Review of Best Practice in Early Childhood Intervention

Findings from the PRECI Consultation

Version 1.0, 21 November 2024
The University of Melbourne

preci
PROFESSIONALS & RESEARCHERS IN EARLY CHILDHOOD INTERVENTION

THE UNIVERSITY OF MELBOURNE

Acknowledgements

The University of Melbourne acknowledges the Traditional Owners of the unceded land on which we work, learn and live: the Wurundjeri Woi-wurrung and Bunurong peoples (Burnley, Fishermans Bend, Parkville, Southbank and Werribee campuses), the Yorta Yorta Nation (Dookie and Shepparton campuses), and the Dja Dja Wurrung people (Creswick campus).

The University also acknowledges and is grateful to the Traditional Owners, Elders and Knowledge Holders of all Indigenous nations and clans who have been instrumental in our reconciliation journey.

We recognise the unique place held by Aboriginal and Torres Strait Islander peoples as the original owners and custodians of the lands and waterways across the Australian continent, with histories of continuous connection dating back more than 60,000 years. We also acknowledge their enduring cultural practices of caring for Country.

We pay respect to Elders past, present and future, and acknowledge the importance of Indigenous knowledge in the Academy. As a community of researchers, teachers, professional staff and students we are privileged to work and learn every day with Indigenous colleagues and partners.

This document has been developed by a University of Melbourne-led Consortium as part of an independent review of best practice in early childhood intervention in Australia.

Funded by the Department of Social Services, the consortium is led by Professor Christine Imms of the University of Melbourne in partnership with Murdoch Children's Research Institute (MCRI), Professionals and Researchers in Early Childhood Intervention (PRECI), SNAICC - National Voice for our Children and Children and Young People with Disability Australia (CYDA).

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1. Introduction

This Consultation Report has been prepared as part of an independent review of early childhood intervention (ECI) best practice commissioned by the Department of Social Services (DSS). The review is being undertaken in fulfilment of Action 2.4 of the Early Childhood Targeted Action Plan, which is part of the implementation of Australia's Disability Strategy 2021-2031.

The purpose of the action is to:

> *review guidance for best practice in ECI and prepare a framework for best practice in ECI that reflects current research and evidence.*

This project will contribute to the second objective of the Early Childhood Targeted Action Plan (TAP):

> *to strengthen the capability and capacity of key services and systems to support parents and carers to make informed choices about their child*

The primary objective of this work is to co-produce an Australian Early Childhood Intervention Practice Framework that is founded on the best available evidence, is practical and can be implemented and evaluated for effectiveness and impact. The goal is that all children growing up in Australia live in thriving families and communities that support their health, development and wellbeing, and that children with developmental concerns, delay, or disability receive the support they need to participate fully in their families and community.

1.1 Aim

The aim of the consultation was to use the results of the desktop reviews (the first stage of the independent review) to support the consultation and co-production processes to inform and to contribute to development of the new Practice Framework.

1.2 Our overall approach

Our goal was to provide the right conditions for participation, collaboration and engagement in the consultation, which includes providing space (opportunity to participate), voice (support to express views), audience (access to decision makers) and influence – that decision makers are open to being influenced by the views expressed (Lundy, 2007). The consultation activities were completed in four parts, each aiming to reach differing groups with the goal of broad reach across Australia to those with an interest in ECI.

The four consultation processes were led by different members of the project consortium:

- Professionals and Researchers in Early Childhood intervention (PRECI) conducted consultations with early childhood practitioners and providers, professional organisations, peak bodies, advocacy groups, researchers and academics
- SNAICC - National Voice for our Children (SNAICC) convened targeted engagements with Aboriginal and Torres Strait Islanders state and national

peak bodies, Aboriginal and Torres Strait Islander community-controlled organisations and families
- The Association for Children with a Disability (ACD) undertook consultations with parents and caregivers
- Healthy Trajectories undertook a qualitative study with young people aged 15-30 years to explore their experiences of childhood interventions and supports.

The draft consultation reports were shared with our national and international expert panel members for their input thought engagement in a 3-hour workshop or individually in writing.

1.3 Report structure

The findings of the different consultations are presented as separate reports, which will be available on the Healthy Trajectories ECI website.

Section 2 of this report provides the findings from the consultations undertaken by PRECI.

Now that this round of consultations has been completed, the next step of the project is to bring together what was heard in the consultations with what was synthesised in the desktop reviews to inform the development of the framework. We will seek stakeholder input, via consultation, to the draft framework and proposed resources through the next phases of the review.

2. Findings from the PRECI Consultations

2.1 Introduction

This is one of four papers that used the desktop review findings (Deliverable 1) to conduct consultation and co-production processes with relevant stakeholders to inform the scope of the new Practice Framework requirements, and to contribute to development of the framework. Professionals and Researchers in Early Childhood Intervention (PRECI) led a comprehensive consultation process, engaging Australia-wide with a diverse range of professionals and targeted advocacy organisations. Meanwhile, other consortium partners, including SNAICC, Association for Children with Disability and University of Melbourne focused on engaging with specific target groups including families, Aboriginal and Torre Strait Islander families and organisations, and young people with disability. These combined efforts ensured that the consultation process captured a broad spectrum of perspectives, contributing to a more inclusive and informed approach.

This paper is a synthesis of what was learned from professionals and advocates who completed a national survey, and/or participated in online or in-person consultations during August-September 2024.

- The professional consultations were conducted by Denise Luscombe and Kerry Bull
- The quantitative data from the survey and polls were analysed by Anoo Bhopti, Airlie Barwell, Denise Luscombe and Georgie Rose
- The qualitative data were analysed by Kerry Bull and Denise Luscombe
- The report was written by Kerry Bull and Denise Luscombe

2.2 Summary of Participants

Consultations

The online and in-person consultations were attended by 676 individuals, with a small number attending both an online and in-person consultation. Participants were from all states and territories of Australia. The attendees were predominantly female, coming from a variety of cultural backgrounds, including Aboriginal background.

Participants came from a diverse range of professional disciplines, sectors and service delivery models. The highest number of registrants (19%) worked in private practice followed closely by 17% in not-for-profit (NFP) organisations.

Survey

The survey was completed by 582 respondents, with representatives from all states and territories of Australia. The respondents were predominantly female, coming from a variety of cultural backgrounds, including Aboriginal background. A broad range of professionals completed the survey with Speech Pathologists, Occupational Therapists and Educators, making up 51% of respondents. 31% of respondents worked in private practice followed by 16% in not-for-profit (NFP) organisations.

2.3 Overview of Key Findings

This report provides an overview of the findings of our consultations with professionals and advocates to inform the development of the Practice Framework. Consultations with families, young people, Aboriginal and Torres Strait Islander communities and relevant organisations, along with the review of the literature, will provide further crucial insights to inform the development of the Practice Framework, and its implementation.

We engaged with over 1,250 people from all sectors across the country through live forums, on-line discussions and a survey. The consultative process involved professionals collaborating in a series of consultation forums, working together through an iterative approach to refine the aims, outcomes, and principles of the Practice Framework.

In our professional consultations, the central place of family, and the importance of community and culture were clear. Underlying all was a conviction that children have a right to be secure, belong, included, to have fun and to participate in family and community life.

The findings indicated a powerful emphasis on relationships: between children and the important adults in their lives, between children and their siblings and peers, in parents/carers' partnerships with professionals, and the collaboration between ECI professionals and their colleagues. Collaboration was also seen to be critical to rebuilding an integrated service system that provided timely and equitable access, seamless pathways and transitions for children and families.

The fundamental importance of strong, mutual relationships at every point was felt to be at the heart of effective ECI.

Through the iterative consultation process, professionals worked together to provide direction about the desired aims, outcomes and principles of the Practice Framework. They wanted to strengthen their focus on positive outcomes for children and families underpinned by evidence-informed practices. There was a clear call to reinvigorate a workforce that is skilled and knowledgeable about ECI. Professionals wanted accountability for providing high quality programs.

From all professionals, there was a gathering wave of concern about the current service system. There was also some tension about the approaches to providing evidence-informed services.

There was concern about the need for thorough implementation of the Practice Framework. This included recommendations about appropriate tools, resources and professional development, developing a national data and evaluation system, addressing implementation drivers and barriers, and supporting strong leadership.

The consultation findings revealed a unified voice among participants, characterised by a strong, authentic commitment to the Early Childhood Intervention (ECI) sector. There was mutual respect evident among professionals, along with a shared dedication to children, families, and the broader community. Participants emphasised the need for change within the sector and stressed that such change could only be achieved through collective efforts and collaboration.

2.4 Methodology

2.4.1 Survey

How did we conduct the survey?

ECI practitioners, professional and advocacy organisations, peak bodies, researchers, academics and policy makers were invited to complete an online survey.

Following ethics approval (2024-30254-56693-3) through the University of Melbourne (UoM), the survey was developed in Qualtrics. The survey was available for the professionals noted above to complete through a QR code or hyperlink promoted through PRECI social media, PRECI website, PRECI Connect newsletter, PRECI consultations and UoM Campaign Monitor email. The 20-minute survey included qualitative and quantitative questions and was open for three weeks during August-September 2024. A total of 582 professionals completed the survey.

The purpose of this survey was to seek information from a broad range of professionals on questions posed by the DSS, related to perceptions of best practice, aims, principles, guidelines, and professional development needs to support awareness and understanding of the Practice framework.

How did we analyse the survey data?

Descriptive Statistics to summarise the survey data using measures such as frequencies, percentages, means, and standard deviations to provide an overview of participant responses were used.

What were the characteristics of the survey participants?

Survey respondents came from all States and Territories of Australia, with 77% of total survey respondents being from NSW, Victoria and Queensland. See Figure 1.\

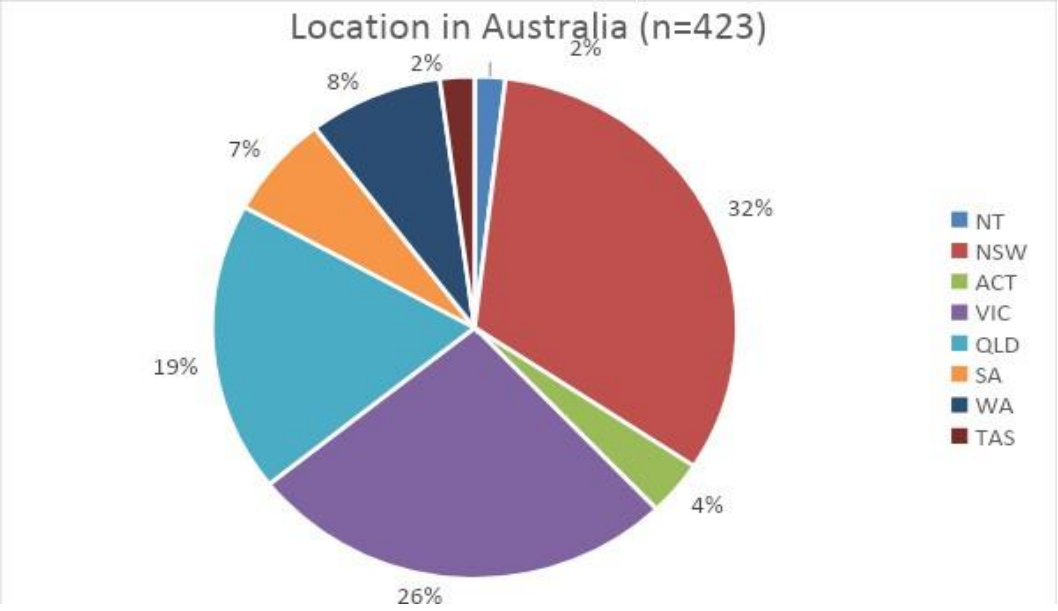


Figure 1: Participation location in Australia

97% of the respondents identified as being a woman with 3% identifying as being a man. A small number of respondents identified as LGBTQIA+ or attended as representatives of the LGBTQIA+ professional community. One percent of respondents were from an Aboriginal background. An open question asking for cultural background highlighted professionals were from Australia, Africa, China, Europe, India, New Zealand, United Kingdom, Middle East, South Africa, and South East Asia, as well as professionals from the Deaf culture.

Profession/Position

A broad range of professionals completed the survey with Speech Pathologists (28%), Occupational Therapists (13%) and Educators (10%), making up 51% of respondents. Social workers (1%), peer workers (1%), paediatricians (1%) and policy makers (4%) were the smallest groups represented. Other professionals who responded (13%) included: advocates, audiologists, behaviour analysts/specialists, community support workers, early childhood coordinators, exercise physiologists, GPs, inclusion support professionals, maternal and child health nurses, migrant support workers, music therapists/musicologists and registered nurses.

See Figure 2.

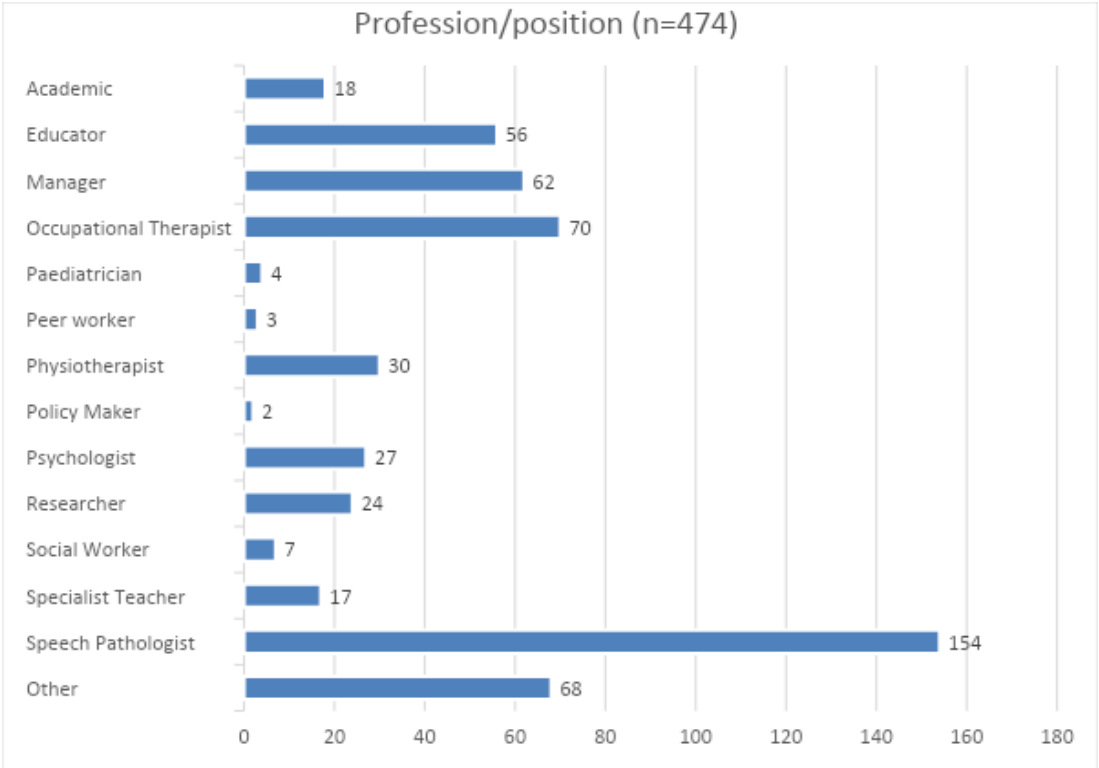


Figure 2: Profession

As the respondents could select more than one answer, many held a dual role within management.

Experience level was relatively evenly distributed with 22% of respondents having less than 5 years' experience, 20% 6-10 years, 30% 11-20 years and 28% more than 20 years' experience.

Organisation and clientele

31% of respondents worked in private practice (62% having up to 20 staff), followed by 16% in not-for-profit (NFP) organisations (with 45% of NFP organisations having more than 50 staff). It can be noted that there was representation from all sectors targeted: education, health and disability/early childhood intervention.

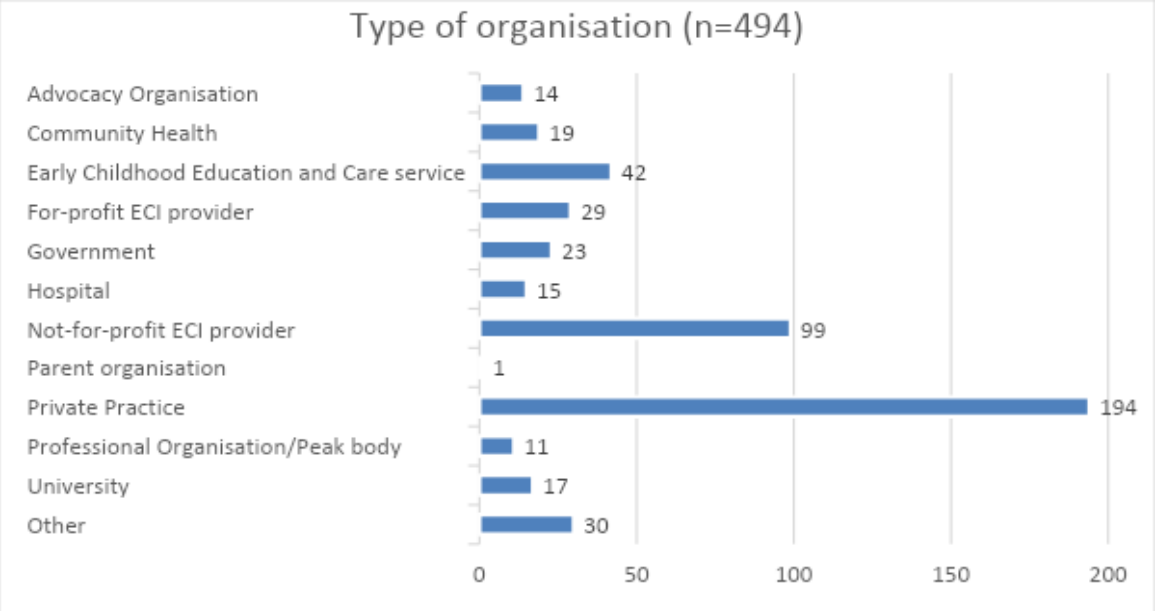


Figure 3: Type of organisation

Other organisational types that responded included: Partners in the Community, consultancy, National Disability Insurance Agency, charity, and after school care.

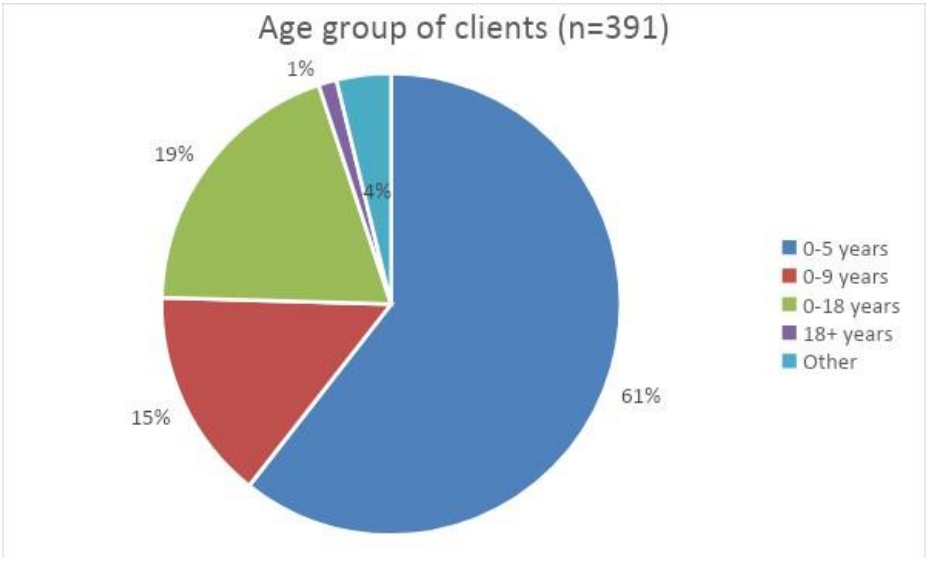


Figure 4: Age group of clients

76% of respondents worked primarily with children under the age of 9 years. 74% of respondents reported that more than 50% of their client base were NDIS participants (54% of respondents having between 75-100% of NDIS clientele).

2.4.2 Consultations

How did we conduct the consultations?

Following ethics approval (2024-30254-56693-3) through the UoM, ECI practitioners, researchers, professional and advocacy organisations, peak bodies, and policy makers were invited to participate in an:

- Online consultation, and/or
- In-person forum

The registration link for generic online and face-to-face consultations was promoted through PRECI social media, PRECI Humanitix platform, PRECI website, PRECI Connect newsletter and UoM Campaign Monitor email. Professionals and organisations were approached individually via email and phone for the targeted online consultations.

What were the characteristics of the consultation participants?

The Humanitix registration process for attending the online and face-to-face consultations included gaining consent for recording and collection of data including the following participant characteristics.

Consultation registrants came from all States and Territories of Australia, with 48% of registrants being from NSW and Victoria. See Figure 5.

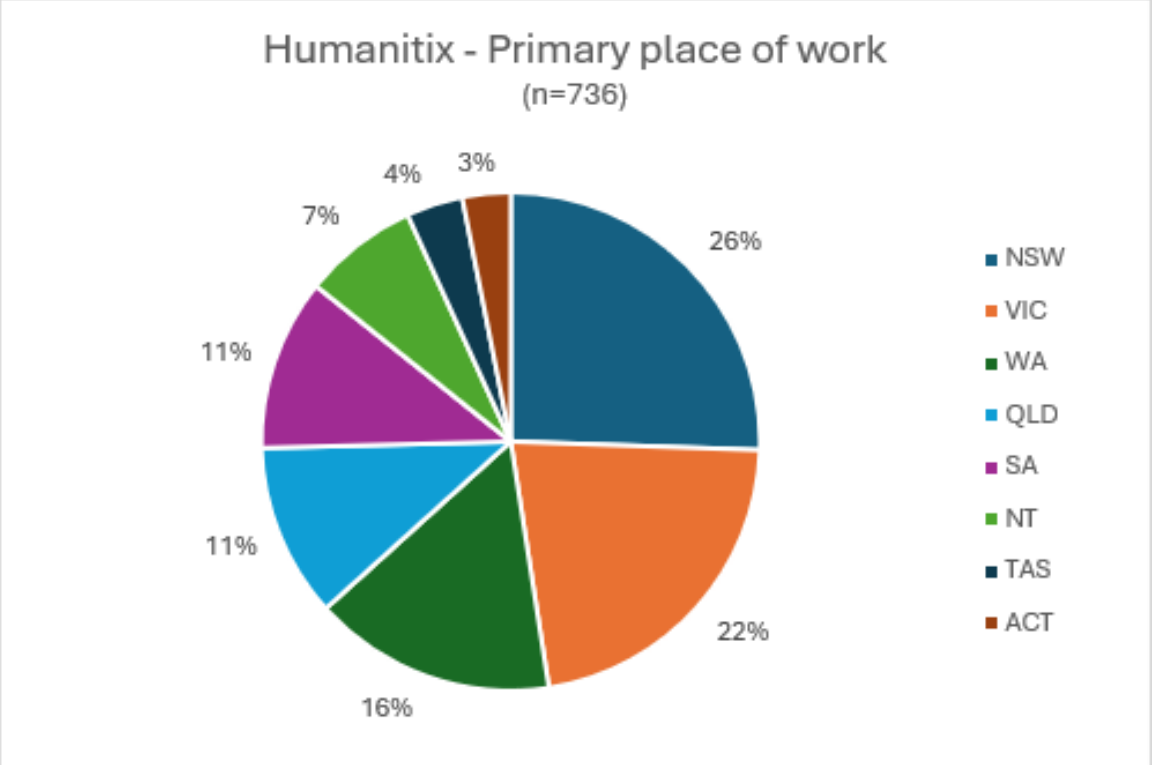


Figure 5: Location of primary place of work

96% of the respondents identified as being a woman with 4% identifying as being a man. Two percent of respondents were from an Aboriginal background. An open question asking for cultural background highlighted professionals originating from

Australia, Africa, Asia, China, Europe, India, United Kingdom, Middle East, and South Africa. Professionals from the Deaf or Diversity cultures also responded.

Profession/Position

A broad range of professionals attended the consultations with 15% being Occupational Therapists, 9% Educators, and 8% Speech Pathologists. Excluding the Other category, peer workers, policy makers, specialist teachers and social workers were the smallest groups represented. See Figure 6.

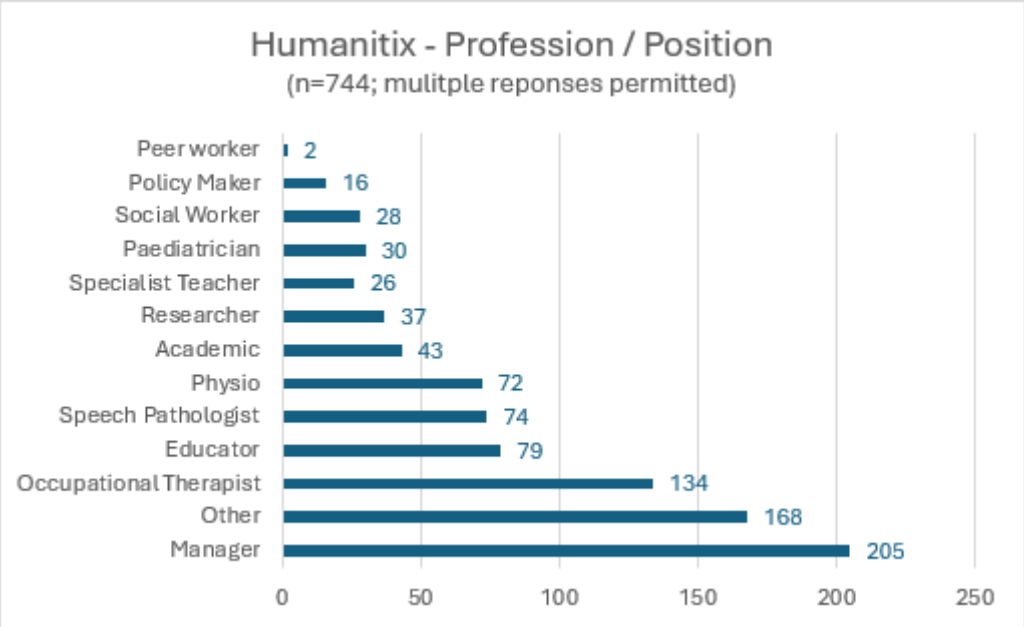


Figure 6: Profession/Position

As the registrants could select more than one answer, 22% of all registrants described their profession/position as including being a manager.

Other professionals who registered included: advocates, art therapists, audiologists, Auslan language specialists, behaviour analysts/specialists, child development practitioners, community support workers, dietitians, early childhood coordinators/practitioners, family support workers, GPs, government agency staff, inclusion support professionals, maternal and child health nurses/leads, migrant support worker, music therapists/musicologists, NDIA staff, paediatric dentist, school principals, teacher of the deaf, psychologists (developmental, educational, clinical) registered/clinical specialist nurses and union organiser.

Experience level was relatively evenly distributed with 24% of respondents having less than 5 years' experience, 20% 6-10 years, 28% 11-20 years and 28% more than 20 years' experience.

Organisation and clientele

19% of registrants worked in private practice (49% having more than 20 staff), followed by 17% in not-for-profit (NFP) organisations (with 73% of NFP organisations having more than 20 staff). There was representation from all sectors targeted: education, health and disability/early childhood intervention.

Figure 7: Organisations

Other organisational types that responded included: Aboriginal Medical Services/ Primary Health/Organisations, Education providers, Partners in the Community, consultancy, National Disability Insurance Agency and Research Institutes.

When asked about the age group of their clientele, 69% of registrants worked primarily with children under the age of 9 years. When asked about the percentage of NDIS participants that made up their client base, 62% of registrants had more than 50% of their client base as NDIS participants (48% of registrants having between 75-100% NDIS clientele).

Online consultations

Online consultations took two forms:

Targeted Consultations

These on-line consultations were through direct invitation to specific groups of ECI practitioners, researchers, professional and advocacy organisations, peak bodies, and policy makers. A total of 256 professionals participated in targeted consultations. The purpose of these sessions was to seek specific information from professionals in the broader field of ECI, gain insights into the use of other relevant frameworks, perceptions of the aims and outcomes of ECI, and implementation barriers and enablers. (See Appendix 1 for example questions)

Participants for the targeted consultations included:

- Academics
- Child Protection Agencies
- Education providers
- Family Advocacy Organisations

- Health providers
- Inclusion support agencies
- Multicultural Advocacy Organisations
- National Disability Services
- NDIA Children's Taskforce
- NDIA National Early Childhood Branch
- Practitioners with less than three years in Early Childhood Intervention
- Peak bodies
- Professional organisations – such as Australian Physiotherapy Association, Australian Psychological Society, Occupational Therapy Australia, Dietitians Australia, Early Childhood Australia, Speech Pathology Australia, Maternal, Child and Family Health Nurses Australia, Australian Association of Social Workers and Australian Society of Developmental Paediatricians
- Researchers
- Rural and remote service providers

Generic Consultations

The online generic consultations were available to all interested professionals and were centred around three topic areas:

- Best practice in ECI – Understanding, challenges and solutions
- Early Childhood Intervention – Aims, principles, outcomes and terminology
- Theory to Practice – Guidelines, resources and professional development

A total of 133 professionals participated in generic consultations. The purpose of these sessions was to seek information from a broad range of professionals on questions posed by the DSS. (See Appendix)

To ensure that there was growth and relevant depth in the questions asked and answers provided by participants over the consultation period, an iterative process was utilised, where the probes for the questions became more targeted over time, reducing repetition of information.

Participants were prompted to 'speak in draft' to encourage freedom of thought and open discussion. They were also requested to be respectful and inclusive in their discussions to allow all participants to be heard.

In-person forums

Forums were held in all capital cities and other major centres such as Launceston, Alice Springs, Broome, Cairns, Kununurra and Karratha. The three-hour forums were facilitated by the same two senior researchers in order to maintain consistency.

Participants were informed about the consultations via PRECI social media, PRECI website, PRECI Connect newsletter and the UoM Campaign Monitor Expression of Interest email. Humanitix was utilised as the platform for registration. A total of 287 professionals participated in the in-person forums.

How did we record and analyse the consultation data?

On-line consultations were recorded through Zoom, including the chat room. The two researchers took written notes throughout the consultations. Poll results were also collected.

In-person forums were voice recorded when participants provided feedback. All the participant documentation (e.g. illustrations of the framework they developed, notes on aims, outcomes and principles) was collected for analysis. Menti-meter data was also collected. All data were uploaded on a secure password-protected UoM SharePoint. Data will be stored on secure UoM drives for 5 years following publication of findings.

Thematic analysis of data collected via Zoom transcripts, recording transcripts, researcher and participant notes were used to systematically explore professionals' perspectives. Creswell's (2021) six steps of thematic analysis were utilised that included Familiarisation, Generating Initial Codes, Searching for Themes, Reviewing Themes, Defining and Naming Themes, Producing the Report.

A senior researcher developed initial themes from the data outlined above. A secondary senior researcher reviewed the documentation and themes. There was a high overlap in individual interpretations, resulting in the development of a shared analytical framework. Consensus was reached in all themes and subthemes.

2.5 Results

Four primary themes were identified from the integrated findings of the survey and consultations. Each of these primary themes included focus areas as indicated on the figure below.

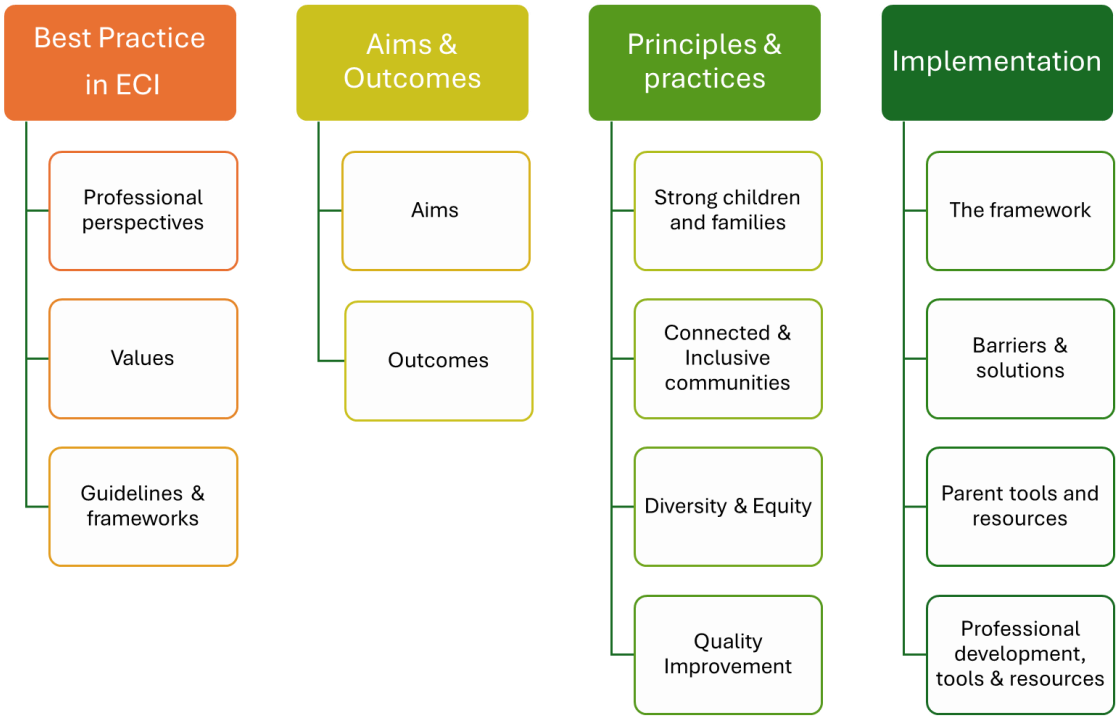


Figure 8: Consultation themes and focus areas

2.5.1 Best practice in ECI

Professional perspectives on Best Practice in ECI

What did we ask?

In the survey and relevant on-line and in-person consultations, we asked: How do you define best practice in ECI?

What did we hear?

Professionals in the early online and in-person consultations described best practice in ECI as:

- utilising best available evidence-informed practices: taking into consideration literature, family experience, clinical experience and judgement, and specific diagnoses while being aware of emerging practices
- services and supports available as early as possible
- easily accessible, equitable, timely, consistent, flexible, responsive and considered
- professionals
    - who are appropriately qualified, skilled, credentialed, ethical and empathic
    - with high standards of training and supervision available, and
    - who have an ongoing commitment to learning and a willingness to reflect and evolve practices over time
- professionals who understand the needs of infants, children and their families and support systems (paediatric specific), including the foundational role of early relationships, experiences, culture and context
- professionals who work in partnership with families and:
    - understand that the family is the best support for the family
    - are family-centred, culturally informed, strengths- and interest-based, trauma-informed, neuro- and disability-affirming
    - use an ecological approach
    - elevate the child's voice and self-advocacy, promoting a sense of identity
    - understand the importance of parent-child relationships and building healthy early attachments
    - are relationship-based
    - provide unbiased information and encourage active participation from the family
    - have a capacity building focus including advocacy and supported choice and control

- focusing on the individual goals/vision/priorities/preferences of the family and child, with clear measurable outcomes
- supporting learning, development, independence, participation and inclusion of all children into mainstream settings, home and community, including transitions between environments, reducing environmental barriers, with the aim of reducing service need
- being delivered/embedded within daily routines and play at home/natural settings, and if not, ensure support to carryover/transfer into the meaningful environments and activities the family and child value and choose
- delivered through a collaborative team including the family, other agencies, organisations, sectors and professions with a variety of team models noted.
- utilising one key person as main family contact to reduce carer burden and overwhelm
- being provided at the intensity required for achievement of positive outcomes
- understanding the value of peer support and peer-led organisations
- understanding the value of collaborating with the lived experience of the community and connect families/children with adults with lived experience eg deaf community

Values

Values were raised in the first online consultation, with mention of organisational and professional values being important to the provision of best practice services and the Practice Framework. Values continued to be raised spontaneously by professionals as the online consultations progressed. It became clear to the senior researchers that values were a critical piece missing from the semi-structured questions that required further exploration.

What did we ask?

In the in-person consultations participants were provided with the following definition of values.

Values are important individual or collective beliefs that motivate people to act one way or another. They serve as a guide for human behaviour and influence priorities in life and work.

Participants were asked to use their mobile phones to complete a confidential Mentimeter and enter the values they recommended should be included in the Practice Framework. Each in-person consultation had a unique code to enable local reflections to be determined via a ‘word cloud’. A word cloud grows and changes in real-time with the frequently submitted words appearing larger.

What did we hear?

In total, there were 1032 individual entries. The deidentified site-specific word clouds are available in Appendix 2. They demonstrate the similarities and differences between the various consultation sites.

As there is no available process for collating the results of different word clouds through Mentimeter, a senior researcher manually analysed and summarised the frequency of the values entered. These were then entered into a unique Mentimeter that reflected the nine top values for all the in-person consultations combined.

Figure 9: Framework values

As noted from the word cloud, respect (n=91), followed by collaboration (n=80) and connection (n=32), was entered most frequently. For analysis purposes, safe/ty (n=19) was reflected as one value, whether entered as a single word or combined with child or cultural safety. Further rankings included: responsive (n=24), flexible (n=18), trust (n=16), accountable (n=16) and reflective (n=15).

Guidelines and frameworks

We sought information about the use of frameworks in both survey and consultations.

What did we ask? - Survey

In the survey we asked the question: 'Do you currently use any specific guidelines or frameworks?'

What did we hear? - Survey

30% of survey respondents responded Yes, 20% No, and 50% did not respond to the question.

The National Guidelines for Best Practice in Early Childhood Intervention was the most commonly utilised Guideline or Framework (n=63). This was followed by discipline-specific guidelines (n=35) such as Speech Pathology Australia Clinical

Guidelines, Early Years Learning Framework (n=29), diagnosis-specific guidelines such as the National Guideline for supporting the learning, participation, and wellbeing of autistic children and their families in Australia or Cerebral Palsy Guidelines (n=24), and the WHO ICF/F Words (n=16).

In the survey, we also asked ‘*’How do you use the framework or guideline?”*

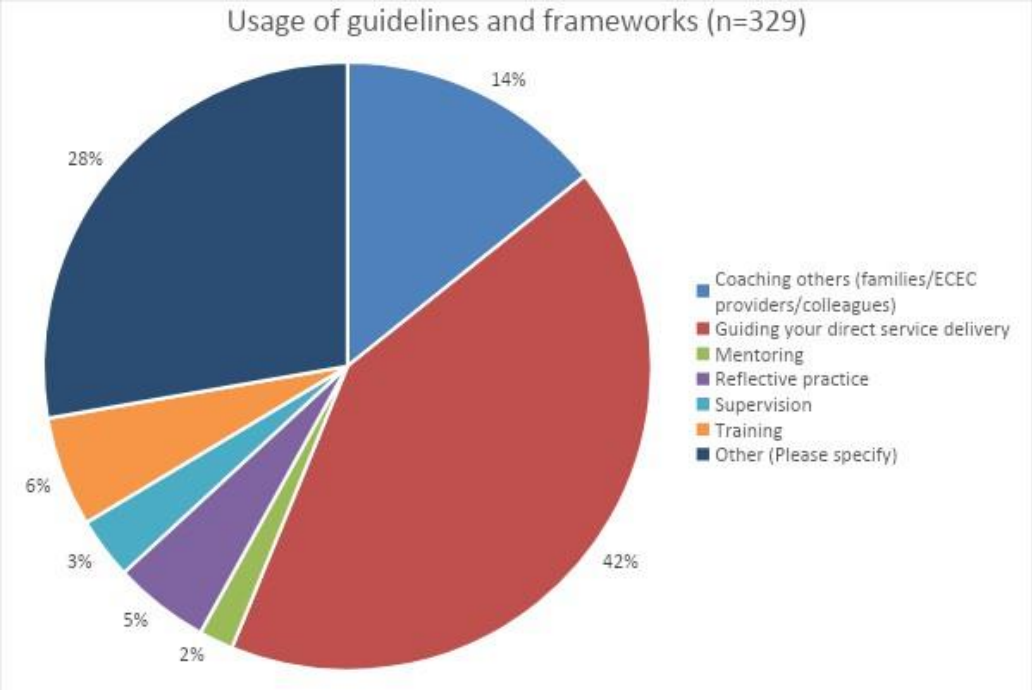


Figure 10: Use of guideline or framework

63% of respondents indicated they used guidelines for all of the reasons provided in the survey.
In addition, respondents utilised guidelines to build family understanding of practice, for advocacy purposes, to support communication between team members, and to support policy development within organisations.

What did we ask? - Consultations

Throughout consultations, we asked the question: ‘What other frameworks or guidelines do you use?’. The responses were consistent with the survey although data was not collected as to which were most commonly utilised.

What did we hear? - Consultations

In the consultations, professionals recommended that the Practice Framework:

- Recognise children’s rights outlined in the UN Convention on the Rights of the Child (1989) to ensure the best interests of the child are upheld and promoted.
- Embed into practice the human rights articulated in the Convention on the Rights of Persons with Disabilities (2006).
- Incorporate an ecological systems framework (Bronfenbrenner, 1977) that situates the child within a series of interconnected environmental systems ranging from immediate (family) to broad societal structures (culture).

Professionals suggested that the Practice Framework interacts with other key frameworks and guidelines so there is no duplication or contractions. In particular, it was seen that the Early Years Learning Framework (EYLF, 2022) offered a critical interface with its “strong and ambitious” focus on the vision of Belonging, Being and Becoming and the associated outcomes, principles and practices.

“A sense of hope and future”

2.5.2 Aims & Outcomes

Aims

What did we ask?

In the survey and some of the relevant consultations, we asked: *What is the aim of ECI?*

In the in-person forums, participants were provided with the following definition of aims: ‘Aims are statements of what Early Childhood Intervention services are seeking to achieve’.

What did we hear?

In the survey, professionals provided significant input into the question of the primary aims of ECI including:

- being timely, taking advantage of neuroplasticity and critical developmental periods, providing early identification of child developmental concerns
- giving children the best start in life during the formative years,
- enriching the child’s development in their environmental and cultural contexts
- assisting children to be their best selves in childhood, adolescence and into the future
- helping children access the same opportunities as their peers
- supporting families to develop strong attachment with their child
- empowering families to advocate for their child
- building family resilience
- reducing the impact of disability, focusing on prevention and intervention
- ensuring access to the supports and therapy they need to thrive
- being able to access specialised equipment, including for communication
- preventing or reducing the need for therapy and supports later in life

In the early online and in-person consultations professionals began defining the aim of ECI primarily in relation to children and families. However, in later consultations there was a recommendation to add a ‘community aim’ in order to capture the social determinants, or conditions needed, for children, families and communities to thrive. Later, one of the groups at an in-person forum raised what they expressed as “an interesting omission” in not having professional aims included. Later groups were

asked their thoughts on adding a professional aim and they agreed it was necessary and provided input into the most appropriate wording.

Through the iterative process in the consultations, professionals 'word-smithed' the aims and settled on the following.

The aims of Early Childhood Intervention are to:

- build on child strengths, interests and preferences in daily life to enhance learning, development, engagement and participation in everyday activities
- honour and extend existing family culture, knowledge, skills and confidence to support child and family quality of life
- understand and promote safe, welcoming, inclusive, responsive and connected communities
- contribute to, and be part of, a collaborative and integrated network of support for families, children, communities and colleagues.

Outcomes

"Seeds are planted at the beginning"

What did we ask? - Consultations

In the consultations, participants were provided with the following definition of outcomes: 'Outcomes are benefits experienced as a result of services and support provided to children and their families'.

In the relevant consultations, we asked: *What do you perceive are the outcomes of ECI?*

What did we hear? - Consultations

Professionals in the initial consultations recommended an approach to defining outcomes that included children and families. Just as they did with aims, participants later added communities as a third element. In the later consultations, participants included professional outcomes and worked together in the final forums to describe outcomes that should be included in the Practice Framework.

It's important to note that some of the proposed outcomes could be better described as the conditions needed to achieve these outcomes. For example, many of the listed professional outcomes are professional competencies and practices. Professionals involved in developing the outcomes during the in-person consultations provided these outcomes, so they have been included here to provide a direct representation of what the researchers heard.

Through the iterative process of the consultations, professionals settled on the following four aims that they envisaged all interacting with each other as indicated in figure 11.

Children are:

- safe and have their needs and rights met
- have strong relationships with their parents/caregivers
- respected and listened to
- encouraged to have a say in the things that are important to them
- included in everyday life as valued as members of their community
- participating, engaging, interacting, playing, learning and developing in daily life in their family and community
- supported through individualised, meaningful and functional goals

Communities are:

- caring and culturally safe
- confident in, and committed to, including all (abilities, backgrounds & circumstances)
- accessible and providing authentic opportunity for participation
- connected and integrated
- communicating and collaborating
- supported to acquire knowledge, skills and resources
- committed to the development and wellbeing of children
- accountable

Families are:

- safe and have their needs and rights met
- understanding and responsive to their child needs
- having meaningful life experiences together
- supported to do their best to meet their family needs (including siblings)
- recognising the strengths and opportunities of their family and their child's potential
- confident, competent and empowered
- heard and confident in advocating for their family
- respected and have their culture honoured
- included, connected and valued as members of their community
- receiving timely access and a seamless journey into/out of services
- offered choice and flexibility in supports (formal & informal) and services

Professionals are:

- culturally sensitive
- accessible and flexible
- appropriately qualified and skilled
- connected, supported and collaborative
- knowledgeable about current evidence and available resources to support understanding of best practice
- continuously learning
- accountable for providing high-quality service
- utilise information and resources available that support children, families and their local community
- reflective about their own beliefs and biases
- advocating for best practice in ECI
- innovative

Figure 11: Outcomes

2.5.3 Principles and practices

What did we ask? - Survey

In the survey, we asked respondents to rate on a scale of 1-10 the extent to which principles and practices identified in the review of national and international framework (Deliverable 1) should be in the Practice Framework (with 1 being 'strongly disagree' to 10 being 'strongly agree').

The 13 principles and practices included:

- Family-centred practices (FCP)
- Child focussed and developmentally responsive practices (CF)
- Strength-based practices (SBP)
- Culturally responsive and affirming practices (RA)
- Inclusive and participatory practices (Inc)
- Providing ECI services in natural learning environments (e.g. home, ECEC, community settings) (LE)
- Promoting responsive interactions (RI)
- Embedded teaching and learning (e.g. intentional and systematic strategies in natural learning environments) (TL)
- Teamwork and leadership (TW)
- Planned transitions (e.g. to support the adjustment of the child and/or family to a new setting/situation) (PT)
- Authentic assessment practices (e.g. for the purposes of screening, determining eligibility for services, individualised planning, monitoring child progress, and measuring child outcomes) (AxP)
- Evidence informed and outcomes focussed practices (IO)
- Evaluation and monitoring of quality ECI practice (Eval) What did we hear? - Survey

What did we hear? – Survey

The mean results indicate all 13 practices were rated highly with mean scores between 8.58 - 9.56. The mode for each of the principles was 10 (that is the most common value in a dataset). The median scores for all the principles were either 9 or 10 (middle value that is least affected by outliers).

The overall standard deviation scores were small, indicating that most of the data points are close to the mean, showing little variability and strong agreement. Family-centred practice was scored most highly as a practice to be included with others following closely.

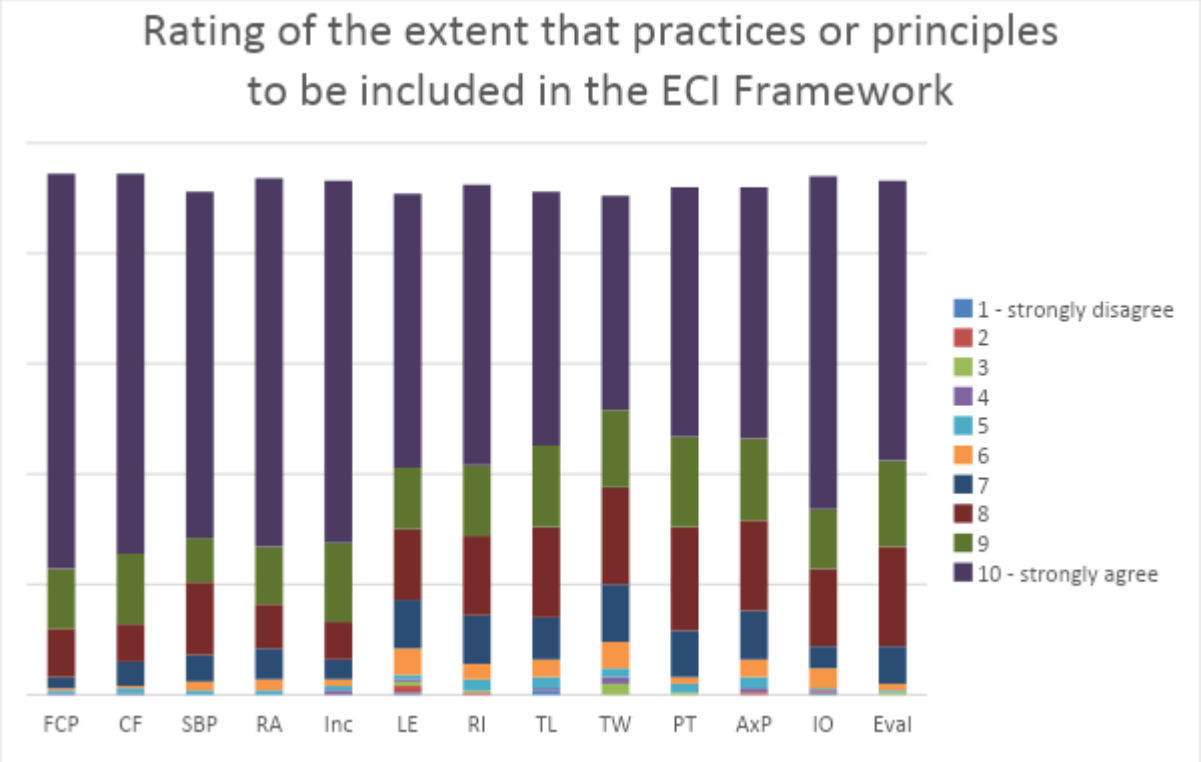


Figure 12: Extent of principles and practices to be included in the Practice Framework

	FCP	CF	SBP	RA	Inc	LE	RI	TL	TW	PT	AxP	IO	Eval
Average rating	9.6	9.5	9.4	9.4	9.4	8.8	9.0	8.9	8.6	9.0	8.9	9.2	9.1

Figure 13: Average rating of extent of principles and practices to be included

Respondents were also asked: '*Are there other practices that you think should be added to the Practice Framework?'*

Responses included:

- Holistic approach
- Individual choice and control
- Social determinants of health and disability outcomes of the family unit
- Attachment and maternal mental health approach
- Responsive parenting
- Child Agency
- Child wellbeing
- Neuro-affirming practice
- Authentic assessment

- Targeted intervention
- Parent-mediated practices
- Data-informed

What did we ask? - Consultations

In the consultations, participants were provided with the following definition of principles and practices:

'Principles are rules, beliefs, or ideas that guide our behaviour. They can serve as the foundation for a system of belief or behaviour or for a chain of reasoning (i.e., a theory of change). Principles are independent of context and apply in all circumstances. They are based on three sources: values, rights and evidence'.

'Practices are the specific actions or behaviours that put these principles into effect. Practices are context-dependent and show how principles are applied in particular circumstances. Practices are based on three sources of evidence: evidence-based research, practitioner practice knowledge and wisdom, and client values, priorities and circumstances'

In relevant consultations, participants were asked about their perceptions of what principles and practices should be included in the framework. We used an iterative process to have participants build on each other's thinking throughout the consultation period.

What did we hear? - Consultations

In the consultations, professionals proposed a set of principles with a high level of agreement. Understandably, principles and practices sometimes merged as professionals grappled with definitions and commonly used terms and phrases. For example, professionals typically refer to 'family-centred practices', but in the consultations, there was unanimous agreement that 'family-centred' should be a principle, or focus area, rather than a practice. This confusion is reflected in the international guidelines and frameworks reviewed in Deliverable 1 of the project. Despite these misinterpretations, there was strong agreement about the four principles and associated focus areas that should be included in the framework, although the words used to title them was sometimes debated. For example, some professionals wanted a principle titled 'connected communities', while others suggested 'collaborative communities' 'capable communities' or 'understanding communities.' In each instance, we have offered wording that was dominant across consultations.

It's important to note that some of the focus areas (e.g. timely and supported access, service pathways and transitions, knowledgeable and skilled workforce), might be described as systems issues or professional competencies. Professionals involved in developing the structure during the in-person consultations situated them within the principles of the framework, so they have been included here to provide a direct representation of what the researchers heard.

Figure 14 displays the four key principles broken down into ten focus areas and the section below further discusses how some practices aligned with those principles

and practices that lead to positive outcomes for children and families. Practices are listed below them. Each of the practices were recommended by professionals in the consultations and in the free text box of the survey asking: 'Are there other practices that you think should be added to the ECI Framework?'

However, before the principles, focus areas and practices are described, it's important to note that there was one key element that professionals highlighted as underpinning an effective Practice Framework: Relationships. They described the interactions between children and the important adults in their lives, the relationships with siblings and peers, partnerships with professionals, and the collaboration between professionals as critical to effective ECI.

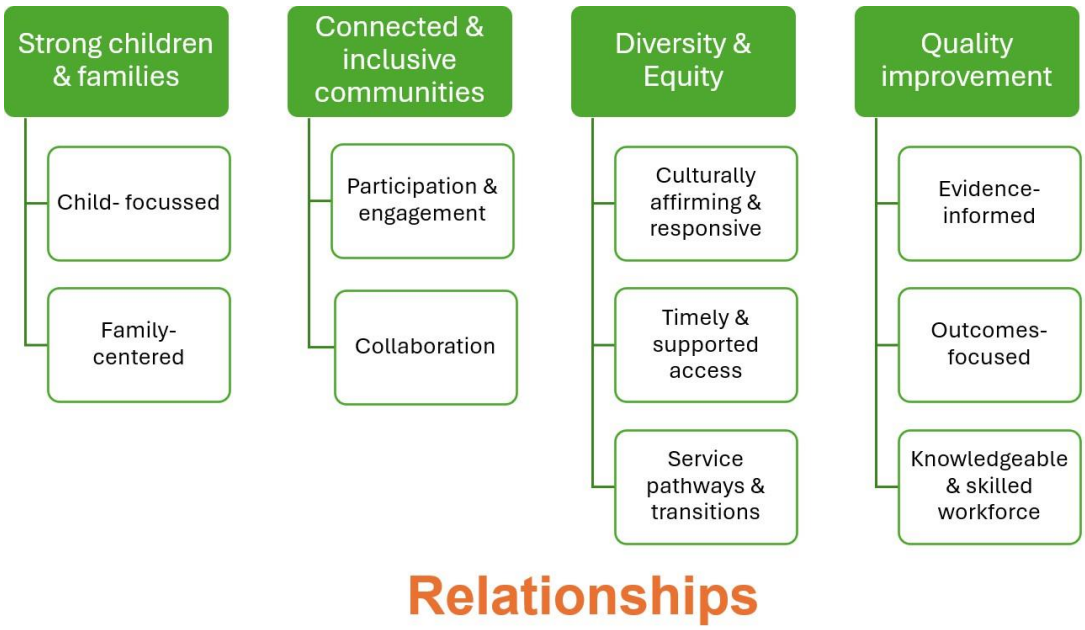


Figure 14: Principles and focus areas

Strong children and families

"Helping mob to be strong, to raise strong kids"

There was common agreement across consultations about the need for child-focussed and family-centred principles to be prominent in the guidelines. There was a compelling argument to have the two focus areas included, to ensure:

- a child-focussed principle and associated practices that are unique to the child (early childhood development and learning, child voice and agency, child safety), and
- a family-centred principle and corresponding practices (e.g. strength-based capacity building, relational practices)

In addition, the majority of professionals wanted the two focus areas to sit firmly alongside each other, and nested within one principle, to illustrate recognition of

children learning and developing within the context of their family. They wanted to demonstrate this through practices that relate to both the child and other members of the family, such as responsive caregiving and attachment.

Child-focused

There was agreement about having a clear focus on the child. We were asked to "*raise the profile of the child*", making it explicit that there are key child-focussed practices that should be addressed within this focus area.

Professionals wanted to highlight child voice and agency in the framework to emphasise practices that enable children to learn how to make good choices and have a say in the things that are important to them. They wanted children to be "*confident in who they are*". They wanted child strengths, interests and preferences to be recognised as drivers that enhance learning, development, engagement and participation. This discussion led to many participants talking about the importance of play in a child's life and for practitioners to embrace play-based learning opportunities.

There was discussion about the need for practitioners to have a core understanding of child development following comments that this was rarely a component of undergraduate training in allied health degrees. Given the view that many courses paid limited attention to paediatrics in general, this was seen as a major area of concern.

Key to this principle was an emphasis on promoting parent-child interactions, secure relationships and attachment. There was also discussion about the role of siblings and peers in promoting learning and development and the perception that their importance in ECI service delivery has been diminished in recent years.

Further, there was discussion about child safety and the role ECI practitioners have in understanding issues related to child abuse/neglect and their interactions with child protection services. Professionals spoke of the increased risk of children with disabilities experiencing abuse/neglect and their understanding of working in the best interests of the child. They raised issues related to children in out-of-home care and their interactions with carers.

Trauma-informed practice was raised on a regular basis throughout the consultations and raised two key issues. First, professionals spoke about the need for ECI practitioners to be trauma- informed and to understand the diverse causes of trauma, including intergenerational trauma, feeding trauma caused via language deprivation or separation. Second, professionals wanted more guidance about implementing trauma-informed practice. One practitioner used the alternate term "trauma-reflective", explaining that ECI professionals should be reflective about whether a child had experienced trauma, but understand this within their scope of practice, and refer on to others, as appropriate. They called for the Practice Framework to consider guidance about these critical issues.

Corresponding practices that were recommended included, to:

- promote safe and secure relationships
- promote responsive and attuned/attached relationships
- heighten child voice, agency and identity
- promote active engagement of the child with siblings and peers

- understand holistic child development and the importance of play and fun
- learn about and utilise the child's strengths, interests and preferences
- understand the importance of the pre-, peri- and post-natal period

Family-centred

Including a family-centred focus area was unanimously recommended by consultation participants and was scored most highly as a principle to be included in the Practice Framework by survey respondents. There was a focus on both the relational aspects as well as strength-based capacity building practices.

Many spoke of the importance of developing a "*respectful relationship*" or "*partnership*" with families based on "trust", "respect" and "compassion". This focus was evident across disciplines, sectors, jurisdictions and models of service delivery. Professionals discussed strength-based capacity building practices as key to their work and a practice that should be utilised whether working with children, families, colleagues or more broadly in the community. As one participant indicated, "*We build our lives on our strengths*". Another noted that practitioners should have a mindset based on "*an assumption of parent competence*".

There was discussion about "*flipping the power dynamic*". That is, not always expecting professionals to build knowledge, skills and confidence of parents, but understanding the intrinsic capacity of parents to do that themselves. They discussed the "*bidirectional*" nature of the relationship. That is, that parents can also build skills and knowledge of professionals.

Professionals highlighted their role in supporting positive parent-child interactions as a key component of child-focussed and family-centred practices and how that related to the current research on child development and learning. They highlighted the need for children and families to have fun together and parents to enjoy being a parent.

There was some discussion in the consultations about family-centredness also incorporating flexible and individualised services. This included being "fluid in support" so families could adapt the intensity of service provision in accordance with their child's and family needs. One practitioner suggested this allows families to "*get off the therapy bandwagon and have time to be a family"*.

Others discussed the need to provide high quality telepractice options, or a hybrid service, so families had more options. This was noted not only for rural and remote families, but certainly highlighted as a viable option for those families who couldn't access in-home services. Others discussed the need for services to provide options for families out of traditional hours and called for the NDIS to "i*ncentivise*" after-hours and weekend ECI.

Professionals in the consultations were concerned that the term family-centred is misused and overused. They sought a definition of 'family-centred', with their understanding that the principle and associated practices is "*broader than having a good relationship with families*". They called for the framework to provide clear definitions and descriptions of "*what it looks like when it's working well*". This request for definitions was later extended to other terms such as inclusion, participation and engagement.

There was also a suggestion that 'family-centred' often becomes 'mother-centred' in ECI and there was a need to broaden practitioners' thinking to fathers, siblings, grandparents and the other important people in a child's life. There was discussion about recognising the impact on siblings and ensuring that siblings '*did not miss out*' and the whole family was supported. Further to this, some discussed the need to recognise the critical support family members can receive from, and give to, their 'informal' network of friends and neighbours. As one professional commented, these informal supports need to be recognised because "*Who are you going to rely on at 2.00am"?*

There was concern expressed about the intensity of ECI services for some, and the disruption to family life stating that "*Families lose their community. The community becomes their therapy team"*. Other participants highlighted the support parents can give, and receive, from other families of children with disability and their concern that opportunities for parents to get together had diminished in recent years. They called for investment in peer support for families. Others raised the importance of connecting families and children with adults with the same lived experience to provide support, understanding and connection. This was highlighted as being a gap area for deaf or hard of hearing children born to hearing parents.

Furthermore, there was a call for other definitions in the framework, such as that of 'family', to ensure an understanding of the diversity of contemporary Australian families, recognition of Aboriginal and Torres Strait Islander family and kinship and those children who are in out-of-home care.

Corresponding practices that were recommended included, to:

- develop trusting and respectful partnerships
- use communication skills such as active listening
- meet families where they are at
- be curious, open, humble, observant, responsive, understanding and attuned understand and respect family values and practices
- understand formal and mobilise informal family supports
- employ strength-based approaches
- acknowledge, enable and build parent capacity
- provide information to enable parents to make informed decisions
- provide a flexible and individualised service
- strengthen advocacy
- utilise coaching and video-modelling

"Inclusion is a basic premise for ECI"

Connected and inclusive communities

Participation and engagement

There was considerable discussion in the consultations about what was meant by inclusion, participation and engagement. Whilst there were differing thoughts about terminology and corresponding definitions, there was general agreement that

children should be "*valued members of society*" and "*participating, engaging, interacting, playing, learning and developing in daily life*".

Professionals talked about inclusion as being a fundamental principle of ECI. For many, this meant children not being segregated in ECEC, school or family life, but learning through their everyday activities and routines in "*the places where they hang out"*. For several others, there was an argument for children needing to be in settings where they could learn skills in preparation for inclusive environments. "*Some children require time in more structured or contrived settings to learn some skills. Some may not even be able to learn from their natural environment at first, and require some learning in a clinical setting, before they will benefit from learning opportunities in their natural environment".*

Professionals discussed some specific challenges for children to engage and participate in social activities with their peers due to individual needs such as enteral feeding/when dietary needs are specific or due to lack of access and availability of different modes of communication/language.

Some professionals suggested that the "NDIS has perversely and inadvertently excluded children". They argued that the proliferation of unregistered allied health practitioners working with children 1:1 in clinical settings where there was "*no evidence that weekly speech, weekly physio, weekly OT makes any difference in the long term*"' was in conflict with best practice in ECI. Another professional viewed inclusion practices in light of the current funding arrangements that didn't support travel to the child's home. "*Perhaps providing some sessions in home environment and some in clinic setting may be a middle ground to keep things financially feasible*". This financial barrier to supporting children's learning in inclusive environments was highlighted as a particular issue for families in rural and remote communities: "*Some families are opting for clinic-based and less naturalistic interventions in an attempt to save funding. Rural and remote families are disadvantaged by this the most. In ECIS days, families accessed services where they needed them, not where it was cheaper to access them*".

Participants wanted children to have opportunities to develop friendships and learn alongside their peers. Some highlighted play-based learning and the importance of children having fun. Others emphasised routines-based approaches and the critical nature of natural learning environments. Participants called for clarification about how to promote learning in the places where children "*live, learn and play*". They also called for the ECI field to foster understanding in the wider community (e.g. hairdresser, gymnastics) about how to include children in typical neighbourhood and community activities. Others called for the need to "*uplift educators' knowledge*" about inclusive practices when discussing the ongoing problem of children being refused placement at ECEC or attending with reduced hours because of the child's disability. This was highlighted as a significant problem for school placement as well. "*There is no data on exclusion - exclusion is often discrete".*

Corresponding practices that were recommended included, to:

- ensure universal access to services
- adopt universal design for learning
- promote parent peer interactions

- support learning in natural environments
- build capacity in the local community
- ensure accessible language

Collaboration

Professionals who had been in the field for some time discussed the significant disruption to sector collaboration experienced over the past decade. Amongst the frustration expressed by professionals about the disruption, there was universal agreement that collaboration was key to improving the service system and promoting better outcomes for children and families. Participants appeared "*thirsty*" for collaboration with their colleagues, whether they were sole practitioners or members of multidisciplinary or transdisciplinary teams. One participant indicated that "*People want to collaborate, but it's undervalued".*

Professionals talked of the "*silos*" and "*disconnect"* between services that were viewed as detrimental to the provision of high quality ECI. This fragmentation was suggested to be another one of the unintended consequences of the NDIS. As one participant commented "*we're competing for business so it's difficult to foster collaboration*". Others commented that there was no incentive for teamwork in the NDIS price guide, so collaboration became a financial impost. As one professional commented, "*We need to recognise the value of multidisciplinary collaboration in a family-centred model, and appropriately fund time for collaboration".*

A range of team models were discussed, such as multidisciplinary, transdisciplinary, team around the child and key worker models. Some consultation participants called for the framework to "*champion*" the key worker transdisciplinary model. Another participant was concerned that the key worker role was "*diluting specialist skills*", whilst others spoke of the varied ways the key worker role is currently being interpreted which has implications for quality. Many advocated for the key worker model, when implemented as intended, with a clear understanding of practitioner scope of practice. There was considerable discussion about the need for practitioners to understand their scope of practice and know when to refer to a colleague from another discipline, regardless of the service delivery model they worked within. Others discussed the merits of alternative models of teamwork that occurred, such as when sole practitioners developed networks with colleagues from other disciplines to ensure a collaborative approach. One participant described collaborative team practices working best when "*Everyone is playing their role".*

In each instance, professionals talked about the importance of what many referred to as a "*wrap-around*" model that had the child and family at the centre and relevant professionals across health, education and disability services working together in a flexible, respectful and unified way. They wanted to "*recognise the village*" involved in supporting children and families to thrive.

Some participants were keen to highlight the critical role of ECEC educators and school teachers in the team. They referred to recent approaches to supporting a team to work well together, such as the Inclusion Together tool. Some also talked about a perceived "power imbalance" where educators felt undervalued by therapists, and also parents at times, who sometimes appeared to listen to medical and allied health practitioners in favour of them.

Other disciplines, such as dieticians and social workers also expressed their disappointment that they were no longer viewed as integral to ECI teams. They were concerned about the impact on timely and appropriate referrals for children and families.

Further to this, there was considerable discussion about the need to think more broadly about a collaborative and integrated service system that included the wider community. One professional suggested there should be "*community developed and led networks, so systems don't work in isolation*". Discussion about government systems fragmentation was also heard in many consultations and perceived as a significant barrier to ECI service provision and collaboration across sectors.

Corresponding practices that were recommended included, to:

- provide 'wrap-around' team approaches
- co-design with community
- work in partnership to achieve shared outcomes
- collaborate agencies and organisations
- utilise one key person to support navigation and services
- share knowledge, skills & resources
- understand the roles of other professionals

Diversity and equity

"Making people feel valued, that they can contribute, rather than just being recipients of services"

Culturally affirming and responsive

Professionals in the consultations talked extensively about issues related to "respecting and honouring" culture and diversity. They wanted a wide lens put on this principle so it encompassed the individual culture within families, neurodiversity, gender-diversity and the linguistic and multicultural richness of our society. They also wanted to pay particular attention to the culture, pride and strength of Aboriginal and Torres Strait Islander children, families and community, but were conflicted about whether to add this as a separate focus area or not. Regardless, there was a uniform call for culturally safe approaches for ECI practitioners working with

Aboriginal and Torres Strait Islander children, families and communities to be described in the Practice Framework.

Professionals working in the remote areas discussed the barrier of a system that is '*westernised and medicalised'* and does not allow time to develop relationships to support family engagement with services. An ideal vision shared by a group of professionals when families have concerns about their child was '*it would be run by the local mob, and you would have aboriginal people working with aboriginal families to deliver".*

There was discussion about the need for practitioners to be "*culturally competent*", and that this be "a given, not a second thought". They discussed unconscious bias and the needs for professionals to be "*open", "curious", "compassionate*" and "*respectful*" in learning from children, families and community in order to develop

positive relationships. They also discussed a lack of understanding about intersectionality.

Some professionals spoke of a lack of understanding about evidence-informed practices such as ECI practitioners advising parents not to raise their child in their mother tongue. Additionally, a professional working in and with the deaf community expressed concern that speech pathologists did not recognise Auslan as a language.

They were also concerned that some professionals were ill-equipped to sensitively manage conversations with families about emerging developmental concerns, particularly in relation to child behaviour, when there were cultural norms or expectations of "*developmentally appropriate behaviour*" that were different from their own.

Professionals also discussed poor access to interpreters and difficulties encountered when practitioners were not trained in how to work with interpreters to best meet the needs of children and families. This included discussion about the terminology used in our sector (e.g. autistic, developmental delay, disability), that do not have equivalent words in some languages. It was suggested that access to interpreters with an understating of ECI was also limited.

Participants discussed professional development opportunities that supported practitioners to "*accept, accommodate and adjust to individual and diverse identity and values"*. However, there was also feedback about the limited availability of appropriate resources, such as children's books and play materials, that represent the diversity of families, community and country that should be used to embed culture in ECEC and schools.

Participants also discussed community attitudes to culture and diversity, including disability, and the role the ECI sector had in strengthening positive attitudes to diversity. They discussed the stigma that can be associated with disability and the need to support children's sense of identity. Several participants paid particular attention to refugees or those who did not have permanent visas in their discussions about cultural diversity and highlighted the barriers they may face in relation to societal attitudes, access to mainstream and specialist services, and support for child and family wellbeing.

There was also discussion about some of the barriers to culturally affirming and responsive practices, such as the lack of culturally appropriate assessment measures, and the significant challenges professionals in rural and remote communities had in accessing training in the use of appropriate tools (e.g. ASQ-TRAK).

There was considerable discussion about the inequity experienced by families living in rural and remote communities, and more specifically the "*postcode inequity*" of families living across Australia. The inequity for Aboriginal and Torres Strait Islander children, families and communities was also highlighted.

Corresponding practices that were recommended included, to:

- respect culture and diversity
- provide culturally safe support and services
- work through and with people respected by the community
- understand multicultural perspectives on child learning and behaviour

- utilise culturally appropriate assessment measures
- promote curious exploration of each family's culture
- utilising interpreter effectively
- reduce barriers to services and supports

Timely and supported access

Issues related to early identification, monitoring and screening of child development were noted throughout the consultations. In particular, concerns were raised that the 'early' has been taken away from ECI with some asking "*Where are the babies?"* Some cited the research on the 'First Thousand Days' and emphasised the need to consider prenatal care and preventative approaches.

There was discussion about the role of Maternal Child and Family Health Nurses (MCFHN) in early monitoring and screening and the different models and availability of this service across jurisdictions. Some indicated that General Practitioners are typically not involved in developmental screening and can sometimes be a barrier to referral to a Paediatrician. Others highlighted the need for professionals to listen to parents when they raised their worries or concerns as they are good reporters of their child's development or behaviour. There was discussion about the professional development required for universal early childhood service providers in child development, developmental delay and how to respond to parents and discuss developmental concerns with parents/caregivers in a sensitive and timely way.

Professionals cited service access as another area that has been significantly disrupted as a consequence of the NDIS. Discussion was centred around wait lists, "*jumping hoops*" to get service, and the inequity of access to services dependent on postcode. As one professional expressed, "*We need to ensure that children and families have individualised support to enable equal opportunities and access to services"*. Inequity was highlighted in several consultations where professionals provided examples of some children and families receiving timely, integrated and flexible access to services, where families on the other side of the river or road had no acceptable service.

Several professionals used phrases such as "*Right time, right intervention, right dose", "Right timing, right information, right intervention for the right child", "Right place, right time, right care*" and "*Right person, right time for the right outcome*" to illustrate the pathway in a concise way.

Professionals wanted a system where preterm infants were monitored effectively, and professionals were knowledgeable and skilled in mitigating secondary developmental problems. The Victorian Infant Hearing Screening Program (VIHSP) was highlighted as an "exemplar" of a timely and effective screening program, however there remained some concern that the service pathway for diagnosis and appropriate intervention was still unclear for some families.

Professionals called for the Practice Framework to clearly articulate the role of mainstream and specialist services across sectors in providing timely access and appropriate support for children and families. One professional commented that "We need to shift focus to address not equity nor equality but justice, fixing the system to offer equal access to both tools and opportunities".

Corresponding practices that were recommended included, to:

- support early identification
- ensure universal screening and monitoring
- sensitively discussing developmental concerns

Service pathways and transitions

Professionals used terms like "*warm referral*" and "*soft entry points*" to describe an approach to supporting families to access appropriate services in an individualised and responsive way. However, they indicated that this was often an ideal rather than a common approach that required services to work together and have "*properly trained people to help families navigate*". Another professional suggested that "*having the one point of contact who lives in the local community and understands the service system and supports available - specialists, mainstream and community*" was necessary to adequately support families to navigate the service system. Others suggested that peers with lived experience were well placed to help parents with the service pathway.

Professionals called for the Practice Framework to clearly articulate the desired pathways for children and families. Importantly, they wanted a responsive and flexible approach that could adapt to local contexts. Others sought an "*effective, efficient and consistent pathway"*. Several professionals talked about the need for families to feel confident about stepping back from ECI services for a period of time, knowing they could re-enter as their child or family circumstances changed. They were concerned that families are reluctant to reduce or withdraw from service with the worry that their 'place' would no longer be available to them in the future. Wait lists, particularly in rural and remote areas, were perceived as driving this concern.

Continuity of care was highlighted with paediatricians and general practitioners signalled as key supports for children and families during the childhood and adolescent years.

One in-person consultation group drew a pathway that involved children and families, professionals and community "*weaving*" together with relationships, collaboration, and shared approaches. Similar illustrations were drawn in other consultations.

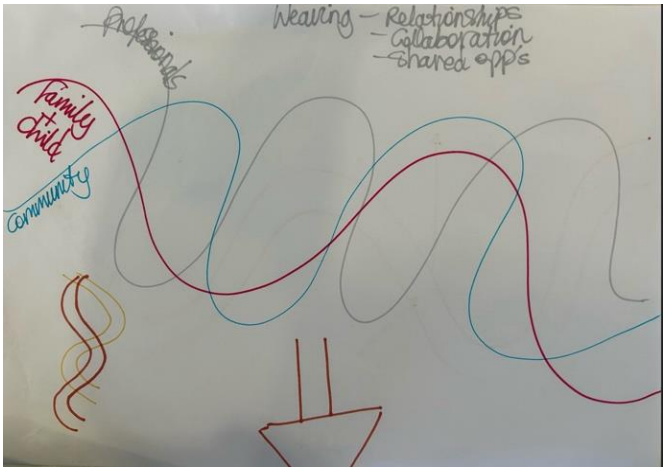


Figure 15: Service pathway

Others spoke of the need to consider a new transition that was now evident as we considered children moving from the current NDIS early childhood approach to the adult model of the NDIS at 9 years of age.

Corresponding practices that were recommended included, to:

- adopt a 'no wrong door' policy
- foster warm referral and soft entry
- understand pathways to access and services within the local community
- support entry to services and supports, including vulnerable children and their families
- build connections with the local community
- support transitions into/out of services and supports

Quality improvement

"Achievable guidance for practitioners"

Evidence-informed

Professionals typically described evidence-informed practice in relation to the triad of the best available literature, professional expertise and parent experience and wisdom. They typically preferred the term 'evidence-informed' rather than 'evidence based' because of their understanding of the three interwoven elements.

Interestingly, several professionals suggested that the literature should be considered more highly than the other two elements. Others commented that the lived experience and wisdom of families should be considered more important than the other areas.

There was also discussion about the perception that Randomised Controlled Trials were 'gold standard' research but had limitations because of the "*messy and complicated"* nature of ECI. Some suggested single case experimental design was more relevant for the field. There was a call for future involvement in practice- based research.

One participant noted that "*There are varying levels of maturity in implementing evidence-based practices*". However, most discussions related to support that would enable practitioners and leaders to keep abreast of the best available research.

There were some suggestions that have been highlighted below about ways that could be supported through the Practice Framework (see Appendix).

The other significant narrative was related to the support required to embed evidence-informed practices into daily work. Practitioners called for more opportunities for supervision, mentoring, coaching and communities of practice, but bemoaned the fact that the pricing structure of the NDIS impinged on these learning opportunities. There were many suggestions highlighted below about tools, resources and professional development could be provided through the Practice Framework.

Many professionals raised the importance of reflective practice. Many also discussed coaching to support them in implementing evidence-informed practices or strategies

as intended. Others discussed the importance of senior clinicians or leaders taking a role in developing their colleagues' practice through modelling and coaching. Some suggested fidelity checklists or resources that described practice in terms of "*What it looks like*" and "*What it doesn't look like*" would be a useful addition to the Practice Framework.

Finally, professionals talked about their perception that parents faced difficulties in finding out about evidence-informed practices and called for an interactive website that provided current and accessible information for professionals and families.

Furthermore, they called for tools and resources that supported parents in making informed decisions about choosing services that aligned with the best available research and their own family values and context. There was a very strong perception that parents would prefer easy-read, multimodal, free, accessible resources, available in a range of community languages.

Corresponding practices that were recommended included, to:

- keep in touch with the literature
- enable innovation
- share skills and knowledge

Outcomes-focused

Professionals involved in consultations were very clear about the need to have an outcomes-based approach in ECI. They articulated child, family, professional and community outcomes that they recommended be included in the Practice Framework.

Further to this there was extensive discussion about goals. Some emphasised the importance of SMART, functional, or participatory child goals. Others raised the need to also attend to family goals that addressed issues such as family quality of life. Still others wanted families to be more involved in outcome measurement "How do we evaluate impact from the family perspective? What are the measures that they would use to determine success?"

Other participants talked about the need to develop goals appropriate to the individual child and family and their context. This was articulated by a therapist in a remote community who said, "*When we're going into a family's homes we're trying to identify therapy goals and priorities but realistically their main priority is finding appropriate housing or having food security. But it's like "Can I help you with doing buttons up?" It seems very inappropriate and not an area of need until their safety is met. That needs to be met first*".

Some professionals discussed the need for children to have a say about the goals that were important to them. This was part of a broader discussion about the need to heighten children's voice and agency so they could increasingly have choice and control. One participant expressed, "*I love the idea of there being a considered approach to the goals where they can be developed by the family, child, or both, depending on individual circumstances*". This was raised as an important consideration given that NDIS goals are currently written from the parent's perspective when the child is under 7 years of age, but from the child's perspective when they are older. Given that ECI in the NDIS is now for children 0-9 years of age,

this was raised as an opportunity for discussion and clarification about children's input into the development of goals.

Whilst the majority of professionals appeared comfortable with the terminology of 'goals' and they are embedded in plan development and implementation in the NDIS, others objected to the term. For example, one professional called for "*A different name for goals please. Your child is not a project or a series of goals to achieve*".

Practitioners discussed the need to use "authentic assessment" practices to monitor outcomes. They listed measures they use in their daily practice including the Canadian Occupational Performance Measure (COPM) and Goal Attainment Scale Light (GAS-LIGHT). Others mentioned the Parent Efficacy and Empowerment Measure (PEEM), Ages and Stages Questionnaire (ASQ) and AusTOMs. Whilst some talked about their use of the International Classification of Functioning (ICF), many more mentioned their use of the F-Words (Functioning, Family, Fitness, Fun, Friends, Future) to support goal development and measurement of child development and functioning. In a consultation in a remote area, practitioners added to the F-Words with Footy, Fishing, and Foraging. Amongst the comments was a strong focus on what one practitioner suggested was "*upskilling and guiding clinicians to use appropriate assessment tools and ways to measure outcomes throughout intervention is so important*".

Professionals feedback in relation to data was consistent and succinct. They called for an approach to national data and evaluation collection and sharing to ensure high quality ECI planning and decision making.

Corresponding practices that were recommended included, to:

- utilise authentic outcome measures
- determine meaningful and functional outcomes together
- gather and review data / evidence
- seek and respond to feedback

Knowledgeable and skilled workforce

There was universal agreement from professionals in online and in-person consultations that the pressures on the ECI workforce were unprecedented. The discussion focussed around three key areas.

- Preparation

  There was universal concern about the lack of appropriate preparation for new graduates to enter the workforce. Early career professionals reflected that their personal effort to prepare themselves for a career in ECI (e.g., part time work as a disability worker) had a more significant impact on their readiness than what was provided in their undergraduate allied health courses. They called for appropriate modules related to areas such as child development, family-centred practice, inclusion in natural learning environments and working in ECEC and schools to better prepare allied health practitioners to be work ready.

- Induction

  Many organisations are reported to be employing new graduates for the first time due to the shortage of allied health practitioners available to work in ECI,

particularly in not-for-profit organisations. This, along with poor undergraduate preparation, services are reporting unprecedented pressure to provide extensive (and costly) induction programs. They called for innovative and collaborative approaches to support new graduates in the early career in ECI.

- Retention

  Professionals talked about a broad range of strategies utilised to retain allied health practitioners in the ECI workforce including financial incentives. They also highlighted approaches that supported their professional development such as effective teamwork, coaching, supervision and mentoring. It was suggested that the Practice Framework could provide guidelines for these professional supports.

Communities of practice, particularly with parent input and perspectives, was also noted as a positive approach. These practical supports were reflected in conversations about the ECEC and schools' sectors. Some also spoke of the role of leadership in policy and advocacy related to staff retention.

When discussing professionals working in the regional and remote areas it was highlighted that "*to future proof long term robust supports in regional areas we need to look after the wellbeing of the practitioners too*"

Corresponding practices that were recommended included:

- Coaching
- Communities of Practice Supervision
- Mentoring
- Joint visits
- Understanding of the impact of isolation on the health and wellbeing of practitioners working in regional and remote areas

2.5.4 Implementation

"I'm hoping to see this in the future, become the practice of early intervention services"

Implementation of the Practice Framework was raised as a critical issue by many professionals in online and in-person consultations. There was a sense of hope in many of the in-person consultations in particular, with participants expressing "*optimism and excitement"* about the possibilities for the future. However, this was not universal. Some were concerned that the framework would not integrate with current frameworks, would be onerous to use, or not adequately supported by government policy. Others were concerned about the limitations of tools and resources, without consideration of current systemic issues and other implementation drivers and barriers. "*Don't waste the ink in the paper. If they're not going to be specific enough for the end user to use*".

Further to this, others talked about the need for practitioners to learn about how to implement evidence-informed practices described in the Practice Framework. That is, the difficult task of learning to "*stop doing some things*", or what was described as de-implementation.

Many professionals talked about the need for professional accountability. Some called for better governance and safeguards for ECI practitioners. As one professional indicated, "*Providers should evidence that they are implementing best practice guidelines if they are to access ECI funding*". Working with professional organisations was highlighted as important for successful implementation as '*individual disciplinary professional bodies do not ensure that registered practitioners have the necessary skills and support for this specialist role'*.

Others discussed the need for data and evaluation systems as essential elements of implementation, whilst others highlighted the need for strong leadership - at the national, state and service level.

Lastly, participants discussed terminology as one of the issues to be resolved prior to implementation. There was extensive discussion about the use of the word 'intervention'. A minority indicated it was important to continue using the term because it identified us as a sector and was used internationally. The majority advocated for a change in terminology, indicating that it was not reflective of our approach to capacity building and was inappropriate for some communities. Some jurisdictions have replaced ECI with Early Childhood Supports. Some common suggestions for alternatives included the following, however, there was considerable debate and certainly no consensus on a substitute: Early Support, Early Childhood Developmental Support, and Early Childhood Supports.

Further to this, professionals asked for clarification or review of other commonly used terms, such as best practice, that was described as "*something that is used so broadly that it no longer means anything, and it is used by so many people to describe what they are doing when they really aren't".* Other words under discussion included goals, natural environments, everyday routines and community.

The framework

Participants in the in-person forums worked together to articulate the aims, outcomes, principles and practices they recommended to be included in the Practice Framework. Following this process, they worked in small groups to visually conceptualise, or 'build' a framework themselves. Provided with a range of expressive modes to document their thinking (e.g. art supplies/stationery), they developed their frameworks with intellectual freedom and creativity. The energy and innovation they brought to the task was inspirational in many of the forums. The process brought professionals from a broad range of disciplines and sectors together to share their expertise and find common ground. However, for some it was difficult to move beyond their deep concerns about the systemic problems that are now evident in the ECI sector. They were asked to 'park' their concerns while they worked together to build a framework of high quality ECI.

Framework illustrations are available in Appendix 3. The examples have been chosen in order to provide insight into the breadth of thinking and conceptualisation rather than choosing exemplars.

Some of the common threads amongst the frameworks included:

- focus on positive relationships (e.g. surrounding or underpinning)
- interconnection between all principles (e.g. cogs, beehive, Venn diagrams)

- local context and culture (e.g. fire, sun)
- growth and nature (e.g. trees, flowers, butterfly)
- relationship to an ecological model (e.g. concentric circles)
- tiers of support (e.g. pyramid, waterfall)
- journey or pathway (e.g. linear, rivers)

A spokesperson from each table discussed their framework to enable all participants to hear how they conceptualized the model. The feedback was audio-recorded for the purpose of data collection and analysis. All the framework and associated materials were collected, collated and analysed by the two senior researchers.

A point raised throughout consultations was the opportunity for the Practice Framework to be flexible enough to be adapted to the local context.

The next activity was then to share the barriers and provide possible solutions

Challenges and solutions

What did we ask?

The survey provided insights into professionals' perceptions of the barriers to implementing best practice by asking the question: ‘What are the constraints that limit you and/or your colleagues’ ability to apply best practice in ECI?’ See figure 16.

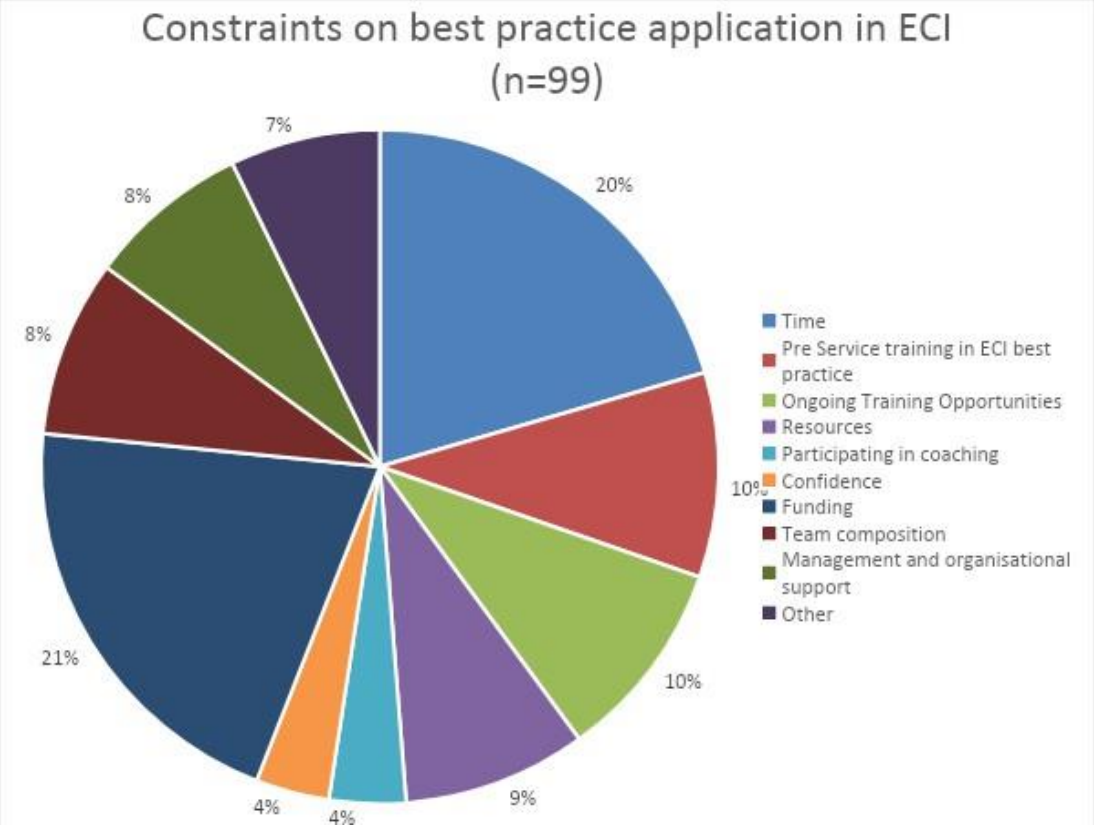


Figure 16: Constraints on best practice in ECI

What did we hear?

Further to this, in-person consultation participants were asked the question: *What are the challenges and solutions in implementation of the ECI framework?*

The responses were collated and clustered into common threads, along with the responses gathered from participants in generic and targeted online consultations when the questions were posed. Responses are provided in Appendix 4.

The highest responses to the question in the survey was 'funding' and 'time'. Interestingly, time was not directly named in the consultations but typically couched just in terms of funding. In particular this was discussed in relation to funding (or time) for collaborative teamwork and travel that allowed practitioners to work in family homes, ECEC, schools and the broader community. Lack of funding for professional development was also raised in survey comments and consultations, particularly by sole traders. Services grappling with "business leakage" because of these funding limitations were raised in many in-person consultations.

Preservice training was indicated as a constraint by 10% of survey respondents. This was also addressed in consultations where we heard professionals dissatisfied with ECI practitioner preparation in tertiary education. This was expressed by early career professionals, managers, and academics alike. They indicated that many allied health students used their own initiatives to be 'work ready' by doing part-time work as disability support workers or selecting an ECI service for the final placement to complete their degree. For some, that converted to a smooth transition to the ECI sector with a job offer in the same service. Others spoke of the extensive induction program required to be an effective ECI practitioner and the necessary ongoing support such as supervision, team meetings, joint visits, coaching and mentoring.

Some called for a cooperative approach to induction training to remove the financial impost on services and disincentive to recruit new graduates.

We also heard similar issues raised in relation to ongoing professional development and access to resources that support high quality service provision. They called for the framework to be supported by accessible professional learning for practitioners on best practice in ECI. Loss of income incurred by NFP organisations, small businesses and sole practitioners to attend training events was also raised as a significant barrier in implementation.

Further to issues of implementation were comments made by in-person consultation participants about the importance of leadership. Professionals recognised the significant impact leaders could have in creating a culture of learning and supporting high quality practice. As one professional indicated, "*There is a broad idea that 'private practice' means 'behind a closed door' but that's not accurate across the board. It's certainly the case at times, but it's dependent upon the private practice of leadership and values"*. Management and organisational support were listed as a constraint on best practice by 8% of survey respondents.

Comments on the survey indicated that family preference, expectations and resistance to best practice was also a barrier. This was also raised in consultations with the recommendation that multimodal resources with key messages about best practice be available across the sector and in a variety of community languages.

Professional development, tools and resources

What did we ask?

During selected online consultations and in-person forums, we asked '*What are your perceptions of the tools, resources and professional development required for ECI Service Providers, practitioners, universities and policy makers to understand and implement the Practice Framework?'*

We utilised Zoom and Mentimeter polls to ask participants about their perceptions of the tools and resources required for understanding and implementation of the Practice Framework.

What did we hear?

Of note, the participants highlighted the need for any tools and resources for professionals to be co-designed, easy to understand, practical, freely accessible (or low cost) and reflective of the Australian context.

Participants highlighted that those benefiting from the tools, resources and professional development included practitioners new to the ECI field, allied health staff, educators, health professionals including MCFHNs, general practitioners and paediatricians, universities, NDIS staff, policy makers, and managers to facilitate 'buy-in' from an organisational level.

The content for the tools, resources and professional development was two-pronged:

- highlighting the framework itself, including the structure, inclusions and implementation, and
- targeting the principles and practices contained within the Practice Framework.

"The Guidelines need to be specific about what is and what is not best practice to highlight the difference for families and for practitioners, particularly those who have never known anything but the current state of ECI delivery".

Written/online resources such as fact sheets (no longer than 1-2 pages), flow charts, posters, FAQs, quick reference guides, implementation and knowledge translation toolkits and infographics were recommended with videos and animations also featuring. Some specifically requested simple guides that describe what each of the principles "looks like/doesn't look like" or "what to do when it's working well".

Respondents requested that these be available within a web-based repository for easy access.

A preference for local, in-person forums, communities of practice and yarning groups were suggested by some respondents.

Professional development options included self-directed training modules (targeting different levels of expertise), online and face to face training, communities of practice, case studies, supervision guides, self-or peer assessment tools, and research summaries.

Contextualising to the local area was highlighted in a variety of ways with recommendations including the value of examples of implementation in different States/Territories and locations, having local champions and local working groups.

Of note, respondents highlighted the need for accountability and one respondent stated "*leaving it to the market is inappropriate*". As such, there were requests for accredited/mandated training, annual training to support registration, and ongoing promotion and professional support to the field to reduce risk of drift. Collaboration with professional and registration bodies such as AHPRA was noted as being important.

Parent/community tools and resources

What did we ask?

During selected online consultations and in-person forums, we asked *'What are your perceptions of the tools and resources families, community and others require to understand the Practice Framework?'*

What did we hear?

Participants perceived that families, community and others required tools and resources that were co-designed and were culturally specific, linguistically respectful, and were available in the language of the family, including Auslan. Health literacy levels were noted as important to take into consideration during development.

Possible tool and resource options focussed on easy to understand and visually appealing formats such as short tip sheets, infographics, YouTube videos (including conversations with families), podcasts, and an interactive activity book.

Questionnaires and checklists were suggested to support families, and others such as community and sporting clubs and mainstream education settings, to understand the Practice Framework and work together to implement it.

Additional recommendations included free seminars in the community to raise public awareness and a parent information line.

It was noted that all of the resources should be freely available and easily accessible.

2.6 Key recommendations

Implications for the Practice Framework:

- develop guidance about child safety and the role ECI practitioners have in understanding issues related to child abuse/neglect and their interactions with child protection services
- provide clear definitions for framework principles, focus areas and other terms such as 'family', 'family-centred practice', 'natural learning environments' etc
- provide clarification practices that promote learning in the places where children "live, learn and play"
- articulate the role of mainstream and specialist services across sectors in providing timely access and appropriate support for children and families
- describe desired pathways for children and families

- discuss the range of models of team collaboration to ensure a shared understanding of approaches (including for sole practitioners)
- provide professional development and resources that are developed by Aboriginal and Torres Strait Islander people/organisations to ensure culturally safe approaches for ECI practitioners
- ensure the Practice Framework and accompanying tools and resources support practices to be culturally responsive
- provide appropriate resources and professional development to ensure the effective implementation of the focus areas or practices, particularly including those that may be introduced since the National Guidelines for Best Practice were published (e.g. child voice and culture and diversity- individual culture within families, neurodiversity, gender-diversity and the linguistic and multicultural richness of our society)
- ensure the framework provides descriptions of best practice and "what it looks like when it's working well"
- provide professional development for ECEC educators and school teachers (including coaching) on inclusive practices
- provide resources and training that support practitioners (including those new to ECI) to provide high quality services related to child, family and community outcomes
- provide support for practitioners to measure outcomes
- provide guidelines and corresponding resources that support leaders, mentors and coaches in implementing evidence-informed practices
- provide multi-modal, practical resources (including easy-read and in community languages), that support parents in making informed decisions about best practice in ECI

Implications for the service system:

- work together to reintegrate and connect services across health, education and disability
- develop a pricing structure that supports the time required for professional development, collaboration and working in natural environments
- invest in peer support for parents
- incentivise after-hours and weekend ECI
- fund innovative and collaborative approaches to support new graduates in their early career in ECI and remove the financial impost on services
- provide governance and safeguards for ECI practitioners that support accountability
- develop an approach to national data collection and sharing to ensure high quality ECI planning and decision making
- provide guidelines and resources that support policy makers in supporting the implementation of evidence-informed practices

3. References

1. Introduction

Lundy, L. (2007). 'Voice' is not enough: conceptualising Article 12 of the United Nations Convention on the Rights of the Child. *British Educational Research Journal*, 33(6), 927-942. https://doi.org/10.1080/01411920701657033

2. Findings from the PRECI consultations

Creswell, J. W. (2021). A concise introduction to mixed methods research. SAGE publications.

4. Appendices

Appendix 1: Example consultation questions

1. What is understood by best practice Early Childhood Intervention (ECI) and how is it interpreted by each stakeholder group?
    a. <ask for specific examples of best practice in action>
2. Who is using current best practice guidance, how is it being used, and what does its use look like?
    a. <ask about the frequency and consistency of using best practice guidance>
3. How is the impact of using best practice guidance monitored and measured?
    a. <ask for specific metrics or evaluation methods used to monitor the impact>
4. What do current practitioners/professionals reference to design their service delivery models and programs?
    a. <ask about sources of these references - academic literature, professional guidelines, peer-reviewed research etc>
5. What are the universal principles that underpin effective ECI in different settings, whether home, clinic or community-based and apply to all children no matter the diagnosis or concern?
    a. <ask if there are any setting-specific principles that are crucial to understand and include>
6. What are the current challenges to achieving the best outcomes for children with developmental concerns/delays or disability, their carers and families?
    a. <ask for systemic and individual-level challenges>
7. What are the constraints that limit an ECI professional's ability to apply current best practice in ECI?
    a. <ask for specific examples of constraints and how frequently they are encountered>
8. What are possible solutions to the above challenges identified?
    a. <enable brainstorming of both short-term and long-term solutions>
9. What tools and resources are available or used currently to support the implementation of best practice in ECI?
    a. <ask about the effectiveness of these tools and resources>
10. What tools or resources are needed to support understanding and application of the new Best Practice Framework?
    a. <ask about existing tools that can be modified>
    b. <ask about the need for new tools to be developed>
11. How do <cultural, socio-economic and geographic> factors influence the implementation of best practice in ECI?
    a. <enable brainstorming of both short-term and long-term solutions>
12. How do you observe families and caregivers perceive the current ECI services?
    a. <ask about possible reasons for the perceptions>
    b. <brainstorm possible solutions>
13. What training and professional development are needed for ECI professionals to effectively implement the new framework?
    a. <in relation to the Framework itself>

b. <in relation to understanding the practices contained within the Framework>
c. <in relation to the implementation of the practices>

Note: To ensure that there is growth and relevant depth in the questions asked and answers provided by participants within the focus groups and forums over the consultation period, an iterative process will be utilised, where the probes for the above questions will become more targeted over time, reducing repetition of information/data provided and collected via the consultation process.

Targeted questions

For each of the targeted consultations, the example questions above will be adapted and individualised to the specific profession or area of expertise, including their place on the family journey in the ECI area.

For example:

For your <discipline or area>, what would be most useful to see within the Best Practice ECI Framework?

For your <discipline or area>, what tools or resources would be most effective in supporting the understanding and application of the Framework?

For your <discipline or area>, what are the key pain points for working in the ECI area, <including new graduates>?

OR

As you are a key player in a family's journey at <identification, diagnosis, planning, assessment, intervention, transition> how can we build in support within the Best Practice Framework for <the family and/or professional experience and outcomes> at these key points?

What would be most useful at these key points for <the families you work with/your profession/team??

Appendix 2: Value word clouds


inclusiveness
trust
non-judgemental
accessibility
holistic
kindness
simplicity
support
collaboration
partnership
respect
equity
quality
responsive
empower
honesty
empowerment
empowering
communication


authentic engagement
culturally responsive
connected relationships
honesty transparency
multi disciplinary
parent authority
trauma i formed
child-centred
cultural sensitivity
nurturing
listen to voices
walking alongside
evidence based
integrity in practice
belonging
trauma informed
strengths based
respect
authenticity
support
connection
community
integrity
collaboration
equity
relationships
family centred
care
holistic
choice
responsive
rural
communication
understanding
human rights
inclusion
inclusive
data informed
advocacy
safe and supported
child and famil focussed
multidisciplinary

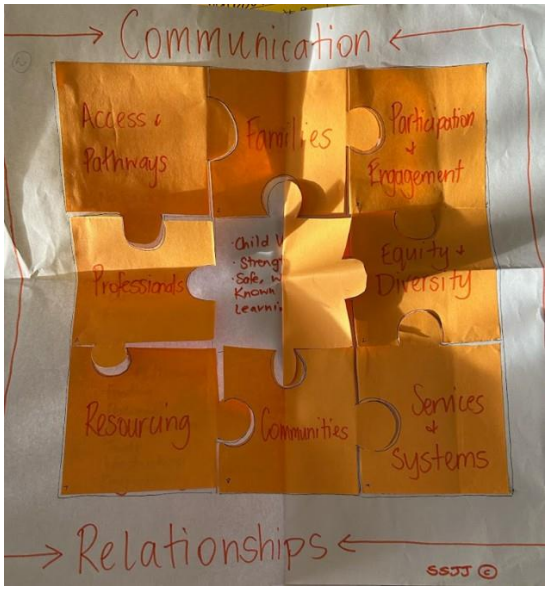

high expectations
therapist autonomy
child focused
reaching potential
understanding
unconscious bias
inclusiveness
rights to be included
collaboration or team
relationships
non judgmental
listening to children
professionalism
adaptive
family-centred
respectful
meaningful
impact
partnership
engagement
family focussed
thriving
hope
collaboration
informed
integrity
respect
inclusivity
trust
inclusion
equity
excellence
mutual respect
family centred
reflective practice
rights to inclusion
optimism
accessible
wellbeing
growth
meaningful participation
participation
diversity and inclusion
evidence based
flexible
affirming
eco-system
family partnership
connection
compassion
transient
relationship
recognition of families e
breaking down silos
trusted
belonging
optimistic
responsive
empowered
child centred
social justice
communication
understandin of uniqueness

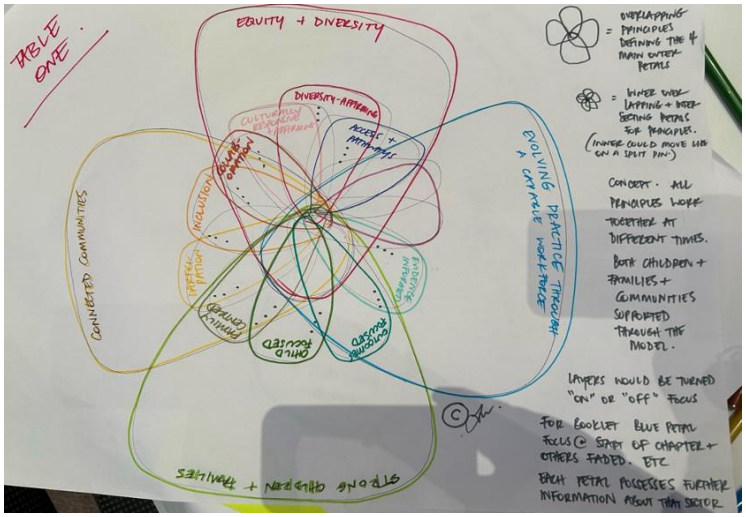

child and family focused
open mindedness
collaborative
integrative
child-led
community
integrity
organic
reflection
compassion
family centred
child-focused
integrated
honesty
respect
holistic
collaboration
evidence-based

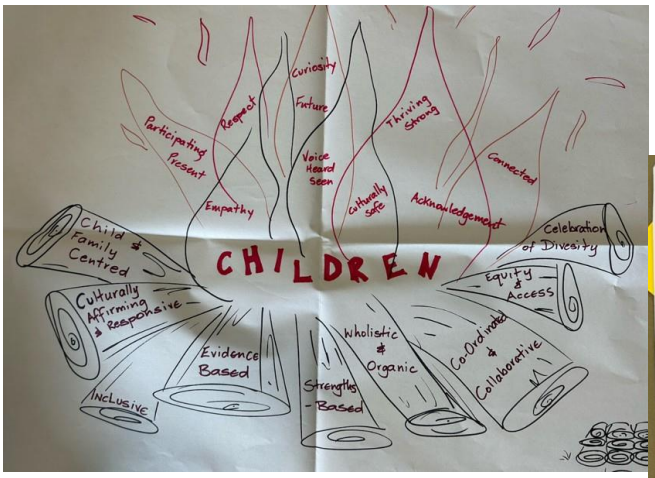

dynamic change
continuous improvement
child and family centred
time to work together
community connectedness
high expectations
holistic
respectful relationships
seamlessness
childs rights
power balance
diversity affirming
collaboration is kek
understanding
evidence
flexibility
responsive relationships
strengths focus
connectedness
sustainability
doing our best
relationships
strengths based
collaborative
child centred
best-practice
compassion
family centred
equity
care
curiosity
inclusive
rights-based
accountable
autonomy
community
collaboration
evolving reflective
independence
kindness
inclusion
inclusivity
access
connectivity
evidence-based
growth
life long learning
capacity building
excellence
empowerment
integrity
respect
empathy
affirming
quality
support for all
family centered
child focussed
accountability
shared goals
child focused
innovation
evidence informed
responsive practice
neuroaffirming
collaborative
individuality
strength based
joyful
evidence based
child focussed inclusion
empathy and timing
relationship
evolving practice
comprehensive
short and long term right
rights of the child
variety and choice
cultural diversity
professional partnerships
variety of services

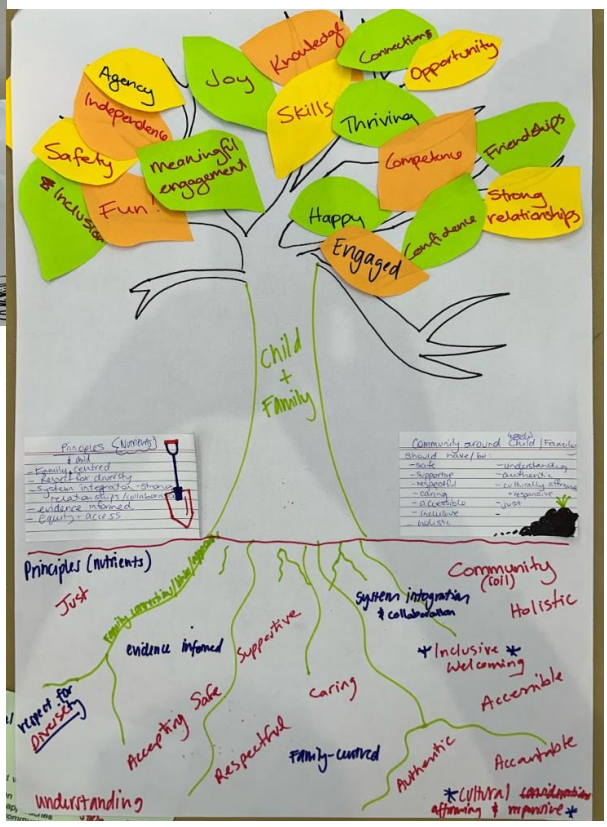

understanding
quality
integrity authenticity
curiosity
individuality
flexible
respect for diversity
optimism
effective
adaptive
integrity
inclusivity
authenticity
family
safety
trust
evidenced based
strengths
equity
child centred
neuroaffirming
relationships
comprehensive
relations
collaboration
respectful
repect
diversity
evidence
listening
respect
inclusion
hopeful
belonging
timely
inclusive
holistic
play
equitable
responsive
neuro affirming
family centred
individualised approach
courageousness
family and child centred
non-judgemental
family beliefs
holistic care
celebrating diversity
responsive to changing ne
flexibility
relational

Appendix 3: Frameworks

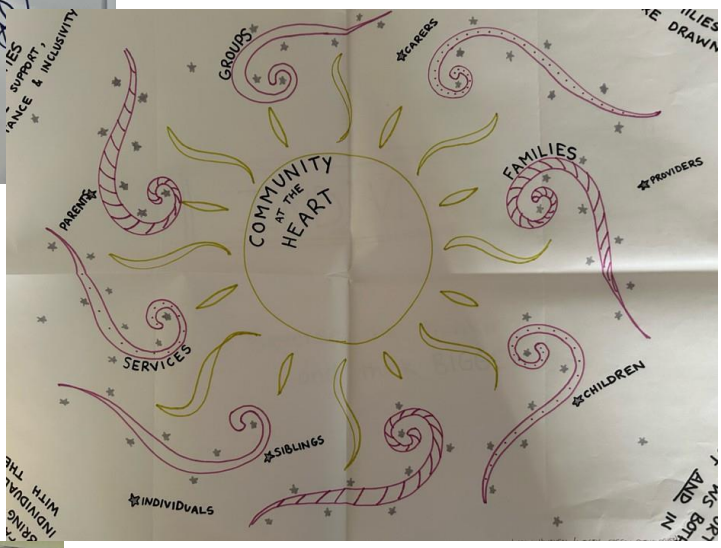


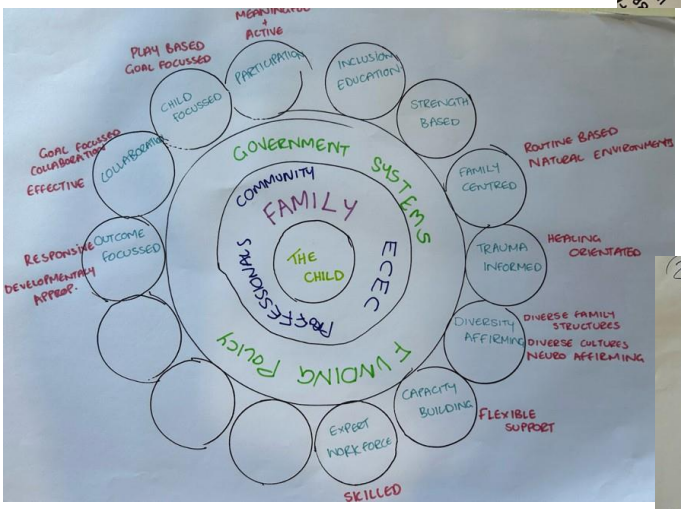


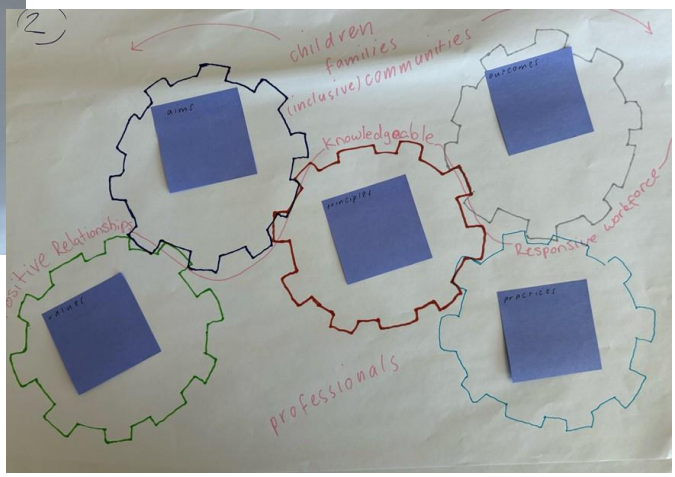




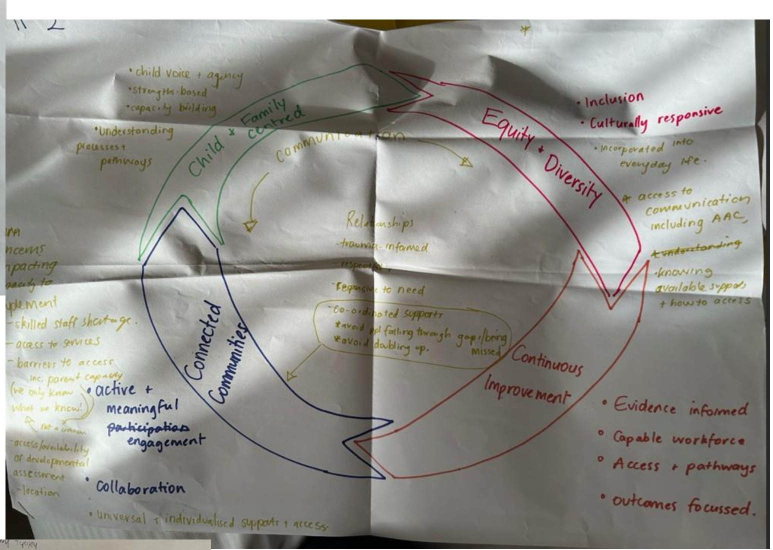

SWEET SWEET HONEY
Outcomes
To feel
Secure
connected
in relationships
they hold
Child
Family
Community
THRIVE
Advocacy
Fun!
Happy + Thriving
Accountability
confidence
Dream + have hope for their future

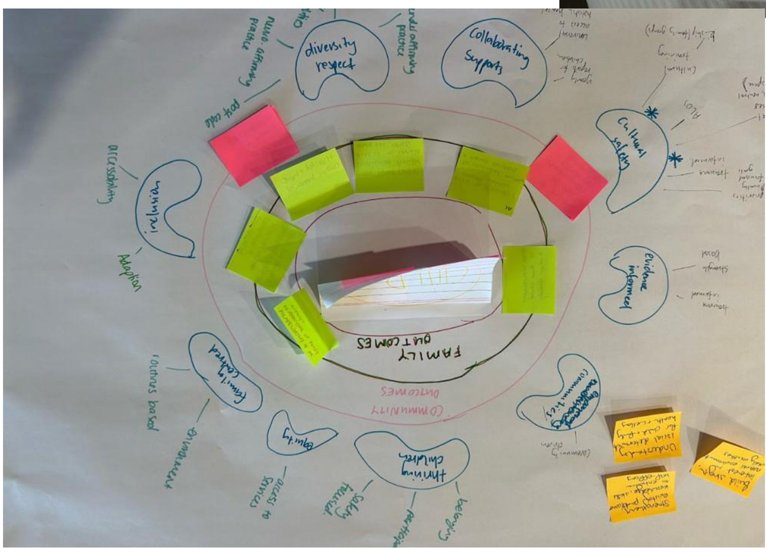

COMMUNITY AT THE HEART
GROUPS
CAREERS
FAMILIES
PROVIDERS
PARENTS
SERVICES
CHILDREN
SIBLINGS
INDIVIDUALS


PLAY BASED
GOAL FOCUSSED
ACTIVE
PARTICIPATION
INCLUSION EDUCATION
CHILD FOCUSSED
STRENGTH BASED
GOAL FOCUSSED
COLLABORATION
EFFECTIVE
COLLABORATIVE
ROUTINE BASED
NATURAL ENVIRONMENTS
FAMILY CENTRED
GOVERNMENT
SYSTEMS
COMMUNITY
FAMILY
THE CHILD
RESPONSIVE
DEVELOPMENTALLY APPROP.
OUTCOME FOCUSSED
TRAUMA INFORMED
HELPING ORIENTATED
DIVERSITY AFFIRMING
DIVERSE FAMILY STRUCTURES
DIVERSE CULTURES
NEURO AFFIRMING
CAPACITY BUILDING
FLEXIBLE SUPPORT
EXPERT WORKFORCE
SKILLED


children
families
(inclusive) communities
knowledgeable
Responsive workforce
professionals


Strong Child + families
Connected + Inclusive communities
Equity + diversity
Quality Improvement
Table 4


child voice + agency
strengths-based
capacity building
understanding processes + pathways
Child + Family centred
communication
Equity + Diversity
Inclusion
Culturally responsive
incorporated into everyday life
access to communication including AAC
knowing available supports + how to access
Relationships
trauma-informed
Responsive to need
co-ordinated supports
Connected Communities
Continuous Improvement
skilled staff shortage
access to services
barriers to access
active + meaningful engagement
Collaboration
universal + individualised supports + access
Evidence informed
Capable workforce
Access + pathways
outcomes focussed.


diversity respect
Collaborating Supports
Cultural safety
inclusion
Evidence informed
Family Centred
Equity
thriving children
FAMILY OUTCOMES
COMMUNITY OUTCOMES

Appendix 4: Challenges and Solutions

Challenge	Solution
Early identification • Not all children are being captured for developmental delay • Babies are not being referred • Fragmented pathways	• Support for GPs to screen/monitor (example of GPSIP Sunshine Coast) • Sector knowledge of appropriate assessments (including culturally appropriate) • Training and coaching to support ECEC educators in developmental delay and in having sensitive conversations with families about developmental concerns and where to go for next steps • Clear referral pathways and soft entry • Timely referrals with central agency for intake • Various pathways recognising needs of children/ families with concerns • Rigour in the provision of support to ensure services are provided using best available evidence
Access & service pathway • Cultural and Linguistically Diverse families do not have access to appropriate information • Marginalised families mistrust in services • Refugees and people on Visas that prevent access to mainstream or specialist services • Poor access in rural/remote areas • Accessing the NDIS – with no support with the process	• Match in cultures between support person and family • Understanding challenges of marginalised and CALD families - being more flexible in contact • Having alternatives to support if families are not ready to connect (e.g. yarning crescent) • More community-based providers that connect • Peer based and lived experience support in service pathway

Challenge	Solution
• Child's needs may be identified however families hit extensive wait lists to access services • Some services are diagnosis dependent	• More preventative family supports • Supporting staff in having critical conversations • Seamless (right support at the right time) • Ensure service pathway and delivery is with, and around, the family
Family decision making • Family expectations (e.g. weekly therapies (SP/OT/PT)) fueled by professionals outside ECI (e.g. GP, MCFHN, Paediatrician) recommending individual therapies. • Perception of families and some community professionals that MORE therapy is better rather than providing information re best practice	• Consistent multi-modal key messages about quality ECI • Family-facing messaging (e.g. videos) that articulate value of play and what quality practice looks like • Quality assurance – provide service rating to support families to make informed choices • Communicating expectations and the rationale for 'why' • Ensure less focus on diagnosis/deficit • Raising Children's Network could be the 'port of call 'to link to each municipality community supports • Support families through empowering them when seeking support • More education around how to use funds successfully
Team collaboration • Allied health professionals are not communicating with one another • Allied health not collaborating with ECEC and schools (and vice-versa) • Professionals are not working to the same goal	• Better funding model incentivizing team collaboration • Professional development to support educators/teachers and allied health in collaborative approaches

Challenge	Solution
Fragmented services • Lack of shared direction between organisations/ disability sector • Fragmentation between community services. providers. Inclusion supports, housing, child safety allied health medical • Parents/carers can't navigate service system • No collaboration between providers • No money for collaboration in NDIS	• Key person to build relationships • Move away from the complexity of everything being individually funded and build back to more collective block funded approach • Support transparency between all stakeholders • Support collaborative co-design • Connection at community level • More crossover between allied health and education (more School Readiness Funding, allied health visits, etc)
ECI Workforce • Financial impost of extensive induction for new graduates • Lack of capability of ECI professionals: allied health, medical, educators • Shortage of experienced professionals across the board – educators/ allied health. • Professionals leaving the ECI sector • Experienced practitioners go into management roles, or they work for themselves • ECI practitioners not seeing and learning from others • Lack of interdisciplinary/ cross pollination learning • Lack of experience in ECI workforce, particularly new graduates impacts on the business model • Lack of lived experience in ECI workforce • Pour cultural diversity in workforce	• NDIS funds mentoring and professional development • Incentive funds for practitioners to move to ECI sector • Funds for services to support final year university placement • Centralised and accessible resources • Regulation/accountability for best practice • More mandated and formal education around programmes for child development (OT/neuroscience etc) • Support at undergraduate level to learn about, and be able to apply, ECI principles • Mandated training alongside WWCC and RRHAN

Challenge	Solution
• Experienced clinicians being '2nd line' of support in management/supervisors, not on the front line • No influence on universities AHP/Psych/Health Practitioner curriculum except on how to run a business	
ECEC workforce • Reliance on new graduates in ECEC • ECEC course structure has changed. One year grad dip Is reduced in placement opportunities and exposure to ECI • Poor quality of ECEC resources	• Increased funding to ECEC staff • Expand interdisciplinary workforce • Improve workforce conditions for example time of to engage in professional development about inclusion • Peer mentoring and coaching on inclusion • Build relationships between ECECs and ECI service providers • Messaging that 'whole team' includes teachers too • Increase of child care staff with specific expertise
Inclusion in ECEC • Backlogs in Inclusion Support Program (ISP) approvals, waitlists and not fully funded for ISP • Documentation requirements to 'prove' the need for inclusion supports • Educators require capacity building supports in inclusive practices	• Increase funding to process faster • Provide clear pathways for families to follow access funding (e.g. Health Care Card means ECEC service can claim disability subsidy • More Allied Health to provide screenings • Simplify the process • Respect ECEC staff as professionals capable of recognising the need in the first place • Train the trainer' models and/or online modules with regular • updates to ensure they are current
Inclusion in schools	• Flexible funding required • Additional supports at schools needed

Challenge	Solution
• Parents working full time – additional supports at school needed • Collaboration is not supported through NDIS funding • Siloed services/funding leads to siloed services • Support and model is different across jurisdictions • Teachers need support to include all children in curriculum	• Multi-tiered models of support offer a framework • In built support into existing educational frameworks (i.e. school curriculum) • Easy interpretation for principals, directors, leaders in the sectors
Best practice - implementation • Not considering WHY – what is the reason the support is needed? • Family availability when both parents working full time and cost of living pressures • Diagnosis dependent funding and supports with a deficit-based focus • Unqualified practitioners due to difficulty with access especially rural and remote • Practitioners not measuring outcomes	• National consistency that also speaks locally • Local resources and consistent high-quality training • Parent peer support available after hours • Investigate incentives for weekend and after-hour service provision • Models of collaborative care required • Develop resources on “What does this look like when it’s happening well?” • Campaigns: Media, info sessions, individualised support group/s community requests • Practice guidelines: ensure it includes ‘What it looks like’ and evaluative frameworks • Require support workshops to ‘do the do’ – modelling- research. Part of wider system i(e.g. modelled by health, social services, education and ECEC, justice, govt politicians) • Have a champion. (e.g. how powerful it was to have Rosie champion the issue of family violence) • Ensure information is available in different languages and modalities

Challenge	Solution
	• Regulation of practitioners
Models of support • Place based programs (e,g, child & family centres) are known to be effective but not enough of them – current inequity • Loss of parent groups • Poor support for parents to navigate the service system • Some children and families need one to one support in order to meaningfully engage and participate	• Need place for families to gather with range of support professionals within a care and educational setting • Bring parents with similar needs together as powerful caring sharing groups • Right space allows all professionals and families to work together in collaboration, not in siloed constructs, also allowing for visits to family environments • Continued 1:1 support if evidence informed and best suited to the child's goals with collaboration and support across environments, coaching within one-to-one sessions and options available to best meet individual needs.
Language • The words used in ECI are not consistent or accessible • We need to shift the narrative from working with • families to working for families. • Professionals are interpreting principles such as family-centered practice differently • 'Intervention' immediately implies doing to not • working with and is inappropriate for some communities and jurisdictions	• Include more family and child voice • Develop shared language – community focus • Consider replacing the word 'Intervention' to Early Connection or Early Engagement or Early Years Connections o Early Childhood support (or other) • Provide clear definitions in the framework • Finding key messages and be aware of the audience and using specific language • Pictures tell a story - words don't
Government/NDIS • Lack of commitment to ongoing funding • Poor structure and policies • No national consistency (e.g. MCFHN)	• Block funding for ECEI for Key Worker model (Trans Disciplinary) • Inclusion in NDIS plan for Key Worker funding if family choose – separate funding. will lead to more professional collaboration – holistic approach (I.e., best practice). – capacity building

Challenge	Solution
• Response is too slow and key transitions are lost • NDIS funding to individual not to community which leaves rural and remote without • NDIS became main pathway which has reduced all other pathways to underfunded or lost • Has changed focus to how much money – not quality service • Loss of specialist skills development • NDIS disincentives for best practice in ECI (e.g. Travel, Collaboration) • Best practice/evidence based – regulation • NDIS price guidelines and who can over support and not necessarily include evidence-based practices means families might be exposed to therapies which are not necessarily evidence based • The elephant in the room" Government blame state/ Commonwealth/ self. Who's responsible?	• Need to establish another statewide pathway • NDIS should not be doing research in EI – should be an objective body • Changes to price guide to accommodate team collaboration and working in natural environments • Actively invest and endorse Practice Framework • Have a champion with ECI knowledge • Bipartisan and cross department commitment to endorse and invest • Mandated or endorsed at high level government for leaders to have buy in (Co design) to make implementation attractive • Make the framework part of EC regulation • No regulatory duplication so that implementation is seamless • Build up informal, free/foundational • Instigate a model that incorporates an early intervention opportunity as in the past, alongside practical resources from NDIS • Remove red tape between government departments

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