Council, *Debates,* 16 February to 10 August 2023, pp 356, 452, 1,069, 1,396, 2,772 and 3,633–3,634.]

[240] Submission 77 from WA Health, 9 November 2022, p 5.

FINDING 1

In relation to the Child and Adolescent Health Service–Child Development Service:

- it is not meeting its self-imposed target median waiting time of six months or less
- median waiting times for most services are increasing, meaning that services are not meeting demand.

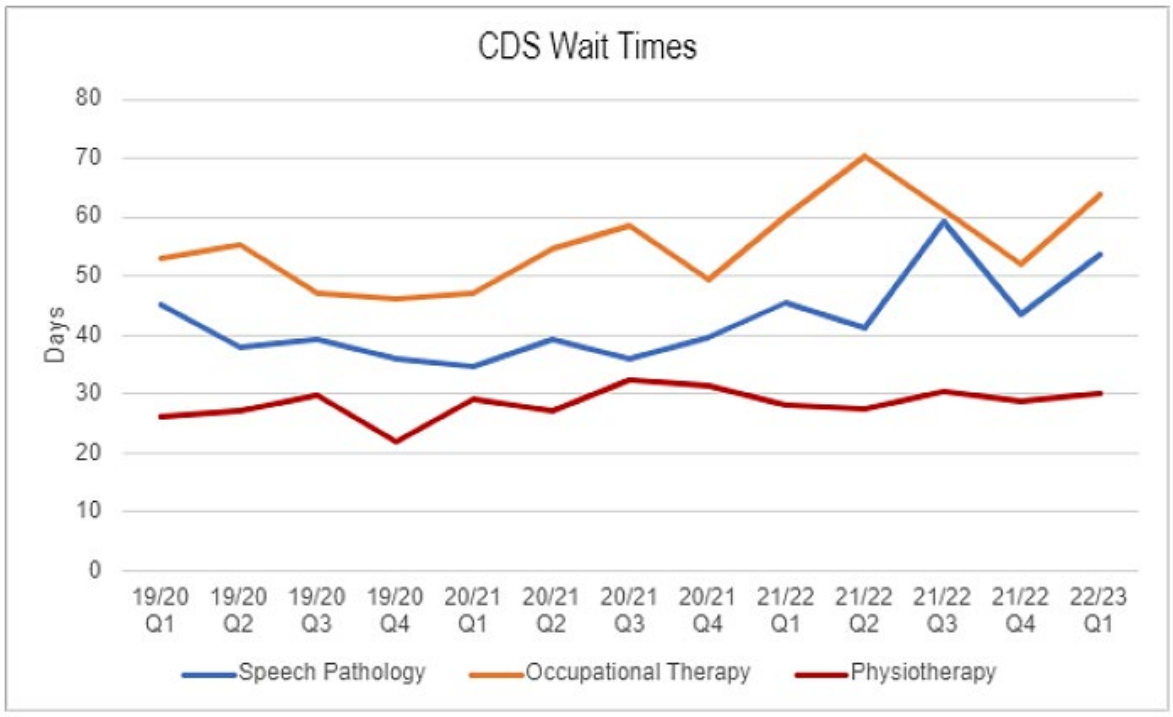
WA Country Health Service – Child Development Service

4.21 WACHS–CDS informed the Committee that because of different data collection methods across the regions, data on waiting times for its services are not easily produced.

Children of all ages (zero to 17 years)

4.22 WA Health provided median waiting times for children of all ages from 2019-20 to the start of 2022-23 for only speech pathology, occupational therapy and physiotherapy (see Figure 9). This is because these disciplines are consistently represented and reported in each region. These figures represent the median waiting times across all seven service regions, and are relatively stable, with the times hovering around 50 days for speech pathology, 60 days for occupational therapy and 30 days for physiotherapy. In terms of waiting times, there is also a discernible upward trend for speech pathology and occupational therapy.

Figure 9. *WA Country Health Service – Child Development Service: Median waiting times for three disciplines averaged across all service regions (children aged zero to 17 years)*



[Source: Submission 77 from WA Health, 9 November 2022, p 63.]

Primary school aged children (five to 11 years)

4.23 When the median waiting times for the same three disciplines are presented for children aged between five and 11 years and for *each* region, the results are considerably more varied and longer than when children of all ages are grouped together. For example, Table 6 on page 53 lists these times as at 9 May 2023.

4.24 Based on the figures in Table 6, as at 9 May 2023, the median waiting times averaged *across all* of the seven regions, for five to 11 year olds, was 105 days for speech pathology, 111 days for occupational therapy and 88 days for physiotherapy.

Table 6. *WA Country Health Service – Child Development Service: Median waiting times (in days) for three disciplines in each service region (children aged 5 to 11 years), as at 9 May 2023*

Region	Speech Pathology		Occupational Therapy		Physiotherapy	
	Days	Months	Days	Months	Days	Months
Kimberley	79.5	2.8	158.0	5.6	193.0	6.9
Pilbara	143.0	5.1	121.0	4.3	203.0	7.2
Midwest	118.5	4.2	128.0	4.6	47.5	1.7
Goldfields	133.0	4.8	164.5	5.9	7.0	0.2
Wheatbelt	76.5	2.7	78.0	2.8	20.0	0.7
South West	57.0	2.0	49.5	1.8	61.0	2.2
Great Southern	125	4.5	75.0	2.7	87.5	3.1
All seven regions (averaged)	105.0	3.8	111.0	4.0	88.0	3.1

[Source: Answer to question on notice 1342, Legislative Council, *Debates*, 2023, p 1,887.]

4.25 WACHS–CDS conceded that 'extended waiting times' are a challenge and acknowledged that delays in diagnosis and interventions can have substantial and lifelong impacts for regional children and their families.[241] It expects all waiting times to continue increasing but cited those for paediatricians, audiologists and psychologists as being particularly problematic.[242]

FINDING 2

Although the WA Country Health Service–Child Development Service does not have target median waiting times, the median waiting times for most services are increasing, meaning that services are not meeting demand.

Impact of excessive waiting times

4.26 Evidence obtained throughout this inquiry, particularly the lived experience of parents, provides context to the statistics and numbers relating to waiting times. The stark reality of delayed intervention – the impact on children and families – is illustrated in the following evidence:

- Problems become worse the longer treatment is delayed, increasing the nature and extent of intervention required:

  > When a parent is seeking assistance for a child – a waitlist of 2 years results in the child's problem escalating and growing in size, which then draws on further medical resources for longer for both child and struggling parents … I have

[241] Submission 77 from WA Health, 9 November 2022, p 63.

[242] Submission 77, pp 8 and 63.

requested [a] paediatric review however that is likely to be 18 months to 2 years away whilst we wait for an assessment for help.[243] **(Parent)**

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The added insult is that he will ultimately require more therapy for longer because of these delays.[244] **(Parent)**

▫▫▫

Failing to intervene when difficulties, inclusive of developmental difficulties, arise can mean that problems experienced by children and young people become more serious and difficult to address.[245] **(WA Health)**

- Children fall further behind in their schooling:

  How much easier it would have been for her and her schooling with early intervention. Only getting diagnosed at 8 with APD [auditory processing disorder] has left her 2 years behind in her spelling ability.[246] **(Parent)**

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  They are receiving no support, no interventions and this has a detrimental effect on their learning capacity as they enter school. I have an extensive list of playgroups, websites, apps and information that I supply to my patient's parents but what they need is actual appointments with the specialist allied health providers and paediatricians.[247] **(GP)**

- There can be a devastating emotional and behavioural impact on children:

  I have a 13 year old daughter that was happily attending school and striving to be her best, to now a girl that is upset, and on the point of giving up with her education.[248] **(Parent)**

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  Meanwhile while we try and sort this out we are trying to work out ways to help our daughter who is refusing to go to school, has numerous meltdowns which involve throwing things at us – including knives.[249] **(Parent)**

  ▫▫▫

  They do not have any friends. They do not go to birthday parties.[250] **(Carer)**

- As well as on the family:

  We are tired and exhausted … Why is this system so difficult- when all we want is a little bit of help to manage a condition which is complex and impacts our family enormously?[251] **(Parent)**

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243 Submission 3 from private citizen, 9 September 2022, p 1.

244 Submission 11 from private citizen, 5 October 2022.

245 Submission 77 from WA Health, 9 November 2022, p 13.

246 Submission 7 from private citizen, 17 September 2022.

247 Submission 51 from Dr R Hunt-Davies, GP, 24 October 2022.

248 Submission 3 from private citizen, 9 September 2022, p 1.

249 Submission 4 from N Amos, 9 September 2022.

250 Private citizen, carer, [*private transcript of evidence], Legislative Council,* p 6.

251 Submission 4 from N Amos, 9 September 2022.

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> The whole system is so broken from start to finish with so many kids falling between the cracks … My son is still not getting the support and interventions that he deserves or needs. Written by one exhausted mother trying to do her best but feeling like she is failing and letting her son down because the system is broken.[252] **(Parent)**

- Families, especially those in the regions, put themselves under emotional and financial stress trying to seek help outside their local community or from private providers:

> We personally have spent over $7000 in the last 12 months obtaining diagnoses for our children. Within the next 2 weeks we will need to spend another $1600, and we can expect a rebate of less than $260.[253] **(Parent)**

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> For most of us in our region in the south here, it would be three days away from home, three days away from school and three days away from our work to access services.[254] **(Isolated Children's Parents' Association of Western Australia)**

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> When you are travelling for five, six, seven or eight hours for an appointment that may last half an hour, it is pretty hard to justify what benefit you get out of it.[255] **(Isolated Children's Parents' Association of Western Australia)**

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> [My child] … was put on a wait list for the state government child development services for speech, OT, psychology and a paediatrician. I couldn't wait the 24 month plus wait times and end[ed] up getting a second job to afford …[their] … therapies and assessments because I knew … [they] … needed the early intervention and a diagnosis. [My child] … was diagnosed … with level 2 Autism and ADHD. The cost financially my family will only recover in 2 years time with a tight budget the cost to my own personal health and mental health will be a lot longer as I continue to fight a new system to get the support … [my child] … needs.[256] **(Parent)**

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> Many families are attempting to access Paediatricians from outside of their local region – seeking referrals to paediatricians in the Perth metropolitan area with considerable inconvenience and additional expense involved in doing so.[257] **(South West Autism Network)**

- Parents are resorting to seeing interstate service providers due to the lengthy public (and private) waiting times in Western Australia:

> In terms of, say, a paediatrician for us [in Tambellup], the waitlists, as you know, are massive. I have a friend who last year was seeing a paediatrician in Adelaide

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252 Submission 21 from private citizen, 21 October 2022.

253 Submission 5 from private citizen, 10 September 2022.

254 K Ross, State Secretary, Isolated Children's Parents' Association, [*transcript of evidence*], *Legislative Council*, 4 April 2023, p 6.

255 K Ross, [*transcript of evidence*], 4 April 2023, p 6.

256 Submission 36, private, 24 October 2022, p 3.

257 Submission 29 from South West Autism Network, 23 October 2022, p 5.

because he had been over here and had done a short stint at a local hospital in a locum setting. She had seen him in an emergency situation. She could not get in to anyone else so was seeing him remotely from Adelaide because there just was not another service available. There are massive waitlists. The children at our local school have been waiting up to a year to see a paediatrician.[258] **(Isolated Children's Parents' Association of Western Australia)**

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I have heard of it [families seeking paediatric appointments interstate] being done. I have heard of patients going internationally as well. Desperate people do desperate things. You have a child who you want the best for and you are going to look at all options. It does make it difficult. We should not have to be doing that, is what I would say.[259] **(Paediatrician)**

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I am considering travelling interstate for a Paediatrician appointment in Victoria.[260] **(Parent)**

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we re-located back [to Albany] just before COVID. … I guess to date I have spent about $7 000 accessing private health services in Perth. I did that privately because child development services in Albany were not an option. When I say "not an option", I mean that the wait times were too long …[261] **(Parent)**

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We have had to look to get services in Adelaide, and found professionals ready and available to take on new patients. Having to travel interstate to find a professional is unacceptable.[262] **(Parent)**

- Necessary adjustments to medication are delayed:

  we all just want our children to be the best they can and it seems the simplest things are blocking the system, I can't increase his medicine as planned because there is no appointment for him at the recommended time.[263] **(Parent)**

- Parental concerns prompting a referral may change or become less clear by the time the child is seen:

  Once a referral is made a child may not be seen for up to a year. Once seen the parent is asked re their goals for their child, if they can't articulate their concerns the case may be closed. Why are school staff being asked to refer if their referral concerns are dismissed. A parent may have been clear on goals and difficulties when the referral was made, but 12 months later they may be less clear.[264] **(Private citizen)**

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258 J Cunningham, President, Isolated Children's Parents' Association, [*transcript of evidence*], *Legislative Council*, 4 April 2023, p 6.

259 Dr R Lethbridge, Director and Chief Executive Officer, Starbloom Paediatrics, [*transcript of evidence*]*, Legislative Council,* 12 December 2022, p 9.

260 Submission 42 from private citizen, 24 October 2022, p 1.

261 D Killey, private citizen, [*transcript of evidence*], *Legislative Council,* 4 April 2023, p 1.

262 Submission 12 from private citizen, 15 October 2022, p 1.

263 Submission 3 from private citizen, 9 September 2022, pp 1-2.

264 Submission 20 from private citizen, 21 October 2022, p 1.

- An increasing burden is placed on teachers and schools:

> Teachers are working hard to fill the gap that specialist shortages have created. The waitlist for services means we are working hard to support children with imputed diagnosis with an incomplete picture. Teachers are not occupational therapists, speech pathologists, physical therapists, psychologists or counsellors yet we are scrambling to support children with sensory needs, physical difficulties, emotional regulation, speech delays and neurological differences. Parents, children and teachers/education assistants are burning out whilst trying to wear multiple hats and do the best they can. There is not enough support out there to give every child the childhood and access to education they deserve.[265] **(Teacher)**

- Encountering long waiting times by the health system leads to a perception amongst some families and others that late intervention is acceptable:

> I am also concerned about the message that long waitlists give to parents. If the health professionals think it is ok not to intervene with developmental issues for their child, perhaps there is no issue.[266] **(Private citizen)**

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> The lack of access to all areas of child development services, in both public and private settings, is frankly a disgrace, and a travesty in 2022 in Western Australia. It is unacceptable and demonstrates a lack of willingness and care for these young people, for their health, their wellbeing, and their futures.[267] **(GP)**

- Faced with long waiting times for CDS, and indeed all child development services, parents may place their children on multiple waitlists in the public, private and non-government sectors for services from the same discipline (for example, speech pathology). This can potentially distort waitlist figures:

> Waiting lists are often long for the CDS – not only does that mean that children do not get the support they need in a timely manner, but it also creates a cycle where children get referred to the CDS 'just in case' so that if they need support by the time they reach the front of the line, they have a spot. This of course however put[s] further pressure on the system and potentially increases waiting lists further.[268] **(Speech pathologist)**

4.27 In the Committee's view, this evidence clearly demonstrates that long waiting times for child development services can result in problems becoming more serious and difficult to address, not only for children but for their families, their schools and treating practitioners.

FINDING 3

Long waiting times for child development services can result in problems becoming more serious and difficult to address, not only for children but for their families, their schools and treating practitioners.

265 Submission 6 from private citizen, teacher, 13 September 2022.

266 Submission 20 from private citizen, 21 October 2022, p 2.

267 Submission 46 from Dr S Ognenis, GP, 24 October 2022.

268 Submission 55 from private citizen, speech pathologist, 24 October 2022, p 3.

FINDING 4

The waiting times for services delivered by the Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service are unacceptably long.

Limited service provision for children aged seven years and older

4.28 The other major issue raised by submitters (along with waiting lists), was CAHS–CDS's limited service provision for children aged seven years and older.[269] For example:

> A huge gap in public developmental services seems to occur for school-aged children. After the age of 7, public allied health services are limited and no ongoing therapy services are available.[270] **(Paediatrician)**

4.29 Due to service capacity constraints, and the importance placed on providing interventions in the early years of life, CAHS–CDS prioritises its allied health services for children who are aged under seven years.[271] This often leaves CAHS–CDS paediatricians to manage older children with little or no allied health practitioner support.[272] CAHS–CDS acknowledged that this is a gap in its service provision:

> As a consequence of the overall demand for services and prioritising CDS allied health resources to focus on early childhood allied health intervention, CDS capacity to provide allied health services for children older than 7 years and young people is limited. This client cohort generally receives allied health assessment and recommendations for how to best manage their difficulties within their everyday life, including their educational setting. Where any additional (minimal) CDS intervention is provided, it continues to be directed by goals collaboratively determined with the young person and/or family and focused on building understanding of the difficulties experienced, on strategies that can assist, and on how to advocate for support needs. Older children and young people who require medical assessment and management [from paediatricians] will continue to receive services as required up to the age of 18 years.[273]

4.30 The Committee explored a practical example of how CAHS–CDS is significantly constrained in its capacity to provide allied health services to children aged seven years and older. For example, students aged seven years and older with certain specific developmental needs, in areas such as speech and language, can typically expect to receive up to four sessions of assessment and planning and are then discharged following feedback to their parent or carer. The Committee has confirmed with CAHS that this service would not include provision for one-on-one therapy.[274]

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269 For example, Submission 10 from private citizen, speech pathologist, 8 October 2022, p 1; Submission 33 from ADHD WA, 24 October, p 3; Submission 35, private, from a paediatrician, 24 October 2022, p 1; and Private citizen, paediatrician, [*private transcript of evidence*], *Legislative Council*, pp 2–3.

270 Submission 1 from Dr J Bullock, paediatrician, 7 September 2022, p 1.

271 Submission 77 from WA Health, 9 November 2022, pp 32–33; A Turnell, Acting Director, Clinical Services, Child Development Service, CAHS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 7.

272 Child Development Service, CAHS, [*private transcript of evidence*], Legislative Council, 25 July 2023, p 11.

273 Submission 77 from WA Health, 9 November 2022, p 33.

274 Hons Donna Faragher, Deputy Chair, and Dr Sally Talbot, Chair, MLCs; and CAHS [*private transcript of evidence*], *Legislative Council*, 25 July 2023, p 12.

Impacts of limited service provision

4.31 The impacts of this service limitation on school-aged children can be profound:

- School-aged children are not receiving the holistic healthcare that they need and deserve:

> The [CAHS–] CDS was funded to deliver a team approach to services where doctors and allied health professionals worked together for a child's best outcomes. However, there has been a systematic reduction of the psychology and social work components of the CDS team to the point where the only psycho-social service provision is to young children. Services for children who are only formally identified later [this is often the case for children with ADHD][275], when the demands of formal schooling are upon them, are almost non-existent. The team aspect of the service has been eroded and allied health practitioners work in isolation to a large degree. This is not best practice and does not lead to good outcomes. It leads to a situation where medication is more often utilised as the only available intervention for older children [with ADHD].[276] **(ADHD WA)**

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> Children with ADHD access Paediatrician-only management within [CAHS–] CDS. They do not have access to psycho-social support or non-medical therapies, which is not best practice for this condition.[277] **(Paediatrician)**

- These children and their families may not have the means to access private services that they require; and they may not be able to access any other free services:

> A huge gap in public developmental services seems to occur for school-aged children. After the age of 7, public allied health services are limited and no ongoing therapy services are available. Free mental health services (eg. HeadSpace; YouthFocus) are not available until children reach the age of 12; unless their mental health issues are severe and they are accepted into the Child and Adolescent Mental Health Service. This is a problem as concurrent anxiety and behavioural difficulties are common in children with developmental problems. There is huge inequity as a result – only children whose families who can afford private services through a medicare rebate/private health insurance or are eligible for NDIS will receive recommended therapy interventions. For children with[out] a formal mental health diagnosis, if the family cannot afford psychology interventions, currently the child is not eligible for any additional assistance at school …[278] **(Paediatrician)**

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> [Children] … are told [by the schools], basically, "We can't get any kind of service for you or support unless you get a written diagnosis from either a paediatrician or

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275 'I would certainly be very apprehensive to diagnose someone with ADHD under five years of age': Private citizen, paediatrician, [*private transcript of evidence*]*, Legislative Council*, p 12.

276 Submission 33 from ADHD WA, 24 October, p 3.

277 Submission 35, private, from a paediatrician, 24 October 2022, p 5. This issue featured in CAHS–CDS's 2023-24 State Budget funding submission (see paragraph 4.70 of this report).

278 Submission 1 from Dr J Bullock, paediatrician, 7 September 2022, p 1. The Committee noted that a school-aged child who has a mental health condition that affects their schooling but no formal diagnosis, their school may still be able to obtain additional funding to support that child, through an 'education adjustment allocation': see paragraphs 3.94 to 3.95 of this report.

> a psychiatrist." So there is the roadblock; they cannot actually get … [a diagnosis].[279] **(Paediatrician)**
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> ▫▫▫
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> [A teenager has] … significant social and sensory issues, … [suspected ASD] … [and has experienced family and domestic violence and abuse]. [This person] … has aged out of the Child Development Services system and … [their family] … does not have the financial means to support a private ASD assessment. [This person's] … case manager has advocated for the Reconnect program to finance a private OT assessment, in view of ongoing clinical support and recommendation of the need for an ASD assessment. The case manager is currently trying to find a service willing/with availability to take … [this person] … close to the family home, but has so far been unable to find one in the area that is taking referrals.[280] **(Parkerville Children and Youth Care)**

- School-aged children who are desperate for help are turning to hospital emergency departments:

> The lack of psycho-social support for school-aged children with complex developmental issues has been part of the cause of increased numbers of Emergency Department presentations for acutely distressed children and their families.[281] **(Paediatrician)**

4.32 CAHS–CDS's limited service delivery to children who are seven years and older is particularly concerning, given that children aged four to eight years are, since at least 2012-13, the largest proportion of children being referred – and that proportion is increasing. The proportion of children aged eight years and older at referral has also increased significantly since 2012-13 (see paragraphs 3.40 to 3.41).

4.33 The implications of this limited service delivery are even more alarming when the excessive waiting times are factored in. For example, a child who is referred to CAHS–CDS at six years of age for speech pathology may need to wait 12 months for their first appointment, by which time they would in most cases receive only a limited service. Catholic Education Western Australia and ADHD WA referred to this problem:

> Given the long wait times, by the time some of these students are offered a service they have aged out, i.e., they are too old for the service they were referred for. Examples are early intervention speech and occupational therapy where there is an age limit to be eligible.[282] **(Catholic Education Western Australia)**
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> ▫▫▫
>
> We found that with our [ADHD WA] members, they tend to identify that there is an issue, go to the GP and then they are referred to CDS. Upon that referral, they are given a general assessment [by CAHS or WACHS–CDS] and usually before the age of six.
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> …

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279 Private citizen, paediatrician, [*private transcript of evidence*], *Legislative Council*, p 3. The Committee noted that a school-aged child who has special education needs but no formal diagnosis for one or more of the disabilities recognised by the DOE, their school may still be able to obtain additional funding to support that child, through an 'education adjustment allocation': see paragraphs 3.94 to 3.95 of this report.

280 Submission 38 from Parkerville Children and Youth Care, 24 October 2022, p 10.

281 Submission 35, private, from a paediatrician, 24 October 2022, p 6.

282 Submission 37 from Catholic Education Western Australia, 24 October 2022, p 4.

> They [referrals to allied health practitioners] are given by the paediatrician or the doctor who sees them at CDS referrals to occupational therapists, to psychologists, to speech therapists, usually because they are wary to prescribe [medication for ADHD] before the age of six. But the issue that we have got is that that appointment is not happening until way after six, so those referrals to the psychologists, the speech therapists and the occupational therapists are not happening; all those services are not available.[283] **(ADHD WA)**

FINDING 5

Child and Adolescent Health Service–Child Development Service's resourcing constraints result in what much of the evidence identifies as a serious deficit of services to children aged seven years and older who have been identified as requiring developmental assessment, intervention and support.

What are the causes of service deficiencies?

Increased demand for child development services

4.34 Both CAHS–CDS and WACHS–CDS submitted that demand for their services has increased over time and continues to do so.[284] The evidence supports this claim. For example, in the 10 years since 2013-14, the demand for CAHS–CDS services has increased by 52%. In the same period, demand for clinical psychology and development paediatrics has gone up by 114% and 132%, respectively.[285] The reasons why demand has increased are complex and varied, and it is beyond the scope of the Inquiry to explore them fully. However, here are some of the suggested causes:

- Increased demand on public, private and non-government service providers for ASD and ADHD assessments and diagnoses. This was reflected in evidence received throughout the inquiry.[286] For example Dr Rob Lethbridge from Starbloom Paediatrics stated in his submission that:

  > At Starbloom, referrals for Attention-Deficit/Hyperactivity Disorder (ADHD) and Autism started to arrive even before we were officially open to referrals, based on rumour and word-of-mouth. We remained open to referrals for less than one week for this specialty due to the overwhelming demand, and we are aware of a colleague who received more than 400 developmental referrals in two weeks.
  >
  > Even as we slowly increase the number of specialist developmental paediatricians working with us as associates, we will not be re-opening developmental referrals due to the backlog that exists from that very brief opening period. Despite clearly documenting on our website and in any advertising that we have no capacity for further referrals, questions about the

283 C Natale, Member, Management Board, Membership Portfolio, ADHD WA, [*transcript of evidence*], *Legislative Council,* 12 December 2022, p 6.

284 Submission 77 from WA Health, 9 November 2022, pp 5 and 8.

285 CAHS, *Annual report 2022-23*, CAHS, 2023, accessed 16 October 2023, p 82.

286 For example, Submission 38 from Parkerville Children and Youth Care, 24 October 2022, pp 1 and 12; Submission 77 from WA Health, 9 November 2022, pp 35–36, 37 and 50; and Submission 81 from Western Australian Council of Social Service, 7 November 2022, p 13.

> availability of developmental assessments are still amongst the most common enquiries that we receive.[287]

He explained this further in a hearing:

> **DONNA FARAGHER**: …The point of closing your books–if I can put it that way–does that extend then to other areas of paediatrics [other than developmental paediatrics]? You mentioned sleep and other things. … does the issue of closing your books with regard to autism and ADHD actually then transcend into those other areas, as well?
>
> **Dr LETHBRIDGE**: Not to the same degree, certainly. … Suffice to say, the demand for various other services … is also quite high. We would not expect to be bereft of patients, but, equally, it is nowhere near the same degree of demand as developmental paediatrics either. When I opened for respiratory and sleep, sure, I have been consistently ticking over patients, but my waiting times are weeks not years.[288]

The Royal Australasian College of Physicians noted that:

> Paediatricians trained in developmental paediatrics and mental health (psychiatry) are in high demand due to increased demand for mental health issues, ADHD, and Autism Spectrum Disorder diagnosis, treatment and support.[289]

- Increased complexity of conditions: There has been an increase in the proportion of children referred to CAHS–CDS with issues in three or more developmental areas.[290]
- Population growth: At 30 June 2010, there were 538,963 children under the age of 18 years.[291] By June 2022, that number had grown to 633,757[292] – an increase of 17.6%.
- Societal issues: Changes in lifestyle, family units, social networks and communication methods have altered the way in which children are now raised.[293] It is becoming apparent that digital technology is a particularly influential and negative factor:

  > Research has also shown that children and young people feel negative about their parent's use of devices and experience less parental warmth, which is resulting in negative outcomes including anxiety and depression. Emerging evidence suggests that parent distraction with devices may be impacting child learning and achievement across various domains.[294]

- COVID-19: Social restrictions during the pandemic led to reduced opportunities to interact with people outside the home environment and to seek help with regard to both assessment and therapy. As Playgroup WA stated:

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287 Submission 84 from Starbloom Paediatrics, 17 November 2022, p 1.

288 Hon Donna Faragher MLC, Deputy Chair, and Dr R Lethbridge, Director and Chief Executive Officer, Starbloom Paediatrics, [*transcript of evidence*], *Legislative Council,* 12 December 2022, p 5.

289 Submission 83 from Royal Australasian College of Physicians, 17 November 2022, p 2.

290 Submission 77 from WA Health, 9 November 2022, p 28.

291 CCYP, *Report of the inquiry into the mental health and wellbeing of children and young people in Western Australia*, CCPY, 2011, accessed 31 August 2023, p 44.

292 CCYP, *Profile of children and young people in WA*, CCYP, 2023, accessed 7 September 2023, p 6.

293 For example, D Zarb, Chief Executive Officer, Playgroup WA, [*transcript of evidence*], *Legislative Council,* 26 July 2023, p 2.

294 Submission 77 from WA Health, 9 November 2022, p 12.

> There have been a number of Australian and international studies published recently identifying an increased risk for developmental delay among babies born during the pandemic. At PGWA [Playgroup WA] we have noted even in the last few months, toddlers coming to playgroup for the first time exhibiting extreme distress as they have never been with anyone but family and have had no experience playing or interacting with other children. During 2020/21 we were aware of babies of 8-10 months old who had never been touched by anyone but their mother nor heard any voice but their mother's. Children's brains grow through relationships and experiences. The reduced opportunities to engage socially in the real world through a variety of experiences outside the home will impact typical child development. During the pandemic, in person Child Health Services ceased as did other child and parent services. This will create significant additional pressure on our existing child health/development and mental health systems, as well as our education sector, over the coming years.[295]

- The NDIS: The scheme requires funding applicants to provide evidence of their disability (see paragraphs 3.113 to 3.118), which often translates, in practice, to the requirement to obtain a diagnosis, with CAHS–CDS or WACHS–CDS often called on to provide the diagnosis.[296]
- The DOE's requirements for providing additional funding or support for students with special education needs generates greater demand for assessments and diagnoses, particularly for the individual disability allocation (see paragraphs 3.96 to 3.97) and LDC enrolment (see paragraphs 3.102 to 3.107).[297] Again, CAHS–CDS and WACHS–CDS are often called on to perform this assessment and diagnosis function.
- Reduction in private sector capacity for some disciplines, particularly developmental paediatrics and clinical psychology, resulting in more demand for other secondary-level child development services in the public sector, including CAHS–CDS and WACHS–CDS,[298] and the non-government sector:

> As the private service has become saturated with a few experienced Paediatricians retiring, there is limited capacity currently to see children as a private service, especially if they have chronic neurodevelopmental and mental health issues.[299]

Limitations in the capacity to provide child development services

4.35 There is a variety of explanations for why CAHS–CDS and WACHS–CDS have not been able to meet the increased demand for their services. Here is a summary of the evidence presented to the Committee, much of it by WA Health:

Insufficient funding

4.36 Despite the greater demand (there has been a 52% increase in referrals to CAHS–CDS since 2013-14)[300], and increasing median waiting times (see paragraphs 4.14 to 4.25), CAHS–CDS

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295 Submission 48 from Playgroup WA, 24 October 2023, p 2.

296 For example, Submission 69 from Western Australian Council of State School Organisations, 2 November 2022, p 3; and Dr B Jongeling, Medical Head of Department, Child Development Service, CAHS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 10.

297 For example, Submission 1 from Dr J Bullock, 7 September 2022, p 1; Submission 28 from private citizen, paediatrician, 23 October 2022, p 2; Submission 82 from Australian Medical Association (WA), 11 November 2022, pp 6 and 7; and Dr B Jongeling, Medical Head of Department, Child Development Service, CAHS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 10.

298 Submission 77 from WA Health, 9 November 2022, p 48.

299 Submission 28 from private citizen, paediatrician, 23 October 2022, p 2.

300 CAHS, *Annual report 2022-23*, CAHS, 2023, accessed 16 October 2023, p 82.

and WACHS–CDS submitted that they have not received a commensurate increase in their funding. Neither of them have been able to obtain a substantial funding uplift since 2010, when a $49.7 million increase in funds was provided.[301] The Committee received further evidence from both CDS providers confirming this (see paragraphs 4.55 to 4.63).

4.37 Amongst other things, inadequate funding has resulted in a shortage of clinical and administrative staff:

> Additional clinical and non-clinical staffing is required to meet the demand for the [CAHS–] CDS.[302]
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> ▫▫▫
>
> WACHS CDS has a limited number of dedicated child development teams and health professionals …[303]

Insufficient space

4.38 The limited capacity of CDS facilities restricts service delivery or the expansion of services:

> [CAHS–] CDS facility capacity is contributing to service delivery challenges. Facilities are being utilised at capacity, with no ability to accommodate further staffing growth. … Provision of clinical services via telehealth relieves some of the pressure on clinical space, however telehealth is not always a suitable mode of service delivery.[304]
>
> ▫▫▫
>
> Community demand for CDS [delivered by WACHS] continues to increase every year, with staffing and facilities being inadequate across country WA.[305]
>
> ▫▫▫
>
> Clinical placements within Community Health [a CAHS service area] are offered to nursing and allied health students from across universities in WA. Recent placement offers have been affected by limitations associated with clinical space and the ability to accommodate additional people on site.[306]

4.39 Limited space also reduces productivity and efficiency:

> we do need to invest in expanded clinical space. That would improve our clinical productivity immediately and enable a CDS to offer more group-based interventions and provide services to more families and, importantly, accommodate more student placements …[307]

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301 Submission 77 from WA Health, 9 November 2022, pp 5–6, 8 and 46; and see also, paragraph 4.75 of this report. WA Health attributed the last increase in block funding to the tabling of a committee report: Education and Health Standing Committee, report 5, *Invest now or pay later: Securing the future of Western Australia's children,* Western Australia, Legislative Assembly, 11 March 2010 (see Table 4 on page 47 of this report).

302 Submission 77, p 6.

303 Submission 77, p 67.

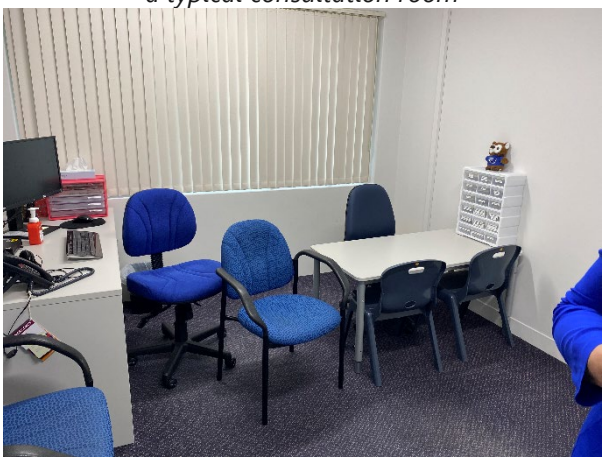
304 Submission 77, p 6. This was addressed in CAHS–CDS's 2023-24 State Budget funding submission (see paragraph 4.70 of this report).

305 Submission 77, p 8.

306 Submission 77, p 70.

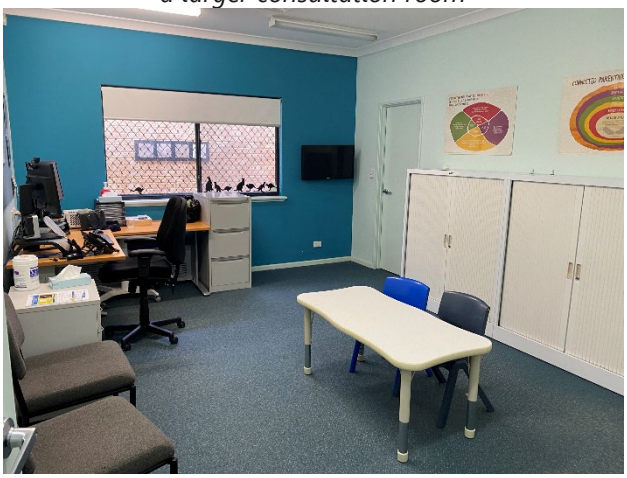
307 S Kiely, Executive Director, Community Health, CAHS, [*transcript of evidence*]*, Legislative Council,* 26 April 2023, p 5.

Figure 10. *Midland Child Development Service, Sayer Street – a typical consultation room*



[Source: Committee site visit, 7 August 2023.]

Figure 11. *Midland Child Development Service, Railway Parade – a larger consultation room*



[Source: Committee site visit, 7 August 2023.

4.40 In regional areas, the frequent co-location of child development services within hospitals has an impact on service delivery and capacity:

> the challenges are related to the types of spaces that our child development services are functioning from at the moment. Often they are on hospital sites and they have sort of shared waiting areas with clinics that are not just for child development services. This certainly impacts then on the types of services that we provide and the competition for space …[308]

4.41 Many facilities are also outdated and not fit for purpose. The Committee observed this for itself during site visits to the Midland and Bentley CDS centres:

- Existing facilities do not maximise engagement opportunities or accessibility for families:

> the biggest opportunity is to build facilities where you can have the team together and you can have the right facilities, … in terms of telehealth appointments, group

[308] L Pereira, Manager, Child Development Service, WACHS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 24.

rooms and those kinds of purpose-built spaces where families can come and get a whole lot of things done together at once.[309]

Figure 12. *Midland Child Development Service, Railway Parade – meeting room and telehealth stations*

[Source: Committee site visit, 7 August 2023.]

- Room size and location does not afford privacy and confidentiality to children and their families and treating clinicians.
- Facilities are not welcoming:

  Facilities for children are not always family friendly, being aged, cold, clinical and scary.[310]

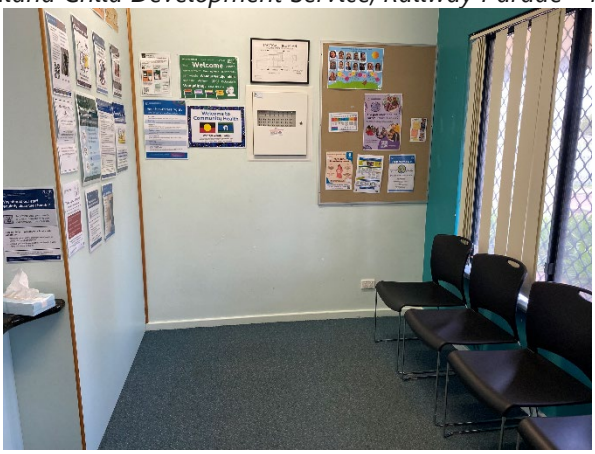
Figure 13. *Bentley Child Development Service*

[Source: Committee site visit, 7 August 2023.]

309 S Kiely, Executive Director, Community Health, CAHS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, pp 25–26.

310 Submission 50 from Dr E Green, paediatrician, 24 October 2022, p 5.

Figure 14. *Midland Child Development Service, Railway Parade – reception area*



[Source: Committee site visit, 7 August 2023.]

The NDIS

4.42 The expansion of the NDIS provider sector has attracted some of the workforce that may otherwise have remained within the CDS system.[311] As WA Health explained:

> An additional pressure and challenge for CDS is the retention and attraction of allied health staff as a result of the development of private NDIS service providers. Private providers have greater flexibility in employment salaries and conditions that can be offered to employees.[312]

COVID-19

4.43 The pandemic resulted in a range of issues that increased demand for CDS (see paragraph 4.34), as well as:

- creating workforce issues, due to staff sickness and/or staff reallocation to testing centres, vaccination clinics and tracing efforts
- the forced cancellation of face-to-face service delivery, due to legal requirements for people to quarantine, isolate and/or distance themselves from others.[313]

Recruitment difficulties

4.44 Both CDS providers have, at times, encountered recruitment difficulties, some of which are outlined in paragraphs 4.42 and 4.43.[314] For example, CAHS–CDS submitted in November 2022 that:

> Some vacancies exist despite ongoing attempts to recruit to all positions. COVID-19 has had an impact on the demand for and well-being of health workers across the world. Recruitment of medical, nursing and allied health staff is reported to be difficult across WA and Australia and is likely to remain so with ongoing competition for a limited, sufficiently skilled workforce between public, private, not

311 Submission 18 from Dyslexia-SPELD Foundation, 21 October 2022, p 4; and Submission 77 from WA Health, 9 November 2022, pp 67–68.

312 Submission 77 from WA Health, 9 November 2022, p 67.

313 Submission 77, pp 6, 18, 46, 48 and 67.

314 Submission 77, pp 46, 48, 50, 51, 52, 53 and 63.

for profit organisations and community-controlled service providers into the foreseeable future.[315]

4.45 By April 2023 however, circumstances had improved:

> **Hon DONNA FARAGHER**: … Do you think that, with what you have put forward [as a funding request for the 2023-24 State Budget], it would be reasonable to think that those positions would be able to be filled?
>
> **Ms KIELY**: I think it is reasonable that those positions would be able to be filled; it is just the time frame in which we fill them. Coming out of COVID, all health systems struggled, and in fact across workforces generally, we struggled to recruit, with a lot of people being burnt out. I can see, particularly in the child health space and across my area [CAHS's Community Health service area], that that is being resolved, our vacancy rates are dropping down, we are getting those cohorts of young people coming through as graduates and we are really getting back on track. I do feel that when we first made our submission to this [Inquiry, in November 2022], it was a very real and live issue and now we are starting to see society getting back to something more normal around recruitment, and also some of our recruitment strategies we have put in place where we have really sold what it means to come and work in the Child Development Services, which is different to perhaps working in a hospital, and we have been able to improve our rates of getting people into positions.[316]

4.46 WACHS–CDS advised the Committee that recruitment and retention, across all seven of its regions, continue to be two of its biggest challenges,[317] due to various reasons, including:

- a lack of accommodation
- workers wanting to specialise in child development services but finding that WACHS offers a generalist caseload.[318]

FINDING 6

Since the end of 2022, the Child and Adolescent Health Service's Community Health service area has been successful in reducing its staff vacancy rates.

Nature and complexity of conditions

4.47 Much of the Inquiry's evidence, including from WA Health, has noted an increase in the complexity of conditions displayed in children requiring child development services.[319] For example:

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315 Submission 77 from WA Health, 9 November 2022, pp 46–47.

316 Hon Donna Faragher MLC, Deputy Chair; and S Kiely, Executive Director, Community Health, CAHS, [*transcript of evidence*], *Legislative Council*, 26 April 2023, p 26.

317 K Miller, Director, Population Health, WACHS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, pp 6 and 7.

318 L Pereira, Manager, Child Development Service, WACHS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 25.

319 For example, Private citizen, paediatrician, [*private transcript of evidence*], *Legislative Council,* p 10; Submission 15 from Dr B Hart, medical practitioner, 18 October 2022, p 60; and Dr B Jongeling, Medical Head of Department, Child Development Service, CAHS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 10 (see paragraph 4.11 of this report).

> I think the families and kids who we are seeing today are so much more complex, and that has happened in the last 10 years with mental health and whatever, so you do burn out a lot quicker, and so you do need that support.[320]
>
> ▫▫▫
>
> A coordinated and integrated approach across the continuum of child and youth health care will ensure the seamless and effective provision of care using integrated care pathways and innovative models of care. It is well recognised that there is considerable fragmentation within health systems, increasing complexity of patient care, and a lack of focus on population health.[321]
>
> ▫▫▫
>
> [In the 10 years since 2012-13,] There has ... been an increase in the proportion of children referred [to CAHS–CDS] with concerns in 3 or more developmental areas.
>
> …
>
> Of children on the active [CAHS–] CDS caseload (data as at 19/09/2022), 72.9% required services from more than one discipline. Furthermore 49.9% of the active CDS caseload had received services from a paediatrician and at least one other discipline.[322]

4.48 Complex developmental needs may lead to children being treated for longer.[323] When either CAHS–CDS or WACHS–CDS is involved, this may mean that the existing capacity of the CDS system is not sufficient to care for new clients. [324]

Inadequate information technology

4.49 WA Health acknowledged that the CDS providers, along with other public health service providers, rely on inadequate and fragmented information technology systems.[325] These systems and infrastructure are outdated, often not fit for purpose and do not support service provision:

- Western Australia does not have a modern system-wide electronic medical record system:

  > WA Health has just begun to engage in the process of what is called the development of the stage 2 business case for the EMR [electronic medical record system]. Basically, we are years away from full implementation.[326]
  >
  > ▫▫▫

320 Private citizen, paediatrician, [*private transcript of evidence*], *Legislative Council,* p 10.

321 Submission 15 from Dr B Hart, medical practitioner, 18 October 2022, p 60.

322 Submission 77 from WA Health, 9 November 2022, pp 28 and 39.

323 Prof A Whitehouse, Bennett Professor of Autism Research, Telethon Kids Institute, [*transcript of evidence*], *Legislative Council,* 9 February 2023, p 13.

324 Submission 35, private, from a paediatrician, 24 October 2022, p 6.

325 Submission 77 from WA Health, 9 November 2022, pp 6, 7, 42 and 58; and Dr S Towler, Chief Medical Officer, Clinical Excellence Division, DOH, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 27.

326 Dr S Towler, Chief Medical Officer, Clinical Excellence Division, DOH, [*transcript of evidence], Legislative Council,* 26 April 2023, p 45.

> The [Telethon Kids] Institute is strongly of the view that [the] State needs to introduce a "Statewide electronic health record" for all children as information on health and wellbeing is siloed and often difficult to access.[327]

- There is inadequate linkage between the information systems used by hospitals and the systems used by the CDS providers:

> where we are seeking to go with our digital future is to ensure there is much better linkage between hospital systems and the community. But this is not an immediate issue and not likely to change in the near future.[328]

- The CAHS–CDS electronic health record system is outdated:

> CDIS was ahead of its time when we first introduced it. … that was a joint work across many clinicians. We put a lot of time into that design, and it has been kind of a bespoke system that supported our services. It also meant … that we are able to give you very detailed information about waitlists, service design, service support and complexity, and all those kinds of things, which other states in Australia dream of, literally. … From that perspective, it has been fantastic. But … it is end of life in terms of the underlying technology.[329]

▫▫▫

> CAHS Community Health currently has two electronic health record systems that are not currently integrated and have restricted functionality compared to what could be expected in a modern, fit for purpose EMR.[330]

- The CDIS also has limited functionality:

> The clinical information within it is not visible to the hospital system or to other community providers, risking fragmentation of care. Importantly the information within CDIS is not accessible to children or their carers, impeding care coordination and appropriate and timely management.[331]

- There are technological limitations at CDS sites:

> The shift of all services to telehealth because of COVID-19 related restrictions was impacted by technological limitations at CDS sites, including challenges with bandwidth, network connections and aging hardware. These issues have begun to be addressed, including upgrades at many sites, but further technology upgrades, improvements and innovation would better support service delivery.[332]

- Collaboration is constrained:

> Improved systems for information sharing and shared health records would help increase collaboration. Other services require a fast and streamlined approach for

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327 Submission 85 from Telethon Kids Institute, 18 November 2022, p 4.

328 Dr S Towler, Chief Medical Officer, Clinical Excellence Division, DOH, [*transcript of evidence], Legislative Council,* 26 April 2023, pp 45-46.

329 Dr B Jongeling, Medical Head of Department, Child Development Service, CAHS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 46.

330 Submission 77 from WA Health, 9 November 2022, p 58.

331 Tabled Paper 2, Inquiry into child development services: Potential questions, tabled by CAHS during hearing held 28 November 2022, p 11.

332 Submission 77 from WA Health, 9 November 2022, p 42.

exchanging medical information with the CDS and obtaining consent for the release of information.[333]

- Technological limitations affect CAHS–CDS and WACHS–CDS's ability to improve efficiency or to increase accessibility for their clients or to make the changes needed to prioritise the patient journey:

> Feedback received from consumers is that they would value the convenience and flexibility of an online appointment booking system. This could also provide efficiencies for [CAHS–] CDS, however it would require a significant investment in an online booking platform and integration of this platform with the CDS electronic health records.[334]
>
> ▫▫▫
>
> An urgent opportunity is that of harnessing the efficiency gains of digital health and ensuring access to patient records across the system so that people do not have to tell their stories repeatedly …[335]
>
> ▫▫▫
>
> What is our digital front door? What is our ability to engage with families the way families and parents are engaging generally? I think that is something that we also need to look at doing as well.[336]

- For regional Western Australia, the Committee heard evidence about WACHS child health nurses having to locate clients with very little information:

> you might sometimes have just a name, and nothing else, and if they're not on our computer system, if they are not registered here at DAHS [Derby Aboriginal Health Service], it can be problematic. So it is a lot of emailing backwards and forwards, trying to liaise with community health up at the hospital to see whether they know who these people are, and then it is a matter of getting in the car and driving around and delivering the letters.[337]

Insufficient supports

4.50 Evidence from WA Health and others highlighted the need to provide sufficient administrative and clinical supports for CDS practitioners to maximise their productivity.

Administrative supports

4.51 Evidence received from CAHS–CDS indicates that clinical staff undertake administrative tasks that are unrelated to their clinical work, and this is particularly the case for allied health staff. While it may vary across sites, these tasks can include:

- managing clinical room scheduling

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333 Submission 16 from Neurosciences Unit, North Metropolitan Health Service – Mental Health, Public Health and Dental Services, 13 October 2022, p 3.

334 Tabled Paper 2, Inquiry into child development services: Potential questions, tabled by CAHS during hearing held 28 November 2022, p 7.

335 Dr Y Anderson, Associate Professor, Community Child Health, Curtin University, [*transcript of evidence], Legislative Council,* 12 May 2023, p 5.

336 Dr B Jongeling, Medical Head of Department, Child Development Service, CAHS, [*transcript of evidence*]*, Legislative Council,* 26 April 2023, p 11.

337 F Austin, Child Health Nurse, Derby Aboriginal Health Service, [*transcript of evidence*], *Legislative Council,* 2 May 2023, pp 5–6.

- coordinating matters relating to the facility management or information and communication technologies
- completing staff recruitment and employment contract paperwork
- paperwork for new staff, such as arranging computer access
- site orientation for new staff
- mandatory workplace hazard inspections
- monitoring clinical resource consumable levels, such as test forms, and arranging reordering
- follow up with families that either have not responded to an appointment offer or need to reschedule an appointment
- coordinating the collection of questionnaire information from families.[338]

4.52 Further questioning by the Committee revealed that in some cases, particularly at smaller sites,[339] there are no administrative staff on site:

> **Ms KIELY**: … We do have sites where there are no admin staff onsite, so the clinical staff there are managing that site, including, if something were to go wrong, making sure that the facility's management team, which we do have in CAHS, is notified of it. They provide a great service to us, but they cannot be across all of our 160 sites in person; some of that needs to be managed at the site. Obviously, when things do go wrong or if there are power outages, which occur quite regularly, there are clinical implications in terms of rescheduling appointments and accessing client lists to get phone numbers. We do have clinical staff performing those functions if they happen, as an ad hoc –
>
> **The CHAIR**: If I am working as an OT, say, for CDS, I might arrive at a facility and find that there is a burst water pipe. Would I then have to go and notify your building managers?
>
> **Ms KIELY**: The building managers will come in and manage the building part of it. They will not be on site. We will need to notify them so that they can provide the appropriate support. Then there is work that needs to be done to let all of the people booked in that day know what has happened and maybe divert some appointments to other clinics.
>
> **The CHAIR**: And that would be the clinician who would have to do that?
>
> **Ms KIELY**: The clinicians will be part of that. They might not do all the ringing around but they will certainly need to access the client records and get that information and make sure that if there is capacity in another site, which there might be for a few hours or they might be going home, which appointments are appropriate to be telehealth and which appointments need to be cancelled and rescheduled. There does need to be some clinical input into that.
>
> **The CHAIR**: Would I be jumping to unwarranted conclusions if I said that is one of the reasons why we should have fewer sites?
>
> **Ms KIELY**: If the sites are purpose built for child development services, yes, fewer sites.

338 Tabled Paper 2 tabled by Dr DJ Russell-Weisz, Director General, DOH, during hearing held 28 November 2022, p 10.

339 Tabled Paper 2 tabled during hearing held 28 November 2022, p 10.

...

Ms TURNELL: That is absolutely one of the benefits of working towards a hub model for all community-based services for CAHS as a whole not just child development services. I will say that from the facilities side of things we have tried quite hard, and our admin team has been great, at trying to shift that over time and take more responsibility around taking a lead in liaising with the facilities team. But it is the small kind of everyday things that if we had more administrative time, would release clinicians to be focused purely on what they do. From an IT perspective, I think about examples as simple as if you are running a group program and you need to set up the technology in the room to run the videos that you are playing to parents, an admin person could go and set up that technology and have it ready to go so that as a clinician you are doing everything that you need to clinically up to the point you walk into the room and deliver the service to families and just press play. Those types of small things add up over time and would create more capacity and efficiency within the clinical setting.[340]

Clinical supports

4.53 On the matter of better clinical supports for CDS practitioners, the Committee received the following evidence:

> Opportunity exists for [CAHS–] CDS to continue to explore flexibility in its workforce models in order to meet the needs of children, young people and their families.[341]
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> ▫▫▫
>
> we need to be innovative and look at ways in which we can address the current issues and redesign our services in a way that we can be sustainable for the next decade.[342]
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> ▫▫▫
>
> I think that demand will always outstrip supply in this area, so we need to think about new structures through which we value and prize our allied health and medical professionals for more complex cases, but actually look at different workforces to get prompt access to those early supports.[343]
>
> ▫▫▫
>
> I would argue that we need to be more creative. We are in an environment where we are not going to get the specialists. We cannot suddenly train a whole lot of people. Even to train nursing staff would take some time. But you need to be more efficient and less resource intensive with the way you manage children. I would argue that there has not been much change for all the time–I have been a paediatrician for over 25 years.[344]
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340 Hon Dr Sally Talbot MLC, Chair; and S Kiely, Executive Director, Community Health, CAHS; and A Turnell, Acting Director, Clinical Services, Child Development Service, CAHS, [*transcript of evidence*], *Legislative Council*, 26 April 2023, pp 28–29.

341 Submission 77 from WA Health, 9 November 2022, p 6.

342 S Kiely, Executive Director, Community Health, CAHS, [*transcript of evidence*], *Legislative Council*, 26 April 2023, p 4.

343 Prof A Whitehouse, Bennett Professor of Autism Research, Telethon Kids Institute, [*transcript of evidence*], *Legislative Council*, 9 February 2023, p 10.

344 Private citizen, paediatrician, [*private transcript of evidence*], p 3.

> Clinical service efficiencies can also be gained by expanding allied health assistants and the administrative workforce because these are the workforces that support clinicians.[345]

What improvements can be addressed immediately?

4.54 As indicated at the beginning of this report, the Committee has sought to address the question about what can be done to reduce unacceptable waiting times and expand CDS provision under the heading of 'now for now'. The following section specifically addresses immediate actions that, in the Committee's view, would reduce waiting times, expand services, particularly to children aged seven years and older, and increase CDS facilities.

Increasing resources

Commensurate funding

4.55 In the Committee's opinion, without additional funding, reductions in unacceptable waiting times and an expansion of CDS provision are unlikely. As stated in paragraph 4.36, both CAHS–CDS and WACHS–CDS submitted that they have not had a significant increase in funding since 2010,[346] despite substantial increases in demand for their services. Further evidence received by the Committee from both CDS providers confirmed this.

4.56 CAHS–CDS is totally block funded[347] by the State Government. In considering previous funding amounts, the Committee observed that CAHS–CDS received a substantial increase in funding in the 2010-11 State Budget. These additional funds were allocated over a four-year period and represented a 7.7% increase in 2011-12, 23.8% in 2012-13, and 8.1% in 2013-14. There was also an 8.0% increase in 2014-15. By contrast, in 2020-21, 2021-22, and 2022-23, the increases were only 2.5%, 4.4% and 2.3%, respectively. In 2023-24, the increase is estimated to be only 0.8%.[348]

4.57 The latest funding figures are not commensurate with the fact that the number of referrals to CAHS–CDS has increased by 10.6% between 2020-21 (31,360)[349] and 2022-23 (approximately 34,691) and that most median waiting times are increasing.[350] In the Committee's view, it is clear that the level of financial investment in CAHS–CDS has not been commensurate with the demand for its services.

4.58 WACHS–CDS has a complex funding arrangement, including some block funding from the State Government for CDS provided by allied health practitioners. In the case of paediatricians providing CDS in regional Western Australia, WACHS advised as follows:

> **Ms Miller**: Our child development services do not attract ABF [activity based funding], but our paediatrician services do. That is just another avenue of revenue coming in.

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345 S Kiely, Executive Director, Community Health, CAHS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 4.

346 $49.7 million over four years: see paragraph 4.75 of this report.

347 Block funding is 'a budget allocation to a particular area. It [block funding] includes the FTE [full-time equivalent staffing] and other goods and services. It has pretty well been determined by the historical cost to provide a service … It is allocated annually, with CPI [Consumer Price Index] increases': K Miller, Director, Population Health, WACHS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 18.

348 Submission 77 from WA Health, 9 November 2022, p 46; Answer to question without notice 137, Legislative Council, *Debates*, 2023, pp 567–568; Hon A Sanderson MLA, Minister for Health, Answer to question on notice B6 from Hon D Faragher MLC, asked at 2023-24 Budget Estimates hearing held 27 June 2023, dated 3 August 2023, p 2; and email from CAHS, 23 October 2023, Attachment 1.

349 Tabled Paper 1 tabled by CAHS and WACHS during hearing held 26 April 2023, p 1.

350 CAHS, *Annual report 2022-23*, CAHS, 2023, accessed 16 October 2023, p 82.

> **The CHAIR**: Paediatricians working in hospitals?
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> **Ms MILLER**: Yes, for paediatric services [in hospital]. Rural Health West is a funding provider for outreach services to country WA. They fund a range of services, many of which are medical services, but there are also some allied health services in there. It provides the costs of covering a regional site visit; for example, a paediatrician provides visits to Laverton and Leonora four times a year …

4.59 On any given day, WACHS paediatricians may provide both medical services and developmental services (CDS), whether they are working in a hospital or at an outreach clinic. Currently, WACHS cannot readily produce costing data on how much time its paediatricians allocate to CDS.[351]

4.60 Similarly to CAHS–CDS, the Committee observed that WACHS–CDS received a substantial increase in funding in the 2010-11 State Budget, allocated over a four-year period. In 2011-12, 2012-13 and 2013-14, the increases were 57%, 36% and 26%, respectively. The yearly funding increases since that time have mainly fluctuated between 1% and 3%, except in 2014-15, when it decreased by 5%.

4.61 WACHS–CDS's Community Health Information System has only been operational in all seven regions since the end of June 2019. This system cannot provide comprehensive referral figures because different systems are still used to enter referrals. However, this system still provides an indicator of trends. For example, the number of referrals rose by 13.8% from 2019-20 (13,478) to 2020-21 (15,336).[352] Although, the number of referrals for 2021-22 (13,480)[353] appears to have fallen, the Committee noted that these figures are unreliable because the manual reporting of these numbers during the second quarter of that financial year was 'de-prioritised due to the COVID-19 pandemic response.'[354] WACHS–CDS anticipates referrals will increase in future.[355]

4.62 Notwithstanding reporting anomalies, given that the median waiting times for most of WACHS–CDS's services are increasing (see Finding 2 on page 53), the Committee is of the view that the level of financial investment in WACHS–CDS has not been commensurate with the demand for its services.

4.63 A need for increased funding for CDS has been a general and consistent underlying theme throughout the Inquiry. It was explicitly supported by the evidence and WA Health's own submission.[356] Some of that evidence includes the following:

> With all that we know about the benefits of early intervention, the difficulties children and families have and are still experiencing when trying to access child development services are untenable. The benefits of investing early in child health is conclusive, and there is increasing urgency for resources in this area.
>
> It is therefore once again the recommendation of this office [Commissioner for Children and Young People] that the State Government make available the funding required to enable vulnerable children across Western Australia to access child

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351 Letter from J Moffet, Chief Executive, WACHS, 25 October 2023, p 2.

352 Tabled Paper 1 tabled by CAHS and WACHS during hearing held 26 April 2023, p 2.

353 Tabled Paper 1 tabled hearing held 26 April 2023, p 2.

354 Submission 77 from WA Health, 9 November 2022, p 64.

355 Submission 77, p 63.

356 For example, Submission 16 from Mental Health Public Health and Dental Services, North Metropolitan Health Service, 19 October 2022, pp 1, 2 and 3; Submission 60 from CCYP, 25 October 2022, p 4; Submission 76 from Pilbara Aboriginal Health Alliance, 8 November 2022, pp 4 and 7; Submission 78 from Western Australian Primary Principals' Association, 10 November 2022, p 4; and Submission 82 from Australian Medical Association (WA), 11 November 2022, pp 2, 5 and 6.

development assessments, interventions and supports they need, and to ensure these children receive services at the point they will have the greatest impact on their long-term development, health and wellbeing.[357]

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[The Pilbara Aboriginal Health Alliance recommends, among other things] Recognition and prioritisation of ongoing and increased funding to support child development services across the Pilbara region. The reliance on multiple funding sources, compounded with workforce difficulties and lack of timely access and service availability negatively impacts children and families who are experiencing lengthy wait times for limited diagnostic assessments and follow up treatment.[358]

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The AMA (WA) notes that a large number of responses [from its members] highlighted the lack of required service funding, the need to urgently increase FTE [full time equivalent positions] and commitment to support the current workforce through further engagement and resource provision.[359]

FINDING 7

Without additional funding for the Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service, significant reductions in waiting times and expansion of service provision, particularly to children aged seven years and older, are unlikely.

FINDING 8

Since its last major uplift in 2010-11 to 2014-15, state government funding for child development services delivered by the Child and Adolescent Health Service–Child Development Service has not been commensurate with demand for these services.

FINDING 9

Since its last major uplift in 2010-11 to 2013-14, state government funding for child development services delivered by the WA Country Health Service–Child Development Service has not been commensurate with demand for these services.

Will increased resources be used effectively?

4.64 CAHS–CDS informed the Committee that it had on three occasions applied unsuccessfully for funding increases in 2021-22 and 2022-23. When a significant funding increase was not approved in 2021-22, CAHS internally reallocated $2.5 million of its approved budget to CAHS–CDS to increase some full time equivalent (FTE) positions across its CDS disciplines, including the doubling of the number of paediatric positions available.[360]

4.65 With respect to the unsuccessful applications for additional funding in 2022-23, WA Health referenced the:

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357 Submission 60 from CCYP, 25 October 2022, p 4.

358 Submission 76 from Pilbara Aboriginal Health Alliance, 8 November 2022, p 7.

359 Submission 82 from Australian Medical Association (WA), 11 November 2022, p 6.

360 Submission 77 from WA Health, 9 November 2022, p 46; and A Turnell, Acting Director, Clinical Services, Child Development Service, CAHS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 19.

- 2022-23 midyear review (released in December 2022) – the aim of this funding submission was to increase the workforce associated with CAHS–CDS's longest waiting times, paediatrician and ASD assessment services.
- 2023-24 State Budget (released in May 2023) – this funding submission addressed all of CAHS–CDS's needs 'going forward', including reducing waiting times for all disciplines.[361]

4.66 In response to questions about the allocation of additional funding to CAHS–CDS, the Government has made it clear on several recent occasions that it is waiting for the results of the Select Committee's consideration of the issues around CAHS–CDS and WACHS–CDS service delivery to guide its decision making about resourcing the CDS system into the future.

4.67 A minority of the Committee, comprising of Hon Donna Faragher MLC, is of the strong view that the Government already has sufficient information to increase funding outside of the Committee process.

4.68 Notwithstanding this concern, the Committee unanimously made a commitment to rigorously examine the extensive amount of evidence presented to it by a wide range of stakeholders, including clinical and non-clinical practitioners, academics, parents and service deliverers. The Committee tested the soundness of each and every proposition contained in, and arising from, this evidence. The Committee intends for the content of this report and the final report to furnish the Government with the guidance it is seeking.

Recruiting more staff

4.69 Through the extensive questioning of CAHS, the Committee explored the assumptions underpinning the 2023-24 State Budget submission. CAHS advised that it predicted that the employment of a further:

- 74.3 permanent FTE clinicians
- 15.3 temporary FTE clinicians
- 39.3 permanent administrative FTE,

would have resulted in reduced median waiting times to the target of six months or less for each discipline, within the first two years of the increased resourcing. The modelling took account of:

- the number of children already waiting for services
- the predicted future referral numbers for each discipline
- caseload management trends for each discipline,

and made the following assumptions:

- increased nursing and allied health involvement in managing referrals for paediatrician services
- an increase in allied health assistant and administrative support across the service
- the introduction of additional FTE from the outset of the 2023-24 financial year.[362]

4.70 The Committee understands that CAHS–CDS's 2023-24 State Budget funding submission also included plans for:

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361 A Turnell, Acting Director, Clinical Services, Child Development Service, CAHS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, pp 20 and 27.

362 Letter from V Jovanovic, Chief Executive, CAHS, 28 June 2023, pp 1–2.

- additional facilities to place the extra staff in the immediate to short-term future (in four strategically-located corridors, separate to the community hubs being built in Murdoch and Midland)
- more cultural engagement officers, including Aboriginal health workers
- the creation of new positions to improve service navigation for clients
- the creation of a new temporary role to investigate opportunities for greater collaboration with the DOE
- more clinical psychologists to work with children from the age of seven years
- technological upgrades, including online child development information and parent education and upgraded SMS appointment reminders.[363]

4.71 The Committee has not been privy to the business cases prepared by CAHS–CDS, nor the detailed modelling underpinning these cases. The Committee sought access to this material but CAHS–CDS did not provide it on the basis of Cabinet-in-confidence. However, the Committee is persuaded by the evidence that CAHS–CDS did provide in relation to these matters and is satisfied that an increase in financial provisions relating to:

- additional staff (clinical and non-clinical)
- expanded and improved facilities (building and information technology),

will have the desired effect of reducing unacceptable waiting times and expanding CAHS-CDS service provision.

4.72 In reaching this view, the Committee has paid particularly close attention to the employment predictions made in the CAHS modelling, particularly in the light of evidence presented at the end of 2022 by CAHS that it was experiencing difficulties similar to other sectors of the economy in attracting staff to fill vacant positions.

4.73 More recent evidence provided to the Committee, however, shows there has been a marked improvement in this situation during 2023 (see paragraph 4.45). Further, CAHS–CDS submitted that its experience with previous recruitment drives indicated that, with adequate funding for permanent positions, it would be able to attract additional staff:

> **Ms KIELY**: … If permanent positions are available, we are an attractive workforce. Part of the downside of having lots of part-timers is of course that the burden of managing multiple people is higher, but we are very used to that and we are an attractive employer because we offer that in WA. We have a lot of women of working age who also have young families. I think some of the restraint we have around recruiting if we were to put on additional positions is that they are often very temporary in nature because we do not have the budget to do so, so we do not get people wanting to put children into child care for a three-month contract. However, if we had permanent positions, there is no way we could recruit 70 additional people in a week, but across time, we would be quite successful in doing that because of the conditions.
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> **The CHAIR**: If they were permanent positions?

[363] Various witnesses, Child Development Service, CAHS, [*private transcript of evidence], Legislative Council,* 25 July 2023, pp 22, 23, 25, 26, 28–29, 32 and 37.

> **Ms KIELY**: If they were permanent positions or long-term. We have a really good structure with the numbers that we have here of good management, good collegial support.[364]

4.74 Evidence from WACHS suggests that its CDS workforce could also be bolstered with additional funding for permanent positions:

> it is one of the biggest issues where we have different funding sources. If it is coming in from outside of the block funding, it tends to be time-limited funding, and that has a huge impact on us from a recruitment and retention point of view. We can only contract health professionals for 12 months to two years or three years in some of the funding arrangements at maximum. It is very difficult to get people to move to country WA on such short-term contractual arrangements. That just adds to the burden of recruitment and retention.[365]

FINDING 10

With additional funding for permanent positions, the Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service will be able to increase their respective workforces.

4.75 The Committee noted that the 2010 funding uplift did result in the predicted reduction of waiting times to an acceptable level.[366]

> In 2010, the government did announce a previous uplift to the Child Development Service and the wait times at that time were just as long as they are now but the [CAHS–] Child Development Service with that investment across four years was able to bring down those wait lists. We halved the wait lists at that time with an investment of $49 million, nearly $50 million, over four years. A lot of the clinicians who are here today were part of the service then and we are able to show that we can reduce wait times when we have appropriate investment to meet the rising demand. Unfortunately, we have not had any significant uplifts since 2010, so the wait times have grown again.

The Committee's view, is that there is every reason to expect that if the requested funding uplift was provided now, a similar outcome could be achieved.

4.76 Given the successful halving of waiting lists after the 2010 funding uplift, the Committee is confident that CAHS–CDS has a proven record of effectively using funding uplifts to reduce waiting times.

FINDING 11

The Child and Adolescent Health Service–Child Development Service has a proven record of effectively utilising funding uplifts to reduce waiting times for its services.

4.77 In November 2022, WACHS–CDS advised the Committee that it was conducting an internal review of its services and would be in a better position, by the end of that process, to apprise

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364 Hon Dr Sally Talbot MLC, Chair; and S Kiely, Executive Director, Community Health, CAHS, [*transcript of evidence*], *Legislative Council*, 26 April 2023, p 25.

365 K Miller, Director, Population Health, WACHS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 19.

366 S Kiely, Executive Director, Community Health, CAHS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 4.

the State Government of any changes to its workforce and resourcing needs.[367] On 2 November 2023, the Committee received a copy of the review report in confidence.[368] On 8 November 2023, WACHS also provided the Committee with an overview of its CDS resourcing requirements, with a request that the contents be regarded as private evidence and be held in confidence.[369]

4.78 After considering this recent material, the Committee makes two observations. First, WACHS has identified gaps in its ability to provide CDS in an effective and equitable manner and confirmed, in devising options to address these gaps, that an increase in the number of clinical and non-clinical staff is required. Second, in WACHS's review report and overview of resource requirements, it has demonstrated that, while the challenges of delivering CDS in regional and remote Western Australia are unique, the priorities it has identified in terms of implementing different options are similar to the priorities identified by CAHS–CDS in that they are firmly focused on reducing unacceptable waiting times and expanding CDS provision. The Committee has concluded, therefore, that this recent material does not appear to contain any additional information which would alter the recommendations made in this interim report.

Improving facilities and information technology

4.79 The Committee also scrutinised the assumptions made in the CAHS modelling about the availability of additional facilities in which to accommodate extra staff in the short term. While it is clear that significant planning for the long term is underway, it became increasingly clear to the Committee that options to make better use of existing facilities do exist. One of these options, for which all stakeholders including CAHS expressed enthusiasm, is to build on the constructive partnerships that currently exist between CAHS–CDS and the DOE's Child and Parent Centres. The Committee is working on the assumption that similar opportunities exist for WACHS.

4.80 The Committee notes that in the case of CAHS–CDS, one of the projects awaiting the provision of sufficient funding resources is the investigation of opportunities for greater collaboration between CAHS–CDS and the DOE. The Committee would expect that such collaboration between WACHS–CDS and the DOE would also be considered.

4.81 As for the technology upgrades included in the CAHS–CDS funding submission for the 2023-24 State Budget, the Committee is acutely aware that the timing of the introduction of the comprehensive electronic medical record system is not under the control of CAHS, involving as it does the entire health system in WA. However, it is the Committee's view that measures such as upgrading SMS appointment reminders, which CAHS–CDS has listed as a priority, have the potential to radically improve the accessibility and effectiveness of CDS. Any resources to be directed to this and other measures to improve parent information and education are to be welcomed. In the Committee's view, these improvements would also be of significant benefit to WACHS–CDS. Further, in the case of WACHS–CDS, systems for entering referrals are in need of improvement (for example, refer to paragraphs 3.62 and 4.61).

4.82 Considering the above evidence, the Committee is persuaded that the assumptions underpinning the CAHS–CDS 2023-24 State Budget funding submission are sound.

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367 L Pereira, Manager, Child Development Service, WACHS, [*transcript of evidence], Legislative Council,* 28 November 2022, p 22. See also, K Miller, Director, Population Health, WACHS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, pp 19–20; and Letter from J Moffet, Chief Executive, WACHS, 4 September 2023, p 2.

368 Letter from J Moffet, Chief Executive, WACHS, 25 October 2023, p 2.

369 Letter from J Moffet, Chief Executive, WACHS, 7 November 2023, p 1.

FINDING 12

The assumptions underpinning the Child and Adolescent Health Service–Child Development Service's 2023-24 State Budget funding submission are sound.

Recommendations

Free and publicly funded child development services

4.83 While the evidence established overwhelming support for the option of providing a funding uplift, it became obvious to the Committee that this evidence was firmly grounded in the view that CDS should continue to be provided as free, publicly funded services in Western Australia. That is the conclusion endorsed by the Committee. The alternative to maintaining free, publicly funded CDS would involve, at least to some degree, one or more of the following options:

- privatisation of CDS
- a restriction of eligibility to exclude certain conditions
- a contraction of service provision.

Any such option would not be acceptable in light of the clear evidence that there is strong support amongst all stakeholders for Western Australia's publicly delivered CDS, which have been envied by other jurisdictions.

RECOMMENDATION 1

The child development services provided by the Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service continue to be free and publicly funded.

Reduction in waiting times and expansion of child development service provision

4.84 As noted earlier (see Finding 7 on page 76), without additional funding, significant reductions in unacceptable waiting times and an expansion of CDS provision, particularly to children aged seven years and older, are unlikely. Therefore, a majority of the Committee, comprising Hons Dr Sally Talbot and Samantha Rowe MLCs, makes Recommendation 2.

RECOMMENDATION 2

The State Government immediately consider providing the Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service the funding increase required to:

a) recruit more clinical staff

b) recruit more non-clinical staff

c) expand and improve building and information technology facilities,

in order to reduce unacceptable waiting times and expand the provision of services, particularly to children aged seven years and older.

4.85 A minority of the Committee, compromising Hon Donna Faragher MLC, is of the strong view that the need to reduce unacceptably long waiting times and expand provision of CDS, particularly to children aged seven years and older, is urgent. Therefore, the Member makes the following recommendation:

Minority Recommendation

The State Government immediately provide the Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service the substantial funding increase required to:

a) recruit more clinical staff

b) recruit more non-clinical staff

c) expand and improve building and information technology facilities,

in order to reduce the unacceptably long waiting times and expand the provision of services, particularly to children aged seven years and older, and that this funding increase be provided no later than the 2024-25 State Budget.

4.86 Based on the findings in this report and the evidence received, all Members are of the opinion that if the State Government provides the funding increase required, it can be confident that waiting times will reduce and the provision of CDS can be expanded.

Monitoring improvements

4.87 The Committee has interrogated the evidence to ensure that any additional funds allocated to CAHS–CDS and WACHS–CDS can be monitored against and linked to outcomes associated with particular priorities. In the case of this report, those priorities are the reduction of unacceptable waiting times and the expansion of CDS provision. While it is beyond the scope or capacity of this inquiry to describe exactly how such a link might be established, there are two particular areas of information and guidance which are, in the Committee's view, of central importance.

4.88 The first is that if waiting times are to be effectively reduced, access to high quality, comprehensive data will be essential. As noted earlier (see paragraph 4.15), it is the unique structure of CAHS–CDS, as a single provider of CDS in the metropolitan area, and its bespoke but outdated CDIS, that allows it to produce data, such as waiting times, readily. As the primary funder of CAHS–CDS, the Government can be confident that the existence of such rigorous data collection systems will ensure that action to reduce waiting times can be closely monitored over the course of the Budget cycle, thereby strengthening CAHS–CDS's resources to reduce the burden of developmental delay on children and families in the metropolitan area and continuing to build on the firm foundations already in place.

4.89 In the case of WACHS–CDS, while the production of data is not as readily obtained across the regions, it nonetheless is able to produce detailed information about waiting times across the disciplines. This capability could be improved and utilised to monitor the effectiveness of additional funding on reducing waiting lists.

4.90 The second is that CAHS–CDS has already made a solid link between the expansion of its service provision and the guidance provided by the Sustainable Health Review about reorienting services provision away from 'profession-based approaches' towards community health needs. As the WA Health submission noted:

> The Sustainable Health Review identifies the need to evaluate workforce roles and scope of practice based on community health needs and interdisciplinary models

> of care, rather than only profession-based approaches.[370] It also identifies the need to expand workforce models that support working to full scope of practice, including nurse practitioners.[371] **The current issues with workforce availability provides an opportunity for [CAHS–] CDS to review and reshape the current workforce mix to fill the gaps where vacancies exist and to better meet the needs of clients.** Multidisciplinary teamwork lends itself to a workforce model that includes a wider range of health care professionals who are able to work in ways that support each other. For example, nurse supported paediatrician appointments; non-specified allied health provision of transdisciplinary programs; or varied workforce models for psychosocial support.[372] (emphasis added)

4.91 The Committee's recommendation is that these two elements establish a framework for monitoring the expenditure of funds by the two CDS providers to ensure that they meet the priorities identified in this report, which the Committee is suggesting be adopted by the Government.

RECOMMENDATION 3

The State Government monitor the effectiveness of its funding of the Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service against the length of the median waiting times (to ensure that the waiting times are reduced and maintained at an acceptable level) using a framework based on existing data collection systems and a measure of community health needs.

4.92 If the Government implements the recommendations from this interim report, the Committee expects that CAHS–CDS and WACHS–CDS will undertake concurrent planning to address their future needs. This will be the subject of the Committee's final report, as outlined in the next chapter.

370 DOH, *Sustainable Health Review Final report to the Western Australian Government*, DOH, 2019, accessed 31 October 2023, p 104, recommendation 25.

371 DOH, *Sustainable Health Review Final report to the Western Australian Government*, recommendation 25.

372 Submission 77 from WA Health, 9 November 2022, p 47.

CHAPTER 5
Addressing other areas for improvement

Chapter summary

5.1 This chapter outlines the priority areas that will be addressed in the Committee's final report.

The final report

5.2 While increased funding is a necessary first step to reducing unacceptable waiting times and expanding CDS provision, the Committee acknowledges that this alone will not be sufficient to ensure that the CDS system is accessible and sustainable. The final report will consider and make recommendations on other strategies to make these improvements.

5.3 Many of the other suggestions made in this Inquiry to improve the CDS system are what Dr Yvonne Anderson described as 'now for later'[373] strategies. The timeframe for implementing these innovations will vary. The Committee received evidence that a variety of innovative practices are currently in development and in some cases, could be implemented very soon, contingent upon funding. Others may take longer to investigate and implement.

5.4 Having identified several issues affecting CDS accessibility and sustainability in this interim report (see paragraphs 4.34 to 4.53), the Committee's final report will examine the following additional issues.

Collaboration and integration of services

5.5 The continuum of child development means that a range of health and social services play a role in identifying issues and ensuring timely intervention.

> The challenge with things like neurodevelopmental development and behaviour is that they cross across from that early identification with either a child health nurse, an early childhood educator, a parent or a caregiver recognising that there is an issue, right across all of these services.[374]

5.6 Improved coordination and integration of services is needed to support early intervention:

- System wide collaboration must be supported by government policy:

> Policy frameworks will need to support and facilitate collaboration between services …[375]

▫▫▫

> It is no good having all of these disparate services arguing and handballing to each other.[376]

- Although child health nurses are not part of CAHS–CDS or WACHS–CDS, they play an important role in the early identification of issues. Attendance at the 12-month and two-year scheduled child health checks is currently low and needs to be improved (in

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373 Dr Y Anderson, Associate Professor, Community Child Health, Curtin University, [*transcript of evidence*], *Legislative Council,* 12 May 2023, p 4. See also, paragraph 1.4 of this report.

374 Dr Y Anderson, [*transcript of evidence*], 12 May 2023, p 8.

375 Submission 16 from Neurosciences Unit, North Metropolitan Health Service – Mental Health, Public Health and Dental Services, 13 October 2022, p 3.

376 Dr M Parker, Neurodevelopmental Paediatrician, [*transcript of evidence], Legislative Council,* 26 April 2023, p 11.

2021-22, the respective rates were 43% and 32% of eligible children in the Perth metropolitan area,[377] and 64% and 42% in regional Western Australia[378]):

> Community child health nurses play a critical role in the early identification of emerging developmental difficulties, however the number of families attending the 12 month and 2-year-old child health checks is currently low.[379]

- An increase in the child health workforce is necessary to strengthen prevention and early identification efforts:

> a commensurate increase in the child health nurse workforce [is needed] to deliver these checks and to actively reach out to families with risk factors that may increase a child's likelihood of experiencing adverse health outcomes.[380]

- Extending cooperative partnerships and information sharing with other health providers will improve early identification and intervention services:

> Working with referrers to increase the proportion of referrals in the 0 to 4 year range is an area of focus for [CAHS–] CDS over the next 12 months.[381]
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>
> Consider opportunities to improve co-prescribing arrangements with general practitioners (GPs), including through investment in GP education, targeted amendments to the Schedule 8 Medicines Prescribing Code, and establishment of standards in reciprocal information sharing between co-prescribing practitioners.[382]

- The need for better collaboration with schools is recognised by a range of stakeholders:[383]

> With additional resourcing, opportunities exist to work collaboratively with the Department of Education and their specialist support services (School of Special Educational Needs; Statewide School Psychology Service; Statewide Speech and Language Service)[[384]] in building teacher capacity and working together with families to plan for and manage the needs of individual children and young people.[385]
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> What came out of the infant, child and adolescent task force about discrete services lacking cohesion, coordination and population at individual levels, I think that goes for child development services as well. To work in with the main players in terms of parents and schools, if we can even increase that coordination and …

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377 Submission 77 from WA Health, 9 November 2022, p 22.

378 Tabled Paper 1 tabled by CAHS and WACHS during hearing held 26 April 2023, p 8.

379 Submission 77 from WA Health, 9 November 2022, p 6.

380 Submission 77, p 7.

381 Submission 77, p 27.

382 Submission 77, p 7.

383 This issue featured in CAHS–CDS's 2023-24 State Budget funding submission (see paragraph 4.70 of this report).

384 See paragraphs 3.99 to 3.107 of this report.

385 Submission 77 from WA Health, 9 November 2022, p 7.

> case management, I think there are some real efficiencies that can be gained in that space.[386]
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> We cannot look at health services in isolation. As my education colleagues have often said to me, "Why does health split children into mental health and physical health, and all these boxes, when education sees the whole child?"[387]

- Navigation of the system is difficult with service delivery not well coordinated between government agencies:

  > There continues to be a lack of coordination in service delivery by Government departments that contributes to children and families "falling through the cracks", with parents having to navigate how to access services in different agencies that makes little sense to those external to Government.[388]

- Families are not aware of the many different government and non-government programs and services options that may be available to them:

  > Further, the myriad of funding programs and support services designed and delivered by different agencies that seem to have no connection to each other contribute to the chaotic and unconnected services in child development.[389]

- Fragmented service delivery results in lost opportunities to engage vulnerable groups:

  > It is also important that services not only be accessible for those able to proactively reach out to see them, but that the services are talking to each other in a way that maximises the likelihood that the appropriate provider will find their way to that child and family.[390]

Access, engagement and equity

5.7 Evidence indicates that there needs to be more focus on delivery of client-centred, accessible and equitable child development services for children of all ages, with families of children aged seven years and older finding access particularly difficult (see paragraphs 4.28 to 4.33). Stakeholders raised the need for the following changes:

- Service delivery that is client centred:

  > I think what a lot of our services do at the moment is that they are created really for producer convenience, not consumer convenience …These are not hard-to-reach people; our services are hard to reach.[391]

- There should be a 'no wrong door' approach which would ensure that parents can obtain the information and services they need:

  > We know that parents need better pathways to navigate how to access services when searching for advice and support. This is another way in which improved

386 T Wong, Child Safe Lead, Catholic Education Western Australia, [*transcript of evidence], Legislative Council,* 20 February 2023, pp 10–11.

387 Dr Y Anderson, Associate Professor, Community Child Health, Curtin University, [*transcript of evidence], Legislative Council,* 12 May 2023, pp 5–6.

388 Submission 85 from Telethon Kids Institute, 18 November 2022, p 5.

389 Submission 85, p 5.

390 Submission 85, p 5.

391 Hon J Weatherill, Director, Thrive by Five, Minderoo Foundation, [*transcript of evidence], Legislative Council,* 9 February 2023, p 6.

collaboration can occur – so that regardless of which "front door" a parent goes through, there should be consistent and quality advice and information on how to access services.[392]

- Improved online services to help parents access reliable information and manage appointments:

  An online booking system, integrated within and enabled alongside the Community Care EMR, will allow access to real time bookings for families and will improve client engagement with the service. In addition, when funded, client portals (integrated in the EMR) will provide the ability for families and clinicians to securely communicate, track progress, and share curated information about clinical issues. This would also reduce the administrative burden on staff and empower families to actively engage in driving their child's care.[393]

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  Support delivery of more online child development information/education through a range of contemporary platforms for all parents, and specifically for parents of children and young people with developmental delay, complex neurodevelopmental disorders, and those with co-morbid mental health issues.[394]

- More help for families navigating a complex system of interrelated health, education and social services:[395]

  They can be overly bureaucratic in terms of the processes and time delays involved and challenging for parents from different cultural backgrounds to engage with.[396]

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  Invest in positions to explicitly support service navigation for families with complex social issues.[397]

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  Invest in … transition coordinator positions to support families transitioning from the CDS to the National Disability Insurance Scheme (NDIS) or to adult services.[398]

- Equitable access to services:

  Currently, the service model is disadvantaging all families, but in particular, rural, remote and lower SES [socio-economic status] families.[399]

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  CAHS has a Statewide service delivery model but a child living in a rural or remote community has a much more complex pathway to services than one living in urban

392 Submission 85 from Telethon Kids Institute, 18 November 2022, p 5.

393 Submission 77 from WA Health, 9 November 2022, p 58.

394 Submission 77, p 7. This issue featured in CAHS–CDS's 2023-24 State Budget funding submission (see paragraph 4.70 of this report).

395 This issue featured in CAHS–CDS's 2023-24 State Budget funding submission (see paragraph 4.70 of this report).

396 Submission 37 from CEWA, 24 October 2022, p 1.

397 Submission 77 from WA Health, 9 November 2022, p 7.

398 Submission 77, p 7.

399 Private citizen, paediatrician, [*private transcript of evidence*], p 1.

areas. Early intervention opportunities are available, but it is challenging for families to have access or be aware of relevant programs.[400]

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there is considerable variation in service models across country WA, which contributes to families having reduced access to early intervention and support services. This relative disadvantage is evident with less access to health professionals, increased distances to travel to services, exclusive reliance on visiting professionals (in-reach models), limited access to transport, childcare and respite services. The barriers to accessing services increase as communities become more geographically remote.[401]

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Families who do not have access to personal transport face additional hardships.[402]

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Access to paediatricians is highly variable across WACHS, both within and between regions and is dependent on historical funding and service arrangements. For example, some communities have no local access to a paediatrician.[403]

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This is particularly the case for Aboriginal children living in regional and remote locations, who are often the most vulnerable and in need, but are not provided with the same access to CDS as those living in the metropolitan area.[404]

- Access to culturally safe services for Aboriginal clients:

  Aboriginal clients are still more likely to never take up an offer of a CDS service than non-Aboriginal clients and further work needs to be done to ensure services offered by the CDS are culturally secure and meet the needs of the family.[405]

- Services which are responsive to the needs of culturally and linguistically diverse families:

  accessing child development services means turning up for appointments and responding to communication, and that does not always go smoothly for our culturally and linguistically diverse families, even with the support of the school.[406]

- More services that are community based or combined in an accessible, appropriate and safe centre:

  I do not feel we have good functioning hubs.[407]

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400 Submission 85 from Telethon Kids Institute, 18 November 2022, p 3.

401 Submission 77 from WA Health, 9 November 2022, p 62.

402 Submission 77, p 64.

403 Submission 77, p 64.

404 Submission 85 from Telethon Kids Institute, 18 November 2022, p 3.

405 Submission 77 from WA Health, 9 November 2022, p 45. This issue featured in CAHS–CDS's 2023-24 State Budget funding submission (see paragraph 4.70 of this report).

406 T Wong, Child Safe Lead, Catholic Education Western Australia, [*transcript of evidence], Legislative Council,* 20 February 2023, p 5.

407 Private citizen, paediatrician, [*private transcript of evidence*], p 5.

> There has got to be more connection with community …[408]
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> WACHS CDS are delivered from a range of facilities. Many are located on hospital sites rather than being part of the local community, which potentially influences a family's decision to access services (e.g. due to stigma, fear or even pragmatic issues such as the challenges of parking with children and prams/wheelchairs).[409]
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> WACHS CDS facilities are not purpose built for children or families and space is at a premium, which impacts on service delivery capacity and can impede appropriate models of care. In addition, families who have children with multiple complex needs, need to attend different locations to receive their services, as CDS are not co-located with other early years providers.[410]

Workforce practice and development

5.8 Stakeholders raised issues relating to recruitment difficulties, workforce models and training pathways. These issues are distinct from the Committee's discussion about the requirement for funding of additional positions (see paragraphs 4.55 to 4.78).

5.9 As previously identified in this interim report:

- CAHS–CDS and WACHS–CDS have, at times, experienced recruitment difficulties (see paragraphs 4.44 to 4.46)
- challenges in recruiting and retaining the CDS workforce have been exacerbated by competition for staff from the NDIS (see paragraph 4.42), especially for WACHS
- changes to work practices and workforce models are needed to improve the efficiency and responsiveness of CAHS–CDS and WACHS–CDS in meeting current challenges (refer to paragraphs 4.50 to 4.53).

5.10 Ongoing issues for further consideration in the final report include:

- A shortage in the number of people who are qualified to be recruited as child development service providers:

  > I think that there is definitely a supply-demand imbalance.[411]
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  > An increase in the available workforce [for recruitment] is needed to ensure vacancies can be filled and services can be provided.[412]
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  > Increasing university places is one strategy to boost the potential workforce. It is acknowledged that there is a need for enhancing collaborative partnerships

[408] Dr E Green, Paediatrician, Southern Paediatrics, [*transcript of evidence], Legislative Council,* 17 February 2023, p 4.

[409] Submission 77 from WA Health, 9 November 2022, p 68.

[410] Submission 77, p 68.

[411] Prof A Whitehouse, Bennett Professor of Autism Research, Telethon Kids Institute, [*transcript of evidence*], *Legislative Council,* 9 February 2023, p 10.

[412] Submission 77 from WA Health, 9 November 2022, p 8.

> between health and higher education sectors to strengthen clinical placement opportunities.[413]
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> It is surprising and sad that Western Australia has only one STP [the Commonwealth Government's specialist training program]-funded CCH [community child health] position [for paediatric trainees] …
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> …
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> In Western Australia, there are eight general paediatric STP-funded positions and one CCH-funded position by STP …[414]
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> There must be sufficient places through training institutions to support a sufficient workforce, including medical, nursing and allied health staff … Across the country, a number of neuropsychology training courses have closed over recent years, and current courses are under threat.[415]
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> The private/non-profit disability space (NDIS funded and privately funded)[[416]] is currently experiencing shortfalls in allied health staffing across Australia which has been projected to be an ongoing problem … Given CDS will need to essentially compete for allied health professionals, a stronger connection between training colleges and universities should be established to ensure a sufficient workforce, particularly for allied health.[417]

- Barriers to rural student placements can have an impact on future recruitment to regional areas:

  > WACHS regularly hosts student clinical placements as a means of exposing students to rural and remote practice, which has shown some translation to students deciding to work in country WA. This is a critical recruitment strategy for WACHS. Despite support being on offer, barriers remain for students undertaking rural student placements, including access to accommodation and the cost of living to the student whilst on placement, such as travel costs to the placement site.[418]

Leadership, planning and innovation

5.11 Stakeholders emphasised the importance of leadership in supporting innovation and organisational reform. For example:

> In terms of the challenges of innovation in a fiscally constrained healthcare environment, for health systems to innovate from within, there needs to be

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413 Submission 77 from WA Health, 9 November 2022, p 70.

414 Prof N Kapur, President, Paediatrics and Child Health Division, Royal Australasian College of Physicians, [*transcript of evidence], Legislative Council,* 17 May 2023, p 7.

415 Submission 16 from Neurosciences Unit, North Metropolitan Health Service – Mental Health, Public Health and Dental Services, 13 October 2022, p 2.

416 Refer to paragraphs 3.79 to 3.124 of this report.

417 Submission 16 from Neurosciences Unit, North Metropolitan Health Service – Mental Health, Public Health and Dental Services, 13 October 2022, p 2.

418 Submission 77 from WA Health, 9 November 2022, p 70.

> support, mandate and dedicated resource to ensure this work can occur alongside operational business as usual.[419]

5.12 CAHS–CDS's work model is seen by some as having remained stationary despite an increasingly demanding and complex operating environment:

> There are inefficiencies within the system. I would say that the system, although it used to be internationally recognised as the model of care, has not moved on for years. It is more like a dinosaur rather than something that we can create where people will look up to us and recognise that we can move forward with how we look after our children.[420]
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> It is not efficient. I think there are elements in the system that strive for efficiency, but they find that very difficult.[421]

5.13 A dedicated leadership position or ministerial portfolio for children was suggested:

> Who is accountable for zero to five? Nobody, actually, really is. There is no one agency and no one level of government that says, "We are responsible for zero to five."[422]
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> There is no clear commitment to prevention and early identification and intervention most of which should be happening well prior to school entry. There is no doubt that the introduction of the NDIS has complicated the situation with its creation of new markets and encouraging of certain activities over others. However, the absence of a clear State based framework contributes to ongoing confusion about responsibilities and direction.
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> …
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> … the fact remains that we as a State do not appear to have any identifiable aspirations in relation to child development services. Similarly, we do not appear to have a framework or plan by which we can assess need, budget for services (even at the basic levels of population growth) or measure outcomes.[423]

5.14 Research is a critical element within the system so that models of care and preventative efforts are continuously improved:

> An important point to mention is that currently there is an increase in childhood referrals for neurodevelopmental disorders and the severity is increasing. I would strongly advocate the need to increase research capacity to look at prevention and symptom reduction in the field. It is important that Government and non-Government organisations provide support for good research that looks at the environmental risk factors and early markers of disease in order that the trajectory can be altered requiring less services.[424]

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419 Dr Y Anderson, Associate Professor, Community Child Health, Curtin University, [*transcript of evidence], Legislative Council,* 12 May 2023, p 5.

420 Private citizen, paediatrician, [*private transcript of evidence*], p 2.

421 Dr M Parker, Neurodevelopmental Paediatrician, [*transcript of evidence], Legislative Council,* 26 April 2023, p 13.

422 Hon J Weatherill, Director, Thrive by Five, Minderoo Foundation, [*transcript of evidence], Legislative Council,* 9 February 2023, p 5.

423 Submission 48 from Playgroup WA, 24 October 2022, pp 3 and 5.

424 Submission 28 from private citizen, paediatrician, 22 October 2022, p 3.

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> Facilitating clinician involvement in research not only supports high-quality translational research that has benefits for children, young people and families, but also supports retention of staff interested in a research career.[425]

Conclusion

5.15 The Committee reiterates that the recommendations made in this interim report and the recommendations that will be made in the final report are of equal weight.

5.16 In addressing the 'now for now', this interim report presents what a majority of the Committee, comprising Hons Dr Sally Talbot and Samantha Rowe MLCs, considers to be a compelling case for the State Government to immediately consider providing the funding increase to CAHS–CDS and WACHS–CDS required to reduce unacceptable waiting times and expand CDS provision, particularly to children aged seven years and older.

5.17 A minority of the Committee, comprising Hon Donna Faragher MLC, is of the strong view that this interim report provides compelling evidence for the State Government to immediately provide the substantial funding increase required for CAHS–CDS and WACHS–CDS to reduce the unacceptably long waiting times and expand CDS provision, particularly to children aged seven years and older. Furthermore, it is the Member's view that this funding increase should be provided no later than the 2024-25 State Budget.

5.18 The Committee expects that if the recommendations in this report about changes to be made 'now for now' are implemented, CAHS–CDS and WACHS–CDS will undertake concurrent planning to address the issues to be raised in the Committee's final report about changes to be made 'now for later'. In the Committee's view, implementing these measures will go a long way to reducing the burden of developmental delay on children and families and help ensure that the development, health and wellbeing of Western Australian children meets the expectations of our community.

[425] Submission 77 from WA Health, 9 November 2022, p 8.

CHAPTER 6
Extension of reporting deadline

6.1 The Committee requests an extension of the reporting date for the Inquiry, from 31 December 2023 to 18 April 2024.

6.2 Since the Legislative Council first extended the Committee's reporting date on 18 May 2023, the Committee has conducted another five hearings and three site visits and received more written evidence.

6.3 The Committee's terms of reference are broad, and evidence provided to the Committee has raised a range of complex matters. Another extension of the reporting deadline is regrettable. However, it will ensure that the Committee produces a final report that befits the importance of the Inquiry and properly discharges its inquiry obligations to the Legislative Council.

Hon Dr Sally Talbot MLC
Chair

APPENDIX 1

STAKEHOLDERS, SUBMISSIONS RECEIVED AND PUBLIC HEARINGS

Stakeholders

Number	From
1.	Department of Health
2.	Child and Adolescent Health Service
3.	Department of Education
4.	Aboriginal Health Council of Western Australia
5.	ADHD WA
6.	Allied Health Professions Australia
7.	Anglicare WA
8.	Association of Independent Schools Western Australia
9.	Audiology Australia
10.	Australian Childcare Alliance WA
11.	Australian Medical Association (WA)
12.	Australian Paediatric Society
13.	Australian Physiotherapy Association
14.	Australian Psychological Society
15.	Australian Research Alliance for Children and Youth
16.	Autism Association of Western Australia
17.	Catholic Education Western Australia
18.	Child Australia
19.	Commissioner for Children and Young People
20.	Commissioner for Children and Young People WA
21.	Curtin Medical School
22.	Department of Communities
23.	Earbus Foundation
24.	Early Childhood Australia
25.	Early Childhood Australia, Western Australia Branch

Number	From
26.	Faculty of Health and Medical Sciences, University of Western Australia
27.	Faculty of Health Sciences, Curtin University
28.	Health and Disability Services Complaints Office
29.	Health Consumers' Council (WA)
30.	Western Australian Mental Health Commission
31.	MercyCare
32.	Minderoo Foundation
33.	Minister for Community Services
34.	Minister for Education
35.	Minister for Health
36.	Office of the Chief Health Officer, Department of Health
37.	Office of the Chief Psychiatrist of Western Australia
38.	Optometry WA
39.	Origins Project
40.	Parkerville Children and Youth Care
41.	Perth Children's Hospital
42.	Pharmaceutical Society of Australia WA Branch
43.	Principals Federation of WA
44.	Private Speech Pathologists' Association of Western Australia
45.	Royal Australian College of General Practitioners Western Australia
46.	Rural Health West
47.	Salvation Army
48.	School of Education, Curtin University
49.	School of Education, Murdoch University
50.	School of Medical and Health Sciences
51.	School of Medicine, University of Notre Dame
52.	School of Paediatrics and Child Health, University of Western Australia
53.	School Psychologists Association of Western Australia
54.	Services for Australian Rural and Remote Allied Health

Number	From
55.	SHINE for Kids
56.	Speech Pathology Australia
57.	Speech Pathology Australia WA Branch
58.	Spinifex Health Service
59.	State School Teachers Union WA
60.	Teach Well
61.	Telethon Kids Institute
62.	The Australian Clinical Psychology Association
63.	The Royal Australian and New Zealand College of Psychiatrists
64.	Tracks to Literacy
65.	Western Australian Council of Social Services
66.	Western Australian Council of State School Organisations
67.	WA Country Health Service (WACHS)
68.	WA Occupational Therapy Association
69.	WA Primary Health Alliance
70.	Western Australian Primary Principals Association
71.	WA Country Health Service – East Pilbara
72.	WA Country Health Service – Gascoyne
73.	WA Country Health Service – Goldfields
74.	WA Country Health Service – Great Southern
75.	WA Country Health Service – Kimberley
76.	WA Country Health Service – Midwest
77.	WA Country Health Service – Pilbara
78.	WA Country Health Service – South West
79.	WA Country Health Service – West Pilbara
80.	WA Country Health Service – West/Inland Pilbara
81.	WA Country Health Service - Wheatbelt
82.	We the People
83.	Western Australian Association for Mental Health

Number	From
84.	WA Centre for Rural Health
85.	Dr Elizabeth Green, Paediatrician
86.	Premier of Western Australia
87.	Allied Health Alliance WA
88.	Beagle Bay Community Health Service
89.	Bega Garnbirringu Health Service
90.	Bidyadanga Aboriginal Community Health Service
91.	Broome Regional Aboriginal Medical Service
92.	Carnarvon Medical Service Aboriginal Corporation
93.	Catholic School Parents WA
94.	Community Kindergarten Association
95.	Derbarl Yerrigan Health Service Aboriginal Corporation
96.	Derby Aboriginal Health Service
97.	EdConnect
98.	Fogarty Foundation
99.	Geraldton Regional Aboriginal Medical Service
100.	Great Southern Aboriginal Health Service
101.	Indigo
102.	Isolated Children's and Parents' Association
103.	Kalparrin
104.	Kimberley Aboriginal Medical Services Council
105.	Linkwest
106.	Maggie Dent
107.	Mawarnkarra Health Service Aboriginal Corporation
108.	Milliya Rumurra Aboriginal Corporation
109.	Moorditj Koort Aboriginal Corporation
110.	Mother Baby Nurture
111.	Ngaanyatjarra Health Service
112.	Ngala

Number	From
113.	Ngangganawili Aboriginal Health Service
114.	Ngnowar Aerwah Aboriginal Corporation
115.	Nindillingarri Cultural Health Service
116.	Nirrumbuk Aboriginal Corporation
117.	Ord Valley Aboriginal Health Service
118.	Play Australia
119.	Playgroup WA
120.	Puntukurnu Aboriginal Medical Service
121.	South West Aboriginal Medical Service
122.	Wanslea
123.	Wirraka Maya Aboriginal Health Service
124.	Yura Yungi Aboriginal Medical Service
125.	Play Matters Collective WA
126.	Allied Health Alliance WA

Submissions received

Number	From
1.	Dr Jennifer Bullock
2.	Sarah Noakes
3.	Private Citizen
4.	Natalie Amos
5.	Private Citizen
6.	Private Citizen
7.	Private Citizen
8.	Iona Presentation College
9.	Private Citizen
10.	Private Citizen
11.	Private Citizen
12.	Private Citizen

Number	From
13.	Lauren Ranger
14.	Naomi Grove
15.	Dr Bret Hart
16.	North Metropolitan Service – Mental Health, Public Health and Dental Services
17.	Linda Savage
18.	Dyslexia-SPELD Foundation
19.	Private Citizen
20.	Private Citizen
21.	Private Citizen
22.	Joanne Dickenson
23.	College of Educational and Developmental Psychologists (WA Branch)
24.	Department of Optometry, University of Western Australia
25.	Rosemary Simpson
26.	Private Citizen
27.	Steph Mather
28.	Private Citizen
29.	South West Autism Network
30.	Private Citizen
31.	Dr Cindy Smith
32.	Fetal Alcohol Spectrum Disorder Collaboration for Assessment and Care Research and Education Incorporated
33.	ADHD WA
34.	Dr Margaret Ker
35.	Private Citizen
36.	Private submission
37.	Catholic Education Western Australia
38.	Parkerville Children and Youth Care
39.	Private Citizen
40.	Optometry Western Australia
41.	Minderoo Foundation

Number	From
42.	Private Citizen
43.	Speech Pathology Australia
44.	Connecting Community for Kids
45.	Catholic School Parents WA
46.	Dr Samuel Ognenis
47.	Isolated Children's Parents' Association of WA
48.	Playgroup WA
49.	Private Citizen
50.	Dr Elizabeth Green
51.	Dr Rebecca Hunt-Davies
52.	Private submission
53.	Maternal Child and Family Health Nurses Australia
54.	Sarah Murthy
55.	Private Citizen
56.	Hayley Cullen
57.	Miracle Babies Foundation
58.	Neurodevelopmental and Behavioural Paediatric Society of Australasia
59.	Dr Jacqueline Meredith Scurlock OAM
60.	Commissioner for Children and Young People
61.	Hon Simone McGurk MLA
62.	Community Kindergarten Association WA
63.	Australian Research Alliance for Children and Youth
64.	Anglicare WA
65.	Ngala
66.	Royal Australian College of General Practitioners
67.	Faculty of Health Sciences, Curtin University
68.	Private Citizen
69.	Western Australian Council of State School Organisations
70.	Puntukurnu Aboriginal Medical Service

Number	From
71.	Australian Childcare Alliance WA
72.	Derbarl Yerrigan Health Service
73.	Australian Psychotherapy Association
74.	Australian Psychological Society
75.	Health and Disability Services Complaints Office
76.	Pilbara Aboriginal Health Service
77.	Department of Health
78.	Western Australian Primary Principals' Association
79.	Aboriginal Health Council of Western Australia
80.	Developmental Occupational Therapy Association of Western Australia and Western Australian Occupational Therapy Association
81.	Western Australian Council of Social Service
82.	Australian Medical Association (WA)
83.	Royal Australasian College of Physicians
84.	Starbloom Paediatrics
85.	Telethon Kids Institute
86.	NursePrac Australia
87.	The Royal Australian and New Zealand College of Psychiatrists
88.	Private Citizen
89.	Royal Australasian College of Physicians

Public hearings

Date	Participants
28 November 2022	Department of Health Dr Helen Wright, Clinical Lead for Health Networks Dr Simon Towler, Chief Medical Officer Mr Jeffrey Moffet, Chief Executive, WA Country Health Service Dr Helen Van Gessel, Executive Director Clinical Excellence, WA Country Health Service Ms Karine Miller, Director Population Health, WA Country Health Service Ms Lesley Pereira, Program Manager CDS, WA Country Health Service Ms Valerie Jovanovic, A/Chief Executive, Child and Adolescent Health Service Ms Sue Kiely, Executive Director Community Health, Child and Adolescent Health Service Ms Anna Turnell, A/Director Clinical Services, Child and Adolescent Health Service Dr Jennifer Green, A/Head of Department for Child Development Services Paediatrics, Child and Adolescent Health Service
	Faculty of Health Sciences, Curtin University Professor Adrian North, Interim Deputy Pro Vice Chancellor
12 December 2022	Speech Pathology Australia (WA Branch) Dr Sharon Smart, Co-Chair Dr Robert Wells, Executive Member
	ADHD WA Dr Michele Toner, Board Chair Dr Roger Paterson, Professional Advisory Body Chair Ms Antonella Segre, Chief Executive Officer Ms Catherine Natale, private citizen
	Starbloom Paediatrics Dr Robert Lethbridge, Director
	Dr Bret Hart

Date	Participants
9 February 2023	Australian Psychological Society and College of Educational and Developmental Psychologists Dr Catriona Davis-McCabe, President Ms Kylie Coventry, Head of Policy
	Minderoo Foundation Hon Jay Weatherill AO, Director, Thrive by Five
	Aboriginal Health Council of WA Ms Kim Gates, Executive Manager Public Health and Continuous Quality Improvement, Aboriginal Health Council of WA Dr Caitlyn White, Public Health Medical Officer, Aboriginal Health Council of WA Ms Tracey Brand, CEO, Derbarl Yerrigan Health Service Dr Kim Isaacs, General Practitioner, Derbarl Yerrigan Health Service Dr Cara Sheppard, Senior Medical Officer, Puntukurnu Aboriginal Medical Service Mr Robby Chibawe, Chief Executive Officer, Puntukurnu
	Telethon Kids Institute Professor Catherine Elliot, Director Research and Deputy Executive Director Professor Andrew Whitehouse, Bennett Chair of Autism & Director CliniKids Ms Fiona Roche, Head of Government Relations
17 February 2023	Dr Elizabeth Green
	Ms Rosemary Simpson
	Kalparrin Ms Carrie Clark, Chief Executive Officer
20 February 2023	Catholic Education Western Australia Ms Karmela Messineo, Senior Team Leader, Teaching and Learning Mr Tim Wong, Child Safe Lead
	Western Australian Primary Principals' Association Mr Niel Smith, President

Date	Participants
20 February 2023	Maternal Child and Family Health Nurses Australia and NursePrac Australia Ms Louise Wightman, Chair, Maternal Child and Family Health Nurses Australia Ms Stephanie Dowden, Children's Nurse Practitioner and Director, NursePrac Australia Ms Carly Martin, Children's Nurse Practitioner, NursePrac Australia
	Connecting Community for Kids and Earbus Foundation Ms Jane Miller, Chief Executive Officer, Connecting Community for Kids Mr Paul Higginbotham, Chief Executive Officer and Founder, Earbus Foundation of WA Ms Lara Shur, Director, Earbus Foundation of WA
2 March 2023	Department of Education Mr Jim Bell, Deputy Director General, Student Achievement Mr Stuart Percival, Director, Disability and Inclusion Ms Lynne Lucas, Director, Student Engagement and Wellbeing Ms Lee Musumeci, Principal, Challis Community Primary School Ms Louise O'Donovan, Principal, Wattleup East Primary School
3 April 2023	South West Aboriginal Medical Service Ms Jodie Ingrey, Maternal and Child Health Coordinator Ms Mariah Egan, Hypnobirthing Coordinator
4 April 2023	Isolated Children's & Parents' Association Ms Jane Cunningham, President Mrs Kym Ross, State Secretary
	Community Kindergarten Association Ms Joanne Matthewson, President
	Ms Danielle Killey
	Ms Cassandra Dressler
26 April 2023	Dr Mark Parker

Date	Participants
26 April 2023	Department of Health Dr Simon Towler, Chief Medical Officer Dr Alide Smit, Consultant Paediatrician Ms Valerie Jovanovic, Chief Executive, Child and Adolescent Health Service Ms Sue Kiely, Executive Director, Community Health, Child and Adolescent Health Service Ms Anna Turnell, A/Director Clinical Services, Child Development Service, Child and Adolescent Health Service Mr Brad Jongeling, Paediatrician Head of Department, Child Development Service, Child and Adolescent Health Service Ms Anne-Marie McHugh, A/Nursing Co-Director, Community Health, Child and Adolescent Health Service Ms Karine Miller, Director Population Health, WA Country Health Service Ms Lesley Pereira, Program Manager, WA Country Health Service Ms Sylvia Lennon, Director Population Health, WA Country Health Service

Date	Participants
1 May 2023	Kimberley Aboriginal Medical Services and Bidyadanga Aboriginal Community (La Grange) Mrs Therese Lesma, Community Welfare Officer, Bidyadanga Aboriginal Community (La Grange) Miss Rosita Billycan, Aboriginal Health Worker, Connected Beginnings, Kimberley Aboriginal Medical Services Mrs Amy Walker, Child Health Nurse and Midwife, Connected Beginnings, Kimberley Aboriginal Medical Services Mr Oskar Stenseke, Senior Manager, Kimberley Aboriginal Medical Services Miss Talika Bal-Bal, Community Navigator, Bidyadanga Aboriginal Community (La Grange) Mr Francis Fernandez, Community Capacity Building Officer, Bidyadanga Aboriginal Community (La Grange) Miss Cheryl Maslin, Child Health Nurse, Kimberley Aboriginal Medical Services Mrs Bernie McHugh, School Health Nurse, Kimberley Aboriginal Medical Services Mrs Abbe Orrick, Allied Health Team Leader, Early Child Supports Program, Kimberley Aboriginal Medical Services Miss Claire Thistleton, Speech Pathologist, Early Childhood Supports Program, Kimberley Aboriginal Medical Services Miss Hanna Lipscomb, Occupational Therapist, Early Childhood Supports Program, Kimberley Aboriginal Medical Services
	WA Country Health Service Kimberley Mr Christopher Hart, Acting Director, Kimberly Population Health Unit Mrs Joline Falls, Senior Occupational Therapist/Allied Health Manager Mrs Sascha Wood, Senior Occupational Therapist, Child Development Service, Kimberley Population Health Unit Dr Anna Robson, Regional Paediatrician
2 May 2023	Derby Aboriginal Health Service Dr Ashleah Fleming, Senior Medical Officer Ms Joanne Moore, Senior Manager Clinical Operations and Remote Ms Francine Austin, Child Health Nurse
12 May 2023	Curtin Medical School, Faculty of Health Sciences Dr Yvonne Anderson

Date	Participants
17 May 2023	Royal Australasian College of Physicians Professor Nitin Kapur, Paediatric and Child Health Division President
17 May 2023	Royal Australian College of General Practitioners Dr Andrew Leech, General Practitioner, WA representative
	Telethon Speech & Hearing Mr Mark Fitzpatrick, Chief Executive Officer
31 May 2023	Faculty of Health Sciences, Curtin University Professor Adrian North Associate Professor Marina Ciccarelli
26 July 2023	Queensland Health Dr Helen Heussler, Senior Medical Officer, Medical Director of Child Development, Division of Medicine
	Playgroup WA Mr David Zarb, Chief Executive Officer

APPENDIX 2

CHILD AND ADOLESCENT HEALTH SERVICE – DIVISION FOCUS

Description of the CAHS services	Focus on development
Primary healthcare	

CAHS-Community Health Nursing services:
• Child Health
  ○ Universal health check schedule from birth
  ○ to school entry (health checks include developmental screening, parent education and capacity building).
  ○ Additional, targeted services where risk is identified.
• School Health
  ○ School entry health check.
  ○ Early detection of physical and psychosocial health anddevelopment issues in primary schools.
  ○ Provision of health education and health counselling for young people in secondary schools.
  ○ Support for children with complex and/or chronic healthneeds.
• Immunisation
  ○ Immunisation services provided within Community Health clinics and in schools.
 	
CAHS-Community Health Aboriginal Health Team
• Expanded health check schedule (health checks include developmental screening, parent education and capacity building).
• Additional, targeted services where risk is identified.
 	
CAHS-Community Health CDS
• Parent education and capacity building pre-referral to the CDS is provided by CDS allied health staff embedded in the Aboriginal Health Team.
• Allied health brief interventions provided by CDS staff embedded in the Aboriginal Health Team.
• Parent education and capacity building pre-referral to CDS is provided by CDS allied health staff embedded in Child and Parent Centres.
• Parent initiated referrals for CDS services are accepted.
 	
CAHS-Community Health Refugee Health Team
• Health service navigation, onward referral and follow up care plans for eligible children up to the age of 18 years.
	Prevention and early identification of developmental difficulties. Provision of brief interventions.

Secondary healthcare	
CAHS-Community Health CDS • Allied health and medical assessment and interventions addressing multiple developmental domains. • Neurodevelopmental disorder diagnostic assessments. • Engagement of other services to help support the needs of a child and family (e.g. education supports) and transition of clients to NDIS and relevant developmental support services.	Specialised child development services for children with difficulties impacting on one or more developmental domains and ranging in complexity
Tertiary healthcare	
CAHS-Community Health CDS • Developmental and medical services for children with complex neurodevelopmental disorders, provided in collaboration with other services (including Perth Children's Hospital specialty departments) as appropriate. CAHS-Neonatology • Care for newborn babies and infants born pre-term or who require specialist treatment in their first months of life. • Follow-up developmental monitoring at 4, 8 and 12 months for babies who may be vulnerable to challenges due to preterm birth, very low birth weight and need for other medical intervention in the neonatal period. Longer term follow-up may also be provided. Child and Adolescent Mental Health Service • Assessment and management of complex and persistent emotional, psychological, behavioural, social and/or mentalhealth problems. Perth Children's Hospital • Single and multidisciplinary interventions for developmental issues associated with medical or surgical conditions.	Specialised services provided to children with developmental impairments together with complex medical, surgical and/or mental health co-morbidities.

[Source: Submission 77 from WA Health, 9 November 2022, pp 16–17, with Committee highlighting].

APPENDIX 3

LETTERS FROM OTHER AUSTRALIAN HEALTH MINISTERS REGARDING WAITING TIMES

The Hon Mary-Anne Thomas MP

Minister for Health
Minister for Health Infrastructure
Minister for Medical Research

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Telephone: +61 3 9096 8561
www.health.vic.gov.au

BAC-CO-34844

Hon Dr Sally Talbot MLC
Chair
Select Committee Inquiry into Child Development Services
Parliament of Western Australia
sccds@parliament.wa.gov.au

Dear Dr Talbot

Thank you for your letter of 14 March 2023 regarding publicly available data on waiting lists for various child development services in Victoria.

The Victorian Government is committed to supporting timely, equitable and high-quality healthcare, with child development services provided by a range public health services and community health services across Victoria.

While information regarding the wait times for services is published by the Victorian Health Information Agency Victoria (https://vahi.vic.gov.au/reports/victorian-health-services-performance), specific wait times for child development services are not included in regular public reporting.

I look forward to hearing more about the outcomes of the Inquiry into Child Development Services. Please don't hesitate to contact Jennifer Bliss, Executive Director, Health Services and Aged Care Policy, Improvement and Engagement at the Department of Health on Jennifer.Bliss@health.vic.gov.au for further information or advice regarding the delivery of services in Victoria.

Yours sincerely

The Hon Mary-Anne Thomas MP

15/04/23

Hon Yvette D'Ath MP
Minister for Health and Ambulance Services
Leader of the House

Queensland Government

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C-ECTF-23/2957

The Honourable Dr Sally Talbot MLC
Chair
Legislative Council Committee Office
18-32 Parliament Place
WEST PERTH WA 6005

20 APR 2023

Email: sccds@parliament.wa.gov.au

Dear Dr Talbot

Thank you for your letter dated 14 March 2023 in relation to a request for information on behalf of the Select Committee for the Legislative Council of the Parliament of Western Australia. In your letter the Committee requested the most recent, publicly available statistical information on waiting times for child development services in Queensland.

Queensland Health does not formally collect the statistical information the Select Committee has requested.

Statistical information relating to the activity and performance of Queensland Health's 106 Hospitals is available via the Queensland Health Hospital Performance website www.performance.health.qld.gov.au and includes information relating to waitlists and initial service events for paediatric medicine, extracted from the Specialist Outpatient Data Collection.

Thank you again for writing to me. Should you require any further information in relation to this matter, I have arranged for Ms Melissa Carter, Deputy-Director General, Healthcare Purchasing and System Performance Division, Department of Health, on telephone (07) 3708 5820 to be available to assist you.

Yours sincerely

YVETTE D'ATH MP
Minister for Health and Ambulance Services
Leader of the House

CHIEF MINISTER

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The Hon Dr Sally Talbot MLC
Legislative Council Western Australia
sccds@parliament.wa.gov.au

Dear Dr Talbot

Thank you for your letter of 14 March 2023 on behalf of the Parliament of Western Australia - Select Committee Inquiry into Childhood Development Services, requesting the most recent, publicly available data on waiting lists for various child development services in the Northern Territory (NT).

Current waiting times for child development services (CDS) are not generally publicly available. Waiting times tend to vary based on staffing ratios and external influences with demand remaining steady and consistently high over time.

I wish you and your colleagues well with the Inquiry and look forward to the Committee's report.

Kind regards

Natasha

NATASHA FYLES

26 APR 2023

NORTHERN TERRITORY GOVERNMENT

Government of South Australia

Hon Chris Picton MP
Minister for Health and Wellbeing

MHW-H23-1571

Hon Dr Sally Talbot MLC
Legislative Council Committee Office
Parliament House
Email: sccds@parliament.wa.gov.au

Dear Dr Talbot Sally

Thank you for your correspondence dated 14 March 2023, regarding the Western Australia Parliamentary Select Committee Inquiry into Child Development Services.

SA Health has a number of patient administration systems that have different reporting capabilities for outpatient waiting list information.

The provision of 'Child Development Services' for South Australians ages 0-18 years is delivered by two distinct health portfolio mechanisms:

a. For single developmental concerns regardless of complexity, children may be referred to public or private specialist clinics.

b. For multiple developmental concerns of significant complexity and/or existing comorbid considerations, children may be referred to specialist multidisciplinary differential diagnostic neurodevelopmental assessment teams. These teams currently operate independently within their parent Local Health Networks (LHNs). A limited number of private providers also conduct multidisciplinary neurodevelopmental assessment, however there is significant out-of-pocket cost and many providers will only assess on a single diagnosis basis (i.e. non-differential).

The current Specialist Outpatient Waiting Time Report (as at 31 March 2023) is a publicly available SA Health resource reporting median and maximum waiting times for reported specialist clinics in metropolitan hospitals. This can be found on the SA Health website by following this link: https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+performance/specialist+outpatient+waiting+time+report.

Once again, thank you for contacting me regarding this matter. I trust this information is of assistance.

Yours sincerely

Chris Picton MP
Minister for Health and Wellbeing

29 / 8 / 2023

Minister for Health and Wellbeing
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SOUTH AUSTRALIA

GLOSSARY

Term	Definition
Aboriginal	the Select Committee into Child Development Services recognises the diverse tribal and language groups of Aboriginal people in Western Australia. For the purposes of this inquiry, the term 'Aboriginal' encompasses all of those groups and also recognises those of Torres Strait Islander descent
ACCHOs	Aboriginal community controlled health organisation
ADHD	attention deficit hyperactivity disorder
AEDC	Australian Early Development Census
AIHW	Australian Institute of Health and Welfare
ASD	autism spectrum disorder
CAHS	Child and Adolescent Health Service, a health service provider in the Western Australian public health system
CAHS–CDS	the team within the Child and Adolescent Health Service that provides secondary and tertiary-level child development services
CAMHS	Child and Adolescent Mental Health Services, a service area within the Child and Adolescent Health Service
CCH	Centre for Community Child Health
CCYP	Commissioner for Children and Young People
CDIS	Child Development Information System, used by the Community Health service area within the Child and Adolescent Health Service
CDS	secondary and tertiary-level child development services provided by CAHS–CDS and WACHS–CDS within Western Australia's public health system
CEWA	Catholic Education Western Australia
child development services	the interventions that can be provided to a child to ensure they develop as well as possible. As this general concept, child development services can include: screening for potential issues; assessments of a child's development; therapy; and the provision of strategies and supports
Committee	Select Committee into Child Development Services
Community Health	a service area within the Child and Adolescent Health Service that comprises Community Health Nursing; Child Development Services (CAHS–CDS); the Aboriginal Health Team and the Refugee Health Team

Term	Definition
community health services	when provided to children, is comprised of child health nursing and school health nursing. Community health nursing services include the universal offer of child health assessments, screening, immunisation, support and parenting advice to the families of every child born in Western Australia. School health nursing services for school aged children include health and development screening on school entry, targeted screening and assessments, support: for student health care planning and the provision of the school based immunisation program
DOC	Department of Communities
DOE	Department of Education
DOH	Department of Health, whose director general is the system manager of the Western Australian public health system
DSM-5	American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 5th edn, American Psychiatric Association Publishing, 2022
DYHS	Derbarl Yerrigan Health Service
EMR	electronic medical record system
FTE	full-time equivalent
GP	general practitioner
Inquiry	the Select Committee into Child Development Services' examination of publicly delivered child development services in Western Australia
KAMS	Kimberley Aboriginal Medical Service
LDC	a Department of Education language development centre
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
PCH	Perth Children's Hospital, a service area within the Child and Adolescent Health Service
SWAMS	South West Aboriginal Medical Service
WACHS	WA Country Health Service, a health service provider in the Western Australian public health system
WACHS–CDS	the teams within the WA Country Health Service that provide secondary and tertiary-level child development services across seven regions – the Kimberley; Pilbara; Midwest; Wheatbelt; Goldfields; South West; and Great Southern

Term	Definition
WA Health	the Western Australian public health system comprised of the Department of Health, seven board governed health service providers, the Quadraplegic Centre and contracted entities, to the extent that they provide health services to the State

Select Committee into Child Development Services

Date first appointed:

31 August 2022

Terms of Reference:

(1) A Select Committee is established to examine child development services in Western Australia.

(2) The Select Committee is to inquire into and report on —

(a) the role of child development services on a child's overall development, health and wellbeing;

(b) the delivery of child development services in both metropolitan and regional Western Australia, including paediatric and allied health services;

(c) the role of specialist medical colleges, universities and other training bodies in establishing sufficient workforce pathways;

(d) opportunities to increase engagement in the primary care sector including improved collaboration across both government and non-government child development services including Aboriginal Community Controlled Organisations; and

(e) other government child development service models and programs operating outside of Western Australia and the applicability of those programs to the State.

(3) The Select Committee is to report no later than 12 months after the motion is agreed to.

(4) The Select Committee shall consist of three members: Hon Dr Sally Talbot (Chair); Hon Donna Faragher; and Hon Samantha Rowe.

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