

CONSULTATION RESPONSE



**Allied Health
Professions
Australia**

National Disability Insurance Agency

Supporting young children and
their families early, to reach their
full potential

February 2021

Allied Health Professions Australia
Level 1, 530 Little Collins Street
Melbourne VIC 3000
Email: office@ahpa.com.au
Website: www.ahpa.com.au

Introduction

Allied Health Professions Australia (AHPA) thanks the National Disability Insurance Agency (NDIA or Agency) for the opportunity to provide input into the Early Childhood Intervention (ECI) *'Supporting young children and their families early, to reach their full potential'* consultation. As the recognised national peak association for Australia's allied health professions, AHPA represents a large workforce of allied health professionals involved in providing supports to young children with disability and their families. Many of those children are participants in the National Disability Insurance Scheme (NDIS), however allied health professionals also frequently work within the mainstream health system as well as the education system and other adjacent systems. This provides a unique insight into the experiences of young children with disability and their families within the NDIS and in those other systems.

Allied health professionals working in the system report many of the same issues outlined in the consultation paper and in the accompanying Early Childhood Intervention Reset report. That includes issues in relation to how quickly families are able to access supports, significant variation in the plans and supports that a person may receive, issues around access to services due to high demand, as well as quality issues. Those allied health professionals also report that many families have very limited understanding of the disability system and what they can expect to receive. It is clear that there is more work needed to enable the sector and families to get the most from the early childhood approach.

The allied health sector is supportive of many of the recommendations in the report and agrees that there is a need to introduce further improvements to support improved outcomes for children and their families. However, AHPA and its members also have significant concerns about a number of the recommendations, and we have outlined these below. We argue strongly that further consideration of how best to achieve the desired outcomes is necessary and we have sought to be constructive in our response. Our feedback below provides a range of suggestions about how improvements may be achieved without reducing scope for clinical decision-making, without adding additional barriers to prevent providers from entering or remaining in the market, and that make better use of professional associations to support high quality services for young people with disability regardless of which scheme a health professional is operating in.

In closing, we note that a range of recommendations in the consultation document, if implemented, will require allied health providers to implement new processes or adhere to updated guidelines. We argue strongly for the value of working with AHPA and the allied health sector as these processes and guidelines are developed to ensure that they reflect real world practice. We also argue strongly for the need to work with peak associations to support the development and rollout of implementation plans that ensure providers are aware of changes and have time to implement these within their practices. The goal of any reforms should be to enable the provider sector to deliver the best and highest quality services and this can only be achieved by working together.

This submission has been developed in consultation with AHPA's allied health association members.

Responses to the individual recommendations

AHPA has sought to provide additional detail and our own recommendations below in relation to the Agency recommendations we feel may need additional refining. Where we have not provided specific feedback, we are broadly supportive of the proposals.

Recommendation 3

Develop and publish new Early Childhood-specific Operating Guidelines (OGs) – so our decision-making processes and best practice evidence are transparent and implemented consistently by partners and NDIS planners.

AHPA is generally supportive of the proposal to publish new operating guidelines about the delivery of early childhood intervention, including guidance about best practice evidence. A key frustration for providers is a lack of consistency as well as uncertainty about the foundation for decision-making. We welcome current work underway in the Agency to introduce greater transparency in relation to its decision-making processes.

In considering the development of guidelines, AHPA notes that there are different philosophies and views about what constitutes best practice and argues that there is a need to more clearly define appropriate practice across a range of different models and settings, including those that involve small and solo providers as part of a broader multidisciplinary team. We welcome work by the Agency to define how early supports, access, planning, implementation and transitions will operate in future. This will not only provide increased consistency but also allow the sector to identify and respond to potential gaps in any proposed models and approaches. We note in this context the importance of ensuring that the Agency considers not only what might constitute best practice in theory or in the context of a larger provider with their own multidisciplinary team, but also how it can enable a range of different models that deliver high quality supports across a range of real world settings. For example, AHPA notes that a consistent concern raised by early childhood providers is ensuring that smaller and solo providers continue to be supported to participate in the scheme and are not locked out due to a preferencing of larger providers who may employ multidisciplinary teams. Such an approach would present significant risks to the availability of services for participants, access to experienced professionals, and capacity to make choices about which service providers to employ. It may also particularly impact those in regional and remote regions. We note also that it will also be critical to define the key worker model, including when it is appropriate, who can take on the role, and where it may have limits or require additional layers of support to address higher levels of complexity. A number of practitioners have argued that the key worker model itself is effective and supported by research but that current implementations are frequently not adopting the full model.

AHPA argues that it will be critical to work closely with the allied health sector, as well as Early Childhood (EC) partners, as the guidelines are developed and implemented. This will ensure that the sector is able to provide input in relation to what constitutes best practice, particularly where there may be gaps in the research base, as well as how best to ensure that the model is one that is flexible enough to allow clinicians to respond to the individual needs of families. For example, we note that the practice of working in home and community settings is called out as best practice, as is collaboration with family members. Both approaches are a crucial foundation for many of the interventions undertaken by allied health professionals and very much supported by the sector. Yet practitioners also flag that there are scenarios in which families actively ask to be able to access centre-based services due to issues or complexities in their home environments, including safety concerns. Similarly, practitioners also report that while working with the family to support them to

work effectively with their child is very much ideal and best practice, there are situations in which this just isn't possible, particularly where a mother is dealing with multiple children with complex needs. In such situations a balanced approach is needed that still seeks to increase capacity within the family but also achieves therapeutic outcomes and supports the family in the way that they most need at a given time.

Finally, we argue for caution about rigid adherence to the concept of evidence-based best practice. While there are interventions that have a solid evidence foundation, there are also many examples of interventions that are recognised as effective by practitioners and families but which may lack a rigorous evidence base. Our experience suggests that there may be gaps in the evidence available for some types of intervention, largely arising as a result of the difficulty and cost of undertaking research in community settings and the lack of research infrastructure to support private allied health practices to participate in research activities. We argue strongly for the development of an Agency-led program that seeks to increase sectoral capacity to undertake research and address evidence gaps.

As a final note, we argue that it will also be important to determine how best to increase awareness in the sector about preferred approaches and the delivery of high-quality early childhood intervention approaches through an appropriate implementation plan. This should include work with peak associations to provide education and support to members.

Recommendations

- **Work with allied health professions to finalise guidelines.**
- **Seek to identify clinical best practice across a range of operational settings and provider structures, as well as how best to work with the structure of the NDIS sector.**
- **Flag practices that are known to be ineffective or low value without otherwise limiting clinical decision-making and ability to respond to individual need.**
- **Partner with professions to develop an implementation plan including planning appropriate implementation timelines and education.**

Recommendation 4

Create a distinct delegate/planner workforce that is exclusively focused on young children and their families, to improve the way families are supported.

AHPA supports the proposal to create a specialised planning workforce focused on early childhood. We recognise the value of supporting the planning workforce to better understand the needs of young children with disability as a foundation for supporting more effective planning. AHPA notes that a strong understanding of the work of individual allied health professions is a key foundation for the work of planners and we reiterate the proposal to develop processes by which individual professions can support training and awareness in the planning workforce about their roles and scope. For example, it may be appropriate to develop a series of webinars for delegates in conjunction with individual professions to support capacity development in that workforce.

AHPA also supports the proposal to have increased advice and support for rural and remote communities to help them more effectively access the expertise and support they require. We note in this context the potential to increase awareness of telehealth-based services that may address the needs of young children in remote communities where there are no local services available. These services are often highly regarded but families may not be aware of how to find or access them.

Recommendations

- **Develop a specialised workforce of EC planners.**
- **Work with professions to support the training of delegates.**
- **Develop the capacity of EC planners to support remote communities to connect to services including telehealth providers.**

Recommendation 5

Continue to work with federal, state and territory governments to identify gaps and strengthen the role of mainstream services, so all young children receive support from the appropriate system when they need it.

AHPA recognises the importance of strengthening the mainstream health, education and other non-NDIS systems, both as a support for participants and to ensure that there are appropriate services for young children with disability available outside of the NDIS where they may be ineligible for early childhood supports. We have argued that this will need to be a key focus for both the Agency, and other governments in the context of the National Disability Strategy. From the perspective of the allied health sector, it is clear that there are gaps in access that have arisen as a result of the introduction of the NDIS, as well as transition issues in relation to responsibility for support, that will need to be addressed. These vary from services no longer being available to children outside of the NDIS, to interface issues between the NDIS and other systems. Mapping and addressing these must be a priority.

AHPA notes that one of the key current issues in the interaction between the NDIS and mainstream services such as those provided by education is that providers in both systems are being explicitly advised that they are not able to provide services such as assessments to support families to access the other system. For example, early childhood providers advise that they are told that they cannot provide assessments to families for the purpose of helping them to access funding through education departments to support their child in education settings. It appears there is a concern about double-dipping or of cost-shifting underpinning this. Similarly, providers have reported that community health services are choosing not to see NDIS participants in the mistaken understanding that those participants can access services funded by the scheme.

The outcome of these barriers is that families are reporting difficulties accessing services outside the NDIS, including relevant health services, and vice versa. In addition to other issues that this may cause, it is also likely contributing to an increased reliance on the NDIS. AHPA argues that there is a clear opportunity to develop better pathways and greater coordination between schemes, particularly focused on supporting smoother entry and transition. We note that the proposal to increase the age at which young children exit the early childhood approach provides additional opportunities specifically in relation to the transition into education.

Recommendations

- **Undertake mapping of adjacent systems and services outside the NDIS such as mainstream health, education, childcare and other services.**
- **Work with other governments to ensure families are supported to access assessments and planning supports to enable access to the most appropriate services for individual needs.**
- **Improve understanding of other services outside the role for families.**

- **Improve education of mainstream providers about the NDIS and its scope.**

Recommendation 6

Consider a range of mechanisms that will enhance compliance of providers with the *NDIS Practice Standards on Early Childhood Supports* and increase awareness by families of providers that adopt that best practice framework.

AHPA and its members have strong concerns about the proposals in recommendation 6, particularly as they relate to forcing compliance with the NDIS Practice Standards on Early Childhood Supports. We strongly disagree with the argument that identifying providers that adhere to the Practice Standards 'will assist families to easily identify providers who are recognised for delivering best practice'. We also raise strong concerns about requiring registration with the NDIS Commission, and the impact this will have on reducing the volume of providers available to provide services.

From the perspective of the allied health sector, it is clear that the introduction of the NDIS Quality and Safeguarding Framework, particularly as it relates to young children with disability, and the requirement for allied health professionals to undertake 'certification'-level audits was a response to concerns from the states and territories arising from the findings of the Royal Commission Royal Commission into Institutional Responses to Child Sexual Abuse. Submissions by AHPA and its members to the Department of Social Services (DSS) at the time that the Framework was being established flagged the lack of risk in the allied health sector as well as the high level of existing regulation of allied health practitioners, where they are either AHPRA-registered or accredited by the appropriate self-regulating health profession. Those arguments were not challenged and AHPA and other industry representatives were successful in working with the NDIS Commission to reduce some aspects of registration requirements in recognition of the overly onerous nature of certification.

AHPA also notes that we have not identified issues relating to inappropriate practice by allied health professionals, despite the high use of unregistered providers by the 80 percent of families self-managing or accessing plan-management for their NDIS early childhood funding. While the consultation paper refers to 'many in the sector being concerned that providers may not be following best practice standards', it is not clear how well-substantiated those concerns are, particularly in the absence of any form of formal review and where it is not clear if potential conflicts of interest exist. It is also not clear to what extent increasing the requirement to adhere to the Early Childhood Practice Standards will address any concerns about the quality of services.

Certification-level registration is extremely expensive, particularly for providers in rural and remote regions who are required to cover the costs of transportation and accommodation for third party auditors. Respondents to recent surveys have flagged costs of \$10,000 and above for audit as being common even where providers are solo, part-time providers. Transport and accommodation costs are additional to this. There are many active early childhood providers who will not be able to meet those costs. As a result, requiring registration will substantially reduce the market as providers will be forced to shift service provision to older children. In conjunction with an increase in age for the early childhood approach, this would result in a substantial increase in thin markets for services already in high demand. We note in this context that while there are many larger providers with very highly experienced staff, many also employ less experienced recent graduates while smaller providers often represent more experienced professionals.

AHPA does not support any of the potential mechanisms flagged to increase adherence with the practice standards and we do not believe it will result in the quality improvement outcomes sought.

AHPA instead proposes that a more appropriate alternative would be to develop an early childhood capability framework, with associated training modules, that providers could voluntarily use regardless of whether they are registered or unregistered providers. Once successfully completed, providers could then list themselves as having completed training and families could be encouraged to use providers that have undertaken this training. This has the benefit of separating clinical practice, in relation to early childhood supports, from practice accreditation. There are a range of ways in which this could be done, including through profession-specific capability improvement activities such as education and resource provision.

AHPA does note our concern about the capacity for larger providers to employ allied health professionals from self-regulating professions that are not accredited by their profession. This applies to professions such as speech pathology and audiology. We argue strongly that while registration with the NDIS Commission is not required for health professionals, it is essential to ensure that those health professionals are subject to regulation as well as meeting ongoing continuing professional development requirements.

Recommendations

- **Focus on quality improvement through an enablement framework, based on improving understanding of EC approaches and overall capability in the sector.**
- **Work with allied health sector to design and roll out capability improvement program.**
- **Require all health professionals operating within the NDIS that are not subject to the National Registration and Accreditation Scheme (NRAS) to be accredited by the relevant self-regulating health profession.**

Recommendation 9

Implement a tailored Independent Assessments (IAs) approach for young children to support consistent access and planning decisions.

AHPA and its members have strong concerns about the proposals in relation to independent assessment for young children with disability. AHPA members have identified a range of concerns that relate to independent assessments more broadly and we refer the Agency to our additional submissions to the independent assessment inquiry. However, in addition to our broader proposals for independent assessments, AHPA notes several EC specific issues.

The first of those issues relates to the workforce that will undertake independent assessments of young children with disability. The current consultation paper proposes that assessments are undertaken by EC partners, noting that EC partners already employ allied health professionals and currently undertake assessments. However, there does not appear to be a requirement under current proposals for EC partners to use allied health professionals to undertake the independent assessment of children. Instead it appears to be free to those EC partners to choose who to utilize for the purpose of assessment. This contrasts with the approach to assessment for any participants seeking to access the NDIS outside of the EC approach, and appears to overlook the work undertaken by AHPA in conjunction with the Agency in relation to identifying appropriate experience, credentialing and quality measures for the assessment workforce. Early childhood educators, while an important part of the workforce, vary significantly in their education and experience and lack a range of specific expertise that we argue is essential as part of appropriate assessment of young children.

AHPA argues strongly for the need to ensure that rigorous standards apply to any assessors working in the early childhood space and argues that it will be important to work closely with the allied health sector to build on previously undertaken work to identify the necessary training and characteristics for the assessor workforce. This is particularly important given the proposals in Recommendation 15 to have EC partners undertake all assessments of young children with disability for all levels of complexity, including children who are deemed eligible for Section 24 entry. Given that these assessors will be responsible for assessments that result in similar access and budget decisions as those for older participants, it would not be appropriate to have lesser requirements in relation to skills, qualifications, and experience.

Aside from assessor workforce concerns, one of the areas of greatest concern for allied health professionals is how the proposed independent assessment process will identify any family capacity and support requirement differences that may be unrelated to individual functional capacity. Similarly, it is not at all clear how the assessment will identify individual needs and goals of participants that may impact overall budgets. The proposed toolkit appears to have no capacity to identifying differences in family capacity and relating to environmental factors such as the availability of other services. For example, two young children with disability may be assessed similarly in relation to their functional capacity. But one family may have a highly capable parent able to provide dedicated support to the child and any needs they may have while in the other family the parent is themselves managing mental ill-health and other health issues that impact their ability to provide support to their child. AHPA notes that the use of allied health professionals as assessors provides significant capacity to use that clinical expertise to provide input as part of the assessment process about environmental factors that might need to be considered. AHPA argues strongly for the need to further adapt the assessment process and to build in clinical input from the highly qualified allied health assessor workforce.

AHPA also notes our continued concern about the potential lack of provisions within the assessment process to account for factors that might make independent assessments more difficult for some young children and their families. We note for example that some young children with autism spectrum disorder (ASD) may have significant issues in working with a health professional they are unfamiliar with. Similarly, we note that issues such as communications capacity arising from functional limitations or due to a culturally and linguistically diverse (CALD) background are not addressed. We argue strongly that there should be capacity for existing providers, that are trusted by the family and have direct experience of the young child with disability and their family, to be utilised for the purpose of undertaking the proposed assessment. This would not preclude the use of a standardised set of tools or a standardised assessment outcome but instead builds on existing relationships and knowledge of the participant.

AHPA notes our strong rejection of any arguments about bias as a reason not to use providers already involved in supporting the child and their families. We note that independent assessments are not clinical care assessments and not directly related to what supports a person might access. We also note that allied health practitioners, like their medical colleagues, are bound by a range of codes and standards that require them to act in the best interests of the person. The proposal to require independent assessments from practitioners that do not know the family is in stark contrast to the focus in the health system of supporting relationships with health professionals as a foundation for more informed care and higher quality assessments.

Recommendations

- **Require the use of allied health professionals as assessors.**

- **Work with allied health sector to further refine training, credentialing and quality assurance requirements for assessor workforce.**
- **Expand assessment to allow clinical input from assessors in relation to other factors likely to contribute to the support needs and plan budget requirements of the child.**
- **Provide capacity for allied health providers already involved with the family, and who meet assessor workforce requirements, to undertake assessments in place of independent assessors.**

Recommendation 12

Increase Early Childhood partner capacity to provide Short Term Early Intervention (STEI) support to eligible young children and families for longer.

AHPA supports the recommendation to increase access to STEI support for eligible young children and families. Allied health practitioners working in early childhood have flagged that there is significant potential for increased use of the STEI supports to provide a more responsive and timely service, particularly in relation to the needs of families who are not eligible for full access to the scheme. However, feedback from the sector suggests that EC partners are already struggling with capacity and available workforce resulting in long wait times.

We note that the Agency has recognised the need to increase resourcing and argue that this will be critical alongside changes to guidelines for the STEI program. There is a strong view in the sector that this will need to be monitored carefully to ensure it is effective, and that EC partners can deliver on the intentions of this recommendation. In addition to careful monitoring, we also argue for the need to involve the sector in the development of an appropriate implementation plan, based on a realistic review of current and future capacity.

Recommendations

- **Increase resourcing for EC partners to support greater use of STEI supports.**
- **Monitor capacity of EC partners to meet need for STEI.**

Recommendation 13

Clarify the interpretation of the developmental delay criteria under Section 25 of the NDIS Act (2013) to improve the consistency and equity of Agency decision making. Establish thresholds for key criteria using Independent Assessments.

AHPA supports the recommendation to clarify developmental delay criteria and to create operational guidelines which more clearly set out how both ‘substantial delay’ and ‘extended duration’ are interpreted. However, we argue that the definition should not be developed internally by the Agency but rather by an independent panel of clinical experts and participant representatives in order to build confidence in the process. Eligibility to the scheme is one of the most sensitive areas and with the greatest potential impact on young children with disability. We argue that increased transparency and independence for the development of criteria provides a strong foundation for improving trust. We further recommend that the updated definitions are subject to review after a 12-month period to ensure that they are providing more effective access and not inadvertently locking out some young children who should be supported by the scheme. We argue that the updated definition should be made publicly available to help families and providers understand the updated criteria.

While AHPA provides its overall support for the recommendation, we argue against the proposal to tie the development of thresholds for developmental delay to the independent assessment process. Our strong view is that there are significant uncertainties about the independent assessment process, given both the uncertainty about the clinical knowledge of the proposed assessor workforce and the need to test whether the proposed toolkit and assessment process is accurately identifying participants that should be supported by the scheme. Given these uncertainties and the largely untested nature of independent assessments for children, we argue that it is not appropriate to link the two together. Instead, the panel identified above should work with the Agency's actuarial branch to monitor intake numbers as well as potential appeals and Administrative Appeals Tribunal decisions of relevance as part of the evaluation process to provide guidance about setting threshold levels.

Recommendations

- **Appoint an independent participant and clinician panel to determine interpretation of developmental delay criteria.**
- **Use panel to set thresholds for key criteria relating to developmental delay.**

Recommendation 14

Increase the age limit for children supported under the Early Childhood Approach from 'under 7' to 'under 9' years of age, to help children and families receive family centred support throughout the transition to primary school.

AHPA and its members are very supportive of the proposal to increase the age limit of children supported under the EC approach, provided the Agency does not introduce a requirement for providers to be registered with the NDIS Commission. As noted previously, we argue that increased age limits provide an important opportunity to better support families during an important time of transition and to increase the level of coordination between the NDIS and other mainstream supports. However, AHPA cautions that any requirement to register with the NDIS Commission will have a major impact on the size of the available workforce of EC providers and this will be exacerbated by an increase in age limits.

While AHPA recognises the rationale for excluding developmental delay from the expanded age limits, we argue that this should be reviewed by the independent clinical and participant advisory committee alongside other aspects of the developmental delay proposals, as outlined in our previous notes to Recommendation 13.

Recommendations

- **Increase age limit for EC approach.**
- **Monitor impact of limiting age increase for young children with developmental delay.**

Recommendation 17

Introduce a 'capacity building support in natural settings' item in the NDIS Price Guide to encourage families and early childhood providers to prioritise supports delivered at home or other natural settings.

AHPA and the allied health providers working in early childhood very much recognise the value of delivering services in natural settings and we broadly support work to encourage families and providers to emphasise this type of approach wherever possible. However, we argue that the development of a separate line item may work against the intentions of greater plan flexibility and may limit the capacity of clinicians and families to make decisions about the most appropriate setting for the child. It also introduces additional complexity for planners, families and providers.

We note in this context that there are a wide range of factors that might lead families to choose clinical settings over home or community environments and that choice and the ability to offer individualised approaches that meet individual need should remain a key priority for EC services. We argue instead for the use of the guidelines on EC practice, proposed in Recommendation 3, in conjunction with a co-designed implementation approach that seeks to educate and enable the broader allied health sector and families about the most effective EC approaches.

Recommendation

- **Provide increased guidance to sector about preferred practice in place of additional natural settings line item.**

Recommendation 18

[Publish new guidance about what is considered ‘reasonable and necessary’ when making decisions around support for children on the autism spectrum, based on evidence found in the Autism Cooperative Research Centre \(CRC\) 2020 report.](#)

AHPA and its members have welcomed and supported the work of the Autism Cooperative Research Centre (CRC). We recognise the value of evidence-informed practice and the importance of ensuring that EC interventions have a strong focus on supporting young children with autism spectrum disorder and their families to achieve the goals and outcomes they have identified as important. The findings in the Autism Interventions Evidence Report show that a range of intervention modes, formats and settings can be effective and align with the principles outlined in the ECEI Reset report.

Despite the value of this work, AHPA argues that caution is required in how the report is used to determine reasonable and necessary interventions. We note that the report itself states that ‘the findings provide key insights into which interventions have research evidence for producing a positive effect’ rather than stating that it provides insights into which interventions are most effective. We also note that the research was based on a review of systematic reviews, reviews that were of variable quality and where only 4 of the systematic reviews met all quality criteria. This reflects a critical factor in relation to the use of evidence as the foundation for clinical practice—namely that there are many areas of clinical practice where only limited research of variable quality has been undertaken. As such it is vital to ensure that lack of research evidence is not conflated with lack of efficacy.

The recent multi-year Medicare Review, undertaken by a range of expert clinical committees on behalf of the Department of Health, found similar issues in relation to many health interventions. Those clinical committees determined that it would not be appropriate to cease funding interventions where there was not a sufficiently rigorous research base, provided there was no evidence of harm or low value. A similar approach that seeks to identify gaps and build research evidence, but that also recognises that research gaps may remain, is essential. For this reason, the allied health sector refers to evidence-informed practice (this is also the term used by the NDIS Commission in its practice standards) and argues that the Agency should take a similar approach.

We also note that there is a difference between reasonable and necessary and clinically effective. For example, a young child with a particular disability may most effectively maintain or gain functional capacity through particular therapeutic interventions. However, this therapeutic approach may not align directly with key goals that the child and their family have, perhaps in relation to community participation. As such it will be important to ensure that the two concepts are not conflated.

Allied health professionals delivering early childhood interventions are highly trained clinical professionals with the expertise and knowledge to tailor their approaches to the needs of the individual child. A wide range of settings, modes and interventions types have the potential to meet the needs of the participant and AHPA argues strongly that any guidance around reasonable and necessary should only seek to identify and limit access to any intervention types that have been determined to be harmful or of low value rather than seeking to place limits on the range of services that can be provided. Similarly, families must be considered those best-placed to determine the greatest priorities for themselves and their child and there must be capacity to set individual goals and priorities.

Recommendations

- **Exercise caution in relation to development of guidance and determination of ‘reasonable and necessary’ based purely on review of available research.**
- **Develop research plan to address knowledge gaps.**
- **Identify dangerous or low-value care in conjunction with sector and undertake work with NDIS Commission to proscribe or limit their use.**

Recommendation 19

Empower Early Childhood partners to provide families with clear advice about the best providers for their child and situation so families can make more informed choices.

AHPA has significant concerns about the proposal to have EC partners guide families in relation to which providers are best suited to their needs. We argue that this proposal has significant issues, including the practical objection that EC partners typically demonstrate highly variable knowledge of locally available services. Practitioner feedback suggests that many EC partners are providing very incomplete lists of potential services to families that are not representative of the range of local options available. It appears clear that EC partners, with individual exceptions, do not currently know their communities well enough to provide complete and accurate information about services. AHPA does argue in this context that we would support work by the Agency to improve data collection and access to information for families about the range of providers available to them, including providers offering telepractice options that may increase access for those families in areas of limited workforce availability.

We also have significant questions about the capacity for EC partners to advise on the best providers, noting that there are a wide range of factors that may influence what makes a provider most appropriate for a particular family, including availability of services. A range of professionals consulted by AHPA and its members have flagged the level of demand for early childhood services and that in many cases families are limited in their options and can only choose the service that is available. We note that the Agency has identified the need to address issues such as potential

conflicts of interest and objectivity through a framework for providing objective and evidence-based advice. While we are not at all certain that such a framework is realistic, we do argue for governance arrangements to be put in place if this proposal is carried forward.

However, AHPA argues that a more effective approach would be to develop a consumer guide that helps families understand what questions to ask. This could be developed in conjunction with participants and the allied health sector, rather than EC partners as a nationally consistent resource. We note in this context that there is potential to develop a low-cost app for families, similar to apps developed for families with children with autism, that provide guidance about the roles and scope of different professions and that prompt families with questions to ask to help identify if the provider is likely to meet their needs. We note also the work of the Victorian Department of Health and Human Services (now Department of Families, Fairness and Housing) allied health capability framework and its associated website, which provides consumers with guidance about how to determine if an allied health provider is likely to suit their needs. This work would provide an effective reference for further work as it was developed in consultation with participants, families and providers.

Recommendations

- **Work with participants and allied health sector to develop consumer guide to help families choose appropriate providers.**
- **Consider development of mobile app consumer guide.**
- **Build on existing work such as the work undertaken in Victoria.**

Recommendation 20

Undertake further ongoing research and study on the outcomes of young children after receiving early intervention support, to inform future policy and operational changes.

AHPA broadly supports an expanded research agenda focused on early childhood, including some of the proposals within Recommendation 20. We recognise the value of tracking long-term outcomes for young children with disability and their families. We also recognise the importance of scheme sustainability and the need to have a focus on cost outcomes for the scheme. At the same time, AHPA cautions in the strongest possible terms about a purely financially focused measure of outcomes that seeks to balance expenditure on early childhood services with a reduction in costs for supports of those with NDIS plans as a means of measuring success. We are particularly concerned about the proposal that this research agenda would drive goal-setting for participants or access to high-value allied health interventions.

AHPA argues that there are a wide range of outcomes that would not be captured by this measure, including goals and outcomes identified as important by participants and their families, scheme priorities such as community participation, as well as potential reduction in mental health issues or interactions with the justice system. We note for example that there is good evidence to suggest that addressing some types of developmental delay and communication-related disabilities can significantly improve capacity to participate in community life with a commensurate reduction in mental health issues. We argue that it would be appropriate to supplement financial research measures with other outcomes measure that focus on the experience and priorities for participants.

AHPA notes that the current proposals appear to provide only limited capacity to translate research into practice. Current proposals appear to focus primarily on driving internal policy, and guidance for EC partners, about which services are most cost effective or have the most easily demonstrated outcomes. This is likely to do little to enable current and future workforces to understand what

contemporary research shows is effective and there is no reference to working with the sector to develop continuing professional development opportunities for practitioners. There is also no reference to how academic findings, as well as the findings of the Agency, will be translated into real world applications. To enable this type of evidence translation, AHPA argues that the Agency requires clinical leads that can support and advise in relation to how best to support uptake of contemporary findings and practice. We also argue that the Agency should formalize an approach to evidence translation in conjunction with allied health peak associations.

Recommendations

- **Expand focus of proposed research agenda to realise opportunities to better understand allied health impact on participant outcomes and shift emphasis away from a scheme sustainability focus.**
- **Develop formalised partnerships with allied health sector to support evidence translation and enablement of workforce.**

Recommendation 22

Ensure providers are using the recently introduced 'provider outcomes report', as a mandatory measure to evaluate the effectiveness of their supports and services.

AHPA and its members supported the introduction of the provider outcomes report and increased guidance by the Agency for providers on how and what they should report. AHPA cautiously supports making this report mandatory, with the caveat that providers working in separate organisations, that is not as employees of the same organization, report barriers in relation to funding for working in a multidisciplinary team to complete the report. Anecdotal feedback from practitioners suggests that increased use of videoconferencing as part of the response to COVID-19 has also increased online case conferencing. This could be facilitated through some minor adjustments to Agency funding.

Recommendation

- **Review and address barriers to completion of provider outcomes report in conjunction with allied health sector prior to changing requirements.**

Recommendation 23

Offer families of young children a 'transition out' plan for up to three months' duration, to support them to transition to the next stage of their lives, if they are no longer eligible for the NDIS.

AHPA supports the proposal to offer a 'transition-out' plan for young children existing the scheme. However, we also argue that there should be greater flexibility for families to remain connected to the scheme, potentially as unfunded or inactive participants, rather than needing to fully leave the scheme. This would better support potential future need for short term interventions to help with transitions and periods of change that may impact a child's support needs as well as reduce the potential administrative burden of re-applying for full access to the scheme.

AHPA also argues that the limitation of six one-hour sessions may be insufficient to meet the intentions of the transition out process and that this should be adjusted to ensure that families have some capacity to increase the number of available hours where the family and supporting allied health professional can demonstrate why additional support is needed. We recognise the need to provide some constraints on this and encourage further work with clinicians to better outline the

sort of services likely to be needed during the transition out phase and what volume of hours is most appropriate.

A number of practitioners have also argued that this would benefit from greater flexibility about when families can access the three-month transition-out support. We have noted above feedback from practitioners that children who are otherwise managing well without supports may require additional temporary assistance during periods of life transition such as when starting school. If a family were to cease supports late in the year but the child were to only start school in February, it would be more appropriate if there was flexibility to choose when those supports were accessed. This would align well with the proposal to have participants remain connected to the scheme rather than fully exiting, with an ability to access that transition-out plan as needed. Alternatively, it may be viable to extend the maximum length of time that the transition-out plan is active without changing the service limits that can be accessed.

As a final note, we recommend evaluation of the transition plan with clinicians and families at an appropriate point after the program has been implemented. An annual review may be most effective.

Recommendation

- **Introduce transition out plans with greater flexibility about total hours and when plan is accessed.**
- **Work with participants and clinicians to evaluate program.**