41ST PARLIAMENT

Compilation 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)

April 2024

Select Committee into Child Development Services

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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.

Explanatory note: Compilation report

This publication is a compilation of the Interim and Final Reports of the Select Committee into Child Development Services. It consists of two parts:

- Part 1 is a republication of the Committee's Interim Report, tabled on 28 November 2023, with original numbering retained.
- Part 2 consists of the Committee's Final Report.

The Interim and Final Reports are here published together, as this is how, in the Committee's view, they should be read.

PART 1: INTERIM REPORT

Republication of the Select Committee into Child Development Services' Interim Report, tabled on 28 November 2023, with original numbering retained.

CONTENTS

Figures

Tables

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:

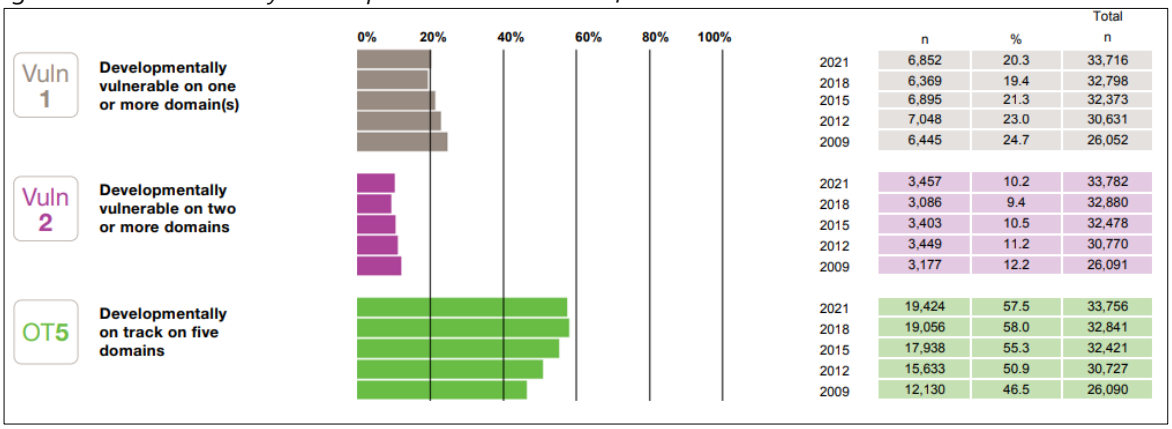
- developmentally on track (developing well)
- developmentally at risk (facing challenges in some aspects of their development)
- developmentally vulnerable (facing some significant challenges in their development).[35]

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).

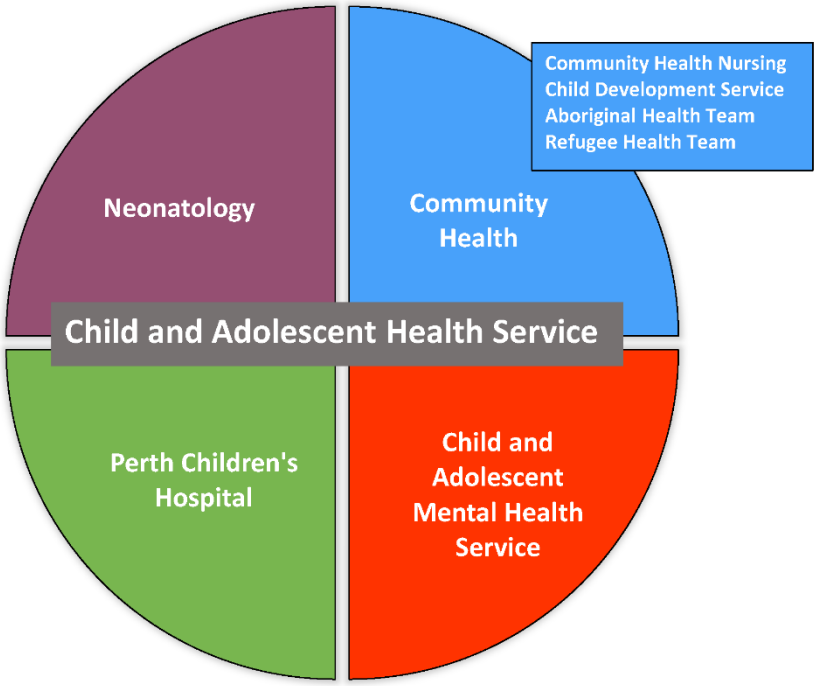
84 Department of Health (DOH), *Service agreements and deeds of amendment (abridged)*, DOH, 2023, accessed 13 November 2023.

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.

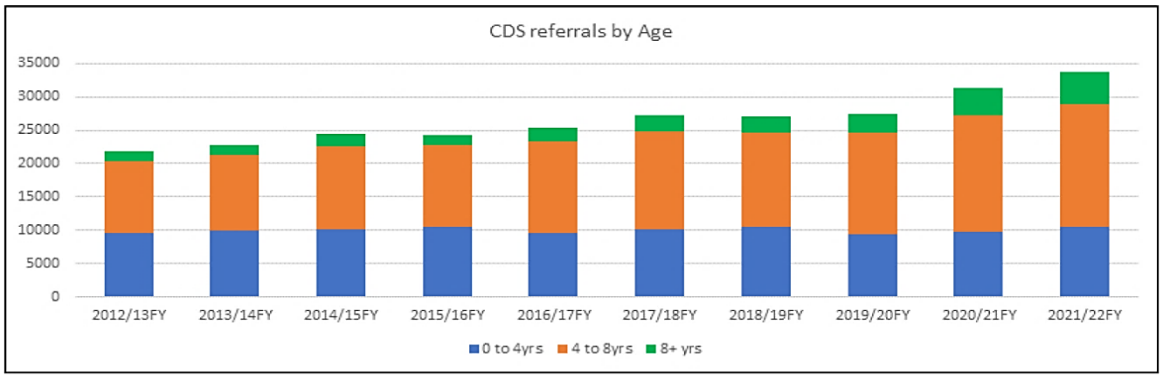
[104] Submission 77, p 27.

[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.

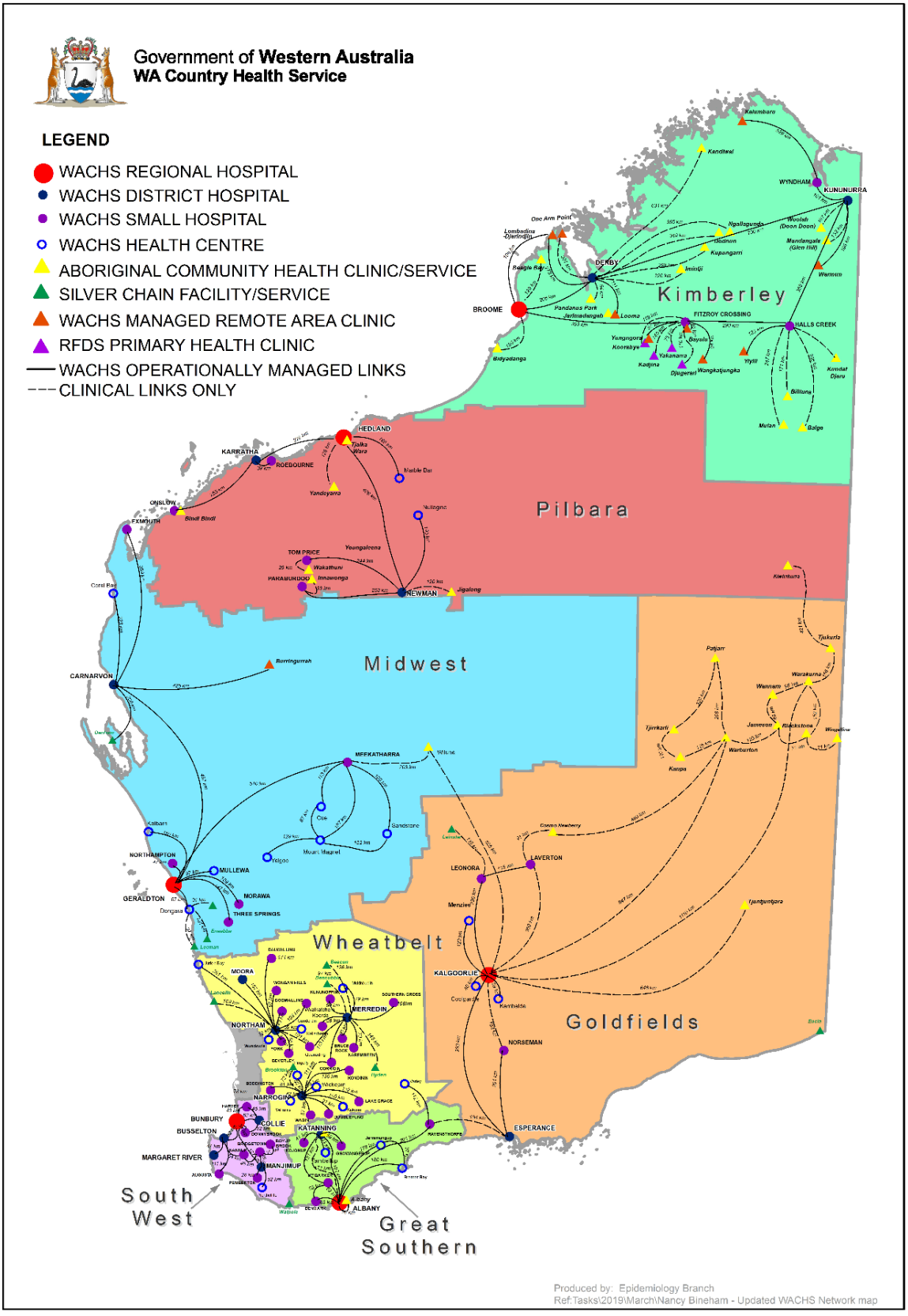
111 A Turnell, Acting Director, Clinical Services, Child Development Service, CAHS, [*transcript of evidence*], *Legislative Council*, 28 November 2022, p 9.

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*

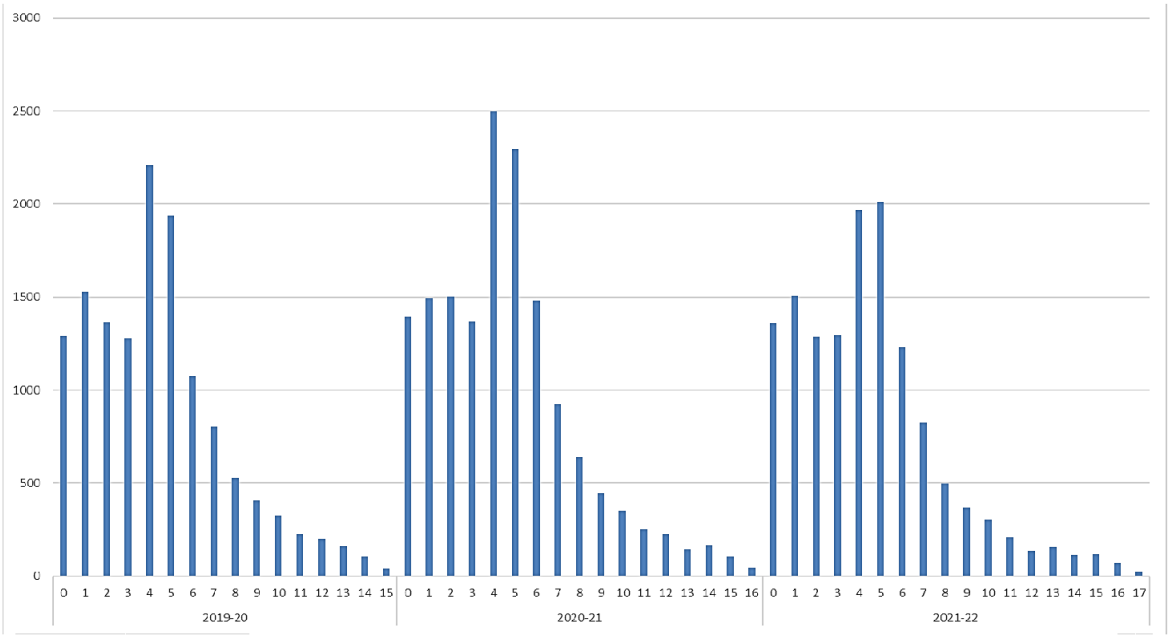
Referral source	**Number of referrals**
Allied health professional	2,623
Another institution	35
Clinician	97
Community	374
Education department	3,148
Emergency department	35
Family or friend	907
General practitioner	1,264
Government agency	15
Inpatient ward	36
Medical practititioner	398
Mental health 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.

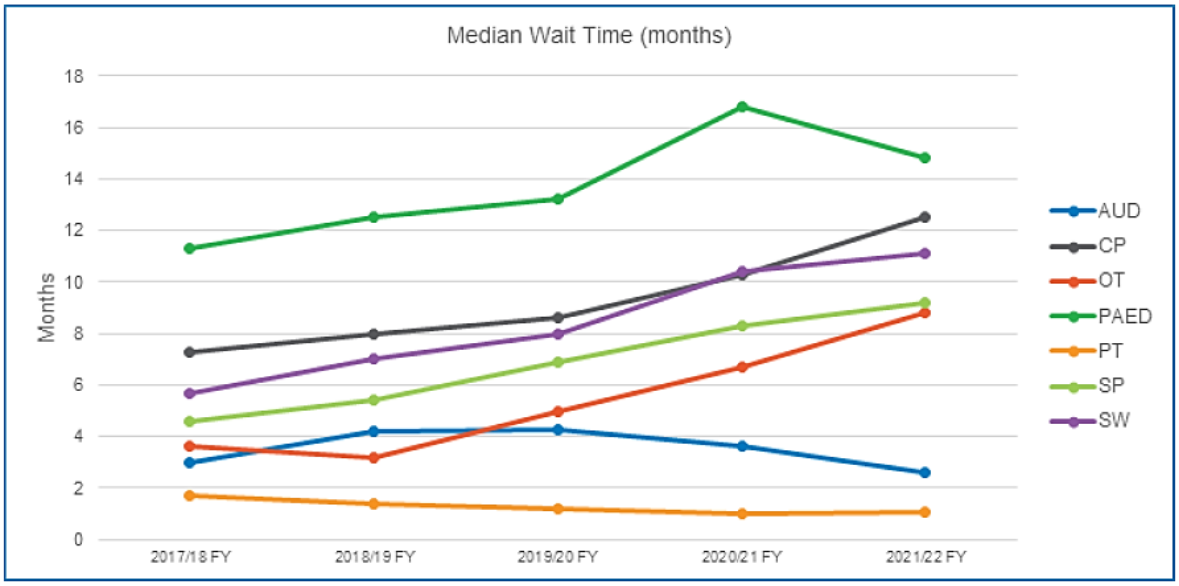
237 Submission 77 from WA Health, 9 November 2022, p 85. See also, footnote 89 of this report.

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.

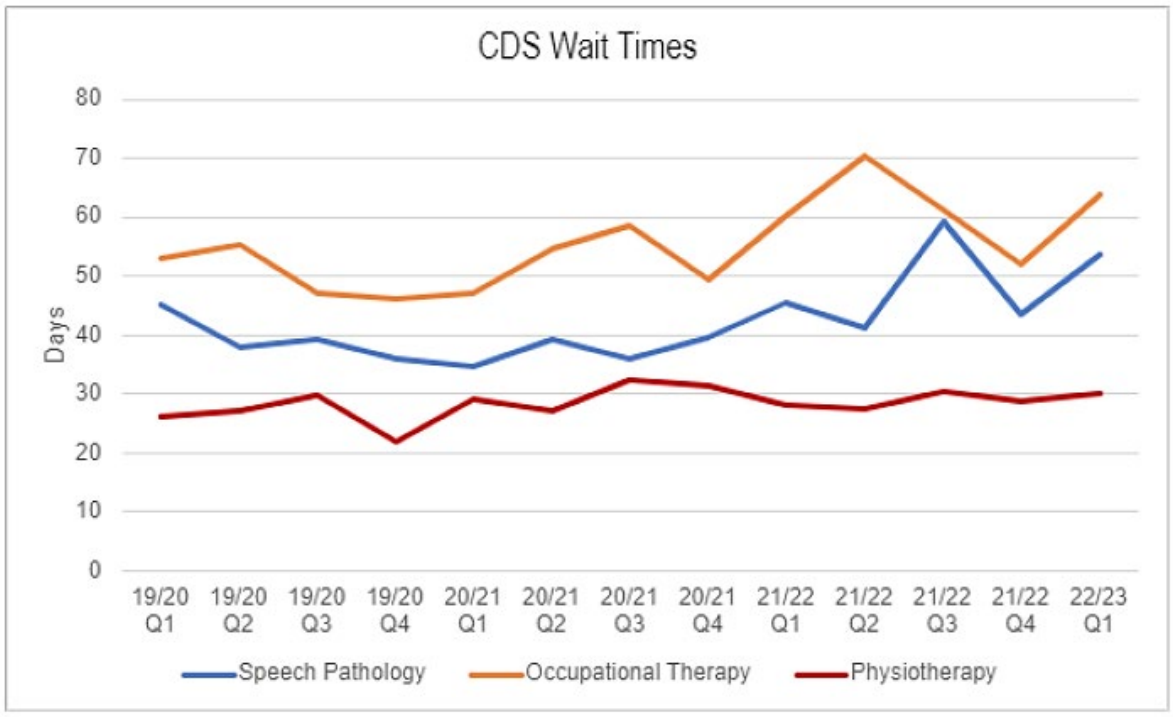
WA Country Health Service – Child Development Service

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)**

  ▫▫▫

  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)**

  ▫▫▫

  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)**

▫▫▫

> [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)**

▫▫▫

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]
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> ▫▫▫
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> Community demand for CDS [delivered by WACHS] continues to increase every year, with staffing and facilities being inadequate across country WA.[305]
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> ▫▫▫
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> 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.

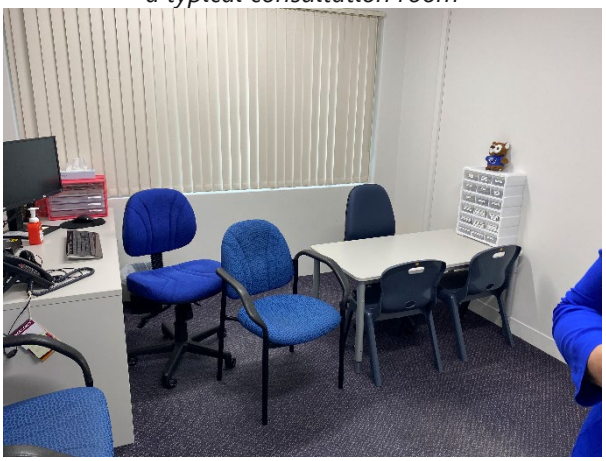
304 Submission 77, p 6. This was addressed in CAHS–CDS's 2023-24 State Budget funding submission (see paragraph 4.70 of this report).

305 Submission 77, p 8.

306 Submission 77, p 70.

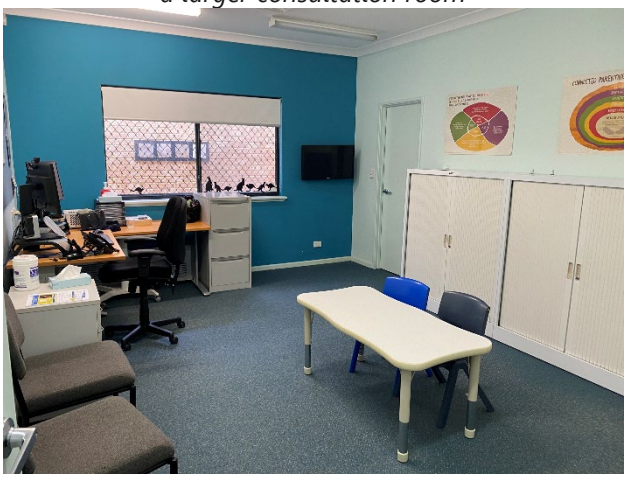
307 S Kiely, Executive Director, Community Health, CAHS, [*transcript of evidence*]*, Legislative Council,* 26 April 2023, p 5.

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]

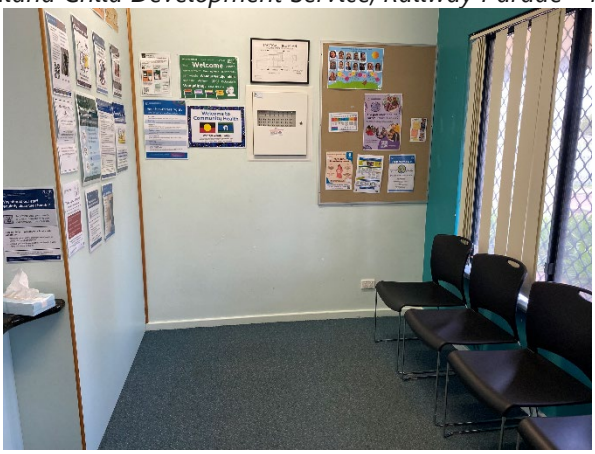
Figure 13. *Bentley Child Development Service*

[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]
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> ▫▫▫
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> 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]
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> ▫▫▫
>
> [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]
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  > ▫▫▫

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]
>
> ▫▫▫
>
> 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]
>
> ▫▫▫
>
> 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]
>
> ▫▫▫

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?
>
> **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]

▫▫▫

[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]

▫▫▫

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.
>
> **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

GPO Box 4057
Melbourne Victoria 3001
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

PART 2: FINAL REPORT

CONTENTS

Figures

Tables

EXECUTIVE SUMMARY

1 This is the final report of the Select Committee into Child Development Services (Committee), tasked with inquiring into and reporting on the following 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.

2 While the Committee's interim report, tabled 28 November 2023 (Interim Report), dealt mainly with considerations (a) and (b), this final report covers considerations (b), (c), (d) and (e).

3 The Interim Report (republished here as Part 1) identified the need for additional funding and resources for the specialised (secondary and tertiary-level) child development services provided by the State's public health system (CDS). This final report (published here as Part 2) considers, and makes recommendations on, strategies to improve the accessibility and sustainability of the CDS system, with the assumption that adequate additional funding and resources will be forthcoming.

4 The Interim Report and this final report are here published together, as this is how, in the Committee's view, they should be read.

5 The Committee notes that, on 9 April 2024, as the Committee was finalising this report, the State Government announced $39 million in funding for CDS as part of the 2024-25 State Budget.

Collaboration and integration of services (Chapters 2 and 3)

6 It is widely perceived that the providers of CDS (the metropolitan Child and Adolescent Health Service and the WA Country Health Service) work in silos. Evidence presented to the Committee clearly indicates that if the CDS system is to be effective and become more accessible and sustainable, the State's public health system (WA Health, which includes the CDS providers) must:

- internally, provide more coordinated and integrated services
- externally, work more collaboratively with organisations outside of WA Health that also contribute to a child's development, health and wellbeing – particularly in areas such as housing, child protection, disability services and education, as well as non-government health services.

Internal collaboration

7 The Committee's consideration of internal collaboration issues is centred on:

- the development and implementation of a statewide electronic medical record system, or at least a Community Care electronic medical record system that is jointly operated by the two CDS providers
- the co-location of related and relevant health services for children in 'hubs', and the positioning of those hubs in places where children are
- better coordination of health services for children.

8 The findings and recommendations pertinent to these issues are Findings 1–7 and Recommendations 1–7.

External collaboration

9 With regard to the CDS providers collaborating with external stakeholders, three themes emerge from evidence received during the Committee's inquiry:

- the need for better communication
- the benefits of a single, online referral system
- the need for the provision of child development training for external stakeholders.

10 The Committee also explores how the CDS providers can interact more, and more effectively, with:

- the Department of Education (including schools and Child and Parent Centres)
- the early childhood education and care sector
- Aboriginal Community Controlled Health Organisations and other non-government organisations
- external stakeholders in the assessment, diagnosis and treatment of children with attention deficit hyperactivity disorder.

11 The findings and recommendations relevant to these issues are Findings 8–24, Recommendations 8–25 and Minority Recommendations 1–5.

Access, engagement and equity (Chapters 4, 5 and 6)

Child Development Services system

12 Some of the risk factors for developmental vulnerability include socio-economic disadvantage (for example, poverty and homelessness), Aboriginality, cultural and linguistic diversity, geographical disadvantage, family and domestic violence and substance abuse. The Committee discusses how the presence of some of these risk factors can, in some cases, lead to a child's developmental delay, or compound their developmental delay by placing barriers on their family's ability to access and engage with support services.

13 The Committee considers how the CDS system is servicing vulnerable populations and whether more could be done. The needs of three vulnerable populations – culturally and linguistically diverse groups, regional and remote populations, and Aboriginal families – are examined in detail.

14 Findings 7, 17 and 25–43, Recommendations 1, 6, 8, 16, 21 and 26–34 and Minority Recommendation 6 are relevant to these issues.

Child health nursing

15 Child health nurses are integral to the child development system. These nurses perform the five universal child health checks for all families, as well as providing additional checks and other services if more assistance is needed. In this way, child health nurses:

- contribute to the prevention and early identification of developmental issues
- provide an avenue for engaging families early
- are a source of referral to CDS.

16 Currently, the universal child health checks are scheduled when a child is 0–14 days, eight weeks, four months, 12 months and two years of age. There is debate about the scheduling of these checks. Changes to the schedule in 2017 are not supported by everyone. The Committee outlines the concerns raised by contributors to the inquiry and the response from WA Health.

17 There is very poor attendance at the two later child health checks, at 12 months and two years of age, particularly in the Perth metropolitan area. This has implications for the child development system because developmental issues may not be identified early and intervention may be delayed. The Committee examines how WA Health is working to improve families' engagement with child health nurses and what else can be done.

18 These topics are the subject of Findings 44–49 and Recommendations 35–41.

Other community-based services

19 Community services such as playgroups, early childhood education and care, and Child and Parent Centres support healthy child development outside of the CDS system. These services can:

- engage all families (including vulnerable families) early because they are considered to be safe, community-based services that are generally accessible
- enable local social connection and support
- provide beneficial developmental opportunities.

Importantly, they can provide a line of sight on children from an early age.

20 The Committee considers the benefits of a more holistic and integrated child development system that harnesses a range of community services.

21 The findings and recommendations relevant to these issues are Findings 18–20 and 50–51, Recommendations 17, 18 and 42–44, and Minority Recommendations 3, 4, 7 and 8.

Workforce practice and development (Chapter 7)

22 With finite resources (in terms of funding, infrastructure and the available workforce), it is clear that if the CDS providers wish to address their service deficiencies and ensure that the CDS system is accessible and sustainable, they also need to:

- maximise the efficiency of their workforce models
- collaborate with external stakeholders to ensure the continued availability of a future workforce.

Maximising efficiency of workforce models

23 Inquiry evidence demonstrates to the Committee that an efficient workforce model is one which allows and encourages every employee to work to the full scope of their practice (or as some stakeholders labelled it, working to the 'top of scope' of practice). Creating an

efficient workforce involves having the right combination of different workers, so that the skills and knowledge of each discipline will complement that of others in the team and allow every worker to practise at the top of their scope of practice.

24 The Committee discusses:

- how the CDS providers are already modifying some of their care pathways to increase efficiency – for example, the trial audiology pathway in regional Western Australia and the trial ADHD care pathway in the Perth metropolitan area
- various suggestions made by stakeholders to achieve greater workforce efficiency, including the:
    - establishment of a 'low intensity workforce' consisting of professionals traditionally not included in the delivery of child development services to provide support for children requiring these services
    - proper recognition and utilisation of child health nurses
    - potential utilisation of nurse practitioners.

25 These issues are the subject of Findings 52 and 53 and Recommendations 45–48.

The future workforce

26 The State Government will need to ensure the continued availability of a future workforce. This will involve collaborating with external stakeholders, such as the Commonwealth Government, universities and health professional training providers to increase:

- university places for allied health, nursing and medical courses
- practical training placements for these university students and graduates.

27 The Committee examines some of the barriers to achieving these increases and how they may be overcome. The CDS providers have a particularly important role in ensuring that there are sufficient practical training placements.

28 The Committee also discusses and endorses the concept of 'interprofessional education', which involves learning from and working with people from other disciplines.

29 These topics are the subject of Findings 54 and 55 and Recommendations 49–55.

Leadership, planning and innovation (Chapter 8)

30 The Committee considers the need for:

- a high level implementation team that is dedicated to leading innovation and organisational reform, including the implementation of the recommendations made by this Committee in its Interim Report and this report
- clear direction from the State Government on ways to prioritise the health and wellbeing of Western Australian children and their families
- a whole-of-government approach to optimising the health and wellbeing of Western Australian children and their families.

31 Recommendations 56 and 57 and Minority Recommendations 9 and 10 are relevant to these issues.

Findings and recommendations

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

RECOMMENDATION 4 Page 20

The Child and Adolescent Health Service's Child Development Service and Child and Adolescent Mental Health Service jointly develop a clear procedure for identifying which of the two services, or whether both services, will assess and treat children who present with complex and co-occurring developmental and mental health issues.

FINDING 5 Page 21

Collaboration between the Child and Adolescent Health Service's Child Development Service and Child and Adolescent Mental Health Service would improve vastly if each service had access to the other's electronic medical record system.

RECOMMENDATION 5 Page 23

For future Community Hubs, the Child and Adolescent Health Service continue to co-locate its Community Health teams, including the Child Development Service, with its Child and Adolescent Mental Health Service.

FINDING 6 Page 24

Collaboration between the Child and Adolescent Health Service's Child Development Service and Perth Children's Hospital (and other public hospitals in the State) would improve vastly if the hospital had access to the Child Development Service's electronic medical record system.

FINDING 7 Page 25

The Community Health Information System is an effective electronic medical record system for the WA Country Health Service, but while awaiting a statewide Community Care electronic medical record system, it could be improved by integrating it with the Child and Adolescent Health Service–Community Health's Child Development Information System where possible and further developing its service data extraction function.

RECOMMENDATION 6 Page 26

The shared Community Care electronic medical record system (see Recommendation 1 of this report) should at least incorporate the same features as the WA Country Health Service's Community Health Information System.

RECOMMENDATION 7 Page 27

The WA Country Health Service co-locate its Child Development Service and Child and Adolescent Mental Health Service, under an expanded hub and spoke model in line with the recommendations of the Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0–18 years in Western Australia.

RECOMMENDATION 8 Page 33

The Child and Adolescent Health Service–Child Development Service (CAHS–CDS) and WA Country Health Service–Child Development Service (WACHS–CDS) give external stakeholders who provide health services, especially those contracted by CAHS–CDS or WACHS–CDS to provide services on their behalf, immediate access to their electronic health record systems when appropriate and with the necessary consents. The shared Community Care electronic medical record system under development (see Recommendation 1 of this report) should have the functionality to allow for this external stakeholder access.

RECOMMENDATION 9 Page 34

The Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service, after obtaining the necessary consents, regularly liaise with, update and consult referrers and other external stakeholders, as appropriate, about their clients.

FINDING 8 Page 36

An online referral system that is incorporated into a shared Community Care electronic medical record system (see Recommendation 1 of this report) would:

- streamline the process for referring children to the Child and Adolescent Health Service and WA Country Health Service, including their respective Child Development Services and Child and Adolescent Mental Health Services
- improve the quality of information contained in referrals.

RECOMMENDATION 10 Page 36

The shared Community Care electronic medical record system (see Recommendation 1 of this report) include an online referral function.

FINDING 9 Page 39

The Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service are uniquely placed to, and should, inform external stakeholders about child development and the service options and pathways they can offer to children who need assistance in this area.

RECOMMENDATION 11 Page 39

The Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service be resourced to investigate, create and seize opportunities to inform external stakeholders about child development and the service options and pathways they can offer to children who need assistance in this area.

For the purposes of this recommendation, the external stakeholders should include teachers, education assistants, childcare workers, community kindergarten parent committees, social workers, child protection officers, playgroup coordinators, general practitioners and other private and non-government sector primary healthcare professionals.

FINDING 10 Page 40

Child Development Service providers and the Department of Education should be working together more closely in recognition of the inherent connection between children's development and their education.

FINDING 11 Page 44

The Department of Education's requirements for medical diagnoses to determine which students are given 'individual disability allocation' funding is unnecessarily placing pressure on child psychiatrists and paediatricians, including those who are employed by the Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service.

FINDING 12 Page 44

A wide range of health practitioners other than psychiatrists and paediatricians, such as allied health professionals, can provide assessments of a child's functional needs.

FINDING 13 Page 44

If the Department of Education was to utilise functional needs assessments rather than medical diagnoses to determine which students are given 'individual disability allocation' funding, it is likely that some pressure that has been placed on psychiatrists and paediatricians for providing diagnoses will be eased.

RECOMMENDATION 12 Page 44

The Department of Education utilise assessments of students' functional needs rather than medical diagnoses to determine which students are given 'individual disability allocation' funding.

FINDING 14 Page 48

The process of applying for a placement at a language development centre can be overly burdensome and time consuming. However, it is acknowledged that this process must be rigorous.

RECOMMENDATION 13 Page 48

The Department of Education and the Child and Adolescent Health Service–Child Development Service work with other relevant stakeholders (such as independent and Catholic schools, and non-government and private speech pathologists, psychologists and paediatricians) to consider and determine how the process of applying for a placement at a language development centre could be improved by being less burdensome, while maintaining the necessary rigour.

RECOMMENDATION 14 Page 48

The State Government consider increasing the number of language development centres across the metropolitan area and delivering more outreach services and support in regional Western Australia.

FINDING 15 Page 66

Increased collaboration between the Department of Education and WA Health with respect to the provision of allied health services relating to child development is desirable.

FINDING 16 Page 66

There is merit in trialling an expanded model of school-based allied health services across selected public schools.

RECOMMENDATION 15 Page 66

The State Government consider trialling an expanded model of school-based allied health services across selected public schools taking the following principles into account:

a) The Child and Adolescent Health Service–CDS (CAHS–CDS) and WA Country Health Service–Child Development Service (WACHS–CDS) should remain the primary providers of public, secondary and tertiary-level child development services.

b) No resources should be diverted from CAHS–CDS or WACHS–CDS to the Department of Education.

c) To prevent cost shifting, schools would not be required to divert funds from their one-line budgets.

d) To prevent children falling through the gaps, the principles of universal access and service provision should be respected.

e) Duplication of CAHS–CDS and WACHS–CDS services is minimised.

f) Involvement of parents and legal guardians in the assessment and treatment of children is maximised.

g) Schools in both metropolitan and regional Western Australia should be involved.

FINDING 17 Page 69

Mobile and relocatable allied health clinics that visit and service mainstream public schools in metropolitan and regional Western Australia, can be an alternative and complementary method of delivering child development services.

RECOMMENDATION 16 Page 69

The State Government investigate the practicability of providing mobile and relocatable allied health clinics that visit and service mainstream public schools in metropolitan and regional Western Australia.

FINDING 18 Page 74

Child and Parent Centres are sites where family programs and services, including primary and secondary-level child development services, can be delivered effectively.

FINDING 19 Page 74

At certain times of day, Child and Parent Centres are crowded. However, there are opportunities to expand the provision of child development services at these centres.

FINDING 20 Page 74

Child and Parent Centres could operate as spokes in a hub and spoke model for delivering child development services.

RECOMMENDATION 17 Page 74

The Child and Adolescent Health Service and WA Country Health Service investigate the feasibility of providing expanded primary and secondary-level child development services at existing Child and Parent Centres.

RECOMMENDATION 18 Page 75

The State Government consider establishing more Child and Parent Centres across the State and, where feasible, include facilities for visiting practitioners from the Child and Adolescent Health Service and WA Country Health Service.

RECOMMENDATION 19 Page 78

The State Government investigate whether additional service capacity and engagement opportunities can be provided by the not-for-profit sector when considering plans to improve access to child development services.

FINDING 21 Page 80

Early childhood education and care centres are sites that are potentially suitable for providing primary and secondary-level child development services.

RECOMMENDATION 20 Page 80

The Child and Adolescent Health Service and WA Country Health Service investigate the possibility of providing primary and secondary-level child development services at early childhood education and care centres.

FINDING 22 Page 83

The current measures available for Aboriginal Community Controlled Health Organisations to provide onsite secondary and tertiary-level child development services are piecemeal, infrequent and often unreliable.

RECOMMENDATION 21 Page 84

The State Government work with Aboriginal Community Controlled Health Organisations to establish the funding mechanism required to employ, or contract the services of, allied health practitioners to provide secondary-level child development services to the children in their local communities.

RECOMMENDATION 22 Page 84

The Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service develop a program, in consultation with Aboriginal Community Controlled Health Organisations, for their staff to undertake practical work experience at an Aboriginal Community Controlled Health Organisation.

FINDING 23 Page 104

The services currently provided by the State's public health system to children living with attention deficit hyperactivity disorder symptoms are insufficient. There is too much congestion at the points of assessment and diagnosis of the disorder, and then again during the treatment of the child.

RECOMMENDATION 23 Page 104

The Child and Adolescent Health Service and WA Country Health Service collaborate with the Commonwealth Government and health professional colleges to develop care pathways for attention deficit hyperactivity disorder that include an expanded range of health practitioners who can assess and diagnose the disorder and treat children with the disorder, particularly general practitioners and nurse practitioners.

RECOMMENDATION 24 Page 104

The Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service investigate the practicability of applying a general practitioner–paediatrician shared care model for children who are suspected of having attention deficit hyperactivity disorder.

FINDING 24 Page 106

Project ECHO networks can be an effective platform for all healthcare practitioners and like-minded professionals from other sectors to connect, share, teach and learn from the practical and theoretical knowledge of others.

RECOMMENDATION 25 Page 106

The Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service utilise Project ECHO networks as a means of collaborating more, and more effectively, with:

- each other
- other service providers within the State's public health system (WA Health)
- stakeholders outside of the State's public health system (WA Health).

FINDING 25 Page 110

Disadvantaged families can face multiple barriers in accessing and engaging with child development services.

FINDING 26 Page 112

It is difficult to determine precisely how many children are commencing school with developmental issues that would benefit from child development services. Evidence suggests that it may be up to 15% of children.

FINDING 27 Page 113

For the 2021-22 financial year, 4,896 appointments (or 6.6%) were classified as 'did not attend' for the Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service combined.

FINDING 28 Page 113

The Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service do not collect consistent or reliable data on the reasons for missed appointments.

FINDING 29 Page 115

From 2020-21 to 2021-22, an average of 5,670 clients per year were discharged from the Child and Adolescent Health Service–Child Development Service following a lack of response to an appointment offer.

FINDING 30 Page 116

From 2020-21 to 2021-22, the WA Country Health Service–Child Development Service conducted multiple follow-ups with an average of 6,274 clients per year following a lack of response to an appointment offer.

RECOMMENDATION 26 Page 117

WA Health expedite the evaluation of the Health Navigator Pilot Program for children in out-of-home care and, if the evaluation is positive, consider a statewide roll-out of the program.

FINDING 31 Page 117

Support service navigators can assist vulnerable clients navigate other beneficial health and social support services available to them, thereby reducing the time that Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service clinicians currently spend providing this assistance.

RECOMMENDATION 27 Page 118

The State Government consider the provision of funding to the Child and Adolescent Health Service and WA Country Health Service to recruit support service navigators, noting that this service does not necessarily need to be provided by Child Development Service providers.

RECOMMENDATION 28 Page 118

The State Government consider providing funding to the Child and Adolescent Health Service–Child Development Service to enable expansion of the Play and Learning program.

RECOMMENDATION 29 Page 121

The Child and Adolescent Health Service–Child Development Service explore ways to improve the effectiveness of its service planning appointments, including identifying when participation of the referrer at the appointment would be beneficial.

FINDING 32 Page 122

Culturally and linguistically diverse families face barriers accessing services and may need extra support to engage with child development services.

RECOMMENDATION 30 Page 123

The Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service explore ways to support the engagement of culturally and linguistically diverse families.

RECOMMENDATION 31 Page 123

The Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service explore outreach and promotion activities that target culturally and linguistically diverse families, including through Child and Parent Centres.

FINDING 33 Page 124

Regional and remote families are disadvantaged in terms of access to early intervention and support services.

FINDING 34 Page 125

There is a higher proportion of children in remote and very remote areas who are developmentally vulnerable compared to children in cities.

FINDING 35 Page 128

Variations in service delivery across regional Western Australia is often not the result of needs driven design, but a variety of other factors including workforce availability and funding arrangements.

FINDING 36 Page 128

The Patient Assisted Travel Scheme does not cover allied health service appointments.

RECOMMENDATION 32 Page 128

The Patient Assisted Travel Scheme be extended to cover allied health service appointments relating to child development services.

FINDING 37 Page 128

Complicated and variable funding of services and lack of coordination with other service providers in regional Western Australia makes individual case management difficult for the WA Country Health Service–Child Development Service.

RECOMMENDATION 33 Page 131

The WA Country Health Service–Child Development Service expedite the development of a resource-demand model to assist the equitable distribution of resources according to need.

FINDING 38 Page 131

The WA Country Health Service–Child Development Service's Community Health Information System has capability limitations that affect information sharing.

FINDING 39 Page 133

A range of technological solutions (such as telehealth, diagnostic technology and robotics) as well as other innovative solutions (such as the mobile and relocatable allied health clinics noted in Finding 17 and Recommendation 16 of this report) would improve access to child development services for regional and remote populations.

RECOMMENDATION 34 Page 133

The State Government explore and invest in technological and other innovative solutions that will improve access to child development services for regional and remote populations.

FINDING 40 Page 134

More than half of Aboriginal children in Western Australia live in regional and remote regions, with many communities in these areas the most disadvantaged in the State.

FINDING 41 Page 134

A greater proportion of Aboriginal children are developmentally vulnerable compared to non-Aboriginal children.

FINDING 42 Page 135

Service deficiencies in regional and remote areas contribute to inadequate provision of timely developmental support for Aboriginal children.

FINDING 43 Page 136

The amount of unmet need for child development services among Aboriginal children is difficult to estimate. Quantifying need requires investment to conduct the deep engagement necessary to identify children who require support.

FINDING 44 Page 155

There is no consensus among health professionals regarding the most effective scheduling of appointments within the universal child health check schedule.

RECOMMENDATION 35 Page 155

The Child and Adolescent Health Service and WA Country Health Service expedite a review to evaluate the efficacy of the current schedule of appointments within the universal child health check schedule.

FINDING 45 Page 156

During 2021-22, only 43% of eligible children in the metropolitan area received their scheduled child health check at 12 months of age and only 32% of eligible children received their scheduled child health check at two years of age.

FINDING 46 Page 157

During 2021-22, 64% of eligible children in regional Western Australia received their scheduled child health check at 12 months of age and 42% of eligible children received their scheduled child health check at two years of age.

FINDING 47 Page 157

Attendance at later child health checks (at 12 months and two years of age) in the metropolitan area and in regional Western Australia are below the internal benchmark of 75% adopted by the Child and Adolescent Health Service and WA Country Health Service.

FINDING 48 Page 159

There are multiple factors that may result in poorer attendance at later child health checks (at 12 months and two years of age) compared to earlier checks.

RECOMMENDATION 36 Page 159

As part of the review referred to in Recommendation 35 of this report, WA Health investigate the reasons for poor attendance at later child health checks to inform possible remedial action by the Child and Adolescent Health Service and WA Country Health Service to improve attendance rates.

RECOMMENDATION 37 Page 161

Child health nurses provide vaccinations under the WA Immunisation Schedule as part of the corresponding child health check where there are appropriate facilities and staffing.

RECOMMENDATION 38 Page 161

The Child and Adolescent Health Service and WA Country Health Service co-locate their immunisation clinics with their child health clinics wherever possible.

FINDING 49 Page 168

There are limited active engagement measures being undertaken by the Child and Adolescent Health Service to improve attendance at later child health checks at 12 months and two years of age. Promotional activities for the most part have consisted of time-limited trials or research projects targeting low socio-economic areas and vulnerable families.

RECOMMENDATION 39 Page 168

The Child and Adolescent Health Service conduct increased targeted and general promotional and educational activities to improve attendance at the 12-month and two-year child health checks. This would include maximising contact with target families at Child and Parent Centres, play groups and family and community centres, as well as vulnerable families with no community connections.

RECOMMENDATION 40 Page 168

The WA Country Health Service expedite the evaluation of the Virtual Child Health Nurse trial service and consider what other measures could be employed to improve attendance at the 12-month and two-year child health checks. This would include maximising contact with target families at Child and Parent Centres, play groups and family and community centres, as well as vulnerable families with no community connections.

RECOMMENDATION 41 Page 170

The Child and Adolescent Health Service and WA Country Health Service provide child health checks outside of normal working hours, including on Saturdays.

FINDING 50 Page 181

A holistic approach to child development, that integrates child and family services, can support better engagement of vulnerable populations and improve child development outcomes.

RECOMMENDATION 42 Page 181

In establishing its Community Hubs, the Child and Adolescent Health Service ensure maximum integration of its child development services with a broad range of other child and family services.

RECOMMENDATION 43 Page 182

With respect to its hubs, the WA Country Health Service ensure maximum integration of its child development services with a broad range of other child and family services.

FINDING 51 Page 182

WA Country Health Service hubs, which offer a range of health services, including secondary and tertiary-level child development services, are not child and family friendly because they are situated at hospital sites and are not co-located with other early childhood service providers.

RECOMMENDATION 44 Page 182

The WA Country Health Service investigate the benefit and feasibility of locating its hubs away from hospital sites.

RECOMMENDATION 45 Page 185

The WA Country Health Service–Child Development Service utilise clinical nurse specialists in its care pathways.

RECOMMENDATION 46 Page 190

The State Government explore opportunities to develop a low intensity workforce which functions in addition to and in support of current community health service provision.

FINDING 52 Page 193

The knowledge and skills of child health nurses are not as well respected, or as highly valued, as they should be, and as they have been in the past.

RECOMMENDATION 47 Page 193

The Child and Adolescent Health Service and WA Country Health Service address the perceived devaluation of child health nurses to ensure that their knowledge and skills are appropriately recognised, valued and utilised.

FINDING 53 Page 198

Nurse practitioners have the appropriate combination of skills and authority to perform tasks that will both complement and supplement the skills and authorities held by the existing workforce disciplines in the Child and Adolescent Health Service–Child Development Service (CAHS–CDS) and WA Country Health Service–Child Development Service (WACHS–CDS). CAHS–CDS and WACHS–CDS should be able to ease some of their workforce pressures by utilising nurse practitioners.

RECOMMENDATION 48 Page 198

The Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service investigate the feasibility of employing nurse practitioners.

RECOMMENDATION 49 Page 201

The State Government work with the Commonwealth Government, Western Australian universities and health professional regulatory bodies to increase university places in allied health, nursing and medical courses, and ensure adequate paediatric content in these courses.

FINDING 54 Page 208

All but one of the Western Australian settings accredited for basic training and core advanced training in paediatrics are in the public health sector.

FINDING 55 Page 210

To ensure that an adequate number of placements exists for health profession students and postgraduate trainees, all relevant stakeholders must consult each other regularly and clearly communicate to each other about the number of placements that are needed and that can realistically be delivered.

RECOMMENDATION 50 Page 210

The Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service (CDS providers) work closely with Western Australian universities to establish a strong framework to support and manage placements with the CDS providers, for health profession students and postgraduate trainees. Within this framework, the CDS providers should also regularly consult these universities, specialist medical colleges and other training bodies.

RECOMMENDATION 51 Page 211

The Department of Education work closely with Western Australian universities to establish a strong framework to support and manage placements within public schools, for allied health and nursing students and postgraduate trainees. Within this framework, the department should also regularly consult these universities and other training bodies.

RECOMMENDATION 52 Page 211

The State Government work with the Commonwealth Government and specialist medical colleges with a view to increasing paediatric specialist training placements in Western Australia that are funded by the Specialist Training Program, particularly in the sub-specialty of community child health.

RECOMMENDATION 53 Page 211

The State Government work with the Commonwealth Government and specialist medical colleges to test the proposition that expanding the Specialist Training Program to include more metropolitan based placements in Western Australia would result in a higher number of Western Australian paediatric trainees completing their specialist training in developmental paediatrics.

RECOMMENDATION 54 Page 214

The Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service ensure that they provide practical training placements that incorporate the principles of interprofessional education.

RECOMMENDATION 55 Page 214

The Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service apply the principles of interprofessional education when planning and providing their services.

RECOMMENDATION 56 Page 215

The State Government establish a high level implementation group whose main terms of reference are to:

- effect the recommendations made by this Committee, in its interim report and this report
- support and mandate reform

  and
- ensure that reform can occur alongside operational business as usual.

RECOMMENDATION 57 Page 218

The State Government consider developing a Child Wellbeing Strategy for Western Australia that satisfies recommendation 1 of the 2019 report by the Commissioner for Children and Young People, entitled *Improving the odds for WA's vulnerable children and young people*.

Minority recommendations

The recommendations of a minority of the Committee, comprising Hon Donna Faragher MLC, are grouped as they appear in the text at the page number indicated:

Minority Recommendation 1 **Page 49**

The State Government increase the number of language development centres and outreach services in Western Australia.

Minority Recommendation 2 **Page 66**

The State Government commence a trial of an expanded model of school-based allied health services across selected public schools immediately.

Minority Recommendation 3 **Page 75**

The Child and Adolescent Health Service and WA Country Health Service provide expanded primary and secondary-level child development services at existing Child and Parent Centres.

Minority Recommendation 4 **Page 75**

The State Government establish more Child and Parent Centres across the State and ensure these centres have appropriate facilities available for visiting practitioners from the Child and Adolescent Health Service and WA Country Health Service.

Minority Recommendation 5 **Page 78**

The State Government identify opportunities to improve its collaboration and partnership with not-for-profit health service providers when developing plans to improve access to child development services particularly in areas where there is limited access to these services.

Minority Recommendation 6 **Page 119**

The State Government provide funding to the Child and Adolescent Health Service–Child Development Service to enable expansion of the Play and Learning program.

Minority Recommendation 7 **Page 181**

The Child and Adolescent Health Service partner with non-government community service organisations to ensure that broader child and family services are co-located in its Community Hubs.

Minority Recommendation 8 **Page 182**

The WA Country Health Service partner with non-government community service organisations to ensure that broader child and family services are co-located in its hubs.

Minority Recommendation 9 **Page 216**

The State Government provide the funding required to give effect to the recommendations made by this Committee, in its interim report and this final report, as well as the minority recommendations. This will ensure the reforms needed to reduce unacceptably long waiting times and expand service provision are delivered for the benefit of children in Western Australia.

Minority Recommendation 10 **Page 218**

The State Government develop a Child Wellbeing Strategy for Western Australia that satisfies recommendation 1 of the 2019 report by the Commissioner for Children and Young People, entitled *Improving the odds for WA's vulnerable children and young people*.

CHAPTER 1
Procedure and context

Final report

1.1 This is the final report of the Select Committee into Child Development Services (Committee) in its examination of publicly delivered child development services in Western Australia (Inquiry).

1.2 For the purposes of the Inquiry, the Committee focused on the specialised (secondary and tertiary-level) child development services provided by the State's public health system (CDS). The two providers within the CDS system are the Child and Adolescent Health Service–Child Development Service (CAHS–CDS) in the Perth metropolitan area and the WA Country Health Service's CDS teams (WACHS–CDS) in regional areas. The Child and Adolescent Health Service (CAHS) and WA Country Health Service (WACHS) are just two of the eight health service providers that, along with the Department of Health (DOH), constitute the Western Australian public health system, referred to as WA Health.[1]

1.3 On 28 November 2023, the Committee tabled its interim report in the Legislative Council, entitled, *Child development services in Western Australia: Valuing our children and their needs* (Interim Report). The purpose of the Interim Report was to address and make recommendations about what can be done immediately to reduce unacceptably long waiting times and expand CDS provision (the 'now for now'). Essentially, the Interim Report (republished here as Part 1) identified the need for additional funding and resources. This final report (published here as Part 2) considers, and makes recommendations on, strategies to improve the accessibility and sustainability of CDS (the 'now for later'), on the assumption that adequate additional funding and resources will be forthcoming.

1.4 The Interim Report also:

- introduced 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
- provided the background and context in which the Interim Report (the 'now for now') and this final report (the 'now for later') can be viewed
- reflected the evidence that had been gathered to that date.

1.5 The material in this final report deals mainly with considerations (b), (c), (d) and (e) from the Committee's term of reference 2.[2]

1.6 The Interim Report and this final report are here published together, as this is how, in the Committee's view, they should be read.

1.7 To ensure that the Committee produced a final report that reflects the importance of the Inquiry and properly discharges its inquiry obligations to the Legislative Council, the Committee sought, and received, a second and final extension of its reporting date, from 31 December 2023 to 18 April 2024.[3]

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1 For more information on WA Health, refer to paragraphs 3.17–3.20 in Select Committee into Child Development Services, interim report, *Child development services in Western Australia: Valuing our children and their needs*, Western Australia, Legislative Council, 28 November 2023, (Interim Report) pp 18–19.

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

3 Legislative Council, *Debates*, 2023, p 6,830.

Private evidence

1.8 Private evidence used in this report is anonymised, except for some evidence provided by CAHS in a private hearing and a private WACHS report. In these two cases, the Committee has not used evidence that CAHS or WACHS requested remain confidential.

Government response to the interim report

1.9 The Government response to the Interim Report[4] was tabled in the Legislative Council on 1 February 2024[5] (see Appendix 1). While the response satisfies the requirements of Standing Order 191(1), the Committee notes that the substance of the report's Recommendations 2 and 3 has been acknowledged rather than addressed.

1.10 While the Committee further notes the Government's commitment that a comprehensive response to these recommendations will be furnished upon the tabling of the Committee's final report, the Committee wishes to confirm the following points:

- The Interim Report made recommendations about what can be done immediately to reduce unacceptably long waiting times and expand CDS provision (the 'now for now').[6]
- The recommendations made in each report are of equal importance (that is, the recommendations in the Interim Report are not 'interim' recommendations); and
- In accordance with the Standing Orders of the Legislative Council, the comprehensive response to the recommendations in both the interim and this final report will be tabled no later than 18 June 2024.

1.11 The Committee has the strong expectation that this comprehensive response will include consideration of both the 'now for now' recommendations in the Interim Report and the 'now for later' recommendations in the final report.

Government funding announcement

1.12 The Committee notes that, on 9 April 2024, as the Committee was finalising this report, the State Government announced $39 million in funding for both CAHS–CDS and WACHS–CDS as part of the 2024-25 State Budget (see Appendix 9).[7]

4 Letter from Hon Amber-Jade Sanderson MLA, Minister for Health and Mental Health, 19 December 2023, p 1.

5 Tabled Paper 2903, Legislative Council, 1 February 2024.

6 Interim Report, p 1, paragraph 1.5.

7 Hon Amber-Jade Sanderson MLA, Minister for Health and Mental Health, *$39 million for major expansion of Child Development Service*, media statement, WA Health, Perth, 9 April 2024, accessed 9 April 2024.

CHAPTER 2
Coordination and integration of services within WA Health

Overview

2.1 As discussed in the Interim Report,[8] the evidence gathered during the Inquiry clearly indicates that if the CDS system is to be effective and become more accessible and sustainable, WA Health (including CAHS–CDS and WACHS–CDS) must:

- internally, provide more coordinated and integrated services
- externally, work more collaboratively with organisations outside of WA Health that also contribute to a child's development, health and wellbeing – particularly in areas such as 'housing, child protection, disability services and education'[9], as well as non-government health services.

2.2 According to the Telethon Kids Institute (TKI), this would ensure that:

> the [public, private and non-government child development] 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.[10]

It would also ensure that service provision is optimised.

2.3 Ngala summarised the need for inter-sector collaboration, as follows:

> Increased engagement and collaboration between Government and non-government sectors, will allow for the experts in the field to be heard. It will raise the opportunities that exists to bring about the change needed. No one sector, organisation or initiative can meet the challenge of creating large scale, positive change for all children. We all have a role to play.[11]

2.4 Both CDS providers are aware of the value of, and the need for better, collaboration and integration of services. WA Health acknowledges that the Sustainable Health Review:

> notes the need to work in partnership **across and beyond the health sector**, and to develop and implement more integrated, connected and visible services, particularly with vulnerable groups, including young people.[12] (emphasis added)

2.5 CAHS–CDS's *Child Development Service: Strategic roadmap 2023–2028* indicates that two of its seven priorities are to:

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8 Interim Report, p 34 (paragraph 3.77) and pp 84–86.

9 Department of Health (DOH), *Sustainable Health Review Final report to the Western Australian Government*, DOH, 2019, accessed 15 December 2023, p 69. See also, Submission 23 from College of Educational and Developmental Psychologists (Australian Psychological Society, WA Branch), 22 October 2022, p 3; Submission 58 from Neurodevelopmental and Behavioural Paediatric Society of Australasia, 26 October 2022, p 3; Submission 63 from Australian Research Alliance for Children and Youth, 26 October 2022, p 2; Submission 74 from Australian Psychological Society (APS), 8 November 2022, p 5; and Submission 78 from Western Australian Primary Principals' Association, 10 November 2022, p 4.

10 Submission 85 from Telethon Kids Institute (TKI), 18 November 2022, p 5.

11 Submission 65 from Ngala, 28 November 2022, p 7.

12 Submission 77 from WA Health, 9 November 2022, p 77. See also, DOH, *Sustainable Health Review Final report to the Western Australian Government*, DOH, 2019, accessed 15 December 2023, p 101.

> Strengthen [internal] collaboration and working relationships to deliver better integration across service areas.
>
> …
>
> Build stronger collaborative partnerships with organisations outside of CAHS where this can help to promote better developmental outcomes for children, young people and their families.[13]

2.6 Similarly, WACHS–CDS operates under eight principles of practice, two of which are particularly relevant:

> **Coordinated Team Approach**
>
> - Our services will demonstrate coordination and collaboration between a range of team members that can contribute to achievement of outcomes, where the term team includes the family.
>
> **Working with Others**
>
> - Our services will actively collaborate and partner with other service providers and community partners
> - We will work together to strengthen community support and transitions for children with health and development needs.[14]

Chapter summary

2.7 This chapter and Chapter 3 will discuss evidence the Committee has received about areas in which the CDS providers may have fallen short of their commitments to work collaboratively, and strategies that could be employed to help rectify those issues. This chapter focuses on the coordination and integration of services within WA Health, specifically with respect to:

- the development and implementation of a statewide electronic medical record system, or at least a Community Care electronic medical record system that is jointly operated by the two CDS providers
- the co-location of related and relevant health services for children in 'hubs', and the positioning of those hubs
- better coordination of health services for children.

2.8 Chapter 3 focuses on collaboration between the CDS providers and entities outside of WA Health.

Collaboration between the Child and Adolescent Health Service and WA Country Health Service

2.9 CAHS–CDS and WACHS–CDS already operate under a memorandum of understanding signed by their overarching health service providers, CAHS (Community Health service area) and WACHS (Population Health service area), respectively.[15] The memorandum is a recognition that, while CAHS–CDS and WACHS–CDS are separate entities which provide

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13 Child and Adolescent Health Service (CAHS), *Child Development Service: Strategic roadmap 2023–2028*, CAHS, 2023 (provided as answer to question on notice 8 asked at hearing held 26 April 2023, attachment 3), p 6.

14 Tabled Paper 5, *Healthy Country Kids Program: Child development service framework*, tabled by the WA Country Health Service (WACHS) during hearing held 28 November 2022, p 20.

15 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. See also, Interim Report, p 32.

services to differing communities, they share very similar objectives and provide comparable services.

2.10 The memorandum outlines the roles and responsibilities of each CDS provider in the areas of:

- service delivery – policy development; resources, and transfer of clients
- the Triple P – Positive Parenting Program
- education and training
- service reporting
- research and quality improvement.[16]

2.11 The Committee notes that under 'Transfer of clients', the memorandum emphasises the importance of ensuring that there is 'continuity of care' for families moving between metropolitan and regional services. Any transfer should also be 'equitable and streamlined'.[17] From evidence presented to the Committee by WA Health, it appears that this objective is hindered by fragmented information systems because the two CDS providers use separate electronic information systems to record their clients' clinical information, and these systems do not communicate with each other.[18]

Statewide electronic medical record system

2.12 CAHS recognises that a single electronic information system for both CDS providers would be beneficial for bridging the gap between Perth metropolitan and regional CDS:

> A single system would facilitate a smooth clinical handover when families move between country and metropolitan areas. This is particularly important for children who move between country and metropolitan regions regularly.
>
> A shared system would also allow more consistent and comparable data collection for community nursing and child development services across the state, which in turn helps to enable more coordinated service planning, service improvement work and research.[19]

2.13 More generally, WACHS–CDS is of the view that:

> A connected and integrated child health clinical information system that follows the child's health journey can improve follow-up, reduce duplication, enhance care planning and service delivery, particularly for high-risk children.[20]

2.14 Currently, CAHS–CDS utilises two electronic health records, the Child Development Information System (CDIS), which is the main record, and Genie:

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16 Tabled Paper 4, hearing held 28 November 2022, pp 2–6, clause 4.

17 Tabled Paper 4, hearing held 28 November 2022, p 4, clause 4.1.3.

18 Submission 77 from WA Health, 9 November 2022, p 67.

19 Tabled Paper 2, *Inquiry into child development services: Potential questions – Response from the Child and Adolescent Health Service*, tabled by CAHS during hearing held 28 November 2022, p 14.

20 Submission 77 from WA Health, 9 November 2022, p 67.

> CDIS is a bespoke electronic health record that was designed for Community Health services[21] and within [CAHS–] CDS it is used to manage the full client journey from referral to discharge.
>
> Genie is an 'off the shelf electronic health record designed for medical practitioners. Genie was rolled out in [CAHS–] CDS in 2018 as it provides a range of medication management functionality that was not available within CDIS. Introducing Genie has significantly improved the safety and quality of medication management within CDS. The system is primarily used by [CAHS–] CDS paediatricians and clinical administration staff that support these paediatricians. These staff groups work across both Genie and CDIS.
>
> Manual administrative processes are in place to upload copies of paediatrician reports from Genie into CDIS so that all CDS staff are able to view information about the medical management of the client.
>
> Client demographic details are updated daily in Genie through an automatic data feed from CDIS. This ensures any newly referred client details are populated in Genie as well as accuracy of the client demographic details between the systems.[22]

2.15 CAHS–CDS gave evidence that while the CDIS has performed well, it is now outdated:

> I think CDIS was ahead of its time when we first introduced it. I think it is important to acknowledge that 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—and I think this is quite important—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. One of things that is important is that we have a service here that crosses all of the metro area … that engages nursing, from child health nursing from birth, right through until kids are aged 18, when they are presenting with developmental issues. It also means that we provide a service where we can make changes to service delivery and have it affect the whole of the metropolitan area. That was the idea of coming in as [CAHS–] Child Development Service as one group. The CDIS program allowed us to do that, and then provide that data and reflect on those things. From that perspective, it has been fantastic. But … it is end of life in terms of the underlying technology. It is expensive for us at times to make changes.[23]

2.16 WACHS–CDS uses the Community Health Information System (CHIS), which was:

> fully implemented across all our seven WACHS regions in 2019. It is actually a Communicare-based module that we have purchased through Telstra Health. Communicare is used in quite a number of Aboriginal-controlled health organisations. The version that we purchased—we actually made quite a number of additions to it to make it more usable for our service. One of the main things that we built into the system was a child development services referral process and that links the referral, the appointment and then the services provided …

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21 Community Health is a service area within CAHS that comprises Community Health Nursing; the Child and Adolescent Health Service–Child Development Service (CAHS–CDS); the Aboriginal Health Team; and the Refugee Health Team. See also, Interim Report, pp 19–21.

22 Tabled Paper 2, *Inquiry into child development services: Potential questions – Response from the Child and Adolescent Health Service*, tabled by CAHS during hearing held 28 November 2022, pp 13–14.

23 Dr B Jongeling, Medical Head of Department, CAHS–CDS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, pp 46–47.

> We also integrated the midwifery notification system so our birth notifications come in electronically. I do not have all the IT-speak but they automatically come into the system. Our child health nurses can actually go in and see within their region all the notifications of births that have happened and then they can actually commence the offering of the child health scheduled appointments from that. They were two fairly large system builds within Communicare that were required.
>
> Our CHIS is actually also linked to webPAS, which means that all people that front up to a service in WACHS, if they are in webPAS, they have a unique medical record number. That unique medical record number and the demographics that are attached to it, as soon as you front up to one of our services and we open up CHIS, that information will automatically come into our system, so then you have every person across WA has one record and it is in one system. It does not matter what health service practitioner logs into that record, all the information is there. It is not just for children, it is birth to death so we provide more than just child health services and child development services in a lot of our WACHS regions. The acute care sector does not use it so it is predominantly used in our community health sector. The other one is that we use it for our general medical staff for primary care, predominantly in the Kimberley. There is a medication management module within the system, also pathology and care planning.[24]

While the CHIS provides the electronic integration of various WACHS services, the system is 'very limited in its capacity to provide "live" and "trend" service data.'[25]

2.17 In its submission to the Inquiry, WA Health supports the Sustainable Health Review's recommendation for the preparation of a 'phased and prioritised [10-year] rollout of an electronic medical record across the WA [public] health system' by July 2029[26] (EMR Program).[27] The Sustainable Health Review panel noted that a statewide electronic medical record system (EMR) can improve the health outcomes and experiences for people with complex health needs, by allowing all health providers to be connected and to share information to support client care.[28]

2.18 CAHS–CDS identified the following benefits that a statewide EMR would provide for its service delivery:

- providing one system for use by all CDS staff, ensuring current clinical information is accessible to the "right users and at the right time" [this would overcome the inefficiencies and potential for errors created when having to work across CAHS–CDS's two electronic health records, the CDIS and Genie[29]]
- integrating information as part of one whole-of-health patient centred record to support shared care planning across community and acute service settings

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24 K Miller, Director, Population Health, WACHS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, pp 27–28.

25 Submission 77 from WA Health, 9 November 2022, p 67.

26 DOH, *Sustainable Health Review Final report to the Western Australian Government*, DOH, 2019, accessed 18 December 2023, p 98, recommendation 22.

27 Submission 77 from WA Health, 9 November 2022, p 58.

28 DOH, *Sustainable Health Review Final report to the Western Australian Government*, DOH, 2019, accessed 18 December 2023, p 99.

29 As discussed in Tabled Paper 2, *Inquiry into child development services: Potential questions – Response from the Child and Adolescent Health Service*, tabled by CAHS during hearing held 28 November 2022, p 14.

- enabling improved access to data, and enhancing data sharing to enable [data] driven decision making and support collaboration for research and clinical advancement
- providing technical opportunities to introduce modern digital health enablers such as remote monitoring, AI enabled decision support, and online screening assessments to reduce administrative burden, and
- improving client and family engagement in their own care through a patient portal and improved "on demand" access to information.[30]

On the basis of evidence received, the Committee expects that a statewide EMR across WA Health would have similar benefits for WACHS–CDS.

2.19 Other stakeholders are also of the view that a statewide EMR for WA Health is required. For example, the TKI submitted that it 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.[31]

2.20 Dr Yvonne Anderson, a paediatrician working across Curtin University, the TKI and CAHS, stated that a statewide EMR would be an 'absolute game changer':

> I appreciate it is complex and I appreciate there are contracts, considerations and a determination of what is going to be right for what jurisdiction, but the inability to be able to sit down before seeing a patient and read their story and learn about them before they walk in the room I find incredibly challenging. I am not speaking [just] in relation to WA, but anywhere I have worked where the information is not available before seeing a patient feels at a human level quite disrespectful because the first thing I do is then ask them to tell their story again. There are lots of examples of efficiencies in terms of automated reminders, text messages through systems, proper dashboards, patient journey dashboards, flow et cetera that could make a world of difference. I think also when issues of data governance, sovereignty and consent are navigated well, then that sharing of information, or a portion of information that is freely available to those who are caring for the child, makes a huge amount of difference in terms of that connectivity.[32]

2.21 WA Health informed the Committee that CAHS–CDS and WACHS–CDS would operate within the Community Care module of a statewide EMR. The EMR Program, which is part of the WA Health Digital Strategy (2020–2023),[33] is being implemented in two stages:

> Community care capability across the WA [public] health system is a priority and included in scope of the Electronic Medical Record (EMR) Program. Stage 1 focuses on transitioning all hospitals from paper records to a digital medical record (DMR) system, plus a suite of immediate clinical priorities including scoping for a Community Care system for CAHS and one WACHS region. Stage 2 will focus on implementing all the core features of a modern EMR for rollout across the state and implementation of the Community Care system to CAHS and WACHS.

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30 Tabled Paper 2, *Inquiry into child development services: Potential questions – Response from the Child and Adolescent Health Service*, tabled by CAHS during hearing held 28 November 2022, p 12.

31 Submission 85 from TKI, 18 November 2022, p 4.

32 Dr Y Anderson, Associate Professor, Community Child Health, Curtin University, [*transcript of evidence*], *Legislative Council,* 12 May 2023, pp 15–16.

33 Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0–18 years in Western Australia (ICA Taskforce), *Final report*, ICA Taskforce, 2022, accessed 15 December 2023, p 99.

> The Community Care system aims to allow for more care to be delivered closer to home, through sharing care plans with community General Practitioners (GPs), allied health specialists and hospital clinicians. Bringing care closer to home is a key recommendation of the Sustainable Review Final Report, to reduce demand in hospitals and improve health outcomes for consumers. Implementation of the Community Care system will benefit and be used by all community health care services across both adult and children, rural, remote and metropolitan services, inclusive of mental health services.
>
> In May 2022, as part of the 2022-23 Budget, $38.1 million was awarded to begin delivery of Stage 1, including the completion of a Community Care Request for Information (RFI) and preparation and development for Stage 2 EMR Business Case. The RFI for a Community Care system is due for completion by 30 June 2023. The RFI process is to identify potential fit for purpose Community Care solutions.[34]

2.22 In its submission, WA Health stated that:

> The implementation of one, state-wide Community Care EMR (proposed for 2024–25) will promote shared care across community health services in WA and allow for better data capture that will inform research and future services.[35]

2.23 WA Health informed the Committee that during the 'request for information' phase of the proposed statewide Community Care EMR, CAHS and WACHS worked jointly on a system that could either operate as a standalone or as an add-on to the future statewide EMR.[36] The proposed Community Care EMR would include:

> an online booking system … [that] … will allow access to real time bookings for families and will improve client engagement with the service.[[37]] In addition, when funded, client portals … 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.[38]

2.24 The Committee is of the view that a Community Care EMR that is shared between CAHS and WACHS is crucial to the sustainability and accessibility of the CDS system, whether it is part of a future statewide EMR or a stand-alone system. A shared Community Care EMR would also incorporate the electronic health records of other service providers within the CAHS and WACHS umbrellas (such as their respective Child and Adolescent Mental Health Services). The development and implementation of a shared Community Care EMR must be prioritised and its planned completion by 30 June 2025 should not be delayed.

FINDING 1

A Community Care electronic medical record system that is shared between the Child and Adolescent Health Service and the WA Country Health Service is crucial to the sustainability and accessibility of the secondary and tertiary-level child development services they provide.

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34 Dr DJ Russell-Weisz, Director General, DOH, Answer to question on notice 6 asked at hearing held 28 November 2022, dated 20 December 2022, p 4.

35 Submission 77 from WA Health, 9 November 2022, p 58.

36 Various witnesses, CAHS–CDS, [*private transcript of evidence*], *Legislative Council,* 25 July 2023, pp 36–39.

37 An online booking system within the statewide electronic medical record system would be comparable to the 'accurate service map' that was recommended by the Pilbara Aboriginal Health Alliance: Submission 76 from Pilbara Aboriginal Health Alliance, 8 November 2022, p 7.

38 Submission 77 from WA Health, 9 November 2022, p 58. Issues of access, engagement and equity in the CDS system are discussed in Chapter 4 of this report.

FINDING 2

A Community Care electronic medical record system that is shared between the Child and Adolescent Health Service and the WA Country Health Service would improve the delivery of all their health services.

RECOMMENDATION 1

WA Health prioritise the development and implementation of a Community Care electronic medical record system that is jointly operated by the Child and Adolescent Health Service and the WA Country Health Service, with implementation to be completed no later than 30 June 2025.

2.25 The establishment of a shared Community Care EMR is also relevant to the discussions about:

- collaboration between CAHS–CDS and other Community Health teams (paragraphs 2.31–2.33)
- collaboration between CAHS–CDS and Child and Adolescent Mental Health Services (paragraphs 2.68–2.71)
- collaboration between CAHS–CDS and Perth Children's Hospital (paragraphs 2.77–2.79)
- collaboration within WACHS (paragraphs 2.83–2.86)
- collaboration between CDS providers and external stakeholders (paragraphs 3.6–3.11 and 3.20–3.32).

Collaboration within the Child and Adolescent Health Service

Within the Child Development Service (CAHS–CDS)

2.26 In its Interim Report, the Committee found that:

> 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. (see Finding 5 of the Interim Report).[39]

2.27 If the State Government provides the funding increase pursuant to Recommendation 2 and the Minority Recommendation of the Interim Report,[40] the Committee anticipates that CAHS–CDS would be able to provide a more collaborative and integrated service, particularly for children who are seven years and older. This would mean, for example, that children in this age range who require developmental paediatric services would have access to a more holistic and integrated team of CDS specialists, comprising a paediatrician and various allied health practitioners as needed, not just a paediatrician working in isolation.[41]

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39 Interim Report, p 61, finding 5.

40 Interim Report, pp 81 and 82.

41 The Committee acknowledges that clinical nurse specialists with advanced practitioner training do support paediatricians in completing developmental assessments: Submission 77 from WA Health, 9 November 2022, p 150.

Between the Child Development Service (CAHS–CDS) and other Community Health teams

2.28 The Community Health service area within CAHS comprises CAHS–CDS and three primary-level healthcare providers:

- Community Health Nursing – provides child health nursing, school health nursing and immunisation services
- Aboriginal Health Team – provides culturally appropriate and secure services to Aboriginal families with children aged zero to five years[42]
- Refugee Health Team – provides support to newly-arrived refugees and humanitarian entrants to connect with community and specialist healthcare services[43].[44]

2.29 As primary healthcare providers, practitioners working in these three teams play a critical role in the early identification of emerging developmental difficulties in children. They are therefore an important referral source for CAHS–CDS and it is vital that the CDS practitioners work collaboratively with these Community Health teams.

2.30 In the WA Health submission, CAHS–CDS advised that one of its areas of priority was to work 'with referrers to increase the proportion of referrals in the 0 to 4 year [age] range'.[45]

Shared information and communications technology

2.31 All Community Health teams have access to the CDIS so there is already a level of information sharing that occurs between them. For example, a child health nurse wishing to refer a child to CAHS–CDS would do so using the CDIS[46] and the nurse could continue to monitor the child's progress using the same system. However:

> A modern EMR will also enable development of a collaborative shared care platform integrating primary, secondary and tertiary health services. This will allow for information sharing and coordinated care planning, improving outcomes for clients, especially those with complex needs who are accessing services across multiple providers.[47]

2.32 For example, using a shared Community Care EMR (as referenced in Recommendation 1 on page 10 of this report) a child health nurse preparing for a child health check appointment would be able to review a CAHS–CDS paediatrician's clinical notes on the child more readily. Currently, the paediatrician's notes would not necessarily be retrievable from the CDIS because the notes would have been created in Genie, and:

- only CAHS–CDS paediatricians, and the clinical administration staff who support them, can access Genie
- it would need to have been manually loaded into the CDIS from the Genie system.[48]

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42 CAHS, *Aboriginal health*, CAHS, 2023, accessed 21 December 2023.

43 CAHS, *Refugee health*, CAHS, 2023, accessed 21 December 2023.

44 For a discussion of the CAHS structure and the focus of each service area, see Interim Report, pp 19–21 and 108-109, Appendix 2.

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

46 Tabled Paper 2, *Inquiry into child development services: Potential questions*, tabled by CAHS during hearing held 28 November 2022, p 20.

47 Submission 77 from WA Health, 9 November 2022, p 58.

48 See paragraph 2.14 in this report.

2.33 Therefore, the Committee reiterates the need for a shared Community Care EMR as per Findings 1 and 2 and Recommendation 1 in this report (pages 9–10). This would deliver the benefits listed at paragraph 2.18, at least within the whole of CAHS and WACHS.

Co-location of services

2.34 The Committee heard evidence that co-located child and family service 'hubs' are increasingly being utilised around the country as a model of service delivery that:

- promotes collaboration between the service providers and the integration of their services
- enhances families' access to, and engagement with, these service providers (this is discussed further in Chapter 6 of this report)[49].

2.35 For example, the Australian Research Alliance for Children and Youth (ARACY) advised that 'co-located child and family services, or "hubs"' have been established in South Australia, Tasmania, Queensland, Victoria and New South Wales. ARACY described these hubs as an important mechanism to ensure that families regularly access health services and child developmental delays are identified early.[50]

2.36 As noted later in this Report at paragraph 2.87, WACHS already operates under a hub and spoke model in each of its regions,[51] enabling the clinicians working at the hubs (which provide CDS amongst other health services) to share information, ideas and expertise. However, to be more child and family friendly, WACHS would like its hubs to be situated within the local community and away from their current hospital sites.[52]

2.37 Dr Yvonne Anderson is supportive of service hubs as a means of facilitating multidisciplinary and interdisciplinary work:

> In relation to integrated models of care, there is a growing evidence base relating to these, of which there are numerous examples. The team at Melbourne children's research institute has published a systematic review on integrated hub models, and piloting of these hubs is underway. The Child Development Service here in WA [CAHS–CDS] is certainly working very hard towards hubs as well. My anecdotal experience with multidisciplinary teams and ways of working is that they are the most satisfying, efficient, collegial and evidence-based ways to work in health, and when these relationships extend across sectors, the outcomes are even more successful. The more we stop the silos between disciplines and provide joined-up services, the better. However, with any models of care, place-based considerations are critical, especially when you consider the geographical challenges of the state and the need for the opportunity for a nuanced type of interaction where required. Any plan on a page needs to be taken with those considerations in mind.[53]

2.38 Within CAHS, Dr Anderson envisages that the service hubs would be comprised of:

> child health nurses, clinical nurse specialists, allied health, [CAHS–]
> CDS paediatricians, general paediatricians, Aboriginal health workers, social

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49 See paragraphs 6.41–6.58 in this report.

50 Submission 63 from Australian Research Alliance for Children and Youth, 26 October 2022, p 4.

51 See Interim Report, p 27, paragraphs 3.50–3.51.

52 Submission 77 from WA Health, 9 November 2022, p 68; and L Pereira, Manager, Child Development Service, WA Country Health Service (WACHS–CDS), [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 26. See also, paragraphs 2.80–2.82 and 6.59–6.60 of this report for more discussion on the location of WACHS hubs.

53 Dr Y Anderson, Associate Professor, Community Child Health, Curtin University, [*transcript of evidence*], *Legislative Council,* 12 May 2023, p 5.

> workers, supported adequately by admin, that work across a geographic location …[54]

2.39 CAHS plans to establish a 'hub and spoke' model for its services, with 12 'Community Hubs' (CAHS Community Hubs) situated across the metropolitan area.[55] Each hub will see the co-location of three out of the four CAHS–Community Health teams, as well as mental health services for children, as follows:

- CAHS's Community Health service area:
  - Aboriginal Health Team
  - Child Health Nursing (child health nurses, school health nurses and immunisation)
  - CAHS–CDS.
- CAHS's Child and Adolescent Mental Health Service (CAHS–CAMHS)[56] (see paragraph 2.45 for a list of the services provided by CAHS–CAMHS).

2.40 The CAHS Community Hubs will aim to provide:

> a 'one-stop shop' for universal, targeted and specialised service provision for CAHS consumers, within a specific geographical region. The Hubs are supported by a network of smaller facilities in the local community, called spokes, which give families the option of also accessing services closer to home.
>
> The co-location of CAHS services will support coordinated, seamless, child-centered care using a collaborative approach to service delivery, making it easier for children, young people and families to access the support they need.
>
> The hubs and spokes will be culturally secure and welcoming for Aboriginal and culturally and linguistically diverse people, and for all children and families in the local areas in which they operate.[57]

2.41 Two CAHS Community Hubs, at Midland and Murdoch, are currently being built and are expected to open in mid-2024 and the end of 2024, respectively.[58] While these hubs are not situated at hospitals, they will be located close to St John of God Midland Public Hospital and Fiona Stanley Hospital, respectively. In addition to the teams listed at paragraph 2.39, the Murdoch CAHS Community Hub will include the specialised CAHS–CAMHS team known as Multisystemic Therapy.[59]

2.42 Armadale, Yanchep/Alkimos, Joondalup, Morley/Mirrabooka, Ellenbrook, Central Perth, Gosnells/Cannington, Mandurah, Rockingham and Fremantle are the locations that have been identified for the remaining 10 CAHS Community Hubs. CAHS is yet to propose a timeline for all of these hubs.[60]

2.43 From a collaboration perspective, the Committee is persuaded by the benefits of CAHS Community Hubs, which incorporate a hub and spoke model.

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54 Dr Y Anderson, Associate Professor, Community Child Health, Curtin University, Answer to question on notice 1a) asked at hearing held 12 May 2023, dated 16 June 2023, p 1.

55 Submission 77 from WA Health, 9 November 2022, p 57.

56 CAHS, *Community Hubs*, CAHS, 2023, accessed 21 December 2023. See Interim Report, pp 19–21 for a discussion of the CAHS structure and an overview of CAHS–CDS.

57 CAHS, *Community Hubs*.

58 Letter from V Jovanovic, Chief Executive, CAHS, 27 March 2024, p 4.

59 CAHS, *Community Hubs*, CAHS, 2023, accessed 21 December 2023. For more information about Multisystemic Therapy, refer to CAHS, *Multisystemic therapy*, CAHS, 2023, accessed 21 December 2023.

60 CAHS, *Hub and spoke model implementation strategy*, CAHS, 2022, pp 92 and 151.

FINDING 3

The Child and Adolescent Health Service's Community Hubs, which incorporate a hub and spoke model, will aid collaboration between the health service teams located at those hubs.

RECOMMENDATION 2

The State Government accelerate the establishment of its remaining 10 planned Child and Adolescent Health Service Community Hubs.

2.44 The Committee notes that there is currently no definite indication that the CAHS Community Hubs will house any child and family-focused community services, such as playgroups, early childhood education and care centres and Child and Parent Centres. However, the co-location of community-based services remains a possibility.[61] The Committee received evidence that hubs would benefit from the inclusion of one or more of these services to ensure maximum engagement of families. This issue is discussed at paragraphs 6.41–6.58.

Between the Child Development Service (CAHS–CDS) and the Child and Adolescent Mental Health Service (CAHS–CAMHS)

2.45 CAHS–CAMHS offers mental health assessments, case management and multidisciplinary intervention for children aged up to 18 years who are experiencing significant mental health concerns that impact severely on their functioning. These concerns can include:

- psychotic symptoms
- severe and complex mood related symptoms
- severe and complex anxiety symptoms
- persisting suicidal ideation, recent suicide attempt and/or serious risk of harm to themselves or others due to severe and complex mental health challenges
- eating disorders
- co-morbid severe and complex mental health symptoms related to substance use
- severe and complex symptoms resulting from trauma.[62]

2.46 CAHS–CAMHS provides the following discipline-specific services:

- nurses
- occupational therapists
- psychiatrists
- psychologists
- social workers
- speech pathologists.

The service also employs Aboriginal mental health workers.[63]

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61 For example, see CAHS, *Hub and spoke model implementation strategy*, CAHS, 2022, pp 30, 38, 47, 63, 69, 70, 72-73 and 133.

62 CAHS, *Community CAMHS*, CAHS, 2023, accessed 21 December 2023.

63 CAHS, *Community CAMHS*.

Coordination of services generally

2.47 Evidence clearly establishes that it is particularly important for CDS providers and child mental health service providers in WA Health to collaborate and work well together because children with developmental disorders often experience co-occurring mental health issues:

> Children and young people with developmental disorders are at a significantly greater risk of developing mental health problems (depression, anxiety etc.) compared to those that are developing typically. It is often the co-morbid mental health issues that impact on school and community participation and success. Paediatricians report increases in mental health co-morbidity in the young people who access CDS services.[64]

2.48 The Committee's terms of reference do not include consideration of mental health services specifically. However the Committee received evidence regarding the current state of these services in Western Australia, with several witnesses being concerned to point out the comorbidities relating to children with developmental delays. This evidence is set out from paragraphs 2.50–2.57 and appears to the Committee to relate mainly to CAHS–CAMHS. The Committee also acknowledges the extensive work done in this area by the Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0–18 years in Western Australia[65] (ICA Taskforce) and is careful not to duplicate that work, noting that the State Government has committed to implementing all of the Taskforce's recommendations.[66]

2.49 For the purposes of this Inquiry, the Committee focused on how the CDS providers could better collaborate with their child mental health counterparts, CAHS–CAMHS in the Perth metropolitan area and the WACHS–Child and Adolescent Mental Health Service (WACHS–CAMHS) in each of the seven WACHS regions.[67] The discussion towards the end of this section (paragraphs 2.61–2.76) focuses on strategies to improve interactions between CAHS–CDS and CAHS–CAMHS. Ways to improve collaboration between WACHS–CDS and WACHS–CAMHS are discussed at paragraphs 2.87–2.91.

2.50 The Australian Psychological Society (APS) and the Western Australian branch of the APS, the College of Educational and Developmental Psychologists, submitted that, like CDS, the waiting times for mental health services are extensive, leading to significant delays in interventions and sometimes, a total lack of access to public services:

> APS members report that the wait lists to see psychologists through these services [other State Government mental health-related services] are extensive, including CAMHS, where families may be re-referred to private practitioners. We have also been informed that parents are waiting 2+ years for CAMHS services, and that children who are 16 years of age when they require help are not added to the waitlist as they will not be able to access services prior to their 18th birthday. This is concerning given the at-risk nature of the cohort of children and young people waiting for support through CAMHS and the GDS [Gender Diversity Service at Perth Children's Hospital].[68]

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64 Submission 77 from WA Health, 9 November 2022, p 34.

65 ICA Taskforce, *Final report*, ICA Taskforce, 2022, accessed 15 December 2023.

66 Mental Health Commission, *Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0–18 years in Western Australia (ICA Taskforce)*, Mental Health Commission, accessed 15 December 2023.

67 The Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, South West and Great Southern. For an overview of WACHS, refer to the Interim Report, pp 25–32.

68 Submission 74 from APS, 8 November 2022, p 7.

▫▫▫

> Waitlists for government services and private paediatricians and psychiatrists are also very long, with many closing their books in the past 12 months. Similarly, appointments with psychologists who have an expertise in child development or are skilled in assessing learning challenges, autism, ADHD or other neurodevelopmental disorders are very long. Many children do not access any services for significant periods of time and it is noted that this goes against the general principal of 'early intervention' (at the time of need) being the most appropriate support for children and families.
>
> …
>
> In Western Australia the public provision of mental health services for children and families appears to end at age 16 years. Most adult services do not accept clients until 18 years.[69]

2.51 Both organisations gave evidence that during that two-year period, while the child in need of mental health services is aged between 16 and 18 years, it can also be very difficult for them to obtain the services they require privately:

> during that two-year period, I will continue to work with them]. I guess that is fine for those who can afford to pay privately or [are] using Medicare, but there will be some children falling through the gaps there.[70]

▫▫▫

> There is a significant gap of 2 years where most families struggle to find services (unless they have been working with some private psychologists who offer long term psychological and transition support. Families of individuals with long term developmental needs including autism and ADHD are frequently caught up in this issue in terms of the smooth transition from paediatrician to adult psychiatrist.[71]

2.52 Further, the College of Educational and Developmental Psychologists alleged that any publicly provided mental health services are insufficient and are only provided to the cases deemed to be 'serious enough':

> intervention supports are limited. For younger children many parents are offered 'handouts' or restricted group (Tier 2) intervention but in the critical early years our CEDP members identify that few children receive the level of intensive support they require to understand and ameliorate the high level challenges they and their family are experiencing. Similarly it is well known by private practitioners in WA that for a child to be seen by CAMHS they need to be expressing suicidal ideation or a similarly critical family challenge. Similarly children with eating disorders are often sent home after a visit to the hospital emergency clinic with many parents commenting they are told the case is not yet 'serious enough'. There is no opportunity to find a practitioner in the public system to comprehensively manage 'lower level' issues that impact both children and families or work with them in the longer term (something that is critical in a child development context).[72]

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69 Submission 23 from College of Educational and Developmental Psychologists, 22 October 2022, pp 1 and 3.

70 Dr C Davis-McCabe, President, APS, [*transcript of evidence*], *Legislative Council,* 9 February 2023, p 7.

71 Submission 23 from College of Educational and Developmental Psychologists, 22 October 2022, p 3.

72 Submission 23, p 1.

2.53 Dr Jennifer Bullock, paediatrician, also suggested that public mental health services are only made available to children with severe mental health issues.[73]

2.54 The Royal Australian and New Zealand College of Psychiatrists submitted that children who have co-occurring developmental and mental health problems find it difficult to see mental health professionals:

> Our members have raised the important role of child development services on a child's overall development health and well being, and express concern about the gaps in service in WA. Currently, where a child presents with emotional and/or behavioural issues that may have some neurodevelopmental foundations (including the presence of mental health disorder and/or the sequelae of interpersonal trauma) there is little to no capacity for this child to be seen in the public or private sectors by a child psychiatrist (nor increasingly, by appropriately trained psychologists and other allied health professionals). This compounds the lack of capacity in public sector child development services, arising as a result of increased referrals and difficulties with throughput.[74]

2.55 Similarly, other stakeholders alleged that CAHS–CAMHS and WACHS–CAMHS do not treat children for mental health concerns when they have co-occurring neurodevelopmental issues like autism spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD).[75] For example, representatives of ADHD WA provided the following oral evidence:

> **Dr TONER**: … CAMHS has a blanket rule that it does not treat ADHD. They actually state that and send parents away.
>
> **The CHAIR**: So, do you think CAMHS should be acknowledging ADHD?
>
> **Dr TONER**: They absolutely should. The Chief Psychiatrist told us that they have no formal mandate not to treat ADHD; it is not a formal policy. But CAMHS often and routinely turn parents away and say, "We do not treat ADHD."
>
> **Dr PATERSON**: And not just ADHD; they refuse to see anything to do with neurodevelopment, so mainly autism and ADHD.
>
> …
>
> … even if they detect it in clients they are already seeing, they refuse to treat it. As a child psychiatrist working in private practice, I am astounded by their attitude. If people are referred to me, autism and ADHD may well be part of the overall clinical picture and I need to be aware of what is going on. But to actually say, "I'm not going to see anyone with a hint of autism or ADHD—go away!" is very unfair and not good practice, not good medicine.[76]

2.56 CAHS–CAMHS's website confirms that parents and carers who are seeking either:

- a diagnostic assessment for their child's neurodevelopmental condition

  or

- management of a child's neurodevelopmental condition,

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

74 Submission 87 from Royal Australian and New Zealand College of Psychiatrists, 25 November 2022, p 1.

75 For example, Submission 33 from ADHD WA, 24 October, p 2; Submission 36, private, 24 October 2022, pp 2 and 3; and Submission 37 from Catholic Education Western Australia (CEWA), 24 October 2022, p 5.

76 Hon Dr Sally Talbot MLC, Chair, Committee; and Dr M Toner, Chair, and Dr R Paterson, Member, Management Board and Chair, Professional Advisory Body, ADHD WA, [*transcript of evidence*], *Legislative Council,* 12 December 2022, p 8.

should seek a referral to either CAHS–CDS or a private paediatrician or psychiatrist. However, the website also asserts that CAHS–CAMHS will treat:

> Children and young people with neurodevelopmental conditions who are also experiencing severe mental health concerns …[77]

2.57 The following exchange between the Committee and CAHS–CDS shows that, in practice, it is not always clear whether CAHS–CDS, CAHS–CAMHS or both service providers, will be involved in treating a child with complex needs:

> **The CHAIR**: … What does a child's pathway look like between CAMHS and CDS? How is it decided which service they will be accessing? For example, if you have a child with ADHD or autism and depression, whose patient do they become?
>
> **Ms TURNELL**: They may well belong to both. Both services have referral criteria that is based around the scope of their service and what they provide. Children can be referred to both services or to one of those services. They can be accepted to both services or to one of those services. Our referral processes are separate and we will both triage based on the referral information and what comes through and also refer to each other as well.
>
> **Dr JONGELING**: … There is a little more complexity to that because it does depend on the referral source. If the referral is being managed by a GP, they may choose to refer a mental health issue to CAMHS. We will not necessarily know about that, particularly if there is not a case of ours. If it is a joint case, if we were already managing that particular child with, I think you said autism and ADHD, in the majority of sites we will have a regular monthly case conference between the psychiatrists and the paediatricians and with allied health support and we will discuss any case where we think it is jointly engaged. We will at times do some joint assessments where possible, or we will share information to provide support as to who is most appropriate for that particular family.
>
> Certainly when we see a child and we are seeking mental health support, there are some differences at times between different CAMHS sites as to how well they will engage with that …
>
> Navigating that issue for families is very difficult, and navigating it for us at times is difficult, and not because of personality issues but just systems of response, I think. Sometimes with autism and depression CAMHS would be happy to engage. They certainly do not in the area of prescribing for ADHD because of the issue of ongoing monitoring and follow-up, so we have been doing some work about how we can accommodate that issue. But it is a complex area. We certainly, in our own service, see the need for having some experienced psychiatrists providing consultative advice, even within our own service, above and beyond CAMHS, but we have no specific role for that yet or funding for that as an issue. But … you cannot completely separate out the developmental issue from the emerging mental health challenge that that family is bringing. If we saw a child with depression, autism and ADHD in our service, it would often be the paediatrician who would start treatment for that, from a medication perspective. You will find even now—and certainly the college of paediatrics has acknowledged it—that there needs to be more discussion between the college of physicians, paediatrics, and the college of psychiatry, because there is a relative lack of child and adolescent psychiatrists around to provide that intervention, and it is increasingly paediatricians, both in the private system and in the public system, who are supporting and managing those complex families. In the space of autism, it is

[77] CAHS, *Community CAMHS*, CAHS, 2023, accessed 21 December 2023.

almost solely paediatrics, with a few psychiatrists adding some supports in, which is what leads to some of the challenges when these children roll up to ED and the need for a kind of quaternary model involving child development psychiatry and support for those. They are all things that have been happening over the last five to 10 years that we did not have as an issue before.

Ms KIELY: I will just make a general comment to add to what Brad and Anna have talked about. When you do have those children, as a general comment, the vast majority of referrals are children aged four to eight, and CAMHS does not see children very often who are below eight. We do have this crossover, and we have spoken about those crossover kids, but the majority is that the Child Development Service sees those younger children with complexity across the range of child developmental concerns, and CAMHS seems, at this point in time, to take on the older kids where mental health is the presenting problem.

Dr JONGELING: It is also worth noting, as I said, that there are sites where it works very well. We have a regular meeting at Joondalup, where I often work, with Clarkson and Hillarys CAMHS, on a monthly basis. It is that relationship building that is so important, so we definitely share cases, talk about issues and try to co-manage complex issues. I think that is a good model for that, as well as the question of co-location in a hub model.[78]

2.58 It appears to the Committee that there is a disconnect between, on the one hand, what the CAHS–CDS and CAHS–CAMHS clinicians are striving to achieve (in terms of cooperating and integrating their services) and, on the other hand what children and their families are experiencing as their clients. While there is an existing level of collaboration between the two service providers, it appears to be inconsistent and dependent on the commitment of individual clinicians to collaboration rather than on any systemic requirements.

2.59 There is a strong perception held outside of the two services that they operate very separately from one another. For example, Dr Mark Parker, a private neurodevelopmental paediatrician, believes that the two services should be amalgamated:

> I think there needs to be a streamlining and amalgamation of existing services under one umbrella of mental health services and child development.[79]

2.60 Dr Andrew Leech, a general practitioner (GP), was of the same view:

> **Dr LEECH**: … The referral process is also confusing. There are various ways to refer patients in the public system: … through [CAHS–] CAMHS and through the [CAHS-] Child Development Service. A lot of GPs do not understand the nuances or differences between each. I do not think each are connected very well. We might refer a child development problem to CAMHS and it is sent back because it is not a relevant referral.
>
> **The CHAIR**: Because it should have gone to CDS.
>
> **Dr LEECH**: It should have gone to CDS. That is quite often what GPs tend to do, because they are not sure which way it should go. That is a waste of one to two months.

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78 Hon Dr Sally Talbot MLC, Chair; A Turnell, Acting Director, Clinical Services, CAHS–CDS, and Dr B Jongeling, Medical Head of Department, CAHS–CDS; and S Kiely, Executive Director, Community Health, CAHS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, pp 51–52.

79 Dr M Parker, neurodevelopmental paediatrician, [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 12.

The CHAIR: Is this a matter of improved communications systems or is it training for the GP?

Dr LEECH: I think it is a matter of connecting the services together into one. I think that would be the ultimate goal, so that we can actually just refer to one place.[80]

FINDING 4

While there is an existing level of collaboration between the Child and Adolescent Health Service's Child Development Service and Child and Adolescent Mental Health Service, the experience of children and their families is that this collaboration is inconsistent and ad hoc.

2.61 The Committee is of the view that the existing level of collaboration between CAHS–CDS and CAHS–CAMHS should be expanded and formalised, and better communicated to referrers and children and their families.

RECOMMENDATION 3

The existing level of collaboration between the Child and Adolescent Health Service's Child Development Service and Child and Adolescent Mental Health Service be expanded and formalised, and better communicated to referrers and children and their families.

2.62 The Committee believes a more integrated service, which would better meet the needs of children and their families, requires the two service providers to develop a clear procedure for identifying which of them will assess and treat children who present with complex and co-occurring developmental and mental health issues. In other words, for every such child, triaging practitioners will be able to systematically determine which service, or whether both services, will be involved in assessing and treating the child. The procedure should also have the flexibility to allow practitioners to exercise some clinical discretion.

2.63 The Committee expects that the development of this procedure will help to:

- ensure that each child is seen by the most appropriate service or services, regardless of where they are initially referred
- avoid either service refusing and/or redirecting a referral without first considering a child's holistic needs.

RECOMMENDATION 4

The Child and Adolescent Health Service's Child Development Service and Child and Adolescent Mental Health Service jointly develop a clear procedure for identifying which of the two services, or whether both services, will assess and treat children who present with complex and co-occurring developmental and mental health issues.

2.64 In formulating Recommendations 3, 4 and 5, the Committee is cognisant of the ICA Taskforce's infants, children and adolescents' Mental Health Strategy (ICA Mental Health Strategy). This strategy will require, among other things, the current CAHS–CAMHS and WACHS–CAMHS to be re-organised into, and deliver, a proposed new model of community

[80] Hon Dr Sally Talbot MLC, Chair; and Dr A Leech, general practitioner, Royal Australian College of General Practitioners (RACGP), [*transcript of evidence*], *Legislative Council,* 17 May 2023, p 4.

mental health services for children and their families – to be known as the Community Infant, Child and Adolescent Mental Health Service, or Community ICAMHS.[81]

2.65 Eight 'key actions' and 32 associated recommendations will guide the implementation of the ICA Mental Health Strategy. Key action 4 involves public mental health services for infants, children and adolescents (such as the current CAHS–CAMHS and WACHS–CAMHS):

> Collaborating with other government and community services to ensure that they can appropriately support children and families[82]

2.66 Recommendation 14 requires these mental health services to:

> Ensure that there is an integrated, multiagency care coordination process to support children, families and carers with complex and co-occurring needs in place[83]

2.67 The Committee considers that its Recommendations 3, 4 and 5 are consistent with the ICA Taskforce's key action 4 and recommendation 14. The Committee's recommendations are also relevant regardless of the ultimate form of CAHS–CAMHS once the ICA Mental Health Strategy has been implemented.

Shared information and communications technology

2.68 CAHS–CDS and CAHS–CAMHS do not currently share an electronic health record. Given the clear overlap of their respective areas of operation and the importance of them working collaboratively, the Committee makes the following finding:

FINDING 5

Collaboration between the Child and Adolescent Health Service's Child Development Service and Child and Adolescent Mental Health Service would improve vastly if each service had access to the other's electronic medical record system.

2.69 Therefore, the Committee reiterates the need for a shared Community Care EMR as per Findings 1 and 2 and Recommendation 1 in this report (pages 9–10). This would deliver the benefits listed at paragraph 2.18, at least within the whole of CAHS and WACHS.

2.70 The Committee notes that its Recommendation 1 is consistent with the ICA Taskforce's key action 7:

> Enhancing ICA [infants, children and adolescents'] mental health services with contemporary infrastructure, technology and research

and recommendation 28:

> Update digital systems, technology and data to better support the delivery and quality of ICA mental health services.[84]

2.71 The ICA Taskforce also makes the following salient comment in relation to the Community Care module of the statewide EMR:

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81 ICA Taskforce, *Final report*, ICA Taskforce, 2022, accessed 15 December 2023, pp 32 and 49.

82 ICA Taskforce, *Final report*, p 71.

83 ICA Taskforce, *Final report*, p 71.

84 ICA Taskforce, *Final report*, p 99.

> Whilst mental health wasn't initially intended to be part of this [stage 1 of the EMR Program,[85] of which the Community Care module is part], there is a small window of opportunity for the requirements for ICA [infants, children and adolescents'] mental health to be integrated into the 'Community Care' module.[86]

Co-location of services

2.72 As detailed in paragraph 2.39, WA Health has already recognised the benefits of co-locating CAHS–CAMHS with three out of the four CAHS–Community Health teams (including CAHS–CDS) at the two CAHS Community Hubs that are currently being built. As noted by Anna Turnell, then Acting Director, Clinical Services, CAHS–CDS:

> **Ms TURNELL**: I think that really brings us back to the hub discussion because that [the co-management of complex cases by CAHS–CDS and CAHS–CAMHS] happens better, naturally, where we already coexist with CAMHS, which happens at two sites where we are at the same location.[[87]] That ability to bring all of those services together in the one hub brings those natural synergies and integration of services better.
>
> **The CHAIR**: So it helps to break down the silo.
>
> **Ms TURNELL**: Yes.[88]

2.73 This approach is consistent with the ICA Taskforce's key action 2:

> Creating an integrated and child-centred ICA [infants, children and adolescents'] mental health system

and recommendation 5:

> Align all specialist community services into regional 'hub and spoke' networks that can deliver more care locally.[89]

2.74 In the Perth metropolitan area, the ICA Taskforce recommended that Community ICAMHS hubs be organised into Perth North, Perth South and Perth East catchments. In regional and remote areas of the State, the ultimate locations of the hubs should be decided by WACHS and its partners in regional service delivery.[90]

2.75 The ICA Taskforce suggested that, ideally, each Community ICAMHS hub would be co-located with:

> GPs, *headspace and Head-to-Health Kids* centres, child development services, early childhood services and education support services

and that the hubs would:

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85 For more information about the EMR Program, refer to paragraph 2.21.

86 ICA Taskforce, *Final report*, ICA Taskforce, 2022, accessed 15 December 2023, p 99.

87 Currently, there are co-located CAHS–CDS centres and CAHS–CAMHS clinics at Renshaw Boulevard in Clarkson and Ameer Street in Rockingham: CAHS, *Clinic locations*, CAHS, 2023, accessed 20 December 2023; and CAHS, *Centre locations*, CAHS, 2023, accessed 20 December 2023.

88 Hon Dr Sally Talbot MLC, Chair; and A Turnell, Acting Director, Clinical Services, CAHS–CDS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 52.

89 ICA Taskforce, *Final report*, ICA Taskforce, 2022, accessed 15 December 2023, p 49.

90 ICA Taskforce, *Final report*, p 50.

> provide an opportunity to bring traditionally separate services together into a single community-based setting as part of a 'one-stop-shop' for all health and mental health supports for children, and their families and carers.[91]

2.76 As noted in paragraph 2.43, from a collaboration perspective, the Committee is persuaded by the benefits of CAHS Community Hubs, which incorporate a hub and spoke model. Therefore, the Committee reiterates Finding 3 and Recommendation 2 on page 14 of this report (accelerating the establishment of CAHS Community Hubs) and makes the following further recommendation:

RECOMMENDATION 5

For future Community Hubs, the Child and Adolescent Health Service continue to co-locate its Community Health teams, including the Child Development Service, with its Child and Adolescent Mental Health Service.

Between the Child Development Service (CAHS–CDS) and Perth Children's Hospital

Shared information and communications technology

2.77 CAHS–CDS advised the Committee that one of the most significant impediments to its collaboration with Perth Children's Hospital (PCH) is the lack of an electronic health record that can be accessed by both services. Even though both service providers operate under the CAHS umbrella,[92] individual licences must be purchased for PCH clinicians to access the CDIS. This only provides limited access and leads to practical difficulties:

> **Dr JONGELING**: … there is still a disconnect between CDIS and Genie, but more concerningly so between Genie, CDIS and the hospital system. The hospital system does not have any clear oversight as to our patients and what we might be doing with them when they roll up in ED. They hopefully will in two weeks' time when we will be uploading at least the paediatric reports into My Health Record for those patients that have My Health Record,[93]
>
> …
>
> **Ms KIELY**: … we do obviously refer to other people. The usual way of doing that is with the parental permission and sending an email. It is a slightly more time-consuming process, but at the moment there is not the ability to share with anybody outside that sort of health system. We cannot even do it particularly well with PCH. We have to send emails through rather than have a shared system with the information readily available, and you can pull it up and have a look as you are talking to someone.
>
> **The CHAIR**: So if a child is admitted to PCH, they cannot access a record that shows their CDS involvement?
>
> **Ms KIELY**: There are only a number of licences we are currently able to afford. I think every major area, in terms of every sort of clinical area in PCH, has a licence to log on and have a look.

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91 ICA Taskforce, *Final report*, pp 50 and 97.

92 Refer to Interim Report, pp 19–21 for an explanation of the CAHS structure.

93 Dr B Jongeling, Medical Head of Department, CAHS–CDS, [*private transcript of evidence*], *Legislative Council,* 25 July 2023, p 36.

> **Ms TURNELL**: In the areas where we have the most overlap of clients, for instance the paediatric rehab early intervention program or the refugee health team.
>
> **The CHAIR**: That is where you have chosen to use those licences?
>
> **The WITNESSES**: Yes.
>
> **Dr JONGELING**: But it is important to note that that is [access to just the] CDIS and it may not have access to all the paediatric stuff that sits in Genie—although it should move to CDIS—but with My Health Record, that will help [for those patients who have a My Health Record].[94]

2.78 Other public hospitals which operate within WA Health, but under other health service providers,[95] also lack access to the CDIS:

> That description about … [the inability to access CDS provider records] … also applies to regional hospital systems. Joondalup does not have access to health department information, nor does Midland—although my understanding is that I think they are building some links for Midland.[96]

FINDING 6

Collaboration between the Child and Adolescent Health Service's Child Development Service and Perth Children's Hospital (and other public hospitals in the State) would improve vastly if the hospital had access to the Child Development Service's electronic medical record system.

2.79 Therefore, the Committee reiterates the need for a shared Community Care EMR as per Findings 1 and 2 and Recommendation 1 in this report (pages 9–10). This would deliver the benefits listed at paragraph 2.18, at least within the whole of CAHS and WACHS.

Co-location of services

2.80 There was no suggestion in the evidence presented to the Committee that CAHS–CDS ought to be co-located with PCH. In fact, WACHS submitted that its CDS teams should be situated within the local community and away from hospital sites, where many of these teams are currently located. WA Health submitted that co-location with a hospital may potentially discourage a family from accessing CDS:

> e.g. due to stigma, fear or even pragmatic issues such as the challenges of parking with children and prams/wheelchairs.[97]

2.81 Ms Lesley Pereira, Manager, WACHS–CDS, also explained that:

> We would have one wing within the regional hospital, for example, where our CDS team is based. Ideally, what we would prefer … is to have facilities that are located within the community, because our children are not necessarily sick when they

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94 Hon Dr Sally Talbot MLC, Chair; S Kiely, Executive Director, Community Health, CAHS; and A Turnell, Acting Director, Clinical Services, CAHS–CDS, and Dr B Jongeling, Medical Head of Department, CAHS–CDS, [*private transcript of evidence*], *Legislative Council,* 25 July 2023, pp 39–40.

95 For example, Joondalup Hospital is overseen by the North Metropolitan Health Service (NMHS) and St John of God Midland Public Hospital comes under the remit of the East Metropolitan Health Service (EMHS): NMHS, *Hospitals*, NMHS, 2022, accessed 11 December 2023; and EMHS, *Hospitals*, EMHS, 2022, accessed 11 December 2023. Refer to Interim Report, pp 18–19 for an overview of WA Health.

96 Dr B Jongeling, Medical Head of Department, CAHS–CDS, [*private transcript of evidence*], *Legislative Council,* 25 July 2023, p 40.

97 Submission 77 from WA Health, 9 November 2022, p 68.

> come for developmental services. I think it is really important that children do not come to a hospital to receive their [child development] services and that the services are located in the community …[98]

The possible relocation of WACHS hubs away from hospital sites is discussed in paragraphs 6.59–6.60.

2.82 The ICA Taskforce also acknowledged the need for the Community ICAMHS[99] hubs, which would include CDS providers, to be 'easily accessible in a non-hospital setting.'[100]

Collaboration within the WA Country Health Service

Shared information and communications technology

2.83 As explained in paragraph 2.16, WACHS has been using the CHIS since 2019. The CHIS already has the elements of a good integrated electronic medical record. In summary, it:

- has the capability of recording a client's medical and health information throughout their lifespan
- has a built-in CDS referral module that links the referral to the client's appointments and the treatments they receive
- has a midwifery module that notifies child health nurses of the birth of children, allowing the nurses to start offering scheduled child health check appointments
- links to webPAS, which allocates every WACHS patient, including WACHS–CDS clients, a unique medical record number that can be used to access the patient's medical and health history within the CHIS.[101]

2.84 However, CHIS does not communicate with CAHS–Community Health's CDIS and is 'very limited in its capacity to provide "live" and "trend" service data.'[102] The CHIS is also predominantly used by WACHS's community health sector only, not the acute care sector.[103] However, the CHIS's ability to link to webPAS may negate this issue.

2.85 In the Committee's opinion, while CHIS is an effective EMR for WACHS, it could be improved by integrating it with the CDIS where possible and further developing its service data extraction function.

FINDING 7

The Community Health Information System is an effective electronic medical record system for the WA Country Health Service, but while awaiting a statewide Community Care electronic medical record system, it could be improved by integrating it with the Child and Adolescent Health Service–Community Health's Child Development Information System where possible and further developing its service data extraction function.

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98 L Pereira, Manager, Child Development Service, WACHS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 26.

99 Refer to paragraph 2.64 for an explanation of Community ICAMHS.

100 ICA Taskforce, *Final report*, ICA Taskforce, 2022, accessed 15 December 2023, p 97.

101 K Miller, Director, Population Health, WACHS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, pp 27–28.

102 Submission 77 from WA Health, 9 November 2022, p 67.

103 K Miller, Director, Population Health, WACHS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 28.

2.86 Therefore, the Committee reiterates the need for a shared community care EMR as per Findings 1 and 2 and Recommendation 1 in this report (pages 9–10). This would deliver the benefits listed at paragraph 2.18, at least within the whole of CAHS and WACHS. The shared Community Care EMR should at least incorporate the same features as the CHIS.

RECOMMENDATION 6

The shared Community Care electronic medical record system (see Recommendation 1 of this report) should at least incorporate the same features as the WA Country Health Service's Community Health Information System.

Co-location of services

2.87 WACHS already operates under a hub and spoke model in each of its regions,[104] and many of its services are already co-located, particularly at the hubs. However, WACHS indicated that its CDS teams would benefit from co-location with its CAMHS teams:

> I think it is really important … [among other things]—to have integrated care with CAMHS, for example—so that families have that one-stop shop. We [WACHS–CDS] do not have that at the moment. We are located on a hospital site, within a wing, potentially, and we do not necessarily have our CAMHS colleagues with us within that ward.[105]
>
> ▫▫▫
>
> In an ideal world, it would be amazing to have colocation of our child development services, CAMHS and community health all in the one location—one place for families to streamline those services.[106]

2.88 There is a CAMHS team in each of the seven WACHS regions.[107] Each WACHS–CAMHS team varies slightly, but they all typically offer the following services and practitioner disciplines at the community clinics across their region:

> specialised assessment, treatment and support to children, young people and their families who are experiencing moderate to severe mental health problems.
>
> Our multidisciplinary team includes doctors, nurses, social workers and Aboriginal Mental Health workers.[108]

2.89 In the WA Health submission to the Inquiry, WACHS supported the ICA Taskforce's recommendation 27:

> Establish new integrated ICA mental health facilities in all regions to support more flexible, responsive and expert care[109]

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104 See Interim Report, p 27, paragraphs 3.50–3.51.

105 L Pereira, Manager, Child Development Service, WACHS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 26.

106 S Wood, Senior Occupational Therapist, Child Development Service, Kimberley Population Health Unit, WACHS, [*transcript of evidence*], *Legislative Council,* 1 May 2023, p 17.

107 The Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, South West and Great Southern. For an overview of WACHS, refer to the Interim Report, pp 25–32.

108 Quoted from the Kimberley CAMHS webpage: WACHS, *Child and Adolescent Mental Health Service (Kimberley)*, WACHS, 2023, accessed 18 December 2023.

109 ICA Taskforce, *Final report*, ICA Taskforce, 2022, accessed 15 December 2023, p 97.

as well as the ICA Taskforce's recommended Community ICAMHS[110] hubs (already discussed in paragraphs 2.73–2.75):

> For consumers this [the Community ICAMHS hubs] means greater convenience for families and an enhanced capacity to coordinate care, but **for service providers in regional and remote WA, it could offer greater economies of scale, professional support and service integration**.[111] (emphasis added)

2.90 In regional and remote areas of the State, the ICA Taskforce recommended that the ultimate locations of the Community ICAMHS hubs should be decided by WACHS and its partners in regional service delivery.[112] While the ICA Taskforce's ideal Community ICAMHS hub would be:

> a purpose-built integrated facility that supports the co-location of Community ICAMHS, with enhanced primary mental health services, GPs, child development services, and a range of other social support services. These hubs need to be easily accessible in a non-hospital setting. These facilities should be child and family friendly and be designed with input from children and families to create therapeutic, low-stimulation, and recovery-oriented environments.

The taskforce also recognised that:

> It is expected that these facilities will look different in regional WA, due to the availability of infrastructure, and geographically dispersed area's that 'Hubs' will need to support. Virtual care will play a crucial role in 'virtually' bringing services together to create Hubs that are both virtually and physically integrated.[113]

2.91 From a collaboration perspective, based on the evidence in this chapter, the Committee is persuaded by the benefits of service hubs. Therefore, the Committee makes the following recommendation:

RECOMMENDATION 7

The WA Country Health Service co-locate its Child Development Service and Child and Adolescent Mental Health Service, under an expanded hub and spoke model in line with the recommendations of the Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0–18 years in Western Australia.

110 Refer to paragraph 2.64 for an explanation of the Community ICAMHS model.

111 Submission 77 from WA Health, 9 November 2022, p 68.

112 ICA Taskforce, *Final report*, ICA Taskforce, 2022, accessed 15 December 2023, p 50.

113 ICA Taskforce, *Final report*, p 97.

CHAPTER 3
Collaboration with entities outside WA Health

Overview

3.1 Outside WA Health, and apart from a child's parents and caregivers, the entities most likely to be involved in a child's development, health and wellbeing include service providers in the areas of education (including early childhood education and care centres), housing, disability services, child protection, community services, and the private and non-government healthcare sectors (for example, not-for-profit health service providers, private paediatricians and Aboriginal Community Controlled Health Organisations). As discussed early in Chapter 2 (see paragraphs 2.1–2.6), evidence suggests that CDS providers also need to collaborate more, and more effectively, with these external stakeholders.

Chapter summary

3.2 In this chapter, the Committee will discuss the need for the CDS providers to:

- communicate better with external stakeholders
- implement a single, online referral system
- provide child development training for external stakeholders.

3.3 The Committee also explores how the CDS providers can interact more, and more effectively, with:

- the Department of Education (including schools and Child and Parent centres)
- the early childhood education and care sector
- Aboriginal Community Controlled Health Organisations and other non-government organisations
- external stakeholders in the assessment, diagnosis and treatment of children with ADHD.

Three themes regarding external stakeholders

3.4 Three themes emerge from evidence received by the Committee in relation to improving collaboration with external stakeholders:

- the need for better communication with, and flow of information to, external stakeholders
- the benefits of a single, online CDS referral system
- the need for the provision of more child development education and awareness for external stakeholders.

Better communication

3.5 The often multifaceted nature of child development issues requires CAHS–CDS and WACHS-CDS practitioners to communicate amongst themselves and with external stakeholders. As Dr Rob Lethbridge, a paediatrician, explained:

> it is a field that requires a lot of communication … [these clients] … are complex. They are interacting with lots of different services often and so you need to talk to the school and the GP. You need to send out questionnaires. You need, in some

> cases, to speak to law enforcement and things like that—in very edge cases, obviously.
>
> By definition, you need to talk to speech pathologists and psychologists for almost every patient. It is about that communication. I think the easiest way that it is done in [CAHS or WACHS–] CDS is that the psychologist is literally next door and you can go, "Hey, what you think about this?" Outside of that, in private, you write a letter to someone that you do not necessarily know, you wait for that to be fed back and then you act on that, and you are not quite sure how you can interpret that.
>
> I think it is a comment rather than a solution, because having a multidisciplinary service where you can just chat obviously lowers that to some degree, but it is going to be a service that requires a huge degree of paperwork and communication because of the nature of it—because of the number of people that need to be involved in understanding this child.[114]

Communication with the referrer

3.6 Despite the importance of communication with external stakeholders, the Committee received evidence that some referrers to CDS providers would not be given any information about the child's progress after the initial referral. For example, the Royal Australian College of General Practitioners (RACGP) submitted that:

> When GPs refer children to paediatric developmental services, we often lose sight of where the referral goes and how it progresses through the system. Our patients and parents frequently ask us for updates, which we cannot give. We would ask that there be a simple, easy-to-use website that can provide us with this information.[115]

3.7 Similar evidence from the following stakeholders was provided about CDS referrals from schools:

- The Western Australian Primary Principals' Association:

> There is a disconnect with the referral process. Schools are often the main referrers yet are not consulted again after the paperwork is submitted. This is a significant issue when parents either do not respond to communication, don't provide enough information, or do not support the details outlined in the referral, and the child is subsequently discharged.
>
> …
>
> There is no communication between the CDS and the school post intervention, so quite often the school is unsure as to what has occurred. This is usually reliant on parents providing written reports and verbal updates.[116]
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> ▫▫▫
>
> I should say that we are also aware that that might be parents that quite often do not take up appointments and never communicate with the school.
>
> …

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

[115] Submission 66 from RACGP, 31 October 2022, p 1.

[116] Submission 78 from Western Australian Primary Principals' Association, 10 November 2022, p 3.

> … [but] quite often once that referral has been made, schools tend to hear not a great deal beyond that as to whether a child has been seen, what the progress reports might be, whether ongoing support has been recommended, an exit report being provided to the school … we just do not see that level of continuity of communication.[117]

- A private citizen:

> Privacy may get in the way of what is best for the child. A report to the referrer has become unusual and notes are not available unless the therapist is still with the service, therapy reports can assist in other assessments external to health as well as allow others in the child's environment to continue strategies beyond clinic time. It is frustrating to provide information to inform child development of a child's needs and progress and not receive any feedback. Appropriate exchanges of information should be obtained and used as a matter of course.[118]

- Catholic Education Western Australia:

> **Mr WONG**: … we need to have wraparound coordinated services that actually talk to each other and share information, but also share progress and roadblocks. I think a lot of the inefficiencies that we are seeing are because everyone is very siloed. Everyone is very good at their work, but they do not communicate with the other services, so that is where I think we have the greatest opportunity.
>
> **Hon DONNA FARAGHER**: To actually have some greater feedback?
>
> **Mr WONG**: Yes, because schools are really, really keen for that feedback. As we pointed out before, teachers are not speech pathologists or OTs, but they are happy for direction to incorporate into their educational programs for individual students.[119]

3.8 Both CDS providers explained that they are sometimes restricted in the amount of information they can share with referrers and other external entities because of the family's unwillingness to consent to disclosing information and/or the parameters placed on any disclosure:

> Another factor can be what consent we have from that family to share information with the school or with the referrer. That obviously helps guide us in terms of how much information we can share along their care journey.[120]
>
> ▫▫▫
>
> We work closely with our teachers if it is a teacher referral, but it is very much based on the consent of the family, and some of our families either do not want us to share that information for various reasons with the school or they do not necessarily have the capacity to understand what we are asking for, so we take that as not consenting to us providing those services.[121]

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117 N Smith, President, Western Australian Primary Principals' Association, [*transcript of evidence*], *Legislative Council,* 20 February 2023, p 4.

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

119 Hon Donna Faragher MLC, Deputy Chair; and T Wong, Child Safe Lead, CEWA, [*transcript of evidence], Legislative Council,* 20 February 2023, pp 9–10.

120 A Turnell, Acting Director, Clinical Services, CAHS–CDS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 8.

121 L Pereira, Manager, Child Development Service, WACHS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 8.

3.9 However, representatives of WACHS–Kimberley accepted that its CDS practitioners do not always provide referrers with adequate feedback:

> Yes. I would probably say that in terms of the referrer, that [missing] feedback loop for the referrer probably is a fair comment. I guess by that time it may be a few months before you see the child, and then you do some work with that. Our focus is on that family, on family partnerships, on upskilling the family to then be able to go back to the referrer, you know, and provide that information. We do work particularly closely with the schools. Each year, all our teams go out to all the schools to do a presentation on who we are, what we do and the best ways to communicate. In remote communities, that is probably a lot better because you are working out of the school, but it can be difficult for that feedback loop, I guess, if you are seeing that client for 12 months, you know, going back to where that referral comes from. We get referrals from parents directly, from child health and from schools.[122]

3.10 Notwithstanding this evidence, Dr Anna Robson, a paediatrician who has worked across metropolitan and regional settings, was of the view that interagency communication occurred more often in the regions:

> one of the strengths of the service—and I think this is true of many rural services, having worked in a variety of settings—is working with and alongside colleagues in CAMHS, education and Catholic Ed. We meet regularly at a clinical level with shared consent to discuss matters. For example, at each Halls Creek visit, I endeavour to link in with CAMHS and the school, and we review each of the children who we have seen, or who they are concerned about but we have not seen, in order to prioritise. There is a lot of shared discussion between agencies with parental consent for that, and with KAMS ECS [the Kimberley Aboriginal Medical Services' Remote Early Childhood Support[123]] staff, because services are thin on the ground. I think that interagency communication, where a patient may have multiple services involved, happens less, or my previous experience is that it has happened less, in metropolitan settings versus rural.[124]

3.11 CAHS–CDS's *Discharge Policy* states that:

> Referrers should be informed of discharge unless it is not considered appropriate due to:
>
> - the time between referral and discharge
> - lack of current involvement of the referrer with the client and family.

CAHS–CDS confirmed that, in practice, the circumstances will determine whether the referrer is informed of a discharge:

> It will occur sometimes; it depends on the situation. But we also have a flexible re-entry process, so if that family or that referrer then make contact with us, we would reopen the file. We are not going to make them go back through a referral wait or wait time.[125]

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122 S Wood, Senior Occupational Therapist, Child Development Service, Kimberley Population Health Unit, WACHS, [*transcript of evidence*], *Legislative Council,* 1 May 2023, pp 13–14.

123 Refer to footnote 338 and paragraph 4.174 for an explanation of the Remote Early Childhood Support program.

124 Dr A Robson, Regional Paediatrician, WACHS–Kimberley, [*transcript of evidence*], *Legislative Council,* 1 May 2023, p 17.

125 A Turnell, Acting Director, Clinical Services, CAHS–CDS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 12.

3.12 In the Committee's view, much of the frustration experienced by referrers could be alleviated by the provision of a client portal. This would allow the client or their parent or legal guardian to access their electronic health record directly and be in a better position to update their GP, their school and other entities, if needed. As previously noted in paragraph 2.23, it is anticipated the client portal would be a feature of the shared Community Care EMR that is the subject of the Committee's Recommendation 1 on page 10 of this report.

3.13 Additionally, certain referrers could be given third party access to a client's electronic health record with the necessary consents. This is the subject of the next heading.

Third party access to electronic health record systems

3.14 The evidence presented to the Committee clearly shows that external stakeholders cannot access existing electronic health record systems operated by CAHS–Community Health (the CDIS and Genie)[126] and WACHS (the CHIS)[127]:

> … [CAHS] do obviously refer to other people. The usual way of doing that is with the parental permission and sending an email. It is a slightly more time-consuming process, but at the moment there is not the ability to share with anybody outside that sort of health system …[128]
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> ▫▫▫
>
> Currently there is no mechanism for visiting health services, funded by sources external to WACHS to access or enter information on a consumer's record [in the CHIS].[129]

3.15 However, there are times when such access would benefit a child who is receiving CDS, such as when their GP requires information about their developmental progress, treatment and the strategies and supports that have been, or will be, put in place.[130]

3.16 The Committee heard evidence of how restrictive it can be for external stakeholders who do not have access to a CDS provider's information system. For example, the Derby Aboriginal Health Service (DAHS) cannot access the CHIS even though it is contracted by WACHS to provide primary healthcare services to residents in that region:[131]

> **Dr FLEMING**: I think, like anything, the communication pathways could be improved. I do not think it is perfect. I think it could be improved.
>
> …
>
> **The CHAIR**: So you do not get access to CHIS?
>
> **Ms MOORE**: No.
>
> **Dr FLEMING**: So that was an issue when we had the floods and a lot of the Fitzroy [Valley] residents were here. We were calling the [Kimberley] hospital, speaking to the allied health team to get access to CHIS because we were seeing the Fitzroy patients here. I guess that was an example —

126 For more information about the CDIS and Genie, refer to paragraph 2.14.

127 For more information about the CHIS, refer to paragraph 2.16.

128 S Kiely, Executive Director, Community Health, CAHS, [*private transcript of evidence*], *Legislative Council,* 25 July 2023, pp 39–40.

129 Submission 77 from WA Health, 9 November 2022, p 67.

130 These issues are discussed in paragraphs 3.6–3.11 of this report.

131 S Kiely, Executive Director, Community Health, CAHS, [*private transcript of evidence*], *Legislative Council,* 25 July 2023, p 39.

The CHAIR: Did that work?

Dr FLEMING: It worked as well as it could at the time given the limitation. So, that was probably a really good example of us all working together and coming up with a really great solution.

The CHAIR: So you were pretty happy with that?

Dr FLEMING: Pretty happy with that. There were obviously teething issues, but I think the fact that we have got someone to call and say, "Can you please look at these records and tell us this person's medication profile?", is really important.[132]

3.17 This temporary arrangement may have been reasonably effective in that emergency situation. However, the Committee is of the opinion that external stakeholders who provide health services, especially those which are contracted by the CDS provider to deliver services on their behalf, should have better access to the CDIS, Genie and/or CHIS and, ultimately, the Community Care EMR. The Committee notes that, technically, a 'contracted health entity', to the extent that it provides health services to the State, is a part of WA Health.[133]

RECOMMENDATION 8

The Child and Adolescent Health Service–Child Development Service (CAHS–CDS) and WA Country Health Service–Child Development Service (WACHS–CDS) give external stakeholders who provide health services, especially those contracted by CAHS–CDS or WACHS–CDS to provide services on their behalf, immediate access to their electronic health record systems when appropriate and with the necessary consents. The shared Community Care electronic medical record system under development (see Recommendation 1 of this report) should have the functionality to allow for this external stakeholder access.

Direct communication with external stakeholders

3.18 A client portal and third party access to electronic health record systems would be beneficial for external stakeholders. However, if the GP, school or other external stakeholder is to have a role in the child's ongoing CDS treatment or in the strategies and supports for the child outside of the CDS system, they will also need to be consulted by CDS practitioners. The Committee envisages that this would involve CDS practitioners communicating directly with the external stakeholder, as and when necessary.

3.19 The RACGP recommended that CDS providers establish a 'dedicated phone line' for GPs to call consultants or senior registrars for developmental advice. It submitted that this would be:

> invaluable in helping GPs initiate early treatments and streamline the referral process.[134]

[132] Hon Dr Sally Talbot MLC, Chair; and Dr A Fleming, Senior Medical Officer, and J Moore, Senior Manager Clinical Operations and Remote, Derby Aboriginal Health Service (DAHS), [*transcript of evidence*], *Legislative Council,* 2 May 2023, pp 10–11.

[133] *Health Services Act 2016* s 19(1)(c) and definition of 'contracted health entity' in s 6.

[134] Submission 66 from RACGP, 31 October 2022, p 2.

RECOMMENDATION 9

The Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service, after obtaining the necessary consents, regularly liaise with, update and consult referrers and other external stakeholders, as appropriate, about their clients.

Single, online referral system

3.20 As discussed in the Interim Report (paragraphs 3.35, 3.36 and 3.59), both CAHS–CDS and WACHS–CDS have an open referral system, meaning that anyone can refer a child for CDS, although referrals made by someone other than the child's parent or legal guardian will require that person's consent. Each CDS provider has a dedicated referral form available on its website. While these forms are the preferred method of referral (because they request the information that is needed), they are non-mandatory and both providers will accept referrals in other formats, including letters, faxes and emails.

3.21 The willingness of CDS providers to accept referrals in any form is admirable. However, it does lead to issues such as duplicated referrals and referrals containing inadequate information, which can then cause further delays in service provision:

> The biggest challenge for us in that referral process is the multiple sources of information that we are getting referrals through, and that if people do not provide enough information at referral, our nursing team end up having to do quite a bit of follow-up to understand more about what the child is actually needing and whether it is genuinely a developmental concern or there is something very different going on for the family that is causing the concerns, whether that is a custody issue or child protection issue or something that would be more appropriately referred elsewhere.[135]

3.22 A number of Inquiry stakeholders contended that the referral process for CDS is too complex. For example, the Western Australian Primary Principals' Association submitted that:

> The referral process itself can be very time consuming and often requires the input of between 3 to 4 staff members.[136]

3.23 Similarly, Dr Elizabeth Green, a recently retired paediatrician, is of the view that the:

> Referral systems are complicated, requiring online access and IT competence or lengthy and time consuming referral forms.[137]

3.24 Australian Childcare Alliance WA (ACA) explained that:

> Referral is a task that ECEC [early childhood education and care] services do not always feel capable or confident about. Some feel this is historically the remit of health professionals and educators, and centre leaders can find completing complex referral paperwork a barrier to ensuring children get the services they need. Simplified referral pathways and paperwork would make this much easier for busy ECEC professionals …[138]

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135 A Turnell, Acting Director, Clinical Services, CAHS–CDS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 43.

136 Submission 78 from Western Australian Primary Principals' Association, 10 November 2022, p 4.

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

138 Submission 71 from Australian Childcare Alliance WA (ACA), 7 November 2022, p 8.

3.25 A single, centralised referral process is a possible solution. The RACGP suggested that:

> There ought to be a central, consistent referral process across all areas of the state, with a timely acknowledgement of the referral.

and that the supporting documentary requirements for referrals should be clearly stated.[139]

3.26 Dr Mark Parker, a paediatrician, is also in favour of the establishment of a 'central referral panel'.[140]

3.27 At a hearing attended by representatives of CAHS (including CAHS–CDS), WACHS (including WACHS–CDS) and DOH, all witnesses appeared to be in favour of a single, central referral system for both CDS providers:

> **The CHAIR**: Could you envisage a situation where you both use the same referral system?
>
> **Ms MILLER**: Yes, absolutely.
>
> **The CHAIR**: There is a lot of nodding going on …[141]

3.28 CAHS–CDS is also interested in developing an online referral system that it believes:

> can improve efficiency, referrer accessibility and the quality of referral information received.[142]

3.29 At a hearing in November 2022, CAHS–CDS advised the Committee that:

> One of the things we are doing is looking at whether there is a platform that we could use for an electronic referral system which would get us the information that we need but also make it a very simple and streamlined process for a referrer at the other end. We did try a system … this year [2022], but, unfortunately, it actually did not work for us; it did not make the process any more efficient, so we have put that system to the side and are now exploring what other options might be out there.[143]

3.30 In later evidence, CAHS–CDS confirmed that it could launch an online referral system relatively quickly. This system could potentially be modified for WACHS–CDS requirements.[144] Dr Yvonne Anderson is supportive of:

> online referral forms, systems and automated consent for sharing of information processes.[145]

3.31 The Committee considers that the shared Community Care EMR referred to in Recommendation 1 on page 10 of this report could incorporate an online referral system. This would streamline the referral process for referrers, the two CDS providers and the other service providers under the CAHS and WACHS umbrellas (such as their respective Child and

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139 Submission 66 from RACGP, 31 October 2022, p 1.

140 Dr M Parker, Neurodevelopmental Paediatrician, [*transcript of evidence*], *Legislative Council,* 26 April 2023, pp 11-12.

141 Hon Dr Sally Talbot MLC, Chair; and K Miller, Director, Population Health, WACHS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 43.

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

143 A Turnell, Acting Director, Clinical Services, CAHS–CDS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 43.

144 Various witnesses, CAHS–CDS, [*private transcript of evidence*], *Legislative Council,* 25 July 2023, pp 38–39.

145 Dr Y Anderson, Associate Professor, Community Child Health, Curtin University, Answer to question on notice 1a asked at hearing held 12 May 2023, dated 16 June 2023, p 1.

Adolescent Mental Health Services). This would also improve the quality of information contained in referrals.

FINDING 8

An online referral system that is incorporated into a shared Community Care electronic medical record system (see Recommendation 1 of this report) would:

- streamline the process for referring children to the Child and Adolescent Health Service and WA Country Health Service, including their respective Child Development Services and Child and Adolescent Mental Health Services
- improve the quality of information contained in referrals.

3.32 The Committee makes the following recommendation.

RECOMMENDATION 10

The shared Community Care electronic medical record system (see Recommendation 1 of this report) include an online referral function.

Child development training

3.33 A clear message from evidence gathered during the Inquiry is that the Western Australian community needs to be more aware of child development and what a child can typically be expected to be demonstrating at each stage of their growth.[146] In the words of the ACA:

> Developmental knowledge needs to be elevated in WA with common tools and resources to spark conversations and enable additional support where needed.[147]

3.34 Such knowledge and awareness is important for parents and caregivers (see Chapter 5),[148] but is vital for those whom the Committee has termed 'external stakeholders'.[149] These are people who interact with children regularly as part of their employment. They can include teachers, education assistants, childcare workers, community kindergarten parent committees, social workers, child protection officers, playgroup coordinators, GPs and other private and non-government sector primary healthcare professionals.

3.35 External stakeholders play an essential role as potential referrers for CDS. They can be an early point of engagement for families and assist in the prompt identification of a child's developmental needs as they occur. The importance of early intervention for optimal child development is discussed in the Interim Report.[150]

3.36 Some of the suggestions for educating various external stakeholders in child development include the following:

> **GPs** have limited child health and development training in their undergraduate university course or in their Australian General Practice Training Program. As outlined in the National Action Plan for the Health of Children and Young People 2020-2030, increasing GP knowledge of child health and development will support

146 Refer to Interim Report, pp 5–9, paragraphs 2.2–2.14.

147 Submission 71 from ACA, 7 November 2022, p 11.

148 Paragraphs 5.18–5.19.

149 Refer to paragraph 3.1.

150 Interim Report, pp 11–13, paragraphs 2.25–2.34.

more prevention and early identification of developmental difficulties. Advocating for changes to training requirements in The Fellowship of the Royal Australian College of General Practitioners (FRACGP) qualification would support this. Training needs to reflect the child development matters for the state in which the GP is practicing in, so there is a need for local advocacy.[151] (emphasis added)

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Primary health care professionals in WA (in particular **GPs**) would also benefit from additional education and tools – there are many who offer inappropriate advice to families such as "don't worry he'll catch up when he gets to school" when ECEC [early childhood education and care] educators have identified developmental red flags.

…

> *"It is not until these children enter into the schooling system that families take this feedback as they can see the impact it has on the child's education,* w[h]ere *if this was picked up when the Early childhood educators raise these issues with families the early intervention would occur 1-3 years earlier before the child entering the schooling system"*[152] (emphases added)

▫▫▫

The other thing we see a lot is children going to a **rapid GP or an immunisation appointment**, parents raising a concern, and someone doing a very cursory look but no assessing and going, "Oh, no, they are fine. Do not worry about it" or "It is okay. When they get to school, they will get their school assessment." That is a very common comment from parents: "We have been told not to worry until they start school." Unfortunately, if you start school with global developmental delay but no label, they cannot get any in-classroom support. They have to have that for the first day of school; otherwise, it is very difficult.[153] (emphasis added)

▫▫▫

The Department of Health could also consider providing free training and professional development for practitioners providing child development support across the state to encourage interaction and collaboration between services. Optimally, this would include **government and non-government** (including **GPs** and **private practice**) **child development professionals** and **Aboriginal Community Controlled Organisations**.[154] (emphases added)

▫▫▫

Teachers and educators would benefit from enhanced knowledge and tools and a common language to assist them in this work. This could include promotion and education of suitable assessment or screening tools (e.g. comprehensive CDS checklists, Ages & Stages Questionnaire, ECSii, PEDS [Parents' Evaluation of Development Status] or others).

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151 Submission 77 from WA Health, 9 November 2022, p 75.

152 Submission 71 from ACA, 7 November 2022, p 11.

153 S Dowden, Paediatric Nurse Practitioner/Director, NursePrac Australia/Just Kids Health Clinic, [*transcript of evidence*], *Legislative Council,* 20 February 2023, p 12.

154 Submission 74 from APS, 8 November 2022, p 11.

> *E.g. – the Tasmanian 3YO preschool program for hard-to-reach children requires the completion of a Parents' Evaluation of Developmental Status (PEDS) check, as well as reporting of PEDS scores and identified pathways within 8 weeks of a child commencing at a centre. To support implementation, Educators are provided ongoing professional development opportunities with funded backfill both for conducting the PEDS check and supporting inclusion, and services receive funding for associated administration costs.*[155] (emphasis added)
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> ▫▫▫
>
> I just feel that there has to be a lot more liaison at having the transition from child health to community hubs located close to schools, to have school community, to have a lot more support in that **early education phase** to actually pick up and start to treat and help and assist children who have problems with language, speech, communication, emotion and have all the attachments of mental health—sadly, anxiety, depression, eating disorders, self-harm, which we have been seeing in younger and younger children. We are not talking about 15 and 16-year-olds; we are talking about three, four, seven-year-olds, sadly.[156] (emphasis added)
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> ▫▫▫
>
> outreach to schools, etc. This outreach could then allow for a 'train-the- trainer' model of support, whereby **education assistants** (for example) can sit in on school-based therapy sessions with parents, to ensure consistency of messaging across all environments. There are examples of these sorts of models within health currently that are in place, but these need to be expanded, and developed across the whole of community health.[157] (emphasis added)

3.37 The Australian Physiotherapy Association noted that WACHS has been liaising with remote area nurses and GPs about the benefits of early physiotherapy to address certain developmental issues. It submitted that this educational strategy 'appear[s] to benefit children, families and communities'.[158]

3.38 As experts in child development, CAHS–CDS and WACHS–CDS practitioners are in a unique position to inform external stakeholders about developmental milestones, as well as the service options and pathways offered by the CDS providers. As an example of what can be achieved in this regard, CAHS–CDS informed the Committee of its teacher capacity building workshops:

> **Ms TURNELL**: … I think for both the Department of Education and us, there is always a resourcing challenge in trying to do more with the same amount of resources. But with some additional resourcing, there are lots of opportunities for us to do more in collaboration with the Department of Education. … in our submission we referenced some teacher capacity-building workshops that CDS had delivered a few years ago, and they were very successful.
>
> **The CHAIR**: At the request of the Department of Education?
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> **Ms TURNELL**: We had additional funding at the time that we had capacity to do that.

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155 Submission 71 from ACA, 7 November 2022, p 11.

156 Dr E Green, Paediatrician, Southern Paediatrics, [*transcript of evidence*], *Legislative Council,* 17 February 2023, p 6.

157 Dr Y Anderson, Associate Professor, Community Child Health, Curtin University, Answer to question on notice 1a asked at hearing held 12 May 2023, dated 16 June 2023, p 1.

158 Submission 73 from Australian Physiotherapy Association, 8 November 2022, p 10.

> **The CHAIR**: Were you reallocated some funds?
>
> **Ms TURNELL**: Yes. It was certainly planned in collaboration with them and it would not have been successful without that, but that is something that we would like the ability to be able to maintain longer term. We are just starting to do some preliminary work with the department's school of special educational needs[159] that is based in Perth Children's Hospital, in looking at how they might be able to support the adolescents that we see in the child development service. That has a lot of potential, but, again, at the moment that team is resourced as it is right now to support mostly the hospital environment …[160]

3.39 The Committee was also pleased to hear evidence that, subject to funding being available, CAHS–CDS proposes to create a temporary role to investigate opportunities for greater collaboration with the Department of Education.[161]

FINDING 9

The Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service are uniquely placed to, and should, inform external stakeholders about child development and the service options and pathways they can offer to children who need assistance in this area.

RECOMMENDATION 11

The Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service be resourced to investigate, create and seize opportunities to inform external stakeholders about child development and the service options and pathways they can offer to children who need assistance in this area.

For the purposes of this recommendation, the external stakeholders should include teachers, education assistants, childcare workers, community kindergarten parent committees, social workers, child protection officers, playgroup coordinators, general practitioners and other private and non-government sector primary healthcare professionals.

Department of Education

Collaboration generally

3.40 As the WA Council of State School Organisations remarked, there is an inherent connection between a child's development and their education:

> Child development and education are closely connected. The triumphs or failings in one area will significantly impact a child's success in the other. Children have better opportunities to achieve developmental milestones when capable and nurturing families support them and [when they are surrounded by] supportive well-resourced communities.[162]

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159 Schools of Special Education Needs are discussed in the Interim Report, p 39, paragraph 3.99.

160 Hon Dr Sally Talbot MLC, Chair; and A Turnell, Acting Director, Clinical Services, CAHS–CDS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, pp 36–37.

161 A Turnell, Acting Director, Clinical Services, CAHS–CDS, [*private transcript of evidence*], *Legislative Council,* 25 July 2023, pp 28–29.

162 Submission 69 from WA Council of State School Organisations, 2 November 2022, p 2.

3.41 Despite this, many Inquiry stakeholders still feel that there are missed opportunities for better collaboration between the two. For example:

> The Western Australian department of education appears to have very little connection with child development services, apart from limited psychological services. In the UK, and in some other Australian states, the education department employs allied health professionals alongside school psychologists. Such a structure provides a unique opportunity for screening and early intervention, and it can enhance early identification of developmental difficulties as well as improve social and academic outcomes for children. Ecological interventions have the greatest impact on child development and greater school-based services would enhance collaboration and information sharing between health and education specialists.[163]

3.42 The Committee is of the view that the CDS providers and the Department of Education (DOE) should be working together more closely, particularly when:

- developmental issues in many children are not identified until they start school
- the current unacceptably long waiting times for CDS are preventing some children from receiving services until, or after, they have started school (see Interim Report)[164]
- metropolitan-based children aged seven and older (that is, the majority of school-aged children) do not have access to the full suite of allied health services that are available to younger children (see Interim Report, finding 5)[165]
- metropolitan-based children aged four to eight years at referral are, since at least 2012-13, the largest proportion of children being referred to CAHS–CDS – and that proportion is increasing. The proportion of metropolitan-based children aged eight years and older at referral has also increased significantly since 2012-13 (see Interim Report).[166]

FINDING 10

Child Development Service providers and the Department of Education should be working together more closely in recognition of the inherent connection between children's development and their education.

Clinical evidence required for 'individual disability allocation' funding

3.43 The Committee has already discussed how the CDS providers can provide information about child development, service options and care pathways to external stakeholders, such as the DOE (paragraphs 3.33–3.39). In turn, many Inquiry stakeholders suggested that the DOE can assist the CDS providers by varying its requirements for 'individual disability allocation' (IDA) funding for additional learning supports.[167]

3.44 Currently, applications for the DOE's IDA funding are diagnosis driven. In particular, diagnoses from either child psychiatrists or paediatricians are often needed, placing mounting pressure on these professions (in the government, non-government and private

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163 Submission 80 from Developmental Occupational Therapy Association WA and WA Occupational Therapy Association (OT Associations), 14 November 2022, p 5.

164 Interim Report, pp 53–58, paragraphs 4.26–4.27, for a discussion of the impact of excessive waiting times.

165 Interim Report, finding 5, p 61. Refer also to pp 58–61, paragraphs 4.28–4.33, for the full discussion of this issue.

166 Interim Report, pp 23–24, paragraphs 3.40–3.41.

167 Refer to Interim Report, p 38, paragraphs 3.96 and 3.97, for an explanation of the Department of Education's (DOE's) individual disability allocation.

sectors) as the incidence of ADHD and ASD increases[168] and developmental conditions become more complex.[169] CDS paediatricians are often called upon to provide these diagnoses and, therefore, along with their non-government and private counterparts, bear the brunt of the mounting pressure.

3.45 The Committee notes that there is a general misconception that the DOE (through mainstream public schools) will not provide any increased educational supports for developmentally challenged students until they obtain a diagnosis for a recognised disability. However, as discussed in the Interim Report[170] and paragraph 3.49, this is not the case.

3.46 Many Inquiry stakeholders are of the opinion that the DOE could change the IDA eligibility criteria by moving away from assessments and diagnoses of disability categories to an assessment of the functional needs of the student – that is, what supports do they need to function well, regardless of the diagnosis of a particular condition(s):

> **Ms PEREIRA**: … Perhaps the only thing I would like to add in terms of the Department of Education is their requirement for a diagnosis for children to access their individual disability allocation. That actually does lead to a burden to paediatrician waitlists, because they require that diagnosis from the paediatrician. I guess we would support the Department of Education moving towards functional presentation: so, what does the child require potentially in a school environment? That leads to allied health then being able to provide that information, rather than relying on just the diagnostic requirement.
>
> **The CHAIR**: … Presumably, that would also apply to CAHS?
>
> **Dr GREEN**: Absolutely.[171]
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> A needs-based model of care would be amazing—amazing. I have been thinking about this for months: how do you fund that? How do you really fund that? Until we have some philosophical questions about what we are prepared to fund full stop in society, right across Australasia at the moment, I think this is going to be the next challenge for paediatricians globally around condition-specific care or funding or allocation of services versus a needs-based approach.[172]
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> Once children enter school, the education department places a significant strain on child development services, requiring certain diagnosis. Rather than assigning funding based on diagnoses, if the education department moved to a functional model for funding this would reduce pressure on CDS services.[173]

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168 Refer to Interim Report, pp 61–62, paragraph 4.34, bullet point 1. ADHD is a condition that is not specifically IDA-funded. However, it often co-occurs with ASD and other conditions which are funded through the IDA system: Refer to Interim Report, p 38, paragraph 3.97 and Australian ADHD Professionals Association (AADPA), *Australian evidence-based clinical practice guideline for attention deficit hyperactivity disorder (ADHD)*, 1st edn, 2022, accessed 29 January 2024, pp 71–72.

169 Refer to Interim Report, p 62, paragraph 4.34, bullet point 2.

170 Interim Report, pp 37–38, paragraphs 3.92–3.95. That is, schools with students who have additional education needs will attract an 'education adjustment allocation'.

171 Hon Dr Sally Talbot MLC, Chair; L Pereira, Manager, Child Development Service, WACHS; and Dr J Green, Acting Head of Department, Paediatrics, CAHS–CDS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 37.

172 Dr Y Anderson, Associate Professor, Community Child Health, Curtin University, [*transcript of evidence*], *Legislative Council,* 12 May 2023, pp 22–23.

173 Submission 82 from Australian Medical Association (WA), 11 November 2022, p 6.

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> Provide more capacity for school (Kindy – year 12) to perform appropriate psychometric assessments of scholastically vulnerable children and provide support on their symptoms rather than their diagnosis.[174]

3.47 Inquiry stakeholders often referred to the requirements for a child to be granted IDA funding for ASD as an example of the DOE's rigid insistence on psychiatrists' and paediatricians' diagnoses:

> **Prof WHITEHOUSE**: … I was lucky enough to author the **national guideline** for how you diagnose autism, and that is approved by the federal government. **We make very clear in that guideline that the presence or absence of a diagnosis should not drive access to supports or eligibility for supports**, yet somehow systems keep doing it. We know that children cannot meet criteria for, say, autism and [yet] require significant supports. Similarly, there might be children who have a diagnosis of autism [but] who do not require significant supports. In terms of functional impairment, a diagnosis is somewhat of an arbitrary threshold.
>
> **The CHAIR**: So a functional assessment, in a sense, is more relevant than a diagnosis?
>
> **Prof WHITEHOUSE**: Absolutely—entirely. …[175] (emphases added)

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> For instance, the Western Australian Department of Education requires a multidisciplinary assessment for them to accept a diagnosis of autism spectrum disorder. The national guidelines came out last year; they came out of Western Australia, and they clearly are not following those guidelines; they are clearly to the contrary. The recommendation is that if it is not clear, then further multidisciplinary assessment is suggested, but I have seen children who are clearly autistic, yet they have to go off for further assessments then they have to be seen again and they have to have supporting reports and things. Once again, that has increased the demand on the system and on people like me [a private paediatrician].[176]

3.48 The Committee notes that similar issues with diagnosis-reliant eligibility have occurred with respect to the National Disability Insurance Scheme (NDIS):[177]

> Many children enter or remain in the NDIS based on an access list. The access lists provide for both automatic access and streamlining of evidence based on disability. These lists can provide simple and transparent access to the scheme for some children. However, they also exacerbate inequity and delay support for children with similar levels of need who may not have a diagnosis on an access list or lack the means to obtain a diagnosis if they don't meet the age criteria for developmental delay. Determining eligibility through a diagnosis-based approach

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174 Submission 28 from private citizen, paediatrician, 23 October 2022, p 3.

175 Hon Dr Sally Talbot MLC, Chair; and Prof A Whitehouse, Bennett Professor of Autism Research, TKI, [*transcript of evidence*], *Legislative Council,* 9 February 2023, p 4.

176 Dr M Parker, neurodevelopmental paediatrician, [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 8.

177 Refer to Interim Report, pp 41–45, paragraphs 3.111–3.124 for a discussion of National Disability Insurance Scheme (NDIS) funding and services.

also fails to provide a good understanding of the needs and circumstances of children and their families.[178]

3.49 When the Committee questioned the DOE about concerns of students being left without additional educational supports prior to obtaining a diagnosis for ASD, the DOE stressed that interim funding would be provided as soon as the student is confirmed as being on a waitlist for assessment.[179] The requirements for this confirmation are as follows:

> Students currently on a waitlist for assessment of ASD can receive an interim IDA if a letter from the assessing practitioners or government agency is provided, confirming they:
>
> – have been accepted for an ASD assessment
>
> – are on the waitlist for assessment or
>
> – have an ASD assessment scheduled.[180]

3.50 The DOE also confirmed that it is already considering basing its IDA funding on students' functional needs rather than medical diagnoses:

> **Mr PERCIVAL**: We are certainly looking at functional needs assessment. There are a number of things packed into that. If you are talking about functional needs assessment, we are actually building a tool around functional needs assessment, and we are currently in a procurement process around that. The function of that is to make it better. The function of the functional needs assessment is to make a better link between an application for resource and the teaching and learning adjustments that are provided. I do not want to leave you thinking that schools leave kids in limbo.[181]
>
> …
>
> **Mr PERCIVAL**: Currently we still have eligibility gateways, those gateways with just those eight criteria [disability categories] that we spoke about, and most systems do. … when schools apply for individual disability allocation, we will give them a standard allocation, you know, "This is what we think". And if they are seeking more of an allocation which most schools do, then they can put in what we call a checklist. The checklist describes the teaching and learning adjustments that the child currently receives, and then as a part of the back end of the work that we do, we look at that across a whole bunch of domains, both academic and non-academic, personal care, the extent to which we liaise with other agencies around those kids, and then we will determine what the [funding] level is. … [the checklist] … is observation and provision based, if you like, of those teaching and learning adjustments. And it is also after the fact … What we have realised is that it is the quintessential chicken and egg story. "What could the school provide if they had X number of dollars that are responding to this particular need" is quite different to, "You are already providing that and so we will resource". So currently, as I mentioned before, we have got a tender at the moment for a functional feeds approach tool. So that would replace the checklist, and it would give us the

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178 Prof B Bonyhady AM and L Paul AO PSM, Co-chairs, *Working together to deliver the NDIS – Independent review into the National Disability Insurance Scheme: Final report*, Department of the Prime Minister and Cabinet, Commonwealth of Australia, 2023, accessed 2 February 2024, p 118.

179 S Percival, Director, Disability and Inclusion, DOE, [*transcript of evidence*], *Legislative Council,* 2 March 2023, p 18.

180 DOE, Answer to question on notice 3 asked at hearing held 2 March 2023, dated 23 March 2023, p 3.

181 S Percival, Director, Disability and Inclusion, DOE, [*transcript of evidence*], *Legislative Council*, 2 March 2023, pp 16–17.

confidence to say, "This is how the child is presenting. This is the level of funding that is required to meet the needs that stem from their presentation."

The CHAIR: So in actual fact, you are telling us that you are responding to that observation—I will call it an observation rather than a criticism. And so it is a valid point to be made —

Mr PERCIVAL: Well, … we are responding to part of it. This is all in the discussions at the moment. The extent to which that can replace a diagnosis and the need for a gateway, most systems still have a gateway. We are at the conceptualisation phase at the moment about the extent to which, and the reliability of other data sources [that] can be used, so things like the Nationally Consistent Collection of Data that collects data on children with imputed or diagnosed disability every year across the country. We are looking at the extent to which we could align the NCCD data with some of the lower levels of allocation of funding, … So very much in the conceptualisation and development phase at the moment. But, we are going to have a go. We are having a go.[182]

FINDING 11

The Department of Education's requirements for medical diagnoses to determine which students are given 'individual disability allocation' funding is unnecessarily placing pressure on child psychiatrists and paediatricians, including those who are employed by the Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service.

3.51 The Committee notes that a wide range of health practitioners other than psychiatrists and paediatricians, such as allied health professionals, can provide assessments of a child's functional needs. If the DOE was to utilise functional needs assessments rather than medical diagnoses to determine which students are given IDA funding, it is likely that some pressure that has been placed on psychiatrists and paediatricians for providing diagnoses will be eased.

FINDING 12

A wide range of health practitioners other than psychiatrists and paediatricians, such as allied health professionals, can provide assessments of a child's functional needs.

FINDING 13

If the Department of Education was to utilise functional needs assessments rather than medical diagnoses to determine which students are given 'individual disability allocation' funding, it is likely that some pressure that has been placed on psychiatrists and paediatricians for providing diagnoses will be eased.

RECOMMENDATION 12

The Department of Education utilise assessments of students' functional needs rather than medical diagnoses to determine which students are given 'individual disability allocation' funding.

[182] Hon Dr Sally Talbot MLC, Chair; and S Percival, Director, Disability and Inclusion, DOE, [*transcript of evidence*], *Legislative Council*, 2 March 2023, pp 29–30.

Referral process for language development centres

3.52 Among other things, speech pathologists employed by the CDS providers complete detailed developmental language disorder diagnostic assessments and associated referrals to the DOE's language development centres (LDCs).[183] LDCs are discussed in more detail in the Interim Report.[184]

3.53 The five LDCs, all within the Perth metropolitan area, offer a limited number of places and, as explained by Speech Pathology Australia, the referral process is therefore rigorous:

> Language development centres (LDC) provide dedicated speech pathology services to a small number of children (~1,200) in WA. Due to the cap on numbers, children must meet the strict eligibility criteria and the demand for places in the LDCs is significantly higher than the number of places available.[185]

3.54 A referral does not guarantee a placement at a LDC and, in that sense, is more akin to an application for enrolment at a centre.

3.55 As an indication of the level of demand for LDCs, CAHS–CDS alone refers approximately 400 students per year.[186] Between 2017 and 2022, the lowest number of referrals completed by CAHS–CDS was 372 (in 2021) and the highest was 523 (in 2019).[187]

3.56 While the eligibility criteria for each LDC is slightly different,[188] they each generally require children to demonstrate that their main developmental issue is a language development difficulty.[189] This means they have:

> **Dr WELLS**: … difficulties with language in their primary language. For most students, that is English; however, they are also asked about their primary, first language or other languages if English is not the only language they speak. They participate in a standardised assessment, so a normative standardised battery assessment, followed by a narrative sample, as well as comprehension questions as part of that sample from a speech pathologist prior to applying to enter the school.[190]

3.57 According to the Fremantle LDC's website, children can apply for entry at kindergarten, pre-primary or Year 1. The entry criteria are as follows:

1. The child must have a significant primary language disorder in one or more language areas.
2. The child needs to demonstrate evidence of learning potential within the average or above average range.

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

184 Refer to Interim Report, pp 39–40, paragraphs 3.102–3.107.

185 Submission 43 from Speech Pathology Australia, 24 October 2022, p 7.

186 A Turnell, Acting Director, Clinical Services, CAHS–CDS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 37.

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

188 'It [the slight differences] would be the type of tests. Usually, we would have to do a cognitive assessment and we would have to follow that up with a battery of language tests. So it would be the type and number of language tests.' T Wong, Child Safe Lead, CEWA, [*transcript of evidence*], *Legislative Council,* 20 February 2023, p 2.

189 R Simpson, Oral language consultant, Tracks to Literacy, [*transcript of evidence*], *Legislative Council,* 17 February 2023, p 12.

190 Dr R Wells, Policy and Advocacy Executive, WA Branch, Speech Pathology Australia, [*transcript of evidence*], *Legislative Council,* 12 December 2022, p 9.

3. The child needs to demonstrate sound adaptive behaviour skills, substantiated by observed descriptive evidence of the child's behaviour in his/her current educational placement or in his/her home. This is to ensure that children are able to fully access our intensive oral language learning program. … This means they need to demonstrate that they will be able to settle into the school environment and participate well.[191]

3.58 The first criterion must be confirmed by a speech pathologist, the second, by the child's parent (or a teacher if the child is already attending school), and the third, by a paediatrician (or a psychologist if the child is already attending school).[192]

3.59 Catholic Education Western Australia (CEWA) submitted that the referral process for LDCs is onerous and should be streamlined:

> overly laborious and highly specific criteria apply. There was a high volume of requests from CEWA schools for access to speech therapists – over 50 for 2022. Each student requires a series of tests as well as inventories from … teachers and parents, which makes each case time intensive. It would be useful if a more streamlined referral process could be formulated in negotiation with schools.[193]

3.60 Mr Tim Wong, a psychologist working CEWA, gave evidence that, on average, a LDC referral application would require around 20 hours of preparation. Mr Wong provided the following summary of a typical referral process:

> **Mr WONG**: Typically, a referral would come through the school. Oftentimes there may be a speech therapist involved in, I guess, nudging the school to make a referral.
>
> **The CHAIR**: So you have speech therapists in schools?
>
> **Mr WONG**: We do not. That might be a private speech therapist that the parents have accessed themselves or through the child development centre. From there, the psychologist would make a preliminary assessment, so it would be looking at the child's work and getting some ideas from, I guess, having an interview with the teacher and the parents to look at what the development of the child's language is to that point to see whether there is a need to go forward with the battery. Once that happens, there is an interview with the school and the parent, and then once the psychologist then commits to the referral process, they would then schedule in the time to assess the child formally with the assessment battery. These are young children usually, so they tire very quickly. Part of the assessment process has to be maximising their output. It is not like you could take them through and do a whole day's battery of tests. You are really working in the mornings. You are really limited to the mornings. So depending on the capability of the child, it may take two or three morning sessions. This would be probably from about when school begins, around about 8.30, you would have a break for morning tea and then go through until lunchtime. And that is depending on the capability. Sometimes with some of these children, particularly if their language is very, very low, you would probably maybe get an hour or so in the morning. So it is a long process doing the assessment. The psychologist would have to mark everything and tabulate the results and formulate the case and provide the report, which is quite lengthy in terms of the format for each of the LDCs. On average, a total case would be 20-plus hours working on a single child. The other part, if I might say, to this is that we are not funded to be able to provide a lot of this individual assessment … What we

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191 Fremantle Language Development Centre (FLDC), *Eligibility & referrals*, FLDC, 2024, accessed 30 January 2024.

192 FLDC, *Eligibility & referrals*, FLDC, 2024, accessed 30 January 2024.

193 Submission 37 from CEWA, 24 October 2022, p 5.

> have done largely is that we have reduced the amount of assessment we do. The only assessment we do really is where we have to have an outcome to access services like LDCs and child development centres.[194]

3.61 CAHS–CDS indicated that their speech pathologists can spend approximately four hours on each language assessment associated with a LDC referral.[195] Additionally, a CAHS–CDS paediatrician or psychologist could be responsible for the 'sound adaptive behaviour skills' component of the referral, amounting to a substantial service outlay by the CDS provider. Along with the time taken to complete the parent's or teacher's questionnaire, the total preparation time for a referral could be burdensome.

3.62 CAHS–CDS acknowledged that there is a need to streamline the LDC referral process, but that any change should occur within its own internal processes and would need to strike an appropriate balance:

> They [LDCs] get more referrals than they can actually accommodate within their school placements, so it is very important for them in being able to assess which referrals are the most appropriate to go into the language development centre. For us, it is about really streamlining and making sure that we are giving them the most important information, and information that maybe is not as important in their decision-making but has been there historically does not need to be done, or thinking about whether there are ways that we can do it more efficiently. For instance, if they are looking for a language sample as part of that referral process, do we actually need to transcribe that or can we give them the recording of that, which then saves us a lot of time? We refer somewhere around 400 students a year. If every referral is taking four hours of speech pathology time to do that referral, that is quite a significant amount of workload. It is getting that balance right between what they need as a school to make good decisions and then trying to be as efficient as possible from our side.[196]

3.63 The Committee is of the view that the LDC referral process can be overly burdensome and time consuming for the parents, teachers and clinicians involved. It is also acknowledged that, due to demand far exceeding availability of placements, the process of selecting the most appropriate applicants must be rigorous. Given the widespread agreement that change is desirable and the many constructive possibilities for change, there would be value in the following parties working together to consider and determine how the referral process could be improved:

- the DOE
- CAHS–CDS
- independent schools
- Catholic schools
- speech pathologists in the non-government and private sectors
- psychologists in the non-government and private sectors
- paediatricians in the non-government and private sectors.

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194 Hon Dr Sally Talbot MLC, Chair; and T Wong, Child Safe Lead, CEWA, [*transcript of evidence*], *Legislative Council*, 20 February 2023, pp 2–3.

195 A Turnell, Acting Director, Clinical Services, CAHS–CDS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 37.

196 A Turnell, [*transcript of evidence*], p 37.

FINDING 14

The process of applying for a placement at a language development centre can be overly burdensome and time consuming. However, it is acknowledged that this process must be rigorous.

RECOMMENDATION 13

The Department of Education and the Child and Adolescent Health Service–Child Development Service work with other relevant stakeholders (such as independent and Catholic schools, and non-government and private speech pathologists, psychologists and paediatricians) to consider and determine how the process of applying for a placement at a language development centre could be improved by being less burdensome, while maintaining the necessary rigour.

3.64 A number of Inquiry stakeholders also suggested that the number of LDCs be increased to alleviate the competitiveness and intensity of the referral process. For example:

> Given the extensive wait times to access Child Development Services [and the high demand for limited LDC placements], it may be worthwhile to consider extending these [LDC] services to allow for greater supports to be provided and lessen the impacts of these long wait times on young children.[197]
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> ▫▫▫
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> These specialist schools [LDCs] provide a high level of developmental support (particularly relating to communication skills) for the children within their walls. However, these schools only support a very small number of children each year in the metro region only[[198]] – barely a few thousand students – a drop in the ocean of students who need support. Furthermore, the LDCs are limited to a particular (all be it large) subgroup of children with communication difficulties and many children have trouble accessing speech pathology support early enough to be referred to these centres. Some of these drawbacks could be partially overcome by increasing the number of LDCs and setting some up in the regions. Increased accessibility to other speech pathology services would also support better access to LDCs.[199]

3.65 The Committee believes that there is merit in increasing the number of LDCs in the metropolitan area and delivering more outreach services and support in the regions.

3.66 A majority of the Committee, comprising Hons Dr Sally Talbot and Samantha Rowe MLCs, makes the following recommendation:

RECOMMENDATION 14

The State Government consider increasing the number of language development centres across the metropolitan area and delivering more outreach services and support in regional Western Australia.

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197 Submission 43 from Speech Pathology Australia, 24 October 2022, pp 7–8.

198 Language development centres do provide outreach services to public schools in regional Western Australia. This is in the form of building teacher and support staff capacity to assist students who have language delays or difficulties: refer to Interim Report, p 40, paragraphs 3.106 and 3.107.

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

3.67 A minority of the Committee, comprising Hon Donna Faragher MLC, makes the following recommendation:

Minority Recommendation 1

The State Government increase the number of language development centres and outreach services in Western Australia.

Allied health services provided in schools

3.68 CAHS–CDS and its predecessors have not historically provided CDS within school settings:

> CAHS CDS has never operated with a metropolitan-wide model of routinely providing services to clients within the school setting.[200]

3.69 In contrast, WACHS–CDS and its predecessors has had a more collaborative relationship with the schools in their regions:

> The historic provision of child development services in schools is variable across the regions of WACHS. Clinicians have provided intervention via group sessions to develop targeted skills for referred clients. WACHS clinicians have also provided general information to parents related to school readiness and participation via workshops. Regions have also worked with schools to support the implementation of whole of class strategies and provided teacher workshops to support the understanding of child development.
>
> Currently, WACHS clinicians continue to work in the school context, particularly on outreach visits, but services are generally directed towards referred clients.[201]

3.70 Regardless of the historical provision of CDS in education settings, WA Health was of the view that:

> Having the resources for the CDS to support early childhood educators, day care centres and teachers in schools would provide greater opportunity for earlier intervention and prevention and lead to enhanced capability for the community to support the child.[202]

3.71 The WA Council of State School Organisations explained why schools would be a suitable place for children to receive CDS:

> Schools are well placed to facilitate early and ongoing support that aids children's health and wellbeing. Some families will, for a number of reasons, struggle to seek out and provide the required health and wellbeing support for their children. Therefore, children and young people who cannot access services outside of school must be identified and given access to the developmental support they require to reach their potential. Schools must be resourced if they are to play the role of facilitators and access points for children's services. Such resources include:
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> - the appropriate technology to support remote appointments, such as telehealth;

[200] Dr DJ Russell-Weisz, Director General, DOH, Answer to question on notice 10 asked at hearing held 28 November 2022, dated 20 December 2022, p 5.

[201] Answer to question on notice 10, p 5.

[202] Answer to question on notice 10, p 5.

- suitable areas where children can comfortably engage in their therapy sessions/appointments;
- expert support for teachers and education assistants who assist in the programs;
- funding for the required FTE [full-time equivalent] allocation to support students to access services that directly support their learning and education outcomes; and
- additional funding to address skills shortages in regional and remote areas.[203]

3.72 As already discussed in the Interim Report, the DOE provides a Statewide School Psychology Service[204] which delivers a range of services including assessment and intervention. The DOE also provides some secondary-level speech pathology services at LDCs, through the Statewide Speech and Language Service.[205] Furthermore, some schools utilise their one-line budget to access speech pathology and other allied health services. The provision of other forms of secondary-level allied health services could, therefore, be seen as a natural extension of what is already offered at DOE schools. These additional services could also complement the existing primary-level healthcare services provided by CAHS and WACHS community health nurses who visit public primary schools and are also based at public high schools[206] (and commonly known as 'school health nurses').[207]

3.73 While school psychologists and LDC staff are employed by the DOE, school health nurses are employed by CAHS and WACHS (which are part of WA Health) and are a working example of how the two health agencies already collaborate with the DOE.

> CAHS and WACHS Community health nurses work in the public-school setting [and also known as 'school health nurses'] under respective Memorandum of Understandings with the Department of Education. To support this partnership, community health nurse and their manager meet regularly with the school leadership team to discuss how the role of the community health nurse can best contribute to student support services. Collaborative health care planning ensures support for children with a range of social, emotional and physical health and disability needs.[208]

The Challis Community Primary School model

3.74 Challis Community Primary School (Challis) in Armadale is an example of a public school that has collaborated with CAHS and various private and non-government organisations to embed primary and secondary-level child development services[209] into their school setting. Some of the features of Challis include the following:

- The Challis Parenting and Early Learning Centre – a child health centre which is co-located with the school. It was relocated from 'elsewhere down the road' at the request

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203 Submission 69 from WA Council of State School Organisations, 2 November 2022, pp 2–3.

204 Interim Report, p 39, paragraphs 3.100–3.101.

205 Interim Report, pp 39–40, paragraphs 3.102–3.107.

206 S Kiely, Executive Director, Community Health, CAHS, and K Miller, Director, Population Health, WACHS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 33.

207 Refer to Interim Report, p 16, paragraph 3.9, for a discussion about the services delivered by school health nurses.

208 Submission 77 from WA Health, 9 November 2022, pp 77–78.

209 Refer to Interim Report, pp 16–17, for an explanation of the different levels of healthcare.

of the school's principal.[210] At the centre, families from the school community and other neighbouring communities have access to primary-level healthcare services provided by 1.2 full-time equivalent child health nurses.[211] These services include the usual scheduled child health and maternity health checks post-birth,[212] but also extend to very early interactions with school staff:

> the Challis Parenting and Early Learning Centre … allows us to connect with mums, predominantly, and their babies from a very young age—from the time they are born. Our child health nurse is notified that there has been a birth in our area and she sets out making a connection with that family. Our school staff are involved in the very early years of the baby's life to increase the protective factors around mum and bub and decrease the risk factors that are likely to lead to vulnerability by the age of, say, three. We try to work in an early intervention model so that there are no gaps and, if we notice a gap, we put in an intervention that is likely to improve the development of the child.
>
> …
>
> [The centre] … starts from birth and goes through to three years of age, and there are all sorts of developmental playgroups and an early intervention program that is on premises for three-year-olds. That is a point of difference.[213]

- Like all other public primary schools, Challis will still host visiting school health nurses,[214] who provide primary-level healthcare services, such as school entry health checks and immunisation.
- On-site therapy provided by fourth-year allied health students from Curtin University who are completing the nine-week interprofessional practical component of their courses (see Appendix 2).[215] The Australian Physiotherapy Association, which endorses the Challis model, provided further evidence of Curtin University collaborating with Challis families:

  > The physiotherapist supervisor [who supervises the fourth-year physiotherapy students during their placements] attends the "New parents" group to provide education to parents on ways to encourage infant play, suitable toys and to help parents implement the Australian 24-hour movement guidelines for children 0-2years.[216]

- Two family support workers:

  > whose entire role is to try and break down any barrier for a family who might not be sending their child to school or who might not be getting their child to appointments. We have a school car. That family support worker, because they have engaged with them from birth, have a very trusting relationship with the families. These families will normally tell the support worker, "I have an

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210 L Musumeci, Principal, Challis Community Primary School, [*transcript of evidence*], *Legislative Council*, 2 March 2023, p 7.

211 L Musumeci, [*transcript of evidence*], p 4.

212 Refer to paragraphs 5.8–5.11 of this report.

213 L Musumeci, Principal, Challis Community Primary School, [*transcript of evidence*], *Legislative Council*, 2 March 2023, pp 4 and 13.

214 L Musumeci, [*transcript of evidence*], p 7.

215 Hon Dr Sally Talbot MLC, Chair, and Hon Donna Faragher MLC, Deputy Chair; L Musumeci, Principal, Challis Community Primary School; and J Bell, Deputy Director General, DOE, [*transcript of evidence*], *Legislative Council*, 2 March 2023, pp 9–11.

216 Submission 73 from Australian Physiotherapy Association, 8 November 2022, p 10.

> appointment coming up. I don't know who with, but this person keeps calling me", for example. The support worker will work all that out for them and put them in the car and take them to the appointment.[217]

3.75 The services provided at Challis by the Curtin University students and the family support workers come at a financial cost, although Mrs Musumeci, Challis' principal, submitted that the alternative would be 'far more expensive'.[218] The Committee was informed that Curtin University charges a fee for the students' supervisors – but that fee is paid through a grant from the Tennex Foundation.[219] The family support workers are paid through the school's flexible one-line budget.[220] Before the current Challis model was established, the school was struggling academically:

> many of our children were either not making it to high school or were not successful in high school. They were going through illiterate, were not graduating from high school and then were not able to contribute to society because they did not have the skills that they needed to be employed. So I would say that the alternative to our model is not a very productive model for society.[221]

3.76 Challis' partnerships vary from year to year, but its most consistent partners are:

- the Minderoo Foundation
- Curtin University (with funding through the Tennex Foundation)
- Foodbank
- Department of Health/WA Health
- The Fathering Project
- Tronox
- the Sebastian Foundation
- the Packer Family Foundation
- the Early Years Partnership
- the City of Armadale
- The Salvation Army
- My World Child Care (out-of-school-hours care).[222]

3.77 Challis is considered a 'full service school' and a 'gold plated version' of the supports that can be provided at a public school. Westfield Park Primary School in Camillo has established 'a similar array of supports' to those available at Challis, and Armadale Senior High School is in the very early stages of building a 'full service school'.[223]

3.78 However, there are many other schools that would have difficulty in replicating the Challis model, either because of the limited size of their one-line budget or their ability to build external partnerships:

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217 L Musumeci, Principal, Challis Community Primary School, [*transcript of evidence*], *Legislative Council*, 2 March 2023, p 20.

218 L Musumeci, [*transcript of evidence*], p 5.

219 L Musumeci, [*transcript of evidence*], p 12.

220 L Musumeci, [*transcript of evidence*], p 20.

221 L Musumeci, [*transcript of evidence*], p 5.

222 DOE, Answer to question on notice 2 asked at hearing held 2 March 2023, dated 23 March 2023, p 2.

223 J Bell, Deputy Director General, DOE, [*transcript of evidence*], *Legislative Council*, 2 March 2023, p 14.

> There is probably a difference in terms of funding that Challis receives because of student characteristics funding. When you look at the student-centred funding model in a totality [school characteristics and student characteristics funding], the two schools [Challis and Hammond Park Primary School[224]] are very different in terms of their location, their ICSEA [Index of Community, Socio-Educational Advantage], the education of parents and all the rest of it. I think that … [Challis] … probably benefits from multiple funding attractions—things like ICSEA, and your educational adjustment funding is probably a bit higher …[225]

3.79 It must also be acknowledged that Challis' success is the culmination of the hard work and dedication of its staff and community, and their efforts are now being rewarded:

> **Mr SMITH**: A school of best practice that is always discussed in this conversation is Challis. They have a service where they really do have a quite a low SCI [correction: SEI or socio-economic index[226]] school, linked to a large proportion of students with either diagnosed or imputed disability. A school like Challis has allied professionals working onsite on a regular basis. Again, this is just my anecdotal observation and knowledge of Challis. They have regular plans that are structured where parents meet with a range of professionals and school staff. They are reviewed regularly and there are also plans before-school care, after-school care programs, breakfast programs and the like. The notion that it takes a community to raise a child lives in a school like Challis, where it is really quite a difficult context and so they just spend their resources on making sure that early intervention strategies are there by the professionals who can provide support directly to children but, as well as, regular ongoing meetings with adults.
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> **The CHAIR**: You are by no means the first witness that has cited Challis as an example in a positive sense. Are other schools adopting that model?
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> **Mr SMITH**: Schools would like to adopt that model —
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> **The CHAIR**: What is stopping them?
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> **Mr SMITH**: Quite often it is allocation of funding. Sometimes knowing where to start might be a concern, not knowing whether schools should be going down the track of trying to employ private speech pathologists, OTs going into partnership with other universities or with private organisations, liabilities around private organisations and what that might mean for the school. I think genuinely just a sense of not knowing where to start and then potentially not having budgets to enact those programs if they did.
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> …
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> Challis does have more money—Challis is a high-need school—but I also believe they have just been able to broker, on the back of the success, ongoing organisations that want to be part of the Challis model. I mean, success breeds success; when people see something working very well, they invariably want to be a part of that, and that might open up the doors for Challis to have greater

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224 Previously known as Wattleup East Primary School.

225 S Percival, Director, Disability and Inclusion, DOE, [*transcript of evidence*], *Legislative Council,* 2 March 2023, p 13.

226 'The Socio-economic Index for schools (SEI) is an index of socio-economic disadvantage. The SEI is expressed numerically ranging from 50.72 to 127.27. Schools with the lowest SEI have the greatest socio-economic disadvantage': DOE, *Socio-economic index for schools*, DOE, accessed 2 February 2024, p 1.

networks or people wanting to offer their services just to be involved in that program.[227]

3.80 Dr Yvonne Anderson advised the Committee that:

> a lot of schools are receiving therapists on an ad hoc basis and are working with children on their therapy needs on an informal arrangement to make sure that they are getting the best out of that "train the trainer" model and ensuring that there are really strong relationships.[228]

3.81 As an example of an ad hoc arrangement that has now been occurring for several years, the Committee received evidence of WACHS–CDS speech pathologists and therapy assistants visiting and working successfully in schools in the Katanning area. The schools pay a fee for the WACHS–CDS practitioners to work with the teaching staff and children who have been identified by the staff as needing additional language supports:

> … in terms of WACHS, our clinicians actually work very closely with the Department of Education on the ground in supporting individual children. A program that we are proud of in WACHS in Katanning is called the kindergarten oral language program, where speech pathologists actually work in the school alongside the teachers to support the development of language for those young children. In Katanning, it is particularly important, because it is difficult to engage some of the families in Katanning. You would understand the levels of vulnerability within the Katanning region. That program allows the children to still receive a good service without the parents necessarily being present, because it is quite difficult in some circumstances to actually engage the family. We did not want the child missing out on the service because we could not engage the parent. The schools in Katanning appear to be very pleased with the program, and it has been ongoing now for a couple of years.[229]

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> In Katanning, [WACHS] Community Health offers a KOLP (Katanning Oral Language Program) for Kindergarten and some Pre-primary children. It was developed by speech pathologist Jan Batchelor and is run in schools. Local schools in the Katanning region (Tambellup, Broomehill, Nyabing, Gnowangerup to name a few) pay a fee and a speech therapist or therapy assistant comes each week to help administer the program. It is a highly valued program. This is one example of how communities are bridging the gap in services offered by the public sector.[230]

3.82 West Greenwood Primary School is another example of a public school using its existing one-line budget creatively:

> I know schools where there is a need employ speech pathologists and schools get creative as well given the size of school budgets and primary government schools not being a terribly big budget. If I can give a personal experience, so the school I was at, West Greenwood Primary School, we used some of our one-line budget to directly work with Edith Cowan University and we brokered final year students so we had a number of final year speech pathology students as part of their university

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227 Hon Dr Sally Talbot MLC, Chair; and N Smith, President, Western Australian Primary Principals' Association, [*transcript of evidence*], *Legislative Council,* 20 February 2023, pp 6–7.

228 Dr Y Anderson, Associate Professor, Community Child Health, Curtin University, [*transcript of evidence*], *Legislative Council,* 12 May 2023, p 8.

229 L Pereira, Manager, Child Development Service, WACHS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 38.

230 Submission 47 from Isolated Children's Parents' Association, 24 October 2022, pp 1–2.

> course come and do practice at our school. So, that would be assessments, working with their own lecturer to then analyse those assessments and the results and help plan some interventions for those kids.
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> It was seen as being a win-win scenario for us to engage directly with ECU and the budget that we had to have run that model as opposed to having a large one-line budget where we could tap into that to employ a 0.2, 0.4 speech pathologist on site. Some of those schools that engage the full wraparound service would most certainly be employing speech pathologists.
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> …
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> … We never knew what number of final-year students we were going to get; usually, around four or five would come to the school over a period and they did work specifically in our early years. It was a program targeted to screen kindy and pre-primary students and develop intervention plans for those students in consultation with their parents.
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> …
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> We very much were in a partnership where it was win-win for students to get some in-school experience and we certainly benefited and got a lot more out of that budget than had we tried to look for a private speech pathologist willing to work one day a week or two days a week in our school.[231]

School-based speech pathology services

3.83 With a view to avoiding the need for some of these ad hoc arrangements that are paid for by individual public schools, the Committee explored the possibility of having statewide, centrally funded, onsite speech pathology services for mainstream public school children. As stated on the North East Metropolitan LDC website:

> With two students in every classroom having Developmental Language Disorder, and many more students in each classroom with other forms of communication difficulties, schools are seeking ways they can best support these students within their schools. They are looking for ways to build staff capacity to provide this support, as well as direct support for these students, to ensure that each child is provided access to a learning program that suits their individual needs, within the school environment.[232]

3.84 An organisation which asked to remain anonymous submitted that:

> from a school learning point of view, the access to Speech Pathology services for language disorders are particularly challenging for primary school-aged children. Services are focused on early intervention while ongoing language disorders continue to impact educational and later workforce outcomes.[233]

3.85 A Perth speech pathologist advised the Committee that Western Australia is one of the few Australian jurisdictions that do not have some form of mainstream public school-based speech pathology services:

> Western Australia is one of the few states in Australia that does not have direct speech pathology services in most (if not all) schools. The concept of speech

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231 N Smith, President, Western Australian Primary Principals' Association, [*transcript of evidence*], *Legislative Council,* 20 February 2023, p 6.

232 North East Metropolitan Language Development Centre (NEMLDC), *About the Speech Pathologists in Schools Program*, NEMLDC, 2024, accessed 1 February 2024.

233 Submission 52 from private organisation, 24 October 2022, p 2.

> pathology services provided in schools is not only common in other parts of Australia, but also in the USA & UK. In other states school based speech pathology services work in conjunction with other service providers like Health and/or private providers. In my view this model should be further encouraged and expanded in WA schools, to supplement the services already provided by private clinics and NGOs, the [CAHS–]CDS (and WACHS) and LDCs (including the Outreach Services).[234]

3.86 Committee research indicates that this assertion is correct. Except for New South Wales, all other Australian states and territories do offer centrally funded, mainstream public school-based speech pathology services to their students, albeit to varying degrees. New South Wales schools must pay for speech pathology services independently (see Appendix 3). All speech pathology services are targeted; that is, they are provided once a possible language disability or delay has been identified in an individual student. For the Australian Capital Territory, it is explicitly stated that services can also extend to support for whole school procedures.

3.87 The Committee heard from Dr Helen (Honey) Heussler, a developmental and behavioural paediatrician and the medical director of Child and Youth Community Services within Children's Health Queensland, about the specialist support services provided in Queensland public schools (through their education department) and how they interact with the child development service providers in their health department:

> From a historical perspective, many, many years ago it was felt that Health should take on the early child development work and that Education would take on the educational developmental work. That was when there was significant input, if you like, for allied health services to be within the education system. I think they are probably overwhelmed in terms of the need. They do do some assessments, and certainly their guidance officers are incredibly supportive and work with CDS [in the health department] a lot in terms of trying to get kids the right support. It is very educationally focused, as it should be. **The speech and other services that are provided within the education system are very much about providing that access to education.** They do assessments, those sorts of things. Where that is available, we certainly liaise very closely with them and will have joined up case conferencing and those sorts of things. It is generally a really positive experience, but there is not a formalised connection, if you like; there is a different focus, I think.[235] (emphasis added)

3.88 Interestingly, the child development services provided by Children's Health Queensland focuses particularly on assessing children and their treatment needs, and then referring them to another service provider for ongoing interventions:

> **Dr HEUSSLER**: As a child development service we provide assessments—that absolutely is our primary remit. We try, where at all possible, to discharge families and children back to the primary referrer. It is a big issue for us in terms of being able to discharge people back, both in the prescribing elements but also sometimes these complex children just have nowhere else to go in terms of specialist supervision in managing their developmental challenges. We have well over 1 500 kids that we are following up, or somewhere in that order, that are still on what we call our medical review panel. We do not tend to provide any intervention beyond short-term holding intervention while they are getting into other services, so it is mainly limited to assessment, which is our primary focus. We

[234] Submission 55 from private citizen, speech pathologist, 24 October 2022, p 3.

[235] Dr H Heussler, Medical Director, Child and Youth Community Services, Children's Health Queensland, [*transcript of evidence*], *Legislative Council,* 26 July 2023, p 8.

may do some short-term intervention while they are waiting to get into another service, but on the whole it is mainly assessment and holding those kids that we cannot find another home for.

Hon DONNA FARAGHER: To use a hypothetical, I appreciate that a child who had been identified with regard to autism or ADHD may require a number of specialists and supports within that; I understand that aspect. If a child has been identified with regard to a speech and language difficulty, which was fairly defined, would it be the case that after the assessment was undertaken you would then refer back to the GP who would then maybe suggest private supports, or are there other supports within the broader health system that they might be able to access from a public health perspective? I am just trying to get an understanding of how the system works in Queensland.

Dr HEUSSLER: We would be referring those children to early intervention services through local EIC [Early Childhood Early Intervention] services. They are generally funded through the NDIS [National Disability Insurance Scheme], our early intervention services.[236] For a single disorder we might put in a short-term piece of work and maybe refer them to local community Hanen programs or something like that. We would get them in the right place for short-term interventions, but somebody who has a speech and language disorder we would not continue to monitor. If we were concerned they were going to struggle—say we saw them at three—if we were really concerned they were going to have a rocky transition into school, we may get our speech pathologist to check in with them in the middle of prep and see how that had gone and see whether they need more supports. It is really the challenge, I think, with child development services. This is a longitudinal, whole-of-life thing. Just seeing them for assessments is sometimes really, really tricky because we know the next time they try and transition from prep to school or from primary school to high school, things go pear-shaped very quickly. As child development specialists, we know that if we set those transitions up well and we are there early if things are starting to go well, we can make the outcome better in the longer term. That sort of longitudinal care is something we all grapple with quite a lot, I think.

Hon DONNA FARAGHER: Thank you for clarifying that.

Dr HEUSSLER: Be that as it may, the model of care is assessment and only hang on to those you absolutely have to.[237]

3.89 This focus on assessments and onward referral without ongoing treatment may explain some of the policy decisions that resulted in allied health services being provided in Queensland public schools.

3.90 In Western Australia, a DOE trial of school-based speech pathology services has been running since 2021 and is expected to finish at the end of 2024. Any DOE schools in the north metropolitan region have the opportunity to participate in the pilot Speech Pathologists in Schools Program. Participating schools will be given a fully inducted speech pathologist who will work with staff and/or students, depending on the school's need. Each school is required to pay for the speech pathologist's services using their own funds, such as their one-line budget.[238] The North East Metropolitan LDC delivers the program:

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236 The NDIS's Early Childhood Approach is discussed in the Interim Report, pp 44–45, paragraphs 3.122–3.124.

237 Dr H Heussler, Medical Director, Child and Youth Community Services, Children's Health Queensland, [*transcript of evidence*], *Legislative Council,* 26 July 2023, p 11.

238 DOE, *North Metropolitan Speech Pathologists in Schools Pilot Program (Flyer)*, DOE, 2023, accessed 2 February 2024, p 2.

> The NEMLDC works with the participating School to understand the work of a school based speech pathologist, and to determine what services the speech pathologist would provide and how they could be best utilized in each school. A service agreement is developed and regularly reviewed and adjusted to ensure the school is receiving the required service.[239]

3.91 A Perth speech pathologist was complimentary of the pilot program and endorsed its extension to other areas of the state:

> This service allows children to receive regular, targeted speech pathology support at school, as well as referral to other external speech pathology services for additional support. The service empowers educators to better support these children in their day-to-day lives, as well as improve the education of other children in the class. Typically this service consists of a combination of in-class capacity building support for the teacher (to help all children, including those with communication needs) with direct intervention for children with difficulties and/or training others (like EAs [education assistants]) to provide such support with guidance. This service overcomes some of the drawbacks of other services in operation in WA, including access barriers for families and the often disconnect between SP services and educators (who spend a lot of time with children). At present this service is free to families, however is paid for fully by schools. As such, only some schools are able to access it from a financial perspective. Furthermore, schools are hampered in their ability to access enough support by how much money can be cut out of their budget. The trial is also only available to schools in the north metro region, with many schools in the south and regions not having access to this service, despite demand for it. Some of these barriers could be overcome by extending the trial/program to all of the Perth metro area (and possibly regions, if sufficient infrastructure is in place) and by the government centrally providing a subsidy/additional funding for schools accessing this service.[240]

Support for mainstream public school-based speech pathology

3.92 When the Committee queried DOE representatives about a mainstream public school-based speech pathology service for Western Australia children, a majority of these DOE witnesses were supportive of the idea:

> **Hon DONNA FARAGHER**: What I am keen to understand from the department is your views and perspectives with regard to proposals that have been put forward. I will admit that I am one of the people who is an advocate for it, but there are many others, and we have certainly received public submissions on this particular idea, which is to actually introduce a form of universal service of speech pathology into schools where direct face-to-face support could be provided to students. That would not be reliant on, to be frank, whether or not a school can afford, through their one-line budget, to pay for a speech pathologist; it would be more of a universal service. Does the department have a view with regard to that?
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> **Mr BELL**: I think … we would welcome any investment that would provide that sort of universal access to schools. It would go without saying that we would all agree that that would be certainly a welcome investment. I understand there are decisions to be made around that level of investment. I am also aware that some of the submissions refer to different proposals that have been put to us. We have tried to honour those and actually liaise with schools on what those proposals are.

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239 North East Metropolitan Language Development Centre (NEMLDC), *About the Speech Pathologists in Schools Program*, NEMLDC, 2024, accessed 1 February 2024.

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

They were not a universal proposition, mind you, either; I think we need to put that on the table. Certainly, our feedback and our conversations with schools are that they would welcome it, but I suppose there is a decision around affordability and relevance to a school need.

If it is the particular proposal you are suggesting [the trial Speech Pathologists In Schools Program (see paragraph 3.90)], there was a cost commitment that was required of schools. There was some equivocation, I think, on schools' behalf as to that level of outlay for what they would have had in terms of a resource in their school. Again, I come back to my original remarks about localised decision-making. The people who manage those one-line budgets and have that flexibility and know the need, they need to make the best decision they can to address that need, and those decisions have ~~gone~~ been made to invest the school's funds[241] elsewhere.

Hon DONNA FARAGHER: … one of the proposals that has been put forward is actually somewhat similar to your school psychology service, where you will have school psychologists who will work across clusters or a number of schools. The cost is not borne by the individual school; it is actually borne by the department and government … What I am trying to get an understanding of is whether or not schools would think that that would be a valuable service, not just … in terms of providing support to teachers, but also that face-to-face support and actually going to where the children are … Would schools see that that would be of benefit in terms of bringing the service to where the children are, so mums and dads do not have to worry about transport or taking time off work? …

Mrs MUSUMECI: My view would be, again, that this is a real opportunity for us to think about working in a way that is different from what we currently do that might not necessarily need an injection of resources. It would be great if, in the spirit of collaboration, we were able to move existing speech pathology resources—if that is what we are referring to—to exactly where they are needed most. AEDC data could inform our planning around what schools and what areas and what regions require more support. If you are asking for my personal opinion, having them co-located on school premises takes away all of the barriers that our families are currently facing.

Hon DONNA FARAGHER: Would you agree with that, Louise?

Mrs O'DONOVAN: Absolutely. I think any support that we can have at school, on school premises, for children to access and families to access, would be welcome.[242]

3.93 The Committee also received the following evidence supporting the proposal for a statewide, centrally funded, mainstream public school-based speech pathology program:

> Providing school based speech pathology services which is run through the Department of Education would bring a greater level of unity between the communication support a child needs, and their every-day, classroom and home reality. This model would in my view, not only support the students who have targeted communication needs, but would also strengthen and improve the education outcomes of all students through the capacity building of educators and in-class support. This model would also reduce educator workload by having

241 Amended via a letter of correction: Letter from L Rodgers, Director General, 16 March 2023, p 1.

242 Hon Donna Faragher MLC, Deputy Chair; J Bell, Deputy Director General, DOE; L Musumeci, Principal, Challis Community Primary School; and Mrs L O'Donovan, Principal, Hammond Park Primary School (previously known as Wattleup East Primary School), [*transcript of evidence*], *Legislative Council*, 2 March 2023, pp 21–22.

another highly qualified pair of hands in the classroom; another well trained pair of eyes and ears to help identify and support students developmental needs. Furthermore, families' access to services (especially at risk families) would in my view be greatly increased, because for many families their local school is much easier (and less intimidating) to get to than a health clinic away from their home.[243]

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The current limitation of responsibility for the provision of services to young children to be partially shifted from the Department of Health and extended to the Department of Education, with the provision of speech pathology services in schools and education settings in WA.[244]

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Hon DONNA FARAGHER: … You talked before with regard to having a greater engagement between health and education. I am interested to hear your views with regard to the idea that we would actually have more services, like allied health services, speech pathology and others, being placed in schools rather than always having, as a general rule, unless the school pays for it, not just the assessment but also the face-to-face support …

[**Witness:**] … I actually think that that model would be absolutely fantastic. To take a child out of school, often they do not actually receive the services they need. If they are embedded within the service, they do not then target these children as being, "Gosh, there's something strange going on". The child is going to feel there is something wrong with them. Often, they just need a little bit of support, right. If you give them a little bit of support early, they may not get all the mental health issues because of failure and inability to keep up. Having them in a school and having all the allied services, including psychology services and, as I said, using some automated systems of identifying issues rather than having these very intensive examinations and doing these really big tests where they basically spend an hour or two—you just cannot see throughput. So you have a system where for all the children's school there are certain things that they have to do or they have to fill out some of the questionnaires …[245]

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The CHAIR: So you refer to the need for greater liaison between all the parties—parents, teachers and CDS—to ensure a genuine case management approach could be employed. What would you envisage in an ideal situation?

Mr SMITH: In an ideal situation, potentially area managers, liaison officers, appointed to a set number of schools like the notion of having full-time para-professionals on site does seem fairly pie in the sky, but the ability to have allied health professionals on your site once or twice a week, whether potentially an area manager who coordinates that group of schools potentially could oversee the distribution of allied professionals to areas of greatest needs, which then allows potentially the specialists on the ground to be working directly with the teachers, the students and the families whilst a coordinator is managing the intervention plans, the time lines, the schedule of assessments. That would be a model I see that would work. And not too different to how our current school psychologists works. School psychologists are in schools. In a primary school you are lucky if you

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

244 Submission 43 from Speech Pathology Australia, 24 October 2022, p 10.

245 Private citizen, paediatrician, [*private transcript of evidence*], pp 12–13.

see two days a week and that is for a big school, school psychologist. They predominantly work with the parents and the staff. They work very little with the students unless they are doing an assessment, and then they just meet on a regular basis to discuss how the plans are being implemented, what progress is being made and then suggest new plans. That model could very much be applied to a CDS model of allied [health] support.

…

Hon DONNA FARAGHER: … can I just be clear, with regard to an allied health service focus, you would actually see that perhaps more with regard to face-to-face support for those students.

Mr SMITH: Absolutely.[246]

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The education department needs to come on board. They need to be appropriately funded to provide grassroots help for our kids. For young kids, allied health, occupational and speech therapy, and school psychology services to support the teachers and the students and the schools, and to provide appropriate reports to people like me.[247]

3.94 An Independent Expert Panel's report to advise Australian education ministers about reform priorities that should be included in the next National School Reform Agreement was published in December 2023. Among other things, the panel recommends that services other than purely educational services be embedded in schools and that links between schools and those other services be strengthened:

RECOMMENDATION 2B

To ensure that all students come to school ready and able to learn, the Panel recommends that all governments take steps to **embed** and strengthen linkages between schools and other services, such as community, family, **health (including speech and occupational therapists)**, and disability support services, by:

i. implementing full-service school models that better integrate these services within schools and improve partnerships between schools and external agencies, institutions and community members. Priority should be given to schools with a high concentration of students experiencing disadvantage, and care should be taken to avoid cost-shifting from other portfolios to education

ii. committing to a 12-month whole-of-government review of the interactions between education and other key Commonwealth and state-based services, with recommendations to National Cabinet by the end of 2026 focused on improving the effectiveness of service delivery to school-aged children through streamlining referral pathways, improved uptake of screening and services before and during school years among priority equity cohorts, and greater preventative investment.[248] (emphases added)

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246 Hon Dr Sally Talbot MLC, Chair, and Hon Donna Faragher MLC, Deputy Chair; and N Smith, President, Western Australian Primary Principals' Association, [*transcript of evidence*], *Legislative Council,* 20 February 2023, pp 4–5.

247 Dr M Parker, neurodevelopmental paediatrician, [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 12.

248 Independent Expert Panel, *Improving outcomes for all: The report of the Independent Expert Panel's Review to Inform a Better and Fairer Education System*, Department of Education, Australian Government, 2023, accessed 2 February 2024, p 93.

3.95 The panel also observed that:

> Stakeholders indicated that government investment in additional support staff in the classroom, including increased access to qualified specialist staff (e.g. speech pathologists, psychologists and counsellors) to assist students with additional needs, would make a real difference in reducing teacher workload. In the Review's survey, around 54 per cent of educators identified more specialist classroom support for students as the biggest area for government investment to improve outcomes. This was the most common response, followed closely by funding for more teachers.[249]

Concerns raised about mainstream public school-based speech pathology

3.96 While CAHS–CDS is willing to engage more with the DOE by building teacher capacity, it has reservations about its own practitioners providing school-based CDS, mainly because educational settings already attract a complex mix of services and service providers, including NDIS funding and supports:

> **Ms TURNELL**: … it may be that we need capacity as a team to be able to work alongside something like the Department of Education School of Special Educational Needs, which has teachers who have experience in the classroom with particular developmental or medical challenges and have a developmental component of that that is a co-team of allied health therapists who are working as part of a multidisciplinary team and teachers who can support schools. Those are the types of models, just at the moment, given the demand we are managing, we do not have capacity to explore.[[250]]
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> …
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> **Ms KIELY**: I think I just want to add … that it does become a far more complex environment in terms of a service delivery environment in the schools because not only do you have the school educational system providing some resources in terms of the speech and language resources, you have the NDIS plans coming into place, and there is a live debate about whether NDIS is supporting schools to provide, so we need to be careful. We have ideas and we think we would have a significant contribution, if funded, to make, but we also need to navigate that well so that we are maximising the value of the other services around the state and federal government at the same time. We want to do it really well.[251]

3.97 The Committee notes, however, that NDIS plans for school students may not be as common in future. A recent independent review of the NDIS recommended that for children under the age of nine years, the scheme should only fund supports for those who are experiencing the most acute developmental difficulties and disabilities, and therefore, have the highest support needs. Children who have lower levels of developmental need, and their families, should be supported outside the NDIS, through mainstream services (such as health and

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249 Independent Expert Panel, *Improving outcomes for all: The report of the Independent Expert Panel's Review to Inform a Better and Fairer Education System*, 2023, p 131.

250 Refer to paragraph 3.38 of this report for a discussion about CAHS–CDS's teacher capacity building workshops.

251 A Turnell, Acting Director, Clinical Services, CAHS–CDS, and S Kiely, Executive Director, Community Health, CAHS, [*private transcript of evidence*], *Legislative Council,* 25 July 2023, p 14.

education)[252] and foundational supports[253].[254] The Independent Review Panel's vision for the future approach to supporting children aged under nine years and their families included the following:

> **Far more support should be available where children are** and reduce the pressure on families having to access the NDIS for support. Implementing a holistic and joined up continuum of supports for children with disability and developmental concerns … should be an urgent priority for all governments. They are the future of our nation and their needs must be met better as early in life as possible.
>
> Children with developmental concerns and disability should be matched with supports that best meet their needs. This requires more mainstream and foundational supports. This would create a continuum of supports, matched to the needs of children and their families, and also relieve pressure on families to have to access the NDIS to be supported.
>
> Children with higher support needs should be able to access the NDIS through a more fair and transparent access process. Children who are eligible for the NDIS should receive a budget based on support needs, determined through child centred assessments.[255] (emphasis added)

3.98 The Independent Review Panel's associated recommendation 6 and action 6.1 are as follows:

> Recommendation 6
>
> **Create a continuum of support for children under the age of 9 and their families**
> **Legislative change required*
>
> Action 6.1
>
> **National Cabinet should agree to jointly invest in a continuum of mainstream, foundational and specialist supports to address the needs of all children with disability and developmental concerns.**
>
> Supports provided outside the NDIS should include mainstream supports (including early identification of children with developmental concerns and inclusive education, *see Actions 2.5 and 2.13*) and foundational supports (including expanded supports for children with emerging developmental concerns and disability and programs, *see Action 1.12*). Within the NDIS, children under the age of 9 with higher levels of need should receive specialist support through a reformed

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252 Mainstream services are defined as 'Mainstream services (also known as universal or essential services) are government services outside the NDIS that all Australians can access and benefit from, regardless of whether or not they have a disability. They include things like health care, education, transport, and employment services': Prof B Bonyhady AM and L Paul AO PSM, Co-chairs, Independent Review Panel, *Working together to deliver the NDIS – Independent review into the National Disability Insurance Scheme: Final report*, Department of the Prime Minister and Cabinet, Commonwealth of Australia, 2023, accessed 2 February 2024, p 290, Glossary.

253 Foundational supports are defined as 'Disability-specific supports that are available for and benefit people with disability, families and carers outside of NDIS individual budgets': *Working together to deliver the NDIS – Independent review into the National Disability Insurance Scheme: Final report*, p 288, Glossary.

254 *Working together to deliver the NDIS – Independent review into the National Disability Insurance Scheme: Final report*, pp 118–127, particularly pp 122–124, recommendation 6 and action 6.1.

255 *Working together to deliver the NDIS – Independent review into the National Disability Insurance Scheme: Final report*, p 122.

> early intervention pathway (*see Action 6.2*). Figure 6 illustrates how these related recommendations come together.[256] (original emphasis)

3.99 If these NDIS review recommendations are implemented, the respective roles of CDS providers and schools, with respect to children with mild to moderate developmental needs, can be expected to grow.

3.100 Dr Yvonne Anderson was cautious also about the proposal to provide CDS in schools:

> You may end up creating duplication. That is the trickiness of the situation. I do not want you to think that I am not enthusiastic about education and health working closer together and having more mobility in the service, because it addresses a lot of the tricky issues around any constraints with physical locations. However, it is very difficult to see in a fiscally constrained environment how you could potentially expand the work and activity without adequate funding and building on an already existing backbone as opposed to a shift in place and potential sector that is controlling that activity.
>
> …
>
> … it [the provision of secondary-level child development services in schools] cannot be the replacement [for the current CAHS–CDS and WACHS–CDS] because if that school does not have the same level [of supports] as, say, Challis, a child could fall through the gaps.[257]
>
> ▫▫▫
>
> another major consideration is that parents are not often present in the school, impacting the progression of any treatment for children provided within school unless this is overcome.
>
> … speech pathology is one of many important aspects to provide during the first 2,000 days to ensure children thrive. However, as clearly pointed out, meeting the needs of a child aged 0-3 years prior to any school contact is also critical, so health services within schools will never be able to provide a universal response.
>
> For education to employ health professionals, on a permanent basis means two different disciplines coming together – issues such as supervision, training and access to the health service all need to be considered. Ideally health workers should be employed by health, with outreach into education, as I have seen examples where education employing health professionals has been unsuccessful. Further, to have health provide care prior to school, and education provide care from school age onwards inadvertently results in a divide and silo at 3 years of age, resulting in children falling through cracks.[258]

3.101 Dr Anderson's concerns could be avoided by ensuring that the current CDS providers remain the primary providers of secondary-level child development services in the State, with school-based allied health services being complementary.

3.102 On the issue of parent participation, school-based practitioners could use strategies to promote that engagement:

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256 Prof B Bonyhady AM and L Paul AO PSM, *Working together to deliver the NDIS – Independent review into the National Disability Insurance Scheme: Final report*, 2023, p 124.

257 Dr Y Anderson, Associate Professor, Community Child Health, Curtin University, [*transcript of evidence*], *Legislative Council,* 12 May 2023, p 9.

258 Dr Y Anderson, Associate Professor, Community Child Health, Curtin University, Answer to question on notice 1c) asked at hearing held 12 May 2023, dated 16 June 2023, p 2.

> **Dr WELLS**: … I absolutely agree that it would be important that any speech pathologist in that type of structure [school-based allied health services] would work with families, beyond just the school boundaries. They would be working with the school community. Ideally, we have spoken about following a response-to-intervention framework, where, at the highest tier—tier 1—the speech pathologist is working with the school administration, with teachers directly and also with the school community to build the capacity of everyone to work on supporting people with communication needs.
>
> **The CHAIR**: That is an ideal … ?
>
> **Dr WELLS**: That is an ideal, and that mirrors our language development centres, which currently use a response-to-intervention framework.
>
> **The CHAIR**: I notice you mentioned that that was built into the Queensland system.
>
> **Dr WELLS**: Yes. I cannot speak to other states, but I know that it is built into the Queensland and Tasmanian systems.[259]

3.103 Given the short-comings of the current CDS system, as summarised at paragraph 3.42, and the recent recommendations of two independent reviews for the Commonwealth Government (the Review to Inform a Better and Fairer Education System[260] and the Independent Review into the NDIS[261]), the Committee notes that CAHS–CDS is aware of the need to work more collaboratively with the DOE.

3.104 As noted in paragraph 3.90, a DOE trial of school based speech pathology services has been running since 2021, through the North East Metropolitan LDC. In light of this and other evidence received, the Committee believes there is merit in trialling an expanded model of school-based allied health services across selected public schools.

3.105 In the design of any such trial, the Committee believes the following principles are important:

- CAHS–CDS and WACHS–CDS should remain the primary providers of CDS.
- No resources should be diverted from CAHS–CDS or WACHS–CDS to the DOE.
- To prevent cost shifting, schools would not be required to divert funds from their one-line budgets.
- To prevent children falling through the gaps, the principles of universal access and service provision should be respected.
- Duplication of CDS is minimised.
- Involvement of parents and legal guardians in the assessment and treatment of children is maximised.
- Schools in both metropolitan and regional Western Australia should be involved.

3.106 The Committee believes it is important to draw attention to the obvious fact that school-based allied health services will not include children aged zero to three years, who are a prime target of all early intervention strategies. This is a key reason why resources cannot be diverted from the CDS system to the provision of school-based services.

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

260 Refer to paragraphs 3.94–3.95 in this report.

261 Refer to paragraphs 3.97–3.99 in this report.

FINDING 15

Increased collaboration between the Department of Education and WA Health with respect to the provision of allied health services relating to child development is desirable.

FINDING 16

There is merit in trialling an expanded model of school-based allied health services across selected public schools.

3.107 A majority of the Committee, comprising Hons Dr Sally Talbot and Samantha Rowe MLCs, makes the following recommendation:

RECOMMENDATION 15

The State Government consider trialling an expanded model of school-based allied health services across selected public schools taking the following principles into account:

a) The Child and Adolescent Health Service–CDS (CAHS–CDS) and WA Country Health Service–Child Development Service (WACHS–CDS) should remain the primary providers of public, secondary and tertiary-level child development services.

b) No resources should be diverted from CAHS–CDS or WACHS–CDS to the Department of Education.

c) To prevent cost shifting, schools would not be required to divert funds from their one-line budgets.

d) To prevent children falling through the gaps, the principles of universal access and service provision should be respected.

e) Duplication of CAHS–CDS and WACHS–CDS services is minimised.

f) Involvement of parents and legal guardians in the assessment and treatment of children is maximised.

g) Schools in both metropolitan and regional Western Australia should be involved.

3.108 A minority of the Committee, comprising Hon Donna Faragher MLC, makes the following recommendation:

Minority Recommendation 2

The State Government commence a trial of an expanded model of school-based allied health services across selected public schools immediately.

Mobile and relocatable allied health services

3.109 Evidence provided to the Committee demonstrates that mobile allied health services are an alternative and complementary method of delivering child development services. The Earbus Program is an existing example of a mobile clinic aimed at reducing the incidence of middle ear disease in Aboriginal and at-risk children in Western Australia (see Interim Report[262] and paragraph 4.146).

[262] Interim Report, p 36, paragraph 3.86.

3.110 Dr Yvonne Anderson informed the Committee that, in Aotearoa New Zealand, mobile clinics are being used to deliver healthcare services at schools:

> Dr Sarah Williams did an incredible thesis looking at the relationship between health and education and has also spearheaded mobile clinics in some of the lower socio-economic schools. These are beautiful clinics in shipping containers that can actually be shifted depending on need. There are other models in the Kaupapa Māori space, or the "by Māori for Māori" space that are actually much more mobile and agile in their delivery.[263]

3.111 The relocatable clinics are known as Whare Hauora.[264] They were first launched in 2018[265] at Panmure Bridge School and later expanded to two further primary school sites.[266] They are similar to shipping containers (measuring approximately 7.2 metres long, 3 metres wide and 3 metres high)[267] and are purpose-built for the delivery of specialist healthcare services, including preventative intervention. Each Whare Hauora contains a small waiting area, a private treatment space and a rear office space. They are also self-contained, with their own air conditioning, water supply and the ability to use a generator.[268]

Figure 1. *An example of a Whare Hauora (side view)*

[Source: Starship, *Starship Community opens first New Zealand in-school relocatable health facility*, Starship, 2019, accessed 5 February 2024.]

263 Dr Y Anderson, Associate Professor, Community Child Health, Curtin University, [*transcript of evidence*], *Legislative Council,* 12 May 2023, p 8.

264 The Māori word 'Whare' translates to 'house, building, residence, dwelling, shed, hut, habitation' and 'Hauora' translates to 'health, vigour': *Te AKA Māori Dictionary*, 2023-2024, accessed 5 February 2024.

265 Starship Foundation, 'Yesterday Whare Hauora – a New Zealand first in-school relocatable health facility …'. [Facebook post], https://m.facebook.com/starshipfoundation/posts/10155792078508785/, 10 August 2018, accessed 5 February 2024.

266 Starship, *Starship Community opens first New Zealand in-school relocatable health facility*, Starship, 2019, accessed 5 February 2024.

267 Dr S Williams, 'The relationship between primary schools and health services in New Zealand: A multicase study', *Auckland University of Technology's Tuwhera (Open access)*, 2022, p 264.

268 Starship, *Starship Community opens first New Zealand in-school relocatable health facility*, Starship, 2019, accessed 5 February 2024.

Figure 2. *An example of a Whare Hauora (entrance view)*

[Source: Starship Community, *Success story: Starship Community*, Starship Community, accessed 5 February 2024.]

3.112 The Whare Hauora were designed by Aotearoa New Zealand's Ministries of Health and Education, and built with the help of private funding.[269] They are owned by the Ministry of Health while being housed on Ministry of Education land, and a memorandum of understanding is in place.[270] The Auckland District Health Board funds and provides the healthcare services.[271] The Whare Hauora have been:

> Hugely popular from the outset, this child, family and practitioner friendly clinic space has:
>
> - Improved health service delivery by providing a safe, fit for purpose facility for health staff
> - Enhanced patient experience by enabling quality healthcare to be delivered in the community for the community
> - Increased access to outpatient health services by utilising the space as a satellite clinic for other health professionals
> - Enabled children with mild to moderate health needs to have these needs met in a timely way and therefore support regular attendance at school.[272]

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269 Starship Community, *Success story: Starship Community*, Starship Community, accessed 5 February 2024.

270 Dr S Williams, 'The relationship between primary schools and health services in New Zealand: A multicase study', *Auckland University of Technology's Tuwhera (Open access)*, 2022, p 264.

271 Starship, *Starship Community opens first New Zealand in-school relocatable health facility*, Starship, 2019, accessed 5 February 2024.

272 Starship Community, *Success story: Starship Community*, Starship Community, accessed 5 February 2024.

FINDING 17

Mobile and relocatable allied health clinics that visit and service mainstream public schools in metropolitan and regional Western Australia, can be an alternative and complementary method of delivering child development services.

RECOMMENDATION 16

The State Government investigate the practicability of providing mobile and relocatable allied health clinics that visit and service mainstream public schools in metropolitan and regional Western Australia.

Allied health services provided in Child and Parent Centres

3.113 Child and Parent Centres (CPCs) are places that offer advice, programs and services to families, with an emphasis on those with young children (up to eight years old).[273] WA Health described CPCs as a collaboration between:

> Departments of Education, Health and Communities, as well as other local service providers. The purpose of these centres is to provide a range of wrap around early learning programs, maternal and child health services, and child support activities to families in the local community. This place-based initiative allows families in the local area easy access to services and contributes to addressing health inequities associated with social determinants.[274]

3.114 There are 22 CPC sites across the State and 13 of them are located in the Perth metropolitan area. Each CPC is situated at a public school (mainly primary schools), providing the host schools with:

> the opportunity to work with families from the time children are born through to starting school and beyond. The centres will assist children to be ready to start school, and to become happy, confident learners.[275]

3.115 While CPCs are situated on DOE land, they are operated by non-government organisations with which the DOE has partnered (see Appendix 4 for a list of centre operators). The services and supports offered at each CPC vary from site to site, but they generally include:

- maternal and child health services
- speech therapy support
- paediatric services and paediatric referrals
- family psychological services
- counselling services
- antenatal classes
- early learning programs
- early literacy/numeracy programs
- cultural programs

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273 Child and Parent Centres (CPCs), *About our centres*, CPCs, accessed 5 February 2024.

274 Submission 77 from WA Health, 9 November 2022, p 78.

275 CPCs, *About our centres*, CPCs, accessed 5 February 2024.

- child support activities
- playgroups, including Best Start Aboriginal playgroups
- school holiday programs
- other child support programs, for example, Rhyme Time, Aboriginal Story Time
- parenting and family support
- parent literacy support
- parent workshops and groups, for example the Positive Parenting Program (Triple P), protective behaviour workshops, new parent and baby groups, young parent workshops (for under 25 year olds) and managing behaviour workshops)
- transition schooling activities
- multicultural programs and services
- referrals to other services.[276]

3.116 The principal of a host school and the CPC coordinator work closely to ensure that their centre provides the services and programs needed by their community.[277] Further, forums for principals from the host and surrounding schools will provide information to CPC coordinators on the prevailing issues within their communities.[278]

3.117 CPCs are considered to be a safe, local and accessible space for parents and caregivers to gain support and get services they may otherwise not seek out.[279] In that sense, CPCs have already broken down many of the barriers preventing families from attending traditional clinical settings.[280]

3.118 CPCs also appear to be highly regarded[281] and well frequented. For example, in 2022-23, CPCs provided 504 programs and services and they were attended by children approximately 73,957 times and by adults, approximately 66,456 times.[282]

3.119 Ngala, the Developmental Occupational Therapy Association of Western Australia and the Western Australian Occupational Therapy Association (OT Associations) identified CPCs as settings that would be suitable for the delivery of CDS, functioning as spokes in a 'hub and spoke' model.[283] However, that opportunity is currently being under-utilised.[284]

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276 CPCs, *About our centres*, CPCs, accessed 5 February 2024.

277 CPCs, *About our centres*. See also, L Musumeci, Principal, Challis Community Primary School, [*transcript of evidence*], *Legislative Council*, 2 March 2023, p 33.

278 L Musumeci, [*transcript of evidence*], p 33.

279 Submission 65 from Ngala, 28 October 2022, p 6.

280 Chapter 6 contains more information about CPCs and other accessible community service providers.

281 Submission 64 from Anglicare WA, 26 October 2022, p 16; and Prof A Whitehouse, Bennett Professor of Autism Research, TKI, [*transcript of evidence*], *Legislative Council,* 9 February 2023, p 13.

282 DOE, *Annual report 2022-23*, DOE, 2023, accessed 5 February 2024, p 47; see also, J Bell, Deputy Director General, and S Percival, Director, Disability and Inclusion, DOE, [*transcript of evidence*], *Legislative Council*, 2 March 2023, pp 31–32.

283 See paragraphs 2.34–2.44 in this report for a discussion about the hub and spoke model.

284 Submission 65 from Ngala, 28 October 2022, p 33; and Submission 80 from OT Associations, 14 November 2022, p 6.

3.120 WA Health confirmed that currently, the only CAHS–CDS practitioners working at CPCs are speech pathologists, who are providing some primary and secondary healthcare services[285] at these centres:

> our speech pathologists that work in the child and parent centres. Part of their time in the child and parent centre is allocated to seeing [CAHS–]CDS clients who have been referred and are on their case load, but part of that time is also allocated to just supporting the child and parent centre and the playgroups and the activity that is going on in that child and parent centre, and … families … [attending] … that centre and giving them advice at that time or supporting them in how to support their child's development within general play, natural environments et cetera. That is a more true primary healthcare model.[286]

3.121 The Committee queried whether CAHS–CDS could better utilise CPCs as a facility for providing CDS and was told that there was inadequate space to do so:

> We talked earlier about the potential opportunity within child and parent centres. I think that is a great opportunity for us to explore further, whether that is additional speech pathology FTE [full-time equivalent] or whether that is other disciplines as well that are engaged in those centres. They do have their own facility constraints as well that have to be considered, but there is potential there …[287]
>
> ▫▫▫
>
> we have not looked at specifically child and parent centres because the child and parent centre services are full to bursting with people in them, and we are often being asked to not attend on certain days so that we can make sure that the [usual CPC] business goes on. There are some physical limitations, but the solutions are definitely in mind. It is not our primary focus; there is an element that is primary care, that we put up solutions, there is a larger element which is funding our mainly secondary service delivery.[288]

3.122 WA Health advised that WACHS–CDS allied health practitioners do provide services from CPCs, as well as primary level healthcare, such as 'collaborating on programs to build community capacity'.[289] Given there are only nine CPCs situated in regional WA,[290] it appears to the Committee that there are only limited opportunities for WACHS–CDS practitioners to work from these centres.

3.123 An early evaluation of the CPC model showed promising results. Another evaluation is currently underway (see paragraphs 6.38–6.39).

Queensland integrated school-based hubs

3.124 CPCs bear some resemblance to the FamilyLinQ sites in Queensland, which are examples of integrated school-based hubs. FamilyLinQ:

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285 Refer to Interim Report, pp 16–17, for an explanation of the different levels of healthcare.

286 A Turnell, Acting Director, Clinical Services, CAHS–CDS, [*private transcript of evidence*], *Legislative Council,* 25 July 2023, p 4.

287 A Turnell, Acting Director, Clinical Services, CAHS–CDS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 36.

288 S Kiely, Executive Director, Community Health, CAHS, [*private transcript of evidence*], *Legislative Council,* 25 July 2023, p 9.

289 Submission 77 from WA Health, 9 November 2022, p 78.

290 Carey Park, Collie Valley, Fitzroy Valley, Halls Creek, Kununurra, Mount Lockyer, Rangeway, Roebourne and South Hedland: CPCs, *Our centre locations,* CPCs, accessed 5 February 2024.

> aims to enhance life outcomes of Queensland children and their families by bringing together early years learning, education, wrap-around health and community services – all under roof.[291]

3.125 FamilyLinQ is a collaboration between a non-government organisation and Queensland's Department of Education, and is supported by Children's Health Queensland Hospital and Health Service. The first FamilyLinQ site, at Kingston State School (a primary school), opened in 2023 and will be followed by another site at a new primary school at Logan Reserve.[292]

3.126 Children enrolled (or are likely to enrol) at the co-located primary school, their parents/carers, siblings and other family members living in the same household can access FamilyLinQ services.[293] Dr Helen (Honey) Heussler, advised the Committee that the Child and Youth Community Services within Children's Health Queensland Hospital and Health Service will provide both general and developmental paediatricians at FamilyLinQ sites.[294]

3.127 FamilyLinQ is based on elements of the Yarrabilba Family and Community Place (Yarrabilba),[295] a trial site which opened in October 2018.[296] It is a purpose-built integrated community facility on the grounds of Yarrabilba State School. Led by an allied health project team at Children's Health Queensland and supported by the local council and the Department of Education, Yarrabilba utilises 'soft entry'[297] approaches to deliver multiple services.[298]

3.128 Child health teams and child development services teams (including developmental paediatricians, speech pathologists, psychologists, social workers, occupational therapists and physiotherapists) operate at Yarrabilba. Other programs are delivered there by community partners, focusing on developmental and family supports and health literacy.[299]

3.129 Yarrabilba is a warm and non-threatening environment and focuses on engaging parents through playgroups, health clinics and KindyLinQ, a play-based program that families can attend in the year before their child starts kindergarten.[300] The program is led by a qualified

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291 FamilyLinQ, *Bringing education, health and community services under the one roof*, FamilyLinQ, 2023, accessed 19 July 2023.

292 FamilyLinQ, *Bringing education, health and community services under the one roof*.

293 FamilyLinQ, *Frequently asked questions*, FamilyLinQ, Queensland Government, accessed 19 July 2023, p 2.

294 Dr H Heussler, Medical Director, Child and Youth Community Services, Children's Health Queensland Hospital and Health Service, [*transcript of evidence*], *Legislative Council,* 26 July 2023, p 2.

295 Letter from Hon Shannon Fentiman MP, Queensland Minister for Health, Mental Health and Ambulance Services, 12 June 2023, p 1.

296 J Allen-keeling, 'Integrated place based hubs – The Yarrabilba Family and Community Place – A proof of concept hub utilizing cross-sector partnerships to enable a shared focus on improving health, development and wellbeing outcomes of children and families living in specific geographical catchment', *International Journal of Integrated Care*, 2021, 20(1):8, DOI: 10.5334/ijic.s4008.

297 Soft entry programs are programs which are delivered in a non-stigmatising way and are offered universally. Playgroups are an example of a soft entry program: Associate Prof K Macfarlane & C Stubbs, The Salvation Army/Griffith University Knowledge Partnership, *The Family Place Approach: Utilising soft entry approaches to create safe spaces for children and families*, accessed 3 July 2023.

298 J Allen-keeling, 'Integrated place based hubs – The Yarrabilba Family and Community Place – A proof of concept hub utilizing cross-sector partnerships to enable a shared focus on improving health, development and wellbeing outcomes of children and families living in specific geographical catchment', *International Journal of Integrated Care*, 2021, 20(1):8, DOI: 10.5334/ijic.s4008.

299 Letter from Hon Shannon Fentiman MP, Queensland Minister for Health, Mental Health and Ambulance Services, 12 June 2023, p 1.

300 L Lauer, S Watters, K Morris & S Griffin, 'Brokering school-community partnerships: Cross-sector advocacy and hard work', in B Cleveland, S Backhouse, P Chandler, I McShane, JM Clinton & C Newton (ed.), *Schools as community hubs: Building 'more than a school; for community benefit*, Springer, Singapore, 2023, p 45, at p 50.

teacher and early years support coordinator.[301] Over time, the services at the hub will change in order to meet changing community needs and demographics.[302]

3.130 Dr Heussler described Yarrabilba as a 'drop-in centre for families and children' and confirmed that the child development services team provides mainly assessments, not ongoing treatment and support:

> Our child development team visits the hub and runs clinics from the hub. It is an in-reach from our service, if you like, to the place-based hub. Children will be seen there. They will have a diagnosis or be assessed and then managed like we would in any of our other tertiary centres. Our child development service really has a remit to focus on assessment, but where we need to keep working with children, it is usually from a medical or a paediatrician perspective and then they will be referred for early intervention or NDIS supports or other supports that way. We are not running a lot of intervention. We will be running some Head to Health[303] services from that hub as well. They are providing more intervention. That will probably come from the same place as well.
>
> …
>
> We regard ourselves as a tertiary child development service, but based in community sites. These children are all referred by general practitioners, so we have a medical referral model here rather than an open, anybody-can-refer model, which puts some barriers in some of the equity story, but we were very keen when we established it to maintain that linkage with primary care. We do accept kids sometimes where that access to general practice is a real problem, particularly for ongoing referrals, but we do strongly believe that ongoing access and work with your local family doctors is really important. We are slightly different in that respect.[304]

3.131 Independent evaluation of the Yarrabilba trial found that the model had many benefits. A first-year baseline evaluation and a third-year evaluation were independently undertaken by Deloitte Access Economics in 2020 and 2021, respectively. The first-year baseline evaluation provided promising evidence that the model had a positive impact with parents and children accessing the health, early education services and social programs offered. The co-location of the integrated services hub with the primary school was reported by families as being responsive to family schedules and enabling improved accessibility of services.[305]

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301 Queensland Government, Early Childhood Education and Care, *KindyLinQ*, Early Childhood Education and Care, 2023, accessed 12 February 2024.

302 L Lauer, S Watters, K Morris & S Griffin, 'Brokering school-community partnerships: Cross-sector advocacy and hard work', in B Cleveland, S Backhouse, P Chandler, I McShane, JM Clinton & C Newton (ed.), *Schools as community hubs: Building 'more than a school; for community benefit*, Springer, Singapore, 2023, p 45, at p 50.

303 A free confidential service funded by the Australian Government that connects people to mental health assistance and supports: Australian Government, Department of Health and Aged Care, Head to Health, *Not feeling like yourself lately? You're not alone*, Head to Health, accessed 12 February 2024.

304 Dr H Heussler, Medical Director, Child and Youth Community Services, Children's Health Queensland Hospital and Health Service, [*transcript of evidence*], *Legislative Council,* 26 July 2023, pp 3–4.

305 L Lauer, S Watters, K Morris & S Griffin, 'Brokering school-community partnerships: Cross-sector advocacy and hard work', in B Cleveland, S Backhouse, P Chandler, I McShane, JM Clinton & C Newton (ed.), *Schools as community hubs: Building 'more than a school; for community benefit*, Springer, Singapore, 2023, p 45, at p 50.

3.132 The third-year evaluation confirmed the first-year baseline evaluation.[306] It also identified Yarrabilba's 'soft entry' model[307] as the key to high-quality service delivery. Increased information sharing among the services was attributed to the co-location of these services, resulting in more timely and holistic support for families. Seventy-one children received an earlier diagnosis or referral than they would have if Yarrabilba had not existed. In addition, nearly 70% of service users reported an improvement in social participation.[308]

3.133 The evaluation highlighted a significant longer-term impact of the model, which was the ability to reach families which otherwise would not have engaged with health, education or social services.[309]

3.134 The Committee considers that CPCs are sites where family programs and services, including primary and secondary-level child development services, can be delivered effectively. CPCs are, however, crowded and limited space is available for visiting nurses and allied health practitioners at certain times of the day.

3.135 The Committee notes that, subject to funding being available, CAHS–CDS proposes to investigate opportunities for greater collaboration with the DOE.[310] The Committee expects that one of the priorities will include investigating how CAHS–CDS can maximise its use of CPCs.

FINDING 18

Child and Parent Centres are sites where family programs and services, including primary and secondary-level child development services, can be delivered effectively.

FINDING 19

At certain times of day, Child and Parent Centres are crowded. However, there are opportunities to expand the provision of child development services at these centres.

FINDING 20

Child and Parent Centres could operate as spokes in a hub and spoke model for delivering child development services.

3.136 A majority of the Committee, comprising Hons Dr Sally Talbot and Samantha Rowe MLCs, makes the following recommendation:

RECOMMENDATION 17

The Child and Adolescent Health Service and WA Country Health Service investigate the feasibility of providing expanded primary and secondary-level child development services at existing Child and Parent Centres.

306 L Lauer, S Watters, K Morris & S Griffin, 'Brokering school-community partnerships: Cross-sector advocacy and hard work', in B Cleveland, S Backhouse, P Chandler, I McShane, JM Clinton & C Newton (ed.), *Schools as community hubs: Building 'more than a school; for community benefit*, Springer, Singapore, 2023, p 45, at p 51.

307 See footnote 297 in this report for a description of 'soft entry' programs.

308 L Lauer, S Watters, K Morris & S Griffin, 'Brokering school-community partnerships: Cross-sector advocacy and hard work', in B Cleveland, S Backhouse, P Chandler, I McShane, JM Clinton & C Newton (ed.), *Schools as community hubs: Building 'more than a school; for community benefit*, Springer, Singapore, 2023, p 45, at p 51.

309 L Lauer et al, *Schools as community hubs: Building 'more than a school; for community benefit*, p 45, at p 51.

310 See Interim Report, pp 77–78, paragraph 4.70.

3.137 A minority of the Committee, comprising Hon Donna Faragher MLC, makes the following recommendation:

Minority Recommendation 3

The Child and Adolescent Health Service and WA Country Health Service provide expanded primary and secondary-level child development services at existing Child and Parent Centres.

3.138 A majority of the Committee, comprising Hons Dr Sally Talbot and Samantha Rowe MLCs, makes the following recommendation:

RECOMMENDATION 18

The State Government consider establishing more Child and Parent Centres across the State and, where feasible, include facilities for visiting practitioners from the Child and Adolescent Health Service and WA Country Health Service.

3.139 A minority of the Committee, comprising Hon Donna Faragher MLC, makes the following recommendation:

Minority Recommendation 4

The State Government establish more Child and Parent Centres across the State and ensure these centres have appropriate facilities available for visiting practitioners from the Child and Adolescent Health Service and WA Country Health Service.

Non-government organisations and the private sector

Not-for-profit organisations

3.140 The Committee notes that there are existing not-for-profit organisations providing child development services in metropolitan and regional Western Australia, such as the Earbus Foundation of Western Australia (Earbus), TKI, Ability WA and Telethon Speech and Hearing (see Interim Report for a discussion of the child development services provided by each of these organisations).[311] Earbus's contributions to child development services are also mentioned at paragraphs 3.109, 4.146 and 7.20 of this report.

3.141 A strong message in the evidence presented by Inquiry stakeholders was that there needs to be more, and better, collaboration between the CDS providers (particularly CAHS–CDS) and the not-for-profit sector. For instance:

> The state needs to be comfortable with the fact that it does need the support of the sector and to stop trying to take back control and manage systems and services that are not ultimately supporting the development of healthy babies, parents, families and communities. Working in partnership with organisations who hold specific focus and specialized skill sets will only enhance the outcomes experienced by parents and young people.[312]

[311] Interim Report, pp 35–36, paragraphs 3.84–3.86.

[312] Submission 65 from Ngala, 28 October 2022, p 7.

▫▫▫

> There is currently a need to develop and utilise innovative models of care within child development services that support collaboration between government and non-government sectors and private practitioners. For example, where the Department of Health is unable to meet current demand, consider contracting services out to other non-government agencies or private practitioners.[313]

▫▫▫

> No matter what the level of funding is to [CAHS– or WACHS–] CDS, resources will always be finite and hence there is a need to identify how best to re-route children to other avenues when CDS is unable to meet demand. Increased collaboration and connection between CDS and private sector and NFP organisations (eg. Ngala, Clinikids [operated by the TKI]) is needed to address this.[314]

3.142 One obvious way in which the CDS providers can collaborate with the not-for-profit sector is to supplement its workforce with workers from this sector. As noted in the Interim Report,[315] CAHS–CDS prefers to provide its services through a directly employed workforce, while WACHS–CDS, out of necessity, often relies upon contracted workers (commonly sourced from the not-for-profit sector) to deliver its services. CAHS–CDS outlined its reservations about outsourcing its services:

> CAHS CDS has historically contracted out some services and this led to challenges to families, clients and staff that are important to learn from, including that:
>
> - Contracting out services detracted from the coordinated and collaborative multidisciplinary approach to client management offered within CDS and CAHS more broadly.
> - Additional internal clinical and administrative resources were required to ensure effective contract management practices and quality control.
> - It was difficult to manage conflicts of interest when the contractors would refer clients to fee-incurring services within their organisation instead of referring to free CDS services.
> - It caused confusion for families that were accessing some services through CDS and others through an external contractor.
> - Some contractors tended to allocate inexperienced clinicians to CDS clients.
> - It was logistically challenging to facilitate group-based services through contractors.
> - A number of contractors opted not to exercise contract extension options or requested extraordinary pricing variations to the contract due to dissatisfaction with their agreed contracted rates.[316]

313 Submission 74 from APS, 8 November 2022, p 12.

314 Submission 85 from TKI, 18 November 2022, p 3.

315 Interim Report, pp 32–33, paragraphs 3.71–3.73.

316 Dr DJ Russell-Weisz, Director General, DOH, Answer to question on notice 13 asked at hearing held 28 November 2022, dated 20 December 2022, pp 7–8.

3.143 Despite CAHS–CDS's reluctance to use contractors, it explained to the Committee that it is willing and able to collaborate with external organisations (including not-for-profit organisations) when appropriate:

> where it is within our capacity to partner with organisations, we will. Often the challenge is the organisation might be looking for a funding component. You know, we do not even have enough funding ourselves and we certainly cannot do that …[317]

3.144 The Committee was informed that there have been some examples of both CDS providers collaborating effectively with the not-for-profit sector:

- The TKI's Inklings program – which provides early intervention for babies showing early behavioural signs of ASD. The program was trialled 'in close partnership with' CAHS–CDS. After positive findings, the program has been implemented in partnership with CAHS and WACHS, and with funding from the NDIS.[318] The TKI's Professor Andrew Whitehouse, who developed Inklings, provided further details about the collaboration with CAHS during the trial:

  > This was part of the wonderful sort of aspects of the CAHS collaboration. Child health nurses screened the children through existing programs and then they were referred on to the Child Development Services, which is where we conducted the intervention.[319]

- Dr Yvonne Anderson was jointly appointed by Curtin University, TKI and CAHS to ensure that research is converted into clinical practice.[320]

- Telethon Speech and Hearing operates in Perth and across the State, 'from Onslow out to the wheatbelt and the southern parts of the Peel region'.[321] It has previously provided speech therapy as a CAHS–CDS contractor, but has more recently developed working relationships with certain WACHS regions:

  > When I started at Telethon Speech and Hearing, which was six years ago, we were doing a contract with them [CAHS–CDS] for a speech therapy clinic for half a day a week, which was not particularly effective or good. We have a very good relationship with WACHS in the Pilbara. That is an ongoing relationship which we treasure. We find them very responsive, and the ability to work together to plan is a positive relationship. We are starting our relationship with WACHS in the wheatbelt, which is a different experience so far.[322]

  CAHS–CDS later advised the Committee that it is assisting Telethon Speech and Hearing with its audiology service:

  > we have actually just partnered with Telethon Speech and Hearing with a clinic that they run in the Peel region. Our Mandurah CDS site is co-located with some other health services and one of them is the Nidjalla Aboriginal health and

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317 A Turnell, Acting Director, Clinical Services, CAHS–CDS, [*private transcript of evidence*], *Legislative Council,* 25 July 2023, p 46.

318 Submission 85 from TKI, 18 November 2022, p 3; and Inklings, *Inklings in WA*, Inklings, 2024, accessed 28 March 2024.

319 Prof A Whitehouse, Bennett Professor of Autism Research, TKI, [*transcript of evidence*], *Legislative Council,* 9 February 2023, p 8.

320 Prof C Elliott, Director of Research, TKI, [*transcript of evidence*], *Legislative Council,* 9 February 2023, p 16.

321 M Fitzpatrick, Chief Executive Officer, Telethon Speech and Hearing, [*transcript of evidence*], *Legislative Council,* 17 May 2023, p 2.

322 M Fitzpatrick, [*transcript of evidence*], p 8.

> wellbeing centre. Telethon Speech and Hearing are running an ear health clinic from that centre for Aboriginal children and trying to do that opportunistically with children that are attending the centre, as well as our Aboriginal health team … helping to get clients to that clinic. They had a bit of a challenge in that they were identifying children during that session who they would actually want to do an audiology assessment [on] with a booth and obviously the centre does not have it, but we are just down the corridor and do, so we have now created capacity in our audiologist diary so that on those clinic days if they identify a child that needs a booth assessment, they then send them down the corridor and we do that opportunistically while the child is there and engaged with the service. So those types of examples, where actually it does not require us to fund another service, it is actually just about working together and trying to connect with those families at the best opportunity for them, we absolutely will do when those opportunities are there.[323]

3.145 In considering the contracting out of services, the Committee noted that several areas of private service provision are under as much waiting list pressure as public CDS providers and are therefore not in a position to have children simply 'rerouted' from the public CDS system.

3.146 The Committee, however, encourages the State Government not to overlook the additional service capacity that can be provided by, and the engagement opportunities present in, the not-for-profit sector when considering plans to improve access to child development services, particularly in areas where there are limited services or access.

3.147 A majority of the Committee, comprising Hons Dr Sally Talbot and Samantha Rowe MLCs, makes the following recommendation:

RECOMMENDATION 19

The State Government investigate whether additional service capacity and engagement opportunities can be provided by the not-for-profit sector when considering plans to improve access to child development services.

3.148 A minority of the Committee, comprising Hon Donna Faragher MLC, makes the following recommendation:

Minority Recommendation 5

The State Government identify opportunities to improve its collaboration and partnership with not-for-profit health service providers when developing plans to improve access to child development services particularly in areas where there is limited access to these services.

Allied health services provided in early childhood education care settings

3.149 The early childhood education and care (ECEC) sector includes formal childcare (long day care and outside-school-hours care).[324] With respect to centre based care, WA Health is of the view that it would be beneficial for CDS providers to have the resources to support ECEC providers as this would:

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323 A Turnell, Acting Director, Clinical Services, CAHS–CDS, [*private transcript of evidence*], *Legislative Council,* 25 July 2023, p 46.

324 Australian Government, Australian Institute of Family Studies, *Child care and early childhood education in Australia*, Australian Institute of Family Studies, 2024, accessed 30 March 2024.

> provide greater opportunity for earlier intervention and prevention and lead to enhanced capability for the community to support the child.[325]

3.150 This support could be in the form of child development training, as already discussed in paragraphs 3.33–3.39, or it could be direct support at the ECEC centre, from CAHS–CDS and WACHS–CDS practitioners and CAHS and WACHS child health nurses.

3.151 The ACA advocated strongly for CAHS and WACHS to partner with the ECEC sector:

> There is an enormous opportunity in WA (as yet untapped) for the state government to improve child development outcomes in WA and ensure more children access vital screening programs by partnering with the ECEC sector. Our sector cares for thousands of children and families across WA every day and this huge reach and relationship with WA families is currently massively underutilised. We want to be part of the solution to ensure early intervention is available to every child who needs it and to achieve better outcomes for children and families.
>
> …
>
> Partnering with the ECEC sector could enable efficient and wide-reaching screening beyond what CACH [Community Health] and CDS can currently offer and ensure population-wide early years responses for best pathways and outcomes for children. Experience shows us that universal approaches are a non-confrontational and effective method of gaining consent for the majority of children to be screened, particularly when health professionals visit a service (e.g., child nurse, speech pathologist).
>
> > *E.g., In South Australia - pilot programs are currently underway by the Caring Futures Institute at Flinders University in collaboration with Goodstart Early Learning and Playgroup SA to boost screening of children up to the age of five, with key checks at 12 and 18 months, as well as at two, three and four years old.*
> >
> > *Goodstart in WA … is currently piloting a limited number of nurse practitioner centre visits (at no cost to families). These initiatives are funded by Goodstart to ensure access to services for some of the most hard-to-reach families. Demand currently outstrips capacity.*[326]

3.152 One form of partnership could be for ECEC centres to be the sites at which primary and secondary-level child development services are provided, functioning as spokes in a 'hub and spoke' model.[327] Under such an arrangement, CAHS or WACHS child health nurses and allied health practitioners could either:

- be embedded in the ECEC centres (although this would require the permanent provision of a suitable workspace)

  or

- visit the centres as part of an out-reach program.

3.153 As pointed out by the ACA, children and their families are already at the ECEC centres, and they are comfortable and familiar with those surroundings. The centres are considered to be accessible places, and already have an advantage over traditional clinical settings.[328]

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325 Dr DJ Russell-Weisz, Director General, DOH, Answer to question on notice 10 asked at hearing held 28 November 2022, dated 20 December 2022, p 5.

326 Submission 71 from ACA, 7 November 2022, pp 3–4 and 6.

327 See paragraphs 2.34–2.44 in this report for a discussion about the hub and spoke model.

328 Chapter 6 contains more information about the ECEC sector and other accessible community service providers.

3.154 The Committee noted that the provision of primary and secondary-level child development services in ECEC centres would also be consistent with the NDIS Independent Review Panel's:

- vision for supporting children aged under nine years and their families– that 'Far more support should be available where children are'
- recommendation 6 relating to a continuum of support for children and their families (see paragraphs 3.97–3.99).

3.155 Another form of partnership between the ECEC sector, CAHS and WACHS could involve ECEC workers, rather than CAHS or WACHS child health nurses and allied health practitioners, conducting the screening of children in their care for certain developmental issues (see paragraphs 7.19–7.22).

3.156 In the Committee's view, ECEC centres are sites that are suitable for providing primary and secondary-level child development services.

FINDING 21

Early childhood education and care centres are sites that are potentially suitable for providing primary and secondary-level child development services.

RECOMMENDATION 20

The Child and Adolescent Health Service and WA Country Health Service investigate the possibility of providing primary and secondary-level child development services at early childhood education and care centres.

3.157 Some children already receive 'additional support' at their ECEC centre, through the Commonwealth Government's Inclusion Support Program:

> WA Children with developmental delays and disabilities are entitled to additional support under the Federal *Inclusion Support Program* which provides extra support for children who may require specific considerations or adaptations to participate fully in ECEC services. This program provides additional support, capacity building for teams and educator hours to support children with additional needs including those who:
>
> - have a disability or developmental delay
> - are presenting with challenging behaviours
> - have a serious medical or health condition, including mental health
> - are presenting with trauma-related behaviours.[329]

3.158 For a child to be eligible for the program, their parents need to provide documentary evidence of their condition, and that evidence must meet the requirements of the program. The ACA submitted that, in some cases, the CDS providers who have been asked to provide the documentary evidence have provided non-compliant paperwork, leaving the child and the centre without additional supports.[330] In one such incident, it is claimed that the child's

[329] Submission 71 from ACA, 7 November 2022, p 7.

[330] Submission 71, pp 7 and 8.

service plan did not meet the program requirements because it was not 'clearly signed by a medical or allied health professional'.[331]

3.159 The alliance recommends that:

- CAHS–CDS and WACHS–CDS ensure that their plans and letters meet the Inclusion Support Program's criteria for documentary evidence 'so children can access this Federal funding as quickly as possible'
- CAHS–CDS and WACHS–CDS staff be educated about the Inclusion Support Program and how they can support a child's access to the program.[332]

3.160 The Committee draws these concerns to the attention of CAHS–CDS and WACHS–CDS so that checks can be made to ensure that staff are fully informed about the Commonwealth Government's Inclusion Support Program.

Allied health services provided in Aboriginal Community Controlled Health Organisations

3.161 As discussed in the Interim Report, Aboriginal Community Controlled Health Organisations (ACCHOs) are primary healthcare providers for members of their local communities, including children and young people. Some ACCHOs are also able to provide onsite secondary and tertiary-level child development services through the following means:

- putting their funding (usually from fragmented and multiple sources) towards employing or contracting the necessary clinicians to provide these services
- clinicians working voluntarily at the ACCHO's health centres or via telehealth
- CAHS–CDS and WACHS–CDS practitioners working at the ACCHO's health centres or via telehealth as part of their outreach program.[333]

3.162 While these measures are beneficial to the receiving communities, they are piecemeal, infrequent and can easily be interrupted, particularly in regional Western Australia. For example:

> WACHS previously provided allied health services from Newman to Jigalong (specifically physiotherapy, occupational therapy and occasionally speech pathology) about once a month. Unfortunately, this has been interrupted due to COVID-19 restrictions and WACHS travel policies in 2022.[334]
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> Previously, PAMS [Puntukurnu Aboriginal Medical Service] was able to utilise PATCHES[335] to provide diagnostic assessments for FASD [foetal alcohol spectrum disorder] in particular, but PATCHES has not visited our communities in the last two years and it appears that there are no future plans to do so.[336]
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> Some services in remote areas said they did not have any visiting allied health services as it was difficult to secure travel for them, whereas others said that they

331 Submission 71, p 18.

332 Submission 71, p 8.

333 Interim Report, p 35, paragraphs 3.82–3.83. See also, Submission 76 from Pilbara Aboriginal Health Alliance, 8 November 2022, p 3.

334 Submission 79 from Aboriginal Health Council of Western Australia (AHC), 11 November 2022, p 7.

335 Patches is a private provider of a health assessment and therapy services: Patches, *Your one-stop-shop for exceptional assessment and therapy services*, Patches, accessed 7 February 2024.

336 Submission 70 from Puntukurnu Aboriginal Medical Service, 4 November 2022, p 2.

> were unable to fill positions that had been vacant for some time. Moreover, ACCHS [Aboriginal Community Controlled Health Services] in very remote areas said children rarely have the opportunity to travel to regional centres or Perth where services may be located given challenges such as vast distances and lack of transport. Other ACCHS said that they had no allied health services unless a child had secured NDIS funding; in those cases, it is sometimes possible to schedule allied health visits when a number of children require similar support.[337]
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> In the Kimberley, access to the Commonwealth-funded National Disability Insurance Agency (NDIA) Remote Early Childhood Service (RECS) was said to be invaluable, providing funding for Early Childhood Early Intervention (ECEI) services and support for children under the age of seven[[338]] if a potential developmental disability was observed by clinicians or parents who were able to refer children. While the grant-based parameters of this program allow for flexibility of use, the short-term nature of the funding is not sustainable. It does, however, provide access to developmental supports without diagnosis or assessment.[339]
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> Another regional ACCHS [Aboriginal Community Controlled Health Services] also utilises RECS [Remote Early Childhood Service] to fund an OT and speech pathologist who are able to spend up to one day a week within the clinic seeing young children. Through RECS, NDIA bulk fund allied health services to children aged zero to seven; however, when children reach the age of seven, funding ceases. If the child continues to experience a developmental delay, and has not had an assessment resulting in an NDIS package, there are challenges with accessing services, the result of which is often long waitlists of up to 12 months to access a paediatrician through WACHS.[340]

3.163 The Derbarl Yerrigan Health Service (DYHS) operating in metropolitan Perth submitted that it receives no funding for allied health services for children:

> The State Government currently provide no investment into allied health services for children that access care at Derbarl. Derbarl do not have funded speech therapists, occupational therapists, developmental social workers or physiotherapists.[341]

This means that children presenting at its health centres will need to be referred to CAHS–CDS, and may experience some of the service deficiencies that were highlighted in the Interim Report.[342] These referrals usually occur through the Koorliny Moort navigation service, based at PCH, and the CAHS–Community Health's Aboriginal Health Team, which offers primary healthcare services.[343]

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337 Submission 79 from AHC, 11 November 2022, p 7.

338 'Remote Early Childhood Services (RECS) help [Aboriginal] children aged under 7 access early supports and services. This is currently a pilot program in Western Australia': Australian Government, NDIS Review, *3. Opportunities*, NDIS Review, accessed 7 February 2024.

339 Submission 79 from AHC, 11 November 2022, p 7.

340 Submission 79, p 7.

341 Submission 72 from Derbarl Yerrigan Health Service (DYHS), 7 November 2022, p 3.

342 Refer to Interim Report, pp 50–61 for a discussion about excessive waiting times for CDS and limited-service provision for children aged seven years and older in the Perth metropolitan area.

343 Submission 72 from DYHS, 7 November 2022, pp 2–3. Refer to Interim Report, pp 108-109, Appendix 2, to see what level of healthcare services are offered by each team within the CAHS–Community Health service area.

FINDING 22

The current measures available for Aboriginal Community Controlled Health Organisations to provide onsite secondary and tertiary-level child development services are piecemeal, infrequent and often unreliable.

3.164 For these reasons, the DYHS and the Aboriginal Health Council of Western Australia (AHC) suggested that ACCHOs be funded to embed allied health services for children into their organisations so that they can provide more holistic healthcare to their local communities.[344] The AHC, which is the peak body for 23 ACCHOs, submitted that:

> Many ACCHS [Aboriginal Community Controlled Health Services] [which provided input into the submission] discussed how valuable it would be to have multi-disciplinary allied health services embedded in the clinic to facilitate an integrated model of care that acts as a 'one stop shop' for families accessing services for their children.[345]

3.165 The Pilbara Aboriginal Health Alliance called for:

> 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.[346]

3.166 The Committee makes three observations. First, an increase in the provision of secondary-level child development services in ACCHOs by embedded allied health practitioners would be consistent with the NDIS Independent Review Panel's:

- vision for supporting children aged under nine years and their families – that 'Far more support should be available where children are'[347]
- recommendation 6 relating to a continuum of support for children and their families (see paragraphs 3.97–3.99).

3.167 Second, investing in ACCHOs in this way would be consistent with priority reform two in the National Agreement on Closing the Gap – building the Aboriginal and Torres Strait Islander community controlled sector.[348]

3.168 Third, the provision of allied health services within ACCHOs would help to ensure that the services are culturally appropriate for Aboriginal children and their families.

3.169 The Committee is of the view that there is merit in assisting ACCHOs to either employ or contract more allied health practitioners.

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344 Submission 72, pp 6 and 8; and Submission 79 from AHC, 11 November 2022, pp 6–7 and 8.

345 Submission 79 from AHC, 11 November 2022, p 7.

346 Submission 76 from Pilbara Aboriginal Health Alliance, 8 November 2022, p 6.

347 Prof B Bonyhady AM and L Paul AO PSM, Co-chairs, *Working together to deliver the NDIS – Independent review into the National Disability Insurance Scheme: Final report*, Department of the Prime Minister and Cabinet, Commonwealth of Australia, 2023, accessed 2 February 2024, p 122.

348 Closing the Gap, *6. Priority reform two – building the community-controlled sector*, Closing the Gap, accessed 28 February 2024.

RECOMMENDATION 21

The State Government work with Aboriginal Community Controlled Health Organisations to establish the funding mechanism required to employ, or contract the services of, allied health practitioners to provide secondary-level child development services to the children in their local communities.

3.170 While increased funding would greatly assist ACCHOs to employ or contract allied health staff, the challenges of providing services in remote and regional areas are multifaceted and immensely complex. For example, if ACCHOs are to be successful in filling these roles, measures must still be taken to attract allied health practitioners to regional areas of the State, including the provision of suitable and sufficient accommodation.

3.171 The DYHS also recommended that:

> the WA State Government facilitate the Derbarl Yerrigan Health Service to work with CAHS Paediatrics and GP Colleges to provide training and supervision to grow a culturally competent workforce that has had clinical time and experience working in an Aboriginal Community Controlled Health Organisation.[349]

3.172 The Committee is aware that both CAHS–CDS and WACHS–CDS staff have received Aboriginal cultural awareness training, and will no doubt continue to do so. The Committee considers that the DYHS's proposal would complement the existing training (known as 'Aboriginal Cultural eLearning: Aboriginal Health and Wellbeing')[350], by providing practical experience of working within an ACCHO.

RECOMMENDATION 22

The Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service develop a program, in consultation with Aboriginal Community Controlled Health Organisations, for their staff to undertake practical work experience at an Aboriginal Community Controlled Health Organisation.

Management of ADHD cases

3.173 Evidence received throughout the Inquiry indicated that the increased demand for ADHD and ASD assessments and diagnoses was a major cause of increased demand for all secondary-level child development service providers, including CAHS–CDS and WACHS–CDS. This section of the report focuses on ADHD assessment and diagnosis.

3.174 Some stakeholders suggest that greater collaboration between GPs, and to a lesser extent, nurse practitioners (both primary-level healthcare providers) and paediatricians (secondary to tertiary-level healthcare providers) in assessing, diagnosing and managing ADHD patients would alleviate the burden on all secondary-level child development service providers.[351]

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349 Submission 72 from DYHS, 7 November 2022, p 8.

350 CAHS, *Annual report 2022-23*, CAHS, 2023, accessed 7 February 2024, p 59, and WACHS, *Annual report 2022-2023*, 2023, accessed 7 February 2024, p 31.

351 Refer to Interim Report, pp 16–17, for an explanation of the different levels of healthcare.

3.175 ADHD is the most common neurodevelopmental disorder in Australian children, with data showing that the prevalence is somewhere between 6% and 10%. The international rate is 5-8%.[352] WA Health advised that:

> There is substantial evidence demonstrating the impact ADHD has on children's social and academic functioning including peer rejection, conduct difficulties and reduced self-esteem. Young people and adults with ADHD experience a range of poorer outcomes including increased prevalence of mental health conditions, poorer educational and future employment outcomes, poorer physical health outcomes, and increased risk of involvement in community correction or juvenile justice system.[353]

3.176 Paediatricians, psychiatrists and psychologists are the three types of clinicians who will usually diagnose ADHD:

> Diagnosing ADHD requires considerable training and experience and is usually carried out by clinicians experienced in the diagnosis of developmental and mental health disorders such as paediatricians, psychiatrists and psychologists. The Australian Evidence-Based Clinical Practice Guideline for Attention Deficit Hyperactivity Disorder, launched in July 2022, recommends clinicians conducting diagnostic assessments should be:
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> - appropriately registered (Australian Health Practitioner Regulation Agency)
> - adequately trained in diagnostic assessment using the Diagnostic and Statistical Manual of Mental Disorders (DSM) and/or the International Classification of Diseases system (ICD)
> - experienced with conducting clinical interviews, administering, and interpreting standardised rating scales and assessment of functional impairment
> - experienced in ADHD diagnostic assessment or undergoing ADHD-specific supervision with an experienced clinician.[354]

3.177 ADHD may be treated with medication (pharmacological interventions), non-medication interventions (such as lifestyle changes and cognitive-behavioural interventions) or a combination of both.[355] Medication is only used cautiously and with close monitoring in children under the age of five years.[356] For children aged five to 17 years, and adults, the

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352 Australian ADHD Guideline Development Group, Australian ADHD Professional Association (AADPA), *Australian evidence-based clinical practice guideline for attention deficit hyperactivity disorder (ADHD)*, 1st edn, AADPA, 2022, accessed 8 February 2024, p 64.

353 Submission 77 from WA Health, 9 November 2022, pp 35–36.

354 Submission 77, p 36. See also, AADPA, *Australian evidence-based clinical practice guideline for attention deficit hyperactivity disorder (ADHD)*, 1st edn, AADPA, 2022, accessed 8 February 2024, p 84.

355 AADPA, *Australian evidence-based clinical practice guideline for attention deficit hyperactivity disorder (ADHD)*, p 94.

356 AADPA, *Australian evidence-based clinical practice guideline for attention deficit hyperactivity disorder (ADHD)*, p 137.

medications offered as first-line treatment[357] are classed as stimulants,[358] and are listed as Schedule 8 poisons, or 'controlled drugs'.[359]

3.178 In Western Australia, pursuant to regulations 116(2)(c) and 126 of the *Medicines and Poisons Regulations 2016*, only registered medical practitioners who:

- work in a stimulant clinic[360]
- are designated by the DOH's Director General as 'stimulant prescribers'[361]

  or

- are appointed by a stimulant prescriber to be a 'stimulant co-prescriber',[362]

can prescribe or supply Schedule 8 stimulants to patients in the general population.[363] The prescription or supply must also comply with the requirements for the stimulant as set out in the current *Schedule 8 Medicines Prescribing Code*,[364] which is approved by the Director General and published on the DOH's website.[365]

3.179 Only the following approved medical specialists can be authorised as stimulant prescribers:

- paediatricians
- paediatric neurologists
- neurologists
- respiratory and sleep physicians
- thoracic medicine physicians
- rehabilitation physicians
- paediatric rehabilitation physicians
- psychiatrists
- child and adolescent psychiatrists
- other specialists as determined by the Director General,[366]

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357 Methylphenidate, dexamfetamine or lisdexamfetamine: Australian ADHD Guideline Development Group, Australian ADHD Professional Association (AADPA), *Australian evidence-based clinical practice guideline for attention deficit hyperactivity disorder (ADHD)*, 1st edn, AADPA, 2022, accessed 8 February 2024, pp 137–138.

358 *Schedule 8 Medicines Prescribing Code*, 13 December 2023, Part 4.

359 *Medicines and Poisons Act 2014* s 4; *Medicines and Poisons Regulations 2016* reg 6; and *Therapeutic Goods (Poisons Standard—February 2024) Instrument 2024* (Cth) (also known as the Standard for the Uniform Scheduling of Medicines and Poisons No. 43) schedule 8.

360 A public health service facility that is approved by the DOH's Director General to be a 'stimulant clinic': *Medicines and Poisons Regulations 2016* reg 127.

361 Designated under regulation 128 of the *Medicines and Poisons Regulations 2016*.

362 Appointed under regulation 129 of the *Medicines and Poisons Regulations 2016*.

363 Medical practitioners prescribing stimulants for patients in hospital or in custody are subject to a different set of requirements: *Medicines and Poisons Regulations 2016* reg 126(3); and *Schedule 8 Medicines Prescribing Code*, 13 December 2023, clause 4.5.9.

364 *Medicines and Poisons Regulations 2016* regs 126(1)(b) and (2)(b)(i).

365 *Medicines and Poisons Act 2014* s 114, definition of 'prescribing code'.

366 *Schedule 8 Medicines Prescribing Code*, 13 December 2023, clause 4.5.

and out of these, only five specialists (paediatricians, paediatric neurologists, neurologists, psychiatrists and child and adolescent psychiatrists) can prescribe stimulants to patients with an ADHD diagnosis.[367]

3.180 A stimulant prescriber must also:

> ordinarily be practising in WA or providing telehealth services to patients residing in WA.[368]

The words 'or providing telehealth services to patients residing in WA' were inserted into clause 4.5.1 of the *Schedule 8 Medicines Prescribing Code* on 13 December 2023.[369] This insertion suggests that stimulant prescribers who ordinarily practise outside of Western Australia are now authorised to prescribe stimulants to patients residing in this state.[370]

3.181 Stimulant prescribers who specialise in the treatment of children may treat patients who are aged:

- between four and 19 years
- between 19 and 25 years, if the patient was treated by that stimulant prescriber prior to reaching 19 years of age.[371]

3.182 Stimulant prescribers who specialise in the treatment of adults may treat patients who are aged:

- 17 years or older
- at least 15 years but less than 17 years, with the Director General's prior written authorisation.[372]

3.183 Essentially, paediatricians, paediatric neurologists and child and adolescent psychiatrists will be the main practitioners who can prescribe stimulants to children for the treatment of diagnosed ADHD.

3.184 A stimulant prescriber may nominate and appoint a 'stimulant co-prescriber' to assist them with prescribing stimulants to a patient. The appointment of a stimulant co-prescriber:

- must be in writing
- must specify the type, form and dosage of the stimulant that the co-prescriber may prescribe for or supply to the patient
- may be subject to conditions
- may, at any time, be amended, suspended or revoked by the stimulant prescriber,

and the DOH's Director General must be notified of an appointment or an amendment, suspension or revocation of the appointment.[373]

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367 *Schedule 8 Medicines Prescribing Code*, clauses 4.7 and 4.7.2.

368 *Schedule 8 Medicines Prescribing Code*, clause 4.5.1

369 *Schedule 8 Medicines Prescribing Code*, Foreword, p i.

370 This is a significant change given that families who have consulted interstate paediatricians and obtained prescriptions for stimulant medication have previously been unable to have those prescriptions dispensed in Western Australia: for example, see Hon Dr Sally Talbot, Chair; and Dr R Paterson, Member, Management Board and Chair, Professional Advisory Body, and C Natale, Member, Management Board, Membership Portfolio, ADHD WA, [*transcript of evidence*], *Legislative Council,* 12 December 2022, pp 13–14.

371 *Schedule 8 Medicines Prescribing Code*, 13 December 2023, clause 4.7.3.

372 *Schedule 8 Medicines Prescribing Code*, clause 4.7.3.

373 *Medicines and Poisons Regulations 2016* reg 129.

3.185 A co-prescriber must 'ordinarily be practising in WA' and is permitted to:

> **prescribe** for the patient, **in accordance with the Stimulant Prescriber's directions**. A Co-prescriber is not permitted to change a patient's treatment and may not alter stimulant type or formulation or dose without authority of the Stimulant Prescriber. Co-prescribers are not permitted to submit notifications of patient treatment.[374] (emphases added)

3.186 The Committee understands that, within the CDS system, it is the paediatricians who can prescribe stimulants to the clients who have been diagnosed with ADHD. WA Health informed the Committee of CDS providers' experience with the current co-prescribing regime for ADHD management:

> **Dr GREEN**: We have been pursuing co-prescribing for several years with GPs, but it has been limited partly by limited numbers of GPs feeling comfortable and agreeing to a co-prescribing agreement; also, limited communication back with the information that we require from GPs; and also large variations in the knowledge that GPs have. So, at the moment, there is very limited training in undergraduate positions and also in GP training programs, so the level of knowledge out there is quite variable. **At the moment, when we set up GP co-prescribing, we come to an agreement with the GP that they are able to prescribe the same medication and dosages that we have asked [for] with a specialist review annually.**
>
> …
>
> **At the moment, the code says that children and adolescents who are prescribed stimulant medications need to come for annual review.**[375] The reason for that is because these children and adolescents are going through big changes in their development and their growth during that time, and they are also at high-risk of developing complications, complicating factors, due to their ADHD. This might include issues with growth. It might include family issues. Often, over time, other developmental issues arise, and we are also looking for sequelae of ADHD and monitoring those, such as not attending school and also mental health issues, which are very common with children with ADHD.
>
> In a co-prescribing model, we would expect that if there were complicating factors that were identified or that arise, that would mean that they would require referral back to the specialist for review and management of those issues. **What we require is that any co-prescribing set-up would mean that GPs provide us with regular information about blood pressure, height/weight percentiles and we have asked that the frequency of a co-prescribing review would be three to fourth monthly but this can be up to six monthly if the child is stable on medication with no issues identified.**
>
> As I mentioned before, there are considerable training requirements required for GPs to feel comfortable and to be adequately trained in managing and co-prescribing stimulant medication. That is something that we would be happy to support and investigate further if required. We would also look into some training models where we could give GPs training placements in the Child Development

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374 *Schedule 8 Medicines Prescribing Code*, 13 December 2023, clause 4.5.5.

375 This is the minimum requirement for specialist review: *Schedule 8 Medicines Prescribing Code*, clause 4.7.5.

> Service, so that means they could increase their practical experience with ADHD in a supported environment as well.[376] (emphasis added)

A call to change existing models of care

3.187 The first *Australian evidence-based clinical practice guideline for attention deficit hyperactivity disorder* endorses further ADHD training for all involved in caring for and supporting people with ADHD, noting that:

> A key gap is the lack of ADHD trained staff, resulting in bottlenecks in the diagnosis and support of people with ADHD.

3.188 The guideline also acknowledges that there is:

> an increasing move to train GPs to diagnose and treat ADHD due to the shortage of medical specialists.

and that, for the following reasons, GPs are a logical practitioner choice for assessing, diagnosing and treating ADHD, which is currently 'the province of' psychiatrists, paediatricians and psychologists:

> GP training [for assessing, diagnosing and treating ADHD] is particularly important because ADHD has implications for poor physical health outcomes (for example, difficulties taking medication regularly, and co-occurring medical and health conditions). GPs also manage chronic disease, making them uniquely placed to support individuals with long-term lifelong disorders, such as ADHD, with specialist care as needed. Accessing healthcare from GPs will also be more affordable, especially for those on low incomes.[377]

3.189 The guidelines recommend that:

> General practitioners and other specialist medical practitioners, paediatricians, psychiatrists, and geriatricians should be supported to increase their skills in identifying, diagnosing, and treating people with ADHD, including prescribing stimulants.[378]

but notes that there are currently no Australian standards for the training of health professionals in the diagnosis and treatment of ADHD.[379]

3.190 WA Health is supportive of an increase in GP co-management of ADHD post diagnosis, but only to a certain point:

> [WA Health will] 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.[380]

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376 Dr J Green, Acting Head of Department, Paediatrics, CAHS–CDS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, pp 34–35.

377 AADPA, *Australian evidence-based clinical practice guideline for attention deficit hyperactivity disorder (ADHD)*, 1st edn, AADPA, 2022, accessed 8 February 2024, p 169.

378 AADPA, *Australian evidence-based clinical practice guideline for attention deficit hyperactivity disorder (ADHD)*, p 170, recommendation 7.4.3.

379 AADPA, *Australian evidence-based clinical practice guideline for attention deficit hyperactivity disorder (ADHD)*, p 169.

380 Submission 77 from WA Health, 9 November 2022, p 7 (see also, p 37).

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> Where children are stable on medication [for ADHD], improved co-prescribing with GPs would decrease the need for CDS medication review appointments and increase paediatrician availability for other services including further assessments. This requires suitable shared care platforms and standards that enables client information sharing between specialists, GPs and families.[381]

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> **Dr GREEN**: … We would support changes to the stimulants prescribing code [the *Schedule 8 Medicines Prescribing Code*] that would allow GPs that have got appropriate training and experience to be able to change dosages within a range that is set up by the specialist. But anything more complicated than that, so the addition of non-stimulant medications, which is what we call adjunct prescribing, or if we are using multiple medications in combination with ADHD stimulants, such as anxiolytics or anti-psychotics, that is best managed by the specialist paediatrician who has got extensive training in that field.
>
> …
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> **Dr TOWLER**: … Recently, we had the launch nationally of the new ADHD guidelines, endorsed by the NHMRC [National Health and Medical Research Council]. I attended that launch, as did the Chief Pharmacist. There was an interest in exploring this opportunity. You just heard the challenges of reaching GPs who will be sufficiently trained, but there is interest in taking that approach. I think, given the challenges of access to paediatricians in the community for ADHD prescriptions to be initiated, there is certainly interest within WA Health to explore it.[382]

3.191 There was also a suggestion that nurse practitioners could have a role in co-prescribing stimulants for ADHD patients:

> Does it need other prescribers within our service? Well, that is hard for me to answer. I think it depends on how well we engage with GPs to do some of that role with supervision and support from us. One presumes there is an ability for nurse practitioners to do prescribing with support as well in certain models. I think that is allowed under PBS [Pharmaceutical Benefits Scheme] guidelines, but, again, it would have to be within a community of support from a service like we would offer, I would suspect.[383]

3.192 However, WA Health was less supportive of GPs assessing and diagnosing ADHD in children:

> Whatever the GP's role in this, they still have the prime importance in that engagement and support for families while children are on waitlist—the non-medication supports that are required. While medication is a key part of ADHD, in fact, for children six and over it is clear it is recommended first line, there are all sorts of stuff around psychoeducation, cognitive behavioural therapy inputs and access to allied health that they can play a role in coordinating. The question around diagnosis is a little more complicated. One needs to be careful. The issues around ADHD are complex. There was a great deal of criticism in the 2000s and late 90s about rates of prescribing. I think we have all—well, not all—come to

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381 Submission 77 from WA Health, 9 November 2022, p 37.

382 Dr J Green, Acting Head of Department, Paediatrics, CAHS–CDS, and Dr S Towler, Chief Medical Officer, Clinical Excellence Division, DOH, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 35.

383 Dr B Jongeling, Medical Head of Department, CAHS–CDS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 49.

> agree that the rate of prescribing was still well below what is considered the incidence of ADHD, which worldwide is 5.3 per cent and maybe up to seven per cent. We are not even at a two per cent level in WA. We are at 1.6 to 1.8 per cent currently. We also do not want to be in a situation where a child presenting with some attention impulsivity, who may well have anxiety or some other trauma going on, is treated, because once children and families are on treatment, that often creates an expectation of "This is the answer" and it narrows the focus of other treatments. We do have to be careful about that, while realising that, yes, it is unacceptable that a child who is 14 and is now really struggling is going to wait two years for an assessment. We need to have some solutions to that. …[384]

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> The assessment and diagnosis of ADHD is quite complex and requires the collection of information from a lot of different sources. The reason why that is important is because there is a lot of other neurodevelopmental and mental health disorders, such as foetal alcohol spectrum disorder, autism spectrum disorder, Tourettes, anxiety, depression or learning difficulties which resemble ADHD. So it means best practice tells us we need to collect a lot of information across a lot of different settings and from a lot of sources, and bear all those other differentials in mind.[385]

3.193 The recent Senate committee inquiry into barriers to consistent, timely and best practice assessment of ADHD and support services for people with ADHD found that, similar to this Inquiry:

> Most submitters supported expanded models of care, although varying evidence was received on which professional group/s should be able to diagnose and oversee patients with ADHD.[386]

3.194 While the Senate inquiry received submissions about GPs in particular, it also noted that psychologists, nurses and nurse practitioners are disciplines that could be considered in expanded models of care for ADHD.[387] The Senate committee recommended that:

> the Australian Government, through the current 'Scope of practice review' and in collaboration with healthcare colleges, develop pathways which could include an expansion of the range of healthcare professionals who are able to provide ADHD assessment and support services, particularly General Practitioners and Nurse Practitioners, and improve the skills of all healthcare professionals who interact with people with ADHD.[388]

3.195 The evidence presented to the current Select Committee centred mainly on the greater involvement of GPs.

Support for greater general practitioner involvement in assessment, diagnosis and treatment

3.196 The Committee was advised by the RACGP that there are some GPs who are willing to take on the responsibility of assessing, diagnosing and treating ADHD:

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384 Dr B Jongeling, [*transcript of evidence*], p 49.

385 Dr J Green, Acting Head of Department, Paediatrics, CAHS–CDS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 44.

386 Community Affairs References Committee, report, *Assessment and support services for people with ADHD*, Parliament of Australia, Senate, 6 November 2023, accessed 9 February 2024, p 136, paragraph 5.24.

387 Community Affairs References Committee, *Assessment and support services for people with ADHD*, pp 136–158.

388 Community Affairs References Committee, *Assessment and support services for people with ADHD*, p 230, recommendation 12.

> The current workforce is not adequate to manage the demand on the system. Training more paediatricians and allied health practitioners is necessary, but this will take many years to translate into clinicians treating patients.
>
> Another immediate option is to upskill specialist GPs to manage a more complex cohort of paediatric patients. The RACGP and the Royal Australasian College of Physicians would have a role in ensuring such training for GPs was adequate to undertake an extended scope of practice.
>
> One area of extreme under-supply, for example, is in the diagnosis and management of ADHD. Public services for diagnosing and managing children with ADHD are almost non-existent, and the availability of private child psychiatrists and paediatricians is also very limited.
>
> Internationally many OECD countries allow primary care physicians to diagnose and treat ADHD, and we believe there is a role for general practice in this area.[389]

3.197 Dr Andrew Leech, a GP and representative of the college, explained why GPs see themselves as being particularly suited to this role. Much of the explanation lies in the fact that GPs often see children and their families across their lifespan and are the first health professional consulted when an issue arises:

> We believe that **general practitioners have a really good oversight of the health care of children—and not just health care but the developmental health, social health and mental health of children. We are well trained in those areas, and we should be able to upskill, train and accredit ourselves in further knowledge around conditions like ADHD** to support a very overwhelmed system. I think GPs have a crucial role in helping this system. We have sort of targeted that with the ADHD side because that is an area that seems to be peaking at the moment in our presentations. Across the board in talking to GPs, from what I am hearing, ADHD is one of the most escalating conditions that we are seeing in our presentations, yet we are stuck because we do not have anywhere to refer them to; there is a roadblock. I think GPs have the ability to be trained in this area and potentially support, treat and diagnose ADHD—non-complex ADHD—while waiting for support from a paediatrician.
>
> **I do not believe that GPs can do this alone.** I think we do need a collaborative approach. We need the support from allied health practitioners, such as psychologists and occupational therapists, who themselves are also overwhelmed and busy, and we need the support from our paediatricians, our developmental paediatricians and our psychiatrists, most of whom as well are at capacity in both private and public. We just feel that we have a role now and a responsibility to be involved in the system and to offer training to those who are interested. As I mentioned, **a large number of GPs are interested in being involved, who would like to develop a training program and an accreditation process to ensure that they are safe with whatever they end up doing in terms of diagnosis and prescribing. I do not think this would be every GP, but it certainly would improve the capacity for children to be seen in a more timely manner**.[390] (emphases added)

3.198 GPs are already supporting many children who are suspected of having ADHD and their families:

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389 Submission 66 from RACGP, 31 October 2022, pp 2–3.

390 Dr A Leech, general practitioner, RACGP, [*transcript of evidence*], *Legislative Council,* 17 May 2023, p 2.

> There have been a lot of comments around GPs being already busy enough. Part of the reason we are busy enough is because we have these families waiting with us for care. They come back to us as the problems escalate, as the child falls out of school, as the mental health conditions start to emerge, as they regress and as the family starts to fall apart. These are real problems that I see day in, day out, and these are problems because we cannot get help. We are actually busy enough because we are supporting these families already. We do need more help. We need more support. We cannot do it alone, but I do think we also have a role and a responsibility to help this system.[391]

3.199 Dr Leech described the types of support GPs can provide while these children and families await a formal ADHD diagnosis, and why GPs should have the opportunity to do more:

> **Dr LEECH**: … The benefit of doing things during that 12-month waiting period is that we do have the capacity and ability to review patients at regular intervals, which I think is a really helpful part of the journey. Part of what patients need is reassurance and support, and we are good at that … In specific case examples … I would suggest to them to come in every school holidays for a review. We would take a full history in terms of their school performance, their home life, their mental health, their sleep, diet and wellbeing in that time. This is very straightforward sort of questioning. A lot of these things can be managed.
>
> **The CHAIR**: And these are managed at the primary care level?
>
> **Dr LEECH**: At the primary care level. If a child is not sleeping, we can deal with that. We will do blood tests; we will do basic investigations. We involve the practice nurse … in doing some basic vital observations and examinations so that we are not having to do all of it in those consults … But we are restricted, because we are not technically allowed to diagnose, so we cannot do as much as we would probably like to do if we were able to do more work around the diagnosis and management … The other thing I would normally do is set up a care plan for the patient to allow some funding—it is not huge, but some funding—towards either an occupational therapist or a psychologist or a dietician or whatever they need, or a mental health care plan to allow that psychology service to start. That can be very valuable. In fact, sometimes that can be a really good early intervention to get underway.
>
> **The CHAIR**: What is it that stops you doing that now?
>
> **Dr LEECH**: Nothing stops us doing that now. The only restriction, I guess, is that parents are seeking more answers around what is actually going on. I think they need, and we need, kind of that second opinion, that second lens, that allied health and paediatric collaborative lens, to make sure that we are actually doing the right thing by that child. We can do these steps and we can provide care, but we are limited in the sense that a lot of families are seeking more and do come back to us quite frustrated that they are unable to get in for that second layer of professional opinion from a paediatrician.[392]

3.200 ADHD WA submitted that GPs who are interested in this practice area, with appropriate training and supervision, should be allowed to assess, diagnose and treat ADHD patients with mild to moderate symptoms:

> GPs with a special interest undergo accreditation and upskilling in ADHD diagnosis and management allowing them to share the care of patients, particularly in the

391 Dr A Leech, [*transcript of evidence*], p 3.

392 Hon Dr Sally Talbot MLC, Chair; and Dr A Leech, [*transcript of evidence*], pp 3–4.

mild to moderate range of symptoms. Severe end and complex needs children will still require referral onto a specialist. GPs who commence care of children with ADHD can have access to a psychiatry telehealth service enabling case conference and review of the plan within a reasonable time frame. This session could include the child, parent, GP and psychiatrist. For this to work, this select group of GPs will require increased prescribing rights for stimulant medication. ADHD WA recently submitted its recommendations to the office of the chief pharmacist regarding proposed Amendments to the Medicines and Poisons Regulations 2016 and the Schedule 8 Medicines Prescribing Code.[393]

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Dr PATERSON: … one of the problems is—I work in adults as well as children—adults, the GPs are more comfortable, and I am more comfortable, handing back patients to them. With children, the paediatricians will say, and they have said it to me, "We need to fine-tune things a bit more with children as they're growing up, so we're a bit reluctant to say 'Off to the GP' pretty much indefinitely. … We're a bit worried they'll get lost." So, paediatricians are hanging onto them. We somehow need to find a way where we can help paediatricians relax and get the GPs more involved.

The CHAIR: So there is some work to be done with paediatricians as well as GPs in revamping that re-prescribing?

Dr PATERSON: Yes, I think so. Paediatricians have to let go. They get a bit sort of protective and with due cause. Children are growing and changing and you need to fine-tune things.[394]

3.201 ADHD WA also advised the Committee that GPs in other countries have greater involvement in ADHD assessments:

Hon DONNA FARAGHER: Can I just clarify? … is this a particular situation that is peculiar to Western Australia in terms of GPs or is it actually something that happens nationwide?

Dr PATERSON: Nationwide.

…

Yes. In some ways, it is international, although some countries have much more GP involvement—Canada, UK, Europe have much more GP involvement. We have been a little cautious here because, as you know, ADHD has been a controversial topic for many years, mostly because the two medications—dextroamphetamine and Ritalin—are restricted, they are on the schedule 8, they can be abused; we have to be careful. But we are finding actually that they are not as dangerous as we thought they were; they are actually very user-friendly. I have been prescribing for 30 years and found them a delight to use. So, yes, it is a nationwide problem, but we are looking at what we can do in WA.[395]

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393 Submission 33 from ADHD WA, 24 October, p 6.

394 Hon Dr Sally Talbot MLC, Chair; and Dr R Paterson, Member, Management Board and Chair, Professional Advisory Body, ADHD WA, [*transcript of evidence*], *Legislative Council,* 12 December 2022, pp 4–5.

395 Hon Donna Faragher MLC, Deputy Chair; and Dr R Paterson, Member, Management Board and Chair, Professional Advisory Body, ADHD WA, [*transcript of evidence*], *Legislative Council,* 12 December 2022, p 4. Similar information was provided by the AADPA during the Senate inquiry: Community Affairs References Committee, report, *Assessment and support services for people with ADHD*, Parliament of Australia, Senate, 6 November 2023, accessed 9 February 2024, p 136, paragraph 5.25.

3.202 Some members of the Australian Medical Association (WA) supported the establishment of a certificate in developmental paediatrics to allow for the possibility of GPs gaining the legal authority to prescribe stimulants for the treatment of ADHD.[396]

3.203 Dr Bret Hart, a medical practitioner who has previously worked as a community child health medical officer at CAHS–CDS, gave evidence about the discontinued practice of CAHS–CDS medical officers assessing children with suspected ADHD. Dr Hart effectively equated the role of these internal medical officers with the proposed role of external, private GPs:

> The delivery of CDS used to include salaried community child health medical officers (CCHMOs). They were Included in the multidisciplinary teams of the suburban-based CDS [centres]. These doctors were trained in conducting Griffiths Developmental assessments and they referred children to relevant allied health staff via team meetings. Despite the fact that it was developed in the 1950s, the Griffiths remains one of the most popular developmental tests.[397]
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> **The CHAIR**: So, can we come now to the other health professionals who are involved with child development services. Clearly, there is a major problem with the supply of professional people. It seems that there are a number of ways that that might be mitigated, but nothing that is going to have an effect tomorrow or even next year. Can you talk us through your views about how one might approach that problem?
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> **Dr HART**: I think probably the quickest, possibly, although, the training needed to enable it to happen is having GPs involved. I guess I am sympathetic to that need because, in effect, I was a GP. Although I had paediatric experience, I did not have the ticket. I was not a qualified paediatrician.
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> We were like a sort of [a] go-between the GP [and the paediatrician and/or allied health practitioners], although we did not have much involvement with the GP …
>
> …
>
> **Dr HART**: I think that [the Griffiths development assessment] could be done by a GP. As happened in our case, if we felt, "Oh, there's something going on here that needs more expert intervention", then we should refer to the paediatrician. I guess we were a bit of a gatekeeper to avoid that, but also, if they did have to re-refer, we would have done all the groundwork. We would have had the speech assessment; the OT, if necessary; social work; clinical psych, all put together in a report to give to the paediatrician—we have done this, this and this. "We feel that you need now to take over because there could be a genetic abnormality" or whatever it is. I think the fact that that has all disappeared, means people are going straight to the paediatrician, and I think that is one of the contributions to the increasing workload for them. …[398]

3.204 It appears to the Committee that, with the current trial of the 'attention, regulation and concentration' care pathway, this practice may be reinstated (see Chapter 7)[399], but with

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396 Submission 82 from Australian Medical Association (WA), 11 November 2022, p 11.

397 Submission 15 from Dr B Hart, medical practitioner, 18 October 2022, p 20.

398 Hon Dr Sally Talbot MLC, Chair; and Dr B Hart, medical practitioner, RACGP, [*transcript of evidence*], *Legislative Council,* 12 December 2022, pp 5–6.

399 Refer to paragraph 7.7 in this report for a discussion of a new care pathway for children with suspected ADHD.

clinical nurse specialists in place of medical officers, which no longer exist within the CDS system.[400]

Support for greater general practitioner involvement in treatment only

3.205 As discussed at paragraphs 3.190–3.192, WA Health's position is clear – it is supportive of expanded GP involvement in ADHD management *post* diagnosis, and within the medicinal treatment boundaries set by the medical specialist.

3.206 The Royal Australasian College of Physicians (RACP), which trains paediatricians and other medical specialists, would like to see greater GP, and possibly nurse practitioner, involvement in the care and management of ADHD patients *after* diagnosis:

> **Prof KAPUR**: As the college position states, that for diagnosis and initial assessment of children with developmental needs that needs to stay with the paediatricians because we think that is complex, requires multiple levels of assessment and requires a lot of training, … paediatricians who have trained for six to seven years have that experience. We are actually not against co-prescribing once the diagnosis is made at a later stage. I have had discussions with Dr Brad Jongeling,[401] who has appeared in your hearings as well, and overall we are supportive of this pathway forward. It is not only general paediatrics. We see there needs to be a triage system where there are some simple cases, which after the initial diagnosis can certainly be managed by general practitioners. In fact, we also see an upward trend in the very complex cases when even a general paediatrician, while it will be a very small minority, may need help and seek assistance from a developmental paediatrician to co-manage this as well. We certainly feel that there is a role for not only general practitioners, but also nurse practitioners as well in the years to come who have trained specifically in this area.
>
> **The CHAIR**: Is the college prepared to get involved in that training or has the college been invited to be involved? What is the status currently?
>
> **Prof KAPUR**: The college per se is not involved in that training. In saying that, once we get our own house in order, we will absolutely be happy to help other colleges to do that. We have had contact from the academy of paediatrics in the psychiatry division to work together on some of these hub-and-spoke models as well, and we absolutely are keen to educate our colleagues if possible. We first though need to get our own training program robust enough so that our general paediatricians who, at the end of that six years of training, have more exposure than we are currently providing in developmental and psychosocial paediatrics.[402]

3.207 Starbloom Paediatrics submitted a very similar view:

> Currently, General Practitioners are allowed to continue to prescribe the same dosage of dexamphetamine for patients with ADHD on an ongoing basis, but any change in medication dose requires a visit to a developmental physician. Expanding the co-prescribing ability to potentially allow a defined 'range' of medication dosage, accompanied by explicit instructions about when to consider such changes and the side-effects to monitor for, would reduce the frequency of [developmental physician] visits. This would empower GPs and allow developmental physicians to see more new patients.

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400 Submission 15 from Dr B Hart, medical practitioner, 18 October 2022, p 20. Refer also to Interim Report, p 21, paragraphs 3.29 and 3.30 and pp 28–29, paragraphs 3.55–3.56.

401 Medical Head of Department, CAHS–CDS.

402 Hon Dr Sally Talbot MLC, Chair; and Prof N Kapur, President, Paediatrics and Child Health Division, RACP, [*transcript of evidence*], *Legislative Council,* 17 May 2023, p 4.

…

> [However] We would advise against any significant change to the requirements for who can make a diagnostic assessment of Autism or ADHD. These assessments are complex, time consuming, and require a high degree of specialist knowledge. Any expansion to who is allowed to make these diagnoses should be treated with caution to maintain accurate diagnosis.[403]

3.208 Dr Yvonne Anderson, a paediatrician working across Curtin University, the TKI and CAHS, recognises there is a need for greater GP involvement in ADHD management, but cautions that the proposal would require a sufficient number of GPs:

> I think the work of GPs is vital in this and GPs do an incredible job. In a lot of ways, they have the hardest job because they have these short appointments and it is usually not one thing that is needing to be solved in that 15 minutes. But you need to know that you have a willing workforce and also make sure that the steps along to where you want to ultimately get to are manageable and achievable. That was something from our New Zealand experience; that is, the bumps in road meant that it did get through but it was not that every GP was on board with that. I certainly think it is worth talking to Health about the discussions that are probably live about GP shared care.[404]

3.209 Similarly, Dr Elizabeth Green, a recently retired paediatrician, warns that GPs must be funded and supported properly if they are to have a greater role in ADHD management *after* diagnosis:

> I think that it would be important to upskill GPs and for those interested in an area of child development and particularly in attention deficit hyperactivity disorder **there will be a place for that, but it has got to be done in a way where the diagnosis is made by—… the paediatrician or child psychiatrist or neurologist.** And then there should be some way of continuing a liaison and support between the diagnosing consultant and the GP, because ADHD is such a complex misunderstood area that it is not just about prescribing stimulants to get children off a waitlist and make everyone feel better, that they are doing the right thing. Medication is not the only way to treat ADHD. It needs so much more support than just medication.]
>
> So I think for GPs, one of the problems is that at the moment there are some great GPs who are really happy and willing to work, and competent. They are as competent as cardiologists or renal physicians or neonatologists or other consultant paediatricians that prescribe medication and often GPs have had more experience, really, than some very specialised paediatricians. So, it is not about paediatricians being exclusive and saying, "We're the only people who can prescribe medication." **But it has got to be something that is actually paid or funded and it has got to have an ongoing education and surveillance.** Otherwise, it is just going to end up being problematic, I think, and at the moment the difficulty will be the workforce issue. There are just not enough GPs. In the country especially, GPs do not have the time to see complex cases.
>
> … it is the comorbidity, the things that go with ADHD that make the management of ADHD such a complex thing and especially if the ADHD has been diagnosed without a diagnosis of developmental trauma or sexual assault. If that has been

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403 Submission 84 from Starbloom Paediatrics, 17 November 2022, pp 3–4.

404 Dr Y Anderson, Associate Professor, Community Child Health, Curtin University, [*transcript of evidence*], *Legislative Council,* 12 May 2023, pp 23–24.

> missed and this child is really actually just a very disturbed child because they may have ADHD but what else is going on is not understood.
>
> …
>
> … it is not just a state thing. It is the federal government; it is a Medicare issue. But for a GP to bulk-bill, it is offensive to expect them to run a practice of high calibre, to go out of their way for what they are being paid at the moment … the **GPs do not have the funding behind them and the support behind them to actually run everything**, everything to do with mental health, child health, ADHD, autism. They are part of the picture, but they have to be funded.[405] (emphases added)

3.210 Dr Mark Parker, a private neurodevelopmental paediatrician, expressed dissatisfaction with a number of aspects of the current stimulant co-prescribing regime. For example, the minimum requirement for a specialist to review a person who is prescribed stimulant medication is once every year.[406] Dr Parker considers this to be insufficient:

> I think this is a very complicated area, particularly for children ... David Coghill is probably the foremost expert on ADHD in WA and to quote him: ADHD is easy to treat but very difficult to treat well. Children by nature of who they are change and vary. I would honestly say that I see patients who are reasonably stable on a six-monthly basis; I think that is not enough … I think six-monthly is already a compromise.[407]

3.211 Dr Parker also has reservations about GPs having greater involvement in ADHD management:

> I think that if GPs are to work in this area, there needs to be robust training. I know that has been talked about, but, in fact, what I am hearing is that a couple of afternoons is not enough. I think they would need to attend an established training service like the child development centre for at least six to 12 months as a registrar in that area to get some idea because it is not just treating the ADHD. It is recognising the comorbidity. It is treating that. It is using adjunctive therapy, other medications and fine tuning … I have a great deal of time for GPs, but there is already a shortage of GPs. It seems like every time there is an issue, GPs are thrown into the mix again. There is a very small group of people who are strongly advocating for this, but I know a lot of GPs, a lot friends and some in senior GP training, who do not agree with it at all. They say "No, we don't want this. People won't come back. They won't get the treatment they need."
>
> …
>
> I agree with co-prescribing where it is done but not with changing things [like medication dosage]. …
>
> …
>
> … There is a small group of people advocating. I do not believe they are representative. I am on the professional advisory board of ADHD WA as well. I know there has been support through them, but I think they really need to look at what the issues are. We are getting a lot of paediatricians coming online who are going to work in the area. To sort of suddenly say "Okay, we'll let lots more people do the job" I think is going to cause problems … There has been a lot in the media

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405 Dr E Green, Paediatrician, Southern Paediatrics, [*transcript of evidence*], *Legislative Council,* 17 February 2023, pp 8-9.

406 *Schedule 8 Medicines Prescribing Code*, 13 December 2023, clause 4.7.5.

407 Dr M Parker, neurodevelopmental paediatrician, [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 10.

over many years about overprescription of stimulants. I do not think we should be loosening those regulations. In fact, I think we should be tightening them. I think we should be requiring appropriate training from paediatricians working in the area as well. You know, kids need more regular follow-up than adults. I can understand maybe GPs being more involved in prescription for adults. Adults do not change as much. Kids change—they change schools, they get bigger, they get older, they come into new problems. … The social issues and these things add to the comorbidity, and the comorbidity is the difficult bit. Writing prescriptions is easy. Writing them properly and for the right people is not easy. …[408]

Existing models of general practitioner–paediatrician/medical specialist shared care

3.212 Dr Leech informed the Committee that he is already successfully trialling a GP–paediatrician shared care model for children who are suspected of having ADHD – within the current stimulant co-prescribing regime:

> **Dr LEECH**: We have a small working group to try and work out a pilot program for GPs to collaborate with a paediatrician in managing and diagnosing ADHD in a more timely manner. I guess the ultimate goal of this is to share this knowledge and experience to help other clinics with a special interest and grow it into something that is quite unique for the state, to allow that sort of team care co-consultation process to happen so that we do a lot of the background work, which is what we are good at. We can take all that history, do the Conners assessment, and examine the child, leaving the paediatrician with all that information to make a formal diagnosis. I think that takes the pressure off having to spend one, two, three hours of multiple consultations with the paediatrician and then also the paediatrician allows us to continue the care of that child. Just using this as an example, we have actually trialled this in my own clinic and it has worked extremely well. We have seen 10 patients now within a month and diagnosed and supported them and started the treatment. I have reviewed them two or three times following this collaboration and diagnosis. The other benefit is the paediatrician is then able to communicate to me her expertise about the diagnosis and I am learning from that. That is incredible knowledge for me as well, to continue upskilling. …
>
> …
>
> … the parents I see say, "Oh. I didn't even realise a GP could be involved in this process." …
>
> **The CHAIR**: That is very interesting. Is that a funded program in your practice, or are you doing it with existing resources?
>
> **Dr LEECH**: I am just doing it with existing resources as a trial. I wanted to prove a concept, and show that we can do collaborative care.
>
> **The CHAIR**: Who else is involved in the team? You said you have got one paediatrician.
>
> **Dr LEECH**: So, it is Professor Desiree Silva and myself and the practice nurse.
>
> **The CHAIR**: A GP and a practice nurse.
>
> **Dr LEECH**: Yes, and we wrote up a full pilot. We pre-consented our patients to the pilot. We are now in the phase of seeking feedback from the patients on their experience, but I can safely say it has been overwhelmingly positive. The response from a lot of these patients—the 10 that I chose were ones that have been on a

[408] Dr M Parker, [*transcript of evidence*], pp 10 and 12.

> one-to-two-year wait for a private paediatrician. They were in tears some of them, to be able to actually have this sorted out in one month, and for me to have that extra ability to talk to the paediatrician as required, which I think is still very important. We do not want to be left abandoned. We still need to be collaborating, because things happen, things go wrong.
>
> **The CHAIR**: And this is still pre-diagnosis, is it?
>
> **Dr LEECH**: This is now pre-going-into-diagnosis and monitoring after diagnosis. We have managed to do that in, what was it, one-to-two-year private wait, down to two months.[409]

3.213 The ADHD working group to which Dr Leech refers has advised the Minister for Health about this shared care trial and presented the information pamphlet that was initially given to patients at his clinic (see Appendix 5). The group is expected to meet further with the Minister and with CAHS about greater GP involvement in ADHD management:

> We have met the minister multiple times about this and we are putting forward our proposal for greater GP involvement in supporting children who are waiting for an ADHD diagnosis in this state, given there is no private paediatrician available that I know of and the public system is around two years. We have met on strategies and solutions on maybe how we could be able to help alleviate some of that through the methods that we have talked about today. We now have a follow-up meeting planned and proposed and we should be meeting with CAHS.[410]

3.214 To further enhance the trial share care model, the ADHD working group proposes to introduce the use of telehealth appointments involving the patient and the whole care team. A similar use of telehealth for immunology patients has achieved very good results:

> The other model that works well in WA is the immunology model, which has been shown to reduce waitlists significantly for children waiting for allergy and immunology assessment, and we are part of that as well. Just as an example, because it might be something that could be useful, when we talked about the option of having a paediatrician available on the phone, we are able to call an immunologist as part of a telehealth service within Fiona Stanley or PCH hospitals and create a Teams meeting whilst we have the patient in the room, and have a consultation pre-booked, but we can have that within a few days, if needed, and we then achieve a plan. We talk about the diagnosis, and we talk about the plan. Quite often that will mitigate the need for that child to be on that waitlist. They are pulled from the waitlist and I think the waitlists have been reduced somewhere around 30 per cent—it might be more than that—but it has been a very positive experience with that particular model, run by Dom Mallon.
>
> …
>
> And we propose that would be a similar model for an ADHD-type diagnosis in that we could work up the child, again with the nurse, and present that case to a paediatrician over a telehealth consultation from within the hospital in a timely manner and have a plan in place, at least to provide us with some kind of reassurance and guidance on the next period of time.[411]

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409 Dr A Leech, general practitioner, RACGP, [*transcript of evidence*], *Legislative Council*, 17 May 2023, pp 7–8.

410 Dr A Leech, [*transcript of evidence*], p 12.

411 Dr A Leech, [*transcript of evidence*], pp 11–12.

Very similar, positive evidence about the use of telehealth appointments was provided by a paediatrician.[412]

3.215 The Committee notes that the Senate Committee's inquiry also received evidence of developing or existing models of GP–specialist shared care for ADHD patients:

- Models are being developed by the Australian ADHD Professional Association (AADPA):

  > The AADPA advised the committee that it is currently involved in 'developing several models of care trials between specialists and GPs, particularly in regional areas', and recommended that 'Australia work towards expanding the professionals involved with diagnosing ADHD'. The AADPA maintained that multidisciplinary models have been 'shown to deliver improved overall care', as well as increasing access and reducing waiting times.[413]

- A model is already operating in the Lifespan Community ADHD Clinic in the western Sydney suburb of Cranebrook (see Figure 3).

Figure 3. *General practitioner–specialist shared care of ADHD patients in western Sydney*

Box 5.1 Integrated care at Lifespan Community ADHD Clinic

In their submission, Lifespan Community ADHD Clinic detailed a new model of integrated care for ADHD being piloted in Western Sydney.

The doctors involved highlighted that they 'believe that treatment for ADHD should be provided in the public sector and in primary care'.

Features of the pilot:

There are a number of aspects to the pilot, including:

- training of GPs alongside experienced clinicians—GPs train with experienced clinicians at the clinic and can then treat participants in general practice, including diagnosing and treating ADHD, with the same prescribing rights as psychiatrists and paediatricians.
- more holistic care—from GPs who know patients and their patient's families;
- specific NSW Ministry of Health Pharmaceuticals Regulatory Unit permissions for trained GPs to prescribe ADHD medications, as other designated prescribers, for the course of the pilot.

Results

Lifespan Community ADHD Clinic advised that through this model the GPs have access to the clinic for more complex patients, peer support and ongoing education, providing better continuity of care into adulthood for patients. One doctor wrote: 'feedback from the local GPs has been very positive and we are already receiving referrals. We have also had positive feedback from 2 families who have already been seen, expressing gratitude for accessibility to assessment in our local area and prompt availability of appointments, and praising [the GP involved] for her skill and expertise'.[43]

[Source: Community Affairs References Committee, report, *Assessment and support services for people with ADHD*, Parliament of Australia, Senate, 6 November 2023, accessed 9 February 2024, p 142, Box 5.1.]

412 Private citizen, paediatrician, [*private transcript of evidence*], p 7.

413 Community Affairs References Committee, report, *Assessment and support services for people with ADHD*, Parliament of Australia, Senate, 6 November 2023, accessed 9 February 2024, p 138, paragraph 5.34.

3.216 The Committee also heard evidence about a Complex Attention and Hyperactivity Disorders Service (CAHDS), which is operated by CAHS at PCH:

> [CAHDS] is a statewide service that works with children, young people (under 18 years old) and families who have persistent difficulties with attention and behaviour.
>
> Children and young people who use this service must have a diagnosis of Attention Deficit Hyperactivity Disorder and are currently being treated for difficulties with paying attention, being hyperactive or controlling impulses.[414]

3.217 CAHDS will perform a multidisciplinary assessment of children who are referred to it. However, CAHDS does not offer ongoing treatment:

> We provide an assessment and recommend further management through services that can work in partnership with the referrer.[415]

3.218 Referrers must fall within the following categories:

- paediatricians
- neurologists
- psychiatrists
- other authorised stimulant prescribers who have been treating the child for attentional issues.[416]

Therefore, CAHS–CDS and WACHS–CDS paediatricians are able to refer their clients to CAHDS where necessary.

3.219 ADHD WA confirmed that CAHDS does not provide treatment; rather, it makes recommendations and provides further opinions to assist the treating specialist.[417] CAHS also informed the Committee that, in addition to the specialist consultation and assessment services, CAHDS:

> provides therapeutic groups to parents of children who are experiencing attentional issues, including ADHD, and children with ADHD.

3.220 Dr Mark Parker was critical of CAHDS:

> There are services that have been set up [for complex ADHD cases] but unfortunately they have failed. CAHDS was set up to deal with some of these issues—that is the complex ADHD service. Initially there were two, then there was one, then they moved it to PCH. But they have a whole team of people and they are only seeing just over 100 people a year. They will not look at comorbidity. I had one patient where I had a very long report and I rang the psychiatrist involved who previously was there, who is lovely and whom I admire, who agreed that the child also had ASD but told me that they were not allowed to look at ASD as part of their mandate. Once again, I think to put all those resources into looking at a

414 CAHS, *Complex Attention and Hyperactivity Disorders Service*, CAHS, 2023, accessed 12 February 2024.

415 CAHS, *Complex Attention and Hyperactivity Disorders Service*.

416 CAHS, *Complex Attention and Hyperactivity Disorders Service*.

417 C Natale, Member, Management Board, Membership Portfolio, and Dr R Paterson, Member, Management Board and Chair, Professional Advisory Body, ADHD WA, [*transcript of evidence*], *Legislative Council,* 12 December 2022, p 8.

problem rather than a person is a big issue. I think those resources could be used far more wisely across the system.[418]

3.221 In response to these criticisms, CAHS provided the following explanations:

- on the issue of CAHDS now providing services from one site only:

  The merging of CAHDS into one site does not reflect halving of capacity, rather it enabled the team to provide a more cohesive service and broaden their service delivery model with full-time coverage of all disciplines.[419]

- regarding whether CAHDS will assess a referred child for co-occurring health issues:

  CAHDS assessments aim to aid the current treating team in their diagnosis and/or treatment recovery options for the young person. CAHDS assessments include a comprehensive assessment that focuses on identifying if there are any comorbidities related to ADHD that may be contributing to young person's complex presentation. Comorbidities assessed for include mental health, neurodevelopmental (e.g., ASD), cognitive (e.g., intellectual disability, memory, executive functioning), learning, and developmental (incorporating comorbidities related to speech and language difficulties, motor, sensory) difficulties. This incorporates a comprehensive list of conditions that are comorbid with ADHD. Since 2021 CAHDS has offered autism spectrum disorder (ASD) assessments for children who have accessed CAHDS. These assessments are completed with children who have undergone a comprehensive CAHDS pathway. Following the formulation of the child's CAHDS assessment if the team identifies that an ASD assessment is indicated, this is provided to the family.[420]

- about how many children CAHDS assesses and assists each year (see Figure 4):

Figure 4. *Number of children assessed and assisted by the Complex Attention and Hyperactivity Disorders Service*

Year	Assessment services	Other non-assessment services^	Total
2019/2020	162	101	263
2020/2021	140	80	220
2021/2022	144	63	207
2022/2023	172	44	216
2023/2024 YTD	177	20	197

^includes for example liaison, advocacy, therapeutic groups, family support

[Source: Letter from V Jovanovic, Chief Executive, CAHS, 27 March 2024, p 3.]

3.222 In the Committee's opinion, the services currently provided by CAHS–CDS, WACHS–CDS and CAHDS to children living with ADHD symptoms are insufficient. More must be done to ease the congestion experienced by these children and their families at the points of assessment

418 Dr M Parker, neurodevelopmental paediatrician, [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 14.

419 Letter from V Jovanovic, Chief Executive, CAHS, 27 March 2024, p 2.

420 Letter from V Jovanovic, p 3.

and diagnosis, and then again during treatment. Until that occurs, these children and their families will continue to wait for unreasonable amounts of time with little or no supports.

FINDING 23

The services currently provided by the State's public health system to children living with attention deficit hyperactivity disorder symptoms are insufficient. There is too much congestion at the points of assessment and diagnosis of the disorder, and then again during the treatment of the child.

3.223 The current problems have been compounded by:

- the limiting of childhood ADHD assessment, diagnosis and treatment to paediatricians, paediatric neurologists and child and adolescent psychiatrists, coupled with
- the relatively low numbers of these specialists.

3.224 It is now time to explore the utilisation of other health practitioners for these activities, particularly GPs and nurse practitioners. As an important source of ADHD services and supports, CDS providers must lead the discussion and be willing to collaborate more, and more effectively, with these other health practitioners, including those working in non-government organisations and the private sector.

RECOMMENDATION 23

The Child and Adolescent Health Service and WA Country Health Service collaborate with the Commonwealth Government and health professional colleges to develop care pathways for attention deficit hyperactivity disorder that include an expanded range of health practitioners who can assess and diagnose the disorder and treat children with the disorder, particularly general practitioners and nurse practitioners.

3.225 Until such time that an expanded range of health practitioners can assess and diagnose ADHD and treat children with the disorder, the Committee considers that there is value in investigating whether there could be a wider application of the GP–paediatrician shared care model such as the one being trialled by Dr Andrew Leech and his ADHD working group (see paragraphs 3.212–3.214) and particularly if a model could be provided within the free and publicly funded CDS system.

RECOMMENDATION 24

The Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service investigate the practicability of applying a general practitioner–paediatrician shared care model for children who are suspected of having attention deficit hyperactivity disorder.

Project ECHO networks – Connecting professionals and sharing knowledge

3.226 The Extension for Community Healthcare Outcomes (ECHO)[421] project model was developed in 2003 by Professor Sanjeev Arora at the University of New Mexico, USA, as a platform for

[421] Centre for Online Health, The University of Queensland, *UQ partners to bring telehealth expertise into regional Northern Australia*, The University of Queensland, 2023, accessed 20 July 2023.

both improving healthcare service delivery and patient outcomes in treating Hepatitis C. Project ECHO is:

> a licensed and trademarked telementoring model which can be used to create virtual knowledge networks, or communities of practice, and incorporates case-based learning strategies from medical education and theoretical frameworks including Social Cognitive Theory, Situated Learning Theory, and Community of Practice Theory.[422]

3.227 Project ECHO has been described as:

> a virtual knowledge sharing model that expands the capacity of professionals from any sector …
>
> ECHO networks are interactive conversational communities of practice, linking like-minded learners to integrate care.
>
> The panel and participants learn and share together through live, facilitated case discussions.[423]

3.228 'ECHO networks' can be formed about any healthcare topic. For example, in Queensland, an ECHO network was created to connect professionals from any sector that supported children and young people.[424] The RACGP submitted that this network enabled:

> GPs and hospital-based specialists [to] share ideas, discuss cases and learn from each other … This program would be very well suited to WA's geography and has the benefit of upskilling GPs, shifting the knowledge to the patient's community rather than pushing the patient to a … hospital [for tertiary-level healthcare].[425]

3.229 The Australian Medical Association (WA) referred to the same ECHO network as a means for upskilling GPs to diagnose and treat ADHD.[426]

3.230 The Rare Diseases ECHO Network is another example of Project ECHO in practice:

> The Rare Care Centre at Peth Children's Hospital, through its education and capacity building services, is the WA host for a rare diseases Project Echo (online community of practice) as well as other workforce education measures (e.g. Rare Diseases 101). These are freely accessible, including for all [CAHS– and WACHS–] CDS staff, and can support early diagnosis and better care to children with the cumulatively common rare diseases, thousands of which will or should be receiving [CAHS– and WACHS–] CDS services. There is an opportunity to build on partnerships between community services and the Rare Care Centre.[427]

3.231 A Northern Australia Telehealth ECHO Network has also been established. On 16 January 2023, the University of Queensland announced that its Centre for Online Health and The

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422 P Moss, N Hartley, D Newcomb and T Russell, 'Measuring the Success of a Project ECHO Implementation: Results from an International e-Delphi Study', *Global Implementation Research and Applications*, 2022, 22:179–194, DOI: 10.1007/s43477-022-00050-7, p 180.

423 Queensland Government, Children's Health Queensland, *Project ECHO*, Children's Health Queensland, 2023, accessed 20 July 2023.

424 Children's Health Queensland, *Project ECHO*.

425 Submission 66 from RACGP, 31 October 2022, p 2.

426 Submission 82 from Australian Medical Association (WA), 11 November 2022, p 11.

427 Submission 77 from WA Health, 9 November 2022, p 83.

Cooperative Research Centre for Developing Northern Australia would collaborate to 'bolster telehealth service delivery, training and knowledge sharing across Northern Australia.'[428]

3.232 The network aims to provide a range of services to its participants, including place-based telehealth training, service development, and research into the practical integration of telehealth into routine models of care. Workshops will cover both fundamental and more specialised aspects of telehealth, including:

- understanding the practical requirements for telehealth
- videoconference communication skills
- integrating telehealth into clinical practice
- developing telehealth sustainable services.[429]

FINDING 24

Project ECHO networks can be an effective platform for all healthcare practitioners and like-minded professionals from other sectors to connect, share, teach and learn from the practical and theoretical knowledge of others.

RECOMMENDATION 25

The Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service utilise Project ECHO networks as a means of collaborating more, and more effectively, with:

- each other
- other service providers within the State's public health system (WA Health)
- stakeholders outside of the State's public health system (WA Health).

428 Centre for Online Health, The University of Queensland, *UQ partners to bring telehealth expertise into regional Northern Australia*, The University of Queensland, 2023, accessed 7 April 2024.

429 Centre for Online Health, *UQ partners to bring telehealth expertise into regional Northern Australia*.

CHAPTER 4
Access, engagement and equity – Child Development Services system

Overview

4.1 Developmental vulnerability and socio-economic disadvantage often coincide. Disadvantage can stem from factors such as poverty, language or cultural differences, Aboriginality and geographic location. Disadvantage contributes to inequitable health and developmental outcomes and it places barriers on the ability of vulnerable populations to access support services.

Chapter summary

4.2 This chapter considers how the CDS system is servicing vulnerable populations and whether more could be done.

4.3 The needs of three vulnerable populations – culturally and linguistically diverse groups, regional and remote populations, and Aboriginal families – are examined in detail.

Disadvantage and developmental vulnerability

4.4 The Interim Report discussed the significance of childhood experience (environmental factors) in child development.[430] Positive environmental factors, such as good nutrition, physical health, and responsive parenting support a child's development. Conversely, risk factors, such as socio-economic disadvantage, make some children more developmentally vulnerable than others.

4.5 This inequity, and its consequences for child developmental outcomes, is recognised by the RACP:

> Many child health inequities start early in childhood and increase along a clear gradient. This means that the greater a child's disadvantage, the worse their health, development and well-being.[431]

4.6 A recent report from the Bankwest Curtin Economics Centre found that disadvantage (often starting in pregnancy) is reflected in poorer language development and early learning outcomes before a child starts school. Disadvantage can be related to various factors:

> The scope and depth of the disadvantages faced by young children and their families are often related to poverty, socio-economic status, regional location, Indigenous status and cultural background.[432]

4.7 The submission from the Western Australian Council of Social Service highlighted the barriers that accompany disadvantage. Poverty increases the risk of developmental delay partly because it creates barriers to accessing early learning opportunities and development services. Children living in disadvantaged areas of WA experience more developmental

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430 See Interim Report, Chapter 2.

431 RACP, *RACP Pre-Budget Submission 2019-2020 – Promoting systems reform, equity, prevention and sustainability*, RACP, February 2019, accessed 11 March 2024, p 10.

432 R Cassells, M Dockery, A Duncan, D Kiely, M Kirkness, T Nguyen, R Seymour, C Twomey, 'The Early Years: Investing in Our Future', *Focus on Western Australia Report Series*, No 13, August 2020, accessed 14 February 2024, p 160.

issues, they access fewer hours of preschool each week, and deprivation impacts their early relationships and experiences.[433]

4.8 Submissions from ARACY, Parkerville Children and Youth Care (Parkerville), CEWA and Anglicare also drew the Committee's attention to the link between disadvantage, developmental vulnerability, and adverse outcomes that continue throughout life.[434] These submissions have all been made public by the Committee and are available on the Committee's webpage.

Vulnerable populations

4.9 Some demographic groups are more vulnerable to poorer developmental, health and wellbeing outcomes. They also experience inequitable access to care.

4.10 The Sustainable Health Review (recommendation 3) seeks to address health inequity for three demographic groups: Aboriginal people, culturally and linguistically diverse (CALD) groups and people living in low socio-economic conditions.[435]

4.11 These are not the only vulnerable populations. Geographic location is another recognised risk factor.[436] The Australian Early Development Census (AEDC) reports that more children in rural and remote areas are developmentally vulnerable compared to children in metropolitan areas. Higher rates of socio-economic disadvantage and limited access to services in rural areas are key factors that influence this inequity.[437]

4.12 WA Health acknowledges that the disadvantage experienced by some families has implications not only for their children's development, but also their ability to engage with CDS providers:

> There are increasing social issues across the community. These represent risk factors that threaten child development as well as impacting significantly on engagement of families with [CAHS– and WACHS–] CDS services.[438]

4.13 Consequently, improving engagement with disadvantaged and at-risk families is a priority for CAHS–CDS:

> I think for us—very much something we are committed to—is strengthening our ability to engage with those families who are at risk and those families who cannot afford private services or who are reluctant to engage with child development services because they have cultural barriers for them.[439]

4.14 The Committee is cognisant of the difficulties and complexities involved. Evidence outlined in the following section shows that poverty and disadvantage affect the ability of vulnerable

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433 Submission 81 from Western Australian Council of Social Services, 7 November 2022, pp 4-10.

434 See for example, Submission 37 from CEWA, 24 October 2022; Submission 38 from Parkerville Children and Youth Care (Parkerville), 24 October 2022; Submission 63 from Australian Research Alliance for Children and Youth (ARACY), 26 October 2022; Submission 64 from Anglicare WA, 26 October 2022, and Submission 81 from Western Australian Council of Social Services, 7 November 2022.

435 DOH, *Sustainable Health Review Final report to the Western Australian Government*, DOH, 2019, accessed 1 February 2024, p 51.

436 DOH, *Sustainable Health Review Final report to the Western Australian Government*, p 75.

437 Australian Early Development Census (AEDC), *How can we improve equity in early childhood? – AEDC 2021 Data Story*, 2023, accessed 5 March 2024, p 5.

438 Submission 77 from WA Health, 9 November 2022, p 44.

439 S Kiely, Executive Director, Community Health, CAHS, [*private transcript of evidence*], *Legislative Council,* 25 July 2023, p 3.

clients to access services, to provide developmental opportunities for their children and to consistently comply with developmental advice regarding therapy or activities.

4.15 NursePrac Australia provided a useful insight, explaining that demonstrating sensitivity to 'the impact of poverty, adversity and stress on parents and their children's development and wellbeing' is an important first step in understanding the challenges facing vulnerable populations.[440] The challenge for the CDS system is to deliver services in a way that is responsive to those needs.

How is the current model failing vulnerable populations?

4.16 Contributors to the Inquiry drew the Committee's attention to the barriers faced by vulnerable families in accessing CDS. They identified failings in the current service delivery model and suggested ways that CDS can more effectively respond to the needs of vulnerable clients.

A cycle of disadvantage

4.17 An inter-generational cycle of disadvantage and unresolved developmental issues can be experienced by vulnerable clients of health services. A nurse practitioner said:

> We just see the cycle repeating. The number of parents that we see who tell us an identical story of what their children are experiencing is so frightening, and they clearly have the same developmental concerns.[441]

4.18 Disadvantaged circumstances can affect parent's ability to navigate an unfamiliar and complex health system:

> We know that when you have attachment disorders, family violence, chaos at home, these are all risk factors. But when you are seeing two to three generations of it … and parents, if they have the same concerns, they have never had support themselves, it is very, very hard for them to navigate as well and often they have had school failure and school refusal and all of those same things their children are experiencing, they have lived through that too and therefore they are not very good advocates for their kids.[442]

4.19 The child development system is not easy to navigate, particularly for vulnerable clients:

> The current CDS service model best fits families with high levels of personal agency, capacity to manage complex system navigation and confident advocacy – we find families without these skills struggle a great deal and need a lot of assistance and support.[443]

4.20 A need for developmental support may not be well understood by parents or given priority over other challenges facing a family:

> In such situations the need for services is also not always well-understood or appropriately prioritised by families – with parent needs and difficulties often getting in the way of critical early intervention for a child. This is seen again and

[440] Submission 86 from NursePrac Australia, 16 November 2022, p 3.

[441] S Dowden, Paediatric Nurse Practitioner/Director, NursePrac Australia/Just Kids Health Clinic, [*transcript of evidence*], *Legislative Council,* 20 February 2023, p 10.

[442] S Dowden, [*transcript of evidence*], p 10.

[443] Submission 86 from NursePrac Australia, 16 November 2022, p 3.

> again in the ECEC sector and is a source of stress for educators who know children are missing out on vital early intervention.[444]

4.21 Delayed development or other issues may not be recognised, or parents may be reluctant to raise concerns with outsiders:

> Parents and carers are often afraid to ask about development worries; they may feel it's their fault, or they will be blamed, or they must be 'bad parents' or they may have little idea of what is normal or delayed development.[445]

4.22 When developmental issues are identified, disadvantaged families are less able to afford private services to bypass long wait times:

> children from higher socio-economic backgrounds are more likely to receive services. Wait times and limited occasions of service in public services have meant that many families do not have access to services for many years and often seek therapy from private providers in the interim. However, current rebates from Medicare GP complex care plans and private health insurance schemes are very low and as such, even families who are eligible for … GP complex care plans or those with private health insurance are often unable to afford private occupational therapy services.[446]

4.23 Some children from low-income families can fall through the gaps. Their families are unable to afford private health services, yet their circumstances are not such that they are readily identified or helped by government support agencies:

> Over the last year, we have noticed a significant increase in referrals and presentations to our clinic for child development/behaviour concerns. Most of this cohort of families have low income and are unable to afford private healthcare. Worryingly, many of these children and families are outside the usual pathways to trigger assessments by community health services or have missed all usual child health checks due to COVID service disruptions and personal factors such as family adversity. Every week now we see at least 2-5 new children with severe developmental concerns, and we know that the likely time to be assessed (even with our vigorous advocacy) is 1-2 years – with little difference between public and private providers.[447]

4.24 Advice that parents seek out private providers for therapy, while well-intentioned, is unhelpful for many families and might be perceived as insensitive to their circumstances:

> Families with very low-income report being advised by CDS to ask their GP for referral to private services and given names of private providers to seek support from.[448]

FINDING 25

Disadvantaged families can face multiple barriers in accessing and engaging with child development services.

444 Submission 71 from ACA, 7 November 2022, p 9.

445 Submission 86 from NursePrac Australia, 16 November 2022, p 2.

446 Submission 80 from OT Associations, 14 November 2022, p 2.

447 Submission 86 from NursePrac Australia, 16 November 2022, p 1.

448 Submission 86, p 3.

Unmet need

4.25 It is difficult to know the extent of unmet need for child developmental support. Some families do not engage with health and other services such as the CDS providers, or they may disengage early by failing to attend appointments or not responding to communication:

> Families with complex risk factors are more likely not to engage with any service but also with the Child Development Service or to disengage.[449]

4.26 Child health and development checks are an important avenue for the identification of developmental issues and early referral to CDS providers. However, poor attendance at later child health checks (at 12 months and two years of age) indicates that many families are not engaging with the service after the four-month check. This means that, for many children, their developmental issues may not be identified until they start school.

4.27 Results from School Entry Health Assessments and the AEDC provide an indication of potential developmental issues that are being identified in school-aged children. The proportion of eligible children who receive the School Entry Health Assessment is very high, at or above 90% throughout WA from 2014 to 2019. The Commissioner for Children and Young People (CCYP) reports that in 2018, 15% of children assessed in the metropolitan area were referred to other services.[450]

4.28 However, the CCYP expresses concern that (as at 2021) there is no information on whether the high proportion of children referred to external providers following school entry health checks have received further care:

> there is no centralised information available on whether metropolitan children recommended for referral to external providers have received appropriate services for any issues identified. In 2018, external providers represent the bulk of referrals (72%) for the School Entry Health Assessment in the metropolitan area. There is currently no obligation on external providers to advise the Department of Health of referral outcomes.[451]

4.29 The CCYP also identified data gaps regarding the proportion of children in out-of-home care and Aboriginal children in regional and remote areas receiving the School Entry Health Assessment.[452]

4.30 The AEDC is a nation-wide data collection and assessment of early childhood development. Data is collected by teachers in children's first year of full-time school.[453] The latest AEDC in 2021 reported that 16.3% of children nationally were identified by teachers as needing further assessment in areas such as medical and physical, behaviour management, emotional and cognitive development. Notably, this figure is in addition to the 5.2% of children with a diagnosed condition that require special assistance at school.[454]

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

450 As at 2021, the Commissioner for Children and Young People (CCYP) reports that no data was available on the proportion of children in regional and remote areas who were referred to other services: CCYP, *Age group 6 to 11 years: Developmental screening*, CCYP, 2021, accessed 20 February 2024.

451 CCYP, *Age group 6 to 11 years: Developmental screening*.

452 CCYP, *Age group 6 to 11 years: Developmental screening*,.

453 Australian Early Development Census, *About the AEDC*, 2022, accessed 20 February 2024.

454 AEDC, *Australian Early Development Census National Report 2021: Early Childhood Development in Australia*, AEDC, 2022, accessed 5 March 2024, p 72.

FINDING 26

It is difficult to determine precisely how many children are commencing school with developmental issues that would benefit from child development services. Evidence suggests that it may be up to 15% of children.

The appointment system and discharge policy

4.31 Contributors to the Inquiry raised concerns about the CDS providers' appointment systems and discharge policies. They contend that service options are not always suitable for vulnerable populations and the appointment system lacks flexibility to accommodate their needs.

4.32 The OT Associations submitted that a lack of flexibility in service delivery options increases the likelihood of missed appointments. Vulnerable populations experience a range of barriers in accessing care (such as cultural considerations or lack of transport) and limited appointment options can be insurmountable for them:

> Currently public child development services tend to be inaccessible to families from culturally and socio-economically diverse backgrounds. The services that are currently provided publicly do not allow for flexibility for families according to cultural needs. Furthermore, appointment times can be inflexible and families who rely on both parents to work, or families of working single parents often miss appointments due to work commitments. As a result, families can easily miss appointments and such non-attendance typically results in discharge from services.[455]

4.33 A private submitter pointed out that attendance at day-time appointments can be very difficult for some clients. The circumstances of some families also make adhering to recommended therapeutic support and engagement activities difficult to maintain:

> The family-centered practice of the CDS is helpful to some families who are in a position to be able to take time off work/drop off their child to appointments in the middle of the day, AND to start with, are themselves in a position to be able to engage in parent training. For many of the most vulnerable children however, this service delivery model is inaccessible to them because their families are not able to get them to/from appointments (e.g. not having a car) or/and (for many) b. not able to access/engage with the parent engagement that is required for children to be supported through the CDS e.g. parents dealing with substance abuse or separation, parents working full time while supporting a family of 7 children.[456]

4.34 Removal of children from the waitlist due to missed appointments was criticised by some contributors. For example, the ACA submitted that CAHS-CDS discharge policy disproportionately affects vulnerable families:

> Vulnerable families should not be declined service after 2 DNAs ("did not arrive") or failing to engage in standard protocols. This can create a confusing merry-go-round where children are identified, referred (possibly multiple times) but never receive the developmental services they need.[457]

4.35 NursePrac Australia submit that vulnerable children are being discharged because of familial circumstances:

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455 Submission 80 from OT Associations, 14 November 2022, p 3.

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

457 Submission 71 from ACA, 7 November 2022, p 9.

> We have had several families who are homeless/living with high adversity being dropped from CDS waitlist as they didn't answer their phone.[458]

4.36 Maternal, Child and Family Health Nurses Australia (MCFHNA) made similar comments in their submission:

> many clients don't attend their Child Development Service appointments then the referral (and service) is cancelled. Vulnerable families who need the service the most find appt system difficult. This includes aboriginal families who would benefit from a dedicated team that could home visit for therapy.[459]

Other evidence and response from Child and Adolescent Health Service

4.37 It is difficult to know the extent to which accessibility issues may contribute to families disengaging from the CDS system.

4.38 Data on missed appointments for CAHS–CDS and WACHS–CDS for the 2021-22 financial year show that 4,896 appointments (or 6.6%) were classified as 'did not attend'.[460] WA Health data collection does not capture reliable information about reasons for non-attendance:

> [CAHS– and WACHS–] CDS clinicians may not know the reason that a family has missed an appointment, and this data is not consistently or reliably captured.[461]

FINDING 27

For the 2021-22 financial year, 4,896 appointments (or 6.6%) were classified as 'did not attend' for the Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service combined.

FINDING 28

The Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service do not collect consistent or reliable data on the reasons for missed appointments.

4.39 The data shows that many clinical hours are being wasted on missed appointments. The Committee understands that collecting data on reasons for missed appointments is likely to be hampered by non-responsiveness from a significant number of clients. However, the admission that 'data is not consistently or reliably captured' is not helpful. It would be hoped that, as the shared Community Care EMR (see Recommendation 1 on page 10 of this report) is improved and expanded, more data about missed appointments will be captured.

4.40 CAHS–CDS maintains that there is flexibility in service delivery and vulnerable families can access additional assistance. CAHS–CDS provided a service policy guideline which outlines the considerations to be included in the planning and provision of services. These include transportation assistance (such as taxi vouchers), home or community visits, and telehealth –

458 Submission 86 from NursePrac Australia, 16 November 2022, p 3.

459 Submission 53 from Maternal, Child and Family Health Nurses Australia (MCFHNA), 24 October 2022, p 7.

460 Tabled Paper 2, Inquiry into child development services: Potential questions, tabled by CAHS during hearing held 28 November 2022, p 7.

461 Tabled Paper 2, hearing held 28 November 2022, p 7.

all of which should be considered at the service planning appointment[462] and are subject to separate policies and procedures.[463]

4.41 CAHS–CDS was, however, unable to provide the Committee with reliable data about the offer, and take up, of flexible service delivery options.

Discharge policy: response from Child and Adolescent Health Service–Child Development Service

4.42 CAHS–CDS disputed evidence from some contributors regarding their discharge policy.[464] It advised that failure to respond to a letter sent to a client following a missed appointment will usually result in discharge from the service. However, if a family is identified as vulnerable, multiple efforts will be made to contact them before they are discharged:

> From a CAHS perspective, we have a standard letter that would go out if a family has missed an appointment. If they do not respond to that, we will discharge, unless we know that there are risk factors for that particular family. If there are risk factors, then we would follow up at least twice more, and possibly more, and we would make sure that those follow-ups are different types of approaches, so not just letters—an SMS or a phone call to the family.[465]

4.43 At-risk families can be identified through referral information and linked child health nursing data but CAHS–CDS acknowledge there may be risk factors of which they are unaware.[466]

4.44 CAHS–CDS indicated that their discharge policy reflects a need to manage high demand[467] and emphasised that their flexible re-entry process enables a family to re-enter the service at the same point they were at prior to discharge.[468]

4.45 Table 1 shows the number of clients discharged, by discipline, after failure to respond to an appointment offer. A client is discharged only from the discipline for which the appointment was offered.[469]

Table 1. *Child and Adolescent Health Service–Child Development Service clients discharged following a lack of response to an appointment offer*

Discipline	**2020-21**	**2021-22**
Audiology	838	584
Nursing	90	144
Clinical psychology	270	221
Occupational therapy	1,204	1,317
Paediatrician	503	492

462 Private evidence.

463 CAHS–CDS *Policy Manual Guideline: Factors impacting on child health and development*, Answer to question on notice 13 asked at hearing held 26 April 2023, p 5.

464 Letter from V Jovanovic, Chief Executive, CAHS, 2 February 2023, p 5.

465 A Turnell, Acting Director, Clinical Services, CAHS–CDS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 12.

466 A Turnell, Acting Director, Clinical Services, CAHS–CDS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, pp 43–44.

467 A Turnell, Acting Director, Clinical Services, CAHS–CDS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 13.

468 A Turnell, [*transcript of evidence*], p 12.

469 DOH, Answer to question on notice 4 asked at hearing held 28 November 2022, dated 20 December 2022, p 3.

Discipline	2020-21	2021-22
Physiotherapy	604	634
Speech pathology	2,313	2,396
Social work	410	349
Total	**6,232**	**6,137**
Unique clients	**5,677**	**5,663**

[Source: DOH, Answer to question on notice 4 asked at hearing held 28 November 2022, dated 20 December 2022, p 3.]

FINDING 29

From 2020-21 to 2021-22, an average of 5,670 clients per year were discharged from the Child and Adolescent Health Service–Child Development Service following a lack of response to an appointment offer.

Discharge policy: response from WA Country Health Service–Child Development Service

4.46 The Committee does not have data from WACHS–CDS regarding the number of clients discharged following a lack of response to an appointment offer. However, WACHS staff record an 'attempted follow-up' item on their information system for every unsuccessful attempt to contact a family. The information recorded in Table 2 on page 116 is likely to be an underestimate of follow-up attempts as it excludes additional attempts that may be conducted by clerical staff.[470]

4.47 WACHS–CDS told the Committee that it had recently developed an engagement policy that requires the service to provide reasonable follow-up before a client is discharged:

> we really have a very clear process in terms of what we need to do as clinicians before a child is ever discharged. If they are ever discharged, it is made known to the referrer that the child is being discharged so we do not lose sight of where that child is. But we certainly would not put on two phone calls and an email and then you are discharged from the service.[471]

4.48 Multiple and varied attempts will be made to contact vulnerable families, including engaging the assistance of the child health nursing team or Aboriginal health workers:

> we do our very best, particularly where there are risk factors and they are vulnerable families, to ensure that we do not lose sight of those families—that they are hooked into another service. We would contact our child health nurse team, for example, who probably knows that family, or our Aboriginal health workers who are in the regions who might know that family and who do go to great lengths actually, particularly where vulnerability is concerned, to find those families. If we cannot get them by phone, we will do a drive by the house.[472]

[470] Answer to question on notice 4 asked at hearing held 28 November 2022, p 3.

[471] L Pereira, Manager, WACHS–CDS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 11.

[472] L Pereira, [*transcript of evidence*], p 13.

Table 2. *WA Country Health Service–Child Development Service attempted follow-up with clients*

Attempted follow-up for allied health disciplines	2020-21	2021-22
Allied health assistant	616	647
Audiology	588	415
Clinical psychology	37	18
Dietetics	1,256	1,045
Occupational therapy	2,695	2,550
Physiotherapy	1,589	1,692
Social work	678	781
Speech pathology	8,743	7,782
Total of follow up attempts	**16,215**	**14,944**
Number of clients	**6,383**	**6,166**

[Source: DOH, Answer to question on notice 4 asked at hearing held 28 November 2022, dated 20 December 2022, pp 3-4.]

FINDING 30

From 2020-21 to 2021-22, the WA Country Health Service–Child Development Service conducted multiple follow-ups with an average of 6,274 clients per year following a lack of response to an appointment offer.

4.49 The data displayed in Tables 1 and 2 show that many thousands of families are not responding to appointment offers from CAHS–CDS and WACHS–CDS. The Committee does not have information as to the reasons behind a lack of response to an appointment offer. While some families may have obtained services elsewhere, the evidence indicates that many children may not be receiving the developmental support they need.

Initiatives to improve engagement

4.50 CAHS–CDS told the Committee that it has introduced or trialled various initiatives to improve engagement with vulnerable groups. For example, around 73% of children on the active CDS caseload require services from more than one discipline. In 2021, CAHS–CDS implemented the 'key contact' model where a family is allocated a clinician to streamline communication and coordination of services.[473]

4.51 However, in many cases, funding constraints have limited the broader implementation of successful strategies:

> we have trialled a number of very specific interventions that would make a difference, we believe, if we had the capacity to roll them out more broadly.[474]

4.52 Two examples of initiatives that CAHS–CDS need additional funding to expand are the 'service navigator' programs and the Play and Learning program.

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[473] Submission 77 from WA Health, 9 November 2022, p 39.

[474] S Kiely, Executive Director, Community Health, CAHS, [*transcript of evidence*], *Legislative Council,* 25 July 2023, pp 2–3.

Health and Support Service Navigators

4.53 A Health Navigator Pilot Program was initiated in late 2022 to improve collaboration and coordination of services for children in out-of-home care. The two-year pilot employs two Health Navigators in two districts (Mirrabooka and the South West) and is a collaboration between the Department of Communities, DOH, CAHS, WACHS and the Southwest Aboriginal Medical Service.[475]

4.54 The Committee agrees with the recommendation of the ACA that there be an evaluation of the Health Navigator Pilot Program,[476] with potential roll-out of the program to include all children in out-of-home care.

RECOMMENDATION 26

WA Health expedite the evaluation of the Health Navigator Pilot Program for children in out-of-home care and, if the evaluation is positive, consider a statewide roll-out of the program.

4.55 In addition to children in out-of-home care, other clients in disadvantaged circumstances often have multiple, intersecting needs.

4.56 WA Health submitted that additional funding for support service navigators would help vulnerable families navigate support services that are available to them and are separate to the CDS system. The service would be:

> focused specifically on helping families to navigate and engage with other services outside of CDS that would help them with issues that the family are facing as a whole, and therefore potentially put them in a better position to be able to engage with developmental services.[477]

4.57 There are also benefits envisioned for CDS provision by reducing the time clinicians currently spend on providing service navigation assistance, diverting them from core therapeutic duties:

> Investment in additional suitably qualified staff would allow families with social issues to be supported in their service navigation while maintaining the CDS specialised team to manage the issues related to the child's development.[478]

FINDING 31

Support service navigators can assist vulnerable clients navigate other beneficial health and social support services available to them, thereby reducing the time that Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service clinicians currently spend providing this assistance.

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475 CAHS, *Annual Report 2022-23*, 2023, accessed 18 February 2024, p 50.

476 Submission 71 from ACA, 7 November 2022, p 10.

477 A Turnell, Acting Director, Clinical Services, CAHS–CDS, [*private transcript of evidence*], *Legislative Council,* 25 July 2023, p 23.

478 Submission 77 from WA Health, 9 November 2022, p 44.

RECOMMENDATION 27

The State Government consider the provision of funding to the Child and Adolescent Health Service and WA Country Health Service to recruit support service navigators, noting that this service does not necessarily need to be provided by Child Development Service providers.

Play and Learning program

4.58 The Play and Learning program is a home visiting, play-based intervention program provided by the CAHS–CDS occupational therapy team for families with complex needs:

> The home visiting program focuses on building parent capacity to support their child's development through play. Clinicians support access and engagement with mainstream CDS services and with local community services to support the family and to promote their child's development.[479]

4.59 An evaluation of the program demonstrated positive outcomes for the parents and children who participated, including an increase in the confidence of parents in supporting their child's needs. CAHS–CDS received the following consumer feedback for the program:

> Before I just let him play by himself, now I play with him, like with animals... I am playing with him. My husband also, they go to the playground with other kids now, because we learned, I mean I know we know it is important and we also did it before, but now we do it more often.[480]

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> [Client's] speech has come along a lot better over the last couple of months, I am able to connect with him on a play level better cause I can understand a bit about what he wants.[481]

4.60 CAHS–CDS told the Committee that the program is currently limited to families with children under three and a half years of age who have been referred for services from multiple disciplines. Additional funding would enable expansion of the service:

> Expanding on this program across all CDS teams would help with the earlier engagement of young children referred to [CAHS–]CDS and provide a strong foundation to prepare families to take on more discipline-specific strategies and support earlier access to disability assessment pathways if needed.[482]

4.61 A majority of the Committee, comprising Hons Dr Sally Talbot and Samantha Rowe MLCs, makes the following recommendation:

RECOMMENDATION 28

The State Government consider providing funding to the Child and Adolescent Health Service–Child Development Service to enable expansion of the Play and Learning program.

4.62 A minority of the Committee, comprising Hon Donna Faragher MLC, makes the following recommendation:

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

480 Submission 77, p 52.

481 Submission 77, p 52.

482 S Kiely, Executive Director, Community Health, CAHS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 4.

Minority Recommendation 6

The State Government provide funding to the Child and Adolescent Health Service–Child Development Service to enable expansion of the Play and Learning program.

What else could be done?

4.63 Contributors to the Inquiry identified a range of potential solutions to service inequity for vulnerable families. Stakeholder recommendations commonly indicate that solutions must be focused, flexible and creative.

Enhanced and flexible service delivery

4.64 Many contributors to the Inquiry contend that the CDS providers adopt a one-size-fits-all approach that does not serve vulnerable families well.

4.65 The ACA suggested that enhanced service pathways and additional support to engage with the services should be provided for at-risk families:

> Children and families with additional risk or needs should be identified and offered additional supports to engage with CDS first time – not dropped off waitlists due to not responding to calls or attending appointments (standard protocols). There are currently no enhanced service pathways and children often miss out on services …[483]

4.66 The Committee has received evidence suggesting that a more flexible service delivery model that is sensitive to the barriers experienced by vulnerable populations should be explored. For example, home visiting and outreach services to places in local communities where families attend will improve engagement. Suggestions from the ACA and others included the following:

- The ACA identified aspects of the CDS system that exclude some vulnerable clients, such as the need for digital literacy and readily available transport. Standard service options (such as telephone appointments or parent workshops) are not suitable for some families for cultural, linguistic or other reasons:

  > Address barriers in … CDS service delivery – including paperwork, digital literacy and access, translated materials, requirement for high parent engagement/knowledge, transport barriers, etc. Consider offering services in home visits or other settings e.g. mobile clinics, visits to ECEC or family support services, local child health clinic or CPC.[484]
  >
  > ▫▫▫
  >
  > Initial phone appointments and parent workshops may not be suitable or accessible for all parents and should not be a requirement of further service provision, face-to-face and flexible options should be available to those who need them.[485]

- CEWA submitted that relationship building at a local level is needed to engage vulnerable populations:

[483] Submission 71 from ACA, 7 November 2022, p 9.

[484] Submission 71, p 10.

[485] Submission 71, p 9.

> It is also important to establish pathways for more holistic methods of support such as early engagement via child health nurses or equivalent; services on site or visit early childhood education and care to support access and develop trust in the services. The AFaFE [Aboriginal Families as First Educators] model is a good model for engagement of Aboriginal parents, carers, families, and communities.[486]

- Parkerville emphasised the need for flexibility and agility in service delivery to respond to the needs of vulnerable families:

> Create priority referral pathways for families in crisis and/or recovering from trauma, who are likely not in a position to meet rigid appointment criteria: flex the system to meet children/families where they are, not where the system thinks they should be.
>
> Design service responses that are agile, and willing to deliver outreach assessment and intervention to those people experiencing homelessness or other multiple and substantial barriers to service access.[487]

Service planning appointments

4.67 Evidence from a nurse practitioner in private practice was that there is often a disconnect between a family's concerns and the information recorded by CAHS–CDS following the initial telephone service planning call:

> We have had so much concern with some of our families that we have started to tell the families to make the phone call from our office, and we will support them through that, and that has been successful, but it is very hard for us to put that into our clinical day.[488]

4.68 She explained that families in disadvantaged circumstances may not be able to articulate their concerns well and this can be reflected in the subsequent service plan:

> the parents who are articulate, who understand health and educational jargon, who are assertive, who feel confident that they understand what is going on will do really well. Unfortunately, they tend to be also quite over-serviced. The parents who have low confidence, low self-esteem, do not understand complex language, have a lot of competing things in their lives, maybe multiple children … they are worried but they do not know how to quantify that worry, they may have been told there is a problem but they do not really know what that means, they tend to do really badly.[489]

4.69 Attendance of the referrer at service planning appointments could also ensure better communication of developmental concerns to CAHS–CDS:

> "Wouldn't it be amazing if that call was to the referrer with the parent uniformly, unless the parent opted not to do it that way", because the richness in the information that we can share when we have done it is transformative for those families.[490]

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486 Submission 37 from CEWA, 24 October 2022, p 6.

487 Submission 38 from Parkerville, 24 October 2022, p 2.

488 S Dowden, Paediatric Nurse Practitioner/Director, NursePrac Australia/Just Kids Health Clinic, [*transcript of evidence*], *Legislative Council,* 20 February 2023, p 6.

489 S Dowden, [*transcript of evidence*], p 6.

490 S Dowden, [*transcript of evidence*], p 7.

4.70 CAHS–CDS disputes the criticism of its service planning appointment process and points out that it is aligned to best practice, scheduled at a time that is mutually convenient for the client and clinician, and that an interpreter will be present if needed.[491]

4.71 CAHS–CDS provided the Committee with a parent evaluation report of the 'First Appointment pilot project' which was conducted during 2016-17. Formal evaluation of the project concluded that the three pilot sites produced consistently positive results. CAHS–CDS reports that consumer feedback is generally positive.[492]

4.72 The Committee agrees that the parent evaluation report shows positive results, although not overwhelmingly so. For instance, over 25% of respondents said they understood their child's developmental needs only 'a little' better after the first appointment and 5% not at all. The Committee also notes that the results outlined in the report were obtained from a relatively small number of clients.[493]

RECOMMENDATION 29

The Child and Adolescent Health Service–Child Development Service explore ways to improve the effectiveness of its service planning appointments, including identifying when participation of the referrer at the appointment would be beneficial.

Spotlight on three vulnerable populations

4.73 The following sections take a closer look at some of the access, engagement and equity issues relating to three vulnerable populations: CALD families, Aboriginal families, and populations in regional and remote areas. The Committee recognises that the issues affecting these demographic groups often intersect.

Culturally and linguistically diverse families

4.74 CALD populations include migrant families, refugees and asylum seekers. For these families, language and communication barriers can result in social isolation and create challenges in accessing health care. A recent study found that:

> People of CALD backgrounds had low utilisation of health services, experienced unmet healthcare needs, and faced barriers in accessing health services.[494]

4.75 While the Committee did not receive submissions specific to CALD groups, CEWA addressed issues facing CALD families in their evidence. CEWA submitted that child development issues may not be diagnosed, or intervention provided in a timely way:

> Families with English as their second language are particularly vulnerable and may not access the Child Development Services for language or cultural reasons; some of these children may go through early childhood care and education without being diagnosed or receiving the support they require.[495]

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491 Letter from V Jovanovic, Chief Executive, CAHS, 2 February 2023, pp 2–3.

492 Letter from V Jovanovic, p 2 and Attachment 3, *CDS First Appointment Parent Evaluation Report*, p 1.

493 A total of 456 parents were randomly selected and invited to provide feedback. A 20% response rate (93 responses) was achieved: Letter from V Jovanovic, Attachment 3, *CDS First Appointment Parent Evaluation Report*, p 7.

494 Khatri, RB and Assefa, Y, Access to health services among culturally and linguistically diverse populations in the Australian universal health care system: issues and challenges, *BMC Public Health* 22, 880 (2022), accessed 1 February 2024, p 7.

495 Submission 37 from CEWA, 24 October 2022, p 5.

4.76 Its experience is that CALD families need extra support to engage with CDS:

> we have highlighted [CALD families] as an area of need because a lot of those families do not know what they do not know. They sometimes receive communications directly and do not understand it, and unless the school is aware of it, things drop away so they are not able to access services that may be available to them. The school does try to support these families as much as possible; however, there needs to be communication between both to begin with … we are a little bit hamstrung in terms of when we do highlight that there is a need, how do we get these families into the places that they need to be, because a lot of the time finance is a big, big reason why they cannot access the support they require.[496]

4.77 CEWA further stated that, even with the assistance of the school, the way in which services are delivered, and the expectations placed on clients, is not sensitive to the needs of CALD families:

> If I may, 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.[497]

FINDING 32

Culturally and linguistically diverse families face barriers accessing services and may need extra support to engage with child development services.

Child and Adolescent Health Service–Child Development Service initiatives to improve engagement

4.78 The submission from WA Health advised that 3.6% (1,072) of children on the active caseload are from families who require an interpreter. CAHS–CDS provides free interpreter services.[498]

4.79 According to CAHS's 2022-23 annual report, the Refugee Health Team within CAHS–Community Health is made up of nurses and one CALD health worker.[499] Services provided by the Refugee Health Team include:

> developmental assessments of infants and children and help [for] families to access child health services and community groups that meet their individual and family needs, including general practitioners and specialist services.[500]

4.80 In terms of improving engagement with CALD families, CAHS–CDS told the Committee that:

> We would also like to look at some roles dedicated to supporting engagement with linguistically diverse families.[501]

4.81 Funding permitted, CAHS–CDS would like to have additional administrative staff to support engagement with CALD families:

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496 K Messineo, Senior Team Leader, Teaching and Learning, CEWA, [*transcript of evidence*], *Legislative Council*, 20 February 2023, p 5.

497 T Wong, Child Safe Lead, CEWA, [*transcript of evidence*], *Legislative Council,* 20 February 2023, p 5.

498 As at 19 September 2022. Submission 77 from WA Health, 9 November 2022, p 45.

499 CAHS, *Annual Report 2022-23*, CAHS, 2023, accessed 18 February 2024, p 48.

500 CAHS, *Annual Report 2022-23*, p 48.

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

> having someone who could specifically focus on arranging transport or making sure appointment information was translated or following up with extra phone calls to make sure the family received information and could understand it, so those types of follow-up, extra steps in engaging, rather than necessarily delivering the service.[502]

RECOMMENDATION 30

The Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service explore ways to support the engagement of culturally and linguistically diverse families.

What else could be done?

4.82 The need for targeted, community level outreach to engage CALD communities was highlighted by contributors to the Inquiry:

- CEWA recommended establishing partnerships in local communities where other services, such as child health services, are accessed.[503]
- The Australian Physiotherapy Association made a similar suggestion:

  > Schedule visits by therapists to community centres where migrants and refugees meet. Many refugees are not aware of therapy services as allied health professionals are not available in their country of origin.[504]

- Professor Andrew Whitehouse of the TKI emphasised the importance of local, easily accessible services:

  > if something requires a referral or another referral, particularly vulnerable families where communication in the language of the referral is different, that is where we lose the families that we so desperately need. And so ease of access within your local community cannot be stressed enough … [505]

4.83 The Committee is of the view that Child and Parent centres (see paragraphs 3.113–3.139) are an ideal way of expanding outreach and promotional activity that target CALD families.

RECOMMENDATION 31

The Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service explore outreach and promotion activities that target culturally and linguistically diverse families, including through Child and Parent Centres.

Regional and remote populations

4.84 Families in regional Western Australia do not have access to the same level of child development services (or other health and social services) available in the metropolitan area.

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502 A Turnell, Acting Director, Clinical Services, CAHS–CDS, [*private transcript of evidence*], *Legislative Council,* 25 July 2023, p 23.

503 Submission 37 from CEWA, 24 October 2022, p 6.

504 Submission 73 from Australian Physiotherapy Association, 7 November 2022, p 10.

505 Prof A Whitehouse, Bennett Professor of Autism Research, TKI, [*transcript of evidence*], *Legislative Council,* 9 February 2023, p 13.

Child development services across regional Western Australia are variable and the families who live there face a range of unique challenges.

4.85 Dr Elizabeth Green, a recently retired paediatrician, was blunt in her assessment of CDS for families in country areas:

> While workforce issues remain, metropolitan child development services will be prioritised. They remain more affordable and reliable than remote centres which are more vulnerable to staff and patient relocations. People in country areas come second.[506]

4.86 WA Health acknowledges the relative disadvantage of regional and remote populations:

> 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.[507]

4.87 These service deficits in regional areas can have significant, and lifelong, impacts on the development of children:

> Extended wait times for access to vital services are common in regional and remote areas, and significant delays in diagnosis and intervention, including delays in meeting NDIS access requirements, can have substantial and lifelong impacts for country children and families.[508]

FINDING 33

Regional and remote families are disadvantaged in terms of access to early intervention and support services.

Developmental vulnerability

4.88 The more remote a community, the greater the developmental vulnerability. AEDC data shows that 27% of children in remote areas and 46% of children in very remote areas are developmentally vulnerable on one or more domains. This compares to 21% of children in cities.[509]

4.89 Evidence from WA Health indicates that over 16% of children in regional Western Australia require CDS:

> Developmental delay and disability affect a significant proportion of children in regional WA. Current state prevalence data indicates that 16.5% (approximately 25,000) of children under fifteen years living in country WA are affected by developmental delay or disability and would likely benefit from support provided by child development services.[510]

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

507 Submission 77 from WA Health, 9 November 2022, p 62.

508 Submission 77, p 63.

509 AEDC, *Australian Early Development Census National Report 2021: Early Childhood Development in Australia*, AEDC, 2022, accessed 6 February 2024, pp 89–90, Appendix 6, Table 29.

510 Submission 77 from WA Health, 9 November 2022, p 60.

FINDING 34

There is a higher proportion of children in remote and very remote areas who are developmentally vulnerable compared to children in cities.

Challenges for health service delivery

4.90 As outlined in the Interim Report,[511] CDS vary across the seven country health service regions:

> Our seven WA Country Health Service regions deliver services to diverse populations with widely varying needs, each with their own unique context.[512]

4.91 A significant proportion (34%) of WACHS–CDS clients (active and waitlist) have identified vulnerability factors, ranging from 25% in the South West and Wheatbelt to 66% in the Kimberley. Vulnerability factors include socio-economic disadvantage, Aboriginality, refugee status, teenage parent/s, drug and alcohol issues, children in out-of-home care, and family and domestic violence.[513]

4.92 A significant proportion of WA's regional population (40%) live in areas with the highest levels of socio-economic disadvantage compared to 7% of people in the metropolitan area.[514]

4.93 Poverty is pronounced in some remote and regional areas of the State. In the East Pilbara for example:

> 69.7 per cent of children and young people ... [are] ... estimated to be living in poverty compared to 3.3 per cent of children and young people in the Perth suburb of City Beach.[515]

4.94 Distance and diversity are characteristic of the Kimberley:

> WACHS Kimberley provides the Child Development Service to a very diverse population of clients and their families, who are spread over this expansive region of 423 000 kilometres. The Kimberley region has approximately 200 Aboriginal communities, over 34 Aboriginal language groups and 49 per cent of the population are Aboriginal or Torres Strait Islander people.[516]

4.95 Disadvantage and developmental vulnerability are also high in many areas of the Kimberley, and extraordinarily so in some communities:

> Australian early childhood development census data for 2020–21 shows that in the majority of areas in the Kimberley, over 40 per cent of children are developmentally vulnerable, and this rises significantly to over 75 per cent in areas such as Halls Creek, in comparison to the WA average of 20.3 per cent.[517]

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511 See Interim Report, pp 25–28, paragraphs 3.47–3.51.

512 J Moffet, Chief Executive, WACHS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 3.

513 WACHS, *Child Development Services (CDS): Review and Next Steps Project report*, July 2023, p 11.

514 WACHS, *Child Development Services (CDS): Review and Next Steps Project report*, p 11.

515 CCYP, *Profile of Children and Young People in WA 2021*, CCYP, accessed 7 February 2024, p 23.

516 S Wood, Senior Occupational Therapist, Child Development Service, Kimberley Population Health Unit, WACHS, [*transcript of evidence*], *Legislative Council,* 1 May 2023, p 2.

517 S Wood, [*transcript of evidence*], p 2.

4.96 Long distances between communities often combines with poor quality, intermittent internet access.[518] Outreach services to smaller, remote communities is limited and can be interrupted by a range of factors such as weather conditions and workforce availability:

> Our teams travel significant distances, driving up to eight hours one way, to provide outreach services to smaller towns and Aboriginal communities. Our teams visit the towns of Fitzroy Crossing, Halls Creek and Wyndham on a regular basis, and 15 remote Aboriginal communities with varying frequency—from monthly to four times a year, although this frequency can be impacted by weather and road conditions, availability of vehicles and flights, and staffing levels.[519]

4.97 Given these challenges, WA Health submitted that service delivery in the regions will necessarily differ to the metropolitan model:

> Services in country WA need to be provided in unique and different ways to metropolitan CDS. One standard CDS service model will not ensure equity for the most vulnerable and disadvantaged children in WA.[520]

4.98 However, evidence to the Committee (including from WA Health itself) indicates that variations in service delivery across the regions is often not the result of needs driven design, but a variety of other factors:

> The service model varies across all regions, depending upon the local service facilities, available workforce, catchment demographics, past and expected service utilisation, availability of alternative service providers and community infrastructure.[521]

4.99 Workforce issues have a significant impact on service delivery. WA Health admit that staffing and facilities are generally inadequate to meet need:

> Community demand for CDS continues to increase every year, with staffing and facilities being inadequate across country WA.[522]

4.100 There are difficulties attracting and maintaining medical staff:

> It goes back to the medical shortage. We cannot get doctors, we cannot get nurses, we cannot get lots of staff at the moment. It is very difficult to attract health professionals up here.[523]

4.101 A reliance on sessional (visiting) services by specialists has consequences for waiting times and quality of service:

> Most WACHS CDS rely on professionals providing sessional services (i.e. a clinician who may visit a hub 3-4 times a year). Sessional services can lead to increased wait times for families, particularly when there are local workforce shortages, and impact on a clinician's capacity to gain adequate knowledge about the family they are working with. This in turn can impact on the clinical outcome for the child and decreased family satisfaction with the service.[524]

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518 S Wood, Senior Occupational Therapist, Child Development Service, Kimberley Population Health Unit, WACHS, [*transcript of evidence*], *Legislative Council,* 1 May 2023, pp 2–3.

519 S Wood, [*transcript of evidence*], p 2.

520 Submission 77 from WA Health, 9 November 2022, p 64.

521 Submission 77, p 61.

522 Submission 77, p 8.

523 Dr A Fleming, Senior Medical Officer, DAHS, [*transcript of evidence*], *Legislative Council,* 2 May 2023, p 20.

524 Submission 77 from WA Health, 9 November 2022, p 64.

4.102 Access to paediatricians is highly variable:

> Whilst the bulk of the WACHS CDS workforce are allied health professionals, paediatricians are important and essential members of a multidisciplinary team. 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.[525]

4.103 The composition of CDS teams varies across the regions and can depend upon workforce availability rather than need:

> The staff composition of CDS teams varies across WACHS. Teams have evolved over time to reflect local need, available human resources and/or historical workforce configurations. Services may be provided by WACHS employed staff, contracted service providers and/or in partnership with other internal and external service providers. Contracting and partnering are pragmatic strategies to cover service/professional team gaps, but they also contribute to disjointed services for families and weaker governance over service provision.[526]

4.104 For example, WACHS in the Kimberley is unable to provide psychology services (including assessments reliant on a psychologist) due to workforce constraints. Evidence from WACHS indicates this situation has existed for many years:

> **The CHAIR**: … within child development … you do not have any psychologists.
>
> **Dr ROBSON**: No.
>
> **The CHAIR**: Is that because you do not have any positions for psychologists?
>
> **Dr ROBSON**: We do not have any positions, no.
>
> **The CHAIR**: Have you ever had positions for psychologists? Do you need positions for psychologists? Is there any reason why you do not have that allocation?
>
> **Mrs WOOD**: I have been here 20 years and we just have never had those.
>
> **The CHAIR**: So what happens to children who need psychological services?
>
> **Mrs WOOD**: That is a great question.[527]

4.105 The shortage of audiologists and psychologists across all WACHS regions is also discussed in the Interim Report.[528]

4.106 Complex funding arrangements are confusing and have a direct impact on service delivery:

> WACHS CDS has complex funding arrangements that varies across regions. Funding sources tend to be based on historical arrangements and may include block funding, Activity Based Funding (ABF) for paediatrician services, Rural Health West funding for some allied health roles and Commonwealth funding for Aboriginal health workers. Employment contracts are therefore often short term

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525 Submission 77, p 64.

526 Submission 77, p 64.

527 Hon Dr Sally Talbot MLC, Chair; and Dr A Robson, Regional Paediatrician, and S Wood, Senior Occupational Therapist, Child Development Service, Kimberley Population Health Unit, WACHS–Kimberley, [*transcript of evidence*], *Legislative Council,* 1 May 2023, p 9.

528 Interim Report, pp 32–33, paragraphs 3.71–3.73.

> and … many CDS professionals are employed on a contract basis or procured through an open contract process.[529]

FINDING 35

Variations in service delivery across regional Western Australia is often not the result of needs driven design, but a variety of other factors including workforce availability and funding arrangements.

4.107 Transport costs can be significant. The Patient Assisted Travel Scheme (PATS) provides financial support to residents in regional Western Australia for travel and accommodation costs associated with specialist medical appointments.[530] However, it does not cover the same expenses for allied health appointments:

> Families who do not have access to personal transport face additional hardships. Consumers tell us that having access to transport is vital to early and ongoing engagement with services. The Patient Assisted Travel scheme does not cover allied health appointments, so families living away from a regional centre face an additional financial burden when accessing services.[531]

FINDING 36

The Patient Assisted Travel Scheme does not cover allied health service appointments.

RECOMMENDATION 32

The Patient Assisted Travel Scheme be extended to cover allied health service appointments relating to child development services.

4.108 Unsurprisingly, the complicated and divergent funding system makes individual case management more difficult. WACHS told the Committee that better coordination between health service providers is needed:

> One of the things that I think might be helpful is to have some kind of mechanism to assist us with coordinating either the funding or the services that come in to different regions. We were talking earlier about an electronic medical record just within Health, but we have the additional burden of people that are coming into the region who we have no awareness of in the region until they are there. We do not necessarily know which children they are seeing. So there is another disconnect that we face within WACHS. So I would appreciate some attention being paid to that area for WACHS.[532]

FINDING 37

Complicated and variable funding of services and lack of coordination with other service providers in regional Western Australia makes individual case management difficult for the WA Country Health Service–Child Development Service.

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529 Submission 77 from WA Health, 9 November 2022, p 69.

530 WACHS, *Am I eligible for PATS?*, WACHS, 2023, accessed 21 March 2024.

531 Submission 77 from WA Health, 9 November 2022, p 64.

532 L Pereira, Manager WACHS–CDS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, pp 58–59.

Comments from other contributors to the Inquiry

4.109 The evidence from WA Health and WACHS outlined in paragraphs 4.90–4.108 candidly recognise the challenges and deficiencies in the delivery of regional CDS. Other contributors to the Inquiry commented on shortfalls in regional services, with some highlighting the resulting inequity for country residents:

- The TKI submitted that it is difficult for families in rural and remote areas to identify and access services available to them:

  > a child living in a rural or remote community has a much more complex pathway to services than one living in urban areas. Early intervention opportunities are available, but it is challenging for families to have access or be aware of relevant programs.[533]

- The Pilbara Aboriginal Health Alliance also commented on the difficulties experienced by regional families in finding accurate, up-to-date information about the availability of local services:

  > Currently there is no one accurate source of information, either public or private, identifying services and their availability, visiting schedules, visit frequency, referral pathways and service requirements, with organisations developing and distributing their own information which can confuse service providers and community members. Without this one source of accurate information, there is a large burden placed on consumers to navigate through the complex health system to find appropriate and suitable services. This would particularly impact not only the transient communities, but the young families that move to the Pilbara and currently access information from multiple resources and platforms. Health service providers would benefit through this platform and use it as a tool for service planning, and ensuring services are complementary and not duplicated.[534]

- Parkerville pointed to regional inequality in service provision:

  > in some areas of our Mid West OOHC [out-of-home care] provision, there are no speech pathologists, no occupational therapists, and only a visiting paediatrician. Child development services prioritise children under 7; our team have found it very challenging for children in our care over the age of 7 to secure referrals or be accepted onto services, and if they do, wait times are long and appointments very few. In cases where urgent support is needed, this has resulted in children having to make regular trips to Perth …[535]

- ARACY submitted that local, adaptable, and responsive services need to be adequately resourced:

  > Services … should be properly resourced to provide local and adaptable models of care to outer-regional and remote areas – including visiting and telepractice models. This also includes the appropriate, secure and long-term resourcing of Aboriginal Community Controlled Health Services to provide culturally safe services in remote and regional areas, via Aboriginal Community Health Clinics and in partnership with mainstream primary and specialist services.[536]

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533 Submission 85 from TKI, 18 November 2022, p 3.

534 Submission 76 from Pilbara Aboriginal Health Alliance, 8 November 2022, p 6.

535 Submission 38 from Parkerville, 24 October 2022, p 5.

536 Submission 63 from ARACY, 26 October 2022, p 2.

- Playgroup WA asserted that the current CDS model entrenches disadvantage:

> PGWA's major concern with the delivery of child development services in WA is that it now entrenches disadvantage. The system has progressively become a market-place where the chances of individual children and families receiving appropriate and timely services are heavily dependent on their economic circumstances and/or where they live. Regional areas are particularly disadvantaged by this system due to difficulty in staffing and as the market seeks profitability in larger population centres.[537]

WA Country Health Service–Child Development Service efforts to improve access to services

4.110 Evidence indicates that there is often good collaboration between WACHS–CDS and Aboriginal Community Controlled Health Organisations (ACCHOs). For example, the South West Aboriginal Medical Service told the Committee that:

> We are fortunate in that we do have a really good relationship with the WACHS staff, and they do put our Aboriginal children as priority to be able to access the services.[538]

4.111 In 2023, WACHS completed a review of its CDS. The report of the review, *Child Development Services (CDS): Review and Next Steps Project report*, is not publicly available but the Committee is aware that it includes recommendations to:

- establish an integrated child development model that includes paediatric and allied health services
- implement strategies to improve service provision including pathways for complex presentations, case management support and consideration of alternative modes of service delivery
- better match workforce to demand and develop flexible workforce models
- strengthen collaboration with internal and external partners, including ACCHOs.[539]

What else could be done?

4.112 The submission from WA Health identified the need for a demand and resources model to assist the provision of equitable service delivery:

> Families are presenting with greater social complexity and vulnerability. Whilst complex, it would be helpful to have some resource/demand model to ensure an equitable distribution of resources based on population size and complexity.[540]

4.113 A review of resources and demand in regional areas was also recommended by Parkerville:

> Undertake an urgent review of service provision in regional areas and/or areas where people experience locational disadvantage, to address the impact of poor availability of critical services for children.[541]

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537 Submission 48 from Playgroup WA, 24 October 2022, pp 2–3.

538 J Ingrey, Maternal Child Health Coordinator, South West Aboriginal Medical Service, [*transcript of evidence*], *Legislative Council,* 3 April 2023, p 3.

539 WACHS, *Child Development Services (CDS): Review and Next Steps Project report*, July 2023, pp 4–5.

540 Submission 77 from WA Health, 9 November 2022, p 67.

541 Submission 38 from Parkerville, 24 October 2022, p 2.

RECOMMENDATION 33

The WA Country Health Service–Child Development Service expedite the development of a resource-demand model to assist the equitable distribution of resources according to need.

4.114 As previously identified by the Committee (paragraphs 2.12–2.25), evidence to the inquiry identified a need for increased investment in IT systems and technological solutions. For example, WACHS's CHIS does not communicate with CAHS–Community Health's information system, CDIS. Consequently, there is no mechanism for visiting health services (who are not funded by WACHS) to access or enter information on a patient's record:

> A connected and integrated child health clinical information system that follows the child's health journey can improve follow-up, reduce duplication, enhance care planning and service delivery, particularly for high-risk children. While communication and information sharing with non-health service providers, such as the Departments of Education, Communities and disability agencies adds further layers of complexity, it should not be impossible to overcome.[542]

FINDING 38

The WA Country Health Service–Child Development Service's Community Health Information System has capability limitations that affect information sharing.

4.115 The Committee therefore reiterates Recommendation 8 of this report (page 33).

4.116 The limited capability of CHIS also affects WACHS's ability to access data:

> Currently the Child Health Information System is very limited in its capacity to provide 'live' and 'trend' service data. Work to improve the data availability and quality is required to support ongoing planning and innovation.[543]

4.117 The Committee reiterates Finding 7 (page 25) of this report. The Committee also reiterates Recommendations 1 and 6 (pages 10 and 26) of this report.

4.118 The viability of telehealth services is circumscribed by network capability and consumer access to digital equipment:

> Overwhelmingly, families are telling us that we should include virtual care in our suite of services to offer families a choice in the way they receive services. However, overall the current digital service provision for CDS is limited.[544]

4.119 In response to demand, WACHS–CDS is trialling 'virtual care' for clinically appropriate services, including child health nursing. The 'Virtual Child Health Nurse' pilot service was launched in May 2022 and is currently available for children aged one–three years in the Kimberley, Pilbara, Goldfields and Midwest regions. The initial feedback from parents is positive.[545]

4.120 The AHC, while appreciating the role of telehealth, explained that telehealth specialist appointments are often more effective if a clinician or Aboriginal health practitioner who

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542 Submission 77 from WA Health, 9 November 2022, p 67.

543 Submission 77, p 67.

544 Submission 77, p 66.

545 WACHS, *Vital child health checks now as close as the phone for country residents*, WACHS, 2023, accessed 30 March 2024.

knows the patient is also present. However, ACCHOs are not funded to provide this assistance and support:

> However, our services are not funded to do that; it is not Medicare rebatable for a GP, a nurse or an Aboriginal health practitioner to sit in on an appointment. Certainly, I have done it, and I am sure we have all done it before with our patients, but we cannot bill for that. It is not a funded way for it to work, but it can be a good model.[546]

4.121 The TKI identified a range of ways that technology could be better utilised to optimise service provision in the regions:

> Early intervention is traditionally intensive and hands on. To better support the delivery of services in WA's vast geographical region, additional investment is needed to explore alternative models and technology solutions. For example, wider use of telehealth services, greater reliance on trusted sources of information such as the Brighter Tomorrows App, and the use of technology and robotics to develop diagnostic and treatment aids such as wearable devices.[547]

4.122 The DAHS described how technological devices can assist in diagnostic services to remote populations who have limited access to health clinicians:

> We have just had funding to purchase some new devices, Visionflex, which is currently being used at Bidgy [Bidyadanga] and Beagle Bay and it is meant to be providing a better telehealth service so that whoever is there with the machine can literally look in ears and throats … I feel like it is just the way we are going to be going, because there is such a shortage of doctors and nurses.[548]

4.123 The DAHS also explained how mobile health clinics, combined with telehealth and diagnostic technology, can improve service provision for remote communities:

> **Dr FLEMING**: … The other thing we have got is a mobile bus that is starting up here. I think Kalgoorlie Bega has it. We are going to have something similar. I mean, that could be fantastic as well if we were providing particular services or programs to go out. As I said, bring it to them.
>
> **The CHAIR**: So what would be on the bus?
>
> **Ms MOORE**: It would be a mobile clinic.
>
> **The CHAIR**: A full service clinic?
>
> **Ms MOORE**: A fully serviced clinic. If we are in the back streets and want to bring the children in for a check or whatever, pop in the van and it is all there.
>
> **Dr FLEMING**: So a nurse could go out with them and call back to the doctor and we could do a telehealth with the Visionflex because we are getting some remote packages and we have got the standalone ones that will be in clinics. We are looking into all of those options.[549]

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546 Dr C White, Public Health Medical Officer, AHC, [*transcript of evidence*], *Legislative Council,* 9 February 2023, p 16.

547 Submission 85 from TKI, 18 November 2022, p 4.

548 Dr A Fleming, Senior Medical Officer, DAHS, [*transcript of evidence*], *Legislative Council,* 2 May 2023, p 17.

549 Hon Dr Sally Talbot MLC, Chair; Dr A Fleming, Senior Medical Officer, DAHS and J Moore, Senior Manager Clinical Operations and Remote, DAHS, [*transcript of evidence*], *Legislative Council,* 2 May 2023, p 17.

FINDING 39

A range of technological solutions (such as telehealth, diagnostic technology and robotics) as well as other innovative solutions (such as the mobile and relocatable allied health clinics noted in Finding 17 and Recommendation 16 of this report) would improve access to child development services for regional and remote populations.

RECOMMENDATION 34

The State Government explore and invest in technological and other innovative solutions that will improve access to child development services for regional and remote populations.

4.124 The Committee also reiterates Finding 17 and Recommendation 16 (page 69 of this report) with respect to mobile and relocatable allied health clinics.

Aboriginal families

4.125 Aboriginal children and young people (aged up to 19 years) represent 7.3% (50,173) of children in Western Australia. Almost 60% of Aboriginal children live in regional and remote areas (compared to only 20% of non-Aboriginal children) and nearly one quarter (23.5%) live in very remote areas.[550] These numbers are significant because the most disadvantaged communities tend to be in regional and rural areas.[551]

4.126 Research by the Bankwest Curtin Economics Centre also shows that children living in remote areas are also the most disadvantaged in terms of early learning. Taking into account access to preschool, developmental outcomes, and the level of resources available to a child,[552] the centre's Early Learning Disadvantage Index shows that:

> Remote areas across the state are typically areas that also have the highest level of early learning disadvantage, with children living in these areas having lower access to preschool, poorer development outcomes in their first year of schooling and lower economic resources to draw from.
>
> Many of the remote areas across WA are also Indigenous communities, which often face multiple socio-economic issues and barriers.[553]

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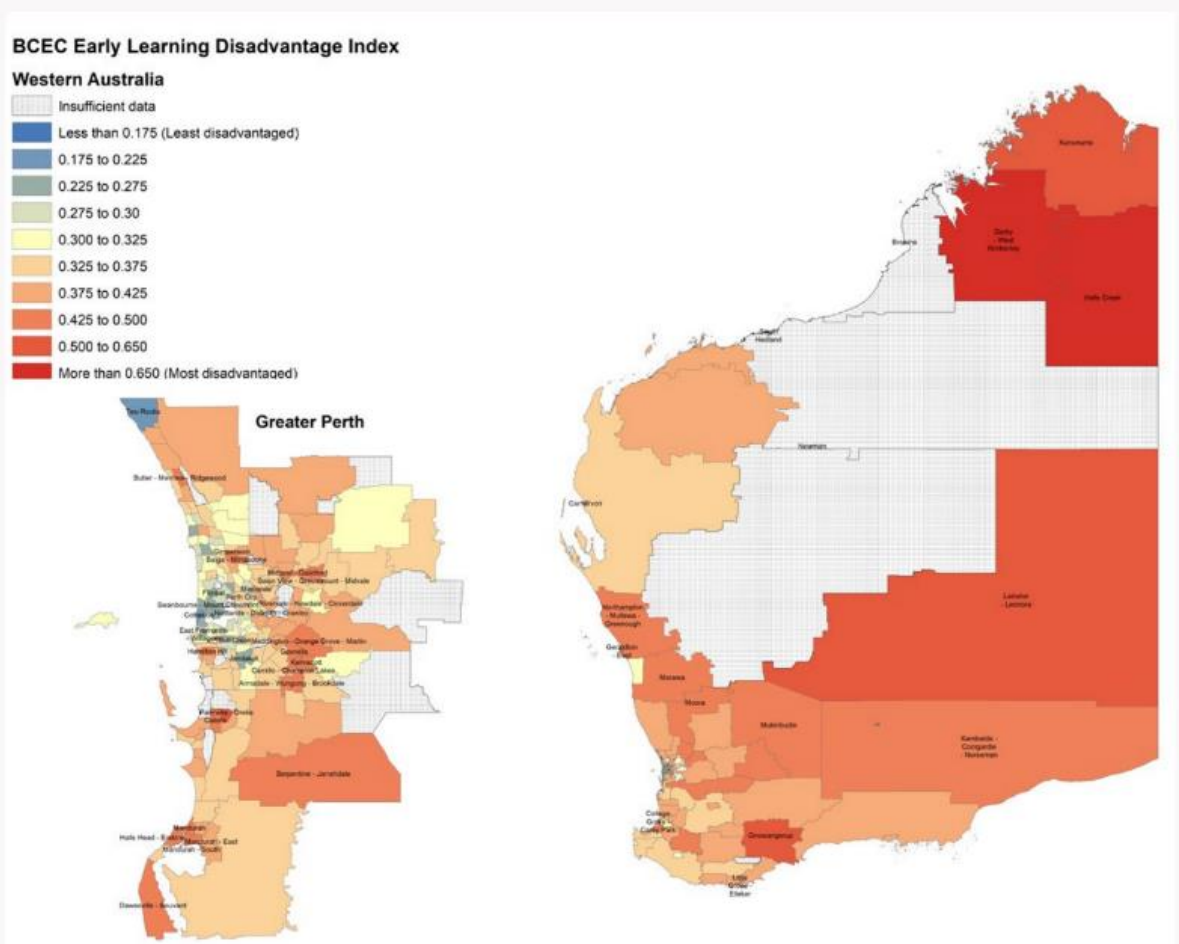
550 CCYP, *Profile of Children and Young People in WA 2023*, CCYP, 2023, accessed 7 February 2024, p 11.

551 Australian Bureau of Statistics, *Socio-Economic Indexes for Areas (SEIFA), Australia*, 27 April 2023, accessed 6 March 2024.

552 R Cassells, M Dockery, A Duncan, D Kiely, M Kirkness, T Nguyen, R Seymour, C Twomey, 'The Early Years: Investing in Our Future', *Focus on Western Australia Report Series*, No 13, August 2020, accessed 14 February 2024, p 97.

553 R Cassells et al, 'The Early Years: Investing in Our Future', p 103.

Figure 5. *Bankwest Curtin Economics Centre's Early Learning Disadvantage Index*



[Source: Bankwest Curtin Economics Centre, 'The Early Years: Investing in Our Future', August 2020, accessed 14 February 2024, p 104.]

FINDING 40

More than half of Aboriginal children in Western Australia live in regional and remote regions, with many communities in these areas the most disadvantaged in the State.

Developmental vulnerability

4.127 According to the 2021 AEDC, 42% of Aboriginal children are developmentally vulnerable in one or more domains compared to 21% of non-Aboriginal children.[554]

FINDING 41

A greater proportion of Aboriginal children are developmentally vulnerable compared to non-Aboriginal children.

[554] AEDC, *Australian Early Development Census National Report 2021: Early Childhood Development in Australia*, AEDC, 2022, accessed 5 March 2024, Appendix 6, Table 31.

4.128 The DYHS submitted that the AEDC data reflects a failure by health and other sectors to provide adequate support to Aboriginal families:

> The AEDC data highlight the important deficits in health, education and social systems to provide timely support for Aboriginal families while children are young. The lack of response to developmental vulnerabilities whilst children are very young increases the risk of school disengagement, the exacerbation of complex health problems, health-risk behaviours and high rates of premature death.[555]

4.129 The AHC expresses concern that early detection of health and developmental issues among children in many Aboriginal communities is not occurring:

> Once a child is born, we know that early detection of developmental delay improves the chance for early intervention. However, many children in our population are not detected until later due to many factors. We have limited diagnostic and therapeutic services in remote areas. Comorbidities, such as ear disease leading to hearing loss, malnutrition and exposure to trauma contribute to [and] exacerbate developmental delay.[556]

FINDING 42

Service deficiencies in regional and remote areas contribute to inadequate provision of timely developmental support for Aboriginal children.

Quantifying need

4.130 Approximately 7% (2,133) of children on CAHS–CDS's active caseload identify as Aboriginal.[557] In regional and remote areas, this proportion increases significantly:

> During Quarter one 2022/23 the total of WACHS CDS referrals comprised approximately 20% of people who identify as Aboriginal. The Kimberley reported that 58% of their referrals were for Aboriginal children while the South West reported a 9% rate.[558]

4.131 It is difficult to know the extent to which these figures represent actual need for CDS among Aboriginal children. The AHC told the Committee there is likely significant unmet need:

> We also cannot quantify the unmet need. In many ways the reasons we cannot quantify the unmet need are representative of some of the problems. Children move in and out of different communities. We only pick up on these developmental issues if the parents generally bring the children in. For instance, at the moment our organisation specifically, we are without a child health nurse, so we do not have the resources at the moment to go out and actively look for children that we have not seen for a while.[559]

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555 Submission 72 from DYHS, 7 November 2022, p 2.

556 Dr C Sheppard, Senior Medical Officer, Puntukurnu Aboriginal Medical Service, [*transcript of evidence*], *Legislative Council,* 9 February 2023, p 7.

557 As at 19 September 2022: Submission 77 from WA Health, 9 November 2022, p 45.

558 Submission 77, p 65.

559 Dr C Sheppard, Senior Medical Officer, Puntukurnu Aboriginal Medical Service, [*transcript of evidence*], *Legislative Council,* 9 February 2023, p 8.

4.132 However, quantifying that need requires deep engagement across communities to identify children who need support. From the ACCHO perspective, Dr Caitlyn White from the AHC stated:

> I have spoken to clinicians and child health nurses from most of our regions recently and there is clear unmet need everywhere … part of that is hard to quantify because it requires a lot of engagement to identify the children who require help … so some of our allied health staff within some of our services have said if they had more staff and more funding, they would be able to go to more communities and engage. And the engagement takes time. So, they need to have a visible presence in those communities, so people build trust and then approach them, and they have found in the places that they have gone, they have got more and more referrals. But they have communities they do not have the resources to reach. They have said if they had the resource to go, they are sure there would be referrals there for children requiring services.[560]

FINDING 43

The amount of unmet need for child development services among Aboriginal children is difficult to estimate. Quantifying need requires investment to conduct the deep engagement necessary to identify children who require support.

Service deficiencies

4.133 The Committee received substantial evidence regarding issues that impact the equitable delivery of CDS for Aboriginal children. The examples provided below, while not exhaustive, indicate both general and specific service deficiencies. The Committee is particularly grateful to the ACCHOs that shared their experience and insights.

4.134 While services vary across Western Australia, certain service deficiencies are commonly reported by all ACCHOs including:

> inconsistent or inadequate access to paediatricians and allied health services, long wait times or poor referral pathways, and delayed diagnoses or no access to diagnostic services.[561]

4.135 The AHC submitted that its members report inadequate access to developmental paediatric assessments, including for foetal alcohol spectrum disorder (FASD), an area of particular concern.[562] The increasing need for FASD diagnoses is not being addressed given the shortage of appropriate specialists:

> One of the most concerning issues raised by several Member ACCHS [Aboriginal Community Controlled Health Services] was the increasing need for FASD assessments. Because the accurate diagnosis of FASD requires assessment by a range of clinicians, this presents a challenge in an environment of health workforce shortages and vast distances between ACCHS and specialist services. The gold standard entails the assessment and diagnosis being conducted by a specialist multi-disciplinary team, including a paediatrician or adolescent physician and psychologist with any combination of a speech pathologist, occupational therapist,

560 Dr C White, Public Health Medical Officer, AHC, [*transcript of evidence*], *Legislative Council,* 9 February 2023, p 8.

561 Submission 79 from AHC, 7 November 2022, p 4.

562 Submission 79, p 4.

social worker and physiotherapist. As such, access to screening and diagnostic services in rural and remote locations is often limited.[563]

4.136 A severe shortage of psychologists and psychiatrists in regional Western Australia not only affects the availability of mental health support services, but also impedes the assessment of conditions such as ASD and ADHD. For example, at a hearing in Derby the Committee heard the following evidence:

> **The CHAIR**: Have you got psychologists?
>
> **Dr FLEMING**: No; not a child psychologist.
>
> **The CHAIR**: So, no psychologists, no psychiatrists. Okay …how many of your referrals are covered by global developmental delay, autism and ADHD?
>
> **Dr FLEMING**: A huge amount. This is [a] big issue.
>
> **The CHAIR**: Most of which require either a psychometric report or a psychiatrist —
>
> **Dr FLEMING**: And we I will just say I was speaking to a colleague, she is having to pay $2 500 for her daughter who goes to the Derby District High School or school up here to get an IQ and cognitive assessment by a private psychologist in Perth because it is not available up here, which is a huge barrier … [564]

4.137 While the extent of undiagnosed developmental issues is unknown, backlogs in assessments are reported by individual ACCHOs:

> Due to a lack of initial assessments, ACCHS [Aboriginal Community Controlled Health Services] clinicians report that a large proportion of children are missing out on support services for undiagnosed developmental delays. A Pilbara-based ACCHS discussed a population of children in Newman and Jigalong who are "massively underserved". The lead clinician pointed to a backlog of children with undiagnosed behavioural and developmental issues, with more than 44 referrals currently on the books. In this particular area, children in need of assessment must travel to Port Hedland to access a WACHS child development paediatrician, which is a vast distance from some of the remote communities needing support.[565]

4.138 Inadequate allied health services are also commonly experienced. The AHC submitted that:

> Many of AHCWA's Member Services noted the lack of allied health services for children, long wait times for services that are available and a need for greater access to multi-disciplinary teams of child allied health professionals, preferably embedded in their ACCHS.[566]

4.139 Although Aboriginal medical services are well placed to provide culturally safe services that are better able to engage Aboriginal clients, they are not resourced to directly engage an allied health and specialist workforce:

> For me, it comes down to health equity issues, especially for very remote communities. We have got access obviously to a GP … and the nurses on the ground, but it takes much more than these two specialised groups to manage that comprehensive primary health care that we are talking about. The [Puntukurnu] AMS [Aboriginal Medical Service] has not been resourced to actually engage allied

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563 Submission 79, p 6.

564 Hon Dr Sally Talbot MLC, Chair; and Dr A Fleming, Senior Medical Officer, DAHS, [*transcript of evidence*], *Legislative Council,* 2 May 2023, p 13.

565 Submission 79 from AHC, 7 November 2022, pp 5-6.

566 Submission 79 from AHC, 7 November 2022, p 6.

> health and specialist services directly. Why should we be scrounging for money everywhere …[567]

4.140 In the metropolitan area, DYHS submitted that there are limited service options for Aboriginal children over the age of five years:

> Currently, children requiring allied health services and support are guided by State Government options, which are to refer Aboriginal children to the CDS Allied Health Team and the CDS Aboriginal Health Team. These teams are focused on the early intervention space 0 – 5 years and find it difficult to continue providing services to children over 5 years. There are also significant wait times to gain access to these services.[568]

4.141 This limitation is particularly consequential for Aboriginal children, who are more likely to be diagnosed late:

> There is a significant gap in care as Aboriginal children and their families can present late with health concerns and developmental concerns; and consequently, it is common for Aboriginal children to miss the opportunity of early intervention/s.[569]

4.142 Inadequate allied health services are particularly acute in areas of regional WA, with some remote communities having no visiting services at all:

> Many of AHCWA's members also noted that their communities do not have access to the full range of multidisciplinary child allied health services. Some services in very remote areas said that they did not have any visiting allied health services at all. When a child is falling behind during a critical developmental period, excessively long delays can have profound consequences and make it incredibly difficult for these children to catch up in their later years. For these kids, school is harder, socialising is harder and other health issues can be made worse.[570]

4.143 Speech pathology services are inadequate and long wait times for assessments are commonplace. Playgroup WA told the Committee that they had funded visits by speech pathologists:

> The children in our playgroup in Warburton, and that is the biggest community there, will not be seeing a speech pathology assessment anytime in the next three to six months. They are like extra forgotten … We have paid for private speechies to attend some of our groups … [571]

4.144 The DAHS also told the Committee that speech pathology services are severely limited and that some remote communities had no outreach services:

> But speech is definitely a tough speciality up here … but also the remotes are not getting access to the speech. There is no outreach.[572]

4.145 Chronic ear infections, experienced by many children in the Kimberley, has the potential to affect hearing, speech, and learning. However, the DAHS reports that many children with

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567 R Chibawe, Chief Executive Officer, Puntukurnu Aboriginal Medical Service, [*transcript of evidence*], *Legislative Council,* 9 February 2023, p 14.

568 Submission 72 from DYHS, 7 November 2022, p 3.

569 Submission 72 from DYHS, 7 November 2022, p 3.

570 K Gates, Executive Manager, Public Health and Continuous Quality Improvement, AHC, [*transcript of evidence*], *Legislative Council,* 9 February 2023, p 3.

571 D Zarb, Chief Executive Officer, Playgroup WA, [*transcript of evidence*], *Legislative Council,* 26 July 2023, p 6.

572 Dr A Fleming, Senior Medical Officer, DAHS, [*transcript of evidence*], *Legislative Council,* 2 May 2023, p 9.

developmental issues have not had a hearing assessment. They call for a better ear health system and improved communication between health professionals:

> A more coordinated broader and deeper ear health system is required with more ready access to audiometry services and ENT … There needs to be good communication between all health professionals who provide services in the Kimberley.[573]

4.146 Effective coordination and communication with non-government service providers can ensure that services are enhanced rather than duplicated in the regions. For example, Earbus provides screening and treatment services in several regions throughout the State, often in partnership with ACCHOs:

> Through the Earbus outreach program our dedicated clinical team visit over 100 locations in regional and remote WA treating thousands of Aboriginal and at-risk children. With a fleet of Earbuses our goal is to eradicate the impacts of hearing loss and Otitis media so that every young person can reach their full potential through listening and learning.[574]

4.147 ACCHOs and other contributors to the Inquiry explained that the CDS model is not suited to the needs of many Aboriginal families.

- The appointment system, usually involving long delays, is not suited to transient families:

> For us, as well, some of our families are quite transient … [if medication] needs to be reviewed or they have run out of a script, and there is no way we can get them straight into a paediatrician down here to try to get them back on their medication, so they end up not on medication. That has happened a couple of times.[575]

- Issues particular to Aboriginal families (such as frequent changes in telephone numbers and transience) increase the frequency of non-attendance at appointments:

> As an example, on Thursday, there are probably around 30 children that I have the current paeds list for. Every phone number I rang, rang out. I went into the child's chart and rang the next of kin and any number that was in there.[576]
>
> ▫▫▫
>
> When you think about these missed appointments … there is a lot of "did not attend". The average Kimberley or remote phone number will change. It could be every three weeks or so … people are in transit and they may go to another service … there are so many levels where that communication breaks down … It is so complex. It is very, very complex on so many levels.[577]

- Active, direct follow up by ACCHOs can provide the kind of support that some families need to keep appointments:

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573 Dr A Fleming, [*transcript of evidence*], p 12.

574 Earbus Foundation of Western Australia, *Welcome: Earbus Foundation of Western Australia*, accessed 19 March 2024. WACHS–CDS is also trialling a proposed new audiology care pathway: see paragraph 7.6 of this report.

575 J Ingrey, Maternal Child Health Coordinator, South West Aboriginal Medical Service, [*transcript of evidence*], *Legislative Council,* 3 April 2023, p 12.

576 F Austin, Child Health Nurse, DAHS, [*transcript of evidence*], *Legislative Council,* 2 May 2023, p 5.

577 C Maslin, Child Health Nurse, Kimberley Aboriginal Medical Services, [*transcript of evidence*], *Legislative Council,* 1 May 2023, p 8.

> I found that sometimes [the school] would hand names onto maybe the clinic or someone where we recognised that a young person may have needed some diagnosis or that. Several times, names we gave up for three or four-year-olds did not appear to be followed up. It could be a year later. Speaking with the parent, "No, nobody chasing up." I think the thing is we need to chase up the families, like we actually need to go to their houses.[578]

- However, there are not enough Aboriginal health workers:

> If we have an Aboriginal health worker with us who is from Derby and knows the community and knows where the families are—if they are not at this house, they could be at this house; if they are not there, they could be at Mowanjum this week as there is a funeral on or whatever—they know everything and they are just invaluable. Unfortunately, we are low on the ground with those sorts of people.[579]

4.148 Frequent turnover of staff can affect the continuity and success of programs:

> Also having programs run really great while the relationship is there, but with a change of staff, sometimes programs do lapse.[580]

4.149 Time limited funding of programs can also affect engagement with services:

> community trust is diminished when a service is only offered for a short period of time and then removed because funding has ceased. Families may not engage in these services when they become transitory, based on a funding model, rather than a community need model.[581]

Engagement with Aboriginal clients

4.150 According to the submission from WA Health, the number of Aboriginal clients discharged from CAHS–CDS without having attended a single appointment 'has reduced over time'.[582] The submission does not provide details of how many Aboriginal children were discharged in these circumstances or the extent to which numbers have been reduced. However, it is apparent the current situation remains unsatisfactory, with WA Health acknowledging the need for better engagement with Aboriginal families:

> Aboriginal clients are still more likely to never take up an offer of a [CAHS–]CDS service than non-Aboriginal clients and further work needs to be done to ensure services offered by the [CAHS–]CDS are culturally secure and meet the needs of the family.[583]

4.151 The DYHS, which operates in the Perth metropolitan area, submit that employing more Aboriginal liaison officers and health workers is essential:

> The process when clients are not able to be contacted needs to be improved by the CDS such as for the CDS to employ Aboriginal staff, do home visits with an Aboriginal Liaison Officer or if the family are not contactable via phone or post to

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578 T Ledesma, Community Welfare Officer, Bidyadanga Aboriginal Community (La Grange), [*transcript of evidence*], *Legislative Council,* 1 May 2023, pp 7-8.

579 F Austin, Child Health Nurse, DAHS, [*transcript of evidence*], *Legislative Council,* 2 May 2023, p 8.

580 F Fernandez, Community Capacity Building Officer, Bidyadanga Aboriginal Community (La Grange), [*transcript of evidence*], *Legislative Council,* 1 May 2023, p 7.

581 Submission 37 from CEWA, 24 October 2022, p 6.

582 Submission 77 from WA Health, 9 November 2022, p 45.

583 Submission 77, p 45.

> develop … more inclusive arrangements to collaborative and engage with families.[584]

4.152 WA Health provided evidence to the Committee that it has implemented a number of strategies that have improved the engagement of Aboriginal families with the service, with examples of programs and other initiatives outlined below.

Community Health Aboriginal Health Team

4.153 Aboriginal families in the Perth metropolitan area can choose to access child health services through mainstream services or, if a child is aged under five years, through the CAHS–Community Health Aboriginal Health Team. The team includes nurses, Aboriginal health workers and liaison officers, a medical officer and allied health staff.[585]

4.154 According to the submission from WA Health, a full developmental assessment can be provided to 'some' children 'to inform and allow quicker referral to NDIS-funded services'.[586] The Committee was not provided with specific information regarding the number of assessments conducted.

4.155 The Aboriginal Health Team may also provide 'brief transdisciplinary allied health interventions'. However, for children that require 'more specific or ongoing assessment and intervention', referral is made to CAHS–CDS.[587] As such, the Aboriginal Health Team is a provider of primary-level child development services.[588]

4.156 While the DYHS welcomes the additional support provided by the Aboriginal Health Team, they point out that the scope and capacity of this service to provide child development services is limited:

> The … Aboriginal Health Team have provided welcomed support through their 9 clinics across Perth. However, eligibly is up to 4 years 11 months. Children five years and over are ineligible to access support. The … Aboriginal health team have 1.0 Full time equivalent (FTE) Speech pathology position and 0.6 FTE [full-time equivalent] Occupational Therapy position. Their role is more transdisciplinary in order to support [CAHS-]CDS referrals and Service Plans for families and developmental support until families are picked up by [CAHS–]CDS and/or WANSLEA[[589]].[590]

Koorliny Moort

4.157 Koorliny Moort, located at PCH, is a care coordinator and navigator service for children with complex needs who require multiple appointments at the hospital.[591] The DAHS praised the coordinating role played by the service:

> Koorliny Moort at Perth Children's Hospital do a fantastic job in coordinating multiple appointments for children from the Kimberley with complex medical

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584 Submission 72 from DYHS, 7 November 2022, p 6.

585 CAHS, *Annual Report 2022-23*, 2023, accessed 18 February 2024, p 48.

586 Submission 77 from WA Health, 9 November 2022, p 24.

587 Submission 77, p 24.

588 Refer to Interim Report, pp 108-109, Appendix 2, to see what level of healthcare services are offered by each team within the CAHS–Community Health service area.

589 Wanslea Family Services is the NDIS's early childhood partner in the Perth metropolitan area and the Great Southern, inner Wheatbelt and South West regions: National Disability Insurance Agency, *Western Australia*, NDIS, 2024, accessed 1 March 2024.

590 Submission 72 from DYHS, 7 November 2022, p 3.

591 CAHS, Perth Children's Hospital, *Koorliny Moort*, accessed 15 February 2024.

> problems. They also act as a communication point letting ACCHOs and patients/families know about appointments.[592]

4.158 Koorliny Moort also operates paediatric clinics in the metropolitan area. Referral can be made to their paediatric service if the family has been unable to access a local general paediatrician or CDS in the metropolitan area.[593]

4.159 The DYHS noted the limitations of this service in relation to the provision of CDS:

> Koorliny Moort have identified their scope as a navigator service into the Child Development Service. KM will not assess referrals that are for children to see a Paediatrician unless there is proof that a CDS referral has also been submitted.[594]

Social worker outreach (Kimberley)

4.160 In the Kimberley, WACHS–CDS engages directly with families, and their social worker provides an outreach program for this purpose:

> a lot of that engagement work is work that we spend a lot of time doing, phoning families, going for a drive, going to their house to try to engage families. Our social worker spends a lot of time—we provide an outreach program for clients who we have not been able to engage. She will go out with an Aboriginal health assistant or another clinician to try to access those families and provide information—let them know about the service and see what their concerns are. There is a lot of time spent following up and trying to engage families in the process, liaising with schools and liaising with the referrers to try to access those families.[595]

Aboriginal health workers/practitioners

4.161 Temporary project funding was used to pilot an Aboriginal health worker role within CAHS-CDS to support the engagement of Aboriginal families at pilot sites. The pilot received positive reviews from staff, but additional funding is required to employ more Aboriginal health workers.[596]

4.162 WACHS–Kimberley told the Committee that the Aboriginal health practitioner role is still in development, but their intention is to employ a number of practitioners once they have completed their training:

> we are in discussions with KAMS [Kimberley Aboriginal Medical Service] as well about how we have jobs for these people once they complete their training. The intention is that once their training is completed WACHS will have positions created for them to go into.[597]

4.163 The AHC is also supportive and envisions expansion of the role to assist in early childhood development monitoring:

> One potential solution includes providing AHW/Ps [Aboriginal health workers/practitioners] with additional skills to support early childhood

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592 Tabled Paper 1, Email from Dr Susannah Warwick dated 1 May 2024, tabled during hearing held 2 May 2023, p 1.

593 CAHS, Perth Children's Hospital, *Koorliny Moort*, accessed 15 February 2024.

594 Submission 72 from DYHS, 7 November 2022, p 2.

595 S Wood, Senior Occupational Therapist, Child Development Service, Kimberley Population Health Unit, WACHS, [*transcript of evidence*], *Legislative Council,* 1 May 2023, p 8.

596 Submission 77 from WA Health, 9 November 2022, pp 45–46.

597 C Hart, Acting Director, Kimberley Population Health Unit, WACHS, [*transcript of evidence*], *Legislative Council,* 1 May 2023, p 8.

> development and further respond to the needs of children in their communities. In this way, every encounter a child has with the service is an opportunity to track that child's developmental progress. This would involve providing training to AHW/Ps to develop the necessary skills and capabilities to make and record developmental observations. While AHCWA has partnered with WACHS to deliver child health education in the past, there is need for additional investment and support to recommence this kind of training. AHW/Ps are integral to ACCHOs in light of their cultural understanding, clinical expertise, and their relationships with clients and community – for these reasons, they play an essential role in providing remote health services. Hence, AHW/Ps are perfectly placed to support the expansion of access to culturally safe child health and development services in remote locations.[598]

The Aboriginal Community Controlled Health Organisation model

4.164 ACCHOs are located throughout Western Australia and provide comprehensive, culturally secure primary healthcare services[599] through a holistic model of care.[600]

4.165 ACCHOs are well placed to provide initial primary care level developmental screening for Aboriginal children. Service provision does not rely solely on attendance at scheduled visits but can be done opportunistically when families attend for other reasons. This is an important advantage of the culturally safe environment provided by ACCHOs:

> Perhaps most importantly, children and their families feel safe in an environment where they have trusted and established relationships with the staff …[601]

4.166 ACCHO health teams maintain an active role in managing and coordinating services for a family. Child health nurses attached to ACCHOs actively engage families, with home visits not uncommon. Many ACCHOs also employ drivers to assist with transport and other arrangements to facilitate attendance at appointments. Health and development issues are discussed in a culturally safe way, with an interpreter or Aboriginal health worker present during the consultation if needed.[602]

4.167 The AHC explained that engagement activities by ACCHOs, while costing more than standard health services, have been shown to work:

> Our services are not really funded for that level of engagement, but we know that is what works, we know that is what is culturally safe and we know that is what is best for the children.[603]

Closing the Gap

4.168 The National Agreement on Closing the Gap, adopted by all Australian governments and Aboriginal peak bodies, took effect on 27 July 2020.[604]

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598 Submission 79 from AHC, 7 November 2022, p 4.

599 Refer to Interim Report, pp 16–17, for an explanation of the different levels of healthcare.

600 K Gates, Executive Manager, Public Health and Continuous Quality Improvement, AHC, [*transcript of evidence*], *Legislative Council,* 9 February 2023, pp 2–3.

601 Submission 79 from AHC, 7 November 2022, p 4.

602 Dr C White, Public Health Medical Officer, AHC, [*transcript of evidence*], *Legislative Council,* 9 February 2023, p 9.

603 Dr C White, [*transcript of evidence*], p 9.

604 National Agreement on Closing the Gap, *Formalities*, Closing the Gap, accessed 22 February 2024.

4.169 Target 4 of Closing the Gap is a commitment to:

> By 2031, increase the proportion of Aboriginal and Torres Strait Islander children assessed as developmentally on track in all five domains of the Australian Early Development Census (AEDC) to 55 per cent.[605]

4.170 The AHC told the Committee that, in addition to other measures, the strengthening of ACCHOs through increased investment and involvement in service delivery will be crucial to meeting this target:

> There are many things that need to happen for this target to be achieved, and we have a long way to go in WA. But whatever steps are taken, the priority reforms in the national agreement must shape WA government activity, particularly priority reform 1, which requires government to partner and share decision-making with Aboriginal people, and priority reform 2, which requires governments to grow and strengthen Aboriginal community–controlled sectors, including via additional investment.[606]

4.171 In committing to building the Aboriginal community-controlled sector to deliver services that meets the needs of Aboriginal people, priority reform two states that:

> The Parties acknowledge that Aboriginal and Torres Strait Islander community-controlled services are better for Aboriginal and Torres Strait Islander people, achieve better results, employ more Aboriginal and Torres Strait Islander people and are often preferred over mainstream services.[607]

Productivity Commission, *Review of the National Agreement on Closing the Gap*, 2024[608]

The Productivity Commission's first Review of the National Agreement on Closing the Gap found that governments are not adequately delivering on the commitment to overcome the entrenched inequality experienced by Aboriginal Australians:

> The Commission's overarching finding is that there has been no systematic approach to determining what strategies need to be implemented to disrupt business-as-usual of governments. What is needed is a paradigm shift. Fundamental change is required, with actions based on a clear logic about how they will achieve that change. (p 3)

In relation to priority reform two (building the community-controlled sector) the Review found that there has been *some* progress in building capability and funding of Aboriginal community controlled organisations (ACCOs). Although some transfer of services to ACCOs has occurred:

> efforts are slow (or ad hoc) and do not reflect the systemic changes that are necessary to transform service systems and improve outcomes. (p 50)

The Review found that ACCOs are not being supported to grow:

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605 National Agreement on Closing the Gap, *Closing the Gap targets and outcomes*, Closing the Gap, accessed 22 February 2024.

606 K Gates, Executive Manager, Public Health and Continuous Quality Improvement, AHC, [*transcript of evidence*], *Legislative Council,* 9 February 2023, p 4.

607 National Agreement on Closing the Gap, clause 43: Closing the Gap, Priority Reform Two – Building the Community-controlled Sector | Closing the Gap, accessed 22/2/24

608 Productivity Commission, *Review of the National Agreement on Closing the Gap*, Productivity Commission, Australian Government, 2024, accessed 28 February 2024.

> ACCOs have knowledges and expertise to lead service design and delivery, yet they are not sufficiently valued in decision-making.
>
> Making the most of ACCOs' knowledges, expertise and connections to community requires governments to adopt policy making and commissioning approaches that enable ACCOs to take the lead in the design and delivery of services that best suit their communities. To support this, governments need to treat ACCOs as essential partners, recognising that they have knowledge of their communities that is not paralleled by governments. (p 50)

Governments need to:

> move away from transactional forms of contracting of community services that focus on narrow problem solving, towards fostering a broader understanding of the wellbeing of Aboriginal and Torres Strait Islander people. This requires government agencies to work collaboratively with ACCOs and communities to identify community needs and priorities, design and deliver services, and enable communities themselves to define the outcomes against which a program or service should be measured. It also requires governments to ensure that ACCOs have a secure base to deliver services and programs through appropriate funding … (p 52)

How Aboriginal Community Controlled Health Organisations are leading the way

4.172 The Committee was impressed by evidence of tangible achievements by ACCHOs in improving engagement of Aboriginal clients with CDS.

4.173 Consistent with the holistic approach to health adopted by ACCHOs, the South West Aboriginal Medical Service provides a broad scope of assistance to their clients. Not only do they assist in arranging PATS transport, they provide financial assistance for dental care, glasses, medical aids and medicines, other transport, accommodation, funeral assistance, specialist clinics, investigations and therapies.[609]

4.174 The Kimberley Aboriginal Medical Service is the lead organisation of a consortium of 10 ACCHOs that partner with the National Disability Insurance Agency in providing the Remote Early Childhood Supports (RECS) program. The program provides short-term, intensive, multidisciplinary allied health support for families with children under the age of seven years who have a disability or developmental delay.[610] The services include:

> assessing children using culturally appropriate assessment tools; the employment of local family support workers to ensure that a regular, culturally safe program is delivered; and connecting families to appropriate services, supports and pathways.[611]

4.175 The Kimberley Aboriginal Medical Service explained that Aboriginal family support workers play a vital role in engaging families and providing ongoing support:

> The Aboriginal family support workers play an absolutely crucial role in the delivery of the RECS program as they are often the first point of contact for families and children. They are also members of the community. They can identify

[609] M Egan, Hypnobirthing Practitioner, South West Aboriginal Medical Service, [*transcript of evidence*], *Legislative Council,* 3 April 2023, pp 5–6.

[610] O Stenseke, Senior Manager, Kimberley Aboriginal Medical Services, [*transcript of evidence*], *Legislative Council*, 1 May 2023, p 2.

[611] O Stenseke, [*transcript of evidence*], p 2.

> children that live in the community who may have a developmental delay or disability and assist with that repeated engagement with the family to start the journey of early intervention therapies. They provide ongoing support to families, which allows for continuity of therapy services between visits from the allied health professionals. The RECS family support worker's roles also provide the opportunity to upskill an Aboriginal workforce living in remote communities and create career pathways into care work or allied health.[612]

4.176 The DYHS in Perth has developed their own paediatric model of care in response to barriers Aboriginal children experience in accessing child development services. Very high attendance rates at appointments demonstrates the success of the service in engaging Aboriginal clients. The model is GP-led and includes nurses and two paediatricians:

> Our GP and primary healthcare model ensures kids are getting holistic child health checks and ensures appropriate referrals are done to the right agencies. For the 100 children that we are case coordinating, we are providing a case management model that we know is working. Our attendance rate is over 90 per cent, which is quite remarkable considering we are working with the most disadvantaged, marginalised families, with many of them already known in the child protection system.[613]

4.177 The DYHS has a close working relationship with families, enabling it to engage well with the families:

> Derbarl's success with its own Paediatric attendance rates is due to a close working relationship with have with families and our ability to arrange appointments, facilitate referrals, and assisting to help families to understand their child. Our service also addresses transport and other barriers to access to services. We also work closely with families to ensure they understand their child's diagnosis and management plans in a culturally safe and respectful manner.[614]

4.178 Culturally secure, multidisciplinary services provided by ACCHOs, such as DYHS's paediatric service, help to address equity issues and Closing the Gap targets.

> It can provide great inroads to addressing the Closing the Gap targets in early childhood and the inequity of health disparity. … We know the significant waitlist faced by our children and families and we have a solution of scaling up our services with wraparound cultural responsiveness.[615]

4.179 However, DYHS does not have the resources to meet demand:

> Some families have expressed interest that they would prefer to have their referral changed from CAHS Koorliny Moort or Child Development Service into the Derbarl paediatric service. Regrettably, due to limited funding and a growing wait list for our Paediatricians, Derbarl is unable to accommodate these requests. We do our best when an appointment becomes available to respond to families that are not engaging with either of the CAHS Paediatric services (CDS or KM). If Derbarl was provided with adequate funding to expand into a comprehensive service, many families and children would receive integrated care.[616]

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612 O Stenseke, [*transcript of evidence*], p 3.

613 T Brand, Chief Executive Officer, DYHS, [*transcript of evidence], Legislative Council,* 9 February 2023, p 6.

614 Submission 72 from DYHS, 7 November 2022, p 6.

615 T Brand, Chief Executive Officer, DYHS, [*transcript of evidence], Legislative Council,* 9 February 2023, p 6.

616 Submission 72 from DYHS, 7 November 2022, p 7.

4.180 The potential of DYHS's paediatric model as a 'sustainable, funded, holistic and comprehensive developmental paediatric clinic'[617] is constrained by the lack of funding for allied health services:

> The State Government currently provide no investment into allied health services for children that access care at Derbarl. Derbarl do not have funded speech therapists, occupational therapists, developmental social workers or physiotherapists.[618]

4.181 The Committee reiterates Recommendation 21 (page 84) of this report.

What else could be done?

4.182 The Committee appreciates that an ever-increasing demand for services compounds the challenge of providing child development services in a jurisdiction as vast as Western Australia. The task is fraught with difficulty and solutions are not simple.

4.183 However, the Committee considers there to be strong and persuasive evidence to support a way forward for Aboriginal children. Consistent with Closing the Gap commitments, the ACCHO sector must be supported as a central and essential partner in the delivery of child development services in Western Australia:

> If Aboriginal people are to enjoy long and healthy lives – Outcome 1 of the National Agreement – the WA Government must work in partnership with the ACCHO sector to improve equitable access to child health services to support early childhood development. Optimal health and wellbeing outcomes for Aboriginal communities will only be achieved through Aboriginal community-led partnerships and locally based solutions. Community-specific circumstances and needs must determine the design and delivery of solutions.[619]

4.184 Evidence to the Committee shows that ACCHOs would welcome funding to provide allied health services. It would enable them to provide the comprehensive health and development service that Aboriginal communities are missing out on:

> **The CHAIR**: … So you are basically saying that the [Puntukurnu] AMS [Aboriginal Medical Service] could be funded to provide those allied health services as well?
>
> **Mr CHIBAWE**: It would make it easier for us, yes.
>
> **Dr WHITE**: We want to see the services available in those communities. We have many where there is no service.[620]

4.185 A funded, comprehensive and holistic paediatric service provided by ACCHOs was described as a 'dream model':

> We have a model of opportunistic medicine and of being quite comprehensive. If we ever had a model of holistic paediatric services to come into our space of primary health care, that would be like the dream model, and that is what we are trying to do at Derbarl Yerrigan … We have gone privately with our paediatricians

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617 T Brand, Chief Executive Officer, DYHS, [*transcript of evidence], Legislative Council,* 9 February 2023, p 6.

618 Submission 72 from DYHS, 7 November 2022, p 3.

619 Submission 79 from AHC, 7 November 2022, p 7.

620 Hon Dr Sally Talbot MLC, Chair; R Chibawe, Chief Executive Officer, Puntukurnu Aboriginal Medical Service and Dr C White, Public Health Medical Officer, AHC, [*transcript of evidence*], *Legislative Council,* 9 February 2023, p 14.

to come in to give us that level of care for our kids to do developmental assessments and so forth.[621]

4.186 The Committee reiterates Recommendation 21 on page 84 of this report.

[621] Dr K Isaacs, General Practitioner and Clinical Lead, Maternal and Child Health, DYHS, [*transcript of evidence*], *Legislative Council,* 9 February 2023, p 10.

CHAPTER 5
Access, engagement and equity – Child health nursing

Overview

5.1 Child health nurses are an important component of child development services. They contribute to the prevention and early identification of developmental issues, provide an avenue for engaging families early, and are a source of referral to CDS.

5.2 The universal child health check schedule consists of five child health assessments for all families, with additional services available if more assistance is needed. There is debate about the scheduling of universal child health checks with changes to the schedule in 2017 not supported by everyone.

5.3 There is very poor attendance at the two later child health checks, at 12 months and two years of age. This has implications for the child development system because developmental issues may not be identified early and intervention may be delayed.

Chapter summary

5.4 In this chapter, the Committee:

- outlines the concerns raised by contributors to the Inquiry about the 2017 changes to the universal schedule and the response from WA Health
- examines how WA Health is working to improve engagement with primary-level child health services and what else can be done.

Child health nursing within WA Health structure

5.5 In the metropolitan area, community health services (comprising child health, school health and immunisation services) are delivered by the Community Health Nursing team within CAHS–Community Health.

5.6 Although Community Health Nursing and CAHS–CDS are discrete teams within the Community Health service area, they are complementary. According to WA Health:

> Community Health nursing teams play an important role in providing parents, young people and teachers with information that promotes positive health and development and early identification of issues.[622]

5.7 In regional Western Australia, WACHS's Healthy Country Kids program includes three service streams, comprising child health, school health and child development services.[623]

The universal child health program

5.8 Child health services in Western Australia provide a schedule of free, universal (available to everyone) child health checks. These appointments play an important role in the prevention and early identification of child health or developmental issues:

> Universal appointments focus on eliciting and responding to parental concerns, the early identification of health and developmental concerns, supporting parenting and the promotion of positive parent-child relationships. The Universal

622 Submission 77 from WA Health, 9 November 2022, p 19.

623 WACHS, *Healthy Country Kids*, 2023, accessed 11 March 2024.

> level of service involves identifying protective and risk factors, undertaking observations and assessments, surveillance and screening, and care planning that may include additional appointments and/or referral to relevant services and programs.[624]

5.9 The universal child health check schedule (for metropolitan and regional families) consists of five health and developmental assessments at 0–14 days, eight weeks, four months, 12 months and two years.[625] Activities and advice during appointments include:

> physical assessment, nutrition, developmental surveillance, immunisation, universal and age-sensitive anticipatory guidance for caregivers, and maternal health and wellbeing.[626]

5.10 Universal appointments enable a child health nurse to assess whether a child is developing normally. If developmental concerns are identified, the child health nurse can arrange for:

- additional consultations
- follow-up and further assessment or activities
- referral to secondary and/or tertiary services.[627]

5.11 There is an additional (sixth) universal child health check, known as the School Entry Health Assessment,[628] and it is performed by school health nurses.[629]

Universal Plus and Partnership services

5.12 Additional child health services, classified as Universal Plus and Partnership services, are available for regional and metropolitan families requiring additional assistance. The services provided under each level of the progressive universalism model adopted by CAHS and WACHS is described as:

> Universal services which are offered to all children and families; Universal Plus services which are offered to those requiring assistance with an identified child health or development issue or a parenting issue impacting on the child, and; Partnership services which are offered to children and their families with complex health and developmental needs requiring intensive support.[630]

5.13 In the metropolitan area, Universal Plus contacts are provided by CAHS to address specific issues or concerns that require a brief intervention. Once the issue is managed or resolved, the client returns to the Universal level of service.[631]

5.14 The Partnership level of service is provided when more complex issues are identified:

> The Partnership level of service is for clients who require help to manage or resolve increasingly complex physical, developmental, psychosocial, behaviours and health concerns, which may be complicated by socioeconomic, social and

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624 Submission 77 from WA Health, 9 November 2022, p 19.

625 CAHS, *Child Health appointments*, accessed 12 February 2024 and WACHS, *Child health services*, accessed 12 February 2024.

626 Submission 53 from MCFHNA, 24 October 2022, p 4.

627 Submission 53, p 4.

628 Tabled Paper 1 tabled by WA Health during hearing held 26 April 2023, p 4.

629 CAHS, *Primary school health*, CAHS, 2023, accessed 29 February 2024; and WACHS, *School health services*, WACHS, 2024, accessed 29 February 2024.

630 WACHS, *Enhanced Child Health Schedule Guideline*, WACHS, 2021, accessed 30 January 2024, p 2.

631 CAHS–Community Health, Clinical Nursing Manual, *Procedure: Universal Plus – child health*, CAHS, 2023, accessed 30 January 2024, p 1.

> environmental factors. In addition, there is a level of risk for children, if these concerns are not addressed.[632]

5.15 In regional Western Australia, WACHS's Enhanced Child Health Schedule (ECHS) provides Universal Plus and/or Partnership levels of service. The ECHS includes the six universal child health checks as well as 10 additional contacts to provide extra support and monitoring.[633]

5.16 Vulnerable populations who may require further assistance include:

> Aboriginal families, refugee families, children of teenage parents, children of parents with mental illness, children of parents affected by drugs and alcohol, or children with disabilities.[634]

Relevance to child development services

5.17 The child health service contributes to the child development system in three main ways:

- prevention and early identification of developmental issues
- early engagement and relationship building with families
- referral to CDS providers.

Prevention and early identification

5.18 Information and advice to parents by child health nurses support healthy child development and can help to prevent the occurrence of developmental issues.[635] The assessment, surveillance and screening activities conducted during appointments are an important, early opportunity for the identification of developmental issues.[636]

5.19 The integral place of child health nursing within the child development system is recognised by the TKI:

> The value of Child Health Nurses, and the associated "Purple Book", is an important component of the WA CDS system, with a visit to the local child health nurse the main (and often only) way for parents to seek information about whether their child is growing and developing as they should. It is also one of the ways in early risk factors can be identified and followed up on.[637]

Early engagement and relationship building

5.20 MCFHNA submitted that a positive therapeutic relationship is known to be one of the best predictors of outcomes[638] and that child health nurses provide 'a platform to build a partnership between the family and the health professional'.[639]

5.21 Dr Elizabeth Green, a recently retired paediatrician, emphasised the pivotal role of child health nurses as a community-based support and first responder for families:

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632 CAHS–Community Health, Clinical Nursing Manual, *Procedure: Universal Plus – child health*, CAHS, 2023, accessed 30 January 2024, p 2.

633 WACHS, *Enhanced Child Health Schedule Guideline*, WACHS, 2021 accessed 30 January 2024, p 2.

634 WACHS, *Enhanced Child Health Schedule Guideline*, p 2.

635 Submission 77 from WA Health, 9 November 2022, p 21.

636 Submission 77, p 19.

637 Submission 85 from TKI, 18 November 2022, p 4.

638 Submission 53 from MCFHNA, 24 October 2022, p 4.

639 Submission 53, p 3.

> There has got to be more connection with community, but before that can happen, I think we have all got to get back to basics because we have sort of forgotten about mums having babies in hospital coming out and needing support. The first responders and first contact has to be the child health nurse. I think, if nothing else from this inquiry, if we can get money, funding and resources … [to get] those trained people who know children and have got adequate training.[640]

5.22 The role of the child health service in early engagement and therapeutic relationship building with families is recognised by CAHS:

> what is important, and the evidence supports, is that early engagement with families, that good relationship with families where they can contact a universal service if they are concerned about anything, and the importance of health literacy.[641]

5.23 MCFHNA agree, submitting that there needs to be sufficient key contact visits (especially in the first year) to foster and embed a positive relationship with the caregiver. However:

> Many child health nurses consider the number of [current] scheduled visits to be too few.[642]

5.24 Changes to the universal schedule in 2017 and debate surrounding the optimal number and timing of visits are discussed in paragraphs 5.26–5.41.

Source of referrals to secondary and tertiary-level child development services

5.25 Complementary to their assessment and screening activities, child health nurses may refer a child to one of the CDS providers or other health services.[643] Their expertise in making early and appropriate referrals is a fundamental part of the child development system. Dr Elizabeth Green said:

> it is about focusing on child health nurses and midwives, initially, for them to see, sort and select the kids who need referral to the existing hubs and silos and areas of expertise that we have.[644]

Changes to the universal schedule

5.26 Following a review of the universal child health check schedule in 2015, the number of universal checks conducted by child health nurses was reduced in 2017, from six to five checks.[645] The universal schedule pre- and post-July 2017 is contained in Table 3 on page 153.

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640 Dr E Green, Paediatrician, Southern Paediatrics, [*transcript of evidence*], *Legislative Council,* 17 February 2023, p 4.

641 A McHugh, Acting Nurse Co-Director, Community Health, CAHS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 12.

642 Submission 53 from MCFHNA, 24 October 2022, p 4.

643 The number and source of referrals to CAHS–CDS and WACHS–CDS is provided in Tables 2 and 3 of the Interim Report, pp 23 and 30.

644 Dr E Green, Paediatrician, Southern Paediatrics, [*transcript of evidence*], *Legislative Council,* 17 February 2023, p 3.

645 An additional (sixth) universal School Entry Health Assessment, performed by school health nurses, is applicable to the pre- and post-July 2017 schedules: Tabled Paper 1 tabled by WA Health during hearing held 26 April 2023, p 4.

Table 3. *Western Australian universal child health check schedule*

Universal child health check schedule	
Pre-July 2017	Post July 2017
0–14 days	0–14 days
6–8 weeks	8 weeks
3–4 months	4 months
8 months	12 months (until 18 months)[646]
18 months	2 years (until the child turns 3)[647]
3–3 ½ years	–

[Source: Tabled Paper 1 tabled by WA Health during hearing held 26 April 2023, p 4.]

5.27 CAHS provided the following reasons for the change to the schedule:

- the new schedule was designed to better fit with important ages and stages of children's growth and learning
- capacity was created to provide extra support when needed, in addition to the universal checks.[648]

5.28 The basis for the change from an eight-month check to a 12-month check was because:

- by 12 months of age, there is rapid development of motor, language, and cognitive skills and many developmental problems can be detected through behavioural assessment and surveillance at this age.
- infants are due for immunisations at 12 months of age.[649]

5.29 The change from the 18-month check to the two-year-old check occurred because:

- it would enable assessment and early intervention before the child starts school
- a number of developmental delays or problems can be identified at this age
- toilet training can be supported at this time.[650]

5.30 CAHS explained that changes to the schedule reflect a focus on progressive universalism which entails providing additional help for vulnerable families. As a result, child health checks are paired with the immunisation schedule so that families can also be reminded that vaccinations are due.[651]

5.31 In response to criticism about the 2017 changes, CAHS maintains that the precise scheduling of universal child health checks is debateable:

> I would say there is no common agreement in Australia or internationally with the number and the spacing of checks …[652]

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646 CAHS, *Child health appointments*, CAHS, 2023, accessed 29 February 2024.

647 CAHS, *Child health appointments*.

648 Tabled Paper 1 tabled by WA Health, during hearing held 26 April 2023, p 4.

649 Tabled Paper 1, hearing held 26 April 2023, p 4.

650 Tabled Paper 1, hearing held 26 April 2023, p 4.

651 A McHugh, Acting Nurse Co-Director, Community Health, and S Kiely, Executive Director, Community Health, CAHS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 15.

652 A McHugh, [*transcript of evidence*], p 12.

5.32 MCFHNA acknowledges that the number and content of child and family health checks are not standardised throughout Australia. However, it points out that there has been no formal evaluation of the 2017 changes to the schedule:

> At a state level, the WA service model has not been evaluated since significant changes to the screening schedule were made in 2017.[653]

5.33 Dr Yvonne Anderson, a paediatrician working across Curtin University, the TKI and CAHS, agrees that there is 'no wonderful evidence that states the right "dose effect"' but considers that 'there is merit in looking at some of the international reviews and responses in terms of the timing of the checks'.[654]

Removal of eight–month check in favour of a 12-month check

5.34 Not all health practitioners support the removal of the eight-month check in favour of an assessment at 12-months of age.

5.35 Dr Yvonne Anderson told the Committee that she has:

> heard loud and clear from many colleagues their angst and anguish about not having that eight to nine–month check.[655]

5.36 A joint submission from the peak bodies for occupational therapists emphasised the importance of assessment at eight to nine months for the early identification of developmental issues:

> Child health nurse developmental reviews play an essential role in early identification and are particularly crucial around the 8–9-month mark where nurses can identify (among other things) delayed motor or language skills, difficulties in vision or hearing and early signs of neurodevelopmental conditions.[656]

5.37 Professor Andrew Whitehouse from TKI made two points regarding removal of the eight-month check:

- In terms of attendance, he surmised that at eight months:

  > there is often a primary carer at home still and so there is a lot of easy access; whereas, at 12 months it really reduced a lot.

- In relation to early identification and intervention for autism, he told the Committee that the 'eight-month check was absolutely critical'.[657]

5.38 Dr Elizabeth Green also emphasised the importance of the eight-month check:

> The other thing that is a problem is the eight-month check for babies, which is the most important check—I cannot stress this enough. If anything else, please bring back the eight-month check for child health nurses and babies.[658]

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653 Submission 53 from MCFHNA, 24 October 2022, p 3.

654 Dr Y Anderson, Associate Professor, Community Child Health, Curtin University, [*transcript of evidence*], *Legislative Council,* 12 May 2023, p 15.

655 Dr Y Anderson, [*transcript of evidence*], p 15.

656 Submission 80 from OT Associations, 14 November 2022, p 1.

657 Prof A Whitehouse, Bennett Professor of Autism Research, TKI, [*transcript of evidence*], *Legislative Council*, 9 February 2023, p 5.

658 Dr E Green, Paediatrician, Southern Paediatrics, [*transcript of evidence*], *Legislative Council,* 17 February 2023, p 5.

Removal of the three-year-old check

5.39 It was drawn to the Committee's attention that the removal of the three-year-old assessment creates a considerable gap between the last scheduled appointment (at two years of age) and commencement of kindergarten (at around four years of age).

5.40 Given poor attendance rates for the 12-month and two-year-old checks, particularly in the Perth metropolitan area (discussed at paragraphs 5.42–5.55 below), this deficiency has significant implications, according to MCFHNA:

> I think, generally, if we know that only 30 per cent of children get their two-year-old health checks, that means 70 per cent are not. There are just no eyes on these children if there are concerns. That is number one, and I think that is really significant.[659]

5.41 The Community Kindergartens Association told the Committee that some developmental issues may not be identified until a child starts kindergarten.[660] This means that referral to a CDS provider may not occur before a child starts kindergarten or school:

> for developmental reasons, this check is critical as it is an opportunity for parents and carers to discuss concerns with the Child Health Nurse, and grant permission for a CDS referral to be made. With the removal of this crucial appointment, children are now less likely to receive intervention and assistance before entering kindergarten.[661]

FINDING 44

There is no consensus among health professionals regarding the most effective scheduling of appointments within the universal child health check schedule.

RECOMMENDATION 35

The Child and Adolescent Health Service and WA Country Health Service expedite a review to evaluate the efficacy of the current schedule of appointments within the universal child health check schedule.

Poor attendance at later checks (12 months and two years)

5.42 In its submission, WA Health identifies low attendance at later child health checks as one of the challenges facing the CAHS–CDS:

> 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.[662]

5.43 Table 4 (page 156) shows a significant decline in attendance for the 12-month and two-year checks in the metropolitan area.

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659 S Dowden, Paediatric Nurse Practitioner/Director, NursePrac Australia/Just Kids Health Clinic, [*transcript of evidence*], *Legislative Council,* 20 February 2023, p 12.

660 J Matthewson, Community Kindergartens Association, [*transcript of evidence*], *Legislative Council,* 4 April 2023, p 2.

661 Submission 62 from Community Kindergartens Association WA, 26 October 2022, p 1.

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

Table 4. *Child and Adolescent Health Service universal contact completion rates*

	0 – 14 days		8 weeks		4 months		12 months		2 years	
Financial year	Number	% of eligible children	Number	% of eligible children	Number	% of eligible children	Number	% of eligible children	Number	% of eligible children
2017-18	26,390	96%	23,195	86%	21,393	79%	11,429	41%	6,686	24%
2018-19	25,611	98%	22,568	87%	21,383	82%	11,608	43%	7,703	28%
2019-20	25,435	99%	22,822	88%	21,623	82%	11,629	44%	7,649	29%
2020-21	25,920	99%	22,932	87%	21,185	83%	11,605	45%	8,586	33%
2021-22	25,894	98%	23,784	90%	22,879	85%	11,516	43%	8,434	32%

[Source: Tabled Paper 1 tabled by WA Health, during hearing held 26 April 2023, p 5.]

FINDING 45

During 2021-22, only 43% of eligible children in the metropolitan area received their scheduled child health check at 12 months of age and only 32% of eligible children received their scheduled child health check at two years of age.

5.44 There is better attendance at these later checks in regional Western Australia (particularly the 12-month check), but there is a significant decline in attendance at the two-year check (Table 5 on page 157). Interestingly, there is lower attendance at earlier checks in the regions compared to the metropolitan area. With respect to these variations between CAHS and WACHS, the Committee was provided with the following information:

> In relation to the first three universal children health contacts and the slightly lower attendance rates compared to the metropolitan area, we offer the following explanation:
>
> - A proportion of WACHS families deliver their babies in Perth and may stay in Perth for some weeks due to medical needs or to access family support.
> - A proportion of Aboriginal families access child health services from Aboriginal Community Controlled Health Services (ACCHS), of which there are many in country WA. Some of these ACCHS are contracted by WACHS to provide child health services however the different data systems used makes integrated reporting of contacts problematic.
> - Models of midwifery and obstetric services in some regions deliver health care for some families in the early months of their child's life. These alternative services impact the uptake of first contacts with child health services.
> - In general, there is little integration of data and reporting across the various agencies that provide health services to families with babies and young children, leading to a lack of comprehensive reporting.
>
> In relation to the 12 month and 2-year contacts, WACHS has actively sought to increase uptake of these checks by;
>
> - Sending reminders to families if they are overdue for these contacts.
> - Offering these contacts in a flexible manner including alternative locations to suit family circumstances.

- Offering families in specific locations a Virtual Child Health Nurse service[663] to complete the 12 month and 2-year contacts.[664]

Table 5. *WA Country Health Service universal contact completion rates*

	0 – 14 days		8 weeks		4 months		12 months		2 years	
Financial year	Number	% of eligible children	Number	% of eligible children	Number	% of eligible children	Number	% of eligible children	Number	% of eligible children
2018-19	5,648	89%	3,452	56%	3,392	55%	4,246	65%	3,115	45%
2019-20	5,248	85%	4,916	78%	4,860	77%	4,121	64%	2,920	44%
2020-21	5,132	82%	4,941	80%	4,730	78%	3,901	64%	2,848	44%
2021-22	5,127	78%	4,941	75%	4,779	72%	3,979	64%	2,636	42%

[Source: Tabled Paper 1 tabled by WA Health, during hearing held 26 April 2023, pp 7–8]

FINDING 46

During 2021-22, 64% of eligible children in regional Western Australia received their scheduled child health check at 12 months of age and 42% of eligible children received their scheduled child health check at two years of age.

5.45 Both CAHS and WACHS have an internal benchmark of 75% attendance of eligible children for the 12-month and two-year child health checks. They concede that the benchmark is difficult to achieve:

> **The CHAIR:** If I can just summarise where I think I did hear agreement was that we should be looking at around 50 per cent as a bare minimum for those older universal checks. We would like to aim for 50. Did I hear you say that, Ms Kiely?
>
> **Ms KIELY:** … I think we have across the two, WACHS and CAHS have an internal benchmark that we have set internally. I think our benchmark is 75. But with the work that we did at Midland, we saw that 70 was really probably worth throwing everything at; it was probably where we were going to get in some areas, so we think that somewhere in there is the benchmark. Officially we are 75 per cent. That is what we are going to hold ourselves to and that is what we report on internally. However, I think anything above 50 is starting to get to a good number.[665]

FINDING 47

Attendance at later child health checks (at 12 months and two years of age) in the metropolitan area and in regional Western Australia are below the internal benchmark of 75% adopted by the Child and Adolescent Health Service and WA Country Health Service.

663 This trial service is discussed in paragraph 4.119 of this report.

664 Letter from J Moffet, Chief Executive, WACHS, 3 April 2024, pp 1–2.

665 Hon Dr Sally Talbot MLC, Chair; and S Kiely, Executive Director, Community Health, CAHS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, pp 17–18.

Response from Child and Adolescent Health Service

5.46 In response to the Committee's questions about poor attendance at later child health appointments, CAHS emphasised that, in addition to group activities at child health clinics, extra appointments are an option if a parent has concerns:

> I would also say that we still continue to see a large amount of families in that period [four to 12 months] for universal-plus appointments. What we would term as universal-plus appointments are families that might be worried about something. That could be from development to growth. It could be anything really that the parent is worried about. In that time period, it is not as though families are not being seen.[666]

5.47 Given the lack of conclusive evidence about the best timing for appointments, CAHS maintains that a flexible system that enables additional appointments is the best approach:

> In relation to timing, there also is no clear evidence at the moment around should you see children at four months, six months, eight months, seven months—there is none. What there is clearly is the need for a universal service where parents can [also] phone and come in if they are concerned.[667]

5.48 The Committee agrees that flexibility in the schedule and capacity for additional contacts is essential. However, implicit in the above statement by CAHS – made in the context of changes to the universal program – seems to be an assumption that parents will recognise developmental issues that will require intervention. As the TKI explained, this is not always the case:

> a visit to the local child health nurse [is] the main (and often only) way for parents to seek information about whether their child is growing and developing as they should.[668]

5.49 The Committee is not convinced that reliance on parent-initiated appointments (additional to the universal schedule) is an adequate way to identify developmental issues. Combined with a reduced universal schedule and poor attendance at later appointments, there is a risk that the pivotal role of child health nurses within the child development system will be diminished.

Why is attendance dropping?

5.50 CAHS told the Committee that they are not sure why attendance has dropped for later child health checks.[669] Parents may be sourcing information elsewhere (including the internet) and the limited online capacity of the Purple Book and appointments may be factors:

> Can I make just one comment, and that is that we do not really know the reason for that. It has been six years since that change [to the universal child health check schedule] was made and society also has moved to different avenues of accessing information and engagement. Clearly, we think it is important that child health nurses are pivotal in playing a role in supporting families with their questions about their child's normal development, play, engagement, language—all of those things. A strong, robust nursing workforce is extremely important in that. But

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666 A McHugh, Acting Nurse Co-Director, Community Health, CAHS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 17.

667 A McHugh, [*transcript of evidence*], p 17.

668 Submission 85 from TKI, 18 November 2022, p 4.

669 Dr B Jongeling, Medical Head of Department, Child Development Service, CAHS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 17.

> parents do access information differently. Even within our own service, our online platform is pretty limited. We are not able to get out and provide that information in ways that we would like to. We are not able to do online booking systems. We have a purple book which captures children's development and reminds families about things, which is to prompt them, but it is not electronic. It does not link to say, "Would you like to make an appointment with your child health nurse? Here is something you can phone or here is an appointment that you could potentially make."[670]

5.51 CAHS is cognisant of at least two other potential factors affecting attendance. As suggested by Professor Whitehouse regarding removal of the eight-month check, many parents have returned to work by the time a child is 12 months of age and, therefore, attending appointments becomes more difficult (see paragraph 5.37). Moreover, if parents have not recognised a developmental delay or other health issue, attending a child health check may be considered unnecessary:

> We probably do not know the total answer of why families do not all come for every single check. Usually, parents have gone back to work by the time their children are one and two and that might be a factor. It might be a factor that families do not actually recognise delay or do not recognise it as an issue at all, or else they recognise that, actually, their child is fine and they do not see the need to come for a child health check. We do not really know.[671]

FINDING 48

There are multiple factors that may result in poorer attendance at later child health checks (at 12 months and two years of age) compared to earlier checks.

RECOMMENDATION 36

As part of the review referred to in Recommendation 35 of this report, WA Health investigate the reasons for poor attendance at later child health checks to inform possible remedial action by the Child and Adolescent Health Service and WA Country Health Service to improve attendance rates.

5.52 The 2015 Edmond review (which informed the 2017 changes to the universal child health check schedule) explained that the scheduling of child health checks is based on several principles, including 'alignment to immunisation schedules to encourage participation in both programs'.[672]

5.53 The Committee also notes that the Edmond review recommended that improved communication and integration should be explored:

> It is recommended that communication and integration should be improved and that this issue should be explored as a subproject. Important issues include: the use of the WA Child and Parent Centres for co-location;[673] the use of 'place based' models such as the Challis model[674] … facilitating links between families

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670 Dr B Jongeling, [*transcript of evidence*], p 17.

671 A McHugh, Acting Nurse Co-Director, Community Health, CAHS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, pp 14–15.

672 K M Edmond, *The Western Australian Metropolitan Birth to School Entry Universal Health Service Delivery Model. Review of evidence with recommendations for an improved service delivery model,* DOH, 2015, p 47.

673 This is discussed at paragraphs 3.113–3.139 of this report.

674 This is discussed at paragraphs 3.74–3.79 of this report.

> and local primary care providers soon after birth (including ensuring the local primary care provider has a copy of the hospital birth discharge summary); offering assistance and educational resources to local community services; holding regular information days;[675] bringing local primary care teams together to meet and greet; liaising with early childhood education services to hold integrated review visits at the time of the 2-3 year universal review visit; community health nurses offering to introduce families to local general practices and early child hood education services; **developing methods to integrate immunisation contacts with universal child health contacts**; encouraging general practitioners and ACCHS to ask families at the time of immunisation if the families have any other child health concerns and to refer back to the community health nurse if there are any concerns.[676] (emphasis added)

5.54 The Committee notes that, since the 2017 change to the universal child health check schedule, there is a closer link between child health checks and the childhood immunisation schedule, particularly at 12 months of age. However, CAHS advised that child health nurses do not necessarily have the facilities required to provide vaccinations:

> **Ms KIELY**: We have lots of child health clinics that are very small, single-room clinics with just one clinician—no admin support; one person there—and we are not set up to deliver vaccinations. When you have got appointments coming in one after the other, to manage the entire vaccination process and provide some oversight as the family sits there afterwards we are just not able to do it. However, wherever we have services where there are multiple clinicians or there is an admin person sitting there, we are seeking to expand our immunisation service.
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> …
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> **Ms McHUGH**: … there is a list of immunisation centres. Just leading on from what Sue has said as well, when a family comes for a child health assessment, they have come for a child health assessment. We would not then say, "Let's immunise your child right now and you can go next door", for example. Or, "This is when it's actually happening." When parents come for a child health assessment, that is quite in-depth often. We then make sure we say to families that this is where it is happening. We vaccinate in community centres. There are a range of centres where we are co-located. But in terms of the set-up of immunisation in relation to cold chain storage and so forth, they would be specific. Not every child health centre could function as an immunisation centre, but we do have a list that we could provide.[677]

5.55 The Committee believes there is merit in integrating child health checks and childhood immunisations. Two obvious methods of achieving this outcome would be:

- enabling child health nurses to provide vaccinations under the WA Immunisation Schedule as part of the corresponding child health check where there are appropriate facilities and staffing
- placing immunisation clinics and child health clinics in the same location wherever possible.

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675 This is discussed at paragraphs 3.33–3.39 of this report.

676 K M Edmond, *The Western Australian Metropolitan Birth to School Entry Universal Health Service Delivery Model. Review of evidence with recommendations for an improved service delivery model,* DOH, 2015, p 73.

677 S Kiely, Executive Director, Community Health, CAHS, and A McHugh, Acting Nurse Co-Director, Community Health, CAHS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 16.

RECOMMENDATION 37

Child health nurses provide vaccinations under the WA Immunisation Schedule as part of the corresponding child health check where there are appropriate facilities and staffing.

RECOMMENDATION 38

The Child and Adolescent Health Service and WA Country Health Service co-locate their immunisation clinics with their child health clinics wherever possible.

Flexible service options

5.56 Flexible service options that make child health services accessible to families are crucial to enable a timely response to changes in a child or family's level of need.[678] The extent to which services are easily accessible for parents, including working parents, may also affect attendance rates at later child health checks.

Evidence from WA Health

5.57 WA Health submitted that flexible service options are available for families and include telephone appointments, drop-in sessions, and group programs:

> Flexible service delivery formats are offered to clients to increase accessibility, including home visits and clinic appointments. Drop-in sessions … and telephone calls provide opportunities for brief consultations to address concerns raised by families. In addition, early parenting education group programs are offered to all families.[679]

5.58 For universal child health checks, home visits are usually limited to the first child health check (0–14 days).[680] Home visits are more commonly utilised for Universal Plus/Partnership level services. This is reflected in the figures presented in Table 6. CAHS advised that:

> While clinic-based appointments provide the most efficient service delivery model [for child health checks], thus making more appointments available to families, home visits can be provided where either the clinician or the family identify that this best meets the needs of the family.[681]

Table 6. *Home visits by Child and Adolescent Health Service child health nurses in 2022 and 2023*

Contact type	Number of contacts in 2022			Number of contacts in 2023		
	Home visits (no.)	Home visits (%)	Total contacts (no.)	Home visits (no.)	Home visits (%)	Total contacts (no.)
Universal check 0–14 days	14,497	58.1	24,938	18,740	78.9	23,764

678 Submission 53 from MCFHNA, 24 October 2022, p 4.

679 Submission 77 from WA Health, 9 November 2022, p 21.

680 For example, the WACHS website advises that a 'child health nurse will be in contact with you shortly after your baby is born to organise your first appointment. This appointment will probably be at your home before your baby is 14 days old': WACHS, *Child health services*, WACHS, 2024, accessed 29 February 2024.

681 Letter from V Jovanovic, Chief Executive, CAHS, 27 March 2024, p 1.

Contact type	Number of contacts in 2022			Number of contacts in 2023		
	Home visits (no.)	Home visits (%)	Total contacts (no.)	Home visits (no.)	Home visits (%)	Total contacts (no.)
Universal check 8 weeks	363	1.6	22,817	411	1.9	21,411
Universal check 4 months	218	1.0	21,726	251	1.2	20,406
Universal check 12 months	118	1.1	11,218	132	1.2	11,257
Universal check 2 years	96	1.3	7,211	111	1.4	7,714
Universal Plus checks*	12,635	20.6	61,346	7,956	21.4	37,112
Partnership checks	2,404	83.0	2,896	2,707	82.4	3,285

Data notes:

Universal and Universal Plus contacts include those provided by Child Health Nursing team, Aboriginal Health Team and Refugee Health Team

Partnership contacts include Partnership and Universal contacts provided by the Partnership Service

*Universal Plus contact numbers in 2022 are inflated due to the split appointment process used in response to COVID-19

[Source: Letter from V Jovanovic, Chief Executive, CAHS, 27 March 2024, pp 1–2.]

Universal Plus and Partnership level services

5.59 Evidence to the Committee indicates that more flexibility is built into services provided at the Universal Plus and Partnership level. For example, WA Health's submission advises that additional supports are available for vulnerable clients 'where risk factors for poor health and development are identified.'[682]

5.60 The Committee also notes that CAHS's guideline for Universal Plus services specifically provides for flexible service delivery options:

> UP appointments can be offered as centre contacts, home visits or via phone call consultation as appropriate.[683]

5.61 WACHS's guideline for its ECHS similarly identifies a need for flexible service delivery at this level of service:

> The ECHS is to be delivered with flexibility to support client needs. Contacts may be conducted over one or more sessions, may be delivered by members of a multidisciplinary team, and in settings which are most suitable for the family.[684]

5.62 The Committee does not have evidence to ascertain the degree to which flexible service delivery options are available for Universal Plus and Partnership level services. However, as

682 Submission 77 from WA Health, 9 November 2022, p 19.

683 CAHS–Community Health, Clinical Nursing Manual, *Procedure: Universal Plus – child health*, CAHS, accessed 30 January 2024, p 4,.

684 WACHS, *Enhanced Child Health Schedule Guideline*, WACHS, 2021, accessed 30 January 2024, p 3.

outlined below, some contributors to the inquiry expressed concern about decreasing accessibility and community engagement by the child health service.

Views expressed by other contributors

5.63 According to Dr Elizabeth Green, difficulties obtaining an appointment locally can lead to increasing gaps in child health assessments for some families:

> Even simple things like the cost of fuel if they have to go out of the area … If the child health nurse who is local has not got an appointment because they are booked … They are very restricted in what appointments they can have. If you miss one appointment, there is a big jump from four months to suddenly 12 and 18 months, because you do not have that eight-month check.[685]

5.64 Another paediatrician, in private evidence, expressed the view that child health nurses are less accessible and less engaged with the community than previously:

> So I think the child health nurses are not valued like they used to be, and they are not in the community, and there probably are not enough of them now, and they have very restrictive hours.[686]

5.65 The same paediatrician suggests that systemic barriers engender and reinforce a lack of community connectivity:

> What has happened is that the child health nurses were so valuable before. They were well educated; they were dedicated; they would do home visiting; and they really knew the children in their community. I do not think that is happening now. There are lots of barriers to set appointments; they see them only at certain times. I presume that connection is not there. So we do find that a lot of people withdraw. They will not go. You have to get everybody along with you and the community behind that. But I am thinking that they have created a lot of barriers, and the system that is being used by the child health nurses is again archaic. Okay, we have the purple book, often people lose that, but everything is done just on paper half the time, you know.[687]

5.66 Playgroup WA have also seen a decreasing connection between child health nurses and local communities:

> We have had lots of conversations with child health over the years because the numbers of people who say they find out about playgroup via child health nurses has sort of like more than halved in the last 10 years. … we know from our families and from the First 1000 Days project that people are spending less time with child health nurses than they were 15, 20 years ago. So we know that child health nurses are not as involved in community activities as much as they used to be, so whether that is an early years group or visiting the playgroup or whatever it might be.[688]

5.67 Playgroup WA warns that there are implications for a child health system that does not place sufficient value on its relationship building role. Families will be less engaged with the service and there will be fewer opportunities for 'warm referrals' to positive developmental opportunities by someone the parent knows and trusts:

> If, as a new vulnerable parent, you do not build a relationship with your child health nurse, then you are not necessarily going to be as likely to be going back

685 Dr E Green, Paediatrician, Southern Paediatrics, [*transcript of evidence*], *Legislative Council,* 17 February 2023, p 5.

686 Private citizen, paediatrician, [*private transcript of evidence*], *Legislative Council*, p 10.

687 Private citizen, paediatrician, [*private transcript of evidence*], p 10.

688 D Zarb, Chief Executive Officer, Playgroup WA, [*transcript of evidence*], *Legislative Council,* 26 July 2023, p 7.

> when you do not have to. If your child health nurse is not able to be as connected with the service system around them, then they cannot make the warm sort of referral. They can say that playgroups are a good idea but that is not the same as saying, "I know Mary down the road and she'd love to have you." … on the whole, the workload of the child health system has been such that they focus on core business or decide what their core business is. From the outside and watching them, I just think their core business cannot work without that connection. I mean, this is all relational work; it is not transactional work.[689]

5.68 Crucially, if the child health system is not reaching most children who are aged more than four months, the opportunity for early identification of issues and the effectiveness of the child development system, is diminished:

> The effectiveness of early identification is also closely linked to the effectiveness of the Child Health system as the Child Health Nurses have initial early contact with families, do initial screening activities and inform families of child development services. The low number of families accessing scheduled child health and development at checks is an issue highlighted in previous inquiries but has been stubbornly hard to shift for many years. This may be related to decreasing opportunity for local child health nurses to develop productive relationships with the families due to increasing caseloads and centralised client contact systems. When a positive relationship is developed with a family in the neonatal period and the value of the child health nurse is clear to the family, they are more likely to access the service for child health and development advice and attend scheduled health and development checks.[690]

5.69 MCFHNA expressed concerns about structural barriers that have reduced the accessibility of child health nurses (such as restrictive operating hours and locations of services) and has narrowed their scope of practice. The following are examples of their comments:

> There are restrictions on the availability and the hours, and there used to be more centres in more places that people could access and more availability of appointments and the time that they spent. Child health nurses do spend more than 10 minutes with a child, but if people are told, "There is a gap now. It is actually eight or six months before you can see someone [again]", they do not come back.[691]
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> ▫▫▫
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> They [families] are not being seen regularly and they are not having that conversation and given that anticipatory guidance about what to expect for language, how a child develops for running and jumping, and when they can do all those things.[692]
>
> ▫▫▫
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> As the child health system and child and family health has narrowed its scope of practice and really drawn down on how many visits and who is available and what they can do and a lot of the parenting programs are not being run, if parents do

689 D Zarb, [*transcript of evidence*], p 7.

690 Submission 48 from Playgroup WA, 24 October 2022, p 3.

691 L Wightman, Chair, MCFHNA Board, [*transcript of evidence*], *Legislative Council,* 20 February 2023, p 13.

692 L Wightman, [*transcript of evidence*], p 13.

not have a good experience in child health and have not been able to connect with someone, they sit outside of any service …[693]

What is the Child and Adolescent Health Service doing to address poor attendance?

5.70 CAHS told the Committee that their efforts to improve attendance at later child health checks will focus on two approaches:

- First, improved digital connection and capacity will provide information to parents and identify children in need:

> Just to summarise for you, I think the two things that we would say as a service that are important to look at as strategies going forward … One is around electronic ways to talk to families and ways in which you can identify the children who need more intensive follow-up to point your scarce resources in that way; and the rest who are doing well get … information about normal child development, for instance.[694]

- Second, extra resources will target areas of need and vulnerable families:

> And then the second way is that for those families that we know live in areas where there is likely to be higher needs, that we focus additional resources in those families. And we have done some things internally to really scan across the metropolitan area and look for both families that had risk factors where we saw them earlier and also availability within our service to book them in and maybe go out and do a home visit. So, there are things that we are doing even though we know that we have got constrained resources. There are things we have put in place along the lines of those two kind of key strategies.[695]

General promotion and information provision

5.71 CAHS recognise the need to promote the importance of regular child health checks:

> Universal level appointments are predominantly parent-initiated. There is a need to continue informing parents about the importance of the early years, to promote the need for regular checks and to engage with families particularly when their child is 12 months and 2 years. This is particularly important for those families with risk factors that may increase the likelihood of a child experiencing adverse health outcomes.[696]

5.72 It was confirmed to the Committee that the child health system can identify families of children who have not presented at the 12-month and two-year checks.[697] Asked whether there is an intention to undertake targeted promotional activity for this group, the response from CAHS did not detail what its 'broadbrush approaches' entailed:

> **The CHAIR:** Do you have any way of targeting them with that three-year old video link? … Let me ask a specific question about whether there is any intention to target the three-year-old program to the people who have not fronted at 12 and

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693 L Wightman, Chair, MCFHNA Board, [*transcript of evidence*], *Legislative Council,* 20 February 2023, p 10.

694 S Kiely, Executive Director, Community Health, CAHS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 18.

695 S Kiely, [*transcript of evidence*], p 18.

696 Submission 77 from WA Health, 9 November 2022, p 22.

697 K Miller, Director, Population Health, WACHS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 31.

> 24 months and then let me ask you the more general question about what follow up is done to try to persuade those people …
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> **Ms KIELY:** I think there is a number of elements that we are trialling in order to increase our connection with families, and there is a range of those connections with families from 12 months up to two years and three years. The video is one. It is more one of those broadbrush approaches where there is a video that is available and it can be sent out to people and it can be referred to in our printed materials, which is available to everybody. That is one strategy.[698]

5.73 The video referred to above, '*Look at Me, I am Three*', was developed as part of a project targeting three year olds and pre-school readiness. A pilot, conducted in September 2022 across two regions in Perth, involved direct messaging a link to the video to parents of children aged between 38 and 42 months. CAHS's advice to the Committee in November 2022 was that:

> The CAHS-CH [Community Health] pilot is due to be completed at the end of November, with further implementation dependent on the outcome of the evaluation.[699]

5.74 The Committee does not have information about whether a broader roll-out of this initiative has occurred. The CAHS website indicates that a promotional poster for the video was developed for places that host families with young children such as libraries and day care centres.[700]

Targeting low socio-economic areas and vulnerable families

5.75 A joint CAHS and WACHS pilot program was conducted in Midland and Bunbury in an effort to improve attendance at the 12-month and two-year health checks:

> We have run some pilots of diverting nursing resources to specifically target areas of low socio-economic status and actively reached out to families at those ages of 12 months and two years to improve engagement. We did see quite a positive response.[701]

5.76 Vulnerable families were contacted directly to remind them about child health checks:

> Other strategies that were tried during the pilot that we did to increase two-year-old and one-year-old checks were things like sending out SMSs and directly phoning families that we knew were higher risk.[702]

5.77 CAHS advise that these types of activities have been shown to improve the uptake of child health services in other jurisdictions and help to build better relationship with families:

> Community Health Nursing have shown that individualised contact (telephone and SMS) results in higher take-up of child health services. This is consistent with the 2019 Parenting in Victoria Today survey results which indicated that approaches

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698 Hon Dr Sally Talbot MLC, Chair; and S Kiely, Executive Director, Community Health, CAHS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 31.

699 Tabled Paper No 2 tabled by CAHS during hearing held 28 November 2022, p 16.

700 CAHS, *Schools and child care,* CAHS, 2023, accessed 24 January 2024.

701 S Kiely, Executive Director, Community Health, CAHS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 14.

702 S Kiely, Executive Director, Community Health, CAHS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 31.

> that increase the bond between the family and the service provider are more likely to impact on participation rates.[703]

5.78 Unfortunately, the full evaluation and recommendations from the trial have not been publicly released. However, CAHS provided the following results for the Midland pilot:

> The proportion of all eligible children seen for universal child health assessments in the pilot Midland region increased from 41% to 57% for the 12-month-check and from 28% to 57% for the 2-year-old check (January 2021 compared with February 2022).[704]

5.79 CAHS told the Committee that it had unsuccessfully applied for funds for a wider roll-out of the trial as part of the 2023-24 State Budget (see discussion in Interim Report at paragraphs 4.64–4.65) but that, if resources were available in the future, CAHS would be able to roll out this type of targeted engagement in low socio-economic areas where the need is greatest.[705]

5.80 In addition to the Midland and Bunbury pilots, CAHS is conducting a small pilot to trial the effectiveness of different wording in direct messaging to families:

> One of the things that we are currently doing to take that SMS trial a little bit further is that we are trialling different types of messages to go out to people here in the metropolitan area. So whether you just use different wording appealing to people's knowledge about what their child is doing, there are different messages that we might send out that might appeal to people. We are doing a current small pilot of what type of messages get people to come through the door.[706]

5.81 While the above evidence refers to 'messages to go out to people here in the metropolitan area', the Committee does not have information about the intended recipients of the messaging – that is, whether it will be universally applied or targeted at vulnerable families.

5.82 Other initiatives to improve outcomes for vulnerable children include the 'Strengthening Child Health Outcomes' research project with the TKI. This research uses data from the CDIS to help identify and target engagement activities toward children more likely to be developmentally vulnerable.[707]

5.83 Evidence to the Committee does not indicate that CAHS considers more active engagement with the general population (as opposed to those considered vulnerable) as a priority at the present time:

> **The CHAIR:** If you could boost the rate of at least the two checks before pre-primary, that would presumably serve both those models of early intervention. It would serve the first one—that you are getting to the child at a very young age—but also it would mean early diagnosis and treatment.
>
> **Ms McHUGH:** I think particularly for those children who are more likely to be vulnerable. There is obviously a proportion of the community that will be absolutely fine and it is really great if they come for their checks; we would want to encourage early checks and that families feel they can and do come for all of the child health checks. But for the families that are particularly vulnerable—the ones

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703 Submission 77 from WA Health, 9 November 2022, p 22.

704 WA Health, Answer to question on notice No 7 asked at hearing held 28 November 2022, dated 23 December 2022, p 5.

705 S Kiely, Executive Director, Community Health, CAHS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 14.

706 S Kiely, Executive Director, Community Health, CAHS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 31.

707 Tabled Paper No 2 tabled by WA Health during hearing held 28 November 2022, p 15.

> that unless we offer them really flexible, targeted services are likely not to engage—they are the ones that we really need to reach. It is really important.[708]

FINDING 49

There are limited active engagement measures being undertaken by the Child and Adolescent Health Service to improve attendance at later child health checks at 12 months and two years of age. Promotional activities for the most part have consisted of time-limited trials or research projects targeting low socio-economic areas and vulnerable families.

RECOMMENDATION 39

The Child and Adolescent Health Service conduct increased targeted and general promotional and educational activities to improve attendance at the 12-month and two-year child health checks. This would include maximising contact with target families at Child and Parent Centres, play groups and family and community centres, as well as vulnerable families with no community connections.

What the WA Country Health Service is doing

5.84 Following on from the Midland/Bunbury pilot, WACHS have commenced a trial of a Virtual Child Health Nurse service for 12-month and two-year child health checks (see paragraph 4.119 of this report).[709]

5.85 In addition to expansion of the virtual child health check service across all regions, more funding would enable WACHS to create a statewide child and adolescent nursing team:

> This team would be part of a team to provide virtual services but also would be part of a fly-in fly-out model to assist regions facing short-term staffing shortages whilst they are progressing recruitment. It is just really to fill some gaps in those periods of time when staff move on and they are not able to fill those positions. At this point in time, we do not have the exact FTE [full-time equivalent] that we would require, but we are looking at working with CAHS for that submission in the future in regard to some extra FTE to support that.[710]

5.86 While a statewide child and adolescent nursing team has merit, the Committee is not aware of a funding submission being finalised.

RECOMMENDATION 40

The WA Country Health Service expedite the evaluation of the Virtual Child Health Nurse trial service and consider what other measures could be employed to improve attendance at the 12-month and two-year child health checks. This would include maximising contact with target families at Child and Parent Centres, play groups and family and community centres, as well as vulnerable families with no community connections.

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708 Hon Dr Sally Talbot MLC, Chair; and A McHugh, Acting Nurse Co-Director, Community Health, CAHS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 14.

709 K Miller, Director, Population Health, WACHS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 30.

710 K Miller, [*transcript of evidence*], p 30.

What else could be done?

Offer services outside of normal working hours

5.87 The Committee understands that child health services are generally offered during normal working hours – 9 am to 5 pm on Mondays to Fridays. Evidence received during the Inquiry suggests that these hours are too restrictive for families (see paragraphs 5.63–5.69).

5.88 The ACA recommends that community health services and CDS should be offered:

> flexibly, in a range of settings and outside of parents working hours including drop-in clinics on weekends, shop front services, clinics at ECEC centres or other community locations.[711]

5.89 In response to Committee questioning, WA Health indicated that child health nurses could be permitted to work on Saturdays, but this would have to be negotiated properly:

> There would have to be a work through of a particular section of the award, but it would not be a no; it would have to be a consultation process. Yes, at the moment, the community nurses award talks about from seven till six and it is Monday to Friday … But the award also offers an opportunity to work with nurses and unions and say that, yes, we would like to run a service on a Saturday. We did start to do that work, but we obviously could not finalise it or go forward anymore until the actual industrial dispute has been settled.[712]

5.90 The Committee received evidence of a free, non-government operated, early intervention program known as Maaraka Dabakarn, which runs on Saturdays and is very well attended. It is available for families with children under eight years of age:[713]

> we [Connecting Community for Kids] have co-designed again with community and services, a program called Maaraka Dabakarn, meaning "hands to steady" in Noongar. The program itself is an early intervention that brings families the opportunity—universal; they do not have eligibility criteria—across four local government areas. That is where our funding bucket supports, so Cockburn, Kwinana, Rockingham, Mandurah, where we will have a Saturday session. I do not want to call it a clinic because it really is more than that. It is a session to bring together families who have concerns about their child. They may be on a waitlist, they may not. They may just want some assurance from someone.
>
> We give them the opportunity to meet with four different therapists, so a speech therapist, an occupational therapist, a behavioural therapist and an early development specialist. We also have Ears2Learn[714] screening there on the day, and Wanslea[715] attend so that they can help families navigate the NDIS if that seems to be what needs to happen. And they get the opportunity to sit with a therapist for 30 minutes in a group session of no more than five families. It enables them to come with the siblings of the children, but also all the caregivers. So it is on a Saturday because most often dad cannot make it if we do not do it on a weekend, but also grandparents and other caregivers can all be getting the same

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711 Submission 71 from ACA, 7 November 2022, p 7.

712 A McHugh, Acting Nurse Co-Director, Community Health, CAHS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 54.

713 Connecting Community for Kids, *Current strategies*, Connecting Community for Kids, accessed 1 March 2024.

714 The Ears2Learn screening program is discussed in paragraph 7.21 of this report.

715 Wanslea Family Services is the NDIS's early childhood partner in the Perth metropolitan area and the Great Southern, inner Wheatbelt and South West regions: National Disability Insurance Agency, *Western Australia*, NDIS, 2024, accessed 1 March 2024.

message to support the child in the same way. Siblings to the family are catered for and we have early childhood staff supporting them at that time.

The idea is that not only will they get some resources from the therapists, but they actually understand what those therapists do and whether or not they are actually on the right queue to begin with. So very often they are not on the right queue; they are sitting waiting for something, and I say "waiting" because that is literally what is happening … What we are saying is that actually being with the therapist and getting in front of a therapist is not actually the panacea. You actually need to know how to support your child yourself as well. And most of that support happens in between those therapy sessions. So let us get started and get something going.

… They are oversubscribed each session. They are self-referral, so no-one is referring, they are not coming from doctors or anywhere else; this is families who off their own bat are coming in on a Saturday, spending three hours with us. And the feedback has been extraordinary. …

… So having that group together, we hope it will mean that it will build peer networks as well, so they walk in and there is a sense of relaxation as we are all in this together, we will work it out together, and they get some tools and opportunities … But overarchingly, the other thing is that they can come and see us next month, and they can see us the next month after that and they can come every month. And in fact, the two sessions that we have had, we have had family come to both … that is fine until they get all the support they need. [716]

5.91 The Committee is of the opinion that CAHS and WACHS should provide child health services outside of normal working hours, including on Saturdays. This would provide working parents with more opportunities to visit, and engage with, a child health nurse.

RECOMMENDATION 41

The Child and Adolescent Health Service and WA Country Health Service provide child health checks outside of normal working hours, including on Saturdays.

Proper recognition and utilisation of child health nurses

5.92 This issue is discussed in Chapter 7, paragraphs 7.25–7.31, of this report.

[716] J Miller, Chief Executive Officer, Connecting Community for Kids, [*transcript of evidence*], *Legislative Council*, 20 February 2023, pp 8–9.

CHAPTER 6
Access, engagement and equity – Other community-based services

Overview

6.1 Community services such as playgroups, early childhood education and care (ECEC) and Child and Parent centres (CPCs) support healthy child development. These services engage families early, enable local social connection and support, and provide beneficial developmental opportunities. Importantly, they can provide a line of sight on children from an early age.

Chapter summary

6.2 This chapter examines the benefits of a more holistic and integrated child development system that harnesses a range of community services.

A holistic approach

6.3 The Interim Report discussed how developmental issues are often complex and multi-layered.[717] Familial health and wellbeing, for instance, are important elements for healthy child development. As Louise Wightman, Chair of the MCFHNA Board, told the Committee:

> when a child comes in, they do not walk in the door on their own.[718]

6.4 Evidence to the Committee indicates that a holistic approach to child development, beginning during pregnancy and continuing throughout childhood, is widely supported. However, several contributors to the Inquiry characterise the current system as fragmented and inconsistent.

6.5 The submission from ARACY describes a child development system that operates in silos:

> Child development requires a holistic approach – with current approaches relying on a medicalised conceptualisation of child development to the exemption of the role of family cohesion and functioning, and the siloing from early childhood education and care.[719]

6.6 Ngala (a non-government organisation that provides parenting and childhood services) submitted that although we know that the wellbeing of parents and babies are interdependent, services tend to focus on either the mother or child in isolation of each other:

> the WA system adopts a reductionist view to the complex needs of families during pregnancy and the early years of life. This has resulted in a fragmented approach to supporting the emotional wellbeing of babies and their families and a lack of appropriate Perinatal Infant Mental Health (PIMH) clinical services.[720]

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717 Interim Report, pp 6–9, paragraphs 2.9–2.14.

718 L Wightman, Chair, MCFHNA Board, [*transcript of evidence*], *Legislative Council,* 20 February 2023, p 11.

719 Submission 63 from ARACY, 26 October 2022, p 2.

720 Submission 65 from Ngala, 28 October 2022, p 6. Ngala explains that Perinatal Infant Mental Health (PIMH) clinical services are services for vulnerable families 'experiencing significant adversity, including infant difficulties, parental mental ill-health, parental substance abuse, family and domestic violence and trauma'.

6.7 Ngala points to a deficiency in preventative services for at-risk families:

> There are also limited services to families, 'at risk' or with complexity, for whom early detection and prevention efforts could reduce unnecessary suffering and avert the need for more costly clinical, tertiary services.'[721]

6.8 The submission from WACOSS describes a fragmented system that is inequitable and difficult to navigate:

> WA's current approach to providing support to mothers and children in the early years of life is fragmented and inconsistent – meaning that whether or not those at risk are able to get timely access to advice and support depends on where they live and their capacity to navigate health and social services across multiple government and NFP agencies.[722]

Community services that support child development

6.9 The Interim Report discussed the importance of early identification of developmental issues to maximise the effectiveness of subsequent intervention and support.[723] Aside from the community health services provided by child health and school health nurses, other community services such as playgroups, the ECEC sector and CPCs can provide a line of sight on children from an early age. These local contact points provide an avenue to reach even the most vulnerable families early, to educate and engage parents, to identify developmental delays, and to connect families with support services.

6.10 Dr Elizabeth Green, paediatrician, explained how a range of community services support the broader child development system:

> Child development services require a multi-disciplinary approach to assist families to parent better, with community outreach options from the time a parent prepares to give birth to their first child. Midwives, lactation specialists, child health nurses and school nurses are often the point of first contact for families. As are educators in formal daycare centres, structured playgroups, kindergartens, early childhood classrooms and after school care facilities.[724]

6.11 Importantly, community services provide an informal, local connection point for parents and children. This can be especially valuable for families that are otherwise socially isolated:

> effective interventions to assist developmentally at-risk children also need to include and support the primary carer. It can be helpful to provide other opportunities to connect and socialise with other adults and other children … [725]

Playgroups

6.12 Playgroup WA is the peak body for playgroups in Western Australia. Playgroups are often operated by parents, although there are facilitated playgroups that cater for children with additional needs.[726] Around 160 community-run playgroups take place on school grounds,

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721 Submission 65, p 6.

722 Submission 81 from Western Australian Council of Social Services, 7 November 2022, p 11.

723 Interim Report, pp 11–13, paragraphs 2.25–2.34.

724 Submission 50 from Dr E Green, paediatrician, 24 October 2022, p 3.

725 Submission 81 from Western Australian Council of Social Services, 7 November 2022, p 10.

726 Submission 48 from Playgroup WA, 24 October 2022, p 1.

with schools now being the second largest venue provider in Western Australia after local governments.[727]

6.13 Playgroup WA informed the Committee that evidence supports the benefits of playgroups for child development:

> We know from correlation studies around the Australian Early Development Census, for instance, that children who participate in playgroup activities are less likely to be vulnerable on any of those [developmental] domains … and that for children from disadvantaged communities, that effect is even higher.[728]

6.14 The benefits derived from playgroups, for children and parents, are indicative of the potential of accessible, local, and supportive networks for families:

> I think that is a reflection of what you can do when you actually create supportive networks in communities.[729]

6.15 According to Playgroup WA, the major problem affecting increased provision of playgroups relates to town planning and a lack of space for community services, especially in newer suburbs:

> Our biggest issue at the moment is … the fact that we are running out of places to have playgroups and that … you go to any new community in Western Australia, you know, in the last 10, 15 years, thousands of houses arrived before community infrastructure, so we have vulnerable families with young children who are always the first customers moving into places where they do not have the option of doing the thing that they need to do the most, which is actually get together and make relationships in the new communities. If you want an example, Brabham in the eastern suburbs is an extraordinary place. It is highly multicultural, filled with young families and has a school that from the outside looks like a military camp because it has got 10 kindergarten classes. There is no space for a playgroup in there. We have funding to do playgroups in there and we had to get out because they had no space.[730]

6.16 Supported playgroups have a facilitator and are usually focused on specific needs, such as children with autism. Playgroup WA operate many supported playgroups, as do other providers such CPCs:

> We run supported playgroups. So we run a significant number of sessions in regional and remote Western Australia with National Indigenous Australians Agency funding. We have 13 Aboriginal staff in communities including Warburton, Pingelly, Quairading, Laverton and Albany. We run PlayConnect+, which is a program focused around children with autism or autism-like symptoms and other sorts of disability. They do not have to have a diagnosis … we run a couple of supported playgroups with Communities for Children funding from Swan Alliance focused on multicultural families.[731]

6.17 Playgroup WA provided the Committee with examples of their engagement activities that support healthy child development:

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727 D Zarb, Chief Executive Officer, Playgroup WA, [*transcript of evidence*], *Legislative Council,* 26 July 2023, p 10.

728 D Zarb, [*transcript of evidence*], p 5.

729 D Zarb, [*transcript of evidence*], p 5.

730 D Zarb, [*transcript of evidence*], p 5.

731 D Zarb, [*transcript of evidence*], p 5.

- Recent activities have focused on the 'first thousand days' and building community connections and a support network for new (and expecting) parents.[732]
- The Mother-Baby Nurture group is a 10-week program, focusing on attachment, for new parents experiencing difficulties. It is operated by appropriately qualified practitioners and is 'funded through Mental Health Commission funding that goes via North Metro Health Service'.[733] The model is showing positive results:

  > we are seeing improvements in parental confidence, decreases in anxiety and depression, and improvements in parental observation and attachment. Everything we want to see is happening and for a 10-week group, it does not suit everybody. If we think people need more intervention, we will refer them on to appropriate services. But the group environment is really powerful in that process as an alternative and sometimes a complement to individual therapy if that is needed.[734]

- Playgroup WA has held discussions with WA Health about child health nurses visiting playgroups, and some small-scale experiments have been conducted.[735] Playgroup WA staff have also taken active steps to facilitate local relationship building with child health nurses:

  > We only had people involved physically from our end for the first two or three weeks, but what they did do in north west metro and south west regional was our staff went around making sure they got to know all the child health nurses, all the other providers, and were there to introduce these people just to nudge them along, and then let the playgroup take over and do it all themselves like we normally do.[736]

Early Childhood Education and Care sector

6.18 Evidence shows that ECEC has numerous benefits for child development:

> there is a growing body of research analysing the impact of ECEC on child wellbeing and development. Within the Australian context, there are consistent findings that quality formal care improves development, school readiness, and future success among children …[737]

6.19 Recognition of these benefits has been reflected in Australian Governments' policies and investments including the National Early Childhood Development Strategy (2009), the National Partnership Agreement on Early Childhood Education, an Early Years Learning Framework, a Closing the Gap initiative, and a National Framework for Protecting Australia's Children.[738]

6.20 The ACA submitted that the ECEC sector, with its enormous reach and the relationships built with families, should be leveraged as a community asset for supporting children with developmental needs.[739]

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732 D Zarb, [*transcript of evidence*], p 3.

733 D Zarb, [*transcript of evidence*], pp 3-4.

734 D Zarb, [*transcript of evidence*], p 4.

735 D Zarb, [*transcript of evidence*], p 9.

736 D Zarb, [*transcript of evidence*], p 10.

737 R Cassells, M Dockery, A Duncan, D Kiely, M Kirkness, T Nguyen, R Seymour, C Twomey, 'The Early Years: Investing in Our Future', *Focus on Western Australia Report Series*, No 13, August 2020, accessed 14 February 2024, p 74.

738 R Cassells et al, 'The Early Years: Investing in Our Future', p 73.

739 Submission 71 from ACA, 7 November 2022, pp 1 and 3–4. See also, paragraph 3.151 of this report for relevant excerpts of the ACA's submission.

6.21 The ACA also submitted that universal services, such as ECEC centres, are the most accessible venues for providing developmental screening.[740] The ECEC sector can, therefore, provide an avenue for addressing gaps in child health assessments before children start school:

> There is currently a big gap between the toddler (2 years) and school health (4 years) check in the WA Child Health schedule that misses this critical time of development. Similarly, hearing and ear health is not currently routinely checked between the Newborn Screening Test and the School Entry Test. This schedule has no capacity to pick up hearing and ear issues in the years between infancy and school entry and missing this critical period can dramatically impact development with far reaching impacts on language, communication, social skills and readiness for school.[741]

6.22 The sector can also provide a bridge for vulnerable families to access and navigate support services. For example, the ACA's submission provided case studies that demonstrate extensive effort by ECEC centres to overcome service issues and deficiencies in CDS for vulnerable clients that include:

- additional support needed by vulnerable families to navigate the system
- shortcomings in the interaction between WA Health and the ECEC centre
- service deficiencies in one system that can impact supports provided by other sectors
- ambiguity regarding responsibility for therapeutic support for children in out-of-home care.[742]

Initiatives and partnerships that support child development

6.23 Goodstart Early Learning (Goodstart) is Australia's largest ECEC provider and not-for-profit social enterprise. It has 53 centres throughout Western Australia and provides early learning and care for around 5,500 families and 7,000 children.[743] Goodstart submitted that 6% of children attending its centres across Australia have a disability or developmental delay and:

> many more have been identified with additional needs and are currently waiting for further assessment.[744]

6.24 Examples of initiatives and partnerships by Goodstart to improve child development outcomes include:

- *EChO* (Enhancing Children's Outcomes) centres in low socio-economic areas that provide allied health services and other intensive support for vulnerable children
- partnering with the *Ears2Learn* project for ear health screening
- nurse practitioner visits to address barriers experienced by vulnerable families accessing services through existing pathways.[745]

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740 Submission 71, p 6. See also, paragraph 3.151 of this report for relevant excerpts of the ACA's submission.

741 Submission 71, p 6.

742 Submission 71, pp 14–18.

743 Submission 71, p 2.

744 Submission 71, p 2.

745 Submission 71, p 2.

Optimising the early childhood education and care sector

Child development training

6.25 The Committee received evidence that funding for training of ECEC workers is needed to develop knowledge of child development and to ensure consistency across the sector. Evidence to the inquiry indicates that:

> [there is] wide variation in early childhood developmental knowledge across the early childhood service system and no common tools and resources for professionals in WA.[746]
>
> ▫▫▫
>
> more funding has to be committed for training positions for childcare workers and early childhood teachers.[747]

6.26 The provision of child development training to external stakeholders is discussed in paragraphs 3.33–3.39 of this report.

Venue for child development services

6.27 The possibility of CAHS and WACHS providing primary and secondary-level child development services at ECEC centres is explored in paragraphs 3.149–3.156 of this report.

Low intensity workforce

6.28 The potential deployment of ECEC workers as a low intensity workforce to support the CDS system is examined further in paragraphs 7.19–7.22 of this report.

Child and Parent Centres

6.29 An overview of CPCs and what they can offer is provided in paragraphs 3.113–3.139 in this report.

6.30 In the metropolitan area, CAHS–Community Health provides both child health and speech pathology services from CPCs. CAHS–CDS speech pathologists working at these centres also spend a small proportion of their time building community capacity to guide the early identification of issues, prior to referral to a CDS provider.[748]

6.31 In regional Western Australia, child health nurses and allied health clinicians provide services from the nine CPCs located in communities identified as having higher developmental vulnerability.[749]

6.32 In addition to playgroups, parenting workshops, child health nursing and onsite speech pathologists, individual CPCs may also host the services of occupational therapists.[750]

6.33 The Learn, Engage and Play (LeaP) research project was conducted by Curtin University and CAHS–CDS to develop and assess therapeutic playgroups as a service model for children at risk of developmental delay and disability.[751] The project involved supported playgroups

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746 Submission 71, p 4.

747 Submission 50 from Dr E Green, paediatrician, 24 October 2022, p 6.

748 Submission 77 from WA Health, 9 November 2022, p 78.

749 Submission 77, p 78.

750 Submission 38 from Parkerville, 24 October 2022, p 12.

751 Curtin University, *Early Intervention*, Curtin Autism Research Group (CARG), accessed 25 February 2024. LEaP 'developed and evaluated a therapeutic playgroup model for children with developmental delays when first

conducted at CPCs by allied health clinicians.[752] CAHS–CDS told the Committee that the concept was 'a great model' that could be reinstated if the resources were available.[753]

6.34 The submission from Parkerville explained the benefit of CPCs in engaging vulnerable families who may not otherwise access mainstream services:

> Parenting is complex and challenging, and this can be exacerbated for families isolated by cultural and language differences, physically isolated by lack of transport and income, pressured by work commitments, family estrangement, inter-generational parenting practices, cultural taboos, shame, depression, drugs and alcohol, FDV and reticence about seeking help. Some parents are not aware that their children have developmental challenges, and key to initiatives like CPCs is to help with identification, and to have them addressed early (Shelby Consulting, 2017). Targeted programs can carry stigma and thereby reduce families' willingness to engage; CPCs mitigate this stigma by offering access to all children and families in an area, and by being located on or near public schools to support families as they lay the foundations for their children's development and learning.[754]

6.35 Parkerville's work with vulnerable families demonstrates that early intervention is best achieved through a constellation of programs that:

> build capacity and community; removing any stigma around or reluctance to seek help by creating a safe, open environment that wraps early intervention support around families.[755]

6.36 It recommended to the Committee that more speech pathology and occupational therapy capacity should be built into early childhood services and integrated service points.[756]

6.37 The OT Associations also consider there to be potential to expand the services provided by CPCs and to accommodate a greater range of health professionals:

> the scope of services could include capacity building in the local community e.g. allied health led sessions within established playgroups and pre-kindy programmes. Within the CPCs, education for families and triage of referrals to child development services could potentially reduce waitlists in both public and private child development services.[757]

6.38 An evaluation of CPCs in 2017 found that the centres are providing a valuable community resource:

> The Initiative is being generally well implemented and is on track to deliver the planned outcomes. There are a number of key success factors, some of which are subtle. They include the warmth and acceptance of the staff, the engagement and

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referred to an early intervention service. Embedded in the … [CAHS–CDS], this consumer driven study was initiated in response to families' desires to have earlier access to developmental information, to obtain support from professionals and to connect with other families experiencing the same challenges. Playgroups were suggested by both [CAHS–]CDS consumers and staff as a potential solution to meet families' information and social needs during this time': TKI, Answer to question on notice 1 asked at hearing held 9 February 2023, dated 27 February 2023, p 1.

752 A Turnell, Acting Director, Clinical Services, CAHS–CDS, [*private transcript of evidence*], *Legislative Council,* 25 July 2023, p 45.

753 A Turnell, [*private transcript of evidence*], p 45.

754 Submission 38 from Parkerville, 24 October 2022, p 10.

755 Submission 38, pp 11-12.

756 Submission 38, p 12.

757 Submission 80 from OT Associations, 14 November 2022, p 6.

> support of the host and surrounding school principals and staff, and the involvement of Aboriginal and CaLD community members.[758]

6.39 On 15 June 2022, the TKI commenced an evaluation of CPCs for the DOE. The project was due for completion by 15 July 2023,[759] but the results have not yet been released publicly.

6.40 The Committee reiterates Findings 18–20 (page 74) and Recommendations 17 (page 74) and 18 (page 75) of this report. A minority of the Committee, comprising Hon Donna Faragher MLC, also reiterates Minority Recommendations 3 and 4 (page 75) of this report.

Integrated child and family centres

Integrated, holistic services

6.41 The Challis model,[760] CPCs and Queensland's Yarrabilba/FamilyLinQ sites[761] are types of co-located child and family services, or integrated child and family centres (ICFCs), which provide families with a service and social hub in a single location. While different models operate in Australia, ICFCs generally provide a range of child and family services including maternal and child health, early learning programs and family support programs:[762]

> ICFCs are designed to be responsive to community need and therefore the mix of supports they offer will vary.[763]

6.42 The Minderoo Foundation emphasised the benefit of universal child and family support services in preventing and remedying many child development issues early:

> the treatment actually is just age-appropriate play-based early learning and appropriate parent support. It is not rocket science; it is just parents being able to witness what good parenting looks like, giving some tips and helping them understand what is happening with their child … These small things can be remedied very easily if they are gotten to very quickly. Instead, you are sitting on the end of a queue, and by the time you get to see somebody, the developmental window closes.[764]

6.43 It contends that the seemingly intractable problems facing the CDS system (long waiting times, inequitable access, and poor engagement with vulnerable populations) requires a fundamental shift in the way the system operates:

> You can try and reduce the friction in that system all day and all night and you will never get anywhere. What you need to do is to create a developmental system for children which has very low barriers to entry—no threshold entry questions—and what you do is you get eyes on every child as early as you possibly can and then needs are identified.[765]

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758 Shelby Consulting Pty Ltd, *Evaluation of the Child and Parent Centre Initiative*, 28 February 2017, p 160.

759 TKI, Answer to question on notice 2 asked at hearing held 9 February 2023, dated 27 February 2023, p 5.

760 See paragraphs 3.74–3.79 in this report.

761 See paragraphs 3.124–3.133 in this report.

762 Social Ventures Australia, *Happy, healthy and thriving: enhancing the impact of our Integrated Child and Family Centres in Australia*, 2023, accessed 27 February 2024, p 20.

763 Social Ventures Australia, *Happy, healthy and thriving: enhancing the impact of our Integrated Child and Family Centres in Australia*, p 21.

764 Hon J Weatherill, Director, Thrive by Five, Minderoo Foundation, [*transcript of evidence*], *Legislative Council,* 9 February 2023, pp 4–5.

765 Hon J Weatherill, [*transcript of evidence*], p 4.

6.44 Playgroup WA expressed a similar view, arguing that the established approach to delivering child development services is not working:

> There are many opportunities to increase engagement and collaboration across the sector. The current situation is piecemeal with a range of government, not for profit and for- profit organisations (including those in private practice operating without any common goals or framework, data collection or measurement). The capacity restrictions in State funded Child Development Services have led to costs being shifted … The traditional model of individual family appointments at limited physical locations with very little outreach into the community, whether that be via early education and care centres, playgroups or family homes, has been ineffective, inefficient, often culturally insensitive, often inaccessible, and has not led to improved developmental outcomes for the children of this state.[766]

6.45 As discussed at the beginning of this chapter, there is wide support for a more holistic and integrated approach to child development. The Minderoo Foundation suggest that:

> We need to take all these bits and pieces that we have, like the infant and maternal health checks, the preschool system, things like the child development services, and actually imagine them in an integrated service system, which you have already begun here with your child and parent centres. There is sort of a nascent early childhood development system through the commonwealth childcare system, and we are seeing that some remote Aboriginal communities have family centres. There are little pockets of attempts.[767]

6.46 A more holistic and better integrated system, such as the Challis model, will provide:

> A coherent relationship between what happens later and what happens earlier so that all the transition points would disappear. There would be line of sight to the child at birth. It is a bit like the Challis model …[768]

6.47 There are different models of ICFCs operating across Australia. Other examples include:

- Aboriginal Child and Family Centres
- Early Years Places (Queensland)
- Child and Family Learning Centres (Tasmania)
- Children's Centres (South Australia)
- Our Place (Victoria)
- Child and Family Centres (Northern Territory).[769]

6.48 ICFCs offer a broader range of social features and benefits, and a warmer, more welcoming, environment than service hub models, such as:

- the current WACHS hubs, from which CDS and other health services are offered
- the CAHS Community Hubs currently being implemented (see paragraphs 2.39–2.44):

> The [ICFC] model focuses on a very deliberate way of working that is child-focused, relational and multidisciplinary. Unlike a [service] hub model, which offers

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766 Submission 48 from Playgroup WA, 24 October 2022, p 4.

767 Hon J Weatherill, Director, Thrive by Five, Minderoo Foundation, [*transcript of evidence*], *Legislative Council,* 9 February 2023, p 5.

768 Hon J Weatherill, [*transcript of evidence*], p 9.

769 Social Ventures Australia, *Happy, healthy and thriving: enhancing the impact of our Integrated Child and Family Centres in Australia*, 2023, accessed 27 February 2024, pp 21–23.

> a single front door to access a range of services, ICFCs are designed to be a space where families with young children can come regardless of whether they are accessing a specific service, and where staff members are trained to build relationships with families in order to make them feel safe, identify their needs and provide appropriate supports.[770]

6.49 Allied health support for capacity building and developmental screening is built into the ICFC model:

> The ICFC operating model depends on allied health supports as a key early intervention measure. Allied health professionals are often embedded into ICFC programs – such as playgroups, long day care or preschools – to screen children for potential issues, build the capacity of ICFC staff delivering the programs and support with referrals.[771]

6.50 However, funding constraints and workforce shortages limit the ability of most ICFCs to provide comprehensive allied health services:

> Comprehensive allied health service provision is a systemic gap across ICFC models.[772]

6.51 Social Ventures Australia and the Centre for Community Child Health recently commissioned Deloitte Access Economics to examine the ICFC model in Australia. They concluded that:

> There is a strong evidence base for the role that ICFCs can play in meeting the needs of vulnerable and disadvantaged families in a uniquely integrated and efficient way – and, in doing so, helping to bridge the gaps in development and wellbeing outcomes that have proven stubbornly persistent in Australia.
>
> … regardless of precisely where on the spectrum of need the threshold is set, there is a strong case for the expansion of ICFC provision and access. In some cases this is simply about addressing gaps in service provision; in other instances it is about improving existing provision for example by extending the array of services.[773]

6.52 Similarly, ARACY recognises the benefit of a more holistic and integrated approach to child and family services:

> Early intervention models such as the co-location of children's health, early learning, and family services (i.e. 'hubs'); sustained nurse home visiting programs and maternal continuity of care models, are important mechanisms to ensure families' regular access to health services and the early identification of child developmental delays.[774]

6.53 It recommends the development of ICFCs to support a holistic approach to child development:

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770 Social Ventures Australia, *Happy, healthy and thriving: enhancing the impact of our Integrated Child and Family Centres in Australia*, p 57.

771 Social Ventures Australia, *Happy, healthy and thriving: enhancing the impact of our Integrated Child and Family Centres in Australia*, p 63.

772 Social Ventures Australia, *Happy, healthy and thriving: enhancing the impact of our Integrated Child and Family Centres in Australia*, p 63.

773 Deloitte Access Economics, *Exploring need and funding models for a national approach to integrated child and family centres*, Social Ventures Australia in partnership with the Centre for Community Child Health, May 2023, accessed 27 February 2024, p 11.

774 Submission 63 from ARACY, 26 October 2022, p 4.

> Develop new and expand existing community hubs and services to include maternal and child health, early childhood education and care, and parent and family support services (eg. Playgroups, parenting programs, peer support and parent groups) – supporting a holistic approach to child development.[775]

6.54 WACHS submitted that it wishes to establish dedicated, child-focused hubs which would offer a range of child-related health and community services, while also providing organisational benefits:

> would support integrated, multi-agency care coordination processes to enhance:
>
> - A more child and family-friendly experience, with services within easy access of one another or under one roof.
> - Acknowledge the complex and co-occurring physical and mental health sequelae of many neurodevelopmental disorders.
> - For clinicians, this would allow for collaboration, information-sharing, cross-pollinations of ideas and expertise.
> - For the system it would enable efficient use of resources, minimising duplication of similar processes.[776]

FINDING 50

A holistic approach to child development, that integrates child and family services, can support better engagement of vulnerable populations and improve child development outcomes.

6.55 A majority of the Committee, comprising Hons Dr Sally Talbot and Samantha Rowe MLCs, makes the following recommendation:

RECOMMENDATION 42

In establishing its Community Hubs, the Child and Adolescent Health Service ensure maximum integration of its child development services with a broad range of other child and family services.

6.56 A minority of the Committee, comprising Hon Donna Faragher MLC, makes the following recommendation:

Minority Recommendation 7

The Child and Adolescent Health Service partner with non-government community service organisations to ensure that broader child and family services are co-located in its Community Hubs.

6.57 A majority of the Committee, comprising Hons Dr Sally Talbot and Samantha Rowe MLCs, makes the following recommendation:

[775] Submission 63, p 4.

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

RECOMMENDATION 43

With respect to its hubs, the WA Country Health Service ensure maximum integration of its child development services with a broad range of other child and family services.

6.58 A minority of the Committee, comprising Hon Donna Faragher MLC, makes the following recommendation:

Minority Recommendation 8

The WA Country Health Service partner with non-government community service organisations to ensure that broader child and family services are co-located in its hubs.

The importance of location

6.59 WACHS already operates under a hub and spoke model in each of its regions,[777] but by its own admission, WACHS hubs (from which CDS are also provided) are not child and family friendly. This is because the hubs are situated at hospital sites rather than within the local community[778] and are not co-located with other early childhood service providers.[779]

6.60 The Committee agrees that WACHS hubs would be better situated within the local community and away from hospital sites. However, the Committee is also cognisant of the often limited infrastructure that is available to support widely dispersed populations in regional Western Australia.

FINDING 51

WA Country Health Service hubs, which offer a range of health services, including secondary and tertiary-level child development services, are not child and family friendly because they are situated at hospital sites and are not co-located with other early childhood service providers.

RECOMMENDATION 44

The WA Country Health Service investigate the benefit and feasibility of locating its hubs away from hospital sites.

777 See Interim Report, p 27, paragraphs 3.50–3.51.

778 See paragraphs 2.80–2.82 of this report.

779 Submission 77 from WA Health, 9 November 2022, p 68.

CHAPTER 7
Workforce practice and development

Overview and chapter summary

7.1 With finite resources (in terms of funding, infrastructure and the available workforce), it is clear that if CAHS–CDS and WACHS–CDS wish to address their service deficiencies and ensure that the CDS system is accessible and sustainable, they also need to:

- maximise the efficiency of their workforce models
- collaborate with external stakeholders to ensure the continued availability of a future workforce.[780]

7.2 This chapter will discuss each of these two topics in turn.

Maximising efficiency of workforce models

7.3 Ideally, in any workplace, each person would be working at or near their maximum professional capacity, or to the 'top of scope' of practice, as some Inquiry stakeholders have labelled it. Creating an efficient workforce model involves having the right combination of different workers, so that the skills and knowledge of each discipline will complement that of others in the team and allow every worker to practise at the top of their scope. For example, within the CDS system, this could mean employing sufficient numbers of administrative staff with adequate experience to support clinicians and maximise their clinical time.[781]

7.4 It also involves workers using the skills and knowledge for which they were hired. For example, within the CDS system, this would involve a speech pathologist assessing a child for developmental language disorder or facilitating a group therapy session. It would not involve conducting site orientation for new staff. This is, in fact, the current situation in CAHS, where clinical staff are dealing with issues ranging from maintenance to room scheduling and monitoring consumables (see Interim Report).[782]

7.5 WA Health is well aware of the need to maximise the efficiency of their workforce models:

> Increasing university places is one strategy to increase the available workforce but this will take years to impact on available workforce. 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. It also identifies the need to expand workforce models that support working to full scope of practice, including nurse practitioners.[[783]] The current issues with workforce availability provides an opportunity for [CAHS– and WACHS–] 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

780 These topics were prefaced in the Interim Report, pp 89–90, paragraphs 5.8–5.10.

781 See Interim Report, pp 71–74, paragraphs 4.50–4.53.

782 Interim Report, pp 71–72, paragraph 4.51.

783 DOH, *Sustainable Health Review Final report to the Western Australian Government*, DOH, 2019, accessed 19 February 2024, p 104, recommendations 24 and 25.

appointments; non-specified allied health provision of transdisciplinary programs; or varied workforce models for psychosocial support.[784]

7.6 WACHS–CDS is currently trialling a proposed new audiology care pathway, whereby trained allied health assistants, rather than audiologists, complete case histories and conduct tests. That information is reviewed by an audiologist, who will then intervene if there are concerns. So far, the results are promising:

> This project aims to improve waiting times and outcomes for audiology clients by introducing a pathway for early contact appointments, using an Allied Health Assistant (AHA) to collect audiological information.
>
> …
>
> - Eight weeks assistance from AHAs reduced the waiting time from six months to 3–4 months.
> - Older children seen within 2–4 weeks of referral.
> - Did not attend … rate of under 1% compared to normal rate of up to 25%.[785]

7.7 CAHS–CDS is running a pilot 'attention, regulation and concentration' (or ARC) care pathway that is led by clinical nurse specialists. Currently, the typical ARC care pathway would be led by a paediatrician. It has been developed to provide children aged five to 16 years with suspected ADHD and their families with more timely assessments and diagnoses, and more supports. It will also potentially allow paediatricians to work at the top of their scope:

> What we are proposing—this pilot is going to start in Armadale in February 2023—is that when the CDS referral comes through to us and the child is identified as having concerns that are consistent with an attention or concentration problem, the family would be contacted by phone by the developmental CNS [clinical nurse specialist]. Once they provide consent to coming onto our pathway, the family is actually given information—so, online resources and strategies that they can employ while they are waiting for formal assessment. The CNS would then be their first face-to-face appointment and it would be the CNS that would complete a lot of the history and information collecting, including the online questionnaires that we require. They would also talk to the school directly and collect all of that extra information we need. Then the second assessment appointment would be in collaboration or in conjunction with the paediatrician as well, and then follow-up would be provided by the CNS at six weeks. They could talk to the paediatrician if there were issues that arose that needed to be discussed with us, and then we would offer a joint review appointment in six months' time.
>
> It means that we are decreasing the cost of the assessments for the children, because we are reducing the amount of paediatric time required whilst still maintaining that high level of information and standards that we require. It also means that there would be a reduction in the waiting time for assessments for the children and the families, but also they are given additional support and resources to help them manage the difficulties that they are having, but they are not currently getting as well. So we would envisage that there are improved outcomes

[784] Submission 77 from WA Health, 9 November 2022, p 47.

[785] WACHS, Answer to question on notice 15 asked at hearing held 26 April 2023, dated 19 May 2023, Attachment, 'Early contact ear health assessments'.

for the child in terms of timely assessment and diagnosis, but also improved satisfaction from parents and supports as well.[786]

7.8 Figure 6 summarises the differences between CAHS–CDS's current and proposed care pathways for ADHD management.

Figure 6. *Differences between Child and Adolescent Health Service–Child Development Service's current and proposed care pathways for ADHD management*

Current service pathway	Suggested pathway
1. Family is contacted for a phone appointment (Service Planning call) to discuss their concerns (CDS allied health clinician or CNS) 2. Child is identified during the call as having primary issues with attention, behaviour regulation and concentration that require a medical assessment 3. Child is referred to a paediatrician for an assessment 4. Family attends their first paediatrician appointment (Paediatrician) 5. Child's parent/guardian is emailed a link to complete a behaviour questionnaire and forward link to the child's teacher to complete (Paediatrician) 6. Information is collected from the child's school and other sources (Paediatrician) 7. Family attends their second paediatrician appointment where the paediatrician determines the child's clinical management plan (Paediatrician) 8. Family is followed-up at 6 weeks and 6 months (Paediatrician)	1. CDS referral is identified as having information that corresponds with the ARC Pathway (CDS intake staff) 2. Family is contacted by phone by the CNS and parent/guardian gives initial *verbal* consent to be included in the Pathway 3. Family is given information (including access to online resources) on how they can help their child at home and at school (CNS) 4. CNS meets the family in person for their first assessment appointment 5. Child's parent/guardian will be emailed a link to complete the behaviour questionnaire and forward the link to the child's teacher to complete, along with a classroom educational and behavioural assessment (CNS) 6. Information is collected from the child's school and other sources (CNS) 7. Family attends their second assessment appointment with a paediatrician who determines the child's clinical management plan after liaising with the CNS involved in their first assessment (Paediatrician) 9. Family is followed-up by the CNS (with consultation with the Paediatrician as required) at 6 weeks and by the CNS / Paediatrician in a joint review appointment in 6 months (CNS, Paediatrician)

[Source: Tabled Paper 2, *Inquiry into child development services: Potential questions – Response from the Child and Adolescent Health Service*, tabled by CAHS during hearing held 28 November 2022, p 21.]

7.9 In contrast, WACHS–CDS appears not to utilise clinical nurse specialists in its service delivery. Given that WACHS–CDS expects waiting times for its paediatric services to continue being problematic, the Committee is of the opinion that WACHS–CDS could benefit from utilising clinical nurse specialists in its care pathways. These nurses could have similar roles to the clinical nurse specialists in CAHS–CDS, including working in partnership with paediatricians to maximise workforce efficiency.

RECOMMENDATION 45

The WA Country Health Service–Child Development Service utilise clinical nurse specialists in its care pathways.

[786] Dr J Green, Acting Head of Department, Paediatrics, CAHS–CDS, [*transcript of evidence*], *Legislative Council,* 28 November 2022, pp 44–45.

7.10 Efficient workforce models do not need to be limited to utilising CAHS–CDS and WACHS–CDS staff.[787] As the APS recommended, the CDS providers should:

> Utilise innovative models of assessment, treatment, and intervention to ensure timely access to child development services with appropriate care, e.g., funded collaboration between government and non-government sectors and private practitioners.[788]

7.11 An example of working to the top of scope of practice and incorporating external stakeholders would be the GP–paediatrician shared care model for ADHD management (see paragraphs 3.187–3.225). The paediatrician could be employed by a CDS provider while the GP would be a private practitioner.

7.12 Out of necessity, WACHS often integrates external stakeholders into its workforce models. For example, primary-level healthcare workers, both within WACHS and from the non-government sector (such as Aboriginal health workers[789] employed by ACCHOs), are called upon to screen children and provide the resulting information to WACHS–CDS staff, who are secondary-level healthcare workers:

> in quite a few areas, the WA Country Health Service works very closely with the Aboriginal medical services. In two regions, we provide the Aboriginal Health Service, and it is actually a very close working relationship, where we really rely on other providers—Aboriginal health workers—to do some of that screening, such as ear health tests. They do all that for us already, and certainly in the Child Development Service, we are employing Aboriginal health workers as well as allied health staff and also welfare officers, just to do some of that low-intensity work, getting families ready for it [CDS]. I think that is probably where we might have a little more flexibility in the country, because we have to and our staff are generalists, and we can actually get things started quite quickly. …
>
> So there are complex layers, and it works differently in each region I think would be fair to say, too, depending on people's networks and relationships and connections.[790]

Low intensity workforce

7.13 The establishment of a 'low intensity workforce' was suggested to the Committee as an innovative model of service provision designed specifically to reduce unacceptably long waiting lists. It involves screening for developmental issues, the collection of health data and (possibly limited) supervised therapy provided by specially trained workers. It could be a means of utilising an existing, external workforce to perform the 'lower intensity' activities or the primary-level healthcare associated with child development services (the 'external low intensity workforce'). It may then remove the need to employ more primary-level healthcare CAHS and WACHS staff and allow secondary to tertiary-level healthcare staff to concentrate on more complex clinical specialist tasks.

7.14 Depending on how the model is implemented, the low intensity workforce could also consist of CAHS and WACHS employees (the 'internal low intensity workforce'). However, proponents of low intensity workforces favoured the external model.

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787 Dr Y Anderson, Associate Professor, Community Child Health, Curtin University, Answer to question on notice 1b) asked at hearing held 12 May 2023, dated 16 June 2023, p 1.

788 Submission 74 from APS, 8 November 2022, p 14.

789 Refer to Interim Report, p 17, paragraph 3.10, for information about Aboriginal health workers.

790 S Lennon, Acting Director, Population Health, WACHS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, pp 53–54.

7.15 The TKI informed the Committee of an external low intensity workforce model that has been used successfully in the United Kingdom to help meet the overwhelming demand for mental health services:

> Like many health systems in Australia, the National Health Service (NHS) in the UK had significant challenges addressing the demand for mental health services.
>
> After several Government reviews, the UK Department of health concluded that traditional training pathways (eg. clinical psychology, family therapy, child psychotherapy) were failing to meet the demands being placed on the NHS, and that a 'low intensity' workforce was required to provide services to people with mild to moderate depression and anxiety. The view was that a new 'low-intensity' workforce might help to reduce wait times and free specialist clinicians (e.g., clinical psychologists, psychiatrists) to work with more complex cases.
>
> There are several key elements of the IAPT [Improving Access to Psychological Treatment] program. The first was the two levels of therapists, described above, that is one for children with complex cases and one for children with mild to moderate severity.
>
> The key innovation here was the training of a 'low intensity' workforce of professionals traditionally not included in the mental health system (eg. community workers), who completed training on a select number of evidence-based therapies known to be effective for mild/moderate data collection. The second [key innovation] was high quality training on evidence-based therapies.
>
> The IAPT is considered a major population health success. In the 10 years (2008-2017), it has trained a further 7,000 therapists, and over 580,000 people were seen in IAPT clinic[s]. Critically, the data collection indicated very positive results on patients. Over 50% of people recovered after their initial block of therapy, and 66% of people showed reliable improvements. Economic analyses have indicated substantial reductions in healthcare utilisations and costs.[791]

7.16 TKI then explained how the United Kingdom model could be implemented for the CDS system:

> The experience of implementing the IAPT model is highly instructive to the current challenges faced by WA child development services. The WA child development services is also seeking to address health issues where early intervention is critical (i.e., developmental delays), but is experiencing significant work force shortages and substantial wait times for children and families. Traditional training pathways (i.e., speech pathology, occupational therapy, physiotherapy, psychology) are also not meeting the demands placed on the system.
>
> The Institute believes that the WA Government has the key ingredients to explore implementing a similar system in WA. First, WA could seek to develop a 'low intensity' work force, who could be used to provide support to children with milder developmental delays. Potential professionals who could make up this cohort include early childhood educators, therapy assistants and other associated professionals. Second, a highly efficacious evidence-based therapy for children with developmental delay, Inklings[792] … has been tested in two randomised controlled trials, and found to be efficacious in reducing developmental problems

791 Submission 85 from TKI, 18 November 2022, p 8.

792 '"Inklings", developed by the Institute's Professor Andrew Whitehouse, is a new early intervention program for babies showing early behavioural signs of autism. Initially trialled in close partnership with the CDS/CAHS, positive findings from the pilot program have led to plans to roll out Inklings across WA with funding from the NDIS, in partnership with CAHS and the Institute': Submission 85 from TKI, 18 November 2022, p 3.

> and increasing skills in infants (aged 6-18 months) showing developmental delay.[793]

7.17 Dr Yvonne Anderson, a paediatrician working across Curtin University, the TKI and CAHS, pointed out that:

> When alleviating the pressure on the health system, whilst developing the skills of other professionals is important in potentially assessing and supporting lower acuity presentations, **this will not assist with the more complex children requiring support**, which is an area of growth in terms of referrals for child development services within health. **Any development of a "low intensity" workforce needs to be in addition** [to] rather than in replacement of **current health service provision**.[794] (emphases added)

7.18 As the TKI submitted, in the context of the CDS system, the external low intensity workforce would not necessarily be health practitioners or even have a background in health. They could work in environments where they are interacting with young children regularly, meaning that they could be very familiar with each of the children, be aware of their individual traits and capabilities, and have an idea of the dynamics in their families. For example, TKI identified ECEC workers as potentially being able to fulfil this role.

Early childhood education and care

7.19 The ACA argued that ECEC centres are an under-utilised asset – not just in terms of a setting in which CDS can be provided (see paragraphs 3.149–3.156) but also because of their educators and carers, who could help screen for child development issues.[795] In the opinion of a child development clinician who wished to provide evidence in private, it would be appropriate for ECEC workers to be part of a low intensity workforce.[796]

7.20 The Committee heard evidence that some ECEC workers have effectively already formed a low intensity workforce. As part of the Ears2Learn program, Goodstart Early Learning Centres in Western Australia provide ear health checks to the children in their care, at no cost to the families, and 'Demand currently outstrips capacity'.[797] The ear checks are performed by the educators and carers in the centres, after receiving training from Earbus.[798] The trained ear screeners have their ear check results reviewed by audiologists from Earbus and undergo six-monthly competencies to maintain their skills.[799] (See Appendix 6 for a flow chart that explains how the ear checks are conducted)

7.21 Connecting Community for Kids advised that Ears2Learn:

> is an example of a community identified and co-designed solution to provide universal access to ear screening for children aged 7 months – 5 years. …
>
> …
>
> Currently there are no universal ear screening programs for young children after The Newborn Hearing Screening Program and before they commence school.

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793 Submission 85 from TKI, 18 November 2022, p 8.

794 Dr Y Anderson, Associate Professor, Community Child Health, Curtin University, Answer to question on notice 1a) asked at hearing held 12 May 2023, dated 16 June 2023, p 1.

795 Submission 71 from ACA, 7 November 2022, p 6.

796 Private citizen, [*private transcript of evidence*], p 4.

797 Submission 71 from ACA, 7 November 2022, p 6.

798 See Interim Report, p 36, paragraph 3.86. See also, paragraphs 3.109 and 4.146 of this report.

799 Submission 44 from Connecting Community for Kids, 24 October 2022, p 3, 'Ears2Learn – Helping your children to thrive', and p 5, 'Program logic – Ears2Learn 2022'.

> Since we began the rapid trials, and further refinement of the Ears2Learn program, Child and Adolescent Health Service have advised that Child Health Nurses will be equipped with tools to enable ear screening and that funding for this is in the forward estimates. This is fantastic news, however less than 25% of all 2 years old's access their developmental check and children in full time childcare are less likely to be able to, and more in need of, accessing this screen.
>
> Ears2Learn was established in 2019 and is now delivered across 15 Goodstart Early Learning Centres in WA and the Moorditj Kulungar Aboriginal playgroup in Kwinana. We have also partnered with the South Metropolitan Ear Health Program (Cockburn Integrated Health) to support Aboriginal children gain immediate access to a referral pathway. Ears2Learn was developed to address the growing issue of poor ear health in young children, acknowledging that children in full time day care have higher rates of ear disease due to proximity of multiple children and also making use of the wonderful relationships childcare staff have with children that enable them to take compliant screens and therefore lessen the need for an audiology booth as the first option.
>
> We have evaluated the program and believe if scaled Ears2Learn provides a viable low-cost and universally accessible opportunity to provide ongoing early intervention ear screening for children across WA.[800]

7.22 In the Committee's view, properly trained and supervised ECEC workers could form the basis of a suitable external low intensity workforce because:

- they are already familiar, and have an established rapport, with the children in their care
- they care for children who are aged zero to five years, which is the optimum age range for conducting early intervention[801]
- for children who attend an ECEC centre regularly, they have the opportunity to conduct scheduled child development screening and/or spot checks as required
- they have the appropriate facilities in which to conduct screening
- the parents of children who attend an ECEC centre regularly may not have the opportunity to take their children to see a child health nurse.

School staff

7.23 Dr Mark Parker, a private neurodevelopmental paediatrician, was supportive of screening and assessment being done at the 'grassroots' level:

> it is no good coming to see me [after being referred by the school] with no information … and then I send them back to either get a private assessment or try to get one through the school and then they are back again. Once again, I have seen them twice. I could have seen them once if things had been done at the grassroots level. I think a lot of the demand would be decreased, too, if they were getting more support through schools.[802]

7.24 WACHS indicated that more education assistants in remote regional schools could help its CDS practitioners ensure that the students in the school continue to adhere to intervention programs:

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800 Submission 44 from Connecting Community for Kids, 24 October 2022, p 1.

801 See Interim Report, pp 11–13, paragraphs 2.25–2.34, for a discussion of early intervention.

802 Dr M Parker, neurodevelopmental paediatrician, [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 12.

> increased numbers of education assistants in some of our more remote schools would also be beneficial for WACHS in that, if we only visit four times a year, for example, we are able to provide a program that an education assistant perhaps could include within what is happening within that school, and we then act as a consultative service, almost, to those very remote schools that we do not get to regularly.[803]

RECOMMENDATION 46

The State Government explore opportunities to develop a low intensity workforce which functions in addition to and in support of current community health service provision.

Proper recognition and utilisation of child health nurses

7.25 While community health nurses (child health nurses and school health nurses) are not strictly part of CAHS–CDS and WACHS–CDS, they do have an important primary healthcare role[804] which can then lead to referrals to the CDS system, if necessary.[805]

7.26 Child health nurses, in particular, have the opportunity to see children at a very young age and will generally interact with families more than once. They are therefore, in a unique position to provide early interventions, which can include identifying potential developmental issues and providing the family with advice, support and strategies. These interventions may be sufficient to divert children away from the CDS system. At the very least, these nurses can support families while they are waiting for secondary child development services.

7.27 A child development clinician who wished to provide evidence in private is concerned that child health nurses are not working to the top of scope of practice:

> The reality is that child health nurses are not providing—they are not working anywhere near the top of scope. At the moment, they are focused really on the churn of getting babies through—to assess babies on weight, height, all of those things that are really important, but the ability to provide therapy and intervene, we are nowhere near that.[806]

7.28 The Committee also heard evidence that child health nurses do not feel as well respected, or as highly valued, as they should be:

> Child health nurses making referrals for babies identified as being developmentally at risk on ASQ [Ages and Stages Questionnaire] at 4 months have these referrals rejected and told wait until 8 months.[807]

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> Members report that some regions in Perth face chronic child health nurse staff shortages with positions left unfilled for lengthy periods meaning that the nurses in those areas face insurmountable workloads with great difficulty obtaining leave

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803 L Pereira, Manager, Child Development Service, WACHS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 53.

804 See Interim Report, pp 16–17, paragraph 3.9.

805 See paragraphs 5.17–5.25 in this report for a discussion of the relevance of child health nurses to the CDS system and child development services more generally.

806 Private citizen, [*private transcript of evidence*], pp 3–4.

807 Submission 53 from MCFHNA, 24 October 2022, p 15.

replacement meaning staff are stressed when taking leave knowing their colleagues will be under pressure.[808]

▫▫▫

"There is low morale that I see in my team and also in my clinical supervision colleagues-across the metropolitan area. Several colleagues are planning to leave, and some early career child health nurses have left already."[809]

▫▫▫

Hon DONNA FARAGHER: … is it a fair reflection, based on what you have just said, that child health nurses and school health nurses do not feel valued by the department and others?

Mrs WIGHTMAN: Yes, that would be an absolutely fair reflection because, as we said, they have extensive knowledge and skills in this area, and their assessments are not respected.

Hon DONNA FARAGHER: On that, given that there are a number of shortages here in Western Australia, both in metropolitan and country WA, for child health nurses, do you think part of the issue is with regard to the lack of value of child health nurses? …

Mrs WIGHTMAN: Absolutely, if you are constantly coming up against brick walls when you are trying to be innovative and suggest flexibility of service and that is not even taken any notice of. What we used to do, five years ago, is something that we can no longer do, and they are saying, "But there are families who have concerns", and you are being told, "Oh, it's too hard. We've got a workforce issue." There is a workforce issue all around Australia, in every workforce, and in every aspect of nursing and midwifery, there is a workforce shortage, but that is not an excuse.[810]

▫▫▫

I think the child health nurses are not valued like they used to be, and they are not in the community, and there probably are not enough of them now, and they have very restrictive hours. I do not think they have regular education, and I say I do not think so because I know that whenever I give a talk to them, … there is just a full house, and they are just thirsty for new information.[811]

▫▫▫

When a positive relationship is developed with a family in the neonatal period and the value of the child health nurse is clear to the family, they are more likely to access the service for child health and development advice and attend scheduled health and development checks.[812]

7.29 The TKI agreed that child health nurses should be prioritised:

The value of Child Health Nurses, and the associated "Purple Book", is an important component of the WA CDS system, with a visit to the local child health

808 Submission 53 from MCFHNA, 24 October 2022, p 6; and see also, p 16.

809 Submission 53, p 6; and see also, p 17.

810 Hon Donna Faragher MLC, Deputy Chair; and L Wightman, Chair, MCFHNA Board, [*transcript of evidence*], *Legislative Council*, 20 February 2023, p 15.

811 Private citizen, paediatrician, [*private transcript of evidence*], p 10.

812 Submission 48 from Playgroup WA, 24 October 2022, p 3.

nurse the main (and often only) way for parents to seek information about whether their child is growing and developing as they should. It is also one of the ways in early risk factors can be identified and followed up on.

The Institute considers additional investment in Child Health Nurses to be critical to support the parents of babies and children to understand child development and assist in the very early identification of development issues. Through regular contact with families, they provide trusted, non-judgemental support in areas such as infant feeding, child development, injury prevention and child safety and protection, and importantly help connect parents and families by encouraging ongoing social support networks. Continued and additional Government support for these services is needed.[813]

7.30 The Committee also heard evidence that child health nurses with more qualifications and experience are not recognised for those attributes:

Ms MARTIN: … It used to be that you had to have postgrad experience to work as a child health nurse because it is autonomous and working at a higher level, but that expectation has been removed in the last two years. …

…

Ms MARTIN: People without postgraduate [qualifications] can get a level 1 position now.

Mrs WIGHTMAN: Yes, they [child health nurses] are all registered nurses and the expectation has been that they would do a postgraduate course in child and family health nursing or child and adolescent family health nursing. Some of them are also registered midwives as well. In has been in the last couple of years that they are taking on registered nurses with no qualifications in a postgraduate course in child and family health and trying to upskill them in the workplace.

The CHAIR: This is the Department of Health, is it?

Mrs WIGHTMAN: Yes.

Hon DONNA FARAGHER: Is that because of shortages? What has precipitated that change in the past two years?

Mrs WIGHTMAN: From what I gather from the members [of MCFHNA] in WA, it began as a reasoning that we needed more of a workforce, but it has also been the case that the qualifications, as they said, were clinical nurses level 2, and they could pay them less as level 1 registered nurses. The requirement I guess for people to do a postgraduate course means that it has become more expensive. Also, members are telling me that people will not go and do that course because they are not guaranteed any employment because the child and family health space has turned into lots and lots of contracts without guaranteed long-term employment. The challenge is that there is no workforce wanting to work when they cannot get a full-time job, so therefore the workforce issue has increased. Members are telling me that during COVID, because the borders were locked, particularly in the north west and rural and remote they often rely on interstate staff to come and work in community health areas and they were unable to get in, so that has actually increased the challenge.[814]

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813 Submission 85 from TKI, 18 November 2022, p 4.

814 Hon Dr Sally Talbot MLC, Chair, and Hon Donna Faragher MLC, Deputy Chair; and C Martin, Paediatric Nurse Practitioner, NursePrac Australia/Just Kids Health Clinic, and L Wightman, Chair, MCFHNA Board, [*transcript of evidence*], *Legislative Council*, 20 February 2023, pp 4–5.

▫▫▫

> With regard to "workforce pathways", MCaFHNA [Maternal, Child and Family Health Nurses Australia] strongly advocates that healthcare must be "appropriate and meet the needs and expectations of the community" through appropriate qualification and expertise in the speciality/specialised field of child and family health nursing. This means that families expect to receive care commensurate with experience and qualifications. They do not expect that they will be provided services by unqualified Child Health professionals. Disappointingly, members report:
>
> > *We face a preference by management that child health nurses are placed as level one nurses.*
> >
> > *We have policies being developed for child health nursing practice by non-nurses.*
> >
> > *We need to ensure that child health screening and appointments are conducted by nurses with a certificate in child heath family nursing.*
>
> MCaFHNA supports the Australian College of Nurses position statement in regard to what constitutes an "appropriately qualified Child and Family Health Nurse" and offer the National Standards of Practice for Maternal, Child and Family Health Nurses in Australia … to support and promote ongoing professional development for Child Health Nurses.[815]

▫▫▫

> It is not just about screening or ticking boxes – it is about providing holistic and specialised health care for families with young children – and being skilled enough to know how and when to intervene.[816]

7.31 In the Committee's opinion, the knowledge and skills of child health nurses ought to be better recognised and valued by CAHS and WACHS. This will help to empower child health nurses by ensuring they can work to the top of their scope of practice, thereby delivering the effective primary-level healthcare on which a fully functional secondary and tertiary CDS system depends.

FINDING 52

The knowledge and skills of child health nurses are not as well respected, or as highly valued, as they should be, and as they have been in the past.

RECOMMENDATION 47

The Child and Adolescent Health Service and WA Country Health Service address the perceived devaluation of child health nurses to ensure that their knowledge and skills are appropriately recognised, valued and utilised.

Potential utilisation of nurse practitioners

7.32 The Committee received evidence that nurse practitioners have much to offer the CDS system, both in terms of an advanced referral source, outside of the system, and as assessors

[815] Submission 53 from MCFHNA, 24 October 2022, p 6; and see also, p 17.

[816] Submission 53, p 17.

of child development, within the system. The Sustainable Health Review panel recognised the value of this profession to the whole of WA Health:

> The WA [public] health system currently utilises Nurse Practitioners however there is an opportunity for expanded use, particularly in areas of community health need. Nurse Practitioners can work across the full spectrum of health service delivery, including acute and community care, and bridge gaps between tertiary and community healthcare in cost-effective ways. Nurse Practitioners can contribute to improved access to care, support primary care providers, reduce emergency department presentations and hospital admissions, and decrease length of stay.[817]

7.33 Currently, there is no nurse practitioner role within the CDS system.[818] The few nurse practitioners who practise in Western Australia tend to work in either a hospital setting or the private sector.[819] Nurse practitioners are:

> all registered nurses. To become a nurse practitioner, you have to have a minimum of five years' advanced practice, then you have to do an accredited master's degree. Then, after you have that and can demonstrate at least 5 000 hours of advanced practice in the last three years, you then apply for endorsement to the national nurses' board. Once you are endorsed as a nurse practitioner, which is not automatic, we can diagnose, we can prescribe, we can order diagnostic tests, we can Medicare bill, we have a provider number, and we can work collaboratively and independently. …[820]
>
> ▫▫▫
>
> nurse practitioners are separately registrable … They do work at a higher level … within their designated scope, which is developed depending on the role they take, they can order medicines. They can also order pathology …[821]

7.34 In comparison, clinical nurse specialists, who do have a role in the CDS system, particularly in CAHS–CDS, are classed as:

> an SRN3 position on the ANF [Australian Nursing Federation] industrial relations [agreement]. An SRN3 position is a manager, a clinical nurse manager, with lots of management responsibility for a region. A clinical nurse specialist in child health, for example, who would lead the partnership stream. Within the award it is really clear that there are roles and responsibilities attached to that. A nurse practitioner … is a much higher level and the role would have a specific remit. So, for example, it might be anaemia in children. It tends to be more of a medical model—a justified medical model. The nurse practitioner might take on something such as management of anaemia within a specific area … for community nursing with well

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817 DOH, *Sustainable Health Review Final report to the Western Australian Government*, DOH, 2019, accessed 19 February 2023, p 104.

818 S Kiely, Executive Director, and A McHugh, Acting Nurse Co-Director, Community Health, CAHS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 32. See also, Interim Report, p 21, paragraphs 3.29–3.30 and pp 28-29, paragraphs 3.54–3.56.

819 For example, they tend to practise in GP clinics. In WACHS, there are 'quite a number of nurse practitioners but very much in the cancer, palliative care and emergency department areas': K Miller, Director, Population Health, WACHS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 33. In CAHS, there are a nurse practitioners who work in Perth Children's Hospital, within a specific scope of practice: A McHugh, Acting Nurse Co-Director, Community Health, CAHS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 33.

820 S Dowden, Paediatric Nurse Practitioner/Director, NursePrac Australia/Just Kids Health Clinic, [*transcript of evidence*], *Legislative Council*, 20 February 2023, p 3.

821 K Miller, Director, Population Health, WACHS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 33.

> children, it [the nurse practitioner role] is not something that we utilise, but we have plenty of clinical nurse specialists.[822]

7.35 Paediatric nurse practitioners, who practise in the private sector, gave evidence that, despite being very experienced in child development and providing very detailed referrals to CAHS–CDS, their referrals are not trusted by paediatricians any more than referrals from non-health professionals:

> Pretty much the way children get into CDS as a referral is that either a child health nurse might do a baseline developmental assessment and it comes up as a flag so they would refer, or a childcare centre might refer or a GP or a school would refer with concerns. And that can be quite a brief amount of information that is given. However, when children come and see us, we do a very detailed assessment. We do a lot of screening. It is all evidence based. We use the same assessment tools that we know other services use. We are able to actually give a lot of information. Unfortunately, unless we have a huge amount of time to lobby and advocate for our clients, our referral is not generally treated any differently from anyone else's, which I think is a wasted opportunity because, essentially, we can pretty well demonstrate that this child has clear signs of autism spectrum disorder evidenced by all of these things or they have clear signs of severe global developmental delay evidenced by these things. We have tried pretty hard to get some shifting there. There is some interest, but I think there is so much a feeling of being overworked and overwhelmed with the volume, and with such a little voice in the system, it has not really progressed.[823]
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> ▫▫▫
>
> I have an example of a family who did not engage with child health services at all early on because the family is illiterate. Mum had drug issues and then went to jail. The two kids ended up going back to dad. Dad did not know anything about child health services, and they are both non-verbal autistic children. That was not picked up until they hit kindy, and the teacher was like, "What is going on here?" The dad was like, "Well, they are perfectly happy in their own world. It is just not my world." He had been managing that on his own. To get him into the services, I probably did nothing but that for three days—on the phone, ringing and trying to get him fast tracked. What I got from CDS was, "We cannot fast track that until someone in CDS sees this child", which was frustrating because I have worked at advanced practice for a very long time. There are a lot of people out there like me who can make these assessments. To be told that we cannot escalate you until a speech pathologist—who do a fantastic job, by the way—or a social worker sees this child to escalate it. I am an advanced practice paediatric nurse. That is the frustration we see.[824]

7.36 With respect to nurse practitioners having a greater role within the CDS system, WA Health is of the view that it is far more efficient and economical to utilise clinical nurse specialists for the assessment of children, particularly when a diagnosis from a paediatrician is indicated.[825] WA Health confirmed that child health nurses are classed at a lower level, and are therefore

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822 A McHugh, Acting Nurse Co-Director, Community Health, CAHS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 32.

823 S Dowden, Paediatric Nurse Practitioner/Director, NursePrac Australia/Just Kids Health Clinic, [*transcript of evidence*], *Legislative Council*, 20 February 2023, p 5.

824 C Martin, Paediatric Nurse Practitioner, NursePrac Australia/Just Kids Health Clinic, [*transcript of evidence*], *Legislative Council*, 20 February 2023, pp 11–12.

825 For example, refer to paragraph 7.7 of this report for a discussion on the proposed expanded role of clinical nurse specialists in ADHD assessment and diagnosis.

less expensive, than nurse practitioners, and they are already employed by CAHS–CDS. There appears to have been no exploration of how nurse practitioners could fit into the existing workforce models and be adequately trained and credentialled for a child development specialty:

> **Ms MILLER**: … nurse practitioners are employed at what we consider an SRN7 level. I suppose I am more curious about: are they [other stakeholders] suggesting the nurse practitioners taking on some of that paediatrician level type of work?
>
> **The CHAIR**: Yes, I think what we have just had described to us is the CNSs working to a certain level consistent with their training and experience, but that a nurse practitioner can provide a higher level of medical intervention that would then take some of the burden away from the paediatricians and the psychologists.
>
> **Ms TURNELL**: I do not think it is that we are averse to the idea; I think it is that we are looking at what is the first next thing we can do, and the next most immediate scalable opportunity that we have is to take the models that we have piloted with clinical nurse specialists and be able to expand them, and we could make an immediate difference on the paediatrician service delivery. Over time, we could certainly then take another step and look at how do we add a nurse practitioner role into that, but that role would need some definition. We would have to think about training pathways, we would have to think about who wants to move into that training pathway, so it would just take longer to have that type of role make an impact on the service delivery.
>
> **Dr JONGELING**: Yes, I would agree. I do not think we have a philosophical objection to their role at all. I do not think it has been either an option or a funding option. I think, as I said earlier, the key issue is with what experience and training do they come to that role, because it is complex work. We would want to both understand that and then ensure that it fitted in with the service designs and service approach that we carry.
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> …
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> **Ms MILLER**: Nurse practitioners have a very specific credentialing process. We would have to define exactly what they are going to do, and then they need to demonstrate their credential to do what they are doing, so yes, it would just be a bit of work.
>
> **The CHAIR**: I see, and there is not an obvious role at the moment —
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> **Ms MILLER**: No.
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> **The CHAIR**: — that the nurse practitioner would step into, is that correct?
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> **Ms MILLER**: Yes.
>
> …
>
> **Hon SAMANTHA ROWE**: So would they [nurse practitioners] not be able to assist the paediatricians and the like with that waitlist and help in terms of reducing that waitlist?
>
> …
>
> … would the nurse practitioners not be able to do the Bayley and the Griffiths [child development assessment tests]?
>
> **Ms MILLER**: No, they can, but we can get a CNS to do that, so why pay an SRN7 to do something that an SRN3 can do?

…

Ms MILLER: So what we would need to look at is what more can the SRN7, the nurse practitioner, do that possibly could reduce it. [doh,tr,26/4/23,p36]

Hon SAMANTHA ROWE: Okay, that the CNS cannot do.

Ms MILLER: Currently, that has not been explored.

…

Ms MILLER: Can I just clarify: with the nurse practitioners, there is a core part to the program, and then you specialise. You need to choose your speciality that you are going to work towards … there are not any core components in there for child development or emergency or whatever. You need to determine after you have done your core subjects then what you specialise in, and then that is where you then go and get credentialed in that particular area, and then, when you register with the nurse practitioner board, they are the things that you register on.

The CHAIR: So there would be a sub-speciality that is child development, presumably.

Ms MILLER: We would have to define what that specialty child development looked like for a nurse practitioner to follow.[826]

7.37 Even though the possibility of nurse practitioners working in the CDS system does not appear to have been explored properly, the RACP indicated that it would be reasonable for suitably trained nurse practitioners to be involved in stimulant co-prescribing for the medicinal treatment of ADHD (see paragraph 3.206). CAHS–CDS's head of paediatrics also acknowledged this (see paragraph 3.191).

7.38 Dr Yvonne Anderson is of the view that nurse practitioners are highly valuable, but agreed with WA Health that in the shorter term, clinical nurse specialists are the more 'obvious opportunity'.[827]

7.39 Given the workforce pressures currently being experienced by the CDS providers, the Committee is of the view that employing nurse practitioners is one obvious solution to easing these pressures. The Committee is aware that clinical nurse specialists are currently being utilised, at least by CAHS–CDS, to reduce the need for paediatricians to conduct developmental assessments.[828] However, CAHS–CDS paediatricians are still relied upon to perform the work that cannot be done by clinical nurse specialists, such as medical diagnoses and the prescription of medicines. Nurse practitioners are ideally positioned to fill this role:

> Nurse practitioners are advanced practice nurses who are legislatively authorised to undertake diagnostic assessment, treat, prescribe and refer patients within their approved scope of practice.
>
> …
>
> Within their scope of practice nurse practitioners:

826 Hon Dr Sally Talbot MLC, Chair, and Hon Samantha Rowe MLC; K Miller, Director, Population Health, WACHS; and A Turnell, Acting Director, Clinical Services, CAHS–CDS, and Dr B Jongeling, Medical Head of Department, CAHS–CDS [*transcript of evidence*], *Legislative Council,* 26 April 2023, pp 34–37.

827 Dr Y Anderson, Associate Professor, Community Child Health, Curtin University, [*transcript of evidence*], *Legislative Council,* 12 May 2023, pp 12–13.

828 For example, refer to paragraph 7.7 of this report.

- perform health assessments
- order and interpret diagnostic investigations
- diagnose and treat a variety of health problems or conditions
- prescribe and deprescribe medications
- initiate and receive appropriate referrals from healthcare professionals.[829]

FINDING 53

Nurse practitioners have the appropriate combination of skills and authority to perform tasks that will both complement and supplement the skills and authorities held by the existing workforce disciplines in the Child and Adolescent Health Service–Child Development Service (CAHS–CDS) and WA Country Health Service–Child Development Service (WACHS–CDS). CAHS–CDS and WACHS–CDS should be able to ease some of their workforce pressures by utilising nurse practitioners.

RECOMMENDATION 48

The Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service investigate the feasibility of employing nurse practitioners.

The future workforce

7.40 In addition to maximising the efficiency of workforce models, the State Government also needs to ensure the continued availability of a future CDS workforce.[830] This will involve collaborating with external stakeholders, such as the Commonwealth Government, universities and health professional training providers.

7.41 WA Health is well aware of a need for stronger workforce pathways.[831] An obvious strategy to boost the future workforce is to increase university places for allied health, nursing and medical courses.[832] However, that must be met with a commensurate increase in practical training positions, both:

- *during* the final year(s) of these university courses – that is, practical training placements for students

  and

- *after* students have graduated from university – that is, the further professional and specialty training that can be required for some disciplines.

7.42 While several witnesses, including the RACP, the AMA and South West Autism Network, make reference to exploring options regarding the use of overseas trained professionals,[833] the Committee has focused attention on exploring options to build and maintain the local workforce.

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829 DOH, *Nurse practitioners in Western Australia*, DOH, 2022, accessed 19 March 2024.

830 This topic was introduced in the Interim Report, pp 89–90, paragraphs 5.8–5.10.

831 Submission 77 from WA Health, 9 November 2022, pp 8 and 70.

832 Submission 77, pp 70, 71, 72 and 73.

833 Submission 89 from RACP, 24 April 2023, p 3; Submission 82 from Australian Medical Association (WA), 11 November 2022, pp 7 and 12; and Submission 29 from South West Autism Network, 23 October 2022, p 16.

Increasing university places

7.43 Professor Adrian North, from Curtin University's Faculty of Health Sciences, which offers many allied health, nursing and medical courses, advised the Committee that the university is willing to increase the number of places for courses that are relevant to CDS. However, as at November 2022, there were three limiting factors:

(i) Commonwealth funding for university places:

> I understand that the University recruits to a level that means we have reached our cap of funding for Commonwealth-supported students. In the context of health sciences disciplines the student contribution alone represents a small proportion of total teaching costs. Consequently any attempt to scale up provision (e.g., via new courses) represents an increase in resource requirements but with relatively little additional resourcing available.[834]

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> because we already recruit to a very high level, … we literally just cannot take anymore [students], essentially; if we take any more students, in effect, we only receive the student contribution, not the full commonwealth-supported contribution.[835]

(ii) The cost of student practical training for the university:

> A number of providers of student fieldwork placements have informed us of their intention to begin or increase charges we must pay in order [for them] to host our students. While we await confirmation of the specific financial impact of this, the net effect is a significant increase in costs which inevitably impacts the resources we have available to undertake other activities.[836]

(iii) The limited availability of student practical training placements (see also, paragraphs 7.48–7.76):

> The COVID pandemic placed enormous strain on the resources of the healthcare system, and required premises to impose strict limitations on who was deemed essential to be on site. One necessary but unfortunate consequence of this has been a significant backlog in students who require access to healthcare premises in order to meet accreditation requirements for their discipline and subsequently graduate into the workforce. We are confident that this will be resolved over time, but in the meantime represents an acute constraint on the supply of graduates in many health-related disciplines.[837]

7.44 In May 2023, after more time had passed since COVID restrictions were removed, Professor North confirmed that the availability of student practical placements was still an issue for universities offering health professional courses:

> One issue that we and I suspect almost all other universities face is that were the placements available, we could take many more students in. That is the thing that constrains our ability to recruit and graduate; it is simply the availability of

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834 Submission 67 from Curtin University, Faculty of Health Sciences, 1 November 2022, p 1. Dr Elizabeth Green and the APS also identified government funding as a limiting factor for university places: Submission 50 from Dr E Green, paediatrician, 24 October 2022, p 7; and Submission 74 from APS, 8 November 2022, p 11.

835 Prof A North, Interim Deputy Pro Vice Chancellor, Faculty of Health Sciences, Curtin University, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 4.

836 Submission 67 from Curtin University, Faculty of Health Sciences, 1 November 2022, p 1.

837 Submission 67, p 1.

> placements. That is by some distance the main barrier, I would say. Eventually, we would hit some sort of natural limit around the capacity of lecture theatres and so on, but, realistically, that [placements] is the pragmatic issue that we have to address here.[838]

7.45 Dr Yvonne Anderson confirmed the presence of the three limiting factors identified by Curtin University, but added that there is another, perhaps the ultimate, limiting factor of employment opportunities:

> courses would also be guided by available workforce predictions, which are loose at best, as it would be unethical for Curtin to graduate thousands of health professionals if they can't find employment.[839]

The OT Associations proposed the introduction of cadetships and bonded placements as strategies to help ensure that recently qualified health professionals have viable career paths within the CDS system.[840]

7.46 The Committee also received suggestions that some allied health university courses are focusing more on services for adults, at the expense of services for children:

> Universities are obviously crucial in training the psychology and medical workforce. There is no longer a specialist **Educational and Developmental Psychology course** in Western Australia.[841] (emphasis added)
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> ▫▫▫
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> The **Educational and Developmental [psychology] Masters course** previously offered at the University of WA, which provided a training pathway for specialising in working with children within a developmental context (child, family, and school), was closed some time ago by the University (it was identified as 'not cost-effective'). This has resulted in a very high demand for services by Educational and Developmental Psychologists in WA and waiting lists for this specialty are extremely long. The provision of training opportunities for those who have an ambition to work as a psychologist with children and families is a critical area of need in Western Australia. It is noted that there are only four training courses left in this specialty in Australia and this needs to be a focus for rectification by all state governments (with the exception of Victoria) across Australia. The WA CEDP [College of Educational and Developmental Psychologists/Australian Psychology Society] branch is very keen for this specialist course to be re-established at one of the Universities in Western Australia as it constitutes a very large gap in services for children and their family in WA.[842] (emphasis added)
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> ▫▫▫
>
> Curtin University and The University of Notre Dame Australia deliver entry-level [**physiotherapy**] courses that include paediatric content. The universities are required to meet the standards set by the Australian Physiotherapy Council who accredit courses. All students participate in lectures and other teaching on campus. A small proportion of students will undertake clinical placements in a paediatric

838 Prof A North, Deputy Pro Vice Chancellor, Faculty of Health Sciences, Curtin University, [*transcript of evidence*], *Legislative Council,* 31 May 2023, p 4.

839 Dr Y Anderson, Associate Professor, Community Child Health, Curtin University, Answer to question on notice 5 asked at hearing held 12 May 2023, dated 16 June 2023, p 3.

840 Submission 80 from OT Associations, 14 November 2022, p 6.

841 Submission 52 from private organisation, 24 October 2022, p 2.

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

> facility. Curricula are frequently reviewed and modified depending on dictates from the Universities. There is a risk that Curtin and Notre Dame may reduce their paediatric teaching, as has been the case in some universities in other Australian states. The APA [Australian Physiotherapy Association] is concerned that paediatrics may be removed from the entry-level courses, which will make recruitment of the workforce difficult, and shift the responsibility of teaching to the paediatric service providers, including CDS [providers].[843]
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> ▫▫▫
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> All core allied health qualifications include curriculum linked to paediatrics and child development; however, it is noted that for some professions child development content may be limited. The current undergraduate **physiotherapy** university courses would benefit from inclusion of standard or core competencies for paediatric curriculum in their courses. Although the importance of this appears to be acknowledged, the main barriers to the implementation include crowded curriculum, limited funding and inadequate opportunities for paediatric placements.[844] (emphasis added)

7.47 WA Health submitted that it would advocate for:

- 'increased places in allied health courses'
- 'a standard set of core competencies for the paediatric curriculum to inform the Physiotherapy course program.'[845]

RECOMMENDATION 49

The State Government work with the Commonwealth Government, Western Australian universities and health professional regulatory bodies to increase university places in allied health, nursing and medical courses, and ensure adequate paediatric content in these courses.

Increasing practical training placements

7.48 Practical training placements include both:

- student practical training placements – required by allied health, nursing and medical students

  and

- postgraduate practical training placements – for example, medical doctors are required to complete additional training, including clinical work, to become medical specialists (these trainee medical specialists are referred to as registrars); and psychology graduates are required to complete at least one placement before they can be registered psychologists.[846]

7.49 Practical training placements are often referred to as 'clinical placements' or simply, 'placements'. As discussed already (see paragraph 7.43), the availability and certainty of student placements can often dictate how many university places are offered.[847] Similarly, the

[843] Submission 73 from Australian Physiotherapy Association, 8 November 2022, pp 8–9.

[844] Submission 77 from WA Health, 9 November 2022, p 71.

[845] Submission 77, p 74.

[846] Dr C Davis-McCabe, President, APS, [*transcript of evidence*], *Legislative Council,* 9 February 2023, p 5.

[847] See also, Prof C Elliott, Director of Research, TKI, [*transcript of evidence*], *Legislative Council,* 9 February 2023, p 10; and Submission 74 from APS, 8 November 2022, p 9.

availability and certainty of postgraduate placements can dictate how many postgraduate training positions are available. This is due to the practical nature of health professional training. Essentially, placements are mandatory for health professional training; without them, the university students and registrars will not be able to complete their overall training and obtain their qualifications.

7.50 A practical training placement requires a workplace that can offer the clinical experience being sought by students or registrars, as well as practitioners who are willing and able to supervise these students or registrars. CAHS–CDS and WACHS–CDS are two such workplaces for allied health, nursing and medical (paediatrics) disciplines. Therefore, the CDS providers must be part of the solution for ensuring placement availability and certainty.

Allied health and nursing students/postgraduate trainees

7.51 The APS provided some suggestions on how WA Health could assist with placements:

> The Department of Health [WA Health] could … support university clinical placements for health professions across a range of services to encourage graduates to work in the child development sector, to reinforce areas of workforce shortage and to promote collaboration between students from different professional backgrounds from an early stage in their careers.[848]
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> ▫▫▫
>
> [Specifically for psychology but applicable to other healthcare disciplines] The Western Australian government needs to establish a placement model to maximise supervisor/trainee ratios regardless of location. With the right support, the APS [Australian Psychological Society] is ideally suited to support such an initiative using similar technology to our 'Find a Psychologist' tool …[849]
>
> ▫▫▫
>
> [Specifically for psychology but applicable to other healthcare disciplines] The Western Australian government also needs to establish a state psychology workforce initiative – including incentivising psychology supervisors to take on interns and registrars, particularly in areas of workforce shortage, to ensure every part of this state has a psychology workforce in development.[850]

7.52 The APS indicated that it could support any State Government efforts to improve placement availability and certainty, by training and approving psychology supervisors.[851]

7.53 The OT Associations suggested that jointly managed student clinics could provide some placements:

> We feel that there is great potential for student clinics (across a range of medical and allied health disciplines) to **WORK COLLABORATIVELY WITH WESTERN AUSTRALIAN PUBLIC SERVICES** to provide increased quality services and greater frequency of service to children with developmental concerns.
>
> Whilst students cannot replace professionals, there is the potential for students to supplement occasions of service and dedicated, structured programmes that are jointly managed by Health Department and universities could potentially address some of the current gaps in child development services in Western Australia. With

848 Submission 74 from APS, 8 November 2022, p 11.

849 Submission 74, p 9.

850 Submission 74, p 10.

851 Submission 74, p 10.

> input from quality, experienced clinicians, these clinics could equip medical and allied health students with the necessary skills to enhance child development services (public and private) as new graduates.
>
> … initiatives in … clinics run jointly by university and health collaboration would likely benefit children and families in rural and remote Western Australia.[852] (original emphasis)

7.54 Associate Professor Marina Ciccarelli from Curtin University noted that student clinics can be beneficial, but may not offer students a 'real world' experience:

> We have some of our own Curtin student-led clinics that are used for final year professional practice placements where there is some opportunity for interprofessional work, but that is not out in community practice; that is within the confines of a Curtin-run clinic.[853]

7.55 WA Health informed the Committee of its current efforts in supporting placements for allied health and nursing students:

> It is acknowledged that there is a need for enhancing collaborative partnerships between health and higher education sectors to strengthen clinical placement opportunities. Student clinical placements are a mandatory component of all health professional courses, providing the opportunity to consolidate and build skills in an industry context.
>
> CAHS Community Health recognises that it plays an important role in the provision of paediatric placements to nursing and allied health students and is committed to supporting their training. Clinical placements within Community Health 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.[[854]] Both workstations and clinical space are at capacity on most days in many Community Health sites. If there was an increased capacity to accommodate more student placements, there would be potential to increase student exposure to Community Health services and subsequent interest in employment with Community Health. Currently more allied health student placements are being offered in other sectors, which appears to be resulting in graduates taking up work in these 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.[855]

7.56 WA Health also provided examples of how the students may be supported when they accept regional placements:

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852 Submission 80 from OT Associations, 14 November 2022, p 4

853 Assoc Prof M Ciccarelli, Dean, Learning and Teaching, Faculty of Health Sciences, Curtin University, [*transcript of evidence*], *Legislative Council,* 31 May 2023, p 4.

854 Th issue of insufficient space was discussed in the Interim Report, pp 64–67, paragraphs 4.38–4.41; p 80, paragraph 4.79; recommendation 2, p 81; and the minority recommendation, p 82.

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

> The University Departments of Rural Health (UDRHs)[856] provide additional support for allied health students to undertake clinical placements in country WA, as well as pathways for high school students into health careers. WA has two UDRH's, the WA Centre for Rural Health (Midwest and Pilbara regions)[857] and Marjarlin Kimberley Centre for Remote Health (Kimberley region)[858]. Two additional UDRH's have been approved for WA in Kalgoorlie (Goldfields region)[859] and Bunbury (South West region)[860] and are anticipated to be operational mid-2023 to early 2024. Rural Health West[861] delivers the Allied Health Rural Clinical Placement Support Program, providing funding grants to students to offset the cost of completing a rural student placement.[862]

7.57 As an indication of how many students obtain placements with the CDS providers, Curtin University advised that CAHS–CDS had placements:

- for 16 final-year speech pathology students in 2022 and 14 final-year students in 2023, out of approximately 150 students who graduate each year. These numbers have remained consistent over the years
- typically, for seven to 10 final-year occupational therapy students each year, out of approximately 240 graduates per year
- typically, for three to four final-year physiotherapy students each year, out of approximately 195 graduates per year. In 2023, six placements were offered.[863]

7.58 There is also some precedent for allied health students completing their placements within public and private schools, rather than in a health setting. Curtin University provided the following summary of five models under which Curtin University speech pathology students provide speech pathology services as part of a school placement:

> 1. All Curtin SP [speech pathology] students (undergraduate and entry-level masters) complete one of their first placements at a school. This model involves students working with school children in schools one-day-per week over 9 weeks in each of the four school terms. There are approximately 135-140 first-year students placed in schools per year in this model. There are approximately six schools per year who participate in this model (about half are government schools). Each participating school budgets for and pays Curtin University for this service. Each school receives the services of one experienced Curtin-employed Clinical Educator, 4-6 SP students in their first year of study, and 1-2 final year SP students who act as mentors to the first-year students. All first-year SP

856 University Departments of Rural Health are commonwealth funded 'academic centres based in rural and remote Australia focused on health education and research.' Their services are delivered by 19 universities throughout Australia: Australian Rural Health Education Network (AHREN), *About University Departments of Rural Health*, AHREN, 2024, accessed 20 February 2024.

857 Delivered by the University of Western Australia: Western Australian Centre for Rural Health (WACRH), About the WA Centre for Rural Health, WACRH, 2024, accessed 20 February 2024.

858 Delivered by the University of Notre Dame: AHREN, *Find a UDRH*, AHREN, 2024, accessed 20 February 2024.

859 Delivered by Curtin University: AHREN, *Find a UDRH*, AHREN, 2024, accessed 20 February 2024.

860 Delivered by Edith Cowan University: AHREN, *Find a UDRH*, AHREN, 2024, accessed 20 February 2024.

861 A not-for-profit rural health workforce agency: Rural Health West, *About us*, Rural Health West, 2024, accessed 20 February 2024.

862 Submission 77 from WA Health, 9 November 2022, pp 70–71.

863 Assoc Prof M Ciccarelli, Dean, Learning and Teaching, Faculty of Health Sciences, Curtin University, [*transcript of evidence*], *Legislative Council,* 31 May 2023, pp 7–8; and Assoc Prof M Ciccarelli, Dean, Learning and Teaching, Faculty of Health Sciences, Curtin University, Answer to question on notice 1 asked at hearing held 31 May 2023, dated 19 June 2023, p 1.

students provide services at a classroom, small group, and individual level. This has proven very successful for the SP students and the schools. Some schools participate year-on-year, and other schools may engage with the program only for a couple of years. When those schools leave, they are typically replaced by another school wanting to participate in this model.

2. Some Language Development Centres (LDC) host final year SP students (we have had between 6-8 student placements per year in a LDC over the past few years). Telethon Speech and Hearing School also host final year SP students (4 placements in 2023) and allow first-year entry-level masters SP students to complete three days of observation where they shadow SP staff at the site.

3. Private clinicians / private practices who provide services in schools (usually contracted by the school) also host Curtin final-year SP students. The numbers of placements can vary from year to year but in 2023 we have at least 26 final year SP students scheduled for a placement in this model. The majority of the SP students' placement will be at a school.

4. Curtin University has an agreement with Challis Primary School, and 8-12 final year SP students complete a placement there each year, The students are supervised by a Curtin-employed Clinical Educator.[[864]]

5. Other schools regularly contact the SP Fieldwork Director to ask for Curtin SP students to provide support to their students, but Curtin is unable to offer SP students (even as volunteers) to schools, unless a qualified Speech Pathologist is able to provide the students with direct supervision or mentorship.[865]

7.59 CEWA is supportive of the possibility of schools hosting allied health students as part of their placements, provided that there is adequate:

- supervision of the students
- assistance for students placed in regional and remote schools, such as the availability of appropriate accommodation.[866]

Paediatric registrars

7.60 Like universities, specialist medical colleges are limited in their ability to provide more training positions for medical doctors by the amount of government funding they receive.[867] However, this government funding is tied to postgraduate practical training placements. The placement funding is obtained from a combination of the following sources:

- State or territory governments – which generally fund placements in 'hospitals and other relevant settings'[868]

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[864] The Challis model of providing allied health services at school is discussed in paragraphs 3.74–3.79 of this report. Other Curtin University allied health students also provide child development services at the Challis Community Primary School: see Appendix 2 of this report.

[865] Assoc Prof M Ciccarelli, Dean, Learning and Teaching, Faculty of Health Sciences, Curtin University, Answer to question on notice 2 asked at hearing held 31 May 2023, dated 19 June 2023, pp 1–2.

[866] K Messineo, Senior Team Leader, Teaching and Learning, and T Wong, Child Safe Lead, CEWA, [*transcript of evidence*], *Legislative Council*, 20 February 2023, p 6.

[867] Submission 50 from Dr E Green, paediatrician, 24 October 2022, p 7; and Submission 58 from Neurodevelopmental and Behavioural Paediatric Society of Australasia, 26 October 2022, p 2.

[868] Submission 83 from RACP, 17 November 2022, p 1.

- The Commonwealth Government's Specialist Training Program (STP) – which:

  > supports training positions in regional, rural and remote areas, and in private facilities.
  >
  > …
  >
  > [The STP] … helps cover the salaries of trainee specialists in training positions outside the traditional metropolitan [public] teaching hospitals.
  >
  > It gives participants experience of a broader range of healthcare settings, including:
  >
  > - private hospitals
  > - specialist rooms
  > - clinics and day surgeries
  > - Aboriginal Medical Services
  > - non-clinical settings.[869]

7.61 Medical specialist trainees must complete at least half of their specialist training 'in an expanded setting outside of a metropolitan public hospital'; that is, through the STP.[870]

7.62 Across Australia and Aotearoa New Zealand, the RACP is the body that is accredited to train medical doctors to become paediatricians:

> The Royal Australasian College of Physicians has a paediatric and child health division, which I am the president of. That is the only training body responsible for physician training in paediatrics in Australia and New Zealand. Community and child health—CCH—is a subspecialty within the paediatrics and child health division of the RACP. The speciality focuses on three broad aspects: development and behaviour, child protection and child population health. While general paediatricians will complete some aspect of community and child health during their [advanced] training and will have some knowledge,[[871]] most developmental paediatricians tend to do a standalone three-year CCH [advanced] training program.[872]

7.63 All paediatric trainees (also known as paediatric registrars) must complete three years of basic training, after which they must complete another three to four years of advanced training in the specialty of general paediatrics and/or 26 paediatric sub-specialties, including community child health, neurology, endocrinology and rehabilitation.[873]

7.64 A Western Australian paediatrician submitted that they would:

> strongly recommend support from the RACP College to ensure that there is a much more efficient system of supporting Paediatricians completing their training

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869 Australian Government, Department of Health and Aged Care, *Specialist Training Program*, Department of Health and Aged Care, 2023, accessed 22 February 2024.

870 Australian Government, Department of Health and Aged Care, *Specialist Training Program*.

871 This would usually consist of six months of experience within their advanced training placement for general paediatrics: Dr B Jongeling, Medical Head of Department, CAHS–CDS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 34.

872 Prof N Kapur, President, Paediatrics and Child Health Division, RACP, [*transcript of evidence*], *Legislative Council,* 17 May 2023, p 2.

873 Submission 83 from RACP, 17 November 2022, p 1. See also, Prof N Kapur, President, Paediatrics and Child Health Division, RACP, [*transcript of evidence*], *Legislative Council,* 17 May 2023, p 8.

> pathways. There are a number of inefficiencies in the system and the training pathways within Western Australia which leaves Paediatric registrars disillusioned, looking at alternative specialties and finding it difficult to complete their training.
>
> I would strongly support registrar and fellow/senior registrar training positions specifically in the field of child development with a rapid pathway into supported clinical and Community Consultant Services.[874]

7.65 In May to June 2023, there were 210 paediatric registrars in Australia approved for advanced training in community child health – 29 of them in Western Australia.[875] Only one out of the 29 was undertaking a placement that was STP-funded (see Figure 7).[876] This means that, during that period at least, the remaining 28 placements for advanced training in community child health were funded by the State Government.

Figure 7. *Paediatric registrar placements in Western Australia funded by the Specialist Training Program*

Facility	Specialty 1	Specialty 2	Trainee Level
Perth Childrens Hospital	Community Child Health	General Paediatrics	Advanced
Hedland Health Campus	General Paediatrics		Advanced
Kalgoorlie Health Campus	General Paediatrics		Basic & Advanced
Kalgoorlie Health Campus	General Paediatrics		Advanced
Broome Hospital	General Paediatrics		Advanced
Perth Childrens Hospital	General Paediatrics		Advanced
Perth Childrens Hospital	General Paediatrics		Advanced
Bunbury Regional Hospital	General Paediatrics		Advanced
Geraldton Regional Hospital	General Paediatrics	Clinical Pharmacology	Advanced

[Source: Letter from Prof N Kapur, President, Paediatrics and Child Health Division, RACP, 7 June 2023, p 2.]

7.66 The RACP clarified that it has no role in the funding of placements, nor does it limit the number of placements. However, the RACP does accredit the placement settings:

> Our college accredits these settings, and these criteria are clearly outlined on our website. In anticipation of this meeting, I did take some feedback from some of my CCH colleagues who say that these criteria are not considered particularly onerous.[877]

7.67 In February 2023, there were eight settings in Western Australia accredited for basic training (see Appendix 7) and 28 'core training sites'[878] accredited for advanced training (see Appendix 8). All but one of these settings are in the public health sector. The 28 accredited advanced training settings consisted of 10 CAHS–CDS centres in the Perth metropolitan area, seven regional public hospitals and health campuses, nine metropolitan public hospitals and health campuses, one public emergency transport service and one private health service.[879]

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874 Submission 28 from private citizen, paediatrician, 22 October 2022, p 3.

875 Prof N Kapur, President, Paediatrics and Child Health Division, RACP, [*transcript of evidence*], *Legislative Council,* 17 May 2023, p 2.

876 Letter from Prof N Kapur, President, Paediatrics and Child Health Division, RACP, 7 June 2023, pp 2 and 6.

877 Prof N Kapur, President, Paediatrics and Child Health Division, RACP, [*transcript of evidence*], *Legislative Council,* 17 May 2023, p 3.

878 They are termed 'core sites' because advanced trainees may undertake non-core training at other locations: Letter from Prof N Kapur, President, Paediatrics and Child Health Division, RACP, 7 June 2023, p 1.

879 Letter from Prof N Kapur, pp 4–5.

FINDING 54

All but one of the Western Australian settings accredited for basic training and core advanced training in paediatrics are in the public health sector.

7.68 CAHS–CDS advised the Committee that it has recently increased its paediatric training placements:

> in the last couple of years we have moved from four to eight [paediatric] trainees coming through because we recognise the need for increasing support; it had been static since probably 2003 before that.[880]
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> ▫▫▫
>
> With adequate resourcing and additional facilities, CAHS CDS currently has the capacity for a moderate increase in paediatric registrar placement numbers while still ensuring adequate supervision by consultant developmental paediatricians.[881]

7.69 WACHS, although requiring its practitioners to practise as generalists,[882] has advanced paediatric training positions in:

> the Regional Resource Centers of Broome (4 positions), Port Hedland (1 position), Geraldton (3 positions), Bunbury (5 positions), Albany (1 position) and Kalgoorlie (1 position). Several of these positions are accredited for the six months training for Community Child Health Paediatrics, where the Registrar remains for 12 months. Funding of additional training positions has been approved by the Commonwealth government and should become available in the short to medium term. All these positions have exposure to child development opportunities and are supervised appropriately by consultant developmental paediatricians.[883]

7.70 Despite the State Government funding most of the community child health placements in Western Australia during May to June 2023, the RACP recommended that WA Health increase its resourcing of these placements. Further, the RACP was willing to collaborate with WA Health and other stakeholders in exploring the accreditation of private sector settings for registrar training:

> The college currently does not even have information on who is working in the private sector. We are trying to make our own system robust so that we have clear sight of who is working what hours in the private sector. The second thing is that while a lot of trainees cannot move to a rural setting and miss out on STP funding, STP funding does cover at least 50 per cent of the time if it is done in the private sector. A great limiting step is the training program and supervisors. If we can identify supervisors who work a considerable [amount of] time in the private sector and then … [link] … it to an STP funding position, I think it will be a win-win for all the trainees as well the community.[884]

7.71 With regard to commonwealth-funded placements, the RACP also suggested that the number of STP-funded placements in community child health should be increased 'so that

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880 Dr B Jongeling, Medical Head of Department, CAHS–CDS, [*transcript of evidence*], *Legislative Council,* 26 April 2023, p 50.

881 Submission 77 from WA Health, 9 November 2022, p 73.

882 See Interim Report, p 28, paragraph 3.54.

883 Submission 77 from WA Health, 9 November 2022, p 74.

884 Prof N Kapur, President, Paediatrics and Child Health Division, RACP, [*transcript of evidence*], *Legislative Council,* 17 May 2023, p 7.

more trainees can be fully equipped' to deal with increasingly complex developmental and behavioural issues in children.[885]

7.72 The RACP also maintains that the focus of STP funding should expand to non-regional areas:

> Because there is a shortage of specialist paediatricians in the developmental sphere, we want STP … to fund some of these positions in the non-rural setting as well. The developmental paediatricians who, because of various reasons—90 per cent being female; an inability to move—are unable to go to a remote setting, can then stay in the metropolitan position, work in the private sector and attract that funding so that there can be more developmental positions created in the private sector. …[886]

7.73 Professor Adrian North provided the following insight into the planning that is required to ensure that there are sufficient placements:

> it is … a case of really long-term planning and a really firm commitment from all concerned. Obviously, as soon as we take a student into year one—there may be some courses that have placements in year one but they are very limited—we are then committed and have to find them a placement in years two, three and four, wherever. We have to be absolutely certain that we are going to have that placement there ready for them.
>
> If we had that certainty with that kind of a time lead, then we could indeed plan by taking in that many people at the beginning of the course. You say these things with some hesitation, but that would be a relatively straightforward thing to do, as long as everyone concerned understood that we have got to now deliver this many placements. From our end as a university, we have to deliver the students, if you like. From the end of the health service, it has to deliver the placements when they fall due in that curriculum.[887]

7.74 The Committee observes that to ensure that an adequate number of placements exists for health profession students and postgraduate trainees, all relevant stakeholders must consult each other regularly and clearly communicate to each other about:

- the level of demand for placements – that is, the number of students and postgraduate trainees needing a placement
- how many placements can realistically be delivered.

7.75 The Committee was advised by WA Health that the DOH, through the Office of the Chief Medical Officer, already liaises regularly with the RACP, the deans of the medical schools and the directors of postgraduate medical education at public hospitals regarding medical workforce training pathways. The Office of the Chief Medical Officer also communicates with the health service providers, including CAHS and WACHS, to identify opportunities for additional training positions.[888]

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885 Submission 89 from RACP, 24 April 2023, p 2.

886 Prof N Kapur, President, Paediatrics and Child Health Division, RACP, [*transcript of evidence*], *Legislative Council,* 17 May 2023, p 7.

887 Prof A North, Deputy Pro Vice Chancellor, Faculty of Health Sciences, Curtin University, [*transcript of evidence*], *Legislative Council,* 31 May 2023, pp 5–6.

888 Submission 77 from WA Health, 9 November 2022, pp 74–75.

FINDING 55

To ensure that an adequate number of placements exists for health profession students and postgraduate trainees, all relevant stakeholders must consult each other regularly and clearly communicate to each other about the number of placements that are needed and that can realistically be delivered.

7.76 The RACP acknowledges its role in the development of the future paediatric workforce and concedes that it will need to reassess its own training protocols. It advised that the following areas may be addressed:

- Greater developmental and behavioural content for general paediatric advanced training:

  > Given most outpatient general paediatric work (both publicly and privately) is development and behavioural, as the peak specialist education and training provider for paediatricians in Australia, we are also assessing our own training structures to improve developmental exposure to general paediatric Advanced Trainees during their training so that they are better equipped to work as a general paediatrician.[889]

- Reducing the general paediatric advanced training period:

  > Traditionally, RACP training programs have been time-based, to ensure that trainees receive sufficient exposure and experience in areas of professional practice relevant to their chosen specialty. The RACP is in the process of reviewing its training curricula, including the curriculum for Advanced Training in General Paediatrics, to shift to a training model that is a hybrid of time- and competency-based training. In this model, minimum time to complete training will remain a requirement, but there will be increased emphasis on assessing trainees' workplace performance, which will inform decisions about trainees' progress through training.
  >
  > In the future it may be possible to move to a model of training that is time-independent; however this is not an objective of the current review process and would require a highly effective and trusted competency-based training model. It is well established that the volume of medical knowledge is growing exponentially, and it is therefore unlikely that the time needed to complete Advanced Training in General Paediatrics could be shortened in the near future. Paediatric Advanced Trainees, particularly in the specialties of Community Child Health and General Paediatrics, make a significant contribution to the care of children with specific developmental needs.[890]

RECOMMENDATION 50

The Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service (CDS providers) work closely with Western Australian universities to establish a strong framework to support and manage placements with the CDS providers, for health profession students and postgraduate trainees. Within this framework, the CDS providers should also regularly consult these universities, specialist medical colleges and other training bodies.

889 Submission 89 from RACP, 24 April 2023, p 2.

890 Letter from Prof N Kapur, President, Paediatrics and Child Health Division, RACP, 7 June 2023, p 2.

RECOMMENDATION 51

The Department of Education work closely with Western Australian universities to establish a strong framework to support and manage placements within public schools, for allied health and nursing students and postgraduate trainees. Within this framework, the department should also regularly consult these universities and other training bodies.

RECOMMENDATION 52

The State Government work with the Commonwealth Government and specialist medical colleges with a view to increasing paediatric specialist training placements in Western Australia that are funded by the Specialist Training Program, particularly in the sub-specialty of community child health.

RECOMMENDATION 53

The State Government work with the Commonwealth Government and specialist medical colleges to test the proposition that expanding the Specialist Training Program to include more metropolitan based placements in Western Australia would result in a higher number of Western Australian paediatric trainees completing their specialist training in developmental paediatrics.

Interprofessional education

7.77 Within health sciences, interprofessional education (IPE) has been described as follows:

> Interprofessional Education … means that you work with students from your own and other health disciplines to learn with, from, and about each other, developing the knowledge, skills and attitudes required for collaboration and quality of client care/service.[891]

7.78 While IPE has featured in Curtin University's Faculty of Health Sciences courses since approximately 2011,[892] the faculty had planned to formerly introduce IPE into its courses just prior to the COVID-19 pandemic.[893] After that pause, the faculty is now offering IPE-embedded courses.[894] Professor Adrian North explained how IPE works in practice:

> So what we are trying to do specifically is take the approach to the education of the students that you see very much in how they practice, whereby they work as a team. So there will be a particular client or patient, depending on the discipline, and a psychologist will contribute to the case management, a medical doctor will contribute to the case management and so on and so on, each bringing their unique perspective. What the focus of the education would be on will be understanding—will be a student in discipline A getting a really good understanding of how different disciplines approach a particular healthcare issue, and then also giving them a whole range of team working skills that help them to

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891 Curtin University, *Faculty of Health Sciences: Interprofessional education*, Curtin University, accessed 22 February 2024.

892 Prof A North, Deputy Pro Vice Chancellor, Faculty of Health Sciences, Curtin University, [*transcript of evidence*], *Legislative Council,* 31 May 2023, p 2.

893 Prof A North, Interim Deputy Pro Vice Chancellor, Faculty of Health Sciences, Curtin University, [*transcript of evidence*], *Legislative Council,* 28 November 2022, pp 9–10.

894 Assoc Prof M Ciccarelli, Dean, Learning and Teaching, Faculty of Health Sciences, Curtin University, [*transcript of evidence*], *Legislative Council,* 31 May 2023, pp 2–4 and 15.

> really get into the nuts and bolts of actually producing the best outcome for the patient or client in that kind of a context. …
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> …
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> It is about holistic care for a patient, because any particular health problem tends to have multiple facets that any one discipline can only help with some of.[895]

7.79 Entry level students start with general, core units, common to all Faculty of Health Sciences students, and IPE elements are integrated gradually as the students progress in experience:

> It moves from exposure [in the first year] to starting with that immersion in the second year to, in the third year, applying their knowledge to solving problems.
>
> …
>
> In fourth year, we have two capstone units—one for occupational therapy and one for speech pathology. In those capstone units, students do not learn anything new; it is about applying their knowledge, skills and understanding of the profession very much in, again, case-based learning.
>
> They have opportunities to work with actors who come in to simulate standardised patients or clients. At the moment, they are doing that in their individual disciplines, but our goal with rolling the IPE out is that there will be opportunity for those OTs and speech pathologists who are doing that around the same time to do it together. We have standardised actors who come in to play a range of different health conditions. This would be an opportunity for students to do that. This is a must-pass unit before they go out into their final year of clinical placements. Again, we are setting them up to see what their clinical reasoning is, if they can communicate with the client before them and if they can explain their role. Our goal now is also to see if they can also work interprofessionally with the client before them around this case and to see how they can demonstrate their knowledge and skills.[896]

7.80 IPE can also enhance a clinician's attitude towards sharing the care of their patients with other disciplines:

> it is not just about the professional skills, but it is that attitude and that mindset. Some of our students who go to some of the disability service providers who use a family–centred practice approach and a team-around-the-child approach use the model where there is a key contact, and the key contact can be any discipline, but that is the one point of contact for families. Families can report how their child is doing to that one person, so they are not having to tell their story over and over and over again. That one key contact can coordinate the care of the OT or the physio or whoever might be relevant to helping that child achieve their goals. There are some organisations that do that particularly well and they use that team-around-the-child approach, which is an evidence-based approach. I think there are some organisations that do have that mindset, do have that approach … we have very many … private providers as well who may be single discipline providers, they are treating the child within the scope of that single discipline.[897]

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895 Prof A North, Interim Deputy Pro Vice Chancellor, Faculty of Health Sciences, Curtin University, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 10.

896 Assoc Prof M Ciccarelli, Dean, Learning and Teaching, Faculty of Health Sciences, Curtin University, [*transcript of evidence*], *Legislative Council,* 31 May 2023, pp 3–4.

897 Assoc Prof M Ciccarelli, Dean, Learning and Teaching, Faculty of Health Sciences, Curtin University, [*transcript of evidence*], *Legislative Council,* 31 May 2023, pp 15–16.

7.81 The Committee heard evidence that IPE is now a well-known, established and highly-regarded method of learning. It is also well-suited to allied health disciplines and child development services:

> **The CHAIR**: Is this something that tertiary educators—is this now part of their lexicon?
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> **Prof NORTH**: Absolutely; within health sciences at least.[898]
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> ▫▫▫
>
> there is this general acceptance of IPE being the way forward and to professional practice being the way in which people are going to be working in the future …[899]
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> ▫▫▫
>
> Curtin is obviously very well known for their interprofessional training, and they produce great clinicians because of that as well. This is a model that is actually very well established, and the interprofessional training can be used in a number of different ways. I completely agree that you need to have your targeted training as well, but, particularly in rural and remote areas, for anyone who has worked in regional areas as an allied health professional, you might be their first port of call; and, for example, if you are an occupational therapist and you have done interprofessional training, you will know when you need to refer. So, you will know what other services that they might need, so you might sort of be that one port of call and then refer and coordinate as time goes on. So, it is a very, very well established model.[900]
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> ▫▫▫
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> Well, it [IPE] certainly is the way to go in an area like this where you need input of speech and OT and all those others. Then, if you end up working in a child development service, where you will have OT and speech and so on, you need to be used to knowing what they know and the fact that they have expertise in a particular area so you can easily refer. It is good to have that right at the beginning of your training to have that broader understanding. Whereas, in my day, there was certainly no mixture of any other service whatsoever or any other discipline; it was just purely medical. That has been a disadvantage over the years—realising that there is much more to it than that. I am all for it, basically.[901]

7.82 The Committee noted that while CDS providers frequently spoke of the benefit of working in multidisciplinary teams and adopting a more holistic approach in meeting the developmental needs of children, there was little acknowledgment of the potential benefit of developing teams competent to take an interprofessional approach.

7.83 This was borne out by Associate Professor Ciccarelli, who informed the Committee that Curtin University's Faculty of Health Sciences has found it difficult to obtain IPE-informed practical training placements for their students:

> To be quite honest, to date we have had very limited opportunities for students to have really meaningful interprofessional fieldwork placements. We are often

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898 Hon Dr Sally Talbot MLC, Chair; and Prof A North, Interim Deputy Pro Vice Chancellor, Faculty of Health Sciences, Curtin University, [*transcript of evidence*], *Legislative Council,* 28 November 2022, p 10.

899 Prof A North, Deputy Pro Vice Chancellor, Faculty of Health Sciences, Curtin University, [*transcript of evidence*], *Legislative Council,* 31 May 2023, p 13.

900 Prof C Elliott, Director of Research, TKI, [*transcript of evidence*], *Legislative Council,* 9 February 2023, p 14.

901 Dr B Hart, medical practitioner, [*transcript of evidence*], *Legislative Council*, 12 December 2022, p 7.

> looking for them, but it is up to the capacity of the host site to be able to offer that in terms of supervision and being able to work and share clients. We have some of our own Curtin student-led clinics that are used for final year professional practice placements where there is some opportunity for interprofessional work, but that is not out in community practice; that is within the confines of a Curtin-run clinic.[902]

7.84 The Committee was also advised that the placements offered by the CDS providers are not IPE-informed:

> With regard to the placement of students at CDS, I spoke to the field work directors for … OT, speech and physiotherapy. They have not been able to do any interprofessional placements with CDS. They have been able to do interprofessional placements with OT and speech with NDIS providers but not with CDS. It has never been offered as an interprofessional education placement. Students who do go there … may see their supervisor working as part of a multidisciplinary team, but it is not an overt interprofessional placement where there are shared clients between disciplines.[903]

7.85 The Committee is persuaded by the merits of IPE because it seems to be an effective way of breaking down existing silos. Such an approach also appears to be consistent with the effective operation of the CDS providers' respective hub and spoke models. The Committee is therefore of the view that this method of learning should be embedded in all placements offered by the CDS providers and that the merits of the interprofessional approach should be given due consideration in health service planning.

RECOMMENDATION 54

The Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service ensure that they provide practical training placements that incorporate the principles of interprofessional education.

RECOMMENDATION 55

The Child and Adolescent Health Service–Child Development Service and WA Country Health Service–Child Development Service apply the principles of interprofessional education when planning and providing their services.

902 Assoc Prof M Ciccarelli, Dean, Learning and Teaching, Faculty of Health Sciences, Curtin University, [*transcript of evidence*], *Legislative Council,* 31 May 2023, p 4.

903 Assoc Prof M Ciccarelli, [*transcript of evidence*], pp 8–9.

CHAPTER 8
Leadership, planning and innovation

The importance of leadership

8.1 As indicated in the Interim Report, leadership is important for supporting innovation and organisational reform.[904] Innovation and organisational reform is essentially what this report is recommending for the CDS providers, CAHS–CDS and WACHS–CDS, and, to a lesser extent, the DOE. Therefore, it stands to reason that a leadership team should be established to guide, coordinate and provide impetus for this reform, particularly as interagency and cross-sector collaboration will be required.

8.2 Dr Yvonne Anderson, a paediatrician working across Curtin University, the TKI and CAHS recognised that there should be:

> support, mandate and [a] dedicated resource to ensure that this [reform] work can occur alongside operational business as usual.[905]

8.3 Starbloom Paediatrics also identified the need for a role within WA Health that is dedicated to systemic improvement:

> There are no doubt inefficiencies in diagnostic and treatment pathways that would benefit from improvement. Working to improve this can only effectively be done by clinicians with experience in the service, and while this is traditionally the job of a Head of Department, the clinical workload is such that this becomes impractical. Cordoning off explicit and protected time for developmental clinicians to work exclusively on service redesign, innovation and improvement would provide long-term dividends but requires investment and sufficient support to ensure that this time does not get lost to clinical work.[906]

RECOMMENDATION 56

The State Government establish a high level implementation group whose main terms of reference are to:

- effect the recommendations made by this Committee, in its interim report and this report
- support and mandate reform

  and
- ensure that reform can occur alongside operational business as usual.

8.4 A minority of the Committee, comprising Hon Donna Faragher MLC, makes the following further recommendation:

[904] See Interim Report, pp 90–91, paragraph 5.11 to 5.13.

[905] Dr Y Anderson, Associate Professor, Community Child Health, Curtin University, [*transcript of evidence*], *Legislative Council,* 12 May 2023, p 5.

[906] Submission 84 from Starbloom Paediatrics, 17 November 2022, p 4.

Minority Recommendation 9

The State Government provide the funding required to give effect to the recommendations made by this Committee, in its interim report and this final report, as well as the minority recommendations. This will ensure the reforms needed to reduce unacceptably long waiting times and expand service provision are delivered for the benefit of children in Western Australia.

The need for a clear whole-of-government approach

8.5 A strong theme in the evidence presented by Inquiry stakeholders was that Western Australia has, at least since the COVID-19 pandemic, failed to prioritise the wellbeing of children and their families, and it is now time to ensure that clear direction is provided in this respect, across the whole of the State Government. For example:

> Raising the profile and need through inquiries such as this one, will go some way to increasing collaboration and engagement. Prior to COVID, Child Wellbeing was considered a government priority and held its place on the State Government Agenda with a working group at the Supporting Communities Forum. This forum was ceased during COVID and when it did resume new priorities were set and child well-being was dropped from the list of priorities. It is imperative that Government brings Child Wellbeing back on the State Government Agenda, this must become and remain a priority.[907]

▫▫▫

> There are lots of forms [of child wellbeing plans]. We currently do not have anything. We do not have any identifiable document. Different states and territories have gone down different ways of doing it, but we do not have any indication, I guess, even at a symbolic level from government I think, about how important it is …[908]

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> As I understand it, there is no coordinated child health strategy for children in WA. In the absence of this, the *National action plan for the health of children and young people 2020–2030* can be drawn upon, and it strikes me that five key priority areas are very aligned to the challenges of this inquiry. They are to improve health equity across populations, empower parents and caregivers to maximise healthy development, to tackle mental health and risky behaviours, to address chronic conditions and preventive health and to strengthen our workforce. There is a clear need to join the dots. Would it not be amazing if WA could articulate its own First 2 000 Days Framework as has been done in New South Wales? Would it not be a huge step forward if there was a mandate to draw sectors together to address the upstream determinants of child health in a coordinated fashion and bring sectors together more effectively to collaborate towards a unified outcome? Equity and sustainability of models is crucial with an emphasis on proportionate universalism. Perhaps this approach would assist with addressing the barriers to achieving excellent healthcare to children and young people. We may all be approaching this complex issue from different standpoints, but we are all unified with the end goal,

907 Submission 65 from Ngala, 28 November 2022, p 7.

908 D Zarb, Chief Executive Officer, Playgroup WA, [*transcript of evidence*], *Legislative Council,* 26 July 2023, p 3.

> which I believe is timely, efficient, appropriate and accessible services for our children.[909]

8.6 The CCYP also highlighted this lack of direction and suggested that there is a need for a Western Australian child wellbeing strategy to provide a whole-of-government approach to this important issue. In the context of child development services, such a strategy would prioritise:

- The development of models of engagement that identify children and young people with developmental vulnerabilities.
- Investment in targeted early intervention for children and young people who are developmentally vulnerable.
- The provision of interventions and supports that build family and community capacity to provide a supportive and nurturing environment for vulnerable children and young people.
- The critical need for early identification of neuro-divergence in children and young people such as Autism and ADHD and access to early treatment and support to support their wellbeing and development.

> There is significant evidence that we need to develop a holistic Child Wellbeing Strategy that provides critical support and services across the life course for all children and young people in WA.
>
> Child Wellbeing Strategy should set whole-of-government targets to improve wellbeing outcomes among children and young people. Targets should be long-term, extend beyond election cycles and span individual agency responsibilities.[910]

8.7 The CCYP noted that the recommendation for a child wellbeing strategy was made by her predecessor, Dr Colin Pettit,[911] was accepted in principle by the Department of Premier and Cabinet in 2019, but has not been implemented to date.[912]

8.8 The previous CCYP also recommended that the strategy be developed by the Department of Premier and Cabinet, on behalf of the State Government.[913] This whole-of-government approach is an acknowledgement that child wellbeing is everyone's responsibility and is not confined to any particular portfolio. This approach is also consistent with the Sustainable Health Review's recommendation 8:

> 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.[914]

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909 Dr Y Anderson, Associate Professor, Community Child Health, Curtin University, [*transcript of evidence*], *Legislative Council,* 12 May 2023, p 6.

910 Submission 60 from J McGowan-Jones, CCYP, 25 October 2022, pp 4 and 5.

911 CCYP, *Improving the odds for WA's vulnerable children and young people*, CCYP, 2019, accessed 26 February 2024, p 28, recommendation 1.

912 Submission 60 from J McGowan-Jones, CCYP, 25 October 2022, pp 4 and 5.

913 CCYP, *Improving the odds for WA's vulnerable children and young people*, CCYP, 2019, accessed 26 February 2024, p 28, recommendation 1.

914 DOH, *Sustainable Health Review Final report to the Western Australian Government*, DOH, 2019, accessed 15 December 2023, p 69.

8.9 Further, the previous CCYP recommended that:

> The strategy should include a resourced, implementation framework with clear outcomes and timelines. Progress on the outcomes should be measured through robust data and regularly reported on.[915]

8.10 The Committee considers that a child wellbeing strategy could provide clear direction for the State Government to prioritise the health and wellbeing of children and their families and ensure that this focus remains steadfast.

8.11 A majority of the Committee, comprising Hons Dr Sally Talbot and Samantha Rowe MLCs, makes the following recommendation:

RECOMMENDATION 57

The State Government consider developing a Child Wellbeing Strategy for Western Australia that satisfies recommendation 1 of the 2019 report by the Commissioner for Children and Young People, entitled *Improving the odds for WA's vulnerable children and young people*.

8.12 Noting the Department of Premier and Cabinet accepted in principle recommendation 1 of the 2019 report by the CCYP, entitled *Improving the odds for WA's vulnerable children and young people,* a minority of the Committee, comprising Hon Donna Faragher MLC, makes the following recommendation:

Minority Recommendation 10

The State Government develop a Child Wellbeing Strategy for Western Australia that satisfies recommendation 1 of the 2019 report by the Commissioner for Children and Young People, entitled *Improving the odds for WA's vulnerable children and young people*.

Hon Dr Sally Talbot MLC

[915] CCYP, *Improving the odds for WA's vulnerable children and young people*, CCYP, 2019, accessed 26 February 2024, p 28, recommendation 1.

APPENDIX 1

GOVERNMENT RESPONSE TO INTERIM REPORT

Hon Amber-Jade Sanderson MLA
Minister for Health; Mental Health

Our Ref: 76-28253

Hon Dr Sally Talbot MLC
Chair
Select Committee into Child Development Services
Parliament House
4 Harvest Terrace
WEST PERTH WA 6005

Dear Dr Talbot

I sincerely thank the Select Committee into Child Development Service for your interim report entitled *Child Development Services in Western Australia: Valuing our children and their needs* and write to provide the State Government's response.

The Western Australian Child Development Service (CDS) provides important multidisciplinary developmental services to Western Australian children and their families.

It is clear from the Committee's interim report that the service is overburdened, having experienced an exponential increase in referrals into the service, outpacing workforce growth. The State Government is resolute in our commitment to initiating reforms to optimise service delivery for WA children and families, while maintaining the inherent strengths of the CDS.

As you are aware, a key strength of the CDS lies in its accessibility, ensuring that it remains inclusive by offering support to children and families, irrespective of their geographical location or financial status. I note the Committee's recommendation that the CDS continue to remain a free and publicly funded service. The State Government wholeheartedly supports this recommendation.

The State Government acknowledges the Committee's additional recommendations concerning the allocation of resources. A comprehensive response to these recommendations will be furnished upon the tabling of the Committee's final report.

The establishment of the Select Committee received support from the State Government, underscoring our commitment to meaningful reform from a solution focused parliamentary inquiry.

I thank the Select Committee for their valuable insights into the Child Development Service, which will be informative of further reforms to the service, and I await the Committee's final report.

Kind regards

HON AMBER-JADE SANDERSON MLA
MINISTER FOR HEALTH; MENTAL HEALTH
19 DEC 2023

Level 5, Dumas House, 2 Havelock Street WEST PERTH WA 6005 Telephone: +61 8 6552 5900
Email: Minister.Sanderson@dpc.wa.gov.au

APPENDIX 2

CHALLIS COMMUNITY PRIMARY SCHOOL – ALLIED HEALTH SERVICES OFFERED

Excerpt from Committee hearing on 2 March 2023 with the DOE, Challis and Wattleup East Primary School (now known as Hammond Park Primary School):

Mrs MUSUMECI: … I set up a partnership with Curtin University and asked if I could have as many of their fourth year allied health students who were completing their degrees across seven, and it is now eight, different disciplines—speech, OT, clinical psychology, physiotherapy, social work, dietetics, and the latest one being GP, or general practitioners—to come on board. What that actually means is that, as a workaround while our children are on a waitlist for [CAHS–]CDS services, I can be comforted by the fact that I can provide them with therapy at school through —

The CHAIR: And so that is pre-diagnosis?

Mrs MUSUMECI: That is pre-diagnosis, yes. That is when a teacher has done a battery of assessments and has realised a child requires, say, a referral for speech pathology, occupational therapy or whatever the therapy might be—it could be psychology or counselling. They will make a referral through to [CAHS–]CDS, where they will be placed on a waitlist after they have gone through whatever the process is to get onto the waitlist in the first place. In the meantime, they can have almost immediate access to these allied health students who are in their fourth year of training.

The CHAIR: And they are presumably getting academic credit for the work that they are doing with you.

…

Mrs MUSUMECI: Absolutely. It is part of their course.

…

Yes. It is called an interprofessional practice placement. They have to work with other allied health professionals. They are learning not to work in silos; they are learning to work across disciplines and keep the child at the centre of their practice. For example, I can tell you that in 2022, 300 young children were referred to the Curtin services that are on school premises, and 300 children received therapy. That is not 300 occasions of service; one child might receive multiple therapy blocks in order to achieve this skill before the therapist exits them. This was 300 individual children just in one year who were referred.

…

Hon DONNA FARAGHER: Can I just ask: how many students do you currently have at your school?

Mrs MUSUMECI: There are 898.

Hon DONNA FARAGHER: Of that, around 300 students each year are receiving support?

Mrs MUSUMECI: Yes.

…

The CHAIR: What happens to the child after that nine weeks?

Mrs MUSUMECI: Well, it depends if the child has achieved the skill or not. If they have not achieved the skill, the Curtin students would continue to work with them.

The CHAIR: With a different [Curtin] student coming in?

Mrs MUSUMECI: Yes.

The CHAIR: … Do you have any data relating to how effective that initial intervention is? Do you get to the stage where you have resolved a problem and you can take somebody off the CDS waiting list?

Mrs MUSUMECI: Absolutely. I do not have that data here with me, but absolutely we do. Otherwise, we would be at a bottleneck. Because it is an intensive service and they work hand in glove with the classroom teacher and often an assistant or a parent, if we are able to include the parents in the service delivery, the child is having multiple opportunities to practice the skill across different environments. That leads to a higher chance of them being able to demonstrate mastery over the skill, in which case we can exit them from that particular block of therapy and work on the next child who is being introduced.

The CHAIR: So they then come off the waitlist and join the mainstream of the school. What percentage of the children would that happen to? Half?

Mrs MUSUMECI: I would not like to guess, but it is enough for me to say this is working and we need to continue with the partnership.

The CHAIR: That is the ultimate object—to get them off the CDS waitlist—not to tide them over until they see the paediatrician or whoever?

Mr BELL: Yes.[916]

[916] Hon Dr Sally Talbot MLC, Chair, and Hon Donna Faragher MLC, Deputy Chair; L Musumeci, Principal, Challis Community Primary School; and J Bell, Deputy Director General, DOE, [*transcript of evidence*], *Legislative Council*, 2 March 2023, pp 9–11.

APPENDIX 3

SPEECH PATHOLOGY IN MAINSTREAM PUBLIC SCHOOLS ACROSS AUSTRALIA

State/Territory Scheme	Method of delivery & Services provided	Eligibility requirements
New South Wales		
Specialist Allied Health and Behaviour Support Provider Scheme The Department of Education (DoE) maintains a panel of pre-qualified allied health providers that schools can access through a stream-lined administrative process. Speech pathology is included in the services on offer.[917] Schools pay individually to engage a provider.[918] Scheme was launched in June 2020. By June 2021, there were 100 pre-qualified providers.[919]	Individually funded by schools. Targeted. Provided at school. Speech pathologist (SP) from provider panel may engage with students during school hours on school grounds. The SP can determine if it will be a one-off session or ongoing. They offer services through: • Face to face • One on one • Virtually/Online • Small groups • Classroom engagement • Workshops.[920] **Services (for students)** • Assessing their skills • Assessing their need for Augmentation and Communication Systems • Supporting development of skills and language • Create strategies • Implement programs • Help create sustainable work environments • Suggest technology support	[no information publicly accessible]

[917] Department of Education, *Progress report: Improving outcomes for students with disability 2021*, Department of Education, New South Wales Government, 2021, accessed 15 February 2023, p 28.

[918] New South Wales Government, Department of Education, *Speech pathology in schools*, Department of Education, accessed 29 January 2024, p 1.

[919] Department of Education, *Progress report: Improving outcomes for students with disability 2021*, Department of Education, New South Wales Government, 2021, accessed 15 February 2023, p 28.

[920] New South Wales Government, Department of Education, *Speech pathology in schools*, Department of Education, accessed 29 January 2024, p 2.

State/Territory Scheme	Method of delivery & Services provided	Eligibility requirements
	• Resources to continue therapy at home.[921] **Services (for teachers)** • Training and education, like a *Personalised Learning and Support Plan* for their students • Team teaching and classroom support.[922]	
Victoria		
Student Support Services The DoE-employed specialist staff (allied health professionals, including SPs, psychologists, social workers, occupational therapists and youth workers). At June 2023, 527 (430.4 FTE) allied health staff were employed.[923] Parents or the school principal (with parental permission) can ask for a student to be referred.[924] **Pre-purchased Program [Kindergarten]** The DoE pre-purchases allied health support, including speech pathology, from local providers to assist funded kindergarten services. SPs from this program work with kindergarten teachers and the parents and families of kindergartners. Access to this program is determined by need. Kindergarten services deemed to have a low level of need (less than $5,000 total	**Student Support Services** Centrally funded. Targeted. Provided at school. If the referral is accepted, the service may: • give advice about the child's learning and wellbeing • provide assessments and reports • help develop parents' knowledge and skills • provide professional learning for the child's teachers • provide therapy and counselling • work with other services if needed. The school and student support services will give progress reports. **Pre-Purchased Program [Kindergarten]**	[no information publicly accessible]

[921] New South Wales Government, Department of Education, *Speech pathology in schools*, Department of Education, accessed 29 January 2024, p 2.

[922] New South Wales Government, Department of Education, *Speech pathology in schools*, Department of Education, accessed 29 January 2024,, p 2.

[923] Department of Education, *Annual report 2022-23*, Department of Education, State Government of Victoria, 2023, accessed 29 January 2024, p 48.

[924] State Government of Victoria, *Extra support from specialist staff in schools*, State Government of Victoria, 2024, accessed 15 February 2024.

State/Territory Scheme	Method of delivery & Services provided	Eligibility requirements
funding) must engage SPs using their own funding.[925] **Speech Pathology in [Primary] Schools (2018-19 to 2022-23)** The government collaborated with community health providers and select public primary schools to improve students' access to these services. Providers also worked with teachers to enhance their knowledge and confidence to support students with speech, language and communication needs. Funding for the program ended on 30 June 2023.[926]	Unclear whether provided at school. SPs deliver their services to kindergarten teachers and parents and families of kindergartners through: • Consultation • Group Training • Other professional services.[927]	
Queensland		
DoE-employed SPs The DoE employs allied health professionals (comprised of over 900 staff) to work in public schools. Disciplines offered are: • Speech-language pathologists • Occupational therapists • Physiotherapists.[928] To be able to access services, parents must provide consent and consult: • Their principal • Head of Special Education or • Regional Senior Speech-Language Pathologist.[929]	Centrally funded. Targeted. Provided at school. The SPs provide: • Advice for teachers and parents • Assessment • Individual and group therapy • Parent, teacher or teacher aide programs. **Services (for students)** SPs work with students to help: • Develop their speech sound system	[no information publicly accessible]

925 State Government of Victoria, *Speech Pathologist (pre-purchased by DE)*, State Government of Victoria, 2024, accessed 15 February 2024.

926 State Government of Victoria, *Speech pathology in schools*, State Government of Victoria, 2022, accessed 29 January 2024.

927 State Government of Victoria, *Speech Pathologist (pre-purchased by DE)*, State Government of Victoria, 2024, accessed 15 February 2024.

928 Queensland Government, Department of Education, *Specialist support staff*, Department of Education, 2023, accessed 29 January 2024.

929 Department of Education, *Speech-language therapy services*, Department of Education, Queensland Government, 2019, accessed 29 January 2024, p 2.

State/Territory Scheme	Method of delivery & Services provided	Eligibility requirements
	• Understand and use language • Manage social interactions at school • Speak fluently • Have a 'healthy voice' • Safely eat and drink at school.[930]	
Tasmania		
DoE-employed SPs In 2021-22, the DoE reported employing 56 (42.35 FTE) SPs.[931] A referral is needed from a teacher or parent. Referral forms are available at schools.[932]	Centrally funded. Targeted. Provided at school. In public schools, SPs work with students and with teachers teacher assistants to help them support their students. They do this through: • Providing professional learning • Whole class or group therapy • Teacher assistant programs • Home programs • Individualised class programs • Individual therapy • Tele-practice.[933]	SPs work with students who: • are difficult to understand when speaking • have difficulty expressing themselves • have a stutter • have difficulty eating or drinking • have complex communication needs • have difficulty with social skills.[934]
South Australia		
Student Support Services The DoE have a group of allied health professionals available for public schools to access, including speech pathology, psychology and social work.[935]	Centrally funded. Targeted. Provided at school. 2023 tele-practice roll-out for speech pathology and psychology services. Public schools engage with these services to get advice and	[no information publicly accessible]

930 Department of Education, *Speech-language therapy services*, Department of Education, Queensland Government, 2019, accessed 29 January 2024, p 1.

931 Department of Education, *Annual report 2021-22*, Department of Education, Tasmanian Government, 2022, accessed 29 January 2024, p 34.

932 Tasmanian Government, Department for Education, Children and Young People (DECYP), *School speech and language pathologists*, DECYP, 2023, accessed 29 January 2024.

933 DECYP, *School speech and language pathologists*, DECYP, 2023, accessed 29 January 2024.

934 DECYP, *School speech and language pathologists*.

935 Government of South Australia, Department for Education, *Student support services*, Department of Education, 2023, accessed 29 January 2024.

State/Territory Scheme	Method of delivery & Services provided	Eligibility requirements
	recommendations of what to implement to better assist students with their needs. The allied health professionals will work with teachers, staff and students. They may: • review existing information • observe the child in class or elsewhere at school • conduct formal assessments and recommendations • discuss the child's learning and behavioural challenges • talk about this with preschool and school staff and family • hold staff training and development sessions • coach and mentor preschool and school staff • help staff to develop strategies • coordinate other services • refer the child to other supports or agencies.[936]	
Northern Territory		
Student Wellbeing and Inclusion Programs and Services The DoE employs allied health professionals to be accessed by children in all public schools. Includes SPs, occupational therapists, psychologists and social workers.[937] When set up in January 2023, it employed 83 staff.[938]	Centrally funded. Targeted. Provided at school. The team collaborates with public schools in a range of areas, including early childhood intervention and ADHD. It also: • helps families and external services work together • works with school staff to provide support for the student • provides individual support services where specialised expertise, assessment and	

[936] Government of South Australia, Department for Education, *Student support services*, Department for Education, 2023, accessed 29 January 2024.

[937] Northern Territory Government, *Get school support for your child*, Northern Territory Government, 2024, accessed 29 January 2024.

[938] Department of Education, *Annual report 2022-2023*, Department of Education, Northern Territory Government, 2023, accessed 29 January 2024, p 30.

State/Territory Scheme	Method of delivery & Services provided	Eligibility requirements
	referrals to external services are required.[939]	
Australian Capital Territory		
Allied Health Service The Education Directorate employs allied health professionals, including speech language pathologists (SLPs), occupational therapists, physiotherapists and social workers, as well as allied health assistants.[940]	Centrally funded. Can be targeted and broad. This service provides supports to public schools, including 'direct services to students on a referral basis'. Services include: • professional learning for school staff • support for whole school procedures • support for class or student group programs • support for individual students. SLPs may assess what intervention is necessary through: • observation • information from parents • sometimes, formal assessments.[941]	For SLP supports, students will have special needs in communication and/or eating and drinking safely.[942]

939 Department of Education, *Annual report 2022-2023*, Department of Education, Northern Territory Government, 2023, accessed 29 January 2024, p 30.

940 Australian Capital Territory Government, Education Directorate, *School psychology, allied health and school-based supports*, Education Directorate, accessed 29 January 2024.

941 Australian Capital Territory Government, Education Directorate, *School psychology, allied health and school-based supports*.

942 Australian Capital Territory Government, Education Directorate, *School psychology, allied health and school-based supports*.

APPENDIX 4

CHILD AND PARENT CENTRES – CENTRE OPERATORS

Child and Parent Centre	Host school	Non-government organisation centre operator
Arbor Grove	Arbor Grove Primary School	AnglicareWA
Banksia Grove	Banksia Grove Primary School	Ngala
Brookman	Brookman Primary School	Parkerville Children and Youth Services
Calista	Calista Primary School	Ngala
Carey Park	Carey Park Primary School	Investing in our Youth
Collie Valley	Wilson Park Primary School	Investing in our Youth
Dudley Park	Dudley Park Primary School	AnglicareWA
East Maddington	East Maddington Primary School	Centrecare
East Waikiki	East Waikiki Primary School	Ngala
Fitzroy Valley	Fitzroy Valley District High School	Marninwarntikura Women's Resource Centre
Gosnells	Gosnells Primary School	Centrecare
Halls Creek	Halls Creek District High School	Wunan Foundation
Kununurra	East Kimberley College	Wunan Foundation
Mount Lockyer	Mount Lockyer Primary School	Wanslea
Rangeway	Rangeway Primary School	Ngala
Roseworth	Roseworth Primary School	The Smith Family
Roebourne	Roebourne District High School	One Tree Community Services
South Hedland	South Hedland Primary School	YMCA Perth (the Y)
Swan	Middle Swan Primary School	The Shire of Mundaring as the Midvale Hub
Warriapendi	Warriapendi Primary School	MercyCare
Westfield Park	Westfield Park Primary School	Parkerville Children and Youth Services
Westminster	Westminster Primary School	The Smith Family

[Source: DOE, Answer to question on notice 8 asked at hearing held 2 March 2023, dated 23 March 2023, p 10.]

APPENDIX 5

PAEDIATRIC ADHD PILOT PROGRAM

About the service

We have developed a more streamlined approach to seeking diagnosis and treatment of ADHD with a new, pilot model of care. We recognise the challenges associated with getting help in this present climate and are aiming to develop a better system. As this is a new concept, we will be seeking feedback to help with improving and developing this into a wider model for other GP clinics and specialists in WA.

How does it work?

GP and Nurse

- For your initial session, please allow one hour at The Garden Family Medical Clinic.
  A review with Dr Andrew Leech or Dr Lauren Johnson will be scheduled with you and your child.
  - At this review there will be opportunity to provide an update on progress, go through Conners Screening results and any other letters from providers or teachers.
  - Even if you have discussed your child's history with the GP, it is still important to attend this session to develop a thorough referral for the paediatrician.
- The clinic nurse will repeat measurements of your child including growth, blood pressure, an eye test, urine test, hearing test and possibly an ECG.
- A follow up appointment will be scheduled with the GP at two weeks following the paediatrician appointment.
  - The purpose of this follow up is to summarise any diagnosis that may have been made, discuss any treatments in more detail and arrange any support services such as psychology or OT if required.
  - The GP may also write a letter to your school.

- Please write down and bring any questions you might have to this appointment.

Paediatrician

- We are currently working in direct collaboration with two paediatricians, Prof Desiree Silva and Dr Aggi Bakowski with others to join soon.
  - One of these two paediatricians will contact you within a 1–2-week period following your GP appointment to arrange a review.
  - Your paediatric appointment will take place within one month, via telehealth or face to face.

Costs involved

Consultation	Goal of session	Cost	Medicare rebate
GP and Practice Nurse	Check general health, review Conners assessment result, complete referral	$250	$117.40
Paediatric assessment	Review of referral, assessment, diagnosis and any required treatment initiation	$600	$240.75
GP - 2 week follow up	Review plan, discuss any questions, referral to psychology, OT or ADHD coach if required	$140	$79.70
Ongoing appointments	Further GP and Paediatric review dependant on each child and their requirements	To be discussed with treating team	To be discussed with treating team
Other inclusions	'ADHD the Go-To-Guide' book Resource pack emailed - best websites, podcasts, books, services, tips and strategies. Co-prescribing - your paediatrician will complete co-prescribing paperwork allowing the GP to complete scripts for the following 12 months. School communication and correspondence.		

Next Steps

If you are happy to proceed with the pilot programme -

- Please email us at hello@thegardenmedical.com or call our healthcare assistants on 6186 7992 with your **child's name, your best email contact, your child's main teachers best email contact and consent for us to contact your child's teacher with a Conner's assessment form** (to be sent via email).
- Please ensure you complete the Conners prior to your first appointment.
- In your email or phone call to us, please provide your preferred day and time for your GP appointment to take place (see below options and providers).
- Places are currently limited and via invite only at this stage due to the overwhelming demand. We anticipate wider rollout over the coming months.

Dr Andrew Leech		**Dr Lauren Johnson**	
Monday 10th July	12pm-1pm	Thursday 13th July	2:30pm-3:30pm
			3:30pm-4:30pm
Tuesday 13th July	10am-11am		
	11am-12pm		
Saturday 15th July	8am-9am		
	9am-10am		
	10am-11am		

[Source: Dr A Leech, general practitioner, RACGP, Answer to question on notice 6 asked at hearing held 17 May 2023, dated 10 August 2023, Attachment.]

APPENDIX 6

EARS2LEARN – HOW EAR CHECKS ARE CONDUCTED

[Source: Submission 44 from Connecting Community for Kids, 24 October 2022, p 4.]

APPENDIX 7

ACCREDITED WA SITES FOR PAEDIATRIC TRAINING (BASIC)

RACP Specialists. Together
EDUCATE ADVOCATE INNOVATE

Accredited Teaching Hospitals
Paediatrics & Child Health – WA
February 2023

Attachment B: Basic Training

Paediatrics & Child Health Principal Training Program – Level 3

Up to 36 months of Basic Training may be undertaken in a Paediatrics & Child Health Principal Training Program – Level 3 (although it need not be in the one hospital)
At least 6 of the 36 months of Basic Training must be spent Paediatrics & Child Health Principal Training Program – Level 3.

Hospital	State	Status	Accredited To	Year of Review
Perth Children's Hospital	WA	Accredited	February 2025	2024

Paediatrics & Child Health Principal Training Program – Level 2

Up to 30 months of the 36 months of Basic Training may be undertaken in a Paediatrics & Child Health Principal Training Program – Level 2.

Hospital	State	Status	Accredited To	Year of Review
Fiona Stanley Hospital	WA	Accredited	February 2026	2025

Paediatrics & Child Health Adjunct Training Program – Secondment

Training in a Paediatrics & Child Health Adjunct Training Program – Secondment will be on rotation from a Paediatrics & Child Health Principal Training Program – Level 2 or Level 3. A maximum of 12 months may be undertaken per Paediatrics & Child Health Adjunct Training Program – Secondment.

Hospital	State	Parent Hospital	Status	Accredited To	Year of Review
Armadale Health Service	WA	Perth Children's Hospital	Accredited	February 2026	2025
Joondalup Health Campus	WA	Perth Children's Hospital	Accredited	February 2026	2025
Kalgoorlie Health Campus	WA	Perth Children's Hospital	Accredited	February 2026	2025
King Edward Memorial Hospital for Women	WA	Perth Children's Hospital	Accredited	February 2026	2025
South West Health Campus Bunbury Hospital	WA	Perth Children's Hospital	Accredited Provisionally	February 2026	2024
St John of God Midland Public and Private Hospital	WA	Perth Children's Hospital	Accredited	February 2026	2025

[Source: Letter from Prof N Kapur, President, Paediatrics and Child Health Division, RACP, 7 June 2023, p 4.]

APPENDIX 8

ACCREDITED WA SITES FOR PAEDIATRIC TRAINING (ADVANCED)

Question 1: At which hospitals / community clinics are Western Australian paediatric trainees (Basic & advanced) placed at during their training?

Response: Following sites are accredited for core training by one of more Advanced Training program. This core training can be for Paediatric programs (i.e. General Paediatrics, Community Child Health etc.) or for Paediatric Trainees in programs that have Paediatric cohorts (i.e. Haematology, Infectious Diseases etc.) I have added a note for sites accredited by one of our Joint College. In the list below, the relevant joint College is ACEM and the core training related to Paediatric Emergency Medicine.

- Albany Regional Hospital
- Armadale Kelmscott Memorial Hospital
- Broome Health Campus
- Bunbury Hospital
- Child Development Services – Armadale
- Child Development Services – Bentley
- Child Development Services – Clarkson
- Child Development Services – Fremantle
- Child Development Services – Joondalup
- Child Development Services – Koondoola
- Child Development Services – Lockridge
- Child Development Services – Midland
- Child Development Services – Rockingham and Mandurah
- Child Development Services – West Perth
- Fiona Stanley Hospital
- Geraldton Health Campus (Geraldton Regional Hospital)
- Hedland Health Campus
- Joondalup Heath Campus
- Kalgoorlie Health Campus
- Karratha Health Campus
- King Edward Memorial Hospital for Women
- Newborn Emergency Transport Service (NETS) WA
- Patches Assessment Service
- Peel Health Campus (accredited by Joint College for RACP core requirements – Paediatric Emergency Medicine)
- Perth Children's Hospital
- Rockingham General Hospital
- Royal Perth Hospital – Wellington St Campus (accredited by Joint College for RACP core requirements – Paediatric Emergency Medicine)
- St John of God Midland Public and Private Hospital

[Source: Letter from Prof N Kapur, President, Paediatrics and Child Health Division, RACP, 7 June 2023, p 5.]

APPENDIX 9

GOVERNMENT FUNDING ANNOUNCEMENT – 9 APRIL 2024

GOVERNMENT OF WESTERN AUSTRALIA

MEDIA STATEMENT
Tuesday, 9 April 2024

Hon. Amber-Jade Sanderson MLA
Minister for Health

$39 million for major expansion of Child Development Service

- $39 million boost to Child Development Service (CDS) amid unprecedent demand
- Will allow for rapid expansion of services and significantly increase workforce
- Part of Cook Government's ongoing commitment to improving CDS for WA kids

The Child Development Service (CDS) will be significantly expanded, with the Cook Government today announcing $39 million to substantially increase staff and overhaul the vital service.

The Cook Government will invest $39 million in both the Child and Adolescent Health Service metropolitan service (CAHS-CDS) and WA Country Health Service regional service (WACHS-CDS), as part of the 2024-25 State Budget.

The funding will facilitate a significant increase in clinical staff, including paediatricians, clinical nurse specialists, speech pathologists, occupational therapists, psychologists and audiologists, in both the metro and regional areas.

The $39 million boost also includes infrastructure funding to lease additional temporary accommodation to allow staff to see more families.

The CDS is the only public child development service 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.

The Service has experienced an unprecedented surge in demand at a time when there is a worldwide shortage of paediatricians. In the past 10 years referrals to CDS paediatricians have risen by 132 per cent.

The substantial funding boost complements other measures already being undertaken by the Cook Government to support the CDS, including:

- Piloting a joint nurse/paediatrician medication review process;
- Piloting combined planning and assessment appointments for suitable patient cohorts;
- Changing the Schedule 8 Prescribing Code to allow approved specialists from interstate to prescribe certain medicines to Western Australian patients via telehealth, removing a barrier for patients;
- Operating on Saturdays at some sites;
- Transitioning to an electronic referrals process;
- Embarking on a refreshed recruitment drive;
- Investigating ways to provide better linkages between the CDS and General Practice; and
- Empowering clinical nurse specialists to work to their full scope of practise to speed up initial access to care for children with suspected ADHD.

Comments attributed to Health Minister Amber-Jade Sanderson:

"There is no other service in the country that does what the CDS does. Our service looks after kids across 2.5 million square kilometres – from Kununurra to Albany – and the staff working in this service do a great job.

"Demand growth for CDS has been far exceeding what you would expect for our population, with referrals growing at an unprecedented rate.

"This $39 million investment will pave the way for a major uplift in CDS staff, especially in clinical roles, and ensures this vital service meets the needs of WA kids and families."

Media contact: Emmeline Drake-Brockman 0428 925 699 or 6552 5900

GLOSSARY

Term	Definition
AADPA	Australian ADHD Professional Association
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
ACA	Australian Childcare Alliance WA
ACCHOs	Aboriginal community controlled health organisation
ADHD	attention deficit hyperactivity disorder
AEDC	Australian Early Development Census
AHC	Aboriginal Health Council of Western Australia
APS	Australian Psychological Society
ARACY	Australian Research Alliance for Children and Youth
ASD	autism spectrum disorder
CAHDS	Complex Attention and Hyperactivity Disorders Service, operated by the Child and Adolescent Health Service from the Perth Children's Hospital
CAHS	Child and Adolescent Health Service, a health service provider in the Western Australian public health system which operates in the Perth metropolitan area
CAHS–CAMHS	Child and Adolescent Health Service–Child and Adolescent Mental Health Service, a service area within the Child and Adolescent Health Service (CAHS) that provides child and adolescent mental health services
CAHS–CDS	Child and Adolescent Health Service–Child Development Service, the team within the Child and Adolescent Health Service (Community Health service area) that provides secondary and tertiary-level child development services

CAHS Community Hub	a hub at which the following Child and Adolescent Health Service (CAHS) teams and service providers are co-located:
	• Community Health service area:
	  ○ Aboriginal Health Team
	  ○ Child Health Nursing
	  ○ Child and Adolescent Health Service–Child Development Service (CAHS–CDS).
	• Child and Adolescent Mental Health Service (CAHS–CAMHS) service area

Term	Definition
CALD	culturally and linguistically diverse
CAMHS	Child and Adolescent Mental Health Service, a service area within the Child and Adolescent Health Service (CAHS), and also the teams within the WA Country Health Service (WACHS), that provide child and adolescent mental health services
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 (CAHS)
CDS	secondary and tertiary-level child development services provided by the Child and Adolescent Health Service–Child Development Service (CAHS–CDS) and WA Country Health Service–Child Development Service (WACHS–CDS) within Western Australia's public health system
CEWA	Catholic Education Western Australia
Challis	Challis Community Primary School in Armadale
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
CHIS	Community Health Information System, used by the WA Country Health Service
Committee	Select Committee into Child Development Services
Community Health/ CAHS–Community Health	a service area within the Child and Adolescent Health Service that comprises Community Health Nursing; the Child Development Service (CAHS–CDS); the Aboriginal Health Team and the Refugee Health Team
community health services	when provided to children, is comprised of child health nursing and school health nursing. 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 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
Community ICAMHS	the ICA Taskforce's recommended community infant, child and adolescent mental health service
CPC	Child and Parent Centre
DAHS	Derby Aboriginal Health Service
DOE	Department of Education

Term	Definition
DOH	Department of Health, whose director general is the system manager of the Western Australian public health system
DYHS	Derbarl Yerrigan Health Service
Earbus	Earbus Foundation of Western Australia
ECEC	early childhood education and care
ECHS	the WA Country Health Service's Enhanced Child Health Schedule
EMR	electronic medical record system
EMR Program	a phased 10-year rollout of a single electronic medical record system across the Western Australian public health system
external stakeholders	entities outside of the Western Australian public health system that are involved in a child's development, health and wellbeing, including service providers in the areas of education (including early education centres and childcare centres), housing, disability services, child protection, community services, and the private and non-government healthcare sectors (including general practitioners)
FASD	foetal alcohol spectrum disorder
FTE	full-time equivalent
Genie	an 'off the shelf' electronic health record designed for medical practitioners, used by paediatricians (and clinical administration staff supporting them) employed by the Child and Adolescent Health Service–Child Development Service (CAHS–CDS)
GP	general practitioner
ICA Mental Health Strategy	the ICA Taskforce's infants, children and adolescents' Mental Health Strategy
ICA Taskforce	Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0–18 years in Western Australia, which released its final report in 2022
ICFC	integrated child and family centre
IDA	the Department of Education's 'individual disability allocation' funding for additional learning supports for students
Inquiry	the Select Committee into Child Development Services' examination of publicly delivered child development services in Western Australia
Interim Report	Select Committee into Child Development Services, interim report, *Child development services in Western Australia: Valuing our children and their needs,* Western Australia, Legislative Council, 28 November 2023
IPE	interprofessional education

Term	Definition
LDC	a Department of Education language development centre
MCFHNA	Maternal, Child and Family Health Nurses Australia
NDIS	National Disability Insurance Scheme
OT Associations	the Developmental Occupational Therapy Association of Western Australia and the Western Australian Occupational Therapy Association
Parkerville	Parkerville Children and Youth Care
PCH	Perth Children's Hospital, a service area within the Child and Adolescent Health Service
RACGP	Royal Australian College of General Practitioners
RACP	Royal Australasian College of Physicians
STP	the Commonwealth Government's Specialist Training Program
TKI	Telethon Kids Institute
WACHS	WA Country Health Service, a health service provider in the Western Australian public health system
WACHS–CAMHS	WA Country Health Service–Child and Adolescent Mental Health Service, the teams within the WA Country Health Service (WACHS), that provide child and adolescent mental health services
WACHS–CDS	WA Country Health Service–Child Development Service, 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
WA Health	the Western Australian public health system comprised of the Department of Health, seven board governed health service providers, the Quadriplegic Centre and contracted entities, to the extent that they provide health services to the State
Yarrabilba	Yarrabilba Family and Community Place, Queensland

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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