

There are many well trained, professional people working within child development and my concerns do not concern individual professionals. My concerns relate to the great southern region, but from conversations with others they are common elsewhere.

Referrals for allied health in child development are encouraged from schools, and a pack is sent to schools. There is a great deal of work in making a referral.

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.

Follow up for families who are difficult to contact. This is Limited. Our most vulnerable families may fall off lists because they change their phone, have no credit or are uneasy about answering an unknown number. Families may easily have moved when there is a long wait list and so they fall off the list. If families move away from a particular health region, they lose their place and need to start again.

Although it makes sense to prioritise younger children, this again means vulnerable children whose parents have not identified needs, do not get referred until they are older. Often all they will get is an assessment.

Number of sessions seems limited, and often with an assistant not a therapist. I would like the evidence on number of sessions, frequency etc to improve a particular issue to be looked at by this committee.

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.

Lack of permanency and promotional positions as well as other employment practises also limit services, such as the practice of not advertising for a known vacancy until well after the previous clinician has left. Other examples such as flying paediatricians from other states because appropriate contracts for local Paediatricians who would have taken a position were not offered (this seems to have been resolved just recently). This also meant families would see a different Dr at each visit. This is both time consuming as each new person gets up to speed with the case, but demoralising for families.

All services are impacted by the changes in child health nurse services such as the three year old healthcheck. Often significant difficulties are now not picked up until a child starts school, and with waitlists they may be well out of early intervention windows, both for effective treatment and funding. Having adequate numbers of child health nurses is essential, to build relationships and trust with families, so they can then be appropriately referred, and supported through this process

In a large region, children living outside the regional city may have very reduced services. There are less medical as well as private therapy services in these towns. Again it is our most vulnerable children who miss out as parents can't afford to take the children to the regional centre if clinicians do not visit the town.

There are some good links between child development staff and schools, but this could be enhanced.

I wonder if having child development services hospital based made them more likely to stop services during Covid. Child development services seemed to be closed to face to face services for a significant time.

There seems very little two way interaction between other professionals such as school based staff, with Perth city child development. Children from regions attending child development at PCH are obviously at high needs, so links back to their own community would be an area to develop.

Waitlists mean children do not get access not only to that service but others. For example, perhaps a child with GDD does not see their child health nurse, or the relationship with the family has not been developed through a range of visits... the child is not referred to the Paediatrician until they attend School, and problems are noted, monitored, strategies put in place, and then parents may get a referral from their GP. A child whose diagnosis of GDD is made after they have started at school, does not get resourcing through Education for this condition for the next 2 years, when further assessment may determine if they have an intellectual disability. Lack of access to Paediatric services also means that children on waitlists do not have access to NDIS.

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. please look at studies which consider the dollars saved later in prison, crime, unemployment and educational failure for every dollar spent on child development services.

I am sorry I do not have time to develop my response with back up of research papers, but I do want the committee to consider the great opportunity they have to collect this research and make a meaningful change to the lives of so many of our children and families.