



AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Submission

Parliamentary Standing Committee Enquiry into the Developmental Needs of 0 - 3 Year Olds in WA

Presented to:

The Principal Research Officer
Community Development and Justice Standing Committee
Legislative Assembly
Parliament House
PERTH WA 6000

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Australian Physiotherapy Association (APA) WA Chapter of the National Paediatrics Group
In conjunction with the APA WA Branch
February 2009

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APA Submission: To the Community Development & Justice Standing Committee Inquiry into the Adequacy of Services to Meet the Developmental Needs of Western Australia's Children

Introduction

The Australian Physiotherapy Association (APA) WA Branch congratulates the Community Development and Justice Standing Committee in its "Inquiry into the adequacy of services to meet the developmental needs of WA's Children" and in conducting a broad consultation process around this issue.

The Australian Physiotherapy Association is the professional association for physiotherapists in Australia. With its membership in excess of 12,000 representing over 75 per cent of practicing physiotherapists in Australia, of which there are 1,200 members in Western Australia, the APA is well placed to make comment on behalf of the physiotherapy profession.

The APA Victorian Chapter of the Paediatric Group was asked to contribute on a similar submission last year 'Early Childhood Intervention Reform Project' presented to Department of Education and Early Childhood Development, and a copy of this is provided here.

Brief Summary of Submission

The Australian Physiotherapy Association welcomes the opportunity to respond to the Community Development and Justice Standing Committee's inquiry into the adequacy of services to meet the developmental needs of Western Australia's children.

There are a number of existing early childhood services offered for children with or at risk of developmental delay and disability. However, these services are fragmented resulting in some children (particularly rural and remote, Aboriginal children, migrants and refugees) being unable to access services that are comprehensive and responsive to their needs.

Furthermore, services have long waiting lists and inadequate staffing so that intervention is not provided in a timely manner and is not coordinated across disciplines.

Funding models for disability need reviewing so that families are not competing for services and "shopping around" for access to therapy. Families in stress following their child's diagnosis or in stress from social and environmental factors do not need the added burden of finding suitable therapy providers and being moved from one service provider to another depending on funding rather than the child's needs. Similarly, therapy providers should not have to compete for funding to extend their services in response to the latest evidence, eg. sleep apnoea has been identified as a significant problem for many children with cerebral palsy yet funding for therapy is difficult to obtain.

General View

a) whether existing government programs are adequately addressing the social and cognitive developmental needs of children, with particular reference to prenatal to 3 years

The APA believes that a young infant's needs and those of its family are best met when all aspects of the infant's development are considered together. That is, there is a very strong relationship between motor, cognitive and social development. Physiotherapy services for infants from birth to 3 years of age should be complemented by other allied health providers, eg. Occupational therapy, speech and language pathologists, social workers. Services provided by these multidisciplinary groups need to be coordinated. Service coordination is defined as an active ongoing process that assists families to access services. The APA believes that early intervention service coordination should be mandated and appropriately resourced by state government to achieve this. There needs to be procedural safeguards that assures the rights for access to coordinated service are met.

There is inadequate funding and significant gaps in services. Particular diagnoses and clinical presentations are more affected by service gaps than others. Waiting times from identification to Early Intervention are too long and the standards suggested by Wang et al (2006) are not being met. In the community infants are waiting for as long as 12 months for therapy services following a diagnosis of being at risk of developmental delay. Infants also have to travel long distance to tertiary centres for therapy as therapy closer to home is unavailable due to either strict intake policies at the local centre or the wait list at the centre places the infant further at risk as they wait for up to 12 months for therapy.

Early intervention requires experienced staff with strong resource and support links as presenting problems are complex or need very specific individualised programs to attain best outcomes. There is poor coordination of resources and the ratio of experienced to inexperienced staff is poor. The cut backs in government systems have seriously under-resourced these areas with difficulty recruiting and retaining staff due to pay differences. Along with reduced service, the amount and quality of staff teaching is decreased. There is also limited potential succession planning for ongoing and developing service provision. More experienced staff leave the disability sector to seek better pay and conditions.

Transition from Early Intervention to pre-school services is ad hoc with fragmentation of services. This may mean the child is faced with an abrupt shift into a pre-school system where minimal support is available. An open door approach is required to enable sufficient levels of communication between the services and involving the families. There is an unnecessary administrative burden to staff and families in getting into, and transitioning out of, service provision facilities.

There are inherent flaws in the funding of early childhood intervention programmes as many of them will only offer services to children who require all three of the Allied Health therapies (Physiotherapy, Occupational Therapy and Speech Pathology), thus excluding children with significant needs in only one or two developmental domains. This only adds to long term needs and costs. Children who have the most to gain from intervention for example those with a mild to moderate developmental delay may not be receiving treatment.

It is well documented that outcomes for all children's learning, physical and mental health following through the life span are improved by good nutrition, nurturing and care in the early years of life. Families and thus children are affected by basic

necessities and their environment– transport, housing, water, community/ government policies and programmes, and employment. Thus families living in outer metropolitan and rural areas are often further disadvantaged as there are fewer services in these areas. People living in these areas often do not have access to transport to travel the distance to health clinics. Health clinics need to be collocated to other community resources and be responsive to community needs. Thus the child health clinic needs to have available resources (both written and practical hands on) to assist parents with ideas of activity and play. At present an assumption is made that parents inherently know how to play with their children and infants but this is not the case. For example, resources are provided but no practical advice is offered to parents on how to implement the advice or how to integrate multiple pieces of information eg. the “tummy play” brochure advises parents that awake time for their infant should include play on their tummy but not what to do if the infant cries, or what toys are suitable to keep the infant entertained; State libraries provide a “Better beginnings” package to encourage parents to read/sing to their infant but some parents are not literate and these are the children at most risk. Combining the advice from both these resources would provide the parents with a much more nurturing wholistic approach to practical parenting.

Recommendations:

Programs for infants from birth to 18mths with advice on crying, sleeping, feeding, play, language, attachment, positioning, and handling.

Programs for children from 18mths to 3 yrs with advice on play, nutrition, early physical activity, link between physical activity and cognitive development (already available via “baby gyms” eg. Gymparoo but this does not target the risk groups (low SES, indigenous, migrants), social skills (eg. controlling behaviour).

b) how to appropriately identify developmentally vulnerable children

Screening, evaluation and assessment are distinct processes with different purposes. Screening (including developmental and health screening) includes activities to identify children who may need further evaluation in order to determine the existence of a delay in development or a particular disability. Evaluation is used to determine the existence of a delay or disability, to identify the child’s strengths and needs in all areas of development. Assessment is used to determine the individual child’s present level of performance and early intervention or educational needs.

Often early detection is difficult as many disabilities are subtle and children who have them may appear to be developing normally at younger ages. Under-detection is nevertheless unfortunate because it may delay the possibilities of early intervention. However therapists and child health nurses have the skills and abilities to assess for developmental delay. It is essential that child health nurses with close links to families and families themselves can refer to child development centres for assessment and management.

The Australian Physiotherapy Association recognizes the benefits of early detection and thus earlier intervention. Screening should be provided for all children via initial developmental surveillance. Screening is designed for the asymptomatic -- for those

thought to be developing normally. Children with obvious problems can simply be referred promptly for early intervention.

Screening is best served by contact with the child health nurses (CHN's) who should be encouraged to actively see "asymptomatic" babies. The screening or developmental surveillance is a longitudinal process that commences with routinely eliciting and addressing parents' concerns, followed by maintaining a record of developmental progress, making accurate and informed observations about the child and parent-child interactions, identifying risk and protective factors that often predict developmental risks and ensuring that needed interventions are promptly delivered. It is therefore important that the child health nurses are well trained in this area.

Periodic use of quality screening tools is recommended to add evidence to the process of surveillance. THE APA concedes that screening may result in over referrals (ie some false positives). However the savings made from early intervention and better long term outcome for those identified outweigh the cost of over referrals.

Recommendation:

Improve funding and training to enable CHN's to longitudinally survey all babies and to utilise expertise within the community for education of families in relation to gross motor development and other developmental skills.

c) which government agency or agencies should have coordinating and resourcing responsibility for the identification and delivery of assistance to 0–3 year old children

Presently there are a number of early intervention service providers who accept children according to their own agency criteria. There is a large population of children needing intervention who are not accepted by any government agency. The families of these children who do not meet the government agency criteria are disadvantaged in access to services as well as having to source and fund private therapy services.

Interagency cooperation, coordination and communication can be poor. There is a need for coordination and communication across agency lines to effectively provide the array of necessary services for young children, infants, toddlers and preschoolers, with disabilities and their families. As agencies are often under resourced many agencies close intakes or intake policies to reduce the numbers of infants and children accepted. Thus the government with some provision of increased funding could increase the time staff have to actively communicate and coordinate services. At present most personnel are overwhelmed with a "clinical load" and do not have time to coordinate services well.

Interagency agreements, policies, procedures, guidelines, personnel development, and other mechanisms must be in place to facilitate communication and coordination across agencies at the state and local levels. Interagency councils at the state and local level, which represent the diversity of their constituents, must engage in ongoing assessment of state and community needs and resources and improve the availability of comprehensive services and supports for all children with need,

regardless of diagnosis/disability type. The role of the local area coordinators can be expanded and revised to help with coordination of care if required.

Recommendation:

That there is adequate funding of personnel to assist therapists and CHN's to coordinate interagency care.

d) what is the best model to ensure interagency and intergovernmental integration of developmental programs delivered to 0–3 year old children

Families requiring early intervention services face a number of barriers to service provision. Workforce issues influence the availability of appropriate staff to see families in need. Compounding this problem of clinical workforce shortages is the increasing number of children and families with complex needs.

A "Community Hub" approach where communities are surveyed and the government responds to local requests has been trialed in other states of Australia eg. Kingston QLD, with success. It brings together a wide range of important buildings and spaces that are shared by everyone in the community providing a focus for peoples sense of community.

The APA believes that the establishment of 'Community Hub' models of care would more effectively utilise existing staff, and provide more adequate care of children who are on waiting lists for early intervention programs. These children are ineligible for other relevant therapies or even progress monitoring, which is extremely problematic given that it is recommended that early childhood intervention commence within two months of diagnosis.

Pooling resources would increase service accessibility and help to ease some of these difficulties. A model of service where parent-child centres provide a variety of services such as occasional care, early intervention services, child care centres and access to maternal child health nurses and paediatricians would maximise resources and reduce 'doubling up', assist in staff recruitment and support, and structure career pathways for physiotherapists and other child health workers.

Recommendation:

The APA recommends that a 'Community Hub' approach to the provision of early childhood intervention services is adopted in order to pool resources and provide increased services that are more flexible.

e) how to best prioritise the resources available for meeting the needs identified

Prioritisation of resources is a complex process for consideration and will require inter-agency and inter-governmental dialogue so that agencies work collaboratively

to ensure equitable access for children and infants with developmental delay. Resources should be prioritised by the needs of the child and family rather than the child's diagnosis *per se*.

Priority should also be considered in terms of long term outcomes, eg. language and social skills that enable children to enter formal education need to be implemented early in the child's life.

Recommendation:

The APA recommends that a collaborative approach between government departments and agencies should be implemented.

f) what is the most appropriate measure of program outcomes

Measures of program outcomes can be across all levels of the International Classification of Functioning, Disability and Health (ICF), short or long term and/or include epidemiological data.

There are specific physiotherapy measures of impairment (eg. the amount of movement in an infant's neck if the infant has a positional torticollis), activity (the ability for an infant to crawl) and participation (the infant and mother can attend playgroup) that reflect the ICF criteria. Furthermore, physiotherapy can also monitor and measure change over time to determine whether programs have a preventative function.

Some other aspects of long term outcomes could include the percentage of infants and toddlers who received early interventions who demonstrate at school age entry:

- positive social-emotional skills (including social relationships);
- acquisition and use of knowledge and skills (including early language/communication);
- use of appropriate behaviours to meet their needs;
- engagement in appropriate gross motor and fine motor activities;

Outcomes for families could include but are not limited to:

- percentage of families participating in early intervention services (enrolment rates);
- percentage of families that can effectively communicate their children's needs; and
- percentage of families that demonstrate the skills to help their children develop and learn.

Some epidemiological long term data could include: health of the population, decrease in crime; decrease in behavioural issues; decrease in Mental Health problems; and increase in literacy levels.

To enable programs to be evaluated would require agreed outcomes between professionals and agencies with the view that the programs are beneficial to the children and their families. Outcomes should be based on a "carrot" approach rather

than the “stick”; that is successful outcomes should be rewarded but unsuccessful outcomes should be reviewed, rather than having funding cuts. Resources should be provided for adequate data collection in terms of facilities and staff.

Recommendation

The APA recommends that outcomes are diverse reflecting the needs of particular disciplines as well as measuring global long term outcomes. Program evaluation should result in improved services.

g) Any other Comments

Paediatric physiotherapy is recognised as a specialised area within the profession, due to the complex needs of the dyad of the child and family. In addition, at risk groups such as Indigenous clients, non-English speaking families, have complex needs. To ensure that all infants and their families receive the best possible care, experienced paediatric physiotherapists are essential in the health care/community teams.

To continue the future supply of paediatric physiotherapists requires adequate provision of supervised placements for new graduates and students. There is a shortage of senior physiotherapy staff in early intervention programmes to act as supervisors or mentors for students and junior staff, contributing to the difficulty in maintaining and developing the high skill levels required in community paediatric physiotherapist positions.

Services for children with developmental delay or disability often include prescription of aids and equipment. Funding resources need to be reviewed so that children have equal access to equipment and aids.

References

1. Roberts G, Howard K, Spittle AJ, Brown NC, Anderson PJ, Doyle LW. 2008. Rates of early intervention services in very preterm children with developmental disabilities at age 2 years. *Journal of Paediatrics and Child Health* 44, 5 (May 1): 276-280.
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AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Submission

Early Childhood Intervention Reform Project

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Executive Summary

The Australian Physiotherapy Association (APA) applauds the Department of Education and Early Childhood Development's (DEECD) decision to investigate the issues arising from current models of service in early childhood intervention programs.

Early childhood intervention services for children with a disability or developmental delay are of great benefit to the community, however much could be done to improve adequacy and accessibility. There is potential for significant improvement in the way health professionals are supported by the DEECD in their provision of service to affected children and families.

A recently published Victorian study involving 236 low birth-weight children, found that although nearly all the children with blindness, deafness and cerebral palsy were receiving services, 72% of children identified with mild, and 49% with moderate to severe cognitive delay were not receiving early intervention services by the age of 2 years. The same study identified that children could wait up to one year from referral before receiving early intervention services. These are worrying statistics, particularly given that children who have the most to gain from timely intervention may not be obtaining treatment. It has also been established that difficulty in accessing early intervention services is higher in groups with low socio-economic status, are members of a minority ethnic group or are children with parents or carers with low education levels.

The APA believes that there are a number of reasons for these problems, which involve staffing, funding, and career pathways for health care workers, and the APA makes the following recommendations in order to help improve access to early intervention services:

- That the DEECD adopt a 'Community Hub' approach to the provision of early childhood intervention services in order to pool resources and provide increased services that are more flexible;
- that physiotherapists undertaking key worker roles be given additional training and support in case management skills;
- that the Department of Human Services (DHS) regularly review referral and intake processes and ensure that they are equitable across its regions. Central intake services should be provided with increased personnel capacity and staff should be provided with ongoing training regarding interpretation of eligibility criteria;
- that program and equipment funding arrangements be reviewed with a view to minimise paperwork and red tape for families and staff. During this review the DHS should consider alternate funding frameworks (for example trust funds) in order to provide cost free therapy for children;
- that Commonwealth and State governments provide adequate funding linked to the employment of a balanced ratio of senior and junior clinical staff;
- that physiotherapists working in all settings should have access to professional development opportunities, study leave and mentoring that is financially supported by their employer. Physiotherapists should receive appropriate remuneration for the type of professional services rendered, which reflects the level of expertise and the nature of the service provided; and
- that suitable remuneration be made available to senior physiotherapists supervising or mentoring students on clinical placement and junior physiotherapy staff.

The Australian Physiotherapy Association

The Australian Physiotherapy Association (APA) is the peak body representing the interests of Australian physiotherapists and their patients. The APA is a national organisation with state and territory branches and specialty subgroups.

The APA corporate structure is one of a company limited by guarantee. The organisation has approximately 12,000 members, some 70 staff and over 300 members in volunteer positions on committees and working parties. The APA is governed by a Board of Directors elected by representatives of all stakeholder groups within the Association.

The APA vision is that all Australians will have access to quality physiotherapy, when and where required, to optimise health and wellbeing. The APA has a Platform and Vision for Physiotherapy 2020 and all its submissions are publicly available via the APA website:

www.physiotherapy.asn.au

The National Paediatric Group

Membership of the National Paediatric Group is open to all APA members with an interest in Paediatric Physiotherapy. The National Paediatric Group is committed to nurturing paediatric physiotherapy practice.

Through its network of members and state represented chapter groups, the National Paediatric Group has always shown continuous improvement. Its vision is to continue to forge the group forward for member services and the services provided to children.

The National Paediatric Group will continue to represent the needs of its members by further developing professional development opportunities, improving the identity and public profile of paediatric physiotherapy and improving access to paediatric physiotherapy for all children who require it.

Early Childhood Intervention Reform Project

The APA applauds the Department of Education and Early Childhood Development's (DEECD) decision to investigate the issues arising from the current models/range of services that are available in early childhood intervention services. We look forward to the development and publication of an options paper and subsequent action plan for early intervention services in Victoria.

Paediatric physiotherapists work in early intervention services across rural and metropolitan regions in both private and public sectors. Physiotherapists make a vital contribution to these services. Members of the Victorian Branch of the APA National Paediatric Group were recently invited to a forum to consider the areas identified by the DEECD, and to discuss and make recommendations for improvement to early intervention services, in particular paediatric physiotherapy.

This submission makes reference to the primary objectives of the Early Childhood Intervention Reform Project, outlining barriers to service and recommendations for improvement.

1. The adequacy of early childhood interventions for children aged 0-6 with a disability or developmental delay

Early childhood intervention services for children with a disability or developmental delay are of great benefit to the community, however much could be done to improve adequacy and accessibility. There is potential for significant improvement in the way health professionals are supported by the DEECD in their provision of service to affected children and families.

A recently published Victorian study involving 236 low birth-weight children, has found that although nearly all children with blindness, deafness and cerebral palsy were receiving services, 72% of children identified with mild, and 49% with moderate to severe cognitive delay were not receiving early intervention services by the age of 2 years. The same study identified that children could wait up to one year from referral before receiving early intervention services, a worrying statistic given that those 'most likely to benefit from prompt involvement with EI [early intervention] are denied a vital opportunity to positively influence their development'¹. It has also been established that difficulty in accessing early intervention services is higher in groups with low socio-economic status, members of a minority ethnic group and/or for children with parents or carers with low education levels².

Community hub model of service

Families requiring early intervention services face a number of barriers to service provision. Workforce issues influence the availability of appropriate staff to see families in need. Compounding this problem of clinical workforce shortages is the increasing number of children and families with complex needs.

The APA believes that the establishment of 'Community Hub' models of care would more effectively utilise existing staff, and provide more adequate care of children who are on waiting lists for early intervention programs. These children are ineligible for other relevant therapies or even progress monitoring, which is extremely problematic given that it is recommended that early childhood intervention commence within two months of diagnosis³.

Pooling resources would increase service accessibility and help to ease some of these difficulties. A model of service where parent-child centres provide a variety of services such as occasional care, early intervention services, child care centres and access to maternal child health nurses and paediatricians would maximise resources and reduce 'doubling up', assist in staff recruitment and support, and structure career pathways for physiotherapists and other child health workers.

The APA recommends that the DEECD adopt a 'Community Hub' approach to the provision of early childhood intervention services in order to pool resources and provide increased services that are more flexible.

Key worker roles

The current move towards key worker models of service delivery has an impact on the delivery of clinical services, as well as the training of graduate physiotherapists. While co-ordinated care for families is an essential part of service, this model reduces resources for clinical service delivery. Physiotherapists can encounter difficulty maintaining their focus on the role of a treating clinician, as case management duties require a skill set that can vary from that of a physiotherapist.

Development of such skills can be demanding, particularly for junior staff who are often still developing their clinical competencies. This group require more support than is currently being provided. In addition, time allocated to each family is not necessarily any greater than that allocated to a clinical role resulting in a reduced capacity for the therapist to deliver timely physiotherapy services.

The APA recommends that physiotherapists undertaking key worker roles be given additional training and support in case management skills.

2. Demand: pressures on early childhood intervention services and variations in access by region and equity group.

Early identification and intervention has been shown to result in improved outcomes for children and families⁴, however problems with the referral process and children on waiting lists can result in disparity of access to services.

Central intake services

Centralised intake processes aim to eliminate disparities across regions, and when functioning efficiently, can be beneficial in identifying and facilitating uptake of early childhood intervention services. However complicated referral procedures and intake staff who lack appropriate training in interpretation of eligibility criteria can delay families' access to suitable services.

Even though they are required to deal with complex and disparate systems across DHS regions, central intake services are under resourced, resulting in difficulty in meeting the increased needs of families. Staff require adequate resources and training to provide for face to face client visits, clarify the needs of the child, and link families into appropriate and available services in a timely manner.

The APA recommends that the DHS regularly review referral and intake processes and ensure that they are equitable across its regions. Central intake services should be provided with increased personnel capacity and staff should be provided with ongoing training regarding interpretation of eligibility criteria.

Access to expertise

Staff expertise and experience varies from service to service. Invariably staff will bring with them specialist knowledge of a particular developmental problem or disability, and in a team environment this is likely to benefit children significantly.

However where a clinician is working in isolation from other physiotherapists in a very small early intervention service, access to services outside his or her specific field may be affected, potentially making equitable client access dependent on location. The implementation of 'Community Hub' models of service would help ensure that all families are able to access suitable services for their children.

The APA recommends that the DEECD adopt the 'Community Hub' approach to the provision of early childhood intervention services in order to provide children with access to physiotherapists with expertise in a variety of areas.

3. The adequacy of early childhood intervention funding arrangements

There have recently been some minor improvements in funding from the Commonwealth and State governments, however more equitable and less onerous funding arrangements are required to address inherent flaws in the funding of early childhood intervention programs.

Silo funding models

Complex funding processes for access to Early Childhood Intervention Services, childcare, Kindergarten Inclusion Support Services and government, catholic and private schools are poorly integrated, resulting in an unnecessary administrative burden to staff and families.

Funding levels influence staff to work within funding constraints rather than concentrating on the provision of equitable service for children. Many families must make multiple, complex funding submissions, pointing towards a lack of integrated funding models.

Complex funding arrangements also make equipment and aids difficult to access, and staff are required to dedicate a significant amount of time to help parents complete numerous funding applications.

The APA recommends that program and equipment funding arrangements be reviewed with a view to minimise paperwork and red tape for families and staff. During this review the DHS should consider alternate funding frameworks (for example trust funds) in order to provide cost free therapy for children.

Staff ratio

Minimal funding for the staffing of early childhood intervention services can result in a focus on the recruitment of junior staff in preference to those with more experience who require higher remuneration. Junior or graduate staff generally need intensive development of professional skills, and need support from experienced clinicians. Employers have a responsibility to ensure that senior staff are available, and have capacity to provide mentoring and support to more junior staff members. Services should therefore be provided with sufficient funding to ensure they are able to provide for a balance of junior and senior clinicians.

The APA recommends that Commonwealth and State governments provide adequate funding linked to the employment of a balanced ratio of senior and junior clinical staff.

4. Transition issues into, and linkages between, early childhood intervention, kindergarten, child care, school and other relevant service providers

Physiotherapists have been integral in driving the shift to enable children to participate and integrate into the mainstream community. A number of barriers to integration between services remain however, and action is required to redress these issues in order to achieve the best possible outcomes for children with developmental delay or disability.

Consistency of services

Transition from highly supported early intervention services to other programs can be traumatic for parents and children. Fragmentation of services often means that the child is faced with an abrupt shift into a school where minimal support is available. An open door approach is required to enable sufficient levels of communication between these services.

Innovative connections between health, DEECD and local councils would help minimize problematic transitions, and provide a consistent level of support to parents across services. 'Community Hubs' providing a number of services in one location may help to facilitate these partnerships.

The APA recommends that the DEECD encourage partnerships between local health, educational and council community services.

5. Workforce development issues

Workforce attrition is a growing problem for physiotherapy. Physiotherapists in the workplace suffer from high rates of 'burn-out', have inconsistent levels of remuneration and often feel that they lack a defined career pathway and/or workplace supported professional development opportunities. These problems impact considerably on services providing support for children with developmental delay and disability.

Life long learning

Young physiotherapists entering the workforce as well as more experienced practitioners must be supported to develop their careers in order to maximise staff retention and recruitment

capabilities. Many physiotherapists working in early intervention services do not have access to paid study leave or mentoring opportunities, which in turn minimises career progression and satisfaction. In addition, disparities between remuneration levels across regions have been reported by physiotherapists in Victoria.

Small team workplace models can also limit capacity to train new graduates and students, compounding difficulties in recruiting and retaining experienced staff.

The APA recommends that physiotherapists working in all settings should have access to professional development opportunities, study leave and mentoring that is financially support by their workplace. Physiotherapists should receive appropriate remuneration for the type of professional services rendered, which reflects the level of expertise and the nature of the service provided.

Training places

Paediatric physiotherapy is recognised as a specialised area within the profession, and the provision of supervised placements for students is essential to ensure the future supply of paediatric physiotherapists. There is a shortage of senior physiotherapy staff in early intervention programs to act as supervisors or mentors for students and junior staff, contributing to the difficulty that many universities are experiencing in locating suitable work placements. This lack of placement opportunity does little to encourage student physiotherapists to choose to develop their expertise in the field of paediatric physiotherapy, compounding the difficulty in attracting suitably experienced and qualified staff to early intervention services. The DEECD needs to place greater emphasis on the importance of student clinical placements in early intervention services and ensure senior clinicians are available to supervise students.

The APA recommends that suitable remuneration be made available to senior physiotherapists supervising or mentoring students on clinical placement and junior physiotherapy staff.

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