

Australian Music Therapy Association

Consultation response: supporting young children and families early, to reach their full potential

About the Australian Music Therapy Association

The Australian Music Therapy Association (AMTA) is the peak body for music therapy in Australia. AMTA represents Registered Music Therapists (RMTs), music therapy students and advocates for access to music therapy on behalf of the community. Our mission is to enable, advance and advocate for excellence in music therapy.

AMTA is the regulating body responsible for registering music therapists, accrediting music therapy courses, and maintaining professional standards and ethics. A member organisation of Allied Health Professions Australia (AHPA) and National Alliance for Self-Regulating Professions (NASRHP), AMTA supports Registered Music Therapists (RMTs) to use research-based practice that actively promotes the health, wellbeing and functioning of Australians.

RMTs work in private practice and in allied health teams in hospitals, residential facilities, community services and schools. They use evidence-based music therapy techniques to promote better health outcomes for vulnerable and unwell Australians. There are currently 626 RMTs in Australia with 152 registered as NDIS providers of music therapy services.

AMTA welcomes the opportunity to provide this response to proposed changes to the NDIS.

AMTA has prepared this response in conjunction with the Disability Working Group of AMTA.

Key points

- AMTA welcomes the promotion of early access to NDIS-funded therapeutic services to promote early intervention and improved outcomes for children and families.
- AMTA strongly endorses increasing the EC approach's age range up to 9 years to support families who have not yet engaged with the NDIS or who have decided to delay school transition.
- AMTA is concerned by the current demand and wait times for ECEI services. There is a risk that the increased focus on short term early intervention will add to this demand, creating increased delays for services.
- AMTA supports planned transitions across life-stages and service delivery schemes to improve children and families' experience and outcomes. AMTA recommends formalised transition periods and processes to enable this to occur successfully.
- AMTA welcomes the new line item for 'capacity building support in natural settings' and recommends the NDIA consider expanding this to include capacity building with families (including when the child is not present).

General questions

Do you have any specific feedback in relation to the increased focus on STEI outside of access to the Scheme

AMTA welcomes the promotion of early access to NDIS-funded therapeutic services due to the potential to improve outcomes for children experiencing developmental delay.

However, AMTA is concerned by the increased focus on Short Term Early Intervention (STEI) and its impact on the availability of existing services. Anecdotal and documented evidence suggests there are long waiting periods for many early childhood services, despite recent efforts¹. NDIA Quarterly Performance Dashboard (31st December 2020) describes delays to planning of over 21 days after a favourable access decision is made, for over one-quarter of participants².

Significant work will need to be done, and state and federal funding would need to be secured to ensure EC Partners can manage the number of families requiring services. The current EC Partner workforce is not at the scale needed for this approach to work.

There is also concern the STEI focus and use of EC Partners could limit choice and control - as families may not have the option, due to financial constraints, to pursue services they consider more appropriate for their child. There may be a potential conflict of interest for EC Partners' advising families to use in-house or affiliated services.

Do you have any specific feedback in relation to the proposed increase in age range for the EC Approach from under 7 to under 9 years of age?

AMTA welcomes the proposed increase in age range to up to 9 years. This change is vital. The increase in age will support children of families who have chosen to delay the commencement of their child's schooling without concern that their funding will be reduced when the child reaches 7 years of age. Pathways for students who enter school with developmental delays to catch up are possible, so support and intervention must continue into the early school years and embed capacity-building for teachers in the early years of school. School entry is a universal transition point providing an opportunity to identify and support children and families who meet NDIS criteria but have not previously accessed services.

Do you have any specific feedback in relation to the desire to see more successful transitions from the Scheme to the next stage of life?

AMTA supports planned transitions across life-stages and service delivery schemes to improve children and families' experience and outcomes and minimise duplication.

A 'transition out' or 'buffer' period is vital, and more community-provided supports tied into the scheme. A longer period of 6 months would be ideal to support the transition and the appropriate closure and termination of therapeutic services. There needs to be good community/mainstream support services available to families to step up when funding ceases to support families.

Family support is essential for children with early intervention needs. However, it remains unclear the degree to which NDIS will fund evidence-based parenting supports. For example, a number of

parent capacity building programs with strong evidence bases³ do not require the child to be present yet have a high impact on children’s development through their benefits for parenting approaches. There appears to be some recognition of this in Improvement Area 6 ‘current NDIS processes do not encourage consideration of the needs of parents and carers, nor the level of supports required by families to implement their child’s plan’. The ‘child’s plan’ might also include a ‘parent plan’ to build capacity and support around the parents but this explicit approach focussing on parents still appears to be somewhat marginalised and unclear.

Early childhood education and care (ECEC) provides a platform accessed by increasing numbers of young children in Australia. Allied Health support onsite in ECEC services, particularly in low socio-economic geographic areas, is a missed opportunity to date (largely because diagnosis is a pre-requisite, rather than a focus on identification and prevention).

Greater Allied Health presence at these locations would act to:

- a) provide direct assessment and service delivery to children and families
- b) build capacity in early childhood educators to support children and families.

This relates to recommendation 17 on a new line item for ‘capacity building support in natural settings’ but needs also to be considered from an outreach point of view – enhancing the aim to reach more eligible families.

How can we help families and carers better understand some of the terms the NDIA, and Early Childhood partners use such as:

- **best practice** (e.g. “method or technique that is considered the most effect way to produce the results“)
- **capacity building** (e.g., “working on developing a person’s strengths and abilities“)
- **natural settings, and/or** (e.g., “Places such as kindergarten, home or places the child frequently visits“)
- **Evidence.**

The use of Plain English, explanations and examples will increase comprehension of these industry-specific terms.

Support with achieving goals

What is the best way for us to check in with families and carers on how their child is tracking to meet the goals for their child?

- The NDIS needs to read and take reports from providers, who detail and track progress on goals, into full consideration.
- Check in by phone every 9-12 months and offer plan rollovers for children with lifelong and permanent disabilities if the family is happy with their supports and their child’s progress. This would avoid inconvenient and unnecessary plan reviews for families who are already overwhelmed with busy therapy and other schedules.

Would a mandatory early childhood provider report developed between families and their provider be useful for tracking against their goals?

Yes. The AMTA welcomes any opportunity to progress person and family-centred approaches in the NDIS. A shared document addressing family-centred goals would be beneficial for families and their providers.

How can we better support families to connect with services that are either funded or available to everyone in the community?

Medical practitioners and community based groups are vital in the flow of information. Service providers at the first point of contact for families (GPs, Maternal and Child Health Nurses, Child care providers for instance) need to understand what other services and pathways are available. In particular, people from CALD backgrounds/ refugees need information translated and access to interpreters to assist at all stages of this process. Additionally, providers need to be educated about the purpose of capacity building - to assist people to grow skills in order that they can access community and mainstream services. Provide incentives or recognition to providers who are providing best-practice services in this way.

How can we make the process of transitioning out of the NDIS something to celebrate?

A “buffer” period of 6 months required, so families don’t feel suddenly cut off from their service and there is adequate time for closure from the services they were purchasing through the scheme.

Targeted support

If you live in a remote or very remote part of Australia, what are some ideas you have on how we can get early childhood supports to work in your community or communities like yours?

- More advocacy and funding for culturally-specific and culturally-provided support to ATSI and CALD families to access the scheme.
- More education about the availability of TIS to registered providers to support CALD families during the provision of supports.
- Online services (such as telehealth) has an important role to play but is limited by access to networks and technology.
- Incentivise service providers to work in these communities in the long term. Fly in fly out services are a stop gap measure so funding needs to be committed to providing realistic incentives for meaningful and effective services to be provided by professionals who can build relationships and develop capacities in the participant and in the community.

How can our Early Childhood partners and mainstream services best support peer-to-peer connections?

Playgroups and evidence-based interventions delivered in similar settings (e.g. group family music therapy early interventions) are ideal approaches to supporting peer-to-peer connections.

How can we better reach and get support to young children and families who experience vulnerability and remove barriers so they can receive outcomes in line with other children and families?

Active outreach will be needed to reach vulnerable families in need of support. Childcare, kindergarten, playgroups and cultural settings (e.g. Aboriginal health services) provide some platforms in which this can be done in the prior-to-school years. Research shows that kindergarten teacher perceptions / assessments of children's developmental competency are quite valid and reliable and this source of information could help to identify where outreach might be most effective⁴.

Greater transparency on providers of best practice

It is recommended that a range of mechanisms be considered to enhance providers' compliance with best practice standards and to provide greater transparency on which providers, both registered and unregistered, are following Early Childhood Intervention best practice.

What mechanisms do you think could help achieve this?

If a best practice accreditation system is to be established then this must be balanced with burden on providers in terms of the administration requirements. The NDIS best practice standards and quality indicators are extensive and thorough, but regular reporting against all of them (depending on the format) could present a high burden for practitioners and increased administrative costs for the NDIS. Instead a set of simplified core principles for reporting / assessment / accreditation could be developed with results presented on a searchable directory for families.

Who would be best placed to lead the development of, and manage, any additional complementary mechanisms?

A branch of the Quality and Safeguards Commission could be established to deal with best practice standards and in particular, non-registered providers. It is highly concerning that the Q&SC is restricted in monitoring unregistered providers who are not meeting basic standards when providing services.

What do you think of the following ideas for potential mechanisms? What are the benefits or concerns with these potential mechanisms?

- Provide greater information to families about the benefits of using providers registered by the NDIS Commission.

This would give incentive for more providers to become registered, as it would be a good marketing tool and differentiate registered providers from those who have opted not to participate in registration.

- Establish a 'quality feedback / rating system'.

This also has some merit whereby participants can give service providers a rating. However, this is also potentially damaging to businesses where a subjective rating of a professional service is given. As Allied Health professionals we cannot advertise recommendations, therefore negative feedback can severely impact a private practice. Mechanisms for feedback, in the form of surveys or ratings would need to be trialled thoroughly and carefully considered for the impacts it may have on providers in a thin market. An accreditation system for providers with a star system that they can advertise on their site would give Participants better guidance and confidence in the service standard.

- **Make registration with the NDIS Commission mandatory for all providers operating in the EC space.**

This has some merits in establishing base line quality standards however in thin markets it is not reasonable. Costs associated with becoming a registered provider are prohibitive for small providers and may result in reduced services available.

- **Require self and plan-managed participants in the new Early Childhood approach to use only registered providers.**

Mandatory registration could work with adequate support for affected providers, including financial support for smaller providers when there is a cost associated with an audit. Without financial support, there is the risk there will not be enough providers to work in the EC space. The report form is certainly helping because it is helping providers to understand ECEI best practice and what's involved. It also alerts smaller providers regarding the standards that need to be met when providing supports to a vulnerable age group.

1. Independent Advisory Council to the NDIS. *Promoting best practice in Early Childhood Intervention in the NDIS*. Online2020.
2. National Disability Insurance Scheme. Quarterly Reports: Quarterly Performance Dashboard. National Disability Insurance Scheme,. <https://www.ndis.gov.au/about-us/publications/quarterly-reports>. Published 2020. Accessed Feb 2021, 2021.
3. <https://pubmed.ncbi.nlm.nih.gov/31630533/>;
<https://pediatrics.aappublications.org/content/146/1/e20193548>
4. Green, M. J., Tzoumakis, S., Laurens, K. R., Dean, K., Kariuki, M., Harris, F., Brinkman, S. A., & Carr, V. J. (2019). Early developmental risk for subsequent childhood mental disorders in an Australian population cohort. *Australian and New Zealand Journal of Psychiatry*, 53(4), 304-315.
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