National guideline for supporting the learning, participation, and wellbeing of autistic children and their families in Australia

Draft Administration and Technical Report

Draft Guideline for public consultation

Consultation period: 18 July 2022 – 29 August 2022

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Acknowledgements

The Guideline Development Group warmly acknowledges the following people who have contributed to the development of Guideline.

Children, families, and community

We warmly acknowledge and thank the children, families, and members of the autistic and autism communities who have so generously shared their experiences, insights, views, and expertise to inform the development the Guideline. This includes participation in the original studies included in the systematic reviews undertaken as part of the development, participating in the community consultation activities, and providing feedback on the Draft Guideline.

Research assistants

We warmly acknowledge and thank the research assistants who contributed their expertise to coding the information that was collected through the community consultation process. The team included Briohny Dempsey (Telethon Kids Institute), Georgina Earl (Telethon Kids Institute), Libby Groves (Griffith University), Emma Hinze (Griffith University), and Rachelle Wicks (Griffith University).

Reference Group

We warmly acknowledge and thank the members of the Reference Group, each of whom represented an organisation that is relevant to supporting the learning, participation, and wellbeing of autistic children and their families. The names of all members of the Reference Group, and their organisations they represented are presented in Chapter 2.

Further assistance

We warmly acknowledge and thank the following people who contributed their expertise to the development of the Guideline. The following people provided advice in relation to the community consultation activities: A/Prof Jenny Cartmel (Griffith University), Dr Marilyn Casley (Griffith University), and Prof Sharynne McLeod (Charles Sturt University) who provided advice in relation to the children and young people consultation activities, A/Prof Zachary Munn who provided advice in relation to GRADE methodology, and Dr Kiah Evans and Dr Bahareh Afsharnejad who provided AGREE-II ratings on a draft of the Guideline. The following people contributed to the preparation of community consultation activities: Dr Emmah Baque (Griffith University), Dr James Best (Junction Street Family Practice), Kelly Clark (Centre for Social Impact, University of Western Australia), Georgia Davies (Victoria University of Wellington), Rhiannon Latham (Queensland Department of Education), Antonina Loncarevic (CliniKids, Telethon Kids Institute), Meghan McAnany (Griffith University), Claire Perrozzi (CliniKids, Telethon Kids Institute), Amanda Porter (personal contribution) Shaun Ruigrok (personal contribution), and Carla Wallace-Watkin (Victoria University of Wellington). The following people at Autism CRC contributed to sharing information with the community about the Guideline development process, hosting online activities (e.g., webinars), and preparing the documents (graphic design, copyediting): Cally Jackson, Jason Kotzur, Darcy Maguire, and Sally Vidler.

1. Introduction

This chapter outlines the purpose and contents of this report.

1.1 Purpose of this report

The purpose of this report is to outline the administrative aspects of the Guideline development process and a detailed summary of the methodology. This report is currently in draft form to support public consultation on the Draft Guideline and will be updated with further information regarding the final stages of the Guideline development process.

1.2 Overview of information presented

This report comprised the following chapters:

1. **Acknowledgements**
2. **Introduction**
3. **Project Administration.** This chapter provides a summary of the Guideline questions, the people involved in its development, project governance, and the Public Consultation process.
4. **Research Methodology.** This chapter provides a summary of the systematic process used to move from Guideline questions to the collection and synthesis of evidence from a variety of sources, through to the formulation of recommendations and the production of the Guideline and associated documents.
5. **Scoping Review of Existing Guidelines.** This chapter presents the aims, method, and results of this systematic review of previously published guidelines from around the world.
6. **Umbrella Review: Effects of Non-pharmacological Supports on Child and Family Outcomes.** This chapter presents the aims, method, and results of this umbrella review (review of reviews) to examine the effects of a variety of non-pharmacological supports.
7. **Systematic Review of Individual and Family Experiences of Accessing Services.** This chapter presents the study aims, method, and results of this systematic review to examine the experiences of autistic children and families accessing supports in Australia.
8. **Community Consultation: Online Survey.** This chapter presents the aims, method, and results of this study seeking the views of all members of the autistic and autism communities.
9. **Community Consultation: Focus Groups.** This chapter presents the study aims, method, and results of this study seeking the views and experiences of autistic adults and parents of autistic children.

10. **Community Consultation: Delphi Study.** This chapter presents the study aims, method, and results of this study seeking the views of practitioners.
11. **Community Consultation: Brief Online Survey.** This chapter presents the study aims, method, and results of this study seeking the views of autistic children, young people, and adults.
12. **Community Consultation: Parent Reflection.** This chapter presents the study aims, method, and results of this study seeking parents' reflections on the experiences of their autistic children.
13. **Community Consultation: Expression Through Artwork.** This chapter presents the study aims and methods that was designed to the seek the views of autistic children, young people, and adults.

2. Project Administration

2.1 Chapter overview

This chapter provides a summary of how the Guideline development project was administered. It begins with a statement of the purpose of the Guideline, scope, and target users to provide context for readers, drawing on the same information presented in the Draft Guideline document. This chapter also includes a summary of the people involved in the Guideline development process, project governance, and the process for obtaining feedback on the Draft Guideline through the Public Consultation process.

2.2 Guideline objectives

The specific objectives were to develop a Guideline that:

1. Describes an evidence-based practice framework for providing supports to autistic children aged 12 years or younger and their families.
2. Contains sufficient flexibility to apply to all children regardless of their age, gender, communication or intellectual capacity, cultural or language background, or where they live in Australia.
3. Is feasible for clinical practitioners to implement across the full breadth of clinical or community settings in Australia.
4. Meets the needs and expectations of children and families receiving the supports.

2.3 Guideline scope

The scope of the Guideline was determined prior to the commencement of the research and community consultation activities. The scope of the Guideline is provided in Table 2.1.

Table 2.1. The scope of the Guideline

Aspect	In scope	Out of scope
Recipients of supports	Children aged 12 years or younger with an autism diagnosis and their family members.	Children and families not meeting this criteria.
Supports and services	Non-pharmacological supports.	Pharmacological therapies and other biological-based therapies.
	Focused on directly supporting the learning, participation, and wellbeing of autistic children, including through addressing environmental and contextual barriers.	Focused on broader aspects of family functioning, including parental mental health.
	Delivered within a clinical or community setting.	Specifically designed for delivery in a medical, primary school, or high school settings.
Outcomes targeted by supports	Learning, participation, and wellbeing.	Outcomes related to conditions that co-occur with autism (e.g., sleep, gastrointestinal function, mental health).

2.4 Guideline target users

The primary target users of this Guideline are practitioners working in Australia who are involved in the planning, selection, delivery and/or monitoring of supports for autistic children and their families.

Secondary target users of this Guideline include the following groups:

- Autistic children and their families can use this Guideline to understand an evidence-based practice framework for accessing and receiving supports.
- Service providers can use this Guideline to align resource allocation with an evidence-based practice framework.
- Australian training providers, including peak bodies and tertiary education institutions, can use this Guideline to tailor clinical and educational resources, courses and qualifications to ensure practitioners achieve the learning outcomes required for the planning, selection, delivery and monitoring of supports.
- Governmental bodies can use this Guideline to make evidence-based policy decisions regarding funding and provision of supports, based on consensus-based recommendations that are relevant to the Australian autistic and autism communities.

2.5 Guideline funding

Autism CRC funded the development of the Guideline and its publication. Andrew Whitehouse (Telethon Kids Institute, University of Western Australia) and David Trembath (Griffith University, Telethon Kids Institute) were appointed Co-chairs of the Guideline Development Group (GDG), and their respective institutions received funding from Autism CRC to support this work. Andrew Whitehouse's and David Trembath's contributions were in-kind, with funding used to employ research fellows/assistants to support the work, to support community consultation activities, and honorariums for the Guideline Development Group and Reference Group members.

2.6 Process for ensuring editorial independence from funders

The GDG had complete editorial independence from Autism CRC in developing the Guideline, with each entity having clearly defined roles and responsibilities. In chronological order, the mechanisms to ensure editorial independence included:

Conceptualisation: Members of the GDG (Rhylee Sulek, David Trembath, Kandice Varcin, Hannah Waddington, Andrew Whitehouse) initially proposed the development of a guideline as one of the recommendations arising from a research review of evidence for the effects of non-pharmacological supports for autistic children and their families. This research was commissioned by the National Disability Insurance Agency and supported by Autism CRC (Whitehouse et al., 2020).

Commissioning: Autism CRC invited Andrew Whitehouse and David Trembath to submit a proposal for the development of a guideline, which was ultimately approved by the Autism CRC board. Andrew Whitehouse and David Trembath consulted with Autism CRC regarding aims, scope, and representation, but retained complete independence in all aspects of the proposal.

Funding agreements: Autism CRC engaged University of Western Australia/Telethon Kids and Griffith University via formal funding agreements. The funding agreement stipulated that each party would ensure that research was conducted in accordance with the Australian Code for the Responsible Conduct of Research (National Health and Medical Research Council [NHMRC], 2018), which highlights the importance of honesty, rigor, and transparency: all of which rely on editorial independence.

Conduct: The GDG were responsible for all aspects of project design and delivery. Autism CRC involvement was limited to (a) receiving updates on progress towards agreed project milestones in accordance with the funding agreements and (b) facilitating the community consultation through sharing information (e.g., overview of activities, invitations to participate) via the Autism CRC website and database, and via social media. The GDG were responsible for drafting the information that Autism CRC shared with the community. All research activities were approved by the Griffith University Human Research Ethics Committee and implemented using Griffith University research infrastructure (e.g., Microsoft Teams for focus groups, REDCap for online surveys). Autism CRC was not involved in evidence synthesis nor formulation or refinement of the recommendations.

External consultation: The GDG were responsible for all consultation regarding the contents of the Guideline, including liaising with and incorporating feedback from the Reference Group.

Draft Guideline: The GDG were responsible for drafting the Guideline. Autism CRC had access to a copy of the Draft Guideline as it was developed to assist with formatting and graphic design. Autism CRC had authority to make changes to the formatting (e.g., organisation branding) and phrasing (e.g., in order to prepare plain language summaries in consultation with the GDG and to improve accessibility) but did not have authority to make changes to the meaning of any statement or recommendation in the Guideline.

Draft Guideline public consultation: Autism CRC will promote the consultation, but the GDG, using Griffith University infrastructure, will be responsible for all other aspects of consultation including receiving and responding to feedback.

Guideline finalisation: The GDG will be responsible for any further changes to the Guideline. Autism CRC's role will be limited to production (e.g., copy editing, formatting).

Dissemination: Autism CRC will announce and promote the Guideline. The GDG will contribute to dissemination activities but will maintain editorial independence in relation to the nature of those activities (e.g., content of presentations).

2.7 Guideline Development Group

The Guideline Development Group was established in accordance with the National Health and Medical Research Council (NHMRC, 2011) requirements to lead the research and community consultation process.

Terms of Reference

The Terms of Reference are presented in Appendix 2.1 and include the following information about the project:

- Background.
- Purpose of the Guideline Development Group.
- Anticipated timeline.
- Membership of the Guideline Development Group.
- Appointment of Chair.
- Responsibilities of Project Team Members.
- Meetings.
- Code of conduct for the Project Team.
- Reporting.

The Terms of Reference were signed by each GDG member ahead of the first meeting. Meetings were held monthly from November 2021 to June 2022 (and will continue monthly until September 2022).

Recruitment

The members of the GDG were identified and appointed via a three-stage process.

1. In the first stage, the Co-chairs identified a range of perspectives that were critical to the development of this Guideline which focuses on autistic children's learning, participation, and wellbeing, as well as the wellbeing of their families. These perspectives included lived expertise (autistic people and parents), professional expertise (medical and allied health), expertise in working alongside Aboriginal and Torres Strait Islander communities, and expertise in human ethics. The Co-chairs also identified research expertise that would be relevant, including in relation to co-designed research, systematic reviews, community consultation, and Guideline development.
2. In the second stage, the Co-chairs identified people who had knowledge, skills, and experience relevant to each of these required perspectives, and distributed invitations via email. Consideration was given to ensuring diversity within the GDG. The email included an introduction to the project and Terms of Reference. The Co-chairs made themselves available to meet with invitees to discuss the Terms of Reference.
3. In the third stage, the invitees returned the signed Terms of Reference to confirm their role within the GDG.

Members

The members of the GDG, including name, position, affiliation, role, and expertise are presented in Table 2.2.

Table 2.2. Members of the Guideline Development Group.

Name	Position, affiliation, role, and expertise
Prof Andrew Whitehouse **(Co-chair)**	Andrew Whitehouse is a Speech Pathologist and Angela Wright Bennett Professor of Autism at the Telethon Kids Institute and the University of Western Australia. Andrew is also the Director of CliniKids, a clinical research centre of excellence for autistic children, and is Autism CRC's Research Strategy Director. He brings over 20 years' clinical research experience in working with autistic children and their families. He also brings experience in Guideline development, having chaired the development of the National Guideline for the Assessment and Diagnosis of Autism in Australia. Andrew was the Co-chair of the Guideline Development Group.
A/Prof David Trembath **(Co-chair)**	David Trembath is an Associate Professor in Speech Pathology at the Menzies Health Institute Queensland, Griffith University and Honorary Research Fellow at CliniKids, Telethon Kids Institute. He brings over 20 years' of clinical-research experience working with autistic children and their families. David was the Co-chair of the Guideline Development Group.

Dr Kandice Varcin	Dr Kandice Varcin is a Research Fellow at the Menzies Health Institute Queensland, Griffith University. She is also a registered psychologist who brings experience and expertise in research focused on autism, early development and the evaluation of therapies and supports for young children and their families.
Dr Hannah Waddington	Dr Hannah Waddington is a senior lecturer at Victoria University of Wellington and the Clinic Lead of the Victoria University of Wellington Autism clinic. She is also a practicing educational psychologist who brings experience in provision of early support to autistic children and their families.
Dr Rhylee Sulek	Dr Rhylee Sulek is a Research Fellow within the School of Health Sciences and Social Work, Griffith University. She brings experience in working with young autistic children and their families when receiving early supports and therapies, and the inclusion of key stakeholders in the co-production of research.
Ms Sarah Pillar	Sarah Pillar is the Integration Project Manager at CliniKids, Telethon Kids Institute. She has a professional background in Speech Pathology and brings experience in providing clinical services to autistic children and their families. Sarah is a PhD candidate through the University of Western Australia.
Mr Gary Allen	Gary Allen is the Senior Policy Officer Human Research Ethics and Research Integrity at Griffith University. Gary has worked in the human research ethics area since 1997, working with a number of research institutions, state and federal departments, private companies and research ethics committees internationally. He also has a degree in education and a professional doctorate in social sciences. Gary brings extensive experience in regards to the national and international governance of ethical conduct in research.
Mx Katharine Annear	Mx Katharine Annear is a founding member of the Autistic Self Advocacy Network of Australia and New Zealand, a registered Developmental Educator, and Casual Academic at Flinders University. They bring lived experience as an Autistic person who also has numerous Autistic family members, and are a passionate advocate for co-design in research and public policy and the translation of research and policy into meaningful practice for disabled people.
Prof Valsamma Eapen	Professor Valsa Eapen is the Chair of Infant, Child and Adolescent Psychiatry at the University of New South Wales. An internationally-recognised child psychiatrist and researcher, Valsa's expertise combines extensive experience in childhood mental health and developmental disorders from a clinical and basic science research perspective.
Ms Jessica Feary	Jess Feary is the Victoria and Tasmania Coordinator for Positive Partnerships. She has a background in occupational therapy and public health and brings over 15 years' experience working with neurodiverse people and their families in clinical, research, policy and educational settings.
Dr Emma Goodall	Dr Emma Goodall is an autistic author, advocate, qualified meditation and mindfulness teacher and adjunct research fellow at the University of Southern Queensland. She is the Manager for Content & Research for Positive Partnerships and also runs Healthy Possibilities, a consultancy offering personal life coaching alongside autism specific continuing professional development for educators and families and NDIS services (many with a link to interoception). Emma speaks widely on the topic of interoception and the role mindful body awareness plays in emotional regulation.

Ms Teresa Pilbeam	Teresa Pilbeam is a special education teacher, an advocate for informal family carers, and has worked alongside First Nations peoples across Australia. Teresa has 30 years' experience in special education, contributed to carer and disability reform for over 10 years, is an Independent Director on government and profit-for-purpose state and federal councils and boards, and has a lived experience of autism spectrum and complex disability. Teresa brings experience and expertise of governance, ways of working with Aboriginal and Torres Strait Islander Peoples, and an enthusiasm for enabling the voice of informal family carers to be heard in cross-sector conversations.
Dr Felicity Rose	Felicity Rose is a Project Manager at Telethon Kids Institute. Her current project is to further implement the National Guideline for the Assessment and Diagnosis of Autism into clinical practice. She has a professional background in science and research and is also the parent of a young person on the autism spectrum.
Dr Nancy Sadka	Dr Nancy Sadka is a Research Fellow at the Olga Tennison Autism Research Centre, La Trobe University. She works in the early identification and diagnosis of autism and is an advocate for families and children on the spectrum over the life span. She also is the mother of two autistic children and brings to the GDG over 25 years' of lived experience.
Dr Natalie Silove	Dr Natalie Silove is a Clinical Associate Professor in the Discipline of Paediatrics and Child Health, University of Sydney and Senior Lecturer (Conjoint) at the School of Psychiatry (UNSW). She is also the Head of Child Development Services; Senior Staff Specialist, Child Development Unit at The Children's Hospital Westmead. She brings over 30 years' experience working with children and young adults with special needs, their families and schools.

Roles within the GDG

All members of the GDG contributed to decision-making in relation to the design, development, and delivery of the Guideline and associated documents. This included reviewing materials, engaging in discussion at monthly GDG meetings, and endorsing the final versions of these documents.

Within the GDG, six members were responsible for developing and progressing the core research and development activities, including designing and completing systematic reviews, community consultation activities, and the Evidence to Decision (EtD) process (described in subsequent chapters): Sarah Pillar, Rhylee Sulek, David Trembath, Kandice Varcin, Hannah Waddington, and Andrew Whitehouse. Sarah Pillar, Rhylee Sulek, Kandice Varcin, and Hannah Waddington held salaried positions, while David Trembath and Andrew Whitehouse made substantial in-kind contributions. Each member contributed to all activities, while taking leadership of one or more activities. Specifically, Sarah Pillar led the systematic review of existing guidelines. Rhylee Sulek led the systematic review of child and family experiences, as well as community consultation involving the online survey and focus groups. Kandice Varcin led the Delphi survey of practitioners. Hannah Waddington led the systematic review of the effects of non-pharmacological supports on child and family outcomes.

Declaration of Interests

The following process was adopted to ensure the declaration and management of any competing interests, in accordance with the NHMRC Guidelines for Guidelines (2016):

Develop a conflict-of-interest policy

The following information constitutes the conflict-of-interest policy used in the development of the Guideline.

Determining if an interest is a conflict of interest

Members of the GDG who were directly responsible for the design and conduct of research activities (Sarah Pillar, Rhylee Sulek, David Trembath, Kandice Varcin, Hannah Waddington, Andrew Whitehouse) each disclosed conflicts of interest using the International Committee of Medical Journal Editors (ICMJE) Disclosure of Potential Conflicts of Interests form (**https://journals.sagepub.com/pb-assets/cmscontent/HPQ/coi_disclosure.pdf**) at the outset of the project, and these forms were made available to one another to review. No major conflicts of interest were identified. All members of the GDG were required to complete the same form prior to having input into the drafting of Guideline recommendations. GDG Co-chairs reviewed all forms and identified processes that would be put in place if required (e.g., self-abstaining or asking group member to abstain from one or more aspects of the guideline development process).

Appoint an independent chair

Autism CRC invited Andrew Whitehouse and David Trembath to act as Co-chairs based on their experience and demonstrated track record of co-designed and ethical research in related projects that included the development of the NHMRC endorsed National Guideline for the Assessment and Diagnosis of Autism in Australia (Andrew Whitehouse; Whitehouse et al., 2018) and the NDIA commissioned synthesis of evidence for non-pharmalogical supports for autistic children and their families (Andrew Whitehouse and David Trembath; Whitehouse et al., 2020). The Co-chairs have no financial interests relevant to the Guideline to declare, and all interests were declared in full to Autism CRC (and published online for the broader community) as part of the process of conducting and reporting the NDIA commissioned research.

Select development group candidates

As indicated above, members of the GDG were selected through a process that involved the Co-chairs first identifying perspectives and expertise that are critical to the development of the Guideline, and then inviting relevant people.

Disclose interests throughout development

All GDG and Reference Group members were required to declare any potential conflicts of interest that arise during the guideline development process by (a) updating their form and (b) notifying the Co-chairs at the start of the following meeting (standard agenda item). GDG members were advised to notify the Co-chairs of any changes in their declarations, prior to providing feedback on any documents outside of GDG meetings (e.g., feedback on the Draft Guideline). The exceptions to this approach were members of the GDG directly involved in day-to-day work on the Guideline (Sarah Pillar, Rhylee Sulek, David Trembath, Kandice Varcin, Hannah Waddington, Andrew Whitehouse) who were required to notify this same group of any new disclosures as they arose and no later than the next weekly working group meeting.

Manage conflicts of interest

It was planned that conflicts arising would be managed according to recommendations in the NHMRC Guidelines for Guidelines (2016) including members recusing themselves and/or being excluded from aspects of the guideline development process, removing a member from the GDG should a serious breach in relation to disclosures occur, and refusing sponsorship where a conflict exists. All decisions were to have been discussed and documented within the GDG and published in the technical manual that accompanies the Guideline. It is noted that these actions have not been required during the development of the Draft Guideline.

Publish declarations of interest in the Guideline

The declarations of interests for all GDG members are provided in Appendix 2.2.

Guideline Development Group meetings

The GDG met via videoconference on a monthly basis from November 2021 to July 2022. Additional monthly meetings are scheduled for August and September 2022. Each meeting followed an agenda, focusing on (a) updates on Guideline activities and (b) discussion and decision-making within the GDG. Minutes of each meeting, along with a rolling record of actions arising and any supporting documents, were circulated between meetings.

The primary focus of each meeting was:

November 2021: Introduction of members, project overview, confirming processes for governance and communication, overview of methodology, and review of proposed timeline.

December 2021: Presentation and discussion of proposed methodology for community consultation.

January 2022: Progress report on systematic reviews and review of draft versions of the community consultation survey and Delphi survey.

February 2022: Progress report on systematic reviews, and review of new drafts of the online survey and Delphi survey.

March 2022: Progress report on systematic reviews, progress report on online survey and focus groups, and discussion of additional consultation activities (brief survey, expressions through art, reflection survey).

April 2022: An email update to GDG members providing a progress report on all research and community consultation activities.

May 2022: Presentation of the Evidence to Decision (EtD) process and discussion of draft Recommendations and Good Practice Points.

June 2022: Presentation and review of the Draft Guideline.

July: 2022: Presentation and discussion of the Draft Guideline Public Consultation process and draft Dissemination and Implementation Plan.

2.8 Reference Group

The Reference Group was established to support the work of the GDG, by providing insight and advice on matters relevant to their constituents. The Reference Group comprised representatives from organisations with members that play a critical role in supporting aspects of children's health, development, education, participation, and wellbeing, and/or supporting parents and families in raising autistic children; that represent Aboriginal and Torres Strait Islander Peoples and represent Culturally and Linguistically Diverse (CALD) communities; as well as from the key Government agency, the National Disability Insurance Agency.

Terms of reference

The Terms of Reference are presented in Appendix 2.3 and include:

- Background (to the project).
- Purpose (of the Guideline Development Group).
- Anticipated timeline for the project.
- Membership of the Reference Group.
- Appointment of Chair.
- Responsibilities of Project Team Members.
- Meetings.
- Code of conduct for the Project Team.
- Reporting.

The Terms of Reference were signed by each Reference Group member ahead of the first of three meetings held during the Guideline development process in February, May and July 2022.

Recruitment

The members of the Reference Group were identified and appointed via a three-stage process.

1. In the first stage, the Co-chairs identified a range of critical aspects of children's health, development, education, participation, and wellbeing that are relevant to the Guideline, alongside aspects related to supporting parents and families in raising autistic children. The Co-chairs also identified the need for representation of

Aboriginal and Torres Strait Islander Peoples, representation of culturally and linguistically diverse communities, and representation from the key Government agency: the National Disability Insurance Agency.

2. In the second stage, the Co-chairs identified organisations, peak bodies, and agencies that are relevant to each of the aspects identified and sent an email invitation to a representative (typically CEO) of each organisation, peak body, or agency inviting their participation and requesting they nominate a representative to attend Reference Group meetings. The email included an introduction to the project and Terms of Reference. The Co-chairs made themselves available to meet with invitees to discuss the Terms of Reference.
3. In the third stage, the nominees returned the signed Terms of Reference to confirm their role within the Reference Group.

Members

The members of the Reference Group are presented in Table 2.3.

Table 2.3. Members of the Reference Group.

Stakeholder group	National peak body	Representative	Position
Autistic people	Autistic Self Advocacy Network – Australia and New Zealand	Lisa Smith (first two meetings)	Member
Family members of autistic people	Autism Awareness Australia	Nicole Rogerson	Chief Executive Officer
First Nations peoples	First Peoples Disability Network Australia	Jess Styles	Director, Programs
Culturally and linguistically diverse communities	Federation of Ethnic Communities' Council of Australia	Daniel Coase	Senior Advisor
Focusing on children's health	Neurodevelopmental and Behavioural Paediatrics Society of Australasia	Ashanthi Munasinghe	Member
Focusing on children's social-communication development	Speech Pathology Australia	Amy Fitzpatrick	Senior Advisor - Disability
Focusing on children's physical development	Australian Physiotherapy Association	Nicole Haynes	Member
Focusing on children's cognitive development	Australian Psychological Society	Tamara Cavenett	President

Focusing on children's sensory development	Occupational Therapy Australia	Karen Brown	Division Manager (ACT, NSW)
Representing service providers (peak body)	Australian Autism Alliance	Frances Scodellaro	Member
Representing services (early childhood)	ReImagine Australia (formerly Early Childhood Intervention Australia)	Trish Hanna	Board Chair
Representing services (education)	Australian Association of Special Education	Patrick Kelly	President
Representing services (rural health)	National Rural Health Alliance	Gabrielle O'Kane	Chief Executive Officer
Representing researchers	Australasian Society for Autism Research	Jessica Paynter	Vice President
Representing policy advisors	Autism Advisory Group to the National disability Insurance Agency	Jim Mullan	Member
Government	National Disability Insurance Agency	Sam Bennett	General Manager Policy, Advice and Research

Declared Interests

The process for declaring interests and managing conflicts of interest was the same as outlined in relation to the GDG above. This included members completing declaration of interests forms which are presented in Appendix 2.4. Given that the Reference Group did not input into the formation of the draft Recommendations, some flexibility was given for members to complete their Declarations of Interest forms.

Reference Group Meetings

The Reference Group met via videoconference on three occasions (February, May, and July 2022). Each meeting followed an agenda, focusing on (a) updates on Guideline activities and (b) discussion of these activities. Minutes of e ach meeting, along with a rolling record of actions arising and any supporting documents, were circulated between meetings.

The primary focus of each meeting was:

February 2022: Introduction of members, project overview, confirming processes for governance and communication, overview of methodology, and review of proposed timeline.

May 2022: Summary of progress towards the development of the Guideline, including research and community consultation activities, and review of upcoming stages of Guideline development.

July 2022: Summary of Draft Guideline documents, Draft Guideline Public Consultation process, and review of subsequent stages of Guideline development.

2.9 Other people who contributed to the Guideline development.

Table 2.4 presents the names, roles, expertise, and organisational affiliation of additional people who contributed to the Guideline development.

Table 2.4 Additional contributors to the Guideline development.

Name	Discipline/Expertise	Organisation	Role
Briohny Dempsey	Occupational therapy	Telethon Kids Institute	Research assistant
Georgina Earl	Neuroscience	Telethon Kids Institute	Research assistant
Libby Groves	Speech pathology	Griffith University	Research assistant
Emma Hinze	Psychology	Griffith University	Research assistant
Rachelle Wicks	Psychology	Griffith University	Research assistant
A/Prof Jenny Cartmel	Social work	Griffith University	Consulted on children and young people consultation
Dr Marilyn Casley	Social work	Griffith University	Consulted on children and young people consultation
Prof Sharynne McLeod	Speech pathology	Charles Sturt University	Consulted on children and young people consultation
Dr Emmah Baque	Physiotherapy	Griffith University	Piloted community consultation activities
Dr James Best	General Practitioner	Junction Street Family Practice	Piloted community consultation activities
Kelly Clark	Personal contribution	University of Western Australia	Piloted community consultation activities
Georgia Davies	Clinic manager	Victoria University of Wellington	Piloted community consultation activities
Rhiannon Latham	Occupation therapy	Queensland Department of Education	Piloted community consultation activities

Antonina Loncarevic	Clinical Psychology	Telethon Kids Institute	Piloted community consultation activities
Meghan McAnany	Personal contribution	Griffith University	Piloted community consultation activities
Claire Perrozzi	Speech Pathology	Telethon Kids Institute	Piloted community consultation activities
Amanda Porter	Personal contribution	Personal contribution	Piloted community consultation activities
Shaun Ruigrok	Personal contribution	Personal contribution	Piloted community consultation activities
Carla Wallace-Watkin	PhD student	Victoria University of Wellington	Piloted community consultation activities
Cally Jackson	Marketing and Communications	Autism CRC	Community engagement regarding Guideline
Jason Kotzur	Marketing and Communications	Autism CRC	Community engagement regarding Guideline
Darcy Maguire	Marketing and Communications	Autism CRC	Community engagement regarding Guideline
Sally Vidler	Marketing and Communications	Autism CRC	Community engagement regarding Guideline

2.10 Consumer representation

The following processes were used to ensure consumers (i.e., members of the autistic and autism communities) were involved in the development of the Guideline.

Guideline Development Group: Multiple people with lived expertise of autism were invited to be members of the GDG. One member is autistic, one member is autistic as well as a parent of autistic children, two members are parents of autistic children, and two members are second-degree relatives of autistic children.

Reference Group: Two organisations were specifically invited to join the Reference Group. The Autistic Self Advocacy Network – Australia and New Zealand is run by and represents autistic people. Autism Awareness Australia is run by and represents parents and other family members of autistic people.

Community consultation activities: A series of research studies were conducted as part of the Guideline development process to inform the recommendations. These were separate to the Public Consultation on the Draft Guideline and were used to gather evidence to inform the drafting of recommendations. The activities included:

- Focus groups for autistic people and parents of autistic children.

- An online community survey that was open to all members of the community including autistic people and family members.
- A brief survey, an expression through art activity, and a parent reflection activity that were designed specifically for autistic children and young people, as well as autistic people of all ages who communicate mainly in ways other than speech.

2.11 Involvement of Aboriginal and Torres Strait Islander Peoples and culturally and linguistically diverse communities

For a Guideline to serve the needs of all Australians, it is critical that the guideline development process gives particular consideration to issues related to Aboriginal and Torres Strait Islander Peoples and culturally and linguistically diverse communities. These considerations include recognising the enduring impact of historical injustices, discrimination, and marginalisation of Aboriginal and Torres Strait Islander Peoples; the importance of understanding and embracing culturally-bound understandings of child development, family, child-rearing practices, and disability; and the need to ensure that every Australian has access to culturally-responsive and appropriate health and education services, delivered by people with appropriate knowledge, skills, understanding, and experience. The GDG took the following steps to ensure the Guideline Recommendations were responsive to these and other considerations relevant to these peoples and communities:

- One member of the GDG (Teresa Pilbeam) was specifically appointed based on significant experience and expertise in working with Aboriginal and Torres Strait Islander Peoples and communities.
- The Reference Group included representatives from the peak organisation serving the health of Aboriginal and Torres Strait Islander Peoples, and the peak organisation representing Australians from culturally and linguistically diverse populations.
- National Aboriginal Community Controlled Health Organisation (NACCHO)
- Federation of Ethnic Communities' Council of Australia
- In consultation with Teresa Pilbeam (GDG member), the GDG:
- Ensured that 12 organisations that represent and/or work closely with Aboriginal and Torres Strait Islander Peoples received a direct invitation to participate in the community consultation process.
- Established with the National Aboriginal Community Controlled Health Organisation (NACCHO) an understanding that Autism CRC seeks to enter into a long-term partnership with Aboriginal and Torres Strait Islander communities, that will grow over time and support *proper way* collaboration and consultation. Short term agreed outcomes included consultation on the Guideline (as a member of the Reference Group), GDG member participation in a yarning circle in Darwin relating to service

provision within the National Disability Insurance Scheme, and consultation regarding key issues in the provision of supports to Aboriginal and Torres Strait Islander children who are autistic.

- Reviewed key documents to inform the development of the Guideline, including the AIATSIS Code of Ethics for Aboriginal and Torres Strait Islander Research (2020).

3. Guideline Methodology

3.1 Introduction

This chapter presents an overview of the research methodology used to develop the Guideline, focusing on application of the GRADE (Grading of Recommendations, Assessment, Development and Evaluations) framework. The detailed methodology and findings of each of the research activities completed as part of the Guideline development process are presented in subsequent chapters.

3.2 NHMRC Guidelines for Guidelines

The Guideline development process adhered to the approach described in the *Guidelines for Guidelines* handbook (NHMRC, 2016). The phases of the development included *planning, developing*, and *reviewing* the Guideline. The final phases of *implementing* and *updating* the Guideline are discussed in Chapter 9. In adhering to the handbook, the Guideline Development Process also met the NHMRC Standards for Guidelines:

- Standard 1 - Be relevant and useful for decision making
- Standard 2 - Be transparent
- Standard 3 – Be overseen by a guideline development group
- Standard 4 - Identify and manage conflicts of interest
- Standard 5 - Be focused on health and related outcomes
- Standard 6 - Be evidence informed
- Standard 7 - Make actionable recommendations
- Standard 8 - Be up-to-date
- Standard 9 - Be accessible

3.3 GRADE

GRADE provides a systematic approach for developing practice recommendations (Schünemann et al., 2013). The process involves (a) identifying clinical questions, (b) collecting relevant research evidence, (c) using the evidence to answer the clinical questions, and (d) in doing so formulate recommendations. In determining the strength of recommendations, the GDG must consider the certainty of evidence for the recommendation, the benefits and risks, the values and preferences of the people whom the recommendation will affect, resource implications, impact on health inequities, acceptability to the people whom the recommendation will affect, and feasibility of implementation. These steps, as applied in this Guideline development process, are outlined below.

3.4 Guideline development process

Step 1: Establishing the Guideline Development Group (GDG)

Purpose: The GDG was responsible for developing the guideline questions, gathering evidence through systematic reviews and community consultation, and using the evidence to formulate – and then grade the strength of - recommendations using an Evidence to Decision (EtD) process. The GDG will also be responsible for considering community feedback on the Draft Guideline during the consultation period (July 18 to August 29), making revisions if appropriate, and endorsing the final version for public release.

Process: The process for determining the roles, and people who ultimately filled those roles, is presented in Chapter 2. Briefly, it included three stages, the first of which was to identify relevant perspectives to inform the Guideline development process, to identify people who could contribute those perspectives, and then invite participation including agreement with the Terms of Reference.

People involved: A detailed description of the 15-member GDG is provided in Chapter 2. Briefly, among the group were autistic adults; parents and other family members of autistic individuals, including children and young adults with complex needs; people with expertise in working alongside Aboriginal and Torres Strait Islander communities; people with expertise in human ethics and research integrity; clinicians with experience in government and non-government sectors; and researchers with expertise in guideline development, including community consultation.

Step 2: Defining Guideline questions

Purpose: Asking relevant questions is critical to the development of a useful Guideline.

Process: The GDG formulated a set of questions about key aspects of clinical practice that would be the focus of all research and consultation activities, and ultimately the recommendations. Within GRADE, questions are typically asked using a consistent format that specifies the *population* (P = population of interest), *intervention* (I = intervention/support that is being trialled), *comparison* (C = the alternative to the intervention/support), and *outcome* (O = the outcome of interest). Such questions should be relevant to the community. For instance, a question that seeks to answer whether one type of support for autistic children is more effective than another, could be framed as “In autistic children aged 0-12 years (population), is *Support A* (Intervention) more effective than *Support B* (Comparison), in increasing children’s participation in daily activities (Outcome)?” To answer this question, there must be sufficient studies involving the specific population, types of supports, and outcome of interest to enable a meta-analysis to be completed, which involves quantitatively combining data from across studies. However, this situation is uncommon in relation to research involving autistic children and their families for several reasons including:

- Few or no studies available to answer questions that are most relevant to practice.

- Where studies are available, they vary in terms of the participant characteristics; nature, amount, and delivery of supports provided, and how outcomes of interest are measured.
- Where studies are available, they also vary in terms of methodological quality including the clear and complete reporting of data needed to complete meta-analyses.

The challenge with using the PICO format extends beyond consideration of whether empirical evidence is available to answer a particular question. Two broader challenges that were particularly relevant to this Guideline were as follows:

- Many questions parents and practitioners want answered do not align with the PICO format, such as “What are appropriate goals for supporting children and families?” and “How should goals be selected?” Conceivably, if there were two or more studies comparing the appropriateness of goals developed using two different methods, it would be possible to compare them to see which method was more appropriate. However, doing so would rely on there being two methods to compare, and then there being sufficient empirical evidence to compare them. At the same time, taking this approach would limit the answer to this question to consideration of just two methods, whereas consulting the autistic and autism communities is likely to yield far more diverse views and preferences in relation to what constitutes appropriate goals and how should they be selected.
- Related to the previous point, answering PICO questions relies on quantitative data. Yet, when it comes to understanding the views and experiences of autistic children, their families, and the broader autistic and autism communities, qualitative data are just as important. Therefore, questions need to be asked in a way that allows people to share a broad range of, at times differing, views and experiences.

Given these challenges and limitations with adopting the PICO format, the GDG elected to formulate questions in a way that would prioritise their relevance to everyday practice. Doing so was consistent with the NHMRC Standard 1 (Be relevant and useful for decision making) to ensure Standard 7 (Make actionable recommendations) could be achieved. For this same reason, the Recommendations included in the Guideline are consensus-based recommendations, drawing on evidence from the research literature, combined with evidence collected through detailed community consultation.

People involved: The questions were developed and endorsed by the GDG.

Step 3: Gathering evidence

Purpose: For a Guideline to be relevant it must be evidence-based. For this Guideline, evidence-based meant being consistent with an *evidence-based practice* framework, that combines the best available research evidence, with evidence from professional practice, and the views and priorities of autistic children and their families. The purpose of gathering evidence was to ensure that recommendations could be formulated in a systematic way, consistent with GRADE, and reflecting multiple converging sources of evidence.

Process: The GDG designed a series of nine research projects to gather the best available evidence from existing research via three systematic reviews as well as six community consultation studies. Ethical approval for the consultation activities was procured through the Griffith University Human Research Ethics Committee (2021/843). The nine studies were:

1. A scoping review of existing guidelines (presented in Chapter 4). This was a scoping review of previously published guidelines and similar best practice recommendations in Australia and overseas. Evidence was used, in combination with other sources, to identify a set of principles and practices that were then considered in the design of research activities. Note that evidence was not used to formulate recommendations, to avoid the risk of circular reasoning, whereby a recommendation in one guideline could be used to justify a recommendation in a later guideline.
2. An umbrella review of the effects of non-pharmacological supports on child and family outcomes (presented in Chapter 5). This was a systematic review of existing systematic reviews that examined these effects. The evidence was used to inform the formulation of recommendations, particularly in relation to Guideline questions about the selection and delivery of supports.
3. A systematic review of the experiences of autistic children and their families accessing supports in Australia (presented in Chapter 6). This was a systematic review of existing studies that examined the experiences of children and families accessing supports in community settings. The evidence was used to inform the formulation of recommendations, particularly in relation to the Guideline question about what guiding principles should be followed when providing supports to autistic children and their families.
4. An online survey designed to understand the experiences of the autistic and autism communities in accessing supports, and their views on best practice (presented in Chapter 7). This was open to all members of the autistic and autism communities. The evidence was used to inform the formulation of recommendations in response to all Guideline questions.
5. A series of focus groups designed to provide an opportunity for autistic adults and parents of autistic children to reflect on and discuss their views and experiences (presented in Chapter 8).
6. A practitioner survey designed to identify areas of consensus for various aspects of clinical practice in supporting autistic children and their families. This followed a Delphi format, with two rounds conducted (presented in Chapter 9).
7. A brief online survey designed to understand the views of autistic children in accessing supports (presented in Chapter 10). This was designed to cater for all children, including those who communicate mainly in ways other than speech. The evidence was used to inform the formulation of recommendations in response to all Guideline questions.
8. A reflection activity in which parents were invited to observe and/or reflect on their autistic children's experiences of accessing supports (presented in Chapter 11). This was designed to cater for all children, including those who communicate mainly in

ways other than speech. The evidence was used to inform the formulation of recommendations in response to all Guideline questions.

9. A consultation activity involving the creation of art, which was designed to cater for autistic children, young people, and adults, including individuals who communicate mainly in ways other than speech (presented in Chapter 12).

The nine research and consultation activities were designed in such a way as to collect evidence from all key stakeholders, including autistic children and their families, as well as members of the broader autistic and autism communities. The sources of evidence (i.e., nine studies) the populations represented by each evidence source are summarised in Table 3.1.

Table 3.1. Sources of evidence and populations represented.

Sources of evidence (i.e., research activities)	**Populations represented by each evidence source**						
	Autistic children	Autistic young people	Autistic adults	Parents	Family members	Practitioners	Other community members
Systematic review of existing guidelines	✓	✓		✓	✓	✓	✓
Systematic review of intervention effects	✓	✓		✓	✓		
Systematic reviews of child and family experiences	✓			✓	✓		
Online community survey		✓	✓	✓	✓	✓	✓
Focus groups			✓				
Delphi surveys							
Brief online survey	✓	✓	✓			✓	
Parent reflection	✓	✓	✓				
Expression through art	✓	✓	✓				

People involved: The research activities were developed by the GDG. Jenny Cartmel (Griffith University), Marilyn Casley (Griffith University), and Sharynne McLeod (Charles Sturt University) provided expert input into the design of consultation activities for autistic children and young people. The following people contributed to the preparation of community consultation activities: Dr Emmah Baque (Griffith University), Dr James Best (Junction Street Family Practice), Kelly Clark (Centre for Social Impact, University of Western Australia), Georgia Davies (Victoria University of Wellington), Rhiannon Latham (Queensland Department of Education), Antonina Loncarevic (CliniKids, Telethon Kids Institute), Meghan McAnany (Griffith University), Claire Perrozzi (CliniKids, Telethon Kids Institute), Amanda Porter (personal contribution) Shaun Ruigrok (personal contribution), and Carla Wallace-Watkin (Victoria University of Wellington). The day-to-day work of gathering evidence was primarily undertaken by six members of the GDG (Sarah Pillar, Rhylee Sulek, David Trembath, Kandice Varcin, Hannah Waddington and Andrew Whitehouse). The coding and analysis of data was undertaken by these same six members of the GDG, with support for qualitative data coding from five research assistants (Briohny Dempsey, Georgina Earl, Libby Groves, Emma Hinze, and Rachelle Wicks).

Step 4: Moving from evidence to recommendations

As presented in the Draft Guideline, and reproduced here, an iterative process, built around an Evidence to Decision (EtD) framework, was used to move from evidence to recommendations (Alonso-Coello, Oxman et al., 2016; Alonso-Coello, Schünemann, et al., 2016). The process was led within the GDG by a *Draft Recommendations Working Group* (DRWG; Sarah Pillar, Rhylee Sulek, David Trembath, Kandice Varcin, Hannah Waddington, and Andrew Whitehouse), and is summarised here.

Iteration 1: Practice statements

The DRWG developed a set of practice statements relating to each of the Guideline questions. The statements took the same form as those used in Round 1 of the Delphi survey, where practitioner consensus on these statements had already been reached.

The DRWG then independently reviewed these statements against the following sources of evidence:

- Evidence emerging from the scoping review of existing Guidelines, the umbrella review of existing research evidence, and the systematic review of children's and families' experience of accessing supports.
- Other relevant research (e.g., neurodiversity-affirming practice, other international reviews of research evidence).
- Conceptual and ethical frameworks (e.g., AIATSIS Code of Ethics for Aboriginal and Torres Strait Islander Research, 2020; International Classification of Functioning, Disability and Health, World Health Organisation, 2001).
- Regulations (e.g., National Disability Insurance Practice Standards Practice and Quality Indicators, 2021).
- Reports (e.g., Disability Royal Commission Interim Report, 2020).
- Conventions (e.g., United Nations Convention on the Rights of the Child, 1989).

During the independent review, each member made a list of suggested edits (additions, deletions, amendments) which were then raised and resolved at a meeting of the DRWG. The first iteration of the statements was shared with the broader GDG, discussed at the monthly meeting, and suggested edits documented.

Iteration 2: Draft recommendations

The DRWG incorporated the feedback from the broader GDG and revised the statements into a set of preliminary recommendations, supported by evidence tables. To do this, the DRWG members independently reviewed the statements against the complete set of evidence from the community Consultation process, which included the:

- Online community survey.

- Brief online survey.
- Focus groups.
- Parent reflections.
- Delphi survey Round 2.

Each member made a list of suggested edits (additions, deletions, amendments) which were then raised and resolved at a meeting of the DRWG. The DRWG also compiled evidence summary tables that were shared with the GDG, alongside the draft recommendations. The GDG provided feedback at the monthly meeting and via suggestions in shared documents, which were subsequently incorporated. Implicit in this process was the fact that not all evidence collected during the research activities converged in such a way as to warrant a recommendation or good practice point. For example, the Umbrella Review (Chapter 5) included collection of evidence regarding the impact of supports on children's autism characteristics, including efforts in some studies to reduce these. Although evidence of these effects was found, there were multiple converging sources of evidence indicating that attempts to reduce autism characteristics is not an appropriate goal (supports should focus on helping children acquire functional and individually meaningful skills), hence this evidence from the umbrella review does not feature in Recommendations or associated Good Practice Points. Accordingly, not all findings from the research activities presented in subsequent chapters feature in the evidence summaries that underpin the Recommendations and Good Practice Points.

Iteration 3: Strength of Recommendation judgments

In the third iteration, the DRWG further revised the recommendation statements, with a focus on creating plain language wording to the extent possible. The DRWG also independently completed a review and judgement of each Recommendation against the seven criteria required within the GRADE Evidence to Decision (EtD) framework (Alonso-Coello, Oxman et al., 2016; Alonso-Coello, Schünemann, et al., 2016). The judgements related to certainty of evidence, benefits and risks, values and preferences, resource implications, equity considerations, acceptability, and feasibility. The judgements occurred over three rounds, with the first involving independent review, followed by two rounds of consensus review.

Based on the judgements, each Recommendation was then classified as either a 'strong' Recommendation or a 'conditional' Recommendation, as per the GRADE process and reflecting the confidence in the clarity of the balance between desirable and undesirable consequences. In the case of this Guideline, 'conditional' Recommendations indicated: uncertainty around alignment with values and preferences of children and families; a possible reduction in health equity; uncertainty around the acceptability of the Recommendation for practitioners; and/or a possible lack of feasibility in implementation. The classifications reflect the judgements of the GDG, based on the available evidence and other relevant considerations such as alignment with international conventions. The complete set of judgements is provided in the Supporting Evidence document.

Iteration 4: Draft Guideline

The DRWG prepared the Draft Guideline and shared it with the GDG, alongside the complete set of evidence summaries and Evidence to Decision (EtD) judgements. These documents were reviewed and then discussed by members at a meeting of the GDG. The GDG endorsed the documents, subject to further minor edits and formatting.

Step 5: Community consultation on Draft Guideline

The GDG prepared the Draft Guideline and supporting documents (Summary of Evidence, Administration and Technical Report) for public consultation, which opened on 18th July 2022 and will close on 29th August 2022 (a 6 week period).

Public consultation activities

The following activities were undertaken ahead of the public consultation period:

- Autism CRC has maintained a webpage devoted the Guideline development, and this was updated to reflect the upcoming consultation period and invitation to participate.
- The GDG announced the upcoming public consultation period, via email distributed to people who had registered specifically for updates on the Guideline, as well as people who were on the Autism CRC communications database more broadly. Further announcements were made via Autism SRC social media, and then re-posted by GDG members.
- Autism CRC hosted a 1-hour free online community webinar, presented by the GDG Co-chairs, to share the purpose, rationale, scope, and methodology employed in developing the Draft Guideline as well as information on how to engage in the public consultation. All people who registered to attend the webinar were sent a link to the recording which was also posted on the Autism CRC website.
- A Co-chair of the Guideline Development Group emailed the office of the Director General, Chief Executive or Secretary of each state, territory and Commonwealth Health Department to prepare those offices for the publication of the Draft Guideline on 18th July 2022. These offices were then directly emailed the Draft Guideline on the 18th July 2022.

The following activities were undertaken during the public consultation period:

- The Autism CRC webpage was updated to include:
- A video explaining the public consultation process, and how people can participate.
- Direct links to the Draft Guideline, Summary of Evidence, and Administration and Technical Report.
- A link to participate in an online feedback survey, via REDCap hosted by Griffith University.
- Autism CRC announced the opening and closing of the public consultation period via email and social media.

- Autism CRC send reminders inviting participation throughout the public consultation period.

Feedback survey

Public consultation feedback was collected via the custom online survey, developed by the GDG and delivered via REDCap (Griffith University). The survey comprised three sections, commencing with participant information and consent, followed by an opportunity to provide general feedback on the guideline sections, and then the option to provide specific feedback on one or more Recommendations and associated Good Practice Points. Participants were able to choose the number of questions they answered and the level of detail provided. Furthermore, participants were able to choose whether to provide feedback as an individual, or on behalf of an organisation.

Step 6: Analysing Feedback and Review

Analysing feedback from Public Consultation

All feedback will be (a) considered by the GDG, (b) shared with the NHMRC to support their evaluation of the Guideline, and (c) made publicly available at the time the Guideline is released

Independent review (AGREE-II)

The Draft Guideline will be reviewed by two independent researchers with experience with the Appraisal of Guidelines for Research & Evaluation Instrument (AGREE-II) checklist: Dr Bahareh Afsharnejad (Curtin University) and Dr Kiah Evans (University of Western Australia. The reviewers will provide their AGREE-II ratings to the Guideline Development Group, who will then discuss these ratings at a meeting with the Co-chairs.

NHMRC reviews

The NHMRC will coordinate two further rounds of independent evaluation, by seeking review from (a) Guideline methodological experts, and (b) content experts.

Final revisions

The GDG will use all information gathered from the analysis of the public consultation feedback and independent and NHMRC reviews to make revisions where appropriate. All changes will be documented and presented in summarised form in the final version of the Administration and Technical Report. The Guideline and all associated documents will be endorsed by the GDG prior to public release.

3.5 Recommendations and Good Practice Points

The Evidence to Decision (EtD) process resulted in a set of Recommendations and Good Practice Points, which were formulated and presented in a way that met the following requirements:

Consensus-based Recommendations

Using the GRADE methodology, recommendations may be described as *evidence-based* or *consensus-based.* Evidence-based recommendations are typically based on evidence derived from one or more systematic reviews containing meta-analyses of empirical data, that are relevant to one or more clinical questions presented using the PICO format. Consensus-based recommendations are typically based on sources of evidence, other than those described for evidence-based recommendations, such as through non-systematic reviews, evidence derived through consensus-based processes (e.g., Delphi studies), and qualitative data pertaining to relevant stakeholders' views and experiences.

For this Guideline, the GDG was unanimous in endorsing the formulation of consensus-based recommendations, for the following reasons explained in Section 3.4:

- The questions that are most relevant to professional practice rarely align with the PICO format.
- There is a lack of empirical evidence on which to make judgements, even if the PICO format was deemed appropriate.
- The GDG determined that it was critical to gather evidence from all relevant stakeholders across the autistic and autism communities, including autistic children, their families, and practitioners to ensure the Recommendations are relevant, acceptable, and feasible.

All Recommendations are clearly labelled as Consensus-Based Recommendations.

Recommendations are defined as "*Key elements of practice that must be followed for a practitioner to deliver evidence-based supports*."

Good Practice Points were linked to specific Recommendations and defined as *"Elements of practice that provide critical context to that Recommendation, such as how a Recommendation should be operationalised in clinical practice, or how it is applied to a specific population or under specific circumstances."*

Language used in formulating Recommendations and Good Practice Points

In drafting the Recommendations and Good Practice Points, the GDG adhered to the following three requirements:

1. The wording must be in plain English, specific, unambiguous, employ consistent terminology, and accessible to parents and practitioners.
2. The wording must convey one or more specific actions that practitioners should take.
3. The wording must reflect the evidence on which the Recommendation or Good Practice Point, in terms of both strength and precision.

4. Scoping Review: Existing Guidelines

4.1 Background

Clinical practice guidelines relating to the provision of non-pharmacological supports for autistic children have been developed around the world. Existing international guidelines contain a variety of guiding principles and recommendations aligned to the international context in which they were developed. Understanding the breadth of principles and recommendations published within existing international guidelines supported the development process of the current Guideline.

Evidence was used, in combination with other sources, to identify a set of principles and practices that were then considered in the design of research activities. Note that evidence was not used to formulate recommendations, to avoid the risk of circular reasoning, whereby a recommendation in one guideline could be used to justify a recommendation in a later guideline

4.2 Aim

The aim of this scoping review was to explore and map key themes across the principles and recommendations published within existing international guidelines. Principles and recommendations were mapped according to a framework to support comparison across existing guidelines, and to ensure that a broad scope of existing considerations and themes relevant to a given area was able to be reviewed during the development of the current Guideline.

4.3 Research question

What are the principles and recommendations within existing international clinical guidelines for support provision for autistic children (0-12 years)?

4.4 Design

A systematic literature search and qualitative review using a framework approach (Gale et al., 2013) was selected as the most appropriate method for addressing the research aim and answering the research question.

4.5 Method

Eligibility

Guidelines were included in the review if they met the following criteria:

- The clinical practice guideline's primary focus was autistic individuals.
- The clinical practice guideline included recommendations for children aged between 0 and 12 years. Clinical practice guidelines that made recommendations for older

individuals were included if the recommendations also included children between 0 and 12 years.

- The clinical practice guideline made recommendations primarily for non-pharmacological supports.
- The clinical practice guideline had been developed for use across more than one of the professional target user groups identified by the current guideline.
- The clinical practice guideline was linked with a state body/government authority and not solely the publication of a private company (e.g., health insurance company).
- The clinical practice guideline had full-text copies available in English.
- The clinical practice guideline was published since 2010.

Existing clinical practice guidelines were excluded if they met any of the following exclusion criteria:

- The clinical practice guideline did not include children under 12.
- The clinical practice guideline primary focus was to provide guidance related to the diagnosis of autism or use of pharmacological supports.
- The full-text was not available, or not available in English.
- The clinical practice guideline had been superseded by an updated version from the same jurisdiction.
- The clinical practice guideline was published prior to 2010.

Literature search strategy

A literature search was conducted on the 17th of December using the following databases: Embase, PsycINFO, Education Resources Information Centre (ERIC), Medline, PubMed, CINAHL, Scopus, EBSCO Education Source, Web of Science Core Collection, Epistemonikos and Google Scholar. Variants and combinations of search terms relating to autism (Autis* OR ASD* OR Asperger*) clinical support (interven* OR therap* OR treat* OR manage* OR support* OR practice*) and guidelines (guide* OR “practice parameter”) were used.

Filters: 2010-2022; Language: English

The reference lists of documents were scrutinised to identify additional relevant existing international guidelines not identified during the database searches.

Guideline selection

All documents retrieved from the searches were imported into EndNote reference management software. Duplicates identified by the software were removed prior to screening. Titles and introduction, purpose and scope of the documents were screened against the inclusion/exclusion criteria by one reviewer (SP). Documents were excluded if they met one or more exclusion criteria. Eligible existing guidelines were not reviewed for quality of development process.

Data extraction and coding of included study data

One reviewer (SP) extracted key guideline details (including title, jurisdiction, year, stated purpose) for each of the included guidelines into a table (see Table 4.1). Included guidelines were imported into the NVivo Software Platform for coding of study results. A coding framework (Gale et al., 2013) was developed and used to code recommendations (see Table 4.2). The framework was developed by six members of the GDG (Sarah Pillar, Rhylee Sulek, David Trembath, Kandice Varcin, Hannah Waddington, and Andrew Whitehouse) based on consideration of:

- Evidence from the existing Guidelines, a previously conducted umbrella review of existing research evidence (Whitehouse et al., 2020).
- Other relevant research (e.g., neurodiversity-affirming practice, other international reviews of research evidence).
- Conceptual and ethical frameworks (e.g., AIATSIS Code of Ethics for Aboriginal and Torres Strait Islander Research, 2020; International Classification of Functioning, Disability and Health, World Health Organisation, 2001).
- Regulations (e.g., National Disability Insurance Practice Standards Practice and Quality Indicators, 2021).
- Reports (e.g., Interim Report of Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 2020).
- Conventions (e.g., United Nations Convention on the Rights of Persons with Disabilities, 2006; United Nations Convention on the Rights of the Child, 1989).

4.6 Results

Guideline Characteristics

A total of 14 guidelines were eligible for inclusion. Table 4.1 presents a summary of the included guidelines. The references for these Guidelines are provided in Appendix 4.1.

Table 4.1. Included guidelines.

	Title	Year	Jurisdiction	Stated Purpose
01	Management of autism in children and young people: A good clinical practice guideline	2014	Belgium	"… provides recommendations based on current scientific evidence for treatment and support of children and adolescents with autism and their family."
02	Autism spectrum disorders in pre-school children: AMS-MOH clinical practice guidelines	2010	Singapore	"… to assist practitioners who are involved in any of the following: surveillance, screening and early identification, referral for assessment, diagnosis and intervention of children with ASD."
03	Autism spectrum disorder: Evidence-based / evidence informed good practice for supports provided to preschool children, their families and carers	2016	Australia	"… to assist with making decisions about the delivery of services to preschool children with autism, and their families and other carers."
04	Assessment, diagnosis and interventions for autism spectrum disorders: A national clinical guideline	2016	Scotland, UK	"… provides recommendations based on current evidence for best practice in the assessment, diagnosis and interventions for children, young people, adults and older adults with ASD."
05	People with autism spectrum disorder: Identification, understanding, intervention	2019	Europe	"… offers guidance on various key aspects from diagnosis to life-long support in view of promoting an evidence based and right-based approach to autism …"
06	Clinical practice guideline on assessment and intervention services for young children with autism spectrum disorders (ASD): 2017 update report of recommendations.	2017	New York state, USA	"… a tool to help assure that infants and young children with disabilities receive early intervention services consistent with their individual needs, resources, priorities, and the concerns of their families."

07	New Zealand autism spectrum disorder guideline	2016	New Zealand	"... to provide guidance on autism spectrum disorder (ASD) in both children and adults in New Zealand."
08	Autism: the NICE guideline on the management and support of children and young people on the autism spectrum	2021	United Kingdom	"... to advise on the management and support of children and young people on the autism spectrum."
09	Autism spectrum disorders: Guide to evidence-based interventions	2012	Missouri state, USA	"... provides information and tools to support individuals with ASDs and their families and to assist healthcare professionals, educators, and other community-based service providers in making informed decisions about selection, implementation, and monitoring of ASD interventions."
10	National Clinical Guideline: The diagnosis and Management of Autism Spectrum Disorder	2019	Qatar	".. to define the appropriate diagnosis and management of Autism Spectrum Disorder (ASD) in children and adults."
11	Clinical practice guidelines: management of autism spectrum disorder in children and adolescents	2014	Malaysia	"... to be a guide for clinical practice, based on the best available evidence at the time of development."
12	Clinical practice guidelines for autism spectrum disorders	2019	India	Nil
13	Autism guidebook for Washington State: A resource for individuals, families and professionals	2016	Washington state, USA	"... to serve as an informational tool to assist in the navigation of available treatments and services, and to understand the language and issues currently related to ASD."
14	Dubai clinical practice guidelines for autism spectrum disorder (ASD) in children and adolescents	2021	Dubai	"...to address the gaps in the fragmented service, encourage evidence based practices and stop the non-evidence based and potentially harmful practices"

Qualitative data

Table 4.2 presents a summary of the codes, number of guidelines for which each code was relevant, and the number of references (i.e., separate quotes included in analysis).

Table 4.2. Coding framework and summary of synthesis.

Coding Framework		**Outcome**	
Context	Question	Number of Guidelines	References
Principles	What guiding principles should be followed when providing supports to autistic children and their families?	12	246
Goal setting	What are appropriate goals for children and families?	14	246
	How should goals be selected?	11	77
Selection and planning	What types of supports might be relevant to children and families?	14	472
	How should these supports be selected?	14	383
	What skills and knowledge are required to plan supports?	13	134
Delivery	Who should deliver supports?	14	162
	In what settings should supports be delivered?	13	99
	In what formats/modes should supports be delivered	14	182
	In what amount should supports be delivered?	12	46
	What are the critical service interfaces for children and families?	8	16
Outcomes, quality, and safeguards	How should the effects of supports be monitored?	13	110
	How can the risk of adverse effects be reduced?	12	32
	How should adverse effects be managed?	5	6
	How should the rights of children and families be protected?	11	87

5. Umbrella Review: Effects of non-pharmacological supports on child and family outcomes

5.1 Background

A synthesis of existing research evidence is critical to the development of any guideline. This evidence can be used to inform the recommendations themselves and to help in determining the strength of those recommendations (NHMRC, 2016). This was an update of the umbrella review conducted as part of the Autism CRC project entitled *Supports for Autistic children: A Synthesis of Research Evidence* (Whitehouse et al., 2020). The process described here relates to the original update, for which the search was conducted in November, 2021. This update should be repeated at regular intervals to ensure that the umbrella review continues to contain the best available evidence.

5.2 Aim

The aims of this umbrella review were to synthesise data from existing systematic reviews regarding: (a) the effects of different non-pharmacological supports on a range of child and family outcomes, (b) any associations between the way in which a support was delivered (e.g., amount of support, the support setting) and the effects of those supports, and (c) any associations between child characteristics and the effects of those supports.

5.3 Research questions

This umbrella review aimed to answer the following research questions:

- Question 1: What non-pharmacological supports have been examined in SRs?
- Question 2: What effects do non-pharmacological supports have on child outcomes?
- Question 3: What effects do non-pharmacological supports have on family wellbeing?
- Question 4: What delivery characteristics influence the effects of supports, with a focus on the amount of support, setting, format, agent (person delivering the support), and mode?
- Question 5: What child characteristics influence the effects of supports, with a focus on child age, core autism characteristics, cognition, and communication skills?

5.4 Design

This project was an umbrella review, which involved systematically searching for, and selecting, relevant systematic reviews, then synthesising and presenting data from those reviews. The original and updated umbrella reviews were conducted in accordance with the procedures outlined in the Joanna Briggs Institute manual for evidence synthesis

(Aromataris et al., 2020) and the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement (Page et al., 2021).

5.5 Method

The protocol for the original synthesis of research evidence was published on Open Science Framework on July 8th 2020 (https://osf.io/54vg8/).

Eligibility

Systematic reviews (SRs) were included in the umbrella review if they met all the following criteria:

- The SR was a meta-analysis or a narrative synthesis (an SR without a meta-analysis). A review was considered "systematic" if it: (1) included a clear statement of the purpose of the review; (2) described the search strategy (e.g., key search terms, multiple relevant databases, specification of search limits); (3) indicated the criteria used to select studies for inclusion; (4) presented all findings relevant to the main purpose of the SR, including those that did not favour the support; and (5) used a method of quality appraisal for each included study.
- The SR included autistic children. SRs that included children described as increased likelihood of autism were included if the SR also included autistic children. SRs that included autistic children and individuals with other developmental conditions were included if outcomes were reported separately for autistic children.
- The SR included children aged between 0 and 12 years. SRs that encompassed older individuals were included if outcomes were reported separately for children 18 years of age or younger.
- The SR reported on at least one non-pharmacological support that targeted the acquisition of developmental or educational skills.
- The SR provided the names of all included practices and categories of support.
- The SR included at least one RCT, quasi-RCT, and/or controlled clinical trial. SRs that included studies with other designs were included only if they also featured at least one RCT, quasi-RCT, and/or controlled clinical trial.
- There was no limit placed on comparison/control group.
- The SR reported summarised, quantitative data on the impact of the support on one or more of the umbrella review's main outcomes of interest. These outcomes, defined in Appendix 5.1 were:
    - Communication, including overall communication, social-communication, expressive language, and receptive language.
    - Sensory development
    - Cognitive development
    - Social-emotional development

  - Motor development
  - Academic skills
  - School/learning readiness
  - Daily activities and participation, including adaptive behaviour, play, and participation, and general outcomes.
  - Overall autism characteristics and restricted and repetitive interests and behaviours [note: This terminology reflects diagnostic criteria and usage in most research in this area]
  - General child outcomes.
  - Family wellbeing and satisfaction: Specifically, parent knowledge and skills, social-emotional wellbeing, financial wellbeing and satisfaction, and child quality of life and satisfaction.
  - Adverse child effects.
- The SR was published in a peer-reviewed journal or as a publicly available scientific report.
- The SR had full-text copies available in the English language.
- The final literature search was conducted in the last 10 years (2012-2021 in the case of the first update).
- SRs were excluded if they met any of the following exclusion criteria:
- The review did not meet the criteria to be considered “systematic”.
- It was an umbrella review, rapid review, scoping review, or “review of reviews”.
- SRs that report on supports with children with developmental conditions other than autism, or where outcomes for autistic children could not be extracted; and those that only included children described as increased likelihood of autism.
- The SR did not include children under 12 and/or included individuals over the age of 18 without separate analysis.
- The SR did not include at least one RCT, quasi-RCT, and/or controlled clinical trial.
- The SR did not report on at least one non-pharmacological support that targeted the acquisition of developmental or educational skills.
- The SR did not provide the names of all included practices and categories of support.
- The SR focussed solely on biological-based therapies such as dietary, sleep, exercise, chiropractic, massage, acupuncture, reflexology, kinesiology, shock therapy, neurofeedback, transcranial magnetic stimulation, hyperbaric oxygen therapy supports; or supports targeting access to or participation in healthcare. While non-pharmacological, these supports were beyond the scope of the umbrella review.

- The SR focused solely on techniques (defined as one specific strategy) and did not include at least one relevant support (i.e., a collection of techniques).
- The SR did not focus on delivery characteristics (i.e., setting, format, agent, or mode) and summarised outcomes across a range of practices across several different categories of support outlined in Sandbank (2020).
- The review summarised outcomes across a range of included and excluded practices.
- The SR did not report summarised outcomes of interest relevant to the current umbrella review- that is a statement of effect size(s) and confidence intervals and/or p-values for meta-analyses, or an in-text statement specifying the number of studies (k >1) evaluating an outcome of interest and the number or percentage of studies that reported positive, negative, and/or null effects for that outcome.
- The SR incorporated theoretical studies, text, and opinion as their primary source of evidence.
- The SR was limited by geographical region, that is, the search and/or inclusion/exclusion criteria were limited to specific countries, continents, or other geographical areas.
- The SR was a thesis, conference paper, newsletter, or protocol.
- The full-text was not available, or not available in English.
- The SR had been superseded by an updated version of the same review (completed after full-text review of all SRs for all other eligibility criteria)
- The review was a scholarly article corresponding to an existing report (completed after full-text review of all SRs for all other eligibility criteria)
- The final literature search was not conducted the last 10 years (i.e., it was conducted before 2012 in the case of the first update)

Literature search strategy

An updated literature search was conducted on November 19th, 2021 using the following databases: PsycINFO, Education Resources Information Centre (ERIC), Medline, PubMed, EMBASE, CINAHL, Cochrane Database of Systematic Reviews, Scopus, EBSCO Education Source, and Epistemonikos. The search terms were: (Autis* OR ASD* OR Asperger* OR pervasive developmental disorder* OR PDD* OR pervasive child development disorder* OR pervasive childhood developmental disorder* OR PCDD* OR disintegrative disorder*) AND (intervention* OR therap* OR treat* OR teach* OR program* OR package*) AND (systematic review* OR systematic literature review* OR evidence synthes* OR meta-analy* OR meta-regression*). The full search strategy for each database is provided in Appendix 5.2. The updated search was limited to SRs published from July 2020, as this was the search end date in the initial umbrella review. Articles from the initial umbrella review that were published in 2010 or 2011 were also excluded because they no longer met the 10-year cut-off. Ancestral searches were conducted using the reference lists of all included SRs and relevant umbrella reviews or ‘reviews of reviews’ identified by the updated database search.

Study selection

All studies retrieved from the updated database searches were imported into the Covidence software platform. Duplicates identified by the software were removed prior to screening. Two reviewers (HW, KV) independently screened the titles and abstracts of the studies against the inclusion/exclusion criteria. Articles were excluded if they met one or more exclusion criteria.

To determine whether supports fell within the scope outlined by Sandbank et al. (2020), the two reviewers referred to a guiding document from the original synthesis of research evidence, which was created based on consensus across four reviewers (Whitehouse et al., 2020; see Appendix 5.3). When a SR identified in the title and abstract screening included a support not covered by this document, the two reviewers (HW + KV) independently determined whether it should be included based on the eligibility criteria. The two reviewers then met to discuss each question of eligibility regarding these new supports and resolved these via consensus.

Next, the two reviewers (HW, KV) independently screened the full-text reports of all potentially relevant articles according to the eligibility criteria. Where the design/s of included studies were not clearly specified, reviewers examined the SR reference list to determine if at least one study with an RCT, quasi-RCT, or controlled cohort design was included. Once the authors had finished individually screening all full-text reports they also excluded any SRs which had (a) been superseded by an updated version of the same review or (b) were scholarly articles corresponding to an existing report.

Following both independent title/abstract screening and independent full-text screening, the two reviewers (HW, KV) discussed and resolved any discrepancies. If an agreement could not be reached, another team member (AW and/or DT) was consulted. The percentage of agreement [agreements/(disagreements + agreements) × 100] was 96.7% for updated title/abstract screening and 81.5% for the updated full-text screening.

One reviewer (HW or KV) also independently determined whether each of the 58 studies included in the original umbrella review met all updated criteria and a second reviewer checked these determinations. Disagreements were resolved via consensus and, where necessary, a third reviewer was consulted (AW and/or DT). Agreement was not calculated on this step.

Data extraction

Data extraction for all included SRs

One reviewer (HW) extracted data for each of the included SRs using a standardised data extraction form (Appendix 5.4). This process had already been completed for those SRs included in the original research synthesis. The reviewers practiced extraction for one SR together and then were randomly assigned to extract data from the remaining SRs using a random list generator. First, data were extracted from the overall SR (SR-level extraction).

For those SRs identified in the updated search, data extraction included: (a) the type of SR, (b) the objectives of the SR, (c) the number of studies included, (d) the design of included studies, (e) the quality of included studies including the assessment tool used, (f) sources of funding and conflicts of interest, (g) location of the included studies, and (h) the characteristics of included participants, interventions/supports, comparison groups, and outcomes (PICO characteristics).

The second stage, outcome level extraction, involved extraction of data related to the effects of supports for each individual practice or category of support included in the SRs and primarily involved two reviewers (KV, HW). Again, this process had been completed for those SRs included in the original research synthesis. The authors practiced extraction for one narrative synthesis and one meta-analysis and were then randomly assigned the remaining articles. The data extracted at this stage included: (a) the name of the practice or category of support (b) the delivery setting (e.g., clinic, home, school), format (individual, group), agent (e.g., clinicians/researchers, parents/caregivers, peers/siblings), and mode (e.g. face-to-face, telepractice), (d) the effect of supports including effect sizes, confidence intervals, and heterogeneity statistics from meta-analyses, and verbatim summaries of effects from narrative syntheses (e) the direction of the effects of supports, and (f) any examination of the influence of amount of support, child characteristics, and delivery characteristics on the effect of supports for the predefined characteristics and outcomes of interest. Information from each SR that was included in summary tables was indicated in bold (see section below titled *Selection of effects for the summary tables*).

A second reviewer (KV or KV) independently extracted information for a randomly selected 18% of SRs. For the remaining 82% of SRs, a second reviewer cross-checked the first reviewer's extraction against the original article. Disagreements were identified and resolved via consensus and, where necessary, a third reviewer (AW/DT) was consulted. For SR level extraction, the percentage of agreement was 89.8% for data independently extracted by two reviewers and 92.8% for the cross-checks. For the outcome level extraction, the percentage of agreement was 78.5% for data independently extracted by two reviewers and 95.3% for the cross-checks.

Focus of SRs

SRs were divided the into three groupings. First, practice/category-focused reviews examined the effect of support within a defined practice/category on child and family outcomes. These SRs enabled determination of the effect of support within a given practice and/or category on child and family outcomes (Questions 2 and 3) to be readily synthesised. These SRs also provided insights into the potential influence of child and delivery characteristics on the effect of supports for a given practice/category (Questions 4 and 5).

Second, outcome-focused reviews examined the effect of supports, combined across practices/categories, on an outcome of interest (e.g., social-communication). For SRs with this focus, it was not possible to delineate the effect of one practice/category of support from another on any given outcome. However, these SRs provided insights into the potential influence of delivery characteristics (Question 4) and child characteristics (Question 5) on the effect of supports relating to a given outcome.

Third, delivery-focused reviews examined the effect of supports with specific delivery characteristics (e.g., setting, format, agent, mode), combined across practices/categories, on child and family outcomes. These SRs also prevented the delineation of the effect of different practices/categories on outcomes. However, these SRs provided insights into how differences in delivery (Question 4) and child characteristics (Question 5) may influence the effects of supports.

Coding of the effects of supports

A positive effect of support represented an increase in child skills/participation and family wellbeing and a reduction in certain autism characteristics. Data extraction for the effect of supports focused on recording one pooled (meta-analysis) or summary (for narrative synthesis) effect for each relevant outcome reported in each SR. Effects derived from between-group and within-group analyses were eligible for extraction, with between-group analyses (i.e., between at least one group receiving support and another group) prioritised where available. On occasions where meta-analyses reported more than one pooled effect for a specific outcome (e.g., main analyses and sensitivity analyses), we extracted the effect that was presented by the SR authors as the primary analysis.

For meta-analyses, findings were recorded as either a positive pooled effect (90/95% confidence intervals of the pooled effect did not overlap with the null), a negative pooled effect (90/95% confidence intervals of the pooled effect did not overlap with the null), or a null effect (90/95% confidence intervals of the pooled effect overlapped with the null). Where a SR did not include a meta-analysis, the recording of an effect of support focused on the summary provided by the SR authors in the Results section. Findings could be recorded as either a summarised positive effect (60% or more of studies reported a positive effect of support), a summarised negative effect (60% or more of studies reported a negative effect of support), a summarised null effect (60% or more of studies reported a null effect of support) or a summarised inconsistent effect (no direction of effect of support meeting a 60% threshold).

The influence of child and delivery characteristics on the effect of supports was summarised by coding the specific independent variable (child or delivery characteristic), the dependent variable(s) (child and family outcomes), and the nature of the influence on the effect of support (as reported by the SR authors, extracted verbatim).

Study quality assessment

Risk of Bias was assessed using the Critical Appraisal Checklist for Systematic Reviews and Research Syntheses (CACSRRS; Appendix 5.5) created by the Joanna Briggs Institute (2020). The form comprised 11 items related to the quality of: (a) the review question, (b) the inclusion criteria, (c) the sources and resources, (d) the criteria for appraising the studies, (e) agreement between raters on extraction and quality appraisal, (f) the methods used to combine studies, (g) the likelihood of publication bias, (h) recommendations for policy and/or practice, and (i) directives for new research. Each item was rated dichotomously, with "yes" indicating a low risk of bias for that item, and "no" indicating a high risk of bias for that item. The item regarding the likelihood of publication bias was rated for meta-analyses only and was rated 'not applicable' for all other SRs. SRs were not excluded based on methodological quality. A summary rating of 'high' was awarded for systematic reviews that met ≥80% of items using the CACSRRS. Systematic reviews that met fewer than 80% of items using the CACSRRS were rated as low. Risk of bias had already been rated for those SRs included in the original umbrella review. The quality of SRs identified in the updated search was independently rated by two reviewers (HW + KV). The percentage of agreement was 90.4%. Disagreements were resolved via consensus.

Selection of effects for the summary tables

The five summary tables provided synthesised information regarding:

- adverse effects
- the effects of specific practices/categories of support on child and family outcomes
- the influence of amount of support on child and family outcomes
- the influence of delivery characteristics (i.e., setting, format, agent, and mode) on child and family outcomes, and
- the influence of child characteristics (i.e., child age, core autism characteristics, cognition, and communication skills) on child and family outcomes.

Table 5.1 outlines the process for selecting information to be included in the summary tables. Information about adverse effects from all relevant SRs was included in the summary table. For each specific category/practice and child/family outcome, we included the relevant effect of support from the meta-analysis with the most recent search end date (referred to herein as the most recent meta-analysis). If there was no meta-analysis pertaining to this category/practice/delivery characteristic and outcome, we used the most recent relevant narrative synthesis. We presented data about influences on the effect of supports from the most recent meta-analysis for each influence type (amount, child characteristic or delivery characteristic), practice/category, and child outcome of interest. Narrative syntheses examining influences on the effects of supports were not included because they did not pool effects across studies.

Table 5.1. Information included in summary tables.

Summary table	Information included in table
Adverse effects	Adverse effects from all SRs which have examined this outcome.
The effects of each practice/category of support	The effect of specific practices/categories of support on each child and family outcome based on the most recent meta-analysis (or narrative synthesis if no relevant meta-analysis).
The influence of amount of support	The influence of amount of support on each child and family outcomes based on the most recent meta-analysis.

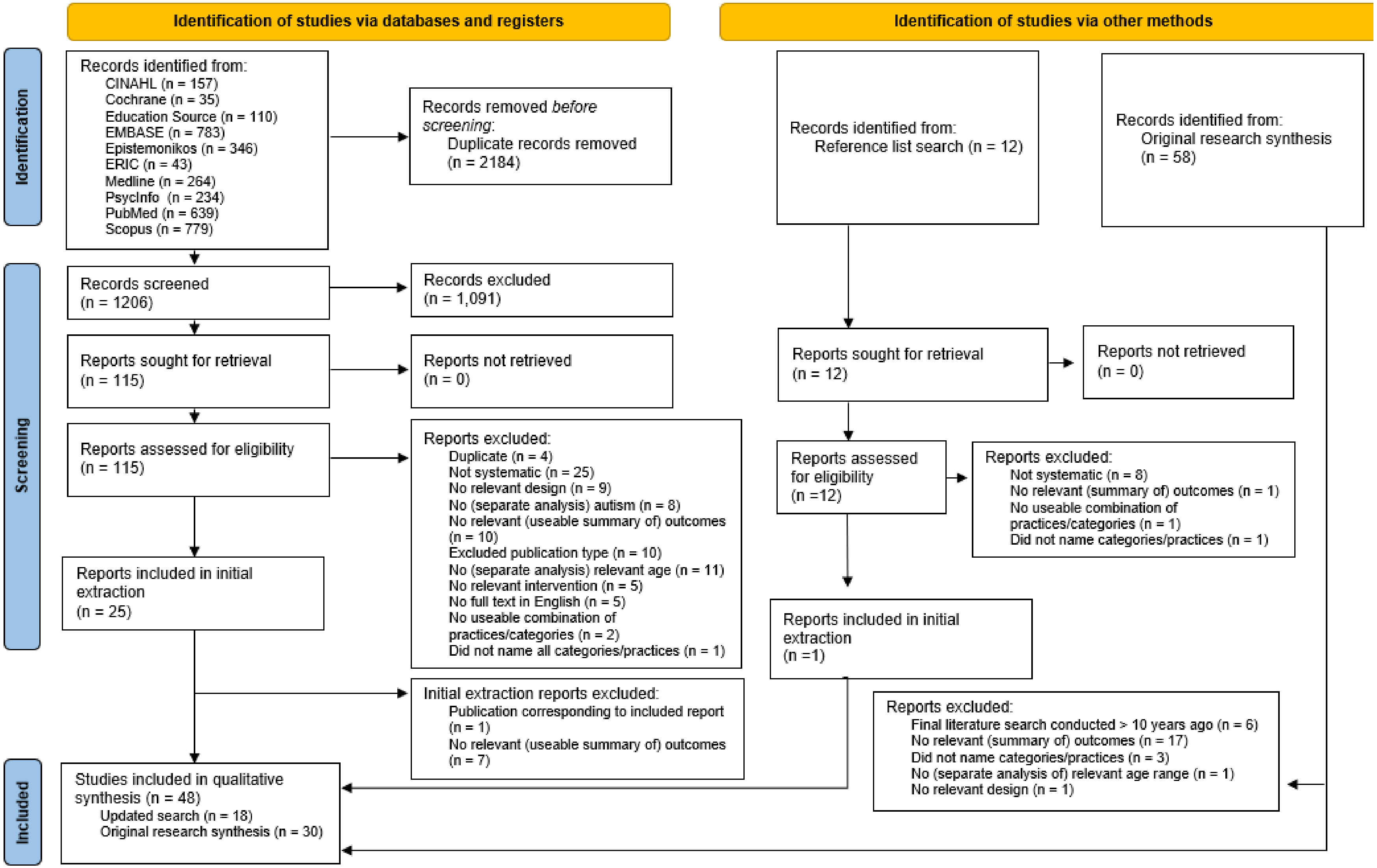
The influence of delivery characteristics (i.e., setting, format, agent, mode)	The influence of delivery characteristics on the effects of supports from the most recent meta-analysis for each delivery type, practice/category and child outcome of interest.
The influence of child characteristics (i.e., child age, core autism characteristics, cognition, and communication skills)	The influence of child characteristics on the effects of supports from the most recent meta-analysis for each characteristic type, practice/category and child outcome of interest.

5.6 Results

Study selection

The PRIMSA flow diagram in Figure 5.1 represents the study selection process (Page et al., 2021). The database search yielded 3,390 records across databases and 1,206 records once duplicates were automatically removed. One-hundred-and-fifteen articles proceeded to full-text review and 90 articles were excluded at this stage (see Appendix 5.6). The most common reasons for exclusion were (a) the review did not meet criteria to be considered systematic; (b) there was no separate summary for individuals ≤ 18 years and/or there were no individuals ≤ 12 years, (c) there was no relevant outcome or no useable summary of relevant outcomes, or (d) the publication was a thesis, conference paper, doctoral dissertation, or umbrella review. Ancestral searches yielded an additional 12 articles, of which 11 were excluded. During extraction, 8 additional articles were excluded, these were predominantly narrative syntheses that did not provide a summary that could be used to determine the effects of supports. That is, it was not possible to determine the overall number of studies evaluating an outcome and/or the number of studies that reported positive, negative, and/or null effects for this outcome. This resulted in the inclusion of 18 new SRs. Twenty-eight of the 58 SRs from the original research synthesis were excluded according to the updated exclusion criteria. The most common reasons for exclusion were (a) the absence of a relevant summary and (b) the SR was published > 10 years ago. The original SRs that were excluded are also listed in Appendix 5.6. Thus, a total of 48 SRs (18 from the updated search and 30 from the original umbrella review) were included in the qualitative synthesis. These are listed in Appendix 5.7.

Figure 5.1. PRISMA flow diagram



Study characteristics

Of the 48 SRs included in the umbrella review, 32 (67%) were meta-analyses, and 16 (33%) were narrative syntheses. The majority of SRs (n=35; 73%) were published between 2019 and 2022, with the remainder (n = 13, 27%) published between 2013 and 2018. The number of studies included in SRs ranged from 5 (Reichow et al., 2018) to 130 (Sandbank et al., 2020), with a median of 17. All but 1 SR (Sandbank et al., 2020) specified the final year of the search, and 37 (77%) of SRs mentioned the presence or absence (i.e., since database inception) of a starting year limit. Of these, 17 (46%) placed a limit on date, whereas 20 (54%) included all prior published research. The authors of 33 SRs (69%) provided information regarding sources of funding to conduct the SR and declarations of interest were reported in 41 SRs (85%). There were five (10%) instances in which authors identified a potential conflict of interest. A detailed outline of study characteristics is provided in Appendix 5.8.

Focus of reviews

There were 29 practice/category-focused SRs (60%; summarised in Appendix 5.9), 5 outcome-focused SRs (10%; summarised in Appendix 5.10), 13 delivery-focused SRs (27%; summarised in Appendix 5.11), and one SR that was both practice/category focused and delivery focused (Deb et al., 2020; summarised in Appendices 5.9 and 5.11).

Study designs

Eligibility criteria for the umbrella review stated that each SR must include at least one study with a controlled-group design (either an RCT, quasi-RCT, or controlled clinical trial). At least 43 SRs (90%) included at least one RCT, and 14 (29%) of these only included RCTs. At least 21 SRs (44%) included at least one non-randomised group design study with a control, 11 (23%) at least one non-randomised group design study without a control, 8 (17%) at least one single case experimental design, and 14 (29%) included other designs such as case studies, retrospective cohort studies, and qualitative studies.

Comparison groups

Only 29 SRs (60%) described the comparison group for each included study, while a further 10 SRs (21%) described the comparison group for a least one study. Of these, 26 SRs (67%) included one or more studies with a wait list control, 30 (78%) included at least one study with a treatment as usual control, and 35 (92%) included at least one study in which the comparison was another type of support.

Participants

Thirty-nine (81%) SRs provided details about the total number of participating individuals. Across these SRs, a total of 38,245 individuals were identified as participants, with SRs ranging from 66 participants (Hardy & Weston, 2020) to 6,240 participants (Sandbank et al., 2020). It was not possible to calculate the number of unique participants due to overlap between included SRs and non-specific reporting. Thirty-two SRs (71%) provided information about the age range of included children. Within these SRs, the youngest child was 11 months old and the oldest individual was 44 years old. Twenty-one SRs reported the mean age across studies or the range of mean ages, the youngest mean age was 2.5 years and the oldest was 18.8 years. Twenty-one SRs (44%) provided the mean percentage of participating males and females, or the range of percentages of males and females across studies. Within these SRs, the percentage of males was most commonly reported and ranged from 21 to 100%, while two studies reported on the percentage of females, which ranged from 15.4% to 19.5%,

There was inconsistent reporting of diagnostic information, although there was evidence of broad representation of autistic children. Authors used terms such as autistic disorder, autism, autism spectrum disorder, Asperger's disorder, high functioning autism, child disintegrative disorder, and pervasive developmental disorders not otherwise specified (PDD-NOS). Children with increased likelihood of being autistic, but no formal diagnosis, were identified as being included in only three (6% of) SRs. Only 26 SRs (54%) identified co-occurring diagnoses for one or more included individuals. In the majority of these SRs, it was not clear if all co-occurring conditions were identified or only particular cooccurring conditions of interest. The most common cooccurring condition, where identified, was cognitive impairment (17 SRs, 35%) followed by anxiety and attention deficit hyperactivity disorder (6 SRs each, 13%).

Study location

Twenty-six SRs (54%) provided information about the geographical locations at which the original studies had been conducted. Of these, all included studies conducted in North America (100%), with Europe (19 SRs, 73%), Australia (21 SRs, 81%), Asia (14 SRs, 54%), South America/Caribbean (3 SRs, 12%). No studies were reported to have been conducted in Africa or the Pacific.

Delivery characteristics

As outlined in Appendices 5.9-5.11 there was substantial variability in setting, agent, format, mode, and amount of support across SRs. Information about the support setting for at least one included study was specified in 32 SRs (67%). Homes were the most common support setting (26 SRs, 81%), followed by clinics (21 SRs, 66%) and educational settings (19 SRs, 59%). 'Other' settings were reported in 15 SRs (47%). These included non-specific 'natural contexts', community centres hospitals, and a theatre. The use of equine-assisted therapy implied delivery in a community setting although this was not specifically stated.

Thirty-five SRs specified the delivery agent for at least one included study. Of these, 31 SRs (89%) included parents and/or caregivers, 23 SRs (74%) included clinicians and/or researchers, 22 SRs (71%) included early childhood staff such as teachers or teaching assistants, and 6 SRs (19%) included peers and/or siblings. Riding instructors were involved in the delivery of equine-assisted supports and several SRs referred to non-specific personnel (e.g., support staff, assistants).

Forty-one SRs specified the delivery format of at least one included study. Of these, all but one (98%) included delivery of supports to individuals, with group-based supports reported in 23 SRs (56%). Further, 38 studies specified the delivery mode of at least one included study. Of these, 24 SRs (63%) included face-to-face delivery, while 7 SRs (28%) included telehealth delivery. Other deliver modes included technology such as video games, apps, online platforms/website, and DVDs, as well as written instructions and materials.

Only 5 SRs (10%) specified the range of amount of support reported in the included SRs. The lowest amount reported was 4 hours and the highest amount was 3276 hours. Two SRs specified the mean amount of support which was 10.8 and 566 hours respectively.

Risk of bias

The quality of SRs, assessed using a modified version of the Critical Appraisal Checklist for Systematic Reviews and Research Syntheses (Joanna Briggs Institute, 2020), yielded scores of 7 to 11 out of 11 (mode = 8) for meta-analyses, and 6 to 9 out of 10 (mode = 9) for narrative syntheses. Twenty-eight SRs were considered “high quality” because they met ≥ 80% of the items, and the remaining 20 were considered “low quality”. Only 5 SRs (10%; all meta-analyses) scored maximum points (Geretsegger et al., 2014; Oono et al., 2013; Reichow et al., 2018; Shi et al., 2021; Tachibana et al., 2018). A full summary of item scores and totals for each SR is provided in Appendix 5.12.

Common areas of strength (criterion met for ≥80% of SRs) were in the inclusion of a clear statement of the review question (Item 1), appropriate inclusion criteria (Item 2), clear search strategy (Item 3), the use of an appropriate critical appraisal tool (Item 5), recommendations for policy/practice (Item 10), and suggestions for future research (Item 11). Common areas of weakness (criterion met for < 80% of SRs) related to accessing appropriate sources including grey literature (Item 4), the use of independent reviewers to assess critical appraisal (Item 6), adoption of methods to minimise extraction errors (Item 7), and a lack of appropriate methods for combining study findings (Item 8). Of the 32 SRs (65%) that included a meta-analysis, 23 (72%) included an assessment of potential publication bias (Item 9).

The quality of studies included within SRs was assessed by the original review authors using a variety of tools (see Appendix 5.8). The most common of these were the original and revised Cochrane Collaboration tools for assessing risk of bias (Higgins et al., 2011; Sterne et al., 2019) followed by the Evaluative Method for Determining Evidence-Based Practice in Autism (Reichow et al., 2008). Twenty-four SRs (50%) were identified as including at least one study at high risk of bias, 5 (10%) as including at least one study with moderate risk of bias, and 2 (4%) as only including studies at low risk of bias. A determination regarding overall risk of bias for included original studies could not be made for 17 SRs (29%) due to insufficient data or the reporting of bias on an item-by-item level, rather than for each study overall.

Question 1: What non-pharmacological supports have been examined in SRs?

The range of non-pharmacological supports examined in the SRs is covered in Appendix 5.8.

Question 2: What effects do non-pharmacological supports have on child outcomes?

The effect of non-pharmacological supports on child outcomes is presented in Appendix 5.13. The effect sizes (for meta-analyses) and author statements (qualitative summaries) are provided in Appendix 5.14. Adverse child effects are presented in Appendix 5.15.

Question 3: What effects do non-pharmacological supports have on family wellbeing?

The effect of non-pharmacological supports on family outcomes is presented in Appendix 5.13. The effect sizes (for meta-analyses) and author statements (qualitative summaries) are provided in Appendix 5.14.

Question 4: What delivery characteristics influence the effects of supports, with a focus on the amount of support, setting, format, agent, and mode?

The influence of delivery characteristics on child outcomes is reported in Appendix 5.16, while the influence of amount of support on child outcomes is reported in Appendix 5.17.

Question 5: What child characteristics influence the effects of supports, with a focus on child age, core autism characteristics, cognition, and communication skills?

The relationship between child characteristics and child outcomes is reported in Appendix 5.18.

6. Systematic Review of Individual and Family Experiences of Accessing Services

6.1 Background

Understanding the experiences of autistic children and their families is a critical element of evidence-based practice. Accordingly, research that has examined these experiences may contribute evidence to inform the formulation of Guideline Recommendations. In this study, the GDG examined evidence from studies that explored the experiences of autistic children and their families who accessed supports in Australia, as part of community-based service provision. Prior to this systematic review, no similar review in the Australian context appears to have been conducted.

6.2 Aim

The aim of this systematic review was to identify and explore original research relating to the experiences of autistic individuals and their family members accessing supports and therapies during childhood.

6.3 Research question

What are the experiences of autistic individuals and their families in accessing therapies and supports during childhood?

6.4 Design

A systematic review was selected as the most appropriate method for addressing the research aim and questions. The review was conducted in accordance with the procedures outlined in the PRISMA statement (Page et al., 2021).

6.5 Method

Eligibility Criteria

Development of the eligibility criteria was an iterative process, with these stages described in detail below.

Stage 1

Both primary studies (peer-reviewed articles utilising either qualitative or quantitative methodologies) and published commentaries or viewpoints of the experiences of autistic individuals accessing or receiving therapies and supports were considered eligible for inclusion if:

- The article specified one or more aims (may be presented as a purpose, objective, aim, or research question) relating to examining the views, experiences, preferences, and/or perceptions of at least one child, and/or family member of at least one child, who accessed therapies and supports during childhood (0-12 years).
- The publication had an aim, objective, or research question which specifically examined the experiences of accessing therapies and supports, or an aspect of service delivery relating to accessing therapy and supports (e.g., planning, delivery) for:
    - Autistic children, or;
    - Parents/caregivers or family members (e.g., siblings, grandparents) of autistic children.
- The publication reports on experiences relevant to one of the guideline question areas (e.g., principles, goal setting).
- For qualitative or quantitative primary studies:
    - These must be published in a peer-reviewed journal.
- For viewpoint/commentary article:
    - These must be published in a peer-reviewed journal, and
    - Author/s must indicate within the article text that their experiences accessing therapies and supports, as an individual and/or parent/caregiver, informed the article.
- Publications reported on experiences accessing a non-pharmacological therapy or support. This could have been explicitly stated or inferred by consensus agreement between two members of the research team responsible for selecting the articles following the search. Evidence on which to make the inference may include reference to the goals, agents, settings, and/or outcomes of the therapies and supports described.
    - The publication reports on experiences during childhood. This can be retrospectively.
- The publication had a full-text copy available in the English language.

Studies were excluded if they met any of the following criteria:

- Publications which describe the experiences of children and families accessing complementary and alternative medicines and/or biologically-based.
- Articles for which the primary aim (may be presented as a purpose, objective, aim, or research question) is to evaluate the therapeutic effects of the therapy or support within a clinical trial.
- Experiences were examined in a thesis, conference abstracts, newsletter, or grey literature (e.g., blog posts, newsletters, websites).

Stage 2

Following initial searches, and in discussion with the Co-chairs of the GDG, a decision was made to further limit articles to those examining the experiences of autistic Australians and their families.

In line with above, the following inclusion criteria was added, with searches re-run to limit to Australian publications:

- The publication reports on experiences of Australian children and/or families. Where not explicitly stated, study authors will be contacted for confirmation, and where no response is received study location will be inferred by consensus agreement between two members of the research team. Evidence on which to make the inference will include the first authors research institute and/or the HREC which approved the study.

Stage 3

Following title and abstract screening by one author (RS), and in discussion with the working group, a decision was made to further refine the eligibility criteria to ensure that included studies were explicitly describing the experiences of autistic children, and their families, in accessing community-based therapies and supports.

Independent screening of the full text articles was then conducted (by RS) applying the following additional criteria.

- Publications must report experiences of autistic children, and their families, in accessing community-based (i.e., fee for service) therapies and supports. This could have been explicitly stated or inferred by consensus agreement between two members of the research team responsible for selecting the articles following the search.
- Publications will be excluded if therapies and supports were provided as part of a research study only (e.g., within a clinical trial or pilot study) rather than as part of community service provision.
- The final criteria applied to full-text evaluations is provided below.

Both primary studies (peer-reviewed articles utilising either qualitative or quantitative methodologies) and published commentaries or viewpoints of the experiences of autistic individuals accessing or receiving therapies and supports were considered eligible for inclusion if:

- The article specified one or more aims (may be presented as a purpose, objective, aim, or research question) relating to examining the views, experiences, preferences, and/or perceptions of at least one child, and/or family member of at least one child, who accessed therapies and supports during childhood (0-12 years).
- The publication had an aim, objective, or research question which specifically examined the experiences of accessing therapies and supports, or an aspect of

service delivery relating to accessing therapy and supports (e.g., planning, delivery) for:

- Autistic children, or;
- Parents/caregivers or family members (e.g., siblings, grandparents) of autistic children.
- The publication reports on experiences relevant to one of the guideline question areas (e.g., principles, goal setting).
- For qualitative or quantitative primary studies:
    - published in a peer-reviewed journal.
- For viewpoint/commentary article:
    - These must be published in a peer-reviewed journal, and
    - Author/s must indicate within the article text that their experiences accessing therapies and supports, as an individual and/or parent/caregiver, informed the article.
- Publications reported on experiences accessing a non-pharmacological therapy or support. This could have been explicitly stated or inferred by consensus agreement between two members of the research team responsible for selecting the articles following the search. Evidence on which to make the inference may include reference to the goals, agents, settings, and/or outcomes of the therapies and supports described.
- The publication reports on experiences during childhood. This can be retrospectively.
- The publication reports on experiences of Australian children or families.
    - Where not explicitly stated, study authors will be contacted for confirmation, and where no response is received study location will be inferred by consensus agreement between two members of the research team. Evidence on which to make the inference will include the first authors research institute and/or the HREC which approved the study.
- Publications must report experiences of autistic children, and their families, in accessing community-based (i.e., fee for service) therapies and supports. This could have been explicitly stated or inferred by consensus agreement between two members of the research team responsible for selecting the articles following the search.
- The publication had a full-text copy available in the English language

Studies were excluded if they met any of the following criteria:

- Publications which describe the experiences of children and families accessing complementary and alternative medicines and/or biologically-based.

- Articles for which the primary aim (may be presented as a purpose, objective, aim, or research question) is to evaluate the therapeutic effects of the therapy or support within a clinical trial.
- Publications will be excluded if therapies and supports were provided as part of a research study only (e.g., within a clinical trial or pilot study) rather than as part of community service provision.
- Experiences were examined in a thesis, conference abstracts, newsletter, or grey literature (e.g., blog posts, newsletters, websites).

Literature search strategy

A literature search was conducted on December 14th 2021 using the following databases: PsycINFO, Education Resources Information Centre (ERIC), Medline, PubMed, EMBASE, CINAHL, Scopus, EBSCO Education Source, and Epistemonikos. The search terms were: (Autism OR ASD OR Asperger OR Aspergers OR “pervasive developmental disorder” OR PDD OR “pervasive child development disorder” OR “pervasive childhood developmental disorder” OR PCDD OR “disintegrative disorder”) AND (intervention OR interventions OR therapy OR therapies OR treatment OR treatments OR teach OR program OR programs OR package OR packages) AND (experience OR feedback OR "social validity" OR view OR opinion OR acceptance OR satisfaction OR perception OR criticism) AND Australia*. The search was not limited by publication date. Ancestral searches were conducted using the reference lists of all included publications. The complete search string for each database is provided in Appendix 6.1.

Study selection

All studies retrieved from database searches were imported into the EndNote software platform. Duplicates identified by the software were removed prior to screening. Initial title and abstract screening (see Stage 2 above) of all identified studies was conducted by one reviewer (RS). Articles were excluded if they met one or more exclusion criteria. A second reviewer (DT) conducted consensus checks on all decisions made at this stage.

Full text screening was then conducted (by RS), against updated eligibility criteria (see Stage 3 above). Articles were excluded if they met one or more exclusion criteria. Consensus checks were then conducted by a second reviewer (DT). Following consensus checks, both reviewers met to resolve disagreements. The percentage of agreement [agreements/(disagreements + agreements) × 100] was 91.4% for the updated full-text consensus checks.

Data extraction and coding of included study data

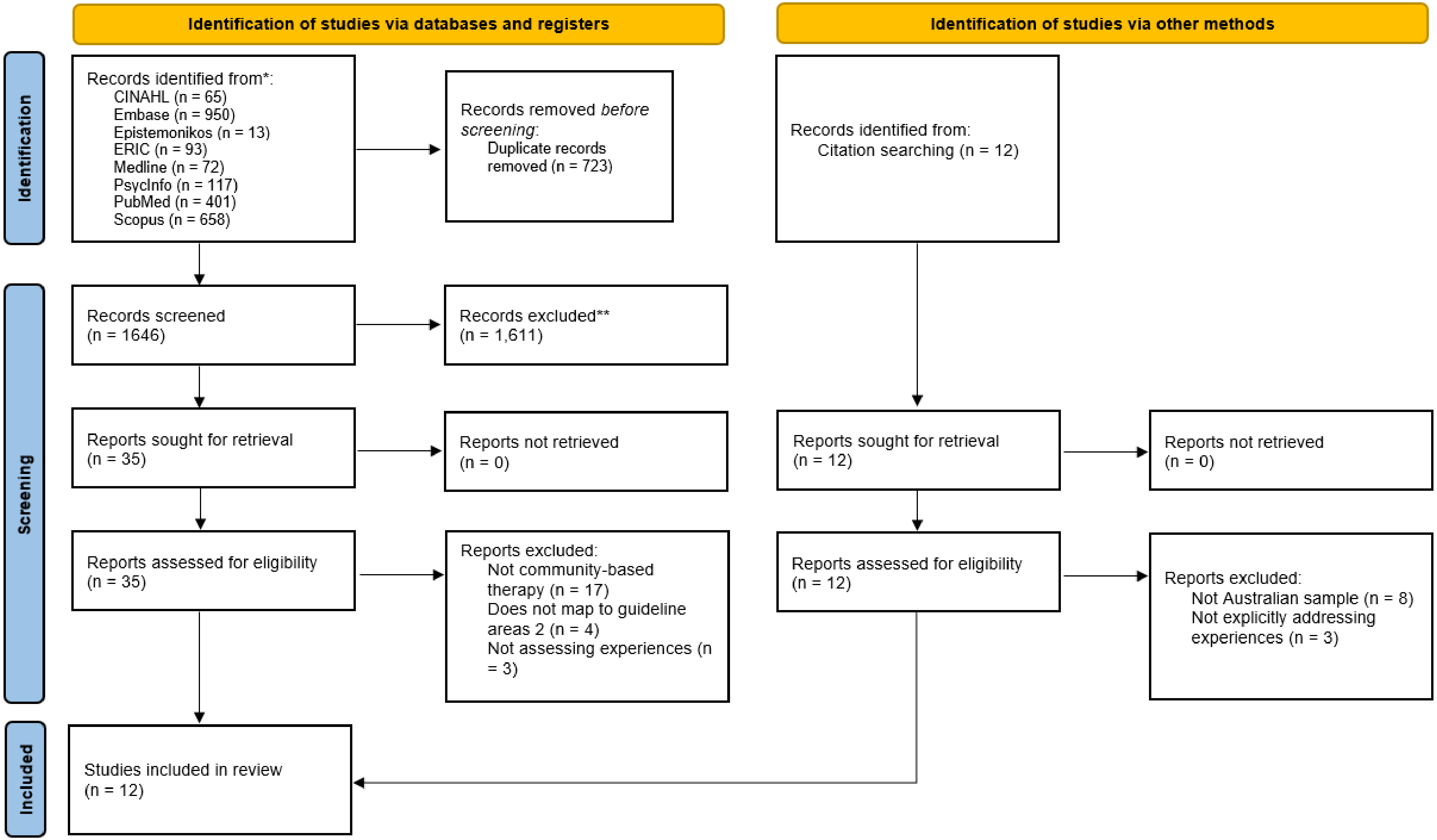
One reviewer (RS) extracted key study details (including author, date, study aim, design, participants, type of therapy and supports included, settings) for each of the included studies into a standardised data extraction form (Appendix 6.2). Following this, included studies were imported into the NVivo Software Platform for coding of study results. The same coding framework used for the systematic review of previous guidelines (Gale et al., 2013; see Chapter 4) was used to code the articles, according 17 underlying principles, with an option to code for ‘other’ when results did not fit an existing principle. To ensure participants quotes published in included qualitative studies were not taken out of context, only the study authors’ interpretations of data collected were coded for the purpose of this review.

6.6 Results

Study selection

The PRISMA diagram in Figure 6.1 outlines the study selection process (Page et al., 2021). The database search yielded 2,369 records across databases and 1,646 records once duplicates were removed. Thirty-five articles proceeded to full-text review and 24 articles were excluded at this stage. The most common reasons for exclusion were (a) therapies and supports were not accessed as part of community-based services (e.g., provided as part of RCT or pilot); (b) study aims did not map onto guideline question areas, (c) studies were concerned with child outcomes accessing therapies and supports, not overall experiences of engaging with these. Ancestral searches yielded an additional 12 articles, of which 11 were excluded.

Figure 6.1 PRISMA Flow Diagram



Study Characteristics

A total of 12 studies were eligible for inclusion. Appendix 6.3 presents a summary of study characteristics, including illustrative quotes related to codes within the coding framework.

Qualitative data

A total of 110 references were coded across the 12 studies. Table 6.1 presents the codes, the number of studies for which the code was relevant, and then number of references (i.e., quotes) that were extracted. These quotes, where relevant to the formulation of Recommendations and Good Practice Points, feature in the corresponding evidence summaries.

Table 6.1. Coding summary.

Codes	Number of Studies	References
Accessible	0	0
Affirming	3	5
Assent (children)	0	0
Child and family-centred	4	18
Coordinated	2	5
Culturally aware and responsive	0	0
Developmental Perspective	1	1
Empirically Supported	5	11
Equity	10	20
Ethical	0	0
Evidence-based approach	1	1
Holistic	6	9
Informed consent (parents)	1	2
Lifespan perspective	2	3
Other	4	8
Personalised	5	11
Qualified practitioners	4	11
Strengths-focused	0	0
Supported	3	5

7. Community Consultation: Online Survey

7.1 Background

Integral to the development of the Guideline was consultation with the autistic and autism communities. Consistent with the recommendations in the Guidelines for Guidelines handbook (NHMRC, 2016), community consultation was conducted to ensure that all relevant stakeholders within Australia were provided with the opportunity to inform the development of the Guideline. This was key to enhancing the relevance and acceptability of the Guideline to the autistic and autism communities. The consultation process was also conducted to (a) complement the current research evidence, and/or (b) gather information and insight from relevant stakeholders where research evidence is currently lacking.

This consultation activity adopted an online survey methodology. This approach was used to enable broad participation and input from all relevant stakeholders, aged 12 years or older, who identified as members of the autistic and/or autism communities.

7.2 Aim

The aim of the online survey was to understand the experiences, views and preferences of the autistic and autism communities regarding the provision of supports for autistic children and their families.

7.3 Research questions

- What are the experiences, views and preferences of the autistic and autism communities regarding the provision of supports for autistic children and their families?
- What are the autistic and autism communities' views on best practice for supporting autistic children and their families?

7.4 Design

An online survey methodology was adopted. This was a one-off survey, accessed via a link on the Autism CRC website. Participants had complete flexibility and autonomy in choosing what questions they would like to answer.

The survey was open to individuals aged 18 years and older for 10.5 weeks, from 16th February to 30th April 2022. After launching the online survey, we sought a variation to our study protocol to include individuals aged 12-17 years. As such, the online survey was open to young people aged 12-17 years for 3.5 weeks, from 6th April to 30th April 2022.

7.5 Method

Ethical approval for this community consultation activity was provided by Griffith University Human Research Ethics Committee (2021/843).

Eligibility

All relevant stakeholders aged 12 years and older, across the autistic and autism communities were eligible to participate in the online survey, including

- Autistic young people and adults
- Parents of autistic children
- Family members of autistic children
- Practitioners who provide services to autistic children and their families
- Members of organisations or services that provide support to autistic children and their families
- Any other relevant stakeholders (e.g., researchers, educators)

Recruitment

Participant recruitment for community consultation activities was predominantly facilitated by Autism CRC. Prior to the release of the consultation activities (including the online survey), Autism CRC invited members of their mailing list (*n*=8,432 representing autistic individuals, parents and family members, and practitioners/service providers working with autistic children and young people) to register their interest in receiving updates regarding development of the Guideline. All individuals who registered their interest in the Guideline received an initial invitation to participate, and subsequent reminders of the survey closing date over the >10-week consultation period. In addition, links to access the online survey were made available via the Autism CRC Supporting Children Guideline website page, and social media (Facebook and Twitter) accounts. Members of the GDG also promoted the online survey throughout their professional networks and social media pages.

After accessing the online survey link, prospective participants were presented with a short video outlining what participation in the survey would entail and highlighting accessibility features of the survey platform. Following this, participants were presented with a Participant Information Statement and Consent Form. All participants were required to provide informed consent before accessing the survey questions.

Tools

An iterative approach was taken to designing the online survey. The structure and items in the survey were predominantly informed by the set of questions developed by the GDG, underpinning all aspects of the Guideline's development related to supporting autistic children and their families. These questions cover five key areas of service provision: (1) overarching principles, (2) goal-setting, (3) selection and planning of supports, (4) delivery of supports, and (5) monitoring and safeguarding of supports. The items in the online survey were developed in conjunction with the Delphi survey (see Chapter 9) to ensure that all stakeholders had an opportunity to provide feedback on all areas intended to be covered in the Guideline.

A draft version of the online survey was circulated to the GDG for feedback. A revised version of the survey (incorporating GDG feedback) was coded in REDCap (a secure web-based application for survey development and distribution) and piloted by five individuals, independent and external to the GDG, who represented a variety of perspectives. These five individuals included two autistic adults, two parents of autistic children, and one practitioner. Feedback provided through the piloting process led to further modifications, including reducing the length of the survey and addressing perceived repetitiveness of some items.

Additional consultation was sought by the Working Group from a member of the GDG regarding the appropriateness and accessibility of the online survey for Aboriginal and/or Torres Strait Islander Peoples. Based on this consultation, additional changes were made to the survey, to allow more flexibility and a streamlined approach to completing the online survey.

The final survey (see Appendix 7.1 and Appendix 7.2) distributed to the community, consisted of both closed questions (that included quantitative and qualitative items) and open ended questions organised across several sections: (a) participant demographics, (b) the opportunity for autistic people and parents of autistic children to share their story of accessing supports, (c) general thoughts about the development of a guideline, (d) a survey of language preferences in relation to autism, and (e) questions gathering information on the five key Guideline areas, as outlined above.

Questions regarding language preferences were included in the survey to ensure an evidence-based approach to selecting terminology for use in the Guideline, supporting documents, and other resources and activities associated with the Guideline (e.g., community webinars). The GDG developed the questions and an *a priori* decision-making framework (Appendix 7.3) that would be used to make the determination. The decision-making framework was designed to ensure terminology selected was both desirable and acceptable to autistic people and parents of autistic children, while taking into consideration of all members of the broader autistic and autism communities.

Participants were provided with multiple pathways to navigate through the survey, including the capacity to skip sections and/or exit the survey at multiple points. The final survey was estimated to take between 15 to 60 minutes to complete depending on which questions participants chose to answer.

Analysis

Quantitative data

The online survey included 17 items that asked participants to rate their agreement with statements on a 5-point Likert-type scale: (1) strongly disagree, (2) disagree, (3) neutral, (4) agree, (5) strongly agree. These statements related to guiding principles should be followed when providing supports to autistic children and their families. For these items, data were exported from REDCap into SPSS (v26) for quantitative analysis. For each item, the median rating and interquartile range was calculated separately for each stakeholder group. In addition, the percentage agreement with each item (i.e., the number of participants rating the item as ‘4’ or ‘5’), the percentage disagreement with each item (i.e., the number of participants rating the item as ‘1’ or ‘2’), and the percentage of neutral responses (i.e., the number of participants rating the item as ‘3’) was calculated separately for each stakeholder group.

Qualitative data

Qualitative data gathered via the online survey, as well as all three other community consultation activities (focus groups, brief survey, parent reflections) were analysed using the Framework method (Gale et al., 2013). The framework method was also used to code the systematic review of existing guidelines (Chapter 4) and the systematic review of individual and family experiences of accessing services (Chapter 6). The process, as it pertained to coding of community consultation activities is presented here and involved the following steps:

Coding framework

A coding framework was developed to reflect, and allow coding of, participant responses to each of the Guideline questions. The codes within the framework reflected the statements presented in the Delphi survey to practitioners, which had in turn been developed through an iterative process that drew on various forms of input, including: (a) systematic review of existing guidelines from other jurisdictions around the world (see Chapter 4), (b) umbrella review of existing research evidence (see Chapter 5), (c) recent, relevant research articles (e.g., Lord et al., 2022, Trembath et al., 2021), (d) frameworks of evidence-based practice (e.g., Sackett et al., 2000), and (e) review and feedback from the GDG. Adopting this approach meant that the GDG could code responses in a consistent manner across the community-consultation activity (e.g., online survey, focus groups, Delphi study, brief survey, parent reflections), thereby ensuring that views and experiences could be compared and contrasted during the process of formulating Recommendations and making judgements within the evidence-to-decision framework. The code book, that contains the complete framework, along with instructions to coders (addressed below) is provided in Appendix 7.3). In applying the coding framework, research assistants had the option of applying an ‘other’ code to any comment that they felt did not fit with an existing code. This approach was adopted to ensure that novel, including contrasting, views could be accounted for in the coding process.

Coding Process

A team of five research assistants was appointed to assist with the coding of all feedback gathered during the community consultation process. The team comprised people with a combination of relevant professional experience and, for two members, lived experience of autism.

The following processes were used to train and then support the research assistants to complete the coding:

- David Trembath (Co-chair) and Emma Hinze (research assistant) worked together, supported by the GDG, to establish the processes that would be used to code the data and support the research assistants in their work. The code book was created along with all administrative processes required to securely and reliably manage the data and coding processes.
- Each of the remaining four research assistants (Briohny Dempsey, Georgia Earl, Libby Groves, Rachelle Wicks) were invited to participate in the project, via an email that briefly outlined the Guideline project and their proposed role (i.e., supporting qualitative analysis). There was an opportunity to discuss the appointment, prior to agreeing. A variation to Griffith University Human Research Ethics Committee to support each person's involved was granted.
- David Trembath and Emma Hinze met with each of the research assistants to:
    - Provide an overview of the project.
    - Review the processes that would be used in data management and coding.
    - Review the codes relevant to each person's role in the coding.
    - Answer any questions arising.
- Each research assistant was then given access to the code book and relevant data, as well as training in NVivo which was used to support the coding process. Emma Hinze was responsible for coordinating data management and fielding queries on a daily basis, with David Trembath available to support Emma at all times.
- All coding occurred in NVivo. Research assistants were allocated different Guideline questions, and then coded the relevant responses from each community consultation activity. For example, the person who coded 'principles' did so for each of the community consultation activities to help ensure a consistent approach. The instructions that were to be followed are presented in Appendix 7.3, but in brief included:
    - Reviewing the code book
    - Within NVivo, reviewing each participant's response and coding according to the framework

    - Completing memos in which the research assistant was asked to reflect on any patterns they were seeing in the data (e.g., prominent themes); differences, contrasts, and/or contradictions in the responses; any challenges they were experiencing in assigning codes; suggestions for possible new or revised codes; reasons for why they may have coded a specific way or anything else that they, at that time, felt was important. These memos (reflections) were used to help create an audit trail, to inform the coding process and interpretation of the data, and to support the research assistants in their work.
- During coding, the team met on a weekly basis to discuss the coding process, as well as to discuss their experience of completing the coding. This meeting was open to all members of the GDG involved in data gathering and coding. The rationale for this meeting was two-fold. First, the meetings provided an additional opportunity to ensure fidelity within the coding process (i.e., in addition to standardised training, standardised coding, and on-call support at all times). Second, the meetings provided an opportunity for team members to share and debrief about their experiences. It became apparent, from the first day of data gathering and coding, that the personal insights and experiences shared by members of the autistic and autism communities were often very confronting in terms of the challenging circumstances people had found themselves in, were experiencing currently, or foresaw themselves and their loved ones experiencing in the future. The focus of the debrief was to share individual feelings, support each other, and identify if any further support was required. Doing so ensured each team member was supported, and in doing so ensured the process was carried out with fidelity.

As indicated above, multiple approaches were used to help ensure the credibility of the coding process (i.e., akin to *reliability* in quantitative research) including employing people with relevant expertise, using a standardised code book and training procedures, ensuring on-call support on a daily basis and weekly team meetings for fidelity and support purposes, and ultimately presenting evidence using people's own words when presenting the evidence summaries. In addition, a credibility check was completed for every quote identified during the coding process was reviewed.

The credibility check was intended to (a) ensure that quotes were attributed to codes accurately and (b) ultimately provide readers of the Guideline with information to inform their interpretation of the data. The instructions were to:

- Review the contents (quote/s) one cell (participant) at a time.
- Ask yourself "Is this quote relevant to the code that has been applied?"
    - If the answer is yes, proceed to next step. In some cases, you may find that the quote is ambiguous because you are only reviewing part of a participant's more expansive response or due to the participant's expression. It is not intended that each quote will be a complete and cohesive statement in

relation to the code, and so provided that in your judgement the quote appears to be relevant, it can be marked yes

    - If the answer is no, ask yourself "Is this quote potentially relevant to addressing one or more other guideline questions?
    - If yes, highlight the quote in yellow.

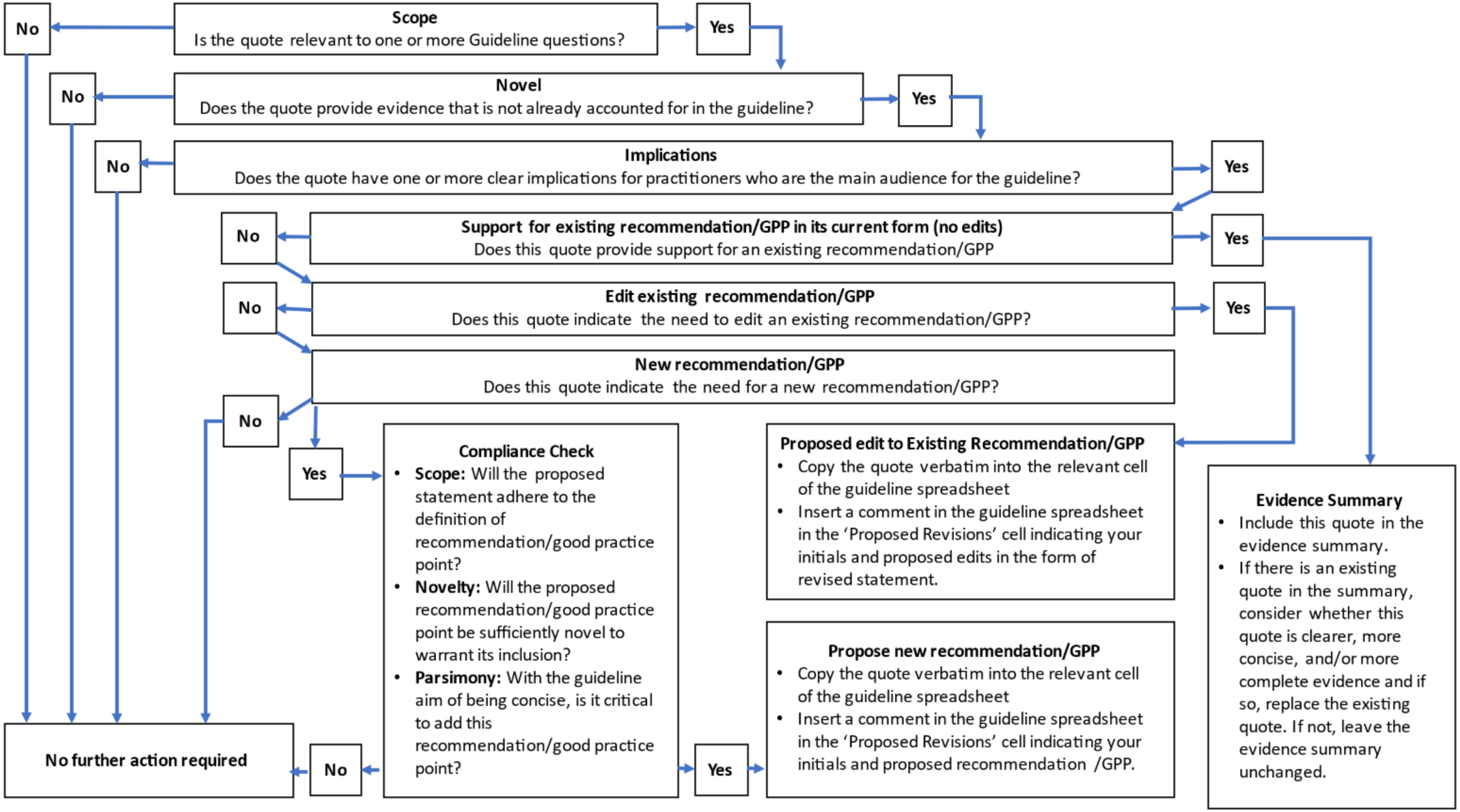
- If no, highlight the quote in red, indicating that the quote does not appear to fit the current code, and does not appear relevant to addressing one or more guideline questions.

This approach resulted in the classification of each quote in each code as either 'relevant to the Guideline and code,' 'relevant to the Guideline, but cannot establish relevance to code,' or 'does not appear to be relevant to the Guideline.' The proportion of responses related to each classification is provided in the Results section for each community consultation study. It is important to note that the person completing the credibility check was reviewing the coded data, not the original transcripts. Accordingly, they did not necessarily have knowledge of the context (e.g., broader statement) from which the quotes had been extracted, which may account for some of the disagreements.

Applying codes in the development of evidence summaries for Recommendations and Good Practice Points.

The following process was developed, and implemented by members of the GDG (Sarah Pillar, David Trembath, Kandice Varcin, Hannah Waddington, Andrew Whitehouse) to ensure that qualitative data gathered during the community consultation activities could (a) be considered in a systematic manner when formulating Recommendations and Good Practice Points and (b) used to populate the evidence summaries for each Recommendation and Good Practice Point in a consistent manner. Implementation of the process with fidelity was supported by (a) documenting the process, (b) producing a video to explain the process that was used to support implementation (including worked examples), and (c) daily interaction with Microsoft Teams to support implementation. Figure 7.1 presents the decisions each panel member made when reviewing each participant's quote, in relation to each code, and determining if/how it would inform the formulation of Recommendations and Good Practice Points and corresponding evidence summaries.

Figure 7.1 Applying codes in the development of evidence summaries for Recommendations and Good Practice Points.



Scope
Is the quote relevant to one or more Guideline questions?

Novel
Does the quote provide evidence that is not already accounted for in the guideline?

Implications
Does the quote have one or more clear implications for practitioners who are the main audience for the guideline?

Support for existing recommendation/GPP in its current form (no edits)
Does this quote provide support for an existing recommendation/GPP

Edit existing recommendation/GPP
Does this quote indicate the need to edit an existing recommendation/GPP?

New recommendation/GPP
Does this quote indicate the need for a new recommendation/GPP?

Compliance Check
- **Scope:** Will the proposed statement adhere to the definition of recommendation/good practice point?
- **Novelty:** Will the proposed recommendation/good practice point be sufficiently novel to warrant its inclusion?
- **Parsimony:** With the guideline aim of being concise, is it critical to add this recommendation/good practice point?

Proposed edit to Existing Recommendation/GPP
- Copy the quote verbatim into the relevant cell of the guideline spreadsheet
- Insert a comment in the guideline spreadsheet in the 'Proposed Revisions' cell indicating your initials and proposed edits in the form of revised statement.

Propose new recommendation/GPP
- Copy the quote verbatim into the relevant cell of the guideline spreadsheet
- Insert a comment in the guideline spreadsheet in the 'Proposed Revisions' cell indicating your initials and proposed recommendation /GPP.

Evidence Summary
- Include this quote in the evidence summary.
- If there is an existing quote in the summary, consider whether this quote is clearer, more concise, and/or more complete evidence and if so, replace the existing quote. If not, leave the evidence summary unchanged.

No further action required

Following application of this process, and at the point where the GDG had reviewed all Draft Recommendations and Good Practice Points, members of the GDG (Sarah Pillar, David Trembath, Kandice Varcin, Hannah Waddington, Andrew Whitehouse) then reviewed the original qualitative data for community consultation activities to identify further participant comments that were relevant to the evidence summaries. This included a quote-by-quote review for every response coded as 'other' during the coding process, to ensure that information that did not fit within the coding framework was considered on multiple occasions, in raw form (i.e., quote by quote) and collectively (when viewed alongside the complete set of data) to ensure that novel Recommendations and Good Practice Points could emerge.

7.6 Results

Participant characteristics

In total, 667 participants provided informed consent to participate in the online survey. This included 88 autistic adults, 229 parents of an autistic child, 21 family members of an autistic person, 107 individuals who provide services to autistic children and their families, 145 members of organisations or services that provide services to autistic children and their families, 38 participants belonging to 'Other' groups, and 39 participants that did not specify any group. Of note, no young people (aged 12-17 years) chose to provide feedback via the online survey.

Demographic information for each group (as self-identified by the person completing the survey) is presented in Tables 7.1 – 7.6.

Autistic adults

Table 7.1 Demographic information of autistic people who provided informed consent for the online survey (n=88).

Autistic Adults	
Other perspectives	Autistic adults brought the following additional perspectives: • Parent/primary caregiver of an autistic person: n=38 • Family member of an autistic person: n=28 • An individual who provides services to autistic children: n=17 • Member of an organisation or service that provides services to autistic children and their families: n=12 • Other: n=15 11 participants did not provide a response.
Age	Autistic adults were in the following age brackets:

	• 18-20 years: n=3 (3%) • 21-30 years: n=14 (16%) • 31-40 years: n=22 (25%) • 41-50 years: n=23 (26%) • 51-60 years: n=13 (15%) • 61-70 years: n=9 (10%) • 71-80 years: n=0 (0%) • 81-90 years: n=1 (1%) 3 participants (3%) did not provide a response.
Gender identity	66 autistic adults identified as female (75%), 11 identified as male (12.5%), 6 as non-binary (7%), 2 as other (2%) and 3 preferred not to say (3%).
Aboriginal and/or Torres Strait Islander Peoples	1 autistic adult (1%) identified as Aboriginal. 84 autistic people did not identify as Aboriginal or Torres Strait Islander (95%). 3 participants (3%) did not provide a response.
State/Territory	Autistic adults resided in the following States/Territories within Australia: • Australian Capital Territory: n=5 (6%) • New South Wales: n=22 (25%) • Northern Territory: n=0 (0%) • Queensland: n=16 (18%) • South Australia: n=8 (9%) • Tasmania: n=4 (4.5%) • Victoria: n=20 (23%) • Western Australia: n=11 (12.5%) 2 participants (2%) were not currently residing in Australia (and as such, were unable to progress any further through the survey).
Location	58 autistic adults lived in a major city (66%) and 28 lived in regional/remote areas (32%). 2 participants (2%) did not provide a response.
Place of birth	74 autistic adults (84%) were born in Australia. 11 were not born in Australia (12.5%). 3 participants (3%) did not provide a response.
Languages other than English	81 (92%) autistic adults were living in homes where only English was spoken. 4 (4.5%) were living in homes where languages other than English was spoken. 3 participants (3%) did not provide a response.
Formal diagnosis of autism	72 autistic adults (82%) had received a formal diagnosis of autism. 4 autistic adults (4.5%) were currently being assessed for a possible diagnosis of autism. 3 autistic adults (3%) self-identified as autistic but had not received a formal diagnosis of

	autism. 3 participants (3%) chose not to share additional information about their diagnosis. 6 participants (7%) did not provide a response.
Age of autism diagnosis	Of the 72 adults that had received a formal diagnosis, the average age of diagnosis was 36.25 years (SD = 15.93), with ages ranging from 3 years to 81 years. 3 participants (4.2%) did not provide a response.
DSM-5 diagnosis level of support	Of autistic adults diagnosed under the DSM-5, the following support levels were associated with the diagnosis: • 8 (27%) were diagnosed at Level 1. • 4 (14%) were diagnosed at Level 2. • 2 (7%) were diagnosed at Level 3. • 13 (45%) were unsure. • 2 (7%) preferred not to say.
Representative DSM-5 level of support	Of autistic adults not diagnosed under the DSM-5, participants reported the following would have been most representative of their supports needs as a child: • 30 (45%) selected Level 1 as most representative. • 20 (30%) selected Level 2 as most representative. • 3 (5%) selected Level 3 as most representative. • 11 (17%) were unsure. • 2 (3%) preferred not to say.
Access to supports between 0-6 years	4 autistic adults (4.5%) reported receiving or accessing supports (for themselves) between the ages of 0-6 years. 74 autistic adults (84%) did not receive or access supports (for themselves) between the ages of 0-6 years. 3 participants (3%) chose not to share this information. 7 participants (8%) did not provide a response.
Access to supports between 7-12 years	3 autistic adults (3%) reported receiving or accessing supports (for themselves) between the ages of 7-12 years. 75 autistic adults (85%) did not receive or access supports (for themselves) between the ages of 7-12 years. 3 participants (3%) chose not to share this information. 7 participants (8%) did not provide a response.

Parents of autistic children

Table 7.2. Demographic information of parents of autistic children who provided informed consent for the online survey (n=229).

Parents of autistic children	
Other perspectives	Parents of autistic children brought the following additional perspectives: • Autistic person: n=38 • Family member of an autistic person: n=31

	- An individual who provides services to autistic children: n=22 - Member of an organisation or service that provides services to autistic children and their families: n=44 - Other: n=17 69 participants did not provide a response.
Age	Parents of autistic children were in the following age brackets: - 21-30 years: n=1 (0.4%) - 31-40 years: n=59 (26%) - 41-50 years: n=116 (51%) - 51-60 years: n=32 (14%) - 61-70 years: n=12 (5%) - 71-80 years: n=3 (1%) 6 participants (3%) did not provide a response.
Gender identity	211 parents identified as female (92.5%), 14 identified as male (6%), 1 as non-binary (0.4%), and 2 preferred not to say (2%). 1 participant (0.4%) did not provide a response.
Aboriginal and/or Torres Strait Islander Peoples	3 parents (1%) identified as Aboriginal. 220 parents (96%) did not identify as Aboriginal or Torres Strait Islander. 6 participants (3%) did not provide a response.
State/Territory	Parents of autistic children resided in the following States/Territories within Australia: - Australian Capital Territory: n=10 (4%) - New South Wales: n=55 (24%) - Northern Territory: n=3 (1%) - Queensland: n=56 (25%) - South Australia: n=8 (3.5%) - Tasmania: n=4 (2%) - Victoria: n=52 (23%) - Western Australia: n=34 (15%) 6 participants (3%) were not currently residing in Australia (and as such, were unable to progress any further through the survey). 1 participant (0.4%) did not provide a response.
Location	171 parents lived in a major city (77%) and 52 lived in regional/remote areas (23%). 6 participants (3%) did not provide a response.

Place of birth	185 parents (81%) were born in Australia. 37 were not born in Australia (16%). 7 participants (3%) did not provide a response.
Languages other than English	210 (92%) parents were living in homes where only English was spoken. 12 (5%) were living in homes where languages other than English was spoken. 7 participants (3%) did not provide a response.
Child's formal diagnosis of autism	244 children had received a formal diagnosis of autism. 19 children had not yet received a formal diagnosis of autism. 1 parent chose not to share additional information about their child's diagnosis. 15 participants did not provide a response to these items.
Child's age of autism diagnosis	Of the 244 children that had received a formal diagnosis, the average age of diagnosis was 11.68 years (SD = 6.37), with ages ranging from 1 year to 41.5 years. 43 participants did not provide their child(ren)'s age.
Child's DSM-5 diagnosis level of support	Of children diagnosed under the DSM-5, the following support levels were associated with the diagnosis: • 39 (16%) were diagnosed at Level 1. • 146 (60%) were diagnosed at Level 2. • 42 (17%) were diagnosed at Level 3. • 13 (5%) were unsure. • 4 parents (2%) preferred not to say.
Child's Representative DSM-5 level of support	Of children not diagnosed under the DSM-5, parents reported the following would have been most representative of their child's supports needs when they were a child: • 18 (3%) selected Level 1 as most representative. • 36 (52%) selected Level 2 as most representative. • 13 (19%) selected Level 3 as most representative. • 2 (3%) were unsure.
Child's access to supports between 0-6 years	Of the 263 children that details were provided for, 195 children (74%) received or accessed supports between the ages of 0-6 years. 68 (26%) children did not receive or access supports between the ages of 0-6 years.
Child's access to supports between 7-12 years	Of the 263 children that details were provided for, 199 children (76%) received or accessed supports between the ages of 7-12 years. 45 (17%) children did not receive or access supports between the ages of 7-12 years. Responses were not provided to this item for 19 children (7%).

Family members of an autistic person

Table 7.3. Demographic information of family members of an autistic person who provided informed consent for the online survey (n=21).

Family members of an autistic person	
Relationship	Family members of autistic people included: • Parent: n=7 • Grandparent: n=6 • Sibling: n=3 • Cousin: n=1 • Aunt: n=1 3 participants did not specify their relationship.
Other perspectives	Family members of autistic people brought the following additional perspectives: • Autistic person: n=2 • Parent of an autistic person: n=2 • An individual who provides services to autistic children: n=3 • Member of an organisation or service that provides services to autistic children and their families: n=6 • Other: n=3 4 participants did not provide a response.
Age	Family members of autistic children were in the following age brackets: • 21-30 years: n=3 (14%) • 31-40 years: n=1 (5%) • 41-50 years: n=3 (14%) • 51-60 years: n=6 (29%) • 61-70 years: n=3 (14%) • 71-80 years: n=4 (19%) 1 participant (5%) did not provide a response.
Gender identity	18 family members identified as female (86%), 2 identified as male (9.5%), and 1 preferred not to say (5%).

Aboriginal and/or Torres Strait Islander Peoples	No family members identified as Aboriginal. 20 family members (95%) did not identify as Aboriginal or Torres Strait Islander. 1 participant (5%) did not provide a response.
State/Territory	Family members of autistic people resided in the following States/Territories within Australia: • Australian Capital Territory: n=0 (0%) • New South Wales: n=6 (29%) • Northern Territory: n=0 (0%) • Queensland: n=4 (19%) • South Australia: n=2 (9.5%) • Tasmania: n=1 (5%) • Victoria: n=3 (14%) • Western Australia: n=5 (24%)
Location	15 family members lived in a major city (71%) and 5 lived in regional/remote areas (24%). 1 participant (5%) did not provide a response.
Place of birth	15 family members (71%) were born in Australia. 5 were not born in Australia (24%). 1 participant (5%) did not provide a response.
Languages other than English	19 (90%) family members were living in homes where only English was spoken. 1 (5%) was living in a home where languages other than English was spoken. 1 participant (5%) did not provide a response.

Individuals who provide services

Table 7.4. Demographic information of individuals who provide services to autistic children who provided informed consent for the online survey (n=107).

Individuals who provide services	
Profession	Individuals who provide services to autistic children and their families included: • Art therapist: n=2 • Behaviour therapist (not board certified): n=8 • Board certified behaviour analyst: n=4 • Developmental educator: n=1 • Educator (early childhood): n=3 • Educator (primary school): n=3 • Educator (high school): n=2

	• Exercise scientist: n=1 • Music therapist: n=2 • Occupational therapist: n=16 • Paediatrician: n=3 • Physiotherapist: n=5 • Play therapist: n=2 • Psychologist: n=31 • Researcher: n=5 • Social worker: n=1 • Speech pathologist: n=19 • Support worker: n=1 • Other: n=6 8 participants did not specify their profession.
Other perspectives	Individuals who provide services to autistic children and their families brought the following additional perspectives: • Autistic person: n=8 • Parent of an autistic person: n=9 • Family member of an autistic person: n=20 • Member of an organisation or service that provides services to autistic children and their families: n=31 • Other: n=4 29 participants did not provide a response.
Service role	Individuals were involved in the delivery of services to autistic children and their families in the following ways: • Providing supports: n=84 • Providing advocacy: n=41 • Supervising others who provide supports: n=45 • Conducting research on supports: n=8 • Responsible for staff and/or business processes that result in the delivery of supports: n=25 • Other: n=11 9 participants did not provide a response.

Organisation type	87 individuals currently worked in private organisations (including non-government organisations) and 20 worked in government organisations. 8 participants did not provide a response.
Service setting	Individuals who provide supports to autistic children did so across the following settings: • Child’s home: n=50 • Hospital (inpatient/outpatient): n=7 • Community clinic (including private practice): n=62 • University clinic: n=3 • Early childhood education centre: n=36 • Early childhood education centre in a specialised setting (catering only to children with additional earning needs): n=22 • Mainstream school: n=48 • Support class/unit within a mainstream school: n=22 • School specifically for autistic children: n=7 • School specifically for children with additional learning needs: n=22 • Other: n=4 11 participants did not provide a response.
Service delivery	Individuals who provide supports to autistic children did so across the following modes: • Face-to-face: n=96 • Tele practice/videoconference: n=69 8 participants did not provide a response.
State/Territory	Individuals providing services (currently) practiced in/across the following States/Territories within Australia: • Australian Capital Territory: n=3 • New South Wales: n=27 • Northern Territory: n=1 • Queensland: n=26 • South Australia: n=6 • Tasmania: n=2 • Victoria: n=24 • Western Australia: n=13 11 participants did not provide a response.

Location	75 individuals provided services in a major city and 42 provided services in regional/remote areas. 8 participants did not provide a response.
Years of experience	Individuals who provide supports had on average 11.79 years (*SD* = 8.78) experience working in clinical practice with autistic children. Years of experience ranged from 1 year to 35 years. 11 participants (10%) did not provide a response.
Caseload	Of individuals who provide supports, the proportion of their caseload that was autistic children in 2021 (i.e., the year prior to completing the online survey) included: • 0-25%: n=13 (12%) • 26-50%: n=19 (18%) • 51-75%: n=25 (23%) • 76-100%: n=42 (39%) 8 participants (7.5%) did not provide a response.
Age groups	In 2021 (i.e., the year prior to completing the online survey) individuals provided supports to autistic children across the following age brackets: • 0-3 years: n=58 • 4-6 years: n=87 • 7-9 years: n=89 10-12 years: n=80 • 13-15 years: n=67 • 16-18 years: n=50 • 19 years and older: n=32 8 participants did not provide a response.
Co-occurring conditions	As part of their practice, individuals provided supports to autistic children with the following co-occurring conditions: • Physical disability (e.g., cerebral palsy): n=47 • Cognitive impairment (e.g., intellectual disability): n=88 • Health conditions (e.g., asthma, metabolic conditions): n=70 • Mental health conditions (e.g., anxiety, depression): n=85 • Genetic conditions (e.g., Fragile X, Down syndrome): n=43 • Sensory impairment (e.g., vision, hearing): n=41 • Other: n=10 9 participants did not provide a response.
Aboriginal and/or Torres Strait	In 2021 (i.e., the year prior to completing the online survey), 47 individuals (44%) provided supports to autistic children and their families who identify as Aboriginal

Islander families Peoples	and/or Torres Strait Islander. 51 individuals (48%) did not provide supports to children and families who identify as Aboriginal and/or Torres Strait Islander. 9 participants (8%) did not provide a response.
Languages other than English	In 2021 (i.e., the year prior to completing the online survey) 64 individuals (60%) provided supports to autistic children and their families who were from non-English speaking countries and spoke languages other than English in the home. 34 individuals (32%) provided supports only to autistic children who were from English-speaking countries and only spoke English in the home. 9 participants (8%) did not provide a response.

Members of organisations

Table 7.5. Demographic information of members of organisations that provide services to autistic children and their families who provided informed consent for the online survey (n=145).

Members of organisations	
Organisational level response	Members of organisations responded to the online survey as: • Individual members: n=118 (83%) • The nominated representative of the organisation (i.e., submitting on behalf of the organisation as a whole): n=24 (17%) 3 participants did not provide a response.
Other perspectives	Members of organisations that services to autistic children and their families brought the following additional perspectives: • Autistic person: n=1 • Parent of an autistic person: n=9 • Family member of an autistic person: n=21 • An individual who provides services to autistic children: n=48 • Member of an organisation or service that provides services to autistic children and their families: n=65 • Other: n=7 34 participants did not provide a response.
Professions	Individuals involved with the organisations represented included: • Aboriginal and Torres Strait Islander health workers or health practitioners: n=15 • Aboriginal and Torres Strait Islander health advocates: n=9 • Art therapists: n=6 • Behaviour therapists (not board certified): n=29 • Board certified behaviour analysts: n=24 • Developmental educators: n=19

	• Educators (early childhood): n=34 • Educators (primary school): n=23 • Educators (high school): n=12 • Exercise scientists: n=5 • General practitioners: n=3 • Music therapists: n=9 • Nurses: n=9 • Occupational therapists: n=55 • Paediatricians: n=9 • Physiotherapists: n=27 • Play therapists: n=3 • Psychiatrists: n=5 • Psychologists: n=49 • Researchers: n=18 • Social workers: n=23 • Speech pathologists: n=57 • Support workers: n=29 • Others: n=31 52 participants did not provide a response.
Service setting	Organisations represented provided supports to autistic children across the following settings: • Child’s home: n=69 • Hospital (inpatient/outpatient): n=4 • Community clinic (including private practice): n=65 • University clinic: n=4 • Early childhood education centre: n=52 • Early childhood education centre in a specialised setting (catering only to children with additional earning needs): n=35 • Mainstream school: n=56 • Support class/unit within a mainstream school: n=44 • School specifically for autistic children: n=33 • School specifically for children with additional learning needs: n=38 • Other: n=19 52 participants did not provide a response.
State/Territory	Organisations represented provided services in/across the following States/Territories within Australia: • Australian Capital Territory: n=13

	• New South Wales: n=37 • Northern Territory: n=7 • Queensland: n=43 • South Australia: n=17 • Tasmania: n=8 • Victoria: n=32 • Western Australia: n=22 52 participants did not provide a response.
Location	80 organisations provided services in a major city and 67 provided services in regional/remote areas. 52 participants did not provide a response.

‘Other’ Participants

Table 7.6. Additional information for individuals who provided informed consent and selected the ‘Other’ category in the online survey (n=38).

Other	
Other description	Individuals who selected ‘Other’ described themselves as: • Members or representatives of a peak body: n=9 • Researchers: n=8 • Members of organisations that have an interest or involvement with autistic people: n=4 • Autistic/neurodiverse people: n=4 • Teacher: n=2 • Practitioner: n=2 • Consultant: n=1 • University employee: n=1 7 participants did not provide a response
Other perspectives	Individuals who selected ‘Other’ brought the following additional perspectives: • Autistic person: n=3 • Parent of an autistic person: n=6 • Family member of an autistic person: n=6 • An individual who provides services to autistic children: n=5 • Member of an organisation or service that provides services to autistic children and their families: n=9 • Other: n=10 15 participants did not provide a response.

Quantitative data

Language/Terminology preferences

The data for the language survey are presented in Table 7.7. Identity first-language (e.g., autistic, autistic children) was the most supported approach among the autistic community, parents of autistic children, service providers, and ‘others,’ while ‘person on the autism spectrum’ was more highly rated among family members and people working in organisations, based on totals produced by summing the proportion of people in each group who rated the terms as either ‘like’, ‘somewhat like’, or ‘strongly like’. These terms were also highly acceptable across all groups, with a minimum 75% in each group rating identify first language acceptable. Consistent with the decision-making framework determined apriori, identity first language was adopted for use in the Guideline and related documents and community activities.

Table 7.7. Results of the language survey.

Terminology preferences		**Which of the following best describes you?**											
		Autistic Person		Parent/ primary caregiver		Family member		Service Provider		Organisation		Other	
		n	%	n	%	n	%	n	%	n	%	n	%
Autistic	Strongly dislike	2	3.3%	8	6.6%	0	0.0%	6	12.8%	7	13.7%	2	13.3%
	Dislike	2	3.3%	13	10.7%	1	12.5%	5	10.6%	9	17.6%	1	6.7%
	Somewhat dislike	4	6.7%	9	7.4%	2	25.0%	4	8.5%	6	11.8%	1	6.7%
	Neutral	4	6.7%	16	13.2%	1	12.5%	10	21.3%	12	23.5%	2	13.3%
	Somewhat like	3	5.0%	8	6.6%	0	0.0%	0	0.0%	5	9.8%	2	13.3%
	Like	8	13.3%	30	24.8%	2	25.0%	8	17.0%	8	15.7%	3	20.0%
	Strongly like	37	61.7%	37	30.6%	2	25.0%	14	29.8%	4	7.8%	4	26.7%

Autistic person (e.g., autistic children)	Strongly dislike	3	5.2%	8	6.8%	0	0.0%	3	6.4%	6	11.8%	2	13.3%
	Dislike	2	3.4%	15	12.7%	1	12.5%	5	10.6%	7	13.7%	2	13.3%
	Somewhat dislike	4	6.9%	9	7.6%	1	12.5%	4	8.5%	9	17.6%	0	0.0%
	Neutral	5	8.6%	17	14.4%	1	12.5%	8	17.0%	13	25.5%	2	13.3%
	Somewhat like	4	6.9%	10	8.5%	1	12.5%	2	4.3%	6	11.8%	2	13.3%
	Like	6	10.3%	34	28.8%	2	25.0%	13	27.7%	7	13.7%	3	20.0%
	Strongly like	34	58.6%	25	21.2%	2	25.0%	12	25.5%	3	5.9%	4	26.7%
Person with autism (e.g., children with autism)	Strongly dislike	30	50.8%	19	16.1%	0	0.0%	5	10.6%	2	3.8%	4	26.7%
	Dislike	6	10.2%	15	12.7%	0	0.0%	5	10.6%	3	5.8%	0	0.0%
	Somewhat dislike	6	10.2%	7	5.9%	1	11.1%	5	10.6%	3	5.8%	1	6.7%
	Neutral	3	5.1%	25	21.2%	3	33.3%	7	14.9%	10	19.2%	5	33.3%
	Somewhat like	5	8.5%	18	15.3%	2	22.2%	7	14.9%	9	17.3%	1	6.7%
	Like	5	8.5%	17	14.4%	3	33.3%	13	27.7%	14	26.9%	3	20.0%
	Strongly like	4	6.8%	17	14.4%	0	0.0%	5	10.6%	11	21.2%	1	6.7%
Person on the autism spectrum (e.g., children on the autism spectrum)	Strongly dislike	17	28.8%	9	7.6%	1	10.0%	5	10.6%	2	3.8%	4	25.0%
	Dislike	6	10.2%	8	6.8%	0	0.0%	7	14.9%	1	1.9%	0	0.0%
	Somewhat dislike	5	8.5%	10	8.5%	0	0.0%	5	10.6%	6	11.5%	1	6.3%
	Neutral	11	18.6%	26	22.0%	1	10.0%	9	19.1%	4	7.7%	6	37.5%
	Somewhat like	6	10.2%	15	12.7%	2	20.0%	5	10.6%	7	13.5%	3	18.8%
	Like	10	16.9%	33	28.0%	5	50.0%	12	25.5%	16	30.8%	2	12.5%
	Strongly like	4	6.8%	17	14.4%	1	10.0%	4	8.5%	16	30.8%	0	0.0%

Person with autism spectrum disorder (e.g., children with ASD)	Strongly dislike	33	55.9%	41	35.0%	2	22.2%	15	31.9%	8	15.7%	9	56.3%
	Dislike	9	15.3%	15	12.8%	2	22.2%	8	17.0%	7	13.7%	1	6.3%
	Somewhat dislike	8	13.6%	13	11.1%	0	0.0%	6	12.8%	5	9.8%	2	12.5%
	Neutral	2	3.4%	14	12.0%	1	11.1%	5	10.6%	11	21.6%	4	25.0%
	Somewhat like	5	8.5%	12	10.3%	2	22.2%	4	8.5%	7	13.7%	0	0.0%
	Like	1	1.7%	10	8.5%	2	22.2%	6	12.8%	7	13.7%	0	0.0%
	Strongly like	1	1.7%	12	10.3%	0	0.0%	3	6.4%	6	11.8%	0	0.0%
Person with autism spectrum condition (e.g., children with ASC)	Strongly dislike	23	39.0%	31	26.5%	0	0.0%	15	31.9%	15	30.0%	4	26.7%
	Dislike	11	18.6%	17	14.5%	3	33.3%	11	23.4%	16	32.0%	2	13.3%
	Somewhat dislike	8	13.6%	14	12.0%	0	0.0%	4	8.5%	3	6.0%	5	33.3%
	Neutral	11	18.6%	24	20.5%	5	55.6%	9	19.1%	5	10.0%	4	26.7%
	Somewhat like	5	8.5%	9	7.7%	0	0.0%	3	6.4%	8	16.0%	0	0.0%
	Like	1	1.7%	11	9.4%	0	0.0%	3	6.4%	2	4.0%	0	0.0%
	Strongly like	0	0.0%	11	9.4%	1	11.1%	2	4.3%	1	2.0%	0	0.0%
Autistic	Unacceptable	7	11.7%	19	16.2%	2	20.0%	10	21.7%	10	20.0%	1	6.7%
	Acceptable	53	88.3%	98	83.8%	8	80.0%	36	78.3%	40	80.0%	14	93.3%
Autistic child	Unacceptable	7	11.7%	26	22.4%	2	22.2%	7	15.2%	12	25.0%	2	13.3%
	Acceptable	53	88.3%	90	77.6%	7	77.8%	39	84.8%	36	75.0%	13	86.7%
Child with autism	Unacceptable	32	54.2%	26	22.4%	0	0.0%	10	21.3%	3	5.9%	3	18.8%
	Acceptable	27	45.8%	90	77.6%	9	100.0%	37	78.7%	48	94.1%	13	81.3%
Child on the autism spectrum	Unacceptable	21	35.6%	13	11.3%	1	10.0%	7	15.2%	4	7.7%	2	12.5%
	Acceptable	38	64.4%	102	88.7%	9	90.0%	39	84.8%	48	92.3%	14	87.5%

Child with autism spectrum disorder (child with ASD)	Unacceptable	40	69.0%	56	48.3%	2	22.2%	22	48.9%	13	27.1%	7	43.8%
	Acceptable	18	31.0%	60	51.7%	7	77.8%	23	51.1%	35	72.9%	9	56.3%
Child with autism spectrum condition (child with ASC)	Unacceptable	41	69.5%	46	40.0%	2	20.0%	22	47.8%	26	53.1%	6	40.0%
	Acceptable	18	30.5%	69	60.0%	8	80.0%	24	52.2%	23	46.9%	9	60.0%

Guiding Principles

The percentage agreement, median, and interquartile range for each of the 17 items related to the Guiding Principles, for each stakeholder group, was included in the Evidence Summaries for the relevant Recommendations as an additional source of supporting evidence.

Qualitative data

A total of 7,708 references (i.e., participant quotes) were coded using the framework, with the distribution of references (i.e., quotes) for each participant group presented in Table 7.8. These quotes, where relevant to the formulation of Recommendations and Good Practice Points, feature in the corresponding evidence summaries.

Table 7.8. Summary of codes and references for each participant group.

Codes	**Number of Coding References for Each Participant Group**					
	Parents	Family	Autistic Person	Service Provider	Organisation	Other
Principles						
Accessible	50	0	13	2	10	1
Assent (children)	4	0	4	0	2	0
Child and family-centred	45	1	15	22	14	4
Coordinated	25	0	4	7	5	1
Culturally aware and responsive	2	0	0	2	0	2
Developmental perspective	9	1	2	2	2	1

Empirically-supported	7	0	4	2	2	0
Equity	17	1	13	1	3	0
Ethical practice	66	1	17	19	21	8
Evidence-based practice approach	18	2	8	11	10	1
Holistic	34	3	7	26	19	8
Informed consent (parents)	0	0	0	0	0	1
Lifespan perspective	10	0	4	2	2	2
Other - Principle	135	1	52	16	18	8
Personalised	47	0	15	24	12	5
Qualified practitioners	58	0	12	12	16	5
Strengths focused	24	1	10	8	4	0
Supported	20	0	4	3	3	1
Understanding the child, family, and context						
Child Understanding	93	10	37	60	74	16
Context understanding	54	4	23	32	34	12
Family understanding	142	8	45	82	87	22
Other Understanding	37	2	18	12	16	3
Goal Setting						
Activities and participation	76	9	28	48	45	16
Environment	12	3	6	7	6	1
Mental and physical functions	22	3	4	14	15	2
Other	27	1	23	13	17	8
Selection - therapies and supports						
Non-Specific - Non-Supported	0	0	0	0	0	0
Non-Specific - Supported	20	1	12	9	19	9

Selection - other	13	1	8	6	7	2
Specific - Non-Supported	1	0	0	1	1	0
Specific - Supported	69	6	25	32	30	10
Delivery						
Amount	93	6	30	47	52	12
Individualised - Amount not specified	48	2	21	28	21	9
Individualised - Indicative amount	11	3	2	7	11	0
Not Applicable	7	0	0	2	3	1
Specified Amount	28	1	7	10	17	2
Clinic	36	6	11	30	23	4
Cultural setting	0	0	1	0	0	0
Education setting	45	3	16	30	30	9
Home	50	6	15	33	27	7
Other	41	3	15	27	31	11
Recreational setting	7	1	0	2	3	2
Social setting	25	1	5	26	20	7
Monitoring of Therapies and Supports						
Costs and benefits	29	2	6	12	21	6
Fidelity	5	0	1	4	4	1
Generalisation	2	0	0	4	2	1
Impact	38	3	13	28	29	6
Maintenance	0	0	0	1	0	1
Other	44	1	18	23	27	4
Progress	50	7	16	28	36	9
Unplanned outcomes	6	1	1	5	4	1

Safety and Wellbeing						
Assessment	6	0	6	7	9	0
Communication	26	3	6	7	14	6
Concerns	5	2	1	1	3	1
Empirical evidence	2	1	3	6	4	2
Experience	8	1	2	9	11	3
Monitoring	14	2	6	7	6	2
Other	47	6	24	26	18	12
Practice standards	9	2	6	13	12	4
Research	3	0	0	2	1	0
Rights	5	0	7	5	5	5
Supervision	0	1	0	3	5	1
Suggestion						
About child, family, and context	163	16	50	90	95	32
Alternatives	12	4	4	5	4	2
Autistic perspectives	9	0	11	6	4	0
Benefits	8	1	6	2	11	0
Clinical evidence	139	11	38	108	118	36
Enhance progress	0	0	0	1	1	0
Impede progress	3	0	1	0	0	0
Other	0	2	1	0	0	0
Relevance (current)	8	1	6	10	9	3
Relevance (future)	6	1	1	3	7	4
Research evidence	29	1	8	31	37	7
Risks	5	0	3	3	3	1

Theoretical Rationale	0	0	0	1	4	0
Who						
Who~ agencies	5	2	2	4	3	0
Who~ family	162	11	61	99	97	21
Who~ other	6	0	6	4	7	0
Who~ participation	3	1	1	2	3	2
Who~ support providers	132	13	46	81	78	16

As indicated above, credibility checks were completed for all quotes that featured in the analysis of qualitative data from the community survey. 99% were classified as ‘relevant to the guideline and code,’ <1% were classified as ‘relevant to the guideline, but cannot establish relevance to code,’ and 0% were classified as ‘does not appear to be relevant to the Guideline. Readers are reminded that the person completing the credibility check was reviewing the coded data, not the original transcripts. Accordingly, they did not necessarily have knowledge of the context (e.g., broader statement) from which the quotes had been extracted.

8. Community Consultation: Focus Groups

8.1 Background

Integral to the development of the Guideline was consultation with the autistic and autism communities. Consistent with the recommendations in the Guidelines for Guidelines handbook (NHMRC, 2016) community consultation was conducted to ensure that all relevant stakeholders within Australia were provided with the opportunity to inform the development of the Guideline. This was key to enhancing the relevance and acceptability of the Guideline to the autistic and autism communities. The consultation process was also conducted to (a) complement the current research evidence, and/or (b) gather information and insight from relevant stakeholders where research evidence is currently lacking.

This consultation activity was conducted to ensure that the experiences, views and preferences of autistic individuals and parents of autistic children were captured in the development of the Guideline.

8.2 Aim

The aim of the focus groups were to understand the experiences, views and preferences of (a) autistic people and (b) parents of autistic children regarding accessing supports for autistic children and their families.

8.3 Research question

What are the experiences, views and preferences of autistic individuals and parents of autistic children regarding the provision of supports for children and their families?

8.4 Design

A qualitative methodology approach was adopted, through a series of focus groups. Eight, online focus groups were run over a 2-week period (7th – 18th March, 2022). Four of the focus groups were open to autistic adults and four were open to parents of autistic children.

8.5 Method

Ethical approval for this community consultation activity was provided by Griffith University Human Research Ethics Committee (2021/843).

Eligibility

Autistic adults and parents of autistic children and young people were eligible to participate in the focus groups.

Recruitment

Participant recruitment for the focus groups was predominantly facilitated by Autism CRC. An invitation to register interest in attending a focus group was distributed to members of Autism CRC mailing lists who identified as either an autistic individual, or the parent of an autistic child(ren). In addition, links to access the focus group registration survey were made available via the Autism CRC Supporting Children Guideline website, and social media (Facebook and Twitter) accounts. Members of the GDG also promoted the focus groups throughout their professional networks and social media pages. Recruitment occurred over a two-week period.

After following the registration link, prospective participants were presented with a Participant Information Statement and Consent Form and required to indicate consent before providing their details and preferences to attend the online focus group. Of the 49 registrations received from autistic individuals, all were allocated to a focus group based on their preferences. Parent registrations exceeded available focus group timeslots (n=115 registrations for 48 positions). Forty-eight parents were assigned to focus groups based on their preferences and in consecutive order of receiving their registration.

Tools

Prior to attending their allocated focus groups, all participants received a link to a short demographic survey coded in REDCap (a secure web-based application for survey development and distribution). This demographic survey was completed online either prior to, or after, their participation in the focus group (see Appendix 8.1).

Focus Group Question Guide

A semi-structured question guide was developed and used across all eight focus groups. The question guide was predominantly informed by the set of questions developed by the GDG, underpinning all aspects of the Guideline's development related to supporting autistic children and their families. The questions developed for the focus groups covered the same six overarching questions posed to participants who completed the online survey:

- What are the most important considerations for practitioners trying to understand the child, family, and their context?
- From your perspective, what are the most important considerations for practitioners when planning, selecting, and prioritising goals for children?
- From your perspective, what are the most important considerations for practitioners when planning and selecting therapies and supports for children?
- From your perspective, what are the most important considerations for practitioners when delivering therapies and supports for children?
- From your perspective, what are the most important considerations for practitioners when monitoring progress and outcomes of therapies and supports for children?
- From your perspective, what are the most important considerations for practitioners to ensure the safety and wellbeing of autistic children and their families?

Focus group facilitation

Each focus group was facilitated, via Microsoft Teams, by two members of the GDG across a two-week period (7th – 18th March, 2022). One facilitator (David Trembath) was consistent across all eight groups, while the second facilitator alternated between different GDG members (Sarah Pillar, Felicity Rose, Kandice Varcin, Hannah Waddington, Andrew Whitehouse). The first facilitator was responsible for (a) coordinating the meeting, (b) introducing the Guideline development process and providing an orientation to the Focus Group, (c) facilitating the discussion, and (d) summarising and concluding the meeting. The second facilitator was responsible for (a) facilitating the discussion via the 'chat' comments (an option available to all participants throughout the entirety of the focus group, as an additional or alternate method of contributing) and (b) providing a summary of insights being shared via the chat comments at the conclusion of the discussion for each of the focus group questions.

Participants were invited to have their video function turned on for the focus group, but this was not a requirement. Participants were also invited to share information in the way they preferred (i.e., through verbal discussion or writing responses using the 'Chat' function).

Each focus group followed the same schedule:

- Fifteen minutes prior to the meeting, the two facilitators joined Microsoft Teams to review planning for the focus group. The 'waiting room' function was activated.
- At the scheduled start time, participants were admitted to the meeting.
- Facilitator 1 presented the introduction to the Guideline development process and focus group orientation (15 minutes).
- Facilitator 1 presented the six focus group questions, one at a time (allowing 15 minutes per question, including time for 2-minute summary of the chat comments by Facilitator 2).
- Facilitator 1 invited the participants to briefly introduce themselves the first time they shared responses to posed questions.
- Facilitator 1 presented a summary of the focus group outcomes, an overview of the next steps, and thanked the participants for their contribution (10 minutes).

A copy of the PowerPoint presentation that was used for all eight focus groups is provided in Appendix 8.2.

Analysis

Focus group transcriptions were auto generated by the Microsoft Teams platform. In two instances, where there was a technical or administrator error with the Microsoft Teams transcription, transcription was completed by Griffith University Transcription service. Transcriptions were checked for accuracy against the recording by a research assistant and de-identified prior to analysis. De-identified transcriptions files were uploaded to NVivo software for analysis. 'Chat' comments were copied from Microsoft Teams into a Word document.

Information collected during the focus groups were coded according to ‘principles’ using the process outlined in detail in relation to the online survey (Chapter 7). This approach – rather than coding according to each section of the code book (e.g., selection of supports, delivery of supports) was adopted *apriori* in the first instance, given that focus groups – by their nature of encouraging discussion – may see participants talk in relation to more than one aspect of the Guideline at once (e.g., a person simultaneously talking about goal setting, selecting an appropriate support, and safeguarding at the same time). However, to ensure that no specific insights, experiences, or suggestions that may be relevant to formulating Recommendations and Good Practice Points were missed, the GDG also reviewed every transcript (discussion and chat) generated from the groups in full to ensure that all information was considered in relation to all Guideline questions, Recommendations and Good Practice Points.

8.6 Results

Participant characteristics

A total of 164 registrations for 96 focus group positions (i.e., 12 slots across 8 focus groups) were received. Of these, a total of 48 participants attended their allocated focus group, of which 20 (42%) were autistic adults, and 28 (58%) were parents of autistic children.

Of the 20 autistic adults that attended the focus groups, 15 (75%) provided some details about themselves through the online demographic survey (see Table 8.1). Of the 28 parents who attended the focus groups, 21 (75%) provided some details about themselves and their child(ren) through the online demographic survey (see Table 8.1).

Table 8.1. Demographic information for autistic adults and parents of autistic children who attended the focus groups.

	Autistic Adults	**Parents of Autistic Children**
Other perspectives	Autistic adults attending the focus groups brought the following additional perspectives: Parent/primary caregiver of an autistic child: n=12 Family member of an autistic person: n=4 Practitioner: n=5 Member of an organisation or service that provides services to autistic children and their families: n=8 5 participants did not provide this information.	Parents of autistic children attending the focus groups brought the following additional perspectives: Autistic person: n=4 Family member of an autistic person: n=1 Practitioner: n=4 Member of an organisation or service that provides services to autistic children and their families: n=5 7 participants did not provide this information.

Age	Autistic adults were in the following age brackets: 31-40 years: n=5 (25%) 41-50 years: n=6 (30%) 51-60 years: n=4 (20%) 5 participants (25%) did not provide this information.	Parents were in the following age brackets: 31-40 years: n=4 (14%) 41-50 years: n=8 (28.5%) 51-60 years: n=8 (28.5%) 61-70 years: n=1 (4%) 7 participants (25%) did not provide this information.
Gender identity	12 autistic adults identified as female (60%), 2 identified as male (10%), and 1 as non-binary (5%). 5 participants (25%) did not provide this information.	20 parents identified as female (71.5%) and 1 as male (3.5%). 7 participants (25%) did not provide this information.
Aboriginal and/or Torres Strait Islander Peoples	No autistic adults identified as Aboriginal or Torres Strait Islander. 5 participants (25%) did not provide this information.	No parents identified as Aboriginal or Torres Strait Islander. 7 participants (25%) did not provide this information.
State/Territory	Autistic adults resided in the following States/Territories within Australia: Australian Capital Territory: n=1 (5%) New South Wales: n=0 (0%) Northern Territory: n=1 (5%) Queensland: n=8 (40%) South Australia: n=0 (0%) Tasmania: n=1 (5%) Victoria: n=3 (15%) Western Australia: n=1 (5%) 5 participants (25%) did not provide this information.	Parents resided in the following States/Territories within Australia: Australian Capital Territory: n=0 (0%) New South Wales: n=11 (39%) Northern Territory: n=0 (0%) Queensland: n=2 (7%) South Australia: n=2 (7%) Tasmania: n=0 (0%) Victoria: n=4 (14%) Western Australia: n=2 (7%) 7 participants (25%) did not provide this information.
Location	9 autistic adults lived in a major city (45%) and 6 lived in regional/remote areas (30%). 5 participants (25%) did not provide this information.	14 parents lived in a major city (50%) and 7 lived in regional/remote areas (25%). 7 participants (25%) did not provide this information.
Place of birth	14 autistic adults (70%) were born in Australia. 1 (5%) was born outside of Australia. 5 participants (25%) did not provide this information.	16 parents (57%) were born in Australia. 4 parents (14%) were born outside of Australia. 8 participants (29%) did not provide this information.

Languages other than English	15 autistic adults (75%) were living in homes where only English was spoken. 5 participants (25%) did not provide this information.	2 parents (7%) were living homes where a language other than English was spoken. 19 (68%) were living in homes where only English was spoken. 7 participants (25%) did not provide this information.
Formal diagnosis of autism	13 autistic adults (65%) had received a formal diagnosis of autism. 1 autistic adult (5%) self-identified as autistic but had not received a formal diagnosis of autism. 1 participant (5%) chose not to share additional information about their diagnosis. 5 participants (25%) did not provide this information.	1 parent (4%) had received a formal diagnosis of autism. 1 parent (4%) self-identified as autistic but had not received a formal diagnosis of autism. 1 parent was currently being assessed for possible autism (4%). 1 participant (4%) chose not to share additional information about their diagnosis. 7 participants (25%) did not provide this information.
Age of autism diagnosis	The average age of diagnosis was 38.46 years (SD = 10.28), with ages ranging from 12 years to 49 years. 7 participants (35%) did not provide a response.	1 parent reported having a formal diagnosis of autism, diagnosed at age 48.
DSM-5 diagnosis level of support	Of autistic adults diagnosed under the DSM-5, the following support levels were associated with the diagnosis: 1 was diagnosed at Level 2. 1 was unsure. 1 preferred not to say. 12 participants did not provide a response.	1 parent reported having a formal diagnosis of autism: they were unsure of their associated support level.
Representative DSM-5 level of support	Of autistic adults not diagnosed under the DSM-5, participants reported the following would have been most representative of their supports needs as a child: 3 selected Level 1 as most representative 8 selected Level 2 as most representative 0 selected Level 3 as most representative 1 preferred not to say. 3 participants did not provide a response.	Of parents who also identified as autistic, but not diagnosed under the DSM-5, the following was reported to be the most representative of their supports needs as a child: 1 selected Level 1 as most representative No other responses were provided to this item.
Access to supports between 0-6 years	No autistic adults reported receiving or accessing supports (for themselves) between the ages of 0-6 years.	No parents that also identified as autistic reported receiving or accessing supports (for themselves) between the ages of 0-6 years.

Access to supports between 7-12 years	No autistic adults reported receiving or accessing supports (for themselves) between the ages of 7-12 years.	No parents that also identified as autistic, reported receiving or accessing supports (for themselves) between the ages of 7-12 years.
Autistic children	Of the 12 autistic adults who were also parents of autistic children, 11 chose to share additional information about their child(ren). There were 22 autistic children amongst the participants in the autistic adults focus groups.	Of the 21 parents of autistic children, 20 chose to share additional information about their child(ren). There were 26 autistic children amongst the participants in the parents of autistic children focus groups.
Child age	The average (current) age of autistic children in the autistic adults focus groups was 14.19 years (SD = 5.54), with ages ranging from 4 years to 25 years.	The average (current) age of autistic children in the parent focus groups was 14.03 years (SD = 7.23), with ages ranging from 3 years to 28 years.
Child age of autism diagnosis	The average age of diagnosis amongst children was 6.95 years (SD = 4.06), with ages ranging from 2 years to 19 years.	The average age of diagnosis amongst children was 5.70 years (SD = 3.17), with ages ranging from 2 years to 13 years.
Child DSM-5 diagnosis level of support	Of children diagnosed under the DSM-5, the following support levels were associated with the children's diagnoses: 1 was diagnosed at Level 1. 15 were diagnosed at Level 2. 3 were diagnosed at Level 3.	Of children diagnosed under the DSM-5, the following support levels were associated with the children's diagnoses: 4 were diagnosed at Level 1. 14 were diagnosed at Level 2. 3 were diagnosed at Level 3. 1 participant was unsure of the support level associated with their child's diagnosis.
Child representative DSM-5 level of support	Of children not diagnosed under the DSM-5, the following was reported to have been the most representative of their supports needs as a child: 1 selected Level 1 as most representative. 1 selected Level 2 as most representative. 1 selected Level 3 as most representative.	Of children not diagnosed under the DSM-5, the following was reported to have been the most representative of their supports needs as a child: 1 selected Level 1 as most representative. 1 selected Level 2 as most representative.
Child access to supports between 0-6 years	14 children (64%) of participants in the autistic adults focus groups accessed supports at some stage between the ages of 0-6 years. 8 (36%) did not access supports between 0-6 years.	16 (61.5%) children of participants in the parent focus groups accessed supports at some stage between the ages of 0-6 years. 10 (38.5%) did not access supports between 0-6 years.

Child access to supports between 7-12 years	18 (82%) children of participants in the autistic adults focus groups accessed supports at some stage between the ages of 7-12 years. 2 families (9%) did not access supports between the ages of 7-12 years. 2 participants (9%) did not provide a response.	22 (85%) children of participants in the parent focus groups accessed supports at some stage between the ages of 7-12 years. 4 families (15%) did not access supports between the ages of 7-12 years.

Quantitative data

No quantitative data were collected in this activity.

Qualitative data

A total of 826 references (i.e., quotes) were coded using the framework, with 407 from group focusing on autistic adults and 419 references from groups focusing on parents. The distribution of references for each code for each group are presented in Table 8.2. These quotes, where relevant to the formulation of Recommendations and Good Practice Points, feature in the corresponding evidence summaries.

Table 8.2. Summary of codes and references for the two types of focus groups.

Codes	Autistic Adults	Parents
Principles		
Accessible	6	17
Assent (children)	7	6
Child and family-centred	81	61
Coordinated	17	37
Culturally aware and responsive	0	2
Developmental perspective	1	5
Empirically-supported	2	2
Equity	1	11
Ethical practice	8	12
Evidence-based practice approach	12	12

Holistic	56	66
Informed consent (parents)	2	0
Lifespan perspective	9	10
Other - Principle	110	87
Personalised	58	46
Qualified practitioners	13	17
Strengths focused	20	16
Supported	4	12

Credibility checks were completed for all quotes that featured in the analysis of qualitative data from the focus groups. 100% were classified as ‘relevant to the guideline and code,’ 0% were classified as ‘relevant to the guideline, but cannot establish relevance to code,’ and 0% were classified as ‘does not appear to be relevant to the Guideline.’ Readers are reminded that the person completing the credibility check was reviewing the coded data, not the original transcripts. Accordingly, they did not necessarily have knowledge of the context (e.g., broader statement) from which the quotes had been extracted.

9. Community Consultation: Delphi Study

9.1 Background

A separate community consultation process was undertaken, specifically with practitioners who provide supports to autistic children and their families. This consultation process adopted the Delphi technique. The Delphi technique refers to a method that is commonly used to collect expert-based opinions and identify consensus agreement on best practice (Jorm, 2015; Jünger et al., 2017; Niederberger & Spranger, 2020). Delphi studies are often used to inform clinical practice when there is insufficient evidence from meta-analyses, randomised controlled trials and/or correlational and observational studies (Jorm 2015; Jünger et al., 2017).

The Delphi study was conducted to directly inform Recommendations within the Guideline by: (a) identifying consensus amongst practitioners on what they consider to be best practice when providing supports to autistic children and their families, and (b) providing an opportunity for qualitative feedback from practitioners that participated in the Delphi surveys.

9.2 Aim

To identify consensus agreement amongst practitioners on what is considered best practice in the provision of supports for autistic children and their families.

9.3 Research question

What do practitioners consider to be best practice in the provision supports for autistic children and their families?

9.4 Design

The Delphi study involved two rounds of online surveys completed by practitioners. In both rounds, quantitative and qualitative data were collected. Quantitative data was used to determine consensus agreement/disagreement amongst practitioners. Qualitative data was collected to (a) inform the modification of items for the Round 2 survey (for those items where consensus was not achieved), and (b) directly inform Recommendations within the Guideline through qualitative evidence.

9.5 Method

Ethical approval for this community consultation activity was provided by Griffith University Human Research Ethics Committee (2021/843).

Eligibility

Practitioners representing professional groups that (a) are directly involved in the provision of supports for autistic children and their families and (b) have expertise in children's physical health, mental health, social-communication development, physical development, cognitive development and/or sensory development were eligible to participate in the Delphi study.

Recruitment

Practitioners were invited to participate in the Delphi study through their membership with one of five professional organisations (see Table 9.1 for a list of participating professional organisations). These professional organisations were each represented by a member on the Reference Group. The reference group members representing these professional organisations were asked to identify up to 20 practitioners from each of their professional organisations that may be willing to participate in the Delphi study. In total, 100 practitioners were invited to participate in the Round 1 survey (n=20 from each professional organisation).

Practitioners who completed the Round 1 survey (either fully or partially) were invited to participate in Round 2. As such, 72 practitioners were sent a personalised link to the Round 2 survey.

Tools

Round 1 survey

Survey items in Round 1 were developed through an iterative process that drew on various forms of input, including: (a) the review of existing guidelines from other jurisdictions around the world (see Chapter 4), (b) the umbrella review of existing research evidence (see Chapter 5), (c) recent, relevant research papers (i.e., Lord et al, 2022, Trembath et al., 2021), (d) frameworks of evidence-based practice (e.g., Sackett et al., 2000), and (e) review and feedback from the GDG.

The Round 1 survey was coded in REDCap (a secure web-based application for survey development and distribution) and piloted by five practitioners who were independent and external to the GDG. These five practitioners represented each professional group invited to participate in the Delphi study: a medical doctor, an occupational therapist, a physiotherapist, a psychologist, and a speech pathologist. Feedback provided through the piloting process led to minor modifications, including clarifying some terms and modifying the format of some items. The Round 1 survey took 40-60 minutes to complete by the pilot participants.

The final Round 1 survey (see Appendix 9.1) was distributed to practitioners via REDCap and included two parts. Part 1 was a demographic survey that asked practitioners about their professional affiliation, geographical location, experience and current practice in working with autistic children and their families. Part 2 asked practitioners to provide their views on what they considered to be best practice in supporting autistic children and their families.

Part 2 included 215 items that asked practitioners to rate their agreement with various statements on a 5-point scale: (1) strongly disagree, (2) disagree, (3) neutral, (4) agree, (5) strongly agree. There were also 26 additional items, distributed throughout each section of the survey, that gave practitioners an opportunity to provide optional qualitative feedback.

The Round 1 survey was open for a two-week period from March 7th to March 20th, 2022.

Round 2 survey

Survey questions in Round 2 were developed based on (a) quantitative ratings and qualitative feedback from practitioners in Round 1, and (b) qualitative feedback obtained through other community consultation activities that were being conducted in parallel to the Delphi study (i.e., online survey [Chapter 7], focus groups [Chapter 8]).

Quantitative items from Round 1 were reviewed against the predetermined consensus criteria (see below in the 'Quantitative analysis' section). Items with partial agreement (n=12), partial disagreement (n=3) or no agreement/disagreement (n=19) were considered for inclusion in the Round 2 survey. Each of these items was reviewed by two members of the GDG (AW, DT). Each member reviewed the distribution of quantitative ratings and the associated qualitative data (i.e., open-ended optional comments provided by practitioners for that item/section). They then met to determine which of the following options was most suitable for that item in Round 2:

- Include the item verbatim in Round 2 (n=19 items)
- Include a modified version of the items in Round 2, based on qualitative feedback from Round 1 associated with that item (n=10 items)
- Do not include the item in Round 2 in the verbatim or modified form, on the basis that the item contributes evidence towards a complementary pattern of responses that have one or more implications (potential Recommendations) in common (n=3 items). For example, there was no consensus agreement or disagreement that services should be predominately child, family, or community focused in Round 1, however, there was consensus agreement that the proportion of child/family/community focused services should be personalised to the child. As such, the items relating to services being predominately child, family, and/or community-focused were not included in the Round 2 survey.

Based on qualitative data obtained through the online survey (Chapter 7) and the focus groups (Chapter 8) that were being conducted in parallel to the Round 1 Delphi survey, we also included 18 new items for rating in Round 2. The new items related to how supports should be selected (n=2 items) and the knowledge, training and experience required by practitioners delivering supports to autistic children and their families (n=16 items).

The final Round 2 survey was distributed to practitioners via REDCap and included the outcomes for all items from Round 1, for practitioners to review (see Appendix 9.2). For those items with consensus agreement/disagreement, practitioners were provided with a summary of the percentage agreement/disagreement and the median and interquartile range for each item. For items with partial consensus agreement/disagreement and those without agreement/disagreement, practitioners were provided with a written summary of results and a graphical (bar graph) distribution of ratings for those items. The survey was setup so that practitioners viewed the summary and the distribution of ratings before rating the item again in Round 2. For the new items, it was highlighted to practitioners that these were new additions to the Round 2 survey.

The Round 2 survey included 42 items for rating on the same 5-point scale as Round 1: (1) strongly disagree, (2) disagree, (3) neutral, (4) agree, (5) strongly agree. In Round 2, there were two items that gave practitioners the option to provide open-ended comments related to the new items.

The Round 2 survey was open from April 19th to May 5th (the survey was open for slightly more than 2 weeks to account for public holidays that occurred over this time).

Analysis

Quantitative analysis

For both rounds, data were exported from REDCap into SPSS (v26) for analysis. Each quantitative survey item was reviewed against the predetermined consensus criteria by one member of the GDG (KV) and categorised (i.e., consensus agreement/disagreement, partial agreement/disagreement, no agreement/disagreement). We used the same predetermined consensus criteria adopted in the Delphi study for National Guideline for the Assessment and Diagnosis of Autism Spectrum Disorders in Australia (Whitehouse et al., 2018).

To determine if consensus had been achieved for quantitative items, two criteria were applied:

- For agreement with statements, we used a median rating of ≥4 (i.e., agree or strongly agree) and an interquartile range (IQR) of ≤1 for agreement with the item; for disagreement with statements, we used median ≤2 (i.e., disagree or strongly disagree) and an interquartile range (IQR) of ≤1 for disagreement with the item
- For agreement with statements, ≥70% of practitioners rated the item as ≥4 (i.e., agree or strongly agree) for agreement with the item; for disagreement with statements, ≥70% of practitioners rated the item as median ≤2 (i.e., disagree or strongly disagree) for disagreement with the item

Consensus agreement or consensus disagreement was achieved if both of the above criteria were met. If only one of the criteria was met, it was considered to be partial consensus agreement/disagreement. If neither criterion were met, the item was considered to not have consensus agreement or consensus disagreement.

In Round 1, items with consensus agreement or disagreement were converted into draft Recommendations and included in the first draft of the Guideline Recommendations (either as a Consensus-Based Recommendation or a Good Practice Point). Items with partial agreement/disagreement or no consensus agreement/disagreement were retained for review and consideration in the Round 2 survey (as outlined in the above section regarding the Round 2 survey development).

In Round 2, items with consensus agreement or disagreement were converted into draft Recommendations and incorporated into the second draft of the Guideline

Recommendations. Items with partial consensus agreement/disagreement or no consensus agreement/disagreement in Round 2 were not considered further and did not inform the Recommendations in the Guideline.

Qualitative analysis

Round 1 qualitative data was used to inform the modification of items in the Round 2 Delphi survey that did not have consensus agreement/disagreement in Round 1. In addition, all qualitative data from Round 1 and Round 2 were read and reviewed (quote by quote) during the Recommendation drafting process. During this process, the qualitative data were used to (a) cross-check and validate the drafted Recommendations against the qualitative data that had been collected, and, (b) where relevant, used as illustrative quotes in support, and/or contextualisation, of Recommendations.

9.6 Results

Participant characteristics

Table 9.1 outlines the professional organisations and the number of practitioners represented in each round of the Delphi study.

Round 1

One hundred practitioners based in Australia were invited to participate in Round 1. Seventy-two practitioners representing six professions from five professional organisations participated in Round 1 (see Table 9.1). Of those, 68 completed the Round 1 survey in full, 4 partially completed the survey. The overall response rate in Round 1 was 72%. Practitioners had, on average, 15 years' experience in working in clinical practice with autistic children (*M* = 15 years, *SD* = 9.60; Range: 1.5-41 years).

The majority of practitioners (n=60, 83%) were currently providing supports to autistic children and their families. Other practitioners were involved in support provision through supervising others in their provision of supports (n=6, 8%), conducting research into clinical practice for autistic children and their families (n=2, 3%), or involved in professional organisations or departments (i.e., education) that support the provision of supports (n=3, 4%). Over half of the practitioners were currently involved in support provision through a combination of these practices (n=37, 51%).

In the previous year (i.e., in 2021), 93% (n=67) of practitioners had provided supports to autistic children aged 0-12 years. Two practitioners (3%) had only provided supports to individuals aged over 12 years in 2021, and three practitioners had not provided supports to autistic people in 2021 (4%).

Across their career, 60% (n=43) of practitioners had predominately provided supports to children aged 12 years or younger, 37.5% (n=27) had predominately provided supports to age groups younger and older than 12 years, and 3% (n=2) of practitioners had predominately provided supports to people over 12 years. The most frequently endorsed age groups that practitioners had provided supports across their career were: 4-6 years (n=63), 7-9 years (n=54), 10-12 years (n=41), and 0-3 years (n=35).

All states and territories were represented in the Round 1 survey. Practitioners were predominately currently practicing in New South Wales (n=22), Victoria (n=21), and Queensland (n=15) with smaller representation from Western Australia (n=5), South Australia (n=5), Australian Capital Territory (n=4), Tasmania (n=1), and Northern Territory (n=1). Seventy percent of practitioners worked with families in major cities, and 30% worked with families in regional/remote areas.

Of practitioners in Round 1, 69% (n=50) currently worked in private, non-government organisations, 15% (n=11) worked in government organisations, and 15% (n=11) worked in both private and government organisations. The most frequently endorsed settings in which practitioners provided supports to autistic children and their families were: community clinics (n=55), mainstream schools (n=33), the child's home (n=28), and early childhood education centres (n=22). Of the 72 practitioners in Round 1, 74% (n=53) delivered supports using both face-to-face and telehealth formats, 25% (n=18) delivered support in a face-to-face format only, and 1% (n=1) delivered supports to autistic children and their families via telehealth only.

Round 2

All seventy-two practitioners that participated in the Round 1 survey were invited to participate in Round 2. Fifty-nine practitioners representing six professions from five professional organisations participated in Round 1 (see Table 9.1). All practitioners completed the Round 2 survey in full. The overall response rate in Round 2 was 82%.

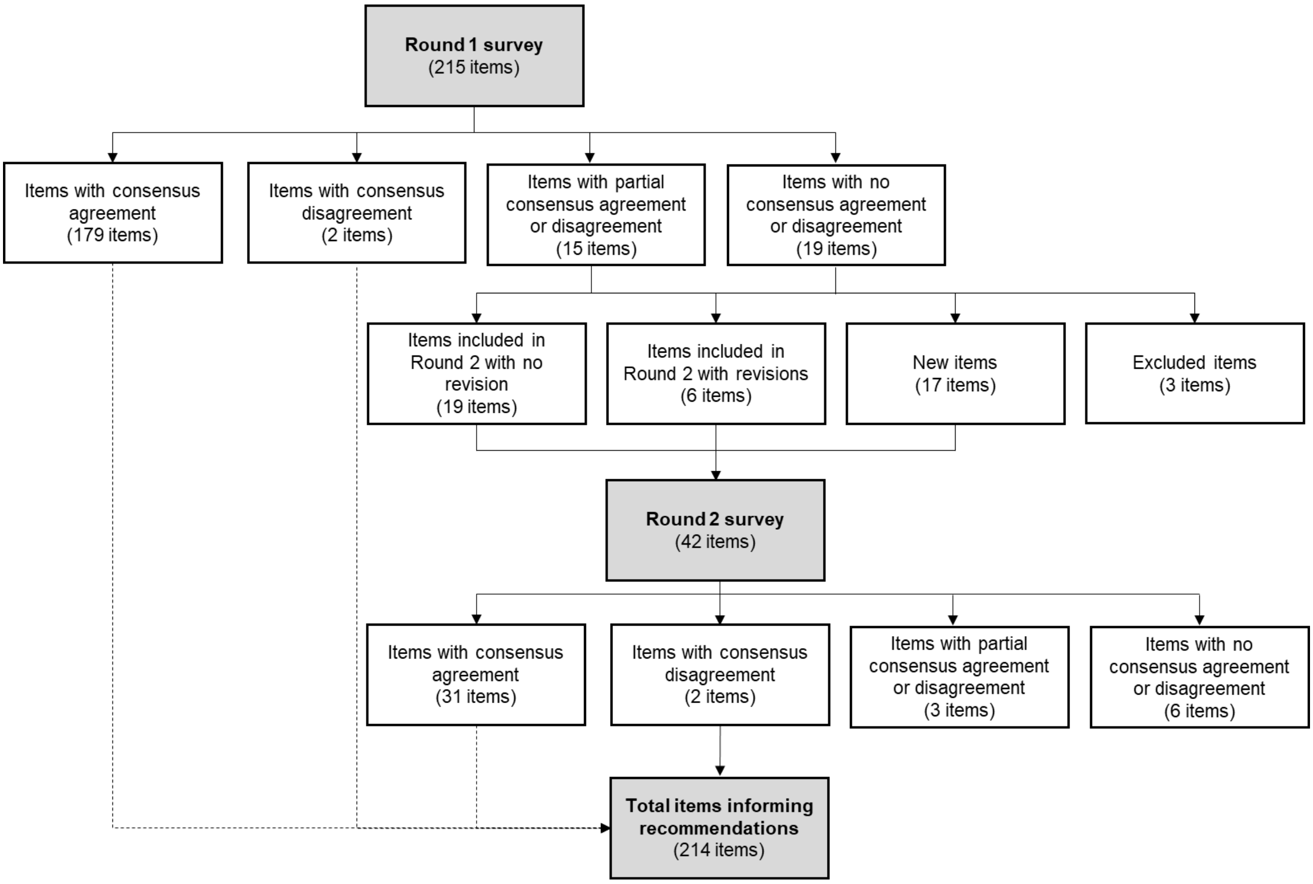
Table 9.1. Professional organisations, practitioner professions, and the number of participants in each Delphi survey round.

Professional organisation	Practitioners	Invited Round 1	Participated Round 1	Participated Round 2
Neurodevelopmental and Behavioural Paediatrics Society of Australia	Medical doctors	20	15 (14 paediatricians, 1 psychiatrist	12 (11 paediatricians, 1 psychiatrist)
Occupational Therapy Australia	Occupational therapists	20	18	15
Australian Physiotherapy Association	Physiotherapists	20	15	14
Australian Psychological Society	Psychologists	20	12	7
Speech Pathology Australia	Speech pathologists	20	12	11
Total		100	72	59

Quantitative data

The summary of results for the items with quantitative ratings are presented in Figure 9.1. Across the two rounds, a total of 214 items with consensus agreement/disagreement informed Recommendations within the Guideline. Percentage agreement/disagreement, median, and interquartile ranges are provided in the Evidence Summaries within the Supporting Evidence document, for each Recommendation that was directly informed by evidence from the Delphi study.

Figure 9.1. Delphi survey rounds quantitative items flowchart.



Qualitative data

As noted above, each round of the Delphi survey gave practitioners an opportunity to provide optional qualitative feedback. These responses were not coded using the coding framework (used for online survey, focus groups, brief survey, and parent reflection) because the coding framework reflected statements in the Delphi survey. Therefore, when making additional comments, they were indicating that the number and nature of statements in the Delphi survey, that were in turn reflected in the coding framework, were insufficient in accounting for their views and experiences (i.e., they had additional views and experiences to offer). Accordingly, every comment by every practitioner was considered on a case-by-case basis, when formulating Recommendations and Good Practice Points, and accompanying evidence summaries.

10. Community Consultation: Brief Online Survey

10.1 Background

Integral to the development of the Guideline was consultation with the autistic and autism communities. Consistent with the recommendations in the Guidelines for Guidelines handbook (NHMRC, 2016), community consultation was conducted to ensure that all relevant stakeholders within Australia were provided with the opportunity to inform the development of the Guideline. This was key to enhancing the relevance and acceptability of the Guideline to the autistic and autism communities. The consultation process was also conducted to (a) complement the current research evidence, and/or (b) gather information and insight from relevant stakeholders where research evidence is currently lacking.

This consultation activity was designed to capture the experiences, views and preferences of autistic children and young people in the Guideline development process. This activity was also open to autistic people who communicate in ways other than speech.

10.2 Aim

The aim of the brief online survey was to understand the experiences, views and preferences of autistic children and young people (and autistic people who communicate in ways other than speech) regarding the provision of supports for autistic children and their families.

10.3 Research question

What are the experiences, views and preferences of autistic children, young people and adults regarding accessing supports?

10.4 Design

An online survey methodology was adopted. This was a one-off survey, comprising three key questions, accessed via a link on the Autism CRC website. The survey was designed so that it could be completed by typing responses with or without the help of a parent/caregiver.

The survey was open from 6th April to 30th April, 2022.

10.5 Method

Ethical approval for this community consultation activity was provided by Griffith University Human Research Ethics Committee (2021/843). A variation was sought to our original, approved protocol, to include this activity to ensure that children and young people had the option to directly share their experiences, views and preferences in accessing supports.

Eligibility

Autistic children and young people aged 0-17 years (and autistic people of all ages whose primary/preferred communication mode is not spoken language) were eligible to participate in the brief online survey.

Recruitment

Participant recruitment for the brief online survey was predominantly facilitated by Autism CRC. Autism CRC sent an invitation and reminder emails to all individuals who registered their interest in the Guideline, informing them of the opportunity for autistic children and young people (including people who communicate in ways other than speech) to contribute to the Guideline's development via the brief online survey. The link to access the brief survey was also made available via the Autism CRC Supporting Children Guideline website, and social media (Facebook and Twitter) accounts. Members of the GDG also promoted the brief online survey throughout their professional networks and social media pages.

After accessing the brief online survey link, prospective participants and/or their parents were presented with a short video outlining what participation in the survey would entail and highlighting accessibility features of the survey platform. Following this, participants were presented with a Participant Information Statement and Consent Form. As part of the Informed Consent process, it was made clear that the parent is responsible for providing informed consent for their child's participation (when the child was under 18 years of age). All participants were required to provide informed consent before accessing the survey questions.

Tools

The brief online survey was coded and distributed via REDCap (a secure web-based application for survey development and distribution). The survey comprised three sections: (1) a demographic survey, (2) the main set of survey questions for the child, young person, or adult, and (3) questions for the parent (see Appendix 10.1).

For the main set of survey questions, parents were asked to describe the activity to the child, young person or adult person in a way that best matches their understanding. Parents were encouraged to use the name of supports that would be most familiar to the child, young person or adult.

- The main part of the survey involved a set of three questions:
- What was/is your most favourite thing about [named support]?
- What was/is your least favourite thing about [named support]?
- What could make it better? (with reference to the [named support]?

For children aged 0-12 years, it was requested that parents ask the child to write or talk about supports they are currently accessing. For children >12 years, it was requested that parents write or talk about supports they accessed when they were under 12 years of age. Children, young people and adults could choose to type their responses independently into the survey, use a voice-to-text option, or have a parent type their responses. It was requested that if the latter option is chosen, that the parent types exactly what the child, young person or adults says to ensure that their own words were captured. There was also the option to complete the set of three questions for more than type of support (i.e., by answering the set of three questions up to 5 times).

In order to help contextualise the responses of the children, young people, and adults, parents were asked to describe (a) what type of supports the child was talking about, (b) what their reflections were about (i.e., whether it was in relation to the entire time they accessed supports or just part of the time), (c) whether the survey was completed independently or with assistance from the parent, and (d) any other information they would like to provide.

All questions were optional. If parents had more than one child, they were able to repeat the survey for each child.

Analysis

Information collected via the brief survey was coded according to 'principles' using the process outlined in detail in relation to the online survey (Chapter 7). This approach – rather than coding according to each section of the code book (e.g., selection of supports, delivery of supports) was adopted because the questions asked of participants in this study were deliberately of a general nature, to ensure participants were free to share whatever they felt was most relevant. However, to ensure that no specific insights, experiences, or suggestions that may be relevant to formulating Recommendations and Good Practice Points were missed, the GDG also reviewed the raw data (i.e., each participant's response to each question) to ensure that all information was considered in relation to all Guideline questions, Recommendations and Good Practice Points.

10.6 Results

Participant characteristics

In total, 46 individuals provided informed consent for the brief online survey. Of these, 35 provided some information beyond informed consent (i.e., 11 individuals provided informed consent but no other information or responses to the survey items).

Table 10.1. Demographic information for participants who completed at least some items of the brief online survey.

Aspect	Summary
Age	The average (current) age of autistic children, young people and adults completing the brief survey was 12.33 years (SD = 7.28), with ages ranging from 4 years to 37 years. 11 individuals did not provide a response.
Gender identity	13 of the autistic children/young people/adults identified as female (28%), 17 identified as male (37%), 1 as non-binary (2%), and 1 preferred not to say (2%). 14 participants (30%) did not provide a response.
Aboriginal and/or Torres Strait Islander Peoples	1 (2%) autistic person identified as Aboriginal. 32 (70%) did not identify as Aboriginal or Torres Strait Islander. 13 participants (28%) did not provide a response.
Born in Australia	30 of the children/young people/adults (65%) were born in Australia. 2 (4%) were not born in Australia. 14 participants (30%) did not provide a response.
Languages other than English	2 children/young people/adults (4%) were living homes where a language other than English was spoken. 31 (67%) were living in homes where only English was spoken. 13 participants (28%) did not provide a response.
Formal diagnosis of autism	30 children/young people/adults (65%) had received a formal diagnosis of autism. 2 (4%) had not received a formal diagnosis of autism. 14 participants (30%) did not provide a response.
Age of autism diagnosis	The average age of diagnosis was 6.29 years (SD = 4.29), with ages ranging from 1 years to 18 years. 18 participants (39%) did not provide a response.
DSM-5 diagnosis level of support	Of children/young people/adults diagnosed under the DSM-5, the following support levels were associated with the child/young person's diagnosis: 7 were diagnosed at Level 1. 11 were diagnosed at Level 2. 11 were diagnosed at Level 3. 1 participant preferred not to say the associated support level. 16 participants did not provide responses.

Representative DSM-5 level of support	Of children/young people/adults not diagnosed under the DSM-5, participants reported the following would have been most representative of their support needs as a child: 2 selected Level 1 as most representative. 0 selected Level 2 as most representative. 5 selected Level 3 as most representative.
Access to supports between 0-6 years	25 (54%) children/young people/adults accessed supports between the ages of 0-6 years. 6 families (13%) did not access supports between 0-6 years. 15 participants (33%) did not provide responses.
Access to supports between 7-12 yearszz	26 (57%) children/young people/adults accessed supports between the ages of 7-12 years. 6 families (13%) did not access supports between the ages of 7-12 years. 14 participants (30%) did not provide a response.

Quantitative data

No quantitative data were collected in this activity.

Qualitative data

A total of 69 references (i.e., quotes) were coded using the framework, with the distribution of references for each code presented in Table 10.2. These quotes, where relevant to the formulation of Recommendations and Good Practice Points, feature in the corresponding evidence summaries.

Table 10.2. Summary of codes and references for the two types of focus groups.

Codes	Total Across All Participants
Principles	
Accessible	4
Assent (children)	2
Child and family-centred	16
Coordinated	1
Culturally aware and responsive	0
Developmental perspective	0
Empirically-supported	0

Equity	0
Ethical practice	8
Evidence-based practice approach	0
Holistic	6
Informed consent (parents)	0
Lifespan perspective	0
Other - Principle	4
Personalised	18
Qualified practitioners	0
Strengths focused	7
Supported	3

Credibility checks were completed for all quotes that featured in the analysis of qualitative data from the brief survey. 100% were classified as ‘relevant to the guideline and code,’ 0% were classified as ‘relevant to the guideline, but cannot establish relevance to code,’ and 0% were classified as ‘does not appear to be relevant to the Guideline.’ Readers are reminded that the person completing the credibility check was reviewing the coded data, not the original transcripts. Accordingly, they did not necessarily have knowledge of the context (e.g., broader statement) from which the quotes had been extracted.

11. Community Consultation: Parent Reflection

11.1 Background

Integral to the development of the Guideline was consultation with the autistic and autism communities. Consistent with the recommendations in the Guidelines for Guidelines handbook (NHMRC, 2016), community consultation was conducted to ensure that all relevant stakeholders within Australia were provided with the opportunity to inform the development of the Guideline. This was key to enhancing the relevance and acceptability of the Guideline to the autistic and autism communities. The consultation process was also conducted to (a) complement the current research evidence, and/or (b) gather information and insight from relevant stakeholders where research evidence is currently lacking.

This consultation activity was designed for parents of autistic people who communicate/d mostly in ways other than speech to share their reflections and observations of their child or young person accessing supports when they were between 0-12 years of age.

11.2 Aim

The aim of this consultation activity was to understand the experiences, views and preferences of autistic children and their families regarding the provision of supports, through parents' observations of their child accessing supports between 0-12 years of age.

11.3 Research question

What are the experiences, views and preferences of autistic children, young people and their families as shared through parent observation regarding accessing supports between 0-12 years of age?

11.4 Design

A qualitative, online survey methodology was adopted. This was a one-off survey designed for parents of autistic children or young people to complete, comprising a set of questions regarding their child or young person's experiences accessing supports. Access to the survey was via a link on the Autism CRC website.

The survey was open from 6th April to 30th April, 2022.

11.5 Method

Ethical approval for this community consultation activity was provided by Griffith University Human Research Ethics Committee (2021/843). A variation was sought to our original, approved protocol, to include this activity to ensure that children, young people and their family's experiences of accessing supports during childhood was included in the Guideline development process.

Eligibility

Parents of children who accessed supports and communicate/d mostly in ways other than speech during the ages of 0-12 years.

Recruitment

Participant recruitment for the parent reflection activity was predominantly facilitated by Autism CRC. Autism CRC sent an invitation and reminder emails to all individuals who registered their interest in the Guideline, informing them of the opportunity to contribute to the Guideline's development via the parent reflection activity. The link to access the parent reflection activity was also made available via the Autism CRC Supporting Children Guideline website, and social media (Facebook and Twitter) accounts. Members of the GDG also promoted the parent reflection activity throughout their professional networks and social media pages.

After accessing the parent reflection survey link, prospective participants were presented with a short video outlining what participation in the activity would entail and highlighting accessibility features of the survey platform. Following this, participants were presented with a Participant Information Statement and Consent Form. As part of the Informed Consent process, it was made clear that the parent was responsible for providing informed consent for their child. All participants were required to provide informed consent before accessing the survey questions.

Tools

The parent reflection survey was coded and distributed via REDCap (a secure web-based application for survey development and distribution). The survey comprised three sections: (1) a demographic survey with questions for parents to complete about their child, young person or adult, (2) questions for the parent to complete about what types of supports, and over what timeframe, they are providing reflections, and (3) a set of questions for the parents to provide reflections on (see Appendix 11.1).

For the set of reflection questions, parents were asked to reflect on, and provide observations to, the following questions:

- What do you think they currently like (or did like if in the past) about accessing these supports? How do/did they show you through their emotions and actions?
- What do you think they do not like (or did not like if in the past) about accessing these supports? How do/did they show you through their emotions and actions?
- What do you think they would like to change about accessing these supports? How do/did they show you through their emotions and actions?
- Is there anything else you would like to share to help us understand their experiences of accessing supports?

For children aged 0-12 years, it was requested that parents reflect on the experiences of supports they are currently accessing. For children >12 years, it was requested that parents reflect on supports they accessed when their child was under 12 years of age.

All questions were optional.

Analysis

Information collected via the parent reflect study was coded according to ‘principles’ using the process outlined in detail in relation to the online survey (Chapter 7). This approach – rather than coding according to each section of the code book (e.g., selection of supports, delivery of supports) was adopted because the questions asked of participants in this study were deliberately of a general nature, to ensure participants were free to share whatever they felt was most relevant. However, to ensure that no specific insights, experiences, or suggestions that may be relevant to formulating Recommendations and Good Practice Points were missed, the GDG also reviewed the raw data (i.e., each participant’s response to each question) to ensure that all information was considered in relation to all Guideline questions, Recommendations and Good Practice Points.

11.6 Results

Participant characteristics

In total, 25 parents/primary caregivers/legal guardians of autistic children, young people or adults provided informed consent to participate in this activity. Demographic information for the children, young people or adults that parents were providing reflections on, is presented in Table 11.1.

Table 11.1. Demographics of children, young people and adults from parent reflections and observation regarding accessing supports.

Aspect	Summary
Age	The average (current) age of autistic children, young people and adults that parents provided reflections on was 11.68 years (SD = 6.61), with ages ranging from 2 years to 23 years.
Gender identity	9 of the autistic children/young people/adults identified as female (36%), and 16 identified as male (64%).
Aboriginal and/or Torres Strait Islander Peoples	3 (12%) autistic children/young people identified as Aboriginal. 21 (84%) did not identify as Aboriginal or Torres Strait Islander. 1 participant (4%) did not provide a response.
Born in Australia	24 of the children/young people/adults (96%) were born in Australia. 1 child/young person/adult (4%) was not born in Australia.
Languages other than English	3 children/young people/adults (12%) were living homes where a language other than English was spoken. 21 (84%) were living in homes where only English was spoken. 1 participant (4%) did not provide a response.
Formal diagnosis of autism	All children/young people/adults (n=25, 100%) had received a formal diagnosis of autism.

Age of autism diagnosis	The average age of diagnosis for children was 4.72 years (SD = 3.46), with ages ranging from 2 years to 14 years.
DSM-5 diagnosis level of support	Of the children/young people diagnosed under the DSM-5, parents reported the following support levels associated with their child/young person's diagnosis: 3 were diagnosed at Level 1. 11 were diagnosed at Level 2. 8 were diagnosed at Level 3. 1 participant was unsure of the associated support level.
Representative DSM-5 level of support	Of children/young people not diagnosed under the DSM-5, parents reported the following would have been most representative of their supports needs as a child: 1 selected Level 1 as most representative. 2 selected Level 2 as most representative. 4 selected Level 3 as most representative.
Access to supports between 0-6 years	21 (84%) out of the 25 children and families accessed supports at some stage between the ages of 0-6 years. 3 families (12%) did not access supports between 0-6 years. 1 participant (4%) did not provide a response.
Access to supports between 7-12 years	16 (64%) out of the 25 children and families accessed supports at some stage between the ages of 7-12 years. 7 families (28%) did not access supports between the ages of 7-12 years. 2 participants (8%) did not provide a response.

Quantitative data

No quantitative data were collected in this activity.

Qualitative data

A total of 70 references (i.e., quotes) were coded using the framework, with the distribution of references for each code presented in Table 11.2. These quotes, where relevant to the formulation of Recommendations and Good Practice Points, feature in the corresponding evidence summaries.

Table 11.2. Summary of codes and references

Codes	Total Across All Participants
Principles	
Accessible	10
Assent (children)	0
Child and family-centred	11
Coordinated	4
Culturally aware and responsive	0
Developmental perspective	2
Empirically-supported	0
Equity	0
Ethical practice	3
Evidence-based practice approach	3
Holistic	3
Informed consent (parents)	0
Lifespan perspective	0
Other - Principle	4
Personalised	22
Qualified practitioners	0
Strengths focused	5
Supported	3

Credibility checks were completed for all quotes that featured in the analysis of qualitative data from the parent reflection activity. 100% were classified as 'relevant to the guideline and code,' 0% were classified as 'relevant to the guideline, but cannot establish relevance to code,' and 0% were classified as 'does not appear to be relevant to the Guideline.' Readers are reminded that the person completing the credibility check was reviewing the coded data, not the original transcripts. Accordingly, they did not necessarily have knowledge of the context (e.g., broader statement) from which the quotes had been extracted.

12. Community Consultation: Expression Through Artwork

12.1 Background

Integral to the development of the Guideline was consultation with the autistic and autism communities. Consistent with the recommendations in the Guidelines for Guidelines handbook (NHMRC, 2016), community consultation was conducted to ensure that all relevant stakeholders within Australia were provided with the opportunity to inform the development of the Guideline. This was key to enhancing the relevance and acceptability of the Guideline to the autistic and autism communities. The consultation process was also conducted to (a) complement the current research evidence, and/or (b) gather information and insight from relevant stakeholders where research evidence is currently lacking.

This consultation activity was designed for autistic people who may prefer to share their experiences, views and preferences regarding supports for autistic children and their families through artistic expression.

12.2 Aim

To capture the experiences, views and preferences of autistic people (of all ages) regarding the provision of supports for autistic children and their families, through artistic expression.

12.3 Research question

What are the experiences, views and preferences of autistic people (as expressed through artwork) regarding the provision and accessing of supports?

12.4 Design

A qualitative methodology approach was adopted, through artwork. Autistic people could submit a piece of art (e.g., a drawing, painting, or any other artwork) online (via a secure online portal) about their experiences and/or feelings of accessing supports.

This activity was open from 6th April to 30th April, 2022.

12.5 Method

Ethical approval for this community consultation activity was provided by Griffith University Human Research Ethics Committee (2021/843). A variation was sought to our original, approved protocol, to include this activity to ensure that autistic people had the option to share their experiences, views and preferences through artistic expression regarding the provision and accessing of supports during childhood.

Participant eligibility

Autistic children, young people and adults who accessed supports between the ages of 0-12 years.

Recruitment

Participant recruitment for the sharing of experiences through artwork was predominantly facilitated by Autism CRC. Autism CRC sent an invitation and reminder emails to all individuals who registered their interest in the Guideline, informing them of the opportunity for autistic people to contribute to the Guideline's development through artistic expression. A link to access information about this activity and how to upload artwork was also made available via the Autism CRC Supporting Children Guideline website, and social media (Facebook and Twitter) accounts. Members of the GDG also promoted this activity throughout their professional networks and social media pages.

After clicking on the link, prospective participants were presented with a short video outlining what participation in this activity would entail. Following this, participants were presented with a Participant Information Statement and Consent Form. For children aged under 18 years, informed consent was the responsibility of their parent.

Tools

This activity was accessed via REDCap (a secure web-based application for survey development and distribution). The activity involved a brief (optional) demographic survey about the autistic person submitting the artwork.

Regarding the artwork, autistic people were invited to produce a piece of art (e.g., a drawing, painting, or any other artwork) about their experiences and/or feelings of accessing supports. Parents (where relevant) were asked to describe the activity to the child, young person or adult person in a way that best matches their understanding.

For children aged 0-12 years, it was requested that parents ask the child to create a piece of art about supports they are currently accessing. For children >12 years, it was requested that they create a piece of art about supports they accessed when they were under 12 years of age.

Participants could then take a photo or scan the artwork and upload it via a provided link in the online survey form.

To help us understand and interpret the artwork, participants were asked to answer some brief questions (to the extent that it was possible) including, 'what is the artwork about?' and any other information they would like to share to help us understand their artwork.

There were also some questions for the parent, where relevant, including what they think the artwork reflects about their child's experiences/feelings accessing supports and what types of supports are reflected. The demographic questions, activity instructions, and associated questions are outlined in Appendix 12.1 and Appendix 12.2.

Analysis

There were no submissions through this mode.

12.6 Results

Participant characteristics

No autistic people chose to share their experiences, views, or preferences regarding the provision and accessing of supports through this mode.

Quantitative data

No quantitative data were collected in this activity.

Qualitative data

There were no submissions through this mode.

13. References

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14. Appendices

The appendices have been prepared for the Draft Administration and Technical Report in draft form. These documents will be further updated and formatted prior to the release of the final Guideline.

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Appendix 2.1	Guideline Development Group – Terms of Reference

Developing a national guideline for supporting the development and participation of children on the autism spectrum, and their families, in Australia

Terms of Reference for the Guideline Development Group

Background

The Autism Cooperative Research Centre (Autism CRC) has commissioned Professor Andrew Whitehouse and Associate Professor David Trembath to develop a national guideline that outlines clinical recommendations for supporting the development and participation of children on the autism spectrum, and their families, in Australia (‘the project’).

Purpose

The Autism CRC has asked Prof Whitehouse and A/Prof Trembath to form a team (‘Guideline Development Group’) that will conduct the background research for the project and prepare the draft and final documents. The Guideline Development Group will exist for the duration of the project.

Anticipated timeline for the project

The project is scheduled to commence on Oct 1st 2021, and be completed by Sept 30th 2022.

Membership of the Guideline Development Group

Membership of the Guideline Development Group is informed by the ‘Guideline for Guidelines’ recommendations provided by the National health and Medical Research Council. The Guideline Development Group comprises Prof Andrew Whitehouse (co-chair), A/Prof David Trembath (co-chair), clinical researchers (X 4), an individual with ethics expertise (X 1), an individual with expertise in the methodology for guideline development (X 1), and representatives from the following communities: autistic adults (X 2), parent/families members of individuals on the autism spectrum (X 2), clinician with a current caseload including children on the autism spectrum (X 2), First Nations peoples (X 1).

Appointment of Chair

The co-chairs of the Guideline Development Group are Professor Whitehouse and Associate Professor Trembath, who will each have clearly delegated duties.

Responsibilities of Project Team Members

Prof Whitehouse (co-Chair) will:

- Along with David Trembath, assumes overall responsibility for delivering the project.

- Coordinate and chair meetings with the Reference Group
- Coordinate all engagement with stakeholders external to the Guideline Development Group, including (but not limited to) the Reference Group, the Autism CRC and the National Disability Insurance Agency.
- Along with a A/Prof Trembath, line manage the clinical researchers.
- Participate in the day-to-day research activities of the project, as guided by A/Prof Trembath.

A/Prof Trembath (co-Chair) will:

- Along with Chair, assume overall responsibility for delivering the project.
- Coordinate and chair meetings with the Guideline Development Group.
- Coordinate all engagement with the Guideline Development Group.
- Along with Prof Whitehouse, line manage the activities of the clinical researchers
- Guide the day-to-day research activities of the project.

The clinical researchers will:

- Attend meetings as required throughout the duration of the project.
- Work under the supervision of Prof Whitehouse and A/Prof Whitehouse to undertake the day-to-day activities of the project.

Other members of the Guideline Development Group:

- Attend meetings as required throughout the duration of the project (all).
- Provide input in the areas of expertise and experience they bring to the Guideline Development Group, such as lived experience of autism, ethics, guideline methodology, and cultural knowledge.
- Respond to ‘out of meeting’ emails from Chair/Deputy Chair requesting guidance.
- Provide feedback on documents that are prepared for the Guideline, within an agreed timeframe (likely 14 days).

Meetings

The Guideline Development Group will meet as often as it agrees or as required, but likely no more than 10 times throughout the duration of the project. The Project Team could expect to meet bi-monthly by videoconference. The Project Team will meet via videoconference at the request of either of the co-chairs or at the request of two or more members of the Project Team. A quorum will be a majority of the Members present in person or by teleconference, including one of the co-Chairs.

Code of conduct for the Project Team

The Guideline Development Group recognises that this is a sensitive project that requires completion within a relatively short timeframe. As such, the Guideline Development Group agrees to the following:

- Conflicts of interest will be declared at the outset of the project, and be updated as any new potential conflicts emerge.
- All communication between Guideline Development Group members will be conducted in a respectful, constructive and cooperative way, and avoiding self-interest.
- The guideline generated by the Guideline Development Group will be based on a balanced evaluation of the strength of the evidence.
- All discussions within the Project Team will remain confidential to that Project Team until the conclusion of the project.

Reporting

The Project Team reports to the Autism CRC Ltd Board.

By signing below, I indicate that I agree to these Terms of reference.

Name	
Signature	

National guideline for supporting the learning, participation, and wellbeing of autistic children and their families in Australia

Appendix 2.2	Guideline Development Group – Declaration of Interests

Autism CRC National Practice Guideline

Disclosure of Interests

Date:	5 May 2022
First Name:	Gary
Surname:	Allen

Origin of Form

This form has been adapted (including direct replication of text where relevant) from:

- The International Committee of Medical Journal Editors (ICMJE) disclosure of interest form (https://www.icmje.org/disclosure-of-interest/)
- The Cochrane Collaboration Disclosure of Potential Conflicts of Interest form (https://community.cochrane.org/sites/default/files/uploads/EPPR/Cochrane-COI-disclosure-form.pdf)

Instructions

The purpose of this form is to provide readers of your review with information about your other interests that could influence how they receive and understand your work. We ask you to disclose all relationships/activities/interests listed below that are related to your involvement in the development of the National Practice Guideline (herein referred to as the *guideline*). “Related” means any relation with for-profit or not-for-profit third parties whose interests may be affected by the content of the guideline. Disclosure represents a commitment to transparency and does not necessarily indicate a bias. Please think broadly when disclosing all relationships/activities/interests that may be relevant to your involvement in the guideline. If you are in doubt about whether to list a relationship/activity/interest, it is preferable that you do so.

Each person will be asked to complete their own form and you are responsible for the accuracy and completeness. In submitting this form, you certify that you have answered every question and have not altered the wording of any of the questions on this form.

If new interests arise during the project, you are required to submit an updated form.

1. Support for your involvement in the development of the guideline.

This section asks for information about your role in the development of the guideline. The time frame for this reporting is that of the work itself, from the initial conception and planning to the present. The requested information is about resources that you received, either directly or indirectly (via your institution), to enable you to complete the work. Writing "None" means that you did the work without receiving any financial support from any third party -- that is, the work was supported by funds from the same institution that pays your salary and that institution did not receive third-party funds with which to pay you. If you or your institution received funds from a third party to support the work, such as a government granting agency, charitable foundation or commercial sponsor, then provide the details. For example, if you received an honorarium from Autism CRC in relation to your involvement, you would name Autism CRC and then indicate the amount of funds received.

Did you or your institution at any time receive payment or services from a third party for any aspect of your involvement in the development of the guideline?

Please add more rows if necessary.

	Name all entities that provided support (or indicate none)	**Description of support (e.g., amount of funding, time in lieu)**
Grant	None	
Consulting fee or honorarium	I am a senior consultant with, and Managing Director of Australasian Human Research Ethics Consultancy Services (AHRECS). I am also the Co-Founder and CEO of Enabled.vip. I am a paid member of the National Mutual Acceptance Committee. I am a full time staff member in the Office for Research, Griffith University	AHRECS (www.ahrecs.com) currently pays me around $5000 per month. Enabled.vip (www.enabled.vip) is currently a voluntary role, though the hope is that it will eventually be a paid role
Support for travel to meetings for the guideline or other purposes	None	
Other	None	

2. Relevant financial activities outside the guideline (2019-2022)

This section asks about your financial relationships with entities in the field of autism that could be perceived to influence, or that give the appearance of potentially influencing, your involvement in the guideline. These relationships may include clinical service providers; companies that sell products that autistic people, their families, or service providers may purchase; and organisations that represent and/or advocate for autistic people, their families, and/or service providers. You should disclose interactions with ANY entity that could be considered broadly relevant to the work. Report all sources of revenue paid (or promised to be paid) directly to you or your institution on your behalf over the 36 months prior to commencing work on the guideline, and up until the point it is submitted to Autism CRC (i.e., 2019-2022). This should include all monies from sources with relevance to the guideline, not just monies from Autism CRC which sponsored the research. Please note that your interactions with Autism CRC that are outside the guideline should also be listed here. If there is any question, please disclose the relationship. For grants you have received for work outside the guideline, you should disclose support only from entities that could be perceived to be affected financially by the published work, such as Government departments and agencies (e.g., National Disability Insurance Scheme), service providers, companies, business (including where self-employed), or foundations supported by entities that could be perceived to have a financial stake in the outcome.

	Name all entities with whom you have this relationship or indicate none (add rows as needed)	**Specifications/comments (e.g., description of support, if payments were made to you or your institution)**

Grants or contracts from any entity (if not indicated in item #1 above).	None	
Royalties or licenses	None	
Consulting fees	None	
Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	None	
Payment for expert testimony	None	
Support for attending meetings and/or travel	None	
Patents planned, issued or pending	None	
Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	None	
Grants or contracts from any entity (if not indicated in item #1 above).	None	
Royalties or licenses	None	
Consulting fees	None	
Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	None	
Payment for expert testimony	None	
Support for attending meetings and/or travel	None	
Patents planned, issued or pending	None	
Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	None	
Stock or stock options	None	
Receipt of equipment, materials, drugs, medical writing, gifts or other services	None	

3. Relevant other activities or relationships, including non-financial relationships (no time limit)

Are there other relationships or activities that readers could be perceived to have influenced, or that could give the appearance of potentially influencing, your involvement in the guideline? If so, please specify.

	Specifications/comments (e.g., description of the relationship/activity/organisations involved)
Development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	None
A personal relationship with another person (e.g., spouse, family member) involved in the development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	None
Development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
A personal relationship with another person (e.g., spouse, family member) involved in the development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
Personal and/or family member experience of accessing therapies and/or support that may be covered in the guideline	None
Other	None

Declaration

If your answer is different from 'No' to any of the questions above, you may have a competing interest which should be declared. These will be reviewed by the co-Chairs of the Guideline Development Group. If the co-Chairs have answered other than ‘none’ to any of the questions above, these will be reviewed by Dr Gary Allen, Senior Policy Officer Human Research Ethics and Research Integrity at Griffith University. In each case, appropriate processes will be put in place to management any conflicts arising. Team members should not be concerned about answering 'yes' to any of the questions. 'Yes' answers do not indicate good or bad, but are simply something to declare on the form and consider for inclusion in the declarations section of the guideline.

Autism CRC National Practice Guideline

Disclosure of Interests

Date:	12/05/2022
First Name:	Katharine Elisabeth
Surname:	Annear

Origin of Form

This form has been adapted (including direct replication of text where relevant) from:

- The International Committee of Medical Journal Editors (ICMJE) disclosure of interest form (https://www.icmje.org/disclosure-of-interest/)
- The Cochrane Collaboration Disclosure of Potential Conflicts of Interest form (https://community.cochrane.org/sites/default/files/uploads/EPPR/Cochrane-COI-disclosure-form.pdf)

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If new interests arise during the project, you are required to submit an updated form.

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Did you or your institution at any time receive payment or services from a third party for any aspect of your involvement in the development of the guideline?

Please add more rows if necessary.

	Name all entities that provided support (or indicate none)	**Description of support (e.g., amount of funding, time in lieu)**
Grant		
Consulting fee or honorarium	The Cooperative Research Centre for Living with Autism (Autism CRC)	Honorarium $5000
Support for travel to meetings for the guideline or other purposes		
Other		

2. Relevant financial activities outside the guideline (2019-2022)

This section asks about your financial relationships with entities in the field of autism that could be perceived to influence, or that give the appearance of potentially influencing, your involvement in the guideline. These relationships may include clinical service providers; companies that sell products that autistic people, their families, or service providers may purchase; and organisations that represent and/or advocate for autistic people, their families, and/or service providers. You should disclose interactions with ANY entity that could be considered broadly relevant to the work. Report all sources of revenue paid (or promised to be paid) directly to you or your institution on your behalf over the 36 months prior to commencing work on the guideline, and up until the point it is submitted to Autism CRC (i.e., 2019-2022). This should include all monies from sources with relevance to the guideline, not just monies from Autism CRC which sponsored the research. Please note that your interactions with Autism CRC that are outside the guideline should also be listed here. If there is any question, please disclose the relationship. For grants you have received for work outside the guideline, you should disclose support only from entities that could be perceived to be affected financially by the published work, such as Government departments and agencies (e.g., National Disability Insurance Scheme), service providers, companies, business (including where self-employed), or foundations supported by entities that could be perceived to have a financial stake in the outcome.

	Name all entities with whom you have this relationship or indicate none (add rows as needed)	**Specifications/comments (e.g., description of support, if payments were made to you or your institution)**
Grants or contracts from any entity (if not indicated in item #1 above).	Department of Social Services – Information Linkages and Capacity Building Grant	Grant made to The Autistic Self Advocacy Network of Australia and New Zealand – my role is subcontracted Operations Manager
Royalties or licenses	None	
Consulting fees	None	
Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	None	
Payment for expert testimony	None	

Support for attending meetings and/or travel	National Disability Insurance Agency	The NDIA Autism Advisory Group – travel and honorarium The Children, Families and Young People's Reference Group for the Independent Advisory Council to the NDIA– travel and honorarium
Patents planned, issued or pending	None	
Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	Non Executive Director Autism CRC Developmental Educators Australia Inc	Annual Directors Fees Chair - Voluntary position – self-regulating professional body
Stock or stock options	None	
Receipt of equipment, materials, drugs, medical writing, gifts or other services	None	

3. Relevant other activities or relationships, including non-financial relationships (no time limit)

Are there other relationships or activities that readers could be perceived to have influenced, or that could give the appearance of potentially influencing, your involvement in the guideline? If so, please specify.

	Specifications/comments (e.g., description of the relationship/activity/organisations involved)
Development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	None
A personal relationship with another person (e.g., spouse, family member) involved in the development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	None
Development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	Lecturer B (Teaching Specialist) Dpt Disability and Community Inclusion, College of Nursing and Health Sciences, Flinders University, South Australia
A personal relationship with another person (e.g., spouse, family member) involved in	None

the development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	
Personal and/or family member experience of accessing therapies and/or support that may be covered in the guideline	None
Other	None

Declaration

If your answer is different from 'No' to any of the questions above, you may have a competing interest which should be declared. These will be reviewed by the co-Chairs of the Guideline Development Group. If the co-Chairs have answered other than ‘none’ to any of the questions above, these will be reviewed by Dr Gary Allen, Senior Policy Officer Human Research Ethics and Research Integrity at Griffith University. In each case, appropriate processes will be put in place to management any conflicts arising. Team members should not be concerned about answering 'yes' to any of the questions. 'Yes' answers do not indicate good or bad, but are simply something to declare on the form and consider for inclusion in the declarations section of the guideline.

Autism CRC National Practice Guideline

Disclosure of Interests

Date:	4th May 2022
First Name:	Valsamma
Surname:	Eapen

Origin of Form

This form has been adapted (including direct replication of text where relevant) from:

- The International Committee of Medical Journal Editors (ICMJE) disclosure of interest form (https://www.icmje.org/disclosure-of-interest/)
- The Cochrane Collaboration Disclosure of Potential Conflicts of Interest form (https://community.cochrane.org/sites/default/files/uploads/EPPR/Cochrane-COI-disclosure-form.pdf)

Instructions

The purpose of this form is to provide readers of your review with information about your other interests that could influence how they receive and understand your work. We ask you to disclose all relationships/activities/interests listed below that are related to your involvement in the development of the National Practice Guideline (herein referred to as the *guideline*). "Related" means any relation with for-profit or not-for-profit third parties whose interests may be affected by the content of the guideline. Disclosure represents a commitment to transparency and does not necessarily indicate a bias. Please think broadly when disclosing all relationships/activities/interests that may be relevant to your involvement in the guideline. If you are in doubt about whether to list a relationship/activity/interest, it is preferable that you do so.

Each person will be asked to complete their own form and you are responsible for the accuracy and completeness. In submitting this form, you certify that you have answered every question and have not altered the wording of any of the questions on this form.

If new interests arise during the project, you are required to submit an updated form.

1. Support for your involvement in the development of the guideline.

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Did you or your institution at any time receive payment or services from a third party for any aspect of your involvement in the development of the guideline?

Please add more rows if necessary.

	Name all entities that provided support (or indicate none)	**Description of support (e.g., amount of funding, time in lieu)**
Grant	None	
Consulting fee or honorarium	None	
Support for travel to meetings for the guideline or other purposes	None	
Other	None	

2. Relevant financial activities outside the guideline (2019-2022)

This section asks about your financial relationships with entities in the field of autism that could be perceived to influence, or that give the appearance of potentially influencing, your involvement in the guideline. These relationships may include clinical service providers; companies that sell products that autistic people, their families, or service providers may purchase; and organisations that represent and/or advocate for autistic people, their families, and/or service providers. You should disclose interactions with ANY entity that could be considered broadly relevant to the work. Report all sources of revenue paid (or promised to be paid) directly to you or your institution on your behalf over the 36 months prior to commencing work on the guideline, and up until the point it is submitted to Autism CRC (i.e., 2019-2022). This should include all monies from sources with relevance to the guideline, not just monies from Autism CRC which sponsored the research. Please note that your interactions with Autism CRC that are outside the guideline should also be listed here. If there is any question, please disclose the relationship. For grants you have received for work outside the guideline, you should disclose support only from entities that could be perceived to be affected financially by the published work, such as Government departments and agencies (e.g., National Disability Insurance Scheme), service providers, companies, business (including where self-employed), or foundations supported by entities that could be perceived to have a financial stake in the outcome.

	Name all entities with whom you have this relationship or indicate none (add rows as needed)	**Specifications/comments (e.g., description of support, if payments were made to you or your institution)**
Grants or contracts from any entity (if not indicated in item #1 above).	None	
Royalties or licenses	None	
Consulting fees	None	
Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	None	
Payment for expert testimony	None	
Support for attending meetings and/or travel	None	
Patents planned, issued or pending	None	

Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	None	
Stock or stock options	None	
Receipt of equipment, materials, drugs, medical writing, gifts or other services	None	

3. Relevant other activities or relationships, including non-financial relationships (no time limit)

Are there other relationships or activities that readers could be perceived to have influenced, or that could give the appearance of potentially influencing, your involvement in the guideline? If so, please specify.

	Specifications/comments (e.g., description of the relationship/activity/organisations involved)
Development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	None
A personal relationship with another person (e.g., spouse, family member) involved in the development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	None
Development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
A personal relationship with another person (e.g., spouse, family member) involved in the development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
Personal and/or family member experience of accessing therapies and/or support that may be covered in the guideline	None

Other	None

Declaration

If your answer is different from 'No' to any of the questions above, you may have a competing interest which should be declared. These will be reviewed by the co-Chairs of the Guideline Development Group. If the co-Chairs have answered other than ‘none’ to any of the questions above, these will be reviewed by Dr Gary Allen, Senior Policy Officer Human Research Ethics and Research Integrity at Griffith University. In each case, appropriate processes will be put in place to management any conflicts arising. Team members should not be concerned about answering 'yes' to any of the questions. 'Yes' answers do not indicate good or bad, but are simply something to declare on the form and consider for inclusion in the declarations section of the guideline.

Autism CRC National Practice Guideline

Disclosure of Interests

Date:	12.5.2022
First Name:	Jess
Surname:	Feary

Origin of Form

This form has been adapted (including direct replication of text where relevant) from:

- The International Committee of Medical Journal Editors (ICMJE) disclosure of interest form (https://www.icmje.org/disclosure-of-interest/)
- The Cochrane Collaboration Disclosure of Potential Conflicts of Interest form (https://community.cochrane.org/sites/default/files/uploads/EPPR/Cochrane-COI-disclosure-form.pdf)

Instructions

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Each person will be asked to complete their own form and you are responsible for the accuracy and completeness. In submitting this form, you certify that you have answered every question and have not altered the wording of any of the questions on this form.

If new interests arise during the project, you are required to submit an updated form.

1. Support for your involvement in the development of the guideline.

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Did you or your institution at any time receive payment or services from a third party for any aspect of your involvement in the development of the guideline?

Please add more rows if necessary.

	Name all entities that provided support (or indicate none)	**Description of support (e.g., amount of funding, time in lieu)**
Grant	None	
Consulting fee or honorarium	Autism CRC	$4000 (not yet received)
Support for travel to meetings for the guideline or other purposes	None	
Other	None	

2. Relevant financial activities outside the guideline (2019-2022)

This section asks about your financial relationships with entities in the field of autism that could be perceived to influence, or that give the appearance of potentially influencing, your involvement in the guideline. These relationships may include clinical service providers; companies that sell products that autistic people, their families, or service providers may purchase; and organisations that represent and/or advocate for autistic people, their families, and/or service providers. You should disclose interactions with ANY entity that could be considered broadly relevant to the work. Report all sources of revenue paid (or promised to be paid) directly to you or your institution on your behalf over the 36 months prior to commencing work on the guideline, and up until the point it is submitted to Autism CRC (i.e., 2019-2022). This should include all monies from sources with relevance to the guideline, not just monies from Autism CRC which sponsored the research. Please note that your interactions with Autism CRC that are outside the guideline should also be listed here. If there is any question, please disclose the relationship. For grants you have received for work outside the guideline, you should disclose support only from entities that could be perceived to be affected financially by the published work, such as Government departments and agencies (e.g., National Disability Insurance Scheme), service providers, companies, business (including where self-employed), or foundations supported by entities that could be perceived to have a financial stake in the outcome.

	Name all entities with whom you have this relationship or indicate none (add rows as needed)	**Specifications/comments (e.g., description of support, if payments were made to you or your institution)**
Grants or contracts from any entity (if not indicated in item #1 above).	Australian Government Department of Education Skills and Employment	Aspect awarded contract for Positive Partnerships from 2021-2024.
Royalties or licenses	**None**	
Consulting fees	La Trobe University	Personal payment for marking of Early Start Denver Model video submissions.
Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	La Trobe University	Delivered lecture as part of autism subject at La Trobe University
Payment for expert testimony	**None**	

Support for attending meetings and/or travel	Every Child Conference (San Francisco)	Travel costs covered to present keynote at Every Child conference in San Francisco
Patents planned, issued or pending	**None**	
Participation on a Data Safety Monitoring Board or Advisory Board	**None**	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	**None**	
Stock or stock options	**None**	
Receipt of equipment, materials, drugs, medical writing, gifts or other services	None	

3. Relevant other activities or relationships, including non-financial relationships (no time limit)

Are there other relationships or activities that readers could be perceived to have influenced, or that could give the appearance of potentially influencing, your involvement in the guideline? If so, please specify.

	Specifications/comments (e.g., description of the relationship/activity/organisations involved)
Development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	Co-authored research papers on the Early Start Denver model. Contributed to the book 'Implementing the Group-Based Early Start Denver Model for Toddlers with Autism' Certified trainer and Certified therapist for Early Start Denver Model Develop and delivery workshops for Positive Partnerships that includes information about supports for autistic students.
A personal relationship with another person (e.g., spouse, family member) involved in the development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	None
Development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
A personal relationship with another person (e.g., spouse, family member) involved in the development and/or	None

delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	
Personal and/or family member experience of accessing therapies and/or support that may be covered in the guideline	None
Other	Worked for Victorian Department of Education and Training. Assisted with the development of the Victorian Autism Education Strategy.

Declaration

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Autism CRC National Practice Guideline

Disclosure of Interests

Date:	9/05/2022
First Name:	Emma
Surname:	GOODALL

Origin of Form

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- The International Committee of Medical Journal Editors (ICMJE) disclosure of interest form (https://www.icmje.org/disclosure-of-interest/)
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Did you or your institution at any time receive payment or services from a third party for any aspect of your involvement in the development of the guideline?

Please add more rows if necessary.

	Name all entities that provided support (or indicate none)	**Description of support (e.g., amount of funding, time in lieu)**
Grant	None	
Consulting fee or honorarium	Autism CRC	Honorarium for attendance at online meetings, reviewing document and providing input. $3,500
Support for travel to meetings for the guideline or other purposes	None	
Other	None	

2. Relevant financial activities outside the guideline (2019-2022)

This section asks about your financial relationships with entities in the field of autism that could be perceived to influence, or that give the appearance of potentially influencing, your involvement in the guideline. These relationships may include clinical service providers; companies that sell products that autistic people, their families, or service providers may purchase; and organisations that represent and/or advocate for autistic people, their families, and/or service providers. You should disclose interactions with ANY entity that could be considered broadly relevant to the work. Report all sources of revenue paid (or promised to be paid) directly to you or your institution on your behalf over the 36 months prior to commencing work on the guideline, and up until the point it is submitted to Autism CRC (i.e., 2019-2022). This should include all monies from sources with relevance to the guideline, not just monies from Autism CRC which sponsored the research. Please note that your interactions with Autism CRC that are outside the guideline should also be listed here. If there is any question, please disclose the relationship. For grants you have received for work outside the guideline, you should disclose support only from entities that could be perceived to be affected financially by the published work, such as Government departments and agencies (e.g., National Disability Insurance Scheme), service providers, companies, business (including where self-employed), or foundations supported by entities that could be perceived to have a financial stake in the outcome.

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Grants or contracts from any entity (if not indicated in item #1 above).	None	
Royalties or licenses	Jessica Kingsley Publishing Springer	Royalties for books paid 6 monthly various amounts Payments for books (2019-2022 $1,000)
Consulting fees	Educational Services Australia PINN – project evaluation	Subject matter expert content and resources reviews (2019, $10,000) Evaluation planning, delivery and report (2022, $8,000)

Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	National Autistic Society, Cork Autism, Reframing Autism, Yellow Ladybugs, Aspect, Spectrum Space	Payments from $100 up to $2000 for presentations and keynotes. Flights and accommodation for live conferences
Payment for expert testimony	None	
Support for attending meetings and/or travel	Positive Partnerships	Paid travel for work meetings and workshops
Patents planned, issued or pending	None	
Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	Australasian Society for Autism Research	Executive Committee member
	Australian Autism Alliance	Co-chair
	Australian Autism Research Council	Executive committee member
	AutismCRC Biobank	Access Committee member
Stock or stock options	None	
Receipt of equipment, materials, drugs, medical writing, gifts or other services	None	

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	Specifications/comments (e.g., description of the relationship/activity/organisations involved)
Development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	I have led and contributed to research that has examined the outcomes relating to developing interoception and improving self-regulation and self-management. My research is published as an MScR thesis and a book a well as forming the basis of a federally funded website developed by Education Services Australia.
A personal relationship with another person (e.g., spouse, family member) involved in the development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	None
Development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied	I am the content writer for Positive Partnerships, a federally funded program that delivers workshops, webinars and online learning for educators and parents of school age students on the autism spectrum (2020-present).

health professional preparation programs)	Wrote and delivered autism information workshops for the South Australian Dept for Education (2015 up to Jan 2020)
A personal relationship with another person (e.g., spouse, family member) involved in the development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
Personal and/or family member experience of accessing therapies and/or support that may be covered in the guideline	None
Other	None

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Autism CRC National Practice Guideline

Disclosure of Interests

Date:	12 May 2022
First Name:	Teresa
Surname:	Pilbeam

Origin of Form

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Did you or your institution at any time receive payment or services from a third party for any aspect of your involvement in the development of the guideline?

Please add more rows if necessary.

	Name all entities that provided support (or indicate none)	**Description of support (e.g., amount of funding, time in lieu)**
Grant	None	
Consulting fee or honorarium	Yes - Autism CRC	$4,000 honorarium yet to be claimed
Support for travel to meetings for the guideline or other purposes	Yes – Invitation from the GDG to attend the NACCHO conference in Darwin in June 2022 as a GDG representative.	Flights and accommodation to be paid by GDG. I will be taking annual leave to attend this event and unpaid leave if I have no annual leave available.
Other	Yes – Autism Queensland	I work full-time for Autism Queensland who require that I take a half day of annual leave to attend each of the GDG meetings and additional leave if required to complete readings or meeting preparation. The leave requests are not guaranteed approval by my line manager and will only be approved if I am not required to complete duties allocated to me on those meeting days. Autism Queensland have requested that they be acknowledged on the final publication of the GDG findings and recommendations.

2. Relevant financial activities outside the guideline (2019-2022)

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	Name all entities with whom you have this relationship or indicate none (add rows as needed)	**Specifications/comments (e.g., description of support, if payments were made to you or your institution)**

Grants or contracts from any entity (if not indicated in item #1 above).	Yes – see Question 3 points 2 and 3 for additional detail,	
Royalties or licenses	None	
Consulting fees	Yes - **RARE AWARENESS EDUCATION, SUPPORT AND TRAINING (RArEST) STAKEHOLDER REFERENCE GROUP – *funded by the Department of Health*** Independent Consultant collaborating to progress the implementation of the National Strategic Action Plan for Rare Diseases. **Member: 2022-current**	Remuneration will be paid in alignment with the Health Consumers NSW Remuneration and Reimbursement of Health Consumers Position Statement.
Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	None	
Payment for expert testimony	None	
Support for attending meetings and/or travel	Yes – Autism Queensland - negative-financial with conservative and discretionary support for approving my annual leave applications to attend the GDG meetings	I work full-time for Autism Queensland who require that I take a half day of annual leave to attend each of the GDG meetings and additional leave if required to complete readings or meeting preparation. The leave requests are not guaranteed approval by my line manager and will only be approved if I am not required to complete duties allocated to me on those meeting days. In return for conservative and discretionary negative-financial leave approval, Autism Queensland have requested that they be acknowledged on the final publication of the GDG findings and recommendations. Autism Queensland have also requested, post-publication of my biography on the Autism CRC website, that I acknowledge them as a key contributor to my skill set utilised by the GDG. I have worked for Autism Queensland

		for almost six (6) years of my 32-year career as a teacher and I have been an informal family carer for over 24 years as a parent of an adult daughter on the autism spectrum. If I were to acknowledge Autism Queensland I would also like to acknowledge my daughter Clarisse for being on the spectrum and having a rare neurological condition, the Queensland Department of Education for employing me as a Special Needs Education Teacher, the network of Carer organisations for taking me into their fold as a person with lived experience, the Federal Department of Social Services for inviting me to be a member and co-chair on various councils and committees, and the Queensland Government Department of Communities, Disabilities, and Carers who provided me the opportunity to lead carer reform as a member and co-chair for multiple terms. Of course, special acknowledgement must go to my parents, husband and three other children for supporting me in my advocacy work for decades and providing me with wise words and guidance.
Patents planned, issued or pending	None	
Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	Yes - **RARE VOICES AUSTRALIA – *not-for-profit advocacy organisation*** Independent Board Director providing oversight of the organisation's operations and strategic direction. **Member: 2022-current**	Volunteer roles with travel and accommodation paid for attendance at Federal Government Councils and Working Groups prior to 2020.
	DISABILITY EMPLOYMENT ADVISORY COUNCIL – *Federal Department of Social Services* Independent Carer Representative advisory position	

	on the Council to provide lived experience and professional perspectives associated with autism when navigating the disability employment space. **Member: 2019-2021**	
	NATIONAL DISABILITY STRATEGY REFORM WORKING GROUP – ***Federal Department of Social Services*** Independent Carer Representative to support the review of the National Disability Strategy and provide insight on how the Strategy is interpreted across Australia's remote Aboriginal and Torres Strait Islander communities, particularly for those First Nation's peoples on the autism spectrum. **Member: 2018-2022**	
	NATIONAL DISABILITY AND CARERS ADVISORY COUNCIL – ***Federal Department of Social Services*** Independent Carer Representative advising on key issues regarding the implementation of the National Disability Strategy (NDS) and the National Disability Insurance Scheme (NDIS). **Member/Acting Chair Carer Reform: 11/2016-2019** **Member: National Disability Strategy Reform Working Group 2018-2019**	
	QUEENSLAND CARERS ADVISORY COUNCIL – ***State Government Department of Communities, Disability and Carers*** Independent Carer Representative to guide and assist with prioritizing key issues relevant to reviewing Carer policy particularly legal implications of the Carer Recognition Act. Appointed as lead writer in the development of a discussion paper to reflect concepts and challenges for *Carers in Education*. **Member: 11/2013-2018**	

	Co-Chair: 2018-2019	
	MONTROSE RESPITE AND THERAPY SERVICES – ***State based not-for-profit disability service provider*** Independent Board Director providing expertise on the NDIS, consumer-directed program development and service delivery. **Board Director: 11/2014-current** **Chair: Board Performance Planning Review Committee 2015-2018** **Chair: Awareness and Fundraising Committee 2014-2017** **Chair: Services and Programs 2017-2019**	
Grants or contracts from any entity (if not indicated in item #1 above).	None	
Royalties or licenses	None	
Consulting fees	None	
Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	None	
Payment for expert testimony	None	
Support for attending meetings and/or travel	Yes – Invitation from the GDG to attend the NACCHO conference in Darwin in June 2022 as a GDG representative.	Flights and accommodation to be paid by GDG. I will be taking annual leave to attend this event and unpaid leave if I have no annual leave available.
Patents planned, issued or pending	None	
Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	Yes – this question has been repeated and relevant declaration can be found where this question appears earlier in this table.	
Stock or stock options	None	
Receipt of equipment, materials, drugs, medical writing, gifts or other services	None	

3. Relevant other activities or relationships, including non-financial relationships (no time limit)

Are there other relationships or activities that readers could be perceived to have influenced, or that could give the appearance of potentially influencing, your involvement in the guideline? If so, please specify.

	Specifications/comments (e.g., description of the relationship/activity/organisations involved)
Development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	Yes – I am employed full-time as a Teacher with Autism Queensland. I currently work within the Specialist Disability School Service (SDSS) which is funded to Autism Queensland by the Queensland Department of Education. The support that is provided to schools is typically in one-off collaborative sessions where I draw upon current evidence-informed research and best practice to support access, participation, and achievement of students with disabilities in schools across Queensland. Yes - In my previous role as Manager of the National Indigenous Programs with Autism Queensland I delivered activities to raise awareness and provide education about autism and the pathways to support services available for Aboriginal and/or Torres Strait Islander peoples. The Early Intervention Indigenous Liaison Officer (EI ILO) program was a national program and was funded to Autism Queensland by the federal Department of Social Services (DSS) and the funding ceased in 2020. The Steppin' Up, Steppin' Out (SUSO) program delivered awareness, education, and goal setting services for remote and very remote Aboriginal and/or Torres Strait Islander communities across Queensland and the Northern Territory. This funding was provided to Autism Queensland under the NDIS ILC stream and operated from July 2018 to June 2020. The Yarning Autism (YA) program delivered community engagement activities to raise awareness of autism across the north and north-west of New South Wales. The program was funded to Autism Queensland under the NDIS ILC stream and operated from July 2018 to June 2020. Yes – Prior to the management role at Autism Queensland I was employed as the National Coordinator of the Early Days programs from 2017 to 2019. Yes – Prior to commencing full-time work with Autism Queensland I was employed as a teacher with the Queensland Department of Education from 1991 to May 2016. Yes – I have held various unpaid roles on Federal and State Councils and Advisory Committees and Not-for-Profit Boards as an Independent Director. Details are provided: **RARE AWARENESS EDUCATION, SUPPORT AND TRAINING (RArEST) STAKEHOLDER REFERENCE GROUP –** ***funded by the Department of Health*** Independent Consultant collaborating to progress the implementation of the National Strategic Action Plan for Rare Diseases. **Member: 2022-current**

RARE VOICES AUSTRALIA – *not-for-profit advocacy organisation*
Independent Board Director providing oversight of the organisation’s operations and strategic direction.
Member: 2022-current

DISABILITY EMPLOYMENT ADVISORY COUNCIL – *Federal Department of Social Services*
Independent Carer Representative advisory position on the Council to provide lived experience and professional perspectives associated with autism when navigating the disability employment space.
Member: 2019-2021

NATIONAL DISABILITY STRATEGY REFORM WORKING GROUP – *Federal Department of Social Services*
Independent Carer Representative to support the review of the National Disability Strategy and provide insight on how the Strategy is interpreted across Australia’s remote Aboriginal and Torres Strait Islander communities, particularly for those First Nation’s peoples on the autism spectrum.
Member: 2018-2022

NATIONAL DISABILITY AND CARERS ADVISORY COUNCIL – ***Federal Department of Social Services***
Independent Carer Representative advising on key issues regarding the implementation of the National Disability Strategy (NDS) and the National Disability Insurance Scheme (NDIS).
Member/Acting Chair Carer Reform: 11/2016-2019
Member: National Disability Strategy Reform Working Group 2018-2019

QUEENSLAND HEALTH – State *Health Department*
Independent Carer Representative providing lived perspectives of a parent of a child with complex disabilities.
Carer Representative: Queensland Children’s Hospital Stakeholder Committee 04/2012-02/2013
Consumer Participant: Highly Specialised Complex Services Project Steering Group 06/2016-2018
Consumer Participant: eHealth Reform Initiatives Working Group 07/2016-2018

QUEENSLAND CARERS ADVISORY COUNCIL – *State Government Department of Communities, Disability and Carers* Independent Carer Representative to guide and assist with prioritizing key issues relevant to reviewing Carer policy particularly legal implications of the Carer Recognition Act. Appointed as lead writer in the development of a discussion paper to reflect concepts and challenges for *Carers in Education*.
Member: 11/2013-2018
Co-Chair: 2018-2019

MONTROSE RESPITE AND THERAPY SERVICES – *State based not-for-profit disability service provider*
Independent Board Director providing expertise on the NDIS, consumer-directed program development and service delivery.
Board Director: 11/2014-current
Chair: Board Performance Planning Review Committee 2015-2018
Chair: Awareness and Fundraising Committee 2014-2017

	Chair: Services and Programs 2017-2019 **CARERS AUSTRALIA –** ***National not-for-profit peak body*** Queensland Carer Representative to support and advise upon the strategic direction of the organisation, promote the Carer role nationally through consultation forums and conferences, and wrote a submission to the 2014 Department of Defence White Paper. **Member: Finance, Audit and Risk Group** **Board Director: 12/2013-11/2015** **Vice President: 12/2015-08/2016** **CARERS QUEENSLAND –** ***State not-for-profit peak body*** Independent Carer Representative with lived experience to identify and guide opportunities for innovation to support sustainability of client services during transition to the NDIS and initiated state-wide Carer Conversations through consultative forums to guide consumer-informed program development. **Chair: Board Performance Policy** **Board Director: 11/2011-08/2016**
A personal relationship with another person (e.g., spouse, family member) involved in the development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	None
Development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	Yes – I am employed full-time as a Teacher with Autism Queensland. I currently work within the Specialist Disability School Service (SDSS) which is funded to Autism Queensland by the Queensland Department of Education. The support that is provided to schools is typically in one-off collaborative sessions where I draw upon current evidence-informed research and best practice to support access, participation, and achievement of students with disabilities in schools across Queensland.
A personal relationship with another person (e.g., spouse, family member) involved in the development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
Personal and/or family member experience of accessing therapies and/or support that may be covered in the guideline	Yes - My adult daughter is on the autism spectrum and my lived experience of supporting her navigate government and non-government systems for 24 years influences my perspectives I provide on the GDG. She has no direct influence on topics for discussion associated with the GDG as those agenda items are confidential.
Other	None

Declaration

If your answer is different from 'No' to any of the questions above, you may have a competing interest which should be declared. These will be reviewed by the co-Chairs of the Guideline Development Group. If the co-Chairs have answered other than ‘none’ to any of the questions above, these will be reviewed by Dr Gary Allen, Senior Policy Officer Human Research Ethics and Research Integrity at Griffith University. In each case, appropriate processes will be put in place to management any conflicts arising. Team members should not be concerned about answering 'yes' to any of the questions. 'Yes' answers do not indicate good or bad, but are simply something to declare on the form and consider for inclusion in the declarations section of the guideline.

Autism CRC National Practice Guideline

Disclosure of Interests

Date:	21/10/202, updated 12/07/2022
First Name:	Sarah
Surname:	Pillar

Origin of Form

This form has been adapted (including direct replication of text where relevant) from:

- The International Committee of Medical Journal Editors (ICMJE) disclosure of interest form (https://www.icmje.org/disclosure-of-interest/)
- The Cochrane Collaboration Disclosure of Potential Conflicts of Interest form (https://community.cochrane.org/sites/default/files/uploads/EPPR/Cochrane-COI-disclosure-form.pdf)

Instructions

The purpose of this form is to provide readers of your review with information about your other interests that could influence how they receive and understand your work. We ask you to disclose all relationships/activities/interests listed below that are related to your involvement in the development of the National Practice Guideline (herein referred to as the *guideline*). "Related" means any relation with for-profit or not-for-profit third parties whose interests may be affected by the content of the guideline. Disclosure represents a commitment to transparency and does not necessarily indicate a bias. Please think broadly when disclosing all relationships/activities/interests that may be relevant to your involvement in the guideline. If you are in doubt about whether to list a relationship/activity/interest, it is preferable that you do so.

Each person will be asked to complete their own form and you are responsible for the accuracy and completeness. In submitting this form, you certify that you have answered every question and have not altered the wording of any of the questions on this form.

If new interests arise during the project, you are required to submit an updated form.

1. Support for your involvement in the development of the guideline.

This section asks for information about your role in the development of the guideline. The time frame for this reporting is that of the work itself, from the initial conception and planning to the present. The requested information is about resources that you received, either directly or indirectly (via your institution), to enable you to complete the work. Writing "None" means that you did the work without receiving any financial support from any third party -- that is, the work was supported by funds from the same institution that pays your salary and that institution did not receive third-party funds with which to pay you. If you or your institution received funds from a third party to support the work, such as a government granting agency, charitable foundation or commercial sponsor, then provide the details. For example, if you received an honorarium from Autism CRC in relation to your involvement, you would name Autism CRC and then indicate the amount of funds received.

Did you or your institution at any time receive payment or services from a third party for any aspect of your involvement in the development of the guideline?

Please add more rows if necessary.

	Name all entities that provided support (or indicate none)	**Description of support (e.g., amount of funding, time in lieu)**
Grant	Autism CRC	0.4FTE, 12 month contract payment to institution (CliniKids, Telethon Kids Institute)
Consulting fee or honorarium	None	
Support for travel to meetings for the guideline or other purposes	None	
Other	None	

2. Relevant financial activities outside the guideline (2019-2022)

This section asks about your financial relationships with entities in the field of autism that could be perceived to influence, or that give the appearance of potentially influencing, your involvement in the guideline. These relationships may include clinical service providers; companies that sell products that autistic people, their families, or service providers may purchase; and organisations that represent and/or advocate for autistic people, their families, and/or service providers. You should disclose interactions with ANY entity that could be considered broadly relevant to the work. Report all sources of revenue paid (or promised to be paid) directly to you or your institution on your behalf over the 36 months prior to commencing work on the guideline, and up until the point it is submitted to Autism CRC (i.e., 2019-2022). This should include all monies from sources with relevance to the guideline, not just monies from Autism CRC which sponsored the research. Please note that your interactions with Autism CRC that are outside the guideline should also be listed here. If there is any question, please disclose the relationship. For grants you have received for work outside the guideline, you should disclose support only from entities that could be perceived to be affected financially by the published work, such as Government departments and agencies (e.g., National Disability Insurance Scheme), service providers, companies, business (including where self-employed), or foundations supported by entities that could be perceived to have a financial stake in the outcome.

	Name all entities with whom you have this relationship or indicate none (add rows as needed)	**Specifications/comments (e.g., description of support, if payments were made to you or your institution)**
Grants or contracts from any entity (if not indicated in item #1 above).	CliniKids, Telethon Kids Institute	I am employed as the 'Integration Project Manager' at CliniKids Telethon Kids Institute. CliniKids provide support services to autistic children, as well as those with developmental delays. The majority of children receiving services through CliniKids receive funding for services through the NDIS. CliniKids also provides training to

		clinicians in autism supports and is integrated with a research team who are engaged in the evaluation of autism supports.
Royalties or licenses	None	
Consulting fees	None	
Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	None	
Payment for expert testimony	None	
Support for attending meetings and/or travel	None	
Patents planned, issued or pending	None	
Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	None	
Stock or stock options	None	
Receipt of equipment, materials, drugs, medical writing, gifts or other services	None	

3. Relevant other activities or relationships, including non-financial relationships (no time limit)

Are there other relationships or activities that readers could be perceived to have influenced, or that could give the appearance of potentially influencing, your involvement in the guideline? If so, please specify.

	Specifications/comments (e.g., description of the relationship/activity/organisations involved)
Development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	I am involved in the delivery or supervision of the delivery of a range of supports, including PACT, JASPER, and a range of speech pathology supports.
A personal relationship with another person (e.g., spouse, family member) involved in the development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	None
Development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied	None

health professional preparation programs)	
A personal relationship with another person (e.g., spouse, family member) involved in the development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
Personal and/or family member experience of accessing therapies and/or support that may be covered in the guideline	None
Other	None

Declaration

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Autism CRC National Practice Guideline

Disclosure of Interests

Date:	9 May 2022
First Name:	Felicity
Surname:	Rose

Origin of Form

This form has been adapted (including direct replication of text where relevant) from:

- The International Committee of Medical Journal Editors (ICMJE) disclosure of interest form (https://www.icmje.org/disclosure-of-interest/)
- The Cochrane Collaboration Disclosure of Potential Conflicts of Interest form (https://community.cochrane.org/sites/default/files/uploads/EPPR/Cochrane-COI-disclosure-form.pdf)

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Did you or your institution at any time receive payment or services from a third party for any aspect of your involvement in the development of the guideline?

Please add more rows if necessary.

	Name all entities that provided support (or indicate none)	**Description of support (e.g., amount of funding, time in lieu)**
Grant	None	
Consulting fee or honorarium	Autism CRC	Honorarium ($4,000)
Support for travel to meetings for the guideline or other purposes	None	
Other	None	

2. Relevant financial activities outside the guideline (2019-2022)

This section asks about your financial relationships with entities in the field of autism that could be perceived to influence, or that give the appearance of potentially influencing, your involvement in the guideline. These relationships may include clinical service providers; companies that sell products that autistic people, their families, or service providers may purchase; and organisations that represent and/or advocate for autistic people, their families, and/or service providers. You should disclose interactions with ANY entity that could be considered broadly relevant to the work. Report all sources of revenue paid (or promised to be paid) directly to you or your institution on your behalf over the 36 months prior to commencing work on the guideline, and up until the point it is submitted to Autism CRC (i.e., 2019-2022). This should include all monies from sources with relevance to the guideline, not just monies from Autism CRC which sponsored the research. Please note that your interactions with Autism CRC that are outside the guideline should also be listed here. If there is any question, please disclose the relationship. For grants you have received for work outside the guideline, you should disclose support only from entities that could be perceived to be affected financially by the published work, such as Government departments and agencies (e.g., National Disability Insurance Scheme), service providers, companies, business (including where self-employed), or foundations supported by entities that could be perceived to have a financial stake in the outcome.

	Name all entities with whom you have this relationship or indicate none (add rows as needed)	**Specifications/comments (e.g., description of support, if payments were made to you or your institution)**
Grants or contracts from any entity (if not indicated in item #1 above).	Autism CRC	Project Manager on a Project Grant for Telethon Kids Institute to co-ordinate project "Implementation of the National Guideline for the Assessment and Diagnosis of ASD in Australia – Health Sector Capacity Building" ($468,000, 2021-2022)
	Autism CRC	Employed by Autism CRC from April 2016 to July 2021
Royalties or licenses	None	
Consulting fees	None	

Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	None	
Payment for expert testimony	None	
Support for attending meetings and/or travel	None	
Patents planned, issued or pending	None	
Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	None	
Stock or stock options	None	
Receipt of equipment, materials, drugs, medical writing, gifts or other services	None	

3. Relevant other activities or relationships, including non-financial relationships (no time limit)

Are there other relationships or activities that readers could be perceived to have influenced, or that could give the appearance of potentially influencing, your involvement in the guideline? If so, please specify.

	Specifications/comments (e.g., description of the relationship/activity/organisations involved)
Development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	I am currently employed by Telethon Kids Institute and CliniKids as a project manager. CliniKids is a service provider of therapies and supports that may be covered within the scope of the Guideline.
A personal relationship with another person (e.g., spouse, family member) involved in the development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	None
Development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
A personal relationship with another person (e.g., spouse, family member) involved in the development and/or delivery of professional	None

preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	
Personal and/or family member experience of accessing therapies and/or support that may be covered in the guideline	I have personal and / or family member experience of accessing therapies and / or supports covered in the guideline through various services providers and using private and public funding.
Other	None

Declaration

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Autism CRC National Practice Guideline

Disclosure of Interests

Date:	09/05/2022
First Name:	Nancy
Surname:	Sadka

Origin of Form

This form has been adapted (including direct replication of text where relevant) from:

- The International Committee of Medical Journal Editors (ICMJE) disclosure of interest form (https://www.icmje.org/disclosure-of-interest/)
- The Cochrane Collaboration Disclosure of Potential Conflicts of Interest form (https://community.cochrane.org/sites/default/files/uploads/EPPR/Cochrane-COI-disclosure-form.pdf)

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Did you or your institution at any time receive payment or services from a third party for any aspect of your involvement in the development of the guideline?

Please add more rows if necessary.

	Name all entities that provided support (or indicate none)	**Description of support (e.g., amount of funding, time in lieu)**
Grant	None	
Consulting fee or honorarium	Autism CRC	Honorarium to participate in the development of the guideline ($4,000)
Support for travel to meetings for the guideline or other purposes	None	
Other	None	

2. Relevant financial activities outside the guideline (2019-2022)

This section asks about your financial relationships with entities in the field of autism that could be perceived to influence, or that give the appearance of potentially influencing, your involvement in the guideline. These relationships may include clinical service providers; companies that sell products that autistic people, their families, or service providers may purchase; and organisations that represent and/or advocate for autistic people, their families, and/or service providers. You should disclose interactions with ANY entity that could be considered broadly relevant to the work. Report all sources of revenue paid (or promised to be paid) directly to you or your institution on your behalf over the 36 months prior to commencing work on the guideline, and up until the point it is submitted to Autism CRC (i.e., 2019-2022). This should include all monies from sources with relevance to the guideline, not just monies from Autism CRC which sponsored the research. Please note that your interactions with Autism CRC that are outside the guideline should also be listed here. If there is any question, please disclose the relationship. For grants you have received for work outside the guideline, you should disclose support only from entities that could be perceived to be affected financially by the published work, such as Government departments and agencies (e.g., National Disability Insurance Scheme), service providers, companies, business (including where self-employed), or foundations supported by entities that could be perceived to have a financial stake in the outcome.

	Name all entities with whom you have this relationship or indicate none (add rows as needed)	**Specifications/comments (e.g., description of support, if payments were made to you or your institution)**
Grants or contracts from any entity (if not indicated in item #1 above).	None	
Royalties or licenses	None	
Consulting fees	None	
Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	None	
Payment for expert testimony	None	
Support for attending meetings and/or travel	None	
Patents planned, issued or pending	None	

Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	None	
Stock or stock options	None	
Receipt of equipment, materials, drugs, medical writing, gifts or other services	None	

3. Relevant other activities or relationships, including non-financial relationships (no time limit)

Are there other relationships or activities that readers could be perceived to have influenced, or that could give the appearance of potentially influencing, your involvement in the guideline? If so, please specify.

	Specifications/comments (e.g., description of the relationship/activity/organisations involved)
Development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	None
A personal relationship with another person (e.g., spouse, family member) involved in the development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	None
Development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
A personal relationship with another person (e.g., spouse, family member) involved in the development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
Personal and/or family member experience of accessing therapies and/or support that may be covered in the guideline	None

Other	None

Declaration

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Declarations of Interests
A/Prof Natalie Silove

Expertise:
Natalie Silove is a Developmental Paediatrician, Senior Staff Specialist and Head of the Child Development Services at The Sydney Childrens Hospital Network Westmead. Natalie is an Associate Clinical Professor at Sydney University and a Co joint at UNSW. Natalie has acted as advisor to State and Commonwealth Governments with regards policies relating to children with disability and autism spectrum disorder. She acts as a medical specialist advisor to the NSW Education Standards Authority and generated the first FRACP consensus statement and guidelines for diagnosis and assessment in autism spectrum disorder.

Clinical Research: NHMRC Grants
Current :

- APP1125449 Prof Adam Guastella, Prof Geraldine Dawson, Prof Cheryl Dissanayake, Prof Valsamma Eapen, Dr Jun Ju Song, Prof Ruth Feldman, **A/Prof Natalie Silove**. Oxytocin enhancement of social learning in the treatment of toddlers with autism. NHMRC Project Grant 2017-2020 $1,228,465
- APP1130251 A/Prof Parisa Aslani, A/Prof Michael Kohn, **A/Prof Natalie Silove,** A/Prof Patrick Kelly, A/Prof Simon Clarke. Asking the right question about attention-deficit hyperactivity disorder in children: a cluster randomised controlled trial. NHMRC Project Grant 2017-2019 $484,930

Past: (AI)

- 2011-2013 Reddihough D, Marraffa C, Hazell P, Multi-site randomised controlled trial of Fluoxetine versus placebo for the treatment of restricted, repetitive and stereotyped behaviours in children and adolescents with autism. NHMRC Project Grant #607332 $481,825
- 2012-2016 Einfeld, S., Sanders, M., Tonge, B. Mental health in children with developmental disabilities. NHMRC Program Grant APP1016919. $5,242,755.
- 2012-2014 Eapen V, Williams K, Jalaludin B. Universal surveillance and Early Identification of Developmental Disorders. NHMRC Partnership Project – APP1013690 $680,59

Other Grants :

- **2019 :Australian Rotary Health/Mental Health of Young Australians Research Grant.** A brief, integrated parent mediated intervention for children with Autism Spectrum Disorder; Dadds M, Guastella A, Hawes D, Tully L, **Silove N**, Eapen V; 2019
- **2019: Department and Education NSW grant :** Validation of telehealth assessments to evaluate response to reading intervention $101 000.00, 2019
- **2007: ARC Linkage Grant** Comparative Analysis of Early Intervention Programs for Young Children with Autism**.** Collaborative project with ASPECT, Sydney University, Macquarie University and The Children's Hospital Completed 2007

Sponsor funded Multi-centre international trials

1. 2019 – present: An Open-Label Extension Study to Assess the Long-Term Safety and Tolerability of ZYN002 Administered as a Transdermal Gel to Children and Adolescents with Fragile X Syndrome – CONNECT-FX Open Label Extension (OLE) Clinical study Of caNNabidiol in childrEn and adolesCenTs with Fragile X (CONNECT-FX OLE)
2. 2018 – present: A Randomized, Double-Blind, Placebo-Controlled Multiple-Center, Efficacy and Safety Study of ZYN002 Administered as a Transdermal Gel to Children and Adolescents with Fragile X Syndrome – CONNECT-FX. Covance Pty Ltd
3. 2017 – June 2018 : A Phase 1/2 , Open Label Study to Assess the Safety and Efficacy of ZYN002 Administered as a Transdermal Gel to Children and Adolescents with Fragile X Syndrome. Covance Pty Ltd. 2012-2013**:**
4. An open label study to evaluate the long term safety and tolerability of AFQ056 in adolescent patients with Fragile X Syndrome. Novartis Pharmaceuticals Australia Pty Ltd.. 2011- 2012: Protocol CAFQ056A2212.
5. A randomized, double-blind, placebo-controlled, parallel group study to evaluate AFQ056 in adolescent patients with Fragile X Syndrome. Novartis Pharmaceuticals Australia Pty Ltd:

6. A Multi – Centre, Double – Blind, Three Arm, Parallel group Study Comparing the Efficacy of Immediate Release Methylphenidate (Ritalin) and modified Release Methylphenidate with Placebo in Children with Attention – Deficit/Hyperactivity Disorder (Protocol number MD-11003-002)
7. An Open Label Safety Study of Methylphenidate Modified Release (Metadate CD) in Children with Attention –deficit/Hyperactivity Disorder (ADHD)who participated in study MD 1003-002 (Protocol No. MD-1003-004) July 2003

Autism CRC National Practice Guideline

Disclosure of Interests

Date:	19/10/21
First Name:	Rhylee
Surname:	Sulek

Origin of Form

This form has been adapted (including direct replication of text where relevant) from:

- The International Committee of Medical Journal Editors (ICMJE) disclosure of interest form (https://www.icmje.org/disclosure-of-interest/)
- The Cochrane Collaboration Disclosure of Potential Conflicts of Interest form (https://community.cochrane.org/sites/default/files/uploads/EPPR/Cochrane-COI-disclosure-form.pdf)

Instructions

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1. Support for your involvement in the development of the guideline.

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Did you or your institution at any time receive payment or services from a third party for any aspect of your involvement in the development of the guideline?

Please add more rows if necessary.

	Name all entities that provided support (or indicate none)	Description of support (e.g., amount of funding, time in lieu)
Grant	Position supported by funding from the Autism CRC	Autism CRC funding provided to Griffith University
Consulting fee or honorarium	None	
Support for travel to meetings for the guideline or other purposes	None	
Other	None	

2. Relevant financial activities outside the guideline (2019-2022)

This section asks about your financial relationships with entities in the field of autism that could be perceived to influence, or that give the appearance of potentially influencing, your involvement in the guideline. These relationships may include clinical service providers; companies that sell products that autistic people, their families, or service providers may purchase; and organisations that represent and/or advocate for autistic people, their families, and/or service providers. You should disclose interactions with ANY entity that could be considered broadly relevant to the work. Report all sources of revenue paid (or promised to be paid) directly to you or your institution on your behalf over the 36 months prior to commencing work on the guideline, and up until the point it is submitted to Autism CRC (i.e., 2019-2022). This should include all monies from sources with relevance to the guideline, not just monies from Autism CRC which sponsored the research. Please note that your interactions with Autism CRC that are outside the guideline should also be listed here. If there is any question, please disclose the relationship. For grants you have received for work outside the guideline, you should disclose support only from entities that could be perceived to be affected financially by the published work, such as Government departments and agencies (e.g., National Disability Insurance Scheme), service providers, companies, business (including where self-employed), or foundations supported by entities that could be perceived to have a financial stake in the outcome.

	Name all entities with whom you have this relationship or indicate none (add rows as needed)	Specifications/comments (e.g., description of support, if payments were made to you or your institution)
Grants or contracts from any entity (if not indicated in item #1 above).	Previous funding to support work on EI Review?	Autism CRC funding provided to Griffith University
	Named CI on successful Griffith University MHIQ Capacity Grant	Project funding.
Royalties or licenses	None	
Consulting fees	None	
Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	None	
Payment for expert testimony	None	
Support for attending meetings and/or travel	None	

Patents planned, issued or pending	None	
Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	None	
Stock or stock options	None	
Receipt of equipment, materials, drugs, medical writing, gifts or other services	None	

3. Relevant other activities or relationships, including non-financial relationships (no time limit)

Are there other relationships or activities that readers could be perceived to have influenced, or that could give the appearance of potentially influencing, your involvement in the guideline? If so, please specify.

	Specifications/comments (e.g., description of the relationship/activity/organisations involved)
Development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	None
A personal relationship with another person (e.g., spouse, family member) involved in the development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	None
Development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
A personal relationship with another person (e.g., spouse, family member) involved in the development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
Personal and/or family member experience of accessing therapies and/or support that	None

may be covered in the guideline	
Other	None

Declaration

If your answer is different from 'No' to any of the questions above, you may have a competing interest which should be declared. These will be reviewed by the co-Chairs of the Guideline Development Group. If the co-Chairs have answered other than ‘none’ to any of the questions above, these will be reviewed by Dr Gary Allen, Senior Policy Officer Human Research Ethics and Research Integrity at Griffith University. In each case, appropriate processes will be put in place to management any conflicts arising. Team members should not be concerned about answering 'yes' to any of the questions. 'Yes' answers do not indicate good or bad, but are simply something to declare on the form and consider for inclusion in the declarations section of the guideline.

Autism CRC National Practice Guideline

Disclosure of Interests

Date:	02/05/22
First Name:	David
Surname:	Trembath

Origin of Form

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Did you or your institution at any time receive payment or services from a third party for any aspect of your involvement in the development of the guideline?

Please add more rows if necessary.

	Name all entities that provided support (or indicate none)	**Description of support (e.g., amount of funding, time in lieu)**
Grant	Autism CRC	Project funding awarded to Griffith University (CIA, 2022-2022, $250,800) to support the guideline development.
Consulting fee or honorarium	None	
Support for travel to meetings for the guideline or other purposes	None	
Other	None	

2. Relevant financial activities outside the guideline (2019-2022)

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	Name all entities with whom you have this relationship or indicate none (add rows as needed)	**Specifications/comments (e.g., description of support, if payments were made to you or your institution)**
Grants or contracts from any entity (if not indicated in item #1 above).	Queensland Government, Australia	Advance Queensland Industry Research Fellowship. $150,000. Optimising telepractice service delivery for individuals on the autism spectrum and their families. (2021-2022)
	Griffith University, Australia	Research grant, $71,112.86, funding for research aimed at laying the foundations for the development of a clinical decision support system for children on the autism spectrum and their families. Trembath, D., Wee-Cheung Liew, A., Whitehouse, A., & Upson, G. (2021-2021)

	Autism CRC	Research grant, $121,000. Synthesis of evidence for autism early intervention approaches. Trembath, D. (2020-2020)
	Commonwealth Department of Health	Consultancy/commercial research. Alcohol, Tobacco and Other Drugs – Fetal Alcohol Spectrum Disorder (FASD) Diagnostic Services – 4-GO41V23. Dawe, S., Harnett, P., Trembath, D. (2021-2024)
	Griffith University, Australia	Research grant. $228,000. Funding to support the development of the Child Health, Learning, and Disability Network at Griffith University (CIA, 2019-2021)
	Channel 7 Children's Foundation Grant	Project grant. $100,000. Evaluation of Lego Robotics program for autistic students (AI, 2020-2022)
	Menzies Health Institute Queensland	Research grant, $50,000. Promoting Knowledge Translation in Teachers of Students with Autism through Peer-to-Peer Professional Development: A Collaborative Interdisciplinary Project. Paynter, J., Adams, D., Simpson, K., Clark, M., Trembath, D., & Westerveld, M. (2018-2019)
	Australian Government Department of Social Services, $232,961.	Research grant, $232,961. Supporting Best Practice in the Assessment and Treatment of Minimally Verbal Children with Autism. Trembath, D., Tucker, M., et al. (2017-2019)
	Menzies Health Institute Queensland	Research grant. $160,000. From Cell to Community: New Frontiers in Integrative Restorative Neurorehabilitation. Lloyd D, Coppieters M, St John J, McConnel H, Zeeman H, Grant G, Thiel D, Trembath D, Pizzolato C, Foster M, Buys N, Lakhani A, Potter L, Canning S. (2018-2019)
	Department of Social Services	Research Grant, $89,445.43. Debunking Autism Treatment Myths. Paynter, J., Keen, D., Trembath, D., Fordyce, K., Joosten, A., Hoppenbrouwers, G., DeBlassio, A., Ecker, U., & Imms, C. (2016-2019)
	Autism CRC	Research grant, $661,989 Longitudinal Study of Students with Autism (LASA), Roberts, J., Trembath, D., Westerveld, M., Keen, D., Simpson, K. Paynter, J., Adams, D. & Howlin, P. (2016-2021)
	Autism CRC	Research grant, $49,986. "How was your day?" Home conversations about their school day in children with Autism Spectrum Disorder. Stirling, L., Dissanayake, C., Sofronoff, K., Westerveld, M., Trembath, D., & Ashburner, J. (2015-2019)
	Autism CRC	Research grant, $25,000. Relate: Technology Supporting Communication in Children on the Autism Spectrum. Trembath, D., Iacono, T., Cox, J., Johnson, R., Rose, V. (2016-2019)
	Education Queensland Horizon Grants Scheme	Research grant, $96,645.61. Listening to the evidence: Using what works to improve educational outcomes for students with autism. Keen, D., Paynter, J., & Trembath, D. (2017-2019)

Royalties or licenses	None	
Consulting fees	None	
Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	Speech Pathology Australia	Honorarium for role as Project Officer responsible for leading the revision of the Speech Pathology Australia Position Statement and Practice Guideline for working with individuals on the autism spectrum (2020-2021, $7,500)
	Humanity Health Group	Griffith University consultancy and commercial research (CCR) to provide professional development to Humanity Health Group (2021, $2500).
	Speech Pathology Australia	Honorarium for preparation of self-guided learning package relating to Autism CRC synthesis of evidence report (2021, $1,400)
	Speech Pathology Australia	Honorarium for presentation of professional development event (webinar) relating to Autism CRC synthesis of evidence report (2021, $840)
	University of Sydney (2021) Deakin University (2021) Macquarie University (2021) Victoria University (2019) Curtin University (2019)	Thesis examination (<$500 on each occasion)
Payment for expert testimony	None	
Support for attending meetings and/or travel	Australian Swim Schools Association	Complementary associate membership to attend webinar titled 'Teaching children with Autism' for research purposes.
	Griffith University	Registration support to attend the Aspect Research Centre for Autism Practice Conference 2021
	Association for Applied Behaviour Analysis Australia	Registration to enable access to online platform to deliver invited address (no exchange of funds)
Patents planned, issued or pending	None	
Participation on a Data Safety Monitoring Board or Advisory Board	National Health and Medical Research Council	Committee fees for work as member of the Grant Management Solution Working Group as per NHMRC schedule.
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	Australasian Society for Autism Research	Executive Committee member (unpaid)
	AEIOU	Member of Research Advisory Committee (unpaid)
	Augmentative and Alternative Communication (journal)	Associate Editor (unpaid)
	Journal of Research in Autism Spectrum Disorders (journal)	Extended Editorial Board Member (unpaid)

	Department of Social Services	Member representing Speech Pathology Australia on the Expert Reference Group to implement the National Guideline for the Assessment and Diagnosis of Autism Spectrum Disorders in Australia (unpaid)
Stock or stock options	None	
Receipt of equipment, materials, drugs, medical writing, gifts or other services	None	

3. Relevant other activities or relationships, including non-financial relationships (no time limit)

Are there other relationships or activities that readers could be perceived to have influenced, or that could give the appearance of potentially influencing, your involvement in the guideline? If so, please specify.

	Specifications/comments (e.g., description of the relationship/activity/organisations involved)
Relationship with Autism CRC	Griffith University is a member of Autism CRC Ltd. I am the 'Alternative Member Representative' for Griffith University, should the primary representative be unavailable and/or my involvement is otherwise required.
Development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	I have led and contributed to research that has examined the outcomes of peer- and parent-mediated augmentative and alternative communication (AAC), parent-mediated therapies and supports, community-based early intervention services. Therapies and supports included in this research include Speech Generating Devices, Key Word Sign, Music and Movement Therapy, the Early Start Denver Model, TOBY Playpad, the AEIOU program, Lego Robotics. I have co-led research that has examined the effects of a range of non-pharmacological therapies and supports via systematic reviews. My research has involved collaboration with a range of service providers including Autism Queensland, AEIOU Foundation, the Autism Specific Early Learning and Care Centres from around Australia, the Nerang Alliance of school and early childhood education centres, Autism Spectrum Australia, CliniKids, Autism SA, ASPECT, and Sanctuary Early Learning Adventure. A complete list of my research publications presenting this research is available at https://scholar.google.com.au/citations?user=q9a9_dUAAAAJ&hl=en
A personal relationship with another person (e.g., spouse, family member) involved in the development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	None

Development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	Since 2004, I have contributed to the development and/or delivery of speech pathology professional preparation programs at the University of Sydney, La Trobe University, and Griffith University. I have also acted as an external reviewer (accreditation) for the Massey University speech pathology program in New Zealand. From 2018-2020, I was tasked with developing and acting as Program Director for two programs in Applied Behaviour Analysis (Graduate Certificate, Masters) at Griffith University.
A personal relationship with another person (e.g., spouse, family member) involved in the development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
Personal and/or family member experience of accessing therapies and/or support that may be covered in the guideline	I have family members who are accessing therapies and supports via the National Disability Insurance Scheme.
Other	None

Declaration

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Autism CRC National Practice Guideline

Disclosure of Interests

Date:	30/04/2022
First Name:	Kandice
Surname:	Varcin

Origin of Form

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Did you or your institution at any time receive payment or services from a third party for any aspect of your involvement in the development of the guideline?

Please add more rows if necessary.

	Name all entities that provided support (or indicate none)	**Description of support (e.g., amount of funding, time in lieu)**
Grant	Autism CRC, Griffith University	Autism CRC research funding provided to Griffith University as salary support for Research Fellow position on the development of the National Practice Guideline. Amount: $65,531
Consulting fee or honorarium	None	
Support for travel to meetings for the guideline or other purposes	None	
Other	None	

2. Relevant financial activities outside the guideline (2019-2022)

This section asks about your financial relationships with entities in the field of autism that could be perceived to influence, or that give the appearance of potentially influencing, your involvement in the guideline. These relationships may include clinical service providers; companies that sell products that autistic people, their families, or service providers may purchase; and organisations that represent and/or advocate for autistic people, their families, and/or service providers. You should disclose interactions with ANY entity that could be considered broadly relevant to the work. Report all sources of revenue paid (or promised to be paid) directly to you or your institution on your behalf over the 36 months prior to commencing work on the guideline, and up until the point it is submitted to Autism CRC (i.e., 2019-2022). This should include all monies from sources with relevance to the guideline, not just monies from Autism CRC which sponsored the research. Please note that your interactions with Autism CRC that are outside the guideline should also be listed here. If there is any question, please disclose the relationship. For grants you have received for work outside the guideline, you should disclose support only from entities that could be perceived to be affected financially by the published work, such as Government departments and agencies (e.g., National Disability Insurance Scheme), service providers, companies, business (including where self-employed), or foundations supported by entities that could be perceived to have a financial stake in the outcome.

	Name all entities with whom you have this relationship or indicate none (add rows as needed)	**Specifications/comments (e.g., description of support, if payments were made to you or your institution)**
Grants or contracts from any entity (if not indicated in item #1 above).	Autism CRC, Griffith University	Autism CRC funding provided to Griffith University as salary support for Research Fellow position on evidence synthesis project commissioned by NDIS from June 2020-December 2020.
Royalties or licenses	None	
Consulting fees	None	

Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	La Trobe University	Payment made to a research account at CliniKids, Telethon Kids Institute for the provision of ADOS-2 training services.
Payment for expert testimony	None	
Support for attending meetings and/or travel	None	
Patents planned, issued or pending	None	
Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	None	
Stock or stock options	None	
Receipt of equipment, materials, drugs, medical writing, gifts or other services	None	

3. Relevant other activities or relationships, including non-financial relationships (no time limit)

Are there other relationships or activities that readers could be perceived to have influenced, or that could give the appearance of potentially influencing, your involvement in the guideline? If so, please specify.

	Specifications/comments (e.g., description of the relationship/activity/organisations involved)
Relationship with Autism CRC	Griffith University is a member of Autism CRC Ltd. I have no other association with Autism CRC Ltd. to declare.
Development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	I was previous employed by (2016-2019), and have ongoing research collaborations with, CliniKids, Telethon Kids Institute – a clinical and research centre that provides diagnostic and intervention services for children on the autism spectrum. In my previous position at CliniKids, Telethon Kids Institute, I was the project coordinator for the Australian Infant Communication and Engagement Study (AICES), a randomized controlled trial evaluating pre-emptive support for infants with early behavioural signs of autism. I was a project team member and co-author of a report commissioned by the National Disability Insurance Agency in 2020: Whitehouse, A., **Varcin, K**., Waddington, H., Sulek, R., Bent, C., Ashburner, J., Eapen, V., Goodall, E., Hudry, K., Roberts, J., Silove, N., Trembath, D. *Interventions for children on the autism spectrum: A synthesis of research evidence*. Autism CRC, Brisbane, 2020. I am a co-author on the following publications, relating to early therapies and support for children on the autism spectrum: o Whitehouse, A.J., **Varcin, K.J.,** Alvares, G.A., Barbaro, J., Bent, C., Boutrus, M., Chetcuti, L., Cooper, M.N., Clark, A., Davidson, E. and Dimov, S., 2019. Pre-emptive intervention versus treatment as usual for infants showing early behavioural risk signs of autism spectrum

	disorder: a single-blind, randomised controlled trial. *The Lancet Child & Adolescent Health*, *3*(9), pp.605-615. ○ Whitehouse, A.J., **Varcin, K.J.**, Pillar, S., Billingham, W., Alvares, G.A., Barbaro, J., Bent, C.A., Blenkley, D., Boutrus, M., Chee, A. and Chetcuti, L., 2021. Effect of preemptive intervention on developmental outcomes among infants showing early signs of autism: A randomized clinical trial of outcomes to diagnosis. *JAMA pediatrics*, *175*(11), pp.e213298-e213298. ○ Trembath, D., Waddington, H., Sulek, R., **Varcin, K.**, Bent, C., Ashburner, J., Eapen, V., Goodall, E., Hudry, K., Silove, N. and Whitehouse, A., 2021. An evidence-based framework for determining the optimal amount of intervention for autistic children. *The Lancet Child & Adolescent Health*, *5*(12), pp.896-904. I have published numerous other papers peer-reviewed journals, in the autism field: https://experts.griffith.edu.au/26397-kandice-varcin/publications
A personal relationship with another person (e.g., spouse, family member) involved in the development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	None
Development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
A personal relationship with another person (e.g., spouse, family member) involved in the development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
Personal and/or family member experience of accessing therapies and/or support that may be covered in the guideline	None
Other	I am a qualified trainer on the Autism Diagnostic Observation Schedule-2, where I lead or co-lead training courses in Australia (approximately 2 per year). I receive payment for my time in delivering these courses.

Declaration

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Group. If the co-Chairs have answered other than ‘none’ to any of the questions above, these will be reviewed by Dr Gary Allen, Senior Policy Officer Human Research Ethics and Research Integrity at Griffith University. In each case, appropriate processes will be put in place to management any conflicts arising. Team members should not be concerned about answering 'yes' to any of the questions. 'Yes' answers do not indicate good or bad, but are simply something to declare on the form and consider for inclusion in the declarations section of the guideline.

Autism CRC National Practice Guideline

Disclosure of Interests

Date:	3/05/2022
First Name:	Hannah
Surname:	Waddington

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This section asks for information about your role in the development of the guideline. The time frame for this reporting is that of the work itself, from the initial conception and planning to the present. The requested information is about resources that you received, either directly or indirectly (via your institution), to enable you to complete the work. Writing "None" means that you did the work without receiving any financial support from any third party -- that is, the work was supported by funds from the same institution that pays your salary and that institution did not receive third-party funds with which to pay you. If you or your institution received funds from a third party to support the work, such as a government granting agency, charitable foundation or commercial sponsor, then provide the details. For example, if you received an honorarium from Autism CRC in relation to your involvement, you would name Autism CRC and then indicate the amount of funds received.

Did you or your institution at any time receive payment or services from a third party for any aspect of your involvement in the development of the guideline?

Please add more rows if necessary.

	Name all entities that provided support (or indicate none)	**Description of support (e.g., amount of funding, time in lieu)**
Grant	Autism CRC	Autism CRC research funding provided to Victoria University of Wellington via Griffith University as salary support for Research Fellow position on the development of the National Practice Guideline. Amount: AUD$55,872
Consulting fee or honorarium	None	
Support for travel to meetings for the guideline or other purposes	None	
Other	None	

2. Relevant financial activities outside the guideline (2019-2022)

This section asks about your financial relationships with entities in the field of autism that could be perceived to influence, or that give the appearance of potentially influencing, your involvement in the guideline. These relationships may include clinical service providers; companies that sell products that autistic people, their families, or service providers may purchase; and organisations that represent and/or advocate for autistic people, their families, and/or service providers. You should disclose interactions with ANY entity that could be considered broadly relevant to the work. Report all sources of revenue paid (or promised to be paid) directly to you or your institution on your behalf over the 36 months prior to commencing work on the guideline, and up until the point it is submitted to Autism CRC (i.e., 2019-2022). This should include all monies from sources with relevance to the guideline, not just monies from Autism CRC which sponsored the research. Please note that your interactions with Autism CRC that are outside the guideline should also be listed here. If there is any question, please disclose the relationship. For grants you have received for work outside the guideline, you should disclose support only from entities that could be perceived to be affected financially by the published work, such as Government departments and agencies (e.g., National Disability Insurance Scheme), service providers, companies, business (including where self-employed), or foundations supported by entities that could be perceived to have a financial stake in the outcome.

	Name all entities with whom you have this relationship or indicate none (add rows as needed)	**Specifications/comments (e.g., description of support, if payments were made to you or your institution)**
Grants or contracts from any entity (if not indicated in item #1 above).	Health Research Council of New Zealand	Randomised controlled trial examining low intensity therapy and parent coaching for young autistic children (PA, 2020-2023, NZD$300k). **H. Waddington,** Whitehouse, A. J. O.

	Cure Kids, New Zealand	Randomised controlled trial comparing naturalistic developmental behavioural intervention, acceptance and commitment therapy, or a combination of these approaches on outcomes for young autistic children and their families (AI, 2022-2023, NZD$500k). McLay, L., Emerson, L., **Waddington, H.,** Macfarlane, S.
	Victoria University of Wellington	Funding to explore the effect of teaching non-autistic older siblings to interact with their autistic younger sibling through play (PI, 2020-2022, NZD$29k). **H. Waddington.**
	IHC Foundation, New Zealand	Funding to develop an autism diagnostic clinic together with Autism New Zealand (AI, 2021-2022, NZD$34k). L. van der Meer, D. Dougan, **H. Waddington**
	IHC Foundation, New Zealand	Funding for further training in the early start Denver model (AI, 2020-2021, NZD$78k). L. van der Meer, D. Dougan, **H. Waddington**
	Auckland University of Technology, New Zealand	Funding to train Auckland Well Child Tamariki Ora Nurses to identify early signs of autism (AI, 2019-2020, 20k). D. Shepherd, L. van der Meer, **H. Waddington.**
	IHC Foundation	Funding for delivery of community therapy based on the early start Denver model (AI, 122k, 2019-2020). L. van der Meer, D. Dougan, **H. Waddington**
	Victoria University of Wellington	Research establishment grant-training Wellington Well Child Tamariki Ora nurses to identify early signs of autism (PI, 10k, 2018). **H. Waddington.**
Royalties or licenses	None	
Consulting fees	None	
Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	None	
Payment for expert testimony	None	

Support for attending meetings and/or travel	Autism CRC	Support to attend the Autism CRC participant day in Brisbane, 2022 (NZD$1332)
	Victoria University of Wellington	Support to virtually attend the International Society for Autism Research Conference, 2021 (USD$375)
Patents planned, issued or pending	None	
Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	Autism New Zealand	Member of research advisory group (unpaid)
	Autism Intervention Trust	Victoria University of Wellington Representative (unpaid)
	University of Canterbury	Member of New Zealand Research Priorities advisory group (unpaid)
	Victoria University of Wellington	Clinic Lead, Victoria University of Wellington Autism Clinic (unpaid)
	Advances in Neurodevelopmental Disorders (journal)	Extended editorial board member (unpaid)
Stock or stock options	None	
Receipt of equipment, materials, drugs, medical writing, gifts or other services	None	

3. Relevant other activities or relationships, including non-financial relationships (no time limit)

Are there other relationships or activities that readers could be perceived to have influenced, or that could give the appearance of potentially influencing, your involvement in the guideline? If so, please specify.

	Specifications/comments (e.g., description of the relationship/activity/organisations involved)
Relationship with Autism CRC	Victoria University of Wellington is a member of Autism CRC ltd. I am the "Member Representative" for Victoria University of Wellington.
Development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	I lead an autism clinic that predominantly provides support to young autistic children and their families based on the early start Denver model. I have led and contributed to research that has examined the outcomes of parent, peer, sibling, and teacher mediated support for autistic children based on the early start Denver model. I have assisted in research examining JASPER-based treatment for a Māori child and led a literature review examining this approach. My research has involved collaboration with a range of service providers including Autism New Zealand, Wellington Kindergarten Associations, Wellington District Health Boards, Well Child/Tamariki Ora, IDEA Services, and CliniKids. A complete list of my research publications is available at: https://scholar.google.co.nz/citations?user=23bLgJoAAAAJ&hl=en&oi=ao

A personal relationship with another person (e.g., spouse, family member) involved in the development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	None
Development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	I lecture in educational psychology at Victoria University of Wellington and Have provided guest lectures on early support for the University of Canterbury.
A personal relationship with another person (e.g., spouse, family member) involved in the development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
Personal and/or family member experience of accessing therapies and/or support that may be covered in the guideline	None- I have autistic family members but am based in New Zealand, so they are not covered by the guideline.
Other	None

Declaration

If your answer is different from 'No' to any of the questions above, you may have a competing interest which should be declared. These will be reviewed by the co-Chairs of the Guideline Development Group. If the co-Chairs have answered other than ‘none’ to any of the questions above, these will be reviewed by Dr Gary Allen, Senior Policy Officer Human Research Ethics and Research Integrity at

Griffith University. In each case, appropriate processes will be put in place to management any conflicts arising. Team members should not be concerned about answering 'yes' to any of the questions. 'Yes' answers do not indicate good or bad, but are simply something to declare on the form and consider for inclusion in the declarations section of the guideline.

Autism CRC National Practice Guideline

Disclosure of Interests

Date:	29th April 2022
First Name:	Andrew
Surname:	Whitehouse

Origin of Form

This form has been adapted (including direct replication of text where relevant) from:

- The International Committee of Medical Journal Editors (ICMJE) disclosure of interest form (https://www.icmje.org/disclosure-of-interest/)
- The Cochrane Collaboration Disclosure of Potential Conflicts of Interest form (https://community.cochrane.org/sites/default/files/uploads/EPPR/Cochrane-COI-disclosure-form.pdf)

Instructions

The purpose of this form is to provide readers of your review with information about your other interests that could influence how they receive and understand your work. We ask you to disclose all relationships/activities/interests listed below that are related to your involvement in the development of the National Practice Guideline (herein referred to as the *guideline*). "Related" means any relation with for-profit or not-for-profit third parties whose interests may be affected by the content of the guideline. Disclosure represents a commitment to transparency and does not necessarily indicate a bias. Please think broadly when disclosing all relationships/activities/interests that may be relevant to your involvement in the guideline. If you are in doubt about whether to list a relationship/activity/interest, it is preferable that you do so.

Each person will be asked to complete their own form and you are responsible for the accuracy and completeness. In submitting this form, you certify that you have answered every question and have not altered the wording of any of the questions on this form.

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Did you or your institution at any time receive payment or services from a third party for any aspect of your involvement in the development of the guideline?

Please add more rows if necessary.

	Name all entities that provided support (or indicate none)	**Description of support (e.g., amount of funding, time in lieu)**
Grant	Yes	The Telethon Kids Institute received funding for a researcher (Sarah Pillar) to support the development of the Guideline. Andrew Whitehouse did not receive any salary or other financial support for working on the guideline.
Consulting fee or honorarium	None	
Support for travel to meetings for the guideline or other purposes	None	
Other	None	

2. Relevant financial activities outside the guideline (2019-2022)

This section asks about your financial relationships with entities in the field of autism that could be perceived to influence, or that give the appearance of potentially influencing, your involvement in the guideline. These relationships may include clinical service providers; companies that sell products that autistic people, their families, or service providers may purchase; and organisations that represent and/or advocate for autistic people, their families, and/or service providers. You should disclose interactions with ANY entity that could be considered broadly relevant to the work. Report all sources of revenue paid (or promised to be paid) directly to you or your institution on your behalf over the 36 months prior to commencing work on the guideline, and up until the point it is submitted to Autism CRC (i.e., 2019-2022). This should include all monies from sources with relevance to the guideline, not just monies from Autism CRC which sponsored the research. Please note that your interactions with Autism CRC that are outside the guideline should also be listed here. If there is any question, please disclose the relationship. For grants you have received for work outside the guideline, you should disclose support only from entities that could be perceived to be affected financially by the published work, such as Government departments and agencies (e.g., National Disability Insurance Scheme), service providers, companies, business (including where self-employed), or foundations supported by entities that could be perceived to have a financial stake in the outcome.

	Name all entities with whom you have this relationship or indicate none (add rows as needed)	**Specifications/comments (e.g., description of support, if payments were made to you or your institution)**
Grants or contracts from any entity (if not indicated in item #1 above).	Since 2019, Andrew Whitehouse has received research funding from the following organisations: National Health and Medical Research Council (NHMRC), Autism CRC, the Waterloo Foundation,	Research funding received that is specific to autism intervention: 1. NHMRC Investigator Grant (CIA Whitehouse, APP1173896). Improving clinical outcomes for children with autism spectrum disorder: A research

	the National Disability Insurance Agency, Griffith University, the New Zealand Health Research Council, the Western Australian State Government (Telethon-Perth Children's Hospital Research Fund), and the Angela Wright Bennett Foundation.	program spanning basic, clinical and implementation science. 2020-2024. 2. Telethon-Perth Children's Hospital Research Fund (CIB Whitehouse). A randomised-controlled trial of group-based very early intervention for infants with autism risk behaviours 2018-2020. or developmental delay 2016-2018. 3. Angela Wright Bennett Foundation (CIA Whitehouse) Funding provided as part of Whitehouse's Chair position, which has been used to trial a new intervention for newborns with a family history of autism. 2019-2024. 4. Commonwealth Department of Social Services, via Autism CRC (CIA Whitehouse). Implementation of the National guideline for the Assessment and Diagnosis of Autism in Australia. 2021-2022. 5. Health Group Seed Grant Scheme, Griffith University (CIB Whitehouse) Laying the foundation for optimal clinical decision-making for children with autism spectrum. 2020-2021. 6. New Zealand Health Research Council (CIB Whitehouse, 20/581) Low-intensity therapy and parent coaching for young children with ASD: An RCT. 2020-2023. 7. National Disability Insurance Agency, via Autism CRC (CIA Whitehouse 1.077RC). Synthesis of evidence for early autism intervention approaches 2020. 8. Waterloo Foundation (CIB Whitehouse) Exercise intervention in developmental coordination disorder. 2020-2022.
Royalties or licenses	Pearson Publishing, UWA Publishing	Andrew Whitehouse is the co-author of the Communication Checklist - Adult (2009) and Communication Checklist -

		Self Report (2009) and in receipt of small royalties based on sales (<$5,000p.a). Andrew Whitehouse is the author of a book with UWA Publishing (*Will Mozart make my Baby Smart*) and in receipt of small royalties based on sales (<$5,000p.a).
Consulting fees	None	Andrew Whitehouse is the Research Strategy Director for the Autism CRC. This is an honorary position and is not supported by any financial remuneration.
Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	None	
Payment for expert testimony	None	
Support for attending meetings and/or travel	Autism CRC	Andrew Whitehouse received support for travel and accommodation to attend the Autism CRC Participant Day in April 2022.
Patents planned, issued or pending	None	
Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	Autism Awareness Australia, Kids are Kids, Ocean Heroes, Australasian Society for Autism Research, Furthering Autistic Children's Education And Schooling	1. Director of Autism Awareness Australia (https://www.autismawareness.com.au/). Role is unpaid. 2. Director of Ocean Heroes: https://oceanheroes.com.au/ . Role is unpaid. 3. President, Australasian Society for Autism Research (https://asfar.org.au/). Role is unpaid. 4. Director of Furthering Autistic Children’s Education and Schooling Inc. Role is unpaid. 5. Patron of ‘Kids are Kids’ (www.kidsarekids.org.au/) which is a service provider for children with developmental difficulties, including autism. Role is unpaid.

		6. Invitee to the Expert Reference Group to implement the National Guideline for the Assessment and Diagnosis of Autism Spectrum Disorders in Australia. Role is unpaid.
Stock or stock options	None	
Receipt of equipment, materials, drugs, medical writing, gifts or other services	None	

3. Relevant other activities or relationships, including non-financial relationships (no time limit)

Are there other relationships or activities that readers could be perceived to have influenced, or that could give the appearance of potentially influencing, your involvement in the guideline? If so, please specify.

	Specifications/comments (e.g., description of the relationship/activity/organisations involved)
Development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	Andrew Whitehouse is the Director of a private allied health clinic, CliniKids: https://clinikids.telethonkids.org.au/. CliniKids is auspiced under the Telethon Kids Institute, and provides diagnostic and intervention services for children on the autism spectrum. The interventions offered within CliniKids are Early Start Denver Model (ESDM), Preschool Autism Communication Therapy (PACT), Joint Attention, Symbolic Play, Emotional Regulation (JASPER), iBASIS-VIPP, as well as general speech pathology, occupational therapy and clinical psychology services. Andrew Whitehouse does not receive any financial or non-financial remuneration for his role as Director of the clinic. Andrew Whitehouse contributed to the development of the iBASIS-VIPP intervention for infants showing early behavioural signs of autism. Andrew Whitehouse contributed to the development of Connected Caregiving intervention for infants who have been taken into out of home foster care. Andrew Whitehouse Chaired the development of the National Guideline for the Assessment and Diagnosis of Autism in Australia.
A personal relationship with another person (e.g., spouse, family member) involved in the development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	None

Development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
A personal relationship with another person (e.g., spouse, family member) involved in the development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
Personal and/or family member experience of accessing therapies and/or support that may be covered in the guideline	Andrew Whitehouse has first degree and second degree family member who are participants within the National Disability Insurance Scheme.
Other	None

Declaration

If your answer is different from 'No' to any of the questions above, you may have a competing interest which should be declared. These will be reviewed by the co-Chairs of the Guideline Development Group. If the co-Chairs have answered other than ‘none’ to any of the questions above, these will be reviewed by Dr Gary Allen, Senior Policy Officer Human Research Ethics and Research Integrity at Griffith University. In each case, appropriate processes will be put in place to management any conflicts arising. Team members should not be concerned about answering 'yes' to any of the questions. 'Yes' answers do not indicate good or bad, but are simply something to declare on the form and consider for inclusion in the declarations section of the guideline.

National guideline for supporting the learning, participation, and wellbeing of autistic children and their families in Australia

Appendix 2.3	Reference Group – Terms of Reference

Developing a national guideline for supporting the development and participation of children on the autism spectrum, and their families, in Australia

Terms of Reference for the Reference Group

7th February 2022

Background

Autism CRC has commissioned the development of a national guideline that outlines clinical recommendations for supporting the development and participation of children on the autism spectrum, and their families, in Australia (‘the project’), to be led by Professor Andrew Whitehouse and Associate Professor David Trembath.

Purpose

Autism CRC has asked Prof Whitehouse and A/Prof Trembath to form a group of individuals representing key stakeholders (‘Reference Group’) that will provide input to the guideline development process throughout the duration the project.

Anticipated timeline for the project

The project is scheduled to commence on Oct 1st 2021, and be completed by Sept 30th 2022.

Membership of the Reference Group

Stakeholder organisations represented in the Reference Group will be determined by the co-chairs of the project (Prof Andrew Whitehouse and A/Prof David Trembath), informed by the ‘Guideline for Guidelines’ recommendations provided by the National Health and Medical Research Council. Stakeholders will be asked to nominate one individual to represent their organisation on the Reference Group. A proxy may attend a meeting if the nominated individual is unable to attend. The Chair of the Reference Group must be informed of the substitution at least one working day prior to the scheduled nominated meeting.

Appointment of Chair

Professor Whitehouse will chair the Reference Group meetings.

Responsibilities of Reference Group Members

The responsibilities of the Committee are as follows:

- Provide feedback on the proposed process for developing the Guideline;
- Provide input on documents and components to be included in the literature review;
- Nominate experts within their professional group to participate in the consultative phase of the project;
- Provide advice on the most essential key components to include in the Guideline;
- Provide feedback on draft versions of the Guideline.

Meetings

The Reference Group will meet as often as it agrees or as required, but likely no more than four times throughout the duration of the project. The Reference Group could expect to meet quarterly via videoconference. The Reference Group will meet at the request of either of the Chair or at the request of a majority of Reference Group members. A quorum will be the Chair plus a majority of the total number of members of the Reference Group.

Code of conduct for the Reference Group

The Reference Group recognises that this is a sensitive project that requires completion within a relatively short timeframe. As such, the Reference Group agrees to the following:

- Conflicts of interest will be declared at the outset of the project, and be updated as any new potential conflicts emerge.
- As individuals, and collectively, we will work at all times with the children and families in mind.
- All communication between Reference Group members will be conducted in a respectful, constructive and cooperative way, and avoiding self-interest.
- Discussions within the Reference Group meetings may be relayed to members within the organisation that the member represents, but should not be discussed beyond that.

Reporting

The Reference Group will report to the Autism CRC Ltd Board or its delegated officers.

By signing below, I indicate that I agree to these Terms of Reference.

Name	
Signature	

National guideline for supporting the learning, participation, and wellbeing of autistic children and their families in Australia

Appendix 2.4	Reference Group – Declaration of Interests

Autism CRC National Practice Guideline

Disclosure of Interests

Date:	21 June 2022
First Name:	Sam
Surname:	Bennett

Origin of Form

This form has been adapted (including direct replication of text where relevant) from:

- The International Committee of Medical Journal Editors (ICMJE) disclosure of interest form (https://www.icmje.org/disclosure-of-interest/)
- The Cochrane Collaboration Disclosure of Potential Conflicts of Interest form (https://community.cochrane.org/sites/default/files/uploads/EPPR/Cochrane-COI-disclosure-form.pdf)

Instructions

The purpose of this form is to provide readers of your review with information about your other interests that could influence how they receive and understand your work. We ask you to disclose all relationships/activities/interests listed below that are related to your involvement in the development of the National Practice Guideline (herein referred to as the *guideline*). “Related” means any relation with for-profit or not-for-profit third parties whose interests may be affected by the content of the guideline. Disclosure represents a commitment to transparency and does not necessarily indicate a bias. Please think broadly when disclosing all relationships/activities/interests that may be relevant to your involvement in the guideline. If you are in doubt about whether to list a relationship/activity/interest, it is preferable that you do so.

Each person will be asked to complete their own form and you are responsible for the accuracy and completeness. In submitting this form, you certify that you have answered every question and have not altered the wording of any of the questions on this form.

If new interests arise during the project, you are required to submit an updated form.

1. Support for your involvement in the development of the guideline.

This section asks for information about your role in the development of the guideline. The time frame for this reporting is that of the work itself, from the initial conception and planning to the present. The requested information is about resources that you received, either directly or indirectly (via your institution), to enable you to complete the work. Writing "None" means that you did the work without receiving any financial support from any third party -- that is, the work was supported by funds from the same institution that pays your salary and that institution did not receive third-party funds with which to pay you. If you or your institution received funds from a third party to support the work, such as a government granting agency, charitable foundation or commercial sponsor, then provide the details. For example, if you received an honorarium from Autism CRC in relation to your involvement, you would name Autism CRC and then indicate the amount of funds received.

Did you or your institution at any time receive payment or services from a third party for any aspect of your involvement in the development of the guideline?

Please add more rows if necessary.

	Name all entities that provided support (or indicate none)	**Description of support (e.g., amount of funding, time in lieu)**
Grant	None	
Consulting fee or honorarium	None	
Support for travel to meetings for the guideline or other purposes	None	
Other	None	

2. Relevant financial activities outside the guideline (2019-2022)

This section asks about your financial relationships with entities in the field of autism that could be perceived to influence, or that give the appearance of potentially influencing, your involvement in the guideline. These relationships may include clinical service providers; companies that sell products that autistic people, their families, or service providers may purchase; and organisations that represent and/or advocate for autistic people, their families, and/or service providers. You should disclose interactions with ANY entity that could be considered broadly relevant to the work. Report all sources of revenue paid (or promised to be paid) directly to you or your institution on your behalf over the 36 months prior to commencing work on the guideline, and up until the point it is submitted to Autism CRC (i.e., 2019-2022). This should include all monies from sources with relevance to the guideline, not just monies from Autism CRC which sponsored the research. Please note that your interactions with Autism CRC that are outside the guideline should also be listed here. If there is any question, please disclose the relationship. For grants you have received for work outside the guideline, you should disclose support only from entities that could be perceived to be affected financially by the published work, such as Government departments and agencies (e.g., National Disability Insurance Scheme), service providers, companies, business (including where self-employed), or foundations supported by entities that could be perceived to have a financial stake in the outcome.

	Name all entities with whom you have this relationship or indicate none (add rows as needed)	**Specifications/comments (e.g., description of support, if payments were made to you or your institution)**
Grants or contracts from any entity (if not indicated in item #1 above).	None	
Royalties or licenses	None	
Consulting fees	None	
Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	None	
Payment for expert testimony	None	
Support for attending meetings and/or travel	None	
Patents planned, issued or pending	None	

Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	None	
Grants or contracts from any entity (if not indicated in item #1 above).	None	
Royalties or licenses	None	
Consulting fees	None	
Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	None	
Payment for expert testimony	None	
Support for attending meetings and/or travel	None	
Patents planned, issued or pending	None	
Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	None	
Stock or stock options	None	
Receipt of equipment, materials, drugs, medical writing, gifts or other services	None	

3. Relevant other activities or relationships, including non-financial relationships (no time limit)

Are there other relationships or activities that readers could be perceived to have influenced, or that could give the appearance of potentially influencing, your involvement in the guideline? If so, please specify.

	Specifications/comments (e.g., description of the relationship/activity/organisations involved)
Development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	None
A personal relationship with another person (e.g., spouse, family member) involved in the development, delivery, and/or evaluation of therapies and/or supports that may be	None

covered within the scope of the guideline	
Development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
A personal relationship with another person (e.g., spouse, family member) involved in the development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
Personal and/or family member experience of accessing therapies and/or support that may be covered in the guideline	None
Other	None

Declaration

If your answer is different from 'No' to any of the questions above, you may have a competing interest which should be declared. These will be reviewed by the co-Chairs of the Guideline Development Group. If the co-Chairs have answered other than ‘none’ to any of the questions above, these will be reviewed by Dr Gary Allen, Senior Policy Officer Human Research Ethics and Research Integrity at Griffith University. In each case, appropriate processes will be put in place to management any conflicts arising. Team members should not be concerned about answering 'yes' to any of the questions. 'Yes' answers do not indicate good or bad, but are simply something to declare on the form and consider for inclusion in the declarations section of the guideline.

Autism CRC National Practice Guideline

Disclosure of Interests

Date:	21 June 2022
First Name:	Karen
Surname:	Brown

Origin of Form

This form has been adapted (including direct replication of text where relevant) from:

- The International Committee of Medical Journal Editors (ICMJE) disclosure of interest form (https://www.icmje.org/disclosure-of-interest/)
- The Cochrane Collaboration Disclosure of Potential Conflicts of Interest form (https://community.cochrane.org/sites/default/files/uploads/EPPR/Cochrane-COI-disclosure-form.pdf)

Instructions

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Did you or your institution at any time receive payment or services from a third party for any aspect of your involvement in the development of the guideline?

Please add more rows if necessary.

	Name all entities that provided support (or indicate none)	**Description of support (e.g., amount of funding, time in lieu)**
Grant	None	
Consulting fee or honorarium	Yes	Occupational Therapy Australia received an honorarium payment of $1,000 to support staff attendance and input to the National Autism Practice Guideline Reference Group. Karen Brown did not receive any direct financial support for working on the guideline.
Support for travel to meetings for the guideline or other purposes	None	
Other	None	

2. Relevant financial activities outside the guideline (2019-2022)

This section asks about your financial relationships with entities in the field of autism that could be perceived to influence, or that give the appearance of potentially influencing, your involvement in the guideline. These relationships may include clinical service providers; companies that sell products that autistic people, their families, or service providers may purchase; and organisations that represent and/or advocate for autistic people, their families, and/or service providers. You should disclose interactions with ANY entity that could be considered broadly relevant to the work. Report all sources of revenue paid (or promised to be paid) directly to you or your institution on your behalf over the 36 months prior to commencing work on the guideline, and up until the point it is submitted to Autism CRC (i.e., 2019-2022). This should include all monies from sources with relevance to the guideline, not just monies from Autism CRC which sponsored the research. Please note that your interactions with Autism CRC that are outside the guideline should also be listed here. If there is any question, please disclose the relationship. For grants you have received for work outside the guideline, you should disclose support only from entities that could be perceived to be affected financially by the published work, such as Government departments and agencies (e.g., National Disability Insurance Scheme), service providers, companies, business (including where self-employed), or foundations supported by entities that could be perceived to have a financial stake in the outcome.

	Name all entities with whom you have this relationship or indicate none (add rows as needed)	**Specifications/comments (e.g., description of support, if payments were made to you or your institution)**
Grants or contracts from any entity (if not indicated in item #1 above).	None	
Royalties or licenses	None	
Consulting fees	None	
Payment or honoraria for lectures, presentations,	None	

speakers bureaus, manuscript writing or educational events		
Payment for expert testimony	None	
Support for attending meetings and/or travel	None	
Patents planned, issued or pending	None	
Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	None	
Grants or contracts from any entity (if not indicated in item #1 above).	None	
Royalties or licenses	None	
Consulting fees	None	
Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	None	
Payment for expert testimony	None	
Support for attending meetings and/or travel	None	
Patents planned, issued or pending	None	
Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	None	
Stock or stock options	None	
Receipt of equipment, materials, drugs, medical writing, gifts or other services	None	

3. Relevant other activities or relationships, including non-financial relationships (no time limit)

Are there other relationships or activities that readers could be perceived to have influenced, or that could give the appearance of potentially influencing, your involvement in the guideline? If so, please specify.

	Specifications/comments (e.g., description of the relationship/activity/organisations involved)
Development, delivery, and/or evaluation of therapies and/or supports that may be covered	None

within the scope of the guideline	
A personal relationship with another person (e.g., spouse, family member) involved in the development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	None
Development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
A personal relationship with another person (e.g., spouse, family member) involved in the development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
Personal and/or family member experience of accessing therapies and/or support that may be covered in the guideline	None
Other	None

Declaration

If your answer is different from 'No' to any of the questions above, you may have a competing interest which should be declared. These will be reviewed by the co-Chairs of the Guideline Development Group. If the co-Chairs have answered other than ‘none’ to any of the questions above, these will be reviewed by Dr Gary Allen, Senior Policy Officer Human Research Ethics and Research Integrity at Griffith University. In each case, appropriate processes will be put in place to management any conflicts arising. Team members should not be concerned about answering 'yes' to any of the questions. 'Yes' answers do not indicate good or bad, but are simply something to declare on the form and consider for inclusion in the declarations section of the guideline.

Autism CRC National Practice Guideline

Disclosure of Interests

Date:	16/5/2022
First Name:	Tamara
Surname:	Cavenett

Origin of Form

This form has been adapted (including direct replication of text where relevant) from:

- The International Committee of Medical Journal Editors (ICMJE) disclosure of interest form (https://www.icmje.org/disclosure-of-interest/)
- The Cochrane Collaboration Disclosure of Potential Conflicts of Interest form (https://community.cochrane.org/sites/default/files/uploads/EPPR/Cochrane-COI-disclosure-form.pdf)

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Did you or your institution at any time receive payment or services from a third party for any aspect of your involvement in the development of the guideline?

Please add more rows if necessary.

	Name all entities that provided support (or indicate none)	**Description of support (e.g., amount of funding, time in lieu)**
Grant	None	
Consulting fee or honorarium	Yes	Autism CRC Received an honorarium of $1000 for membership of the Reference Group
Support for travel to meetings for the guideline or other purposes	None	
Other	None	

2. Relevant financial activities outside the guideline (2019-2022)

This section asks about your financial relationships with entities in the field of autism that could be perceived to influence, or that give the appearance of potentially influencing, your involvement in the guideline. These relationships may include clinical service providers; companies that sell products that autistic people, their families, or service providers may purchase; and organisations that represent and/or advocate for autistic people, their families, and/or service providers. You should disclose interactions with ANY entity that could be considered broadly relevant to the work. Report all sources of revenue paid (or promised to be paid) directly to you or your institution on your behalf over the 36 months prior to commencing work on the guideline, and up until the point it is submitted to Autism CRC (i.e., 2019-2022). This should include all monies from sources with relevance to the guideline, not just monies from Autism CRC which sponsored the research. Please note that your interactions with Autism CRC that are outside the guideline should also be listed here. If there is any question, please disclose the relationship. For grants you have received for work outside the guideline, you should disclose support only from entities that could be perceived to be affected financially by the published work, such as Government departments and agencies (e.g., National Disability Insurance Scheme), service providers, companies, business (including where self-employed), or foundations supported by entities that could be perceived to have a financial stake in the outcome.

	Name all entities with whom you have this relationship or indicate none (add rows as needed)	**Specifications/comments (e.g., description of support, if payments were made to you or your institution)**
Grants or contracts from any entity (if not indicated in item #1 above).	None	
Royalties or licenses	None	
Consulting fees	None	
Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	None	
Payment for expert testimony	None	
Support for attending meetings and/or travel	None	

Patents planned, issued or pending	None	
Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	None	
Grants or contracts from any entity (if not indicated in item #1 above).	None	
Royalties or licenses	None	
Consulting fees	None	
Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	None	
Payment for expert testimony	None	
Support for attending meetings and/or travel	None	
Patents planned, issued or pending	None	
Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	Yes	President of the Board, Australian Psychological Society, paid part-time.
Stock or stock options	None	
Receipt of equipment, materials, drugs, medical writing, gifts or other services	None	

3. Relevant other activities or relationships, including non-financial relationships (no time limit)

Are there other relationships or activities that readers could be perceived to have influenced, or that could give the appearance of potentially influencing, your involvement in the guideline? If so, please specify.

	Specifications/comments (e.g., description of the relationship/activity/organisations involved)
Development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	None
A personal relationship with another person (e.g., spouse, family member) involved in the development, delivery, and/or evaluation of therapies	None

and/or supports that may be covered within the scope of the guideline	
Development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	Australian Psychological Society (the society for which I'm president) provides courses and CPD in the area of Autism for psychologists. I have limited, if any, connection with this work and do not believe it presents a conflict of interest to my decision making.
A personal relationship with another person (e.g., spouse, family member) involved in the development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
Personal and/or family member experience of accessing therapies and/or support that may be covered in the guideline	None
Other	None

Declaration

If your answer is different from 'No' to any of the questions above, you may have a competing interest which should be declared. These will be reviewed by the co-Chairs of the Guideline Development Group. If the co-Chairs have answered other than 'none' to any of the questions above, these will be reviewed by Dr Gary Allen, Senior Policy Officer Human Research Ethics and Research Integrity at Griffith University. In each case, appropriate processes will be put in place to management any conflicts arising. Team members should not be concerned about answering 'yes' to any of the questions. 'Yes' answers do not indicate good or bad, but are simply something to declare on the form and consider for inclusion in the declarations section of the guideline.

Autism CRC National Practice Guideline

Disclosure of Interests

Date:	9 July 2022
First Name:	Daniel
Surname:	Coase

Origin of Form

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- The International Committee of Medical Journal Editors (ICMJE) disclosure of interest form (https://www.icmje.org/disclosure-of-interest/)
- The Cochrane Collaboration Disclosure of Potential Conflicts of Interest form (https://community.cochrane.org/sites/default/files/uploads/EPPR/Cochrane-COI-disclosure-form.pdf)

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1. Support for your involvement in the development of the guideline.

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Did you or your institution at any time receive payment or services from a third party for any aspect of your involvement in the development of the guideline?

Please add more rows if necessary.

	Name all entities that provided support (or indicate none)	**Description of support (e.g., amount of funding, time in lieu)**
Grant	Autism CRC	Member of an organisation that received an honorarium of $1000 for membership of the Reference Group
Consulting fee or honorarium	None	
Support for travel to meetings for the guideline or other purposes	None	
Other	None	

2. Relevant financial activities outside the guideline (2019-2022)

This section asks about your financial relationships with entities in the field of autism that could be perceived to influence, or that give the appearance of potentially influencing, your involvement in the guideline. These relationships may include clinical service providers; companies that sell products that autistic people, their families, or service providers may purchase; and organisations that represent and/or advocate for autistic people, their families, and/or service providers. You should disclose interactions with ANY entity that could be considered broadly relevant to the work. Report all sources of revenue paid (or promised to be paid) directly to you or your institution on your behalf over the 36 months prior to commencing work on the guideline, and up until the point it is submitted to Autism CRC (i.e., 2019-2022). This should include all monies from sources with relevance to the guideline, not just monies from Autism CRC which sponsored the research. Please note that your interactions with Autism CRC that are outside the guideline should also be listed here. If there is any question, please disclose the relationship. For grants you have received for work outside the guideline, you should disclose support only from entities that could be perceived to be affected financially by the published work, such as Government departments and agencies (e.g., National Disability Insurance Scheme), service providers, companies, business (including where self-employed), or foundations supported by entities that could be perceived to have a financial stake in the outcome.

	Name all entities with whom you have this relationship or indicate none (add rows as needed)	**Specifications/comments (e.g., description of support, if payments were made to you or your institution)**
Grants or contracts from any entity (if not indicated in item #1 above).	None	
Royalties or licenses	None	
Consulting fees	None	
Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	None	
Payment for expert testimony	None	
Support for attending meetings and/or travel	None	

Patents planned, issued or pending	None	
Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	None	
Grants or contracts from any entity (if not indicated in item #1 above).	None	
Royalties or licenses	None	
Consulting fees	None	
Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	None	
Payment for expert testimony	None	
Support for attending meetings and/or travel	None	
Patents planned, issued or pending	None	
Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	None	
Stock or stock options	None	
Receipt of equipment, materials, drugs, medical writing, gifts or other services	None	

3. Relevant other activities or relationships, including non-financial relationships (no time limit)

Are there other relationships or activities that readers could be perceived to have influenced, or that could give the appearance of potentially influencing, your involvement in the guideline? If so, please specify.

	Specifications/comments (e.g., description of the relationship/activity/organisations involved)
Development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	None
A personal relationship with another person (e.g., spouse, family member) involved in the development, delivery, and/or evaluation of therapies	None

and/or supports that may be covered within the scope of the guideline	
Development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
A personal relationship with another person (e.g., spouse, family member) involved in the development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
Personal and/or family member experience of accessing therapies and/or support that may be covered in the guideline	None
Other	None

Declaration

If your answer is different from 'No' to any of the questions above, you may have a competing interest which should be declared. These will be reviewed by the co-Chairs of the Guideline Development Group. If the co-Chairs have answered other than ‘none’ to any of the questions above, these will be reviewed by Dr Gary Allen, Senior Policy Officer Human Research Ethics and Research Integrity at Griffith University. In each case, appropriate processes will be put in place to management any conflicts arising. Team members should not be concerned about answering 'yes' to any of the questions. 'Yes' answers do not indicate good or bad, but are simply something to declare on the form and consider for inclusion in the declarations section of the guideline.

Autism CRC National Practice Guideline

Disclosure of Interests

Date:	21/06/2022
First Name:	Amy
Surname:	Fitzpatrick

Origin of Form

This form has been adapted (including direct replication of text where relevant) from:

- The International Committee of Medical Journal Editors (ICMJE) disclosure of interest form (https://www.icmje.org/disclosure-of-interest/)
- The Cochrane Collaboration Disclosure of Potential Conflicts of Interest form (https://community.cochrane.org/sites/default/files/uploads/EPPR/Cochrane-COI-disclosure-form.pdf)

Instructions

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1. Support for your involvement in the development of the guideline.

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Did you or your institution at any time receive payment or services from a third party for any aspect of your involvement in the development of the guideline?

Please add more rows if necessary.

	Name all entities that provided support (or indicate none)	**Description of support (e.g., amount of funding, time in lieu)**
Grant	None	
Consulting fee or honorarium	None	
Support for travel to meetings for the guideline or other purposes	None	
Other	None	

2. Relevant financial activities outside the guideline (2019-2022)

This section asks about your financial relationships with entities in the field of autism that could be perceived to influence, or that give the appearance of potentially influencing, your involvement in the guideline. These relationships may include clinical service providers; companies that sell products that autistic people, their families, or service providers may purchase; and organisations that represent and/or advocate for autistic people, their families, and/or service providers. You should disclose interactions with ANY entity that could be considered broadly relevant to the work. Report all sources of revenue paid (or promised to be paid) directly to you or your institution on your behalf over the 36 months prior to commencing work on the guideline, and up until the point it is submitted to Autism CRC (i.e., 2019-2022). This should include all monies from sources with relevance to the guideline, not just monies from Autism CRC which sponsored the research. Please note that your interactions with Autism CRC that are outside the guideline should also be listed here. If there is any question, please disclose the relationship. For grants you have received for work outside the guideline, you should disclose support only from entities that could be perceived to be affected financially by the published work, such as Government departments and agencies (e.g., National Disability Insurance Scheme), service providers, companies, business (including where self-employed), or foundations supported by entities that could be perceived to have a financial stake in the outcome.

	Name all entities with whom you have this relationship or indicate none (add rows as needed)	**Specifications/comments (e.g., description of support, if payments were made to you or your institution)**
Grants or contracts from any entity (if not indicated in item #1 above).	None	
Royalties or licenses	None	
Consulting fees	None	
Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	None	
Payment for expert testimony	None	
Support for attending meetings and/or travel	None	
Patents planned, issued or pending	None	

Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	None	
Grants or contracts from any entity (if not indicated in item #1 above).	None	
Royalties or licenses	None	
Consulting fees	None	
Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	None	
Payment for expert testimony	None	
Support for attending meetings and/or travel	None	
Patents planned, issued or pending	None	
Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	None	
Stock or stock options	None	
Receipt of equipment, materials, drugs, medical writing, gifts or other services	None	

3. Relevant other activities or relationships, including non-financial relationships (no time limit)

Are there other relationships or activities that readers could be perceived to have influenced, or that could give the appearance of potentially influencing, your involvement in the guideline? If so, please specify.

	Specifications/comments (e.g., description of the relationship/activity/organisations involved)
Development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	None
A personal relationship with another person (e.g., spouse, family member) involved in the development, delivery, and/or evaluation of therapies and/or supports that may be	None

covered within the scope of the guideline	
Development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
A personal relationship with another person (e.g., spouse, family member) involved in the development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
Personal and/or family member experience of accessing therapies and/or support that may be covered in the guideline	Yes. Child and myself receiving therapies similar or the same as some interventions covered in the guideline.
Other	None

Declaration

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Autism CRC National Practice Guideline

Disclosure of Interests

Date:

19th May, 2022

First Name:

Trish

Surname:

Hanna

Origin of Form

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- The International Committee of Medical Journal Editors (ICMJE) disclosure of interest form (https://www.icmje.org/disclosure-of-interest/)
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Did you or your institution at any time receive payment or services from a third party for any aspect of your involvement in the development of the guideline?

Please add more rows if necessary.

Name all entities that provided support (or indicate none)

Description of support (e.g., amount of funding, time in lieu)

Grant

Autism CRC : Autism practice guidelines

Consulting fee or honorarium

Received an honorarium of $1000 for membership of the Reference Group

Support for travel to meetings for the guideline or other purposes

None

Other

None

- **Relevant financial activities outside the guideline (2019-2022)**

This section asks about your financial relationships with entities in the field of autism that could be perceived to influence, or that give the appearance of potentially influencing, your involvement in the guideline. These relationships may include clinical service providers; companies that sell products that autistic people, their families, or service providers may purchase; and organisations that represent and/or advocate for autistic people, their families, and/or service providers. You should disclose interactions with ANY entity that could be considered broadly relevant to the work. Report all sources of revenue paid (or promised to be paid) directly to you or your institution on your behalf over the 36 months prior to commencing work on the guideline, and up until the point it is submitted to Autism CRC (i.e., 2019-2022). This should include all monies from sources with relevance to the guideline, not just monies from Autism CRC which sponsored the research. Please note that your interactions with Autism CRC that are outside the guideline should also be listed here. If there is any question, please disclose the relationship. For grants you have received for work outside the guideline, you should disclose support only from entities that could be perceived to be affected financially by the published work, such as Government departments and agencies (e.g., National Disability Insurance Scheme), service providers, companies, business (including where self-employed), or foundations supported by entities that could be perceived to have a financial stake in the outcome.

Name all entities with whom you have this relationship or indicate none (add rows as needed)

Specifications/comments (e.g., description of support, if payments were made to you or your institution)

Grants or contracts from any entity (if not indicated in item #1 above).

None

Royalties or licenses

None

Consulting fees

None

Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events

None

Payment for expert testimony

None

Support for attending meetings and/or travel

None

Patents planned, issued or pending

None

Participation on a Data Safety Monitoring Board or Advisory Board

None

Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid

None

Grants or contracts from any entity (if not indicated in item #1 above).

None

Royalties or licenses

None

Consulting fees

None

Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events

None

Payment for expert testimony

None

Support for attending meetings and/or travel

None

Patents planned, issued or pending

None

Participation on a Data Safety Monitoring Board or Advisory Board

None

Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid

None

Stock or stock options

None

Receipt of equipment, materials, drugs, medical writing, gifts or other services

None

- **Relevant other activities or relationships, including non-financial relationships (no time limit)**

Are there other relationships or activities that readers could be perceived to have influenced, or that could give the appearance of potentially influencing, your involvement in the guideline? If so, please specify.

Specifications/comments (e.g., description of the relationship/activity/organisations involved)

Development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline

None

A personal relationship with another person (e.g., spouse, family member) involved in the development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline

None

Development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)

None

A personal relationship with another person (e.g., spouse, family member) involved in the development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)

None

Personal and/or family member experience of accessing therapies and/or support that may be covered in the guideline

None

Other

None

Declaration

If your answer is different from 'No' to any of the questions above, you may have a competing interest which should be declared. These will be reviewed by the co-Chairs of the Guideline Development Group. If the co-Chairs have answered other than ‘none’ to any of the questions above, these will be reviewed by Dr Gary Allen, Senior Policy Officer Human Research Ethics and Research Integrity at Griffith University. In each case, appropriate processes will be put in place to management any conflicts arising. Team members should not be concerned about answering 'yes' to any of the questions. 'Yes' answers do not indicate good or bad, but are simply something to declare on the form and consider for inclusion in the declarations section of the guideline.

Autism CRC National Practice Guideline

Disclosure of Interests

Date:	29/06/2022
First Name:	Nicole
Surname:	Haynes

Origin of Form

This form has been adapted (including direct replication of text where relevant) from:

- The International Committee of Medical Journal Editors (ICMJE) disclosure of interest form (https://www.icmje.org/disclosure-of-interest/)
- The Cochrane Collaboration Disclosure of Potential Conflicts of Interest form (https://community.cochrane.org/sites/default/files/uploads/EPPR/Cochrane-COI-disclosure-form.pdf)

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Did you or your institution at any time receive payment or services from a third party for any aspect of your involvement in the development of the guideline?

Please add more rows if necessary.

	Name all entities that provided support (or indicate none)	**Description of support (e.g., amount of funding, time in lieu)**
Grant	Autism CRC	Member of an organisation that received an honorarium of $1000 for membership of the Reference Group
Consulting fee or honorarium		
Support for travel to meetings for the guideline or other purposes	None	
Other	None	

2. Relevant financial activities outside the guideline (2019-2022)

This section asks about your financial relationships with entities in the field of autism that could be perceived to influence, or that give the appearance of potentially influencing, your involvement in the guideline. These relationships may include clinical service providers; companies that sell products that autistic people, their families, or service providers may purchase; and organisations that represent and/or advocate for autistic people, their families, and/or service providers. You should disclose interactions with ANY entity that could be considered broadly relevant to the work. Report all sources of revenue paid (or promised to be paid) directly to you or your institution on your behalf over the 36 months prior to commencing work on the guideline, and up until the point it is submitted to Autism CRC (i.e., 2019-2022). This should include all monies from sources with relevance to the guideline, not just monies from Autism CRC which sponsored the research. Please note that your interactions with Autism CRC that are outside the guideline should also be listed here. If there is any question, please disclose the relationship. For grants you have received for work outside the guideline, you should disclose support only from entities that could be perceived to be affected financially by the published work, such as Government departments and agencies (e.g., National Disability Insurance Scheme), service providers, companies, business (including where self-employed), or foundations supported by entities that could be perceived to have a financial stake in the outcome.

	Name all entities with whom you have this relationship or indicate none (add rows as needed)	**Specifications/comments (e.g., description of support, if payments were made to you or your institution)**
Grants or contracts from any entity (if not indicated in item #1 above).	None	
Royalties or licenses	None	
Consulting fees	None	
Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	None	
Payment for expert testimony	None	
Support for attending meetings and/or travel	None	

Patents planned, issued or pending	None	
Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	Australian Physiotherapy Association	National Paediatric Chair and member of the National Advisory Council for the APA.
Grants or contracts from any entity (if not indicated in item #1 above).	None	
Royalties or licenses	None	
Consulting fees	None	
Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	None	
Payment for expert testimony	None	
Support for attending meetings and/or travel	None	
Patents planned, issued or pending	None	
Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	None	
Stock or stock options	None	
Receipt of equipment, materials, drugs, medical writing, gifts or other services	None	

3. **Relevant other activities or relationships, including non-financial relationships (no time limit)**

Are there other relationships or activities that readers could be perceived to have influenced, or that could give the appearance of potentially influencing, your involvement in the guideline? If so, please specify.

	Specifications/comments (e.g., description of the relationship/activity/organisations involved)
Development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	Business owner, share holder and clinician in a company that provided therapeutic supports to autistic children.
A personal relationship with another person (e.g., spouse, family member) involved in the development, delivery, and/or evaluation of therapies	None

and/or supports that may be covered within the scope of the guideline	
Development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
A personal relationship with another person (e.g., spouse, family member) involved in the development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
Personal and/or family member experience of accessing therapies and/or support that may be covered in the guideline	None
Other	None

Declaration

If your answer is different from 'No' to any of the questions above, you may have a competing interest which should be declared. These will be reviewed by the co-Chairs of the Guideline Development Group. If the co-Chairs have answered other than ‘none’ to any of the questions above, these will be reviewed by Dr Gary Allen, Senior Policy Officer Human Research Ethics and Research Integrity at Griffith University. In each case, appropriate processes will be put in place to management any conflicts arising. Team members should not be concerned about answering 'yes' to any of the questions. 'Yes' answers do not indicate good or bad, but are simply something to declare on the form and consider for inclusion in the declarations section of the guideline.

Autism CRC National Practice Guideline

Disclosure of Interests

Date:	21/6/22
First Name:	Patrick
Surname:	Kelly

Origin of Form

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Did you or your institution at any time receive payment or services from a third party for any aspect of your involvement in the development of the guideline?

Please add more rows if necessary.

	Name all entities that provided support (or indicate none)	**Description of support (e.g., amount of funding, time in lieu)**
Grant	Patrick Kelly National president AASE	Member of an organisation that received an honorarium of $1000 for membership of the Reference Group
Consulting fee or honorarium	None	
Support for travel to meetings for the guideline or other purposes	None	
Other	None	

2. Relevant financial activities outside the guideline (2019-2022)

This section asks about your financial relationships with entities in the field of autism that could be perceived to influence, or that give the appearance of potentially influencing, your involvement in the guideline. These relationships may include clinical service providers; companies that sell products that autistic people, their families, or service providers may purchase; and organisations that represent and/or advocate for autistic people, their families, and/or service providers. You should disclose interactions with ANY entity that could be considered broadly relevant to the work. Report all sources of revenue paid (or promised to be paid) directly to you or your institution on your behalf over the 36 months prior to commencing work on the guideline, and up until the point it is submitted to Autism CRC (i.e., 2019-2022). This should include all monies from sources with relevance to the guideline, not just monies from Autism CRC which sponsored the research. Please note that your interactions with Autism CRC that are outside the guideline should also be listed here. If there is any question, please disclose the relationship. For grants you have received for work outside the guideline, you should disclose support only from entities that could be perceived to be affected financially by the published work, such as Government departments and agencies (e.g., National Disability Insurance Scheme), service providers, companies, business (including where self-employed), or foundations supported by entities that could be perceived to have a financial stake in the outcome.

	Name all entities with whom you have this relationship or indicate none (add rows as needed)	**Specifications/comments (e.g., description of support, if payments were made to you or your institution)**
Grants or contracts from any entity (if not indicated in item #1 above).	None	
Royalties or licenses	None	
Consulting fees	None	
Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	None	
Payment for expert testimony	None	
Support for attending meetings and/or travel	None	

Patents planned, issued or pending	None	
Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	None	
Grants or contracts from any entity (if not indicated in item #1 above).	None	
Royalties or licenses	None	
Consulting fees	None	
Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	None	
Payment for expert testimony	None	
Support for attending meetings and/or travel	None	
Patents planned, issued or pending	None	
Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	None	
Stock or stock options	None	
Receipt of equipment, materials, drugs, medical writing, gifts or other services	None	

3. Relevant other activities or relationships, including non-financial relationships (no time limit)

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	Specifications/comments (e.g., description of the relationship/activity/organisations involved)
Development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	None
A personal relationship with another person (e.g., spouse, family member) involved in the development, delivery, and/or evaluation of therapies	None

and/or supports that may be covered within the scope of the guideline	
Development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
A personal relationship with another person (e.g., spouse, family member) involved in the development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
Personal and/or family member experience of accessing therapies and/or support that may be covered in the guideline	None
Other	None

Declaration

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Autism CRC National Practice Guideline

Disclosure of Interests

Date:	11/07/2022
First Name:	Mullan
Surname:	James

Origin of Form

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Did you or your institution at any time receive payment or services from a third party for any aspect of your involvement in the development of the guideline?

Please add more rows if necessary.

	Name all entities that provided support (or indicate none)	**Description of support (e.g., amount of funding, time in lieu)**
Grant	None	
Consulting fee or honorarium	None	
Support for travel to meetings for the guideline or other purposes	None	
Other	None	

2. Relevant financial activities outside the guideline (2019-2022)

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Grants or contracts from any entity (if not indicated in item #1 above).	None	
Royalties or licenses	None	
Consulting fees	None	
Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	None	
Payment for expert testimony	None	
Support for attending meetings and/or travel	None	
Patents planned, issued or pending	None	

Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	None	
Grants or contracts from any entity (if not indicated in item #1 above).	None	
Royalties or licenses	None	
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Stock or stock options	None	
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	Specifications/comments (e.g., description of the relationship/activity/organisations involved)
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A personal relationship with another person (e.g., spouse, family member) involved in the development, delivery, and/or evaluation of therapies and/or supports that may be	None

covered within the scope of the guideline	
Development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
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Other	None

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Autism CRC National Practice Guideline

Disclosure of Interests

Date:	11/05/2022
First Name:	Sujeeva Ashanthi
Surname:	Munasinghe

Origin of Form

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Please add more rows if necessary.

	Name all entities that provided support (or indicate none)	**Description of support (e.g., amount of funding, time in lieu)**
Grant	None	
Consulting fee or honorarium	None	
Support for travel to meetings for the guideline or other purposes	None	
Other	None	

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Grants or contracts from any entity (if not indicated in item #1 above).	None	
Royalties or licenses	None	
Consulting fees	Private Paediatric Practice	Dr Ashanthi Munasinghe works in Private Paediatric practice (Hollywood Medical Specialist Centre, Nedlands WA) for 1 day each week and in Public Paediatric practice 3 days per week working for the Child Development Service (Child & Adolescent Health Service WA). In both roles I

		am involved in the assessment and ongoing follow-up of children (aged 0-18y) with developmental issues including ASD. The role involves assessment, ongoing monitoring of developmental progress, support for pharmacological interventions and health reviews for the children seen.
Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	None	
Payment for expert testimony	None	
Support for attending meetings and/or travel	None	
Patents planned, issued or pending	None	
Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid		Ordinary member of the Neurodevelopmental & Behavioural Paediatric Society of Australasia- a not for profit organization of doctors with a specialist clinical or academic interest in neurodevelopmental paediatrics
Grants or contracts from any entity (if not indicated in item #1 above).	None	
Royalties or licenses	None	
Consulting fees	None	
Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	None	
Payment for expert testimony	None	
Support for attending meetings and/or travel	None	
Patents planned, issued or pending	None	
Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	None	
Stock or stock options	None	

Receipt of equipment, materials, drugs, medical writing, gifts or other services	None	

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Are there other relationships or activities that readers could be perceived to have influenced, or that could give the appearance of potentially influencing, your involvement in the guideline? If so, please specify.

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A personal relationship with another person (e.g., spouse, family member) involved in the development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	None
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A personal relationship with another person (e.g., spouse, family member) involved in the development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
Personal and/or family member experience of accessing therapies and/or support that may be covered in the guideline	None
Other	None

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Autism CRC National Practice Guideline

Disclosure of Interests

Date:	5 May 2022
First Name:	Gabrielle
Surname:	O’Kane

Origin of Form

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- The Cochrane Collaboration Disclosure of Potential Conflicts of Interest form (https://community.cochrane.org/sites/default/files/uploads/EPPR/Cochrane-COI-disclosure-form.pdf)

Instructions

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1. Support for your involvement in the development of the guideline.

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Did you or your institution at any time receive payment or services from a third party for any aspect of your involvement in the development of the guideline?

Please add more rows if necessary.

	Name all entities that provided support (or indicate none)	**Description of support (e.g., amount of funding, time in lieu)**
Grant	None	
Consulting fee or honorarium	Autism CRC	An honorarium of $1,000 for my involvement in the Reference Group for Autism CRC Project
Support for travel to meetings for the guideline or other purposes	None	
Other	None	

2. Relevant financial activities outside the guideline (2019-2022)

This section asks about your financial relationships with entities in the field of autism that could be perceived to influence, or that give the appearance of potentially influencing, your involvement in the guideline. These relationships may include clinical service providers; companies that sell products that autistic people, their families, or service providers may purchase; and organisations that represent and/or advocate for autistic people, their families, and/or service providers. You should disclose interactions with ANY entity that could be considered broadly relevant to the work. Report all sources of revenue paid (or promised to be paid) directly to you or your institution on your behalf over the 36 months prior to commencing work on the guideline, and up until the point it is submitted to Autism CRC (i.e., 2019-2022). This should include all monies from sources with relevance to the guideline, not just monies from Autism CRC which sponsored the research. Please note that your interactions with Autism CRC that are outside the guideline should also be listed here. If there is any question, please disclose the relationship. For grants you have received for work outside the guideline, you should disclose support only from entities that could be perceived to be affected financially by the published work, such as Government departments and agencies (e.g., National Disability Insurance Scheme), service providers, companies, business (including where self-employed), or foundations supported by entities that could be perceived to have a financial stake in the outcome.

	Name all entities with whom you have this relationship or indicate none (add rows as needed)	**Specifications/comments (e.g., description of support, if payments were made to you or your institution)**
Grants or contracts from any entity (if not indicated in item #1 above).	None	
Royalties or licenses	None	
Consulting fees	None	
Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	None	
Payment for expert testimony	None	
Support for attending meetings and/or travel	Therapeutic Good Administration	Gabrielle O’Kane is a representative on the

		Therapeutic Good Advertising Consultative Committee.
Patents planned, issued or pending	None	
Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	None	
Grants or contracts from any entity (if not indicated in item #1 above).	None	
Royalties or licenses	None	
Consulting fees	None	
Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	None	
Payment for expert testimony	None	
Support for attending meetings and/or travel	None	
Patents planned, issued or pending	None	
Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	None	
Stock or stock options	None	
Receipt of equipment, materials, drugs, medical writing, gifts or other services	None	

3. Relevant other activities or relationships, including non-financial relationships (no time limit)

Are there other relationships or activities that readers could be perceived to have influenced, or that could give the appearance of potentially influencing, your involvement in the guideline? If so, please specify.

	Specifications/comments (e.g., description of the relationship/activity/organisations involved)
Development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	None
A personal relationship with another person (e.g., spouse, family member) involved in	Gabrielle O’Kane has a second degree family member who is a participant within the National Disability Insurance Scheme

the development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	
Development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
A personal relationship with another person (e.g., spouse, family member) involved in the development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
Personal and/or family member experience of accessing therapies and/or support that may be covered in the guideline	None
Other	None

Declaration

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Autism CRC National Practice Guideline

Disclosure of Interests

Date:	12/07/2022
First Name:	Jessica
Surname:	Paynter

Origin of Form

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- The International Committee of Medical Journal Editors (ICMJE) disclosure of interest form (https://www.icmje.org/disclosure-of-interest/)
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Did you or your institution at any time receive payment or services from a third party for any aspect of your involvement in the development of the guideline?

Please add more rows if necessary.

	Name all entities that provided support (or indicate none)	Description of support (e.g., amount of funding, time in lieu)
Grant	Autism CRC	Member of an organisation (Australian Society for Autism Research) that received an honorarium of $1000 for membership of the Reference Group
Consulting fee or honorarium	None	None
Support for travel to meetings for the guideline or other purposes	None	None
Other	None	None

2. Relevant financial activities outside the guideline (2019-2022)

This section asks about your financial relationships with entities in the field of autism that could be perceived to influence, or that give the appearance of potentially influencing, your involvement in the guideline. These relationships may include clinical service providers; companies that sell products that autistic people, their families, or service providers may purchase; and organisations that represent and/or advocate for autistic people, their families, and/or service providers. You should disclose interactions with ANY entity that could be considered broadly relevant to the work. Report all sources of revenue paid (or promised to be paid) directly to you or your institution on your behalf over the 36 months prior to commencing work on the guideline, and up until the point it is submitted to Autism CRC (i.e., 2019-2022). This should include all monies from sources with relevance to the guideline, not just monies from Autism CRC which sponsored the research. Please note that your interactions with Autism CRC that are outside the guideline should also be listed here. If there is any question, please disclose the relationship. For grants you have received for work outside the guideline, you should disclose support only from entities that could be perceived to be affected financially by the published work, such as Government departments and agencies (e.g., National Disability Insurance Scheme), service providers, companies, business (including where self-employed), or foundations supported by entities that could be perceived to have a financial stake in the outcome.

	Name all entities with whom you have this relationship or indicate none (add rows as needed)	Specifications/comments (e.g., description of support, if payments were made to you or your institution)
Grants or contracts from any entity (if not indicated in item #1 above).	Department of Social Services AEIOU Foundation (above funding) Education Queensland	Research funding (end 2019) via Autism Specific Early Learning and Care Centres including AEIOU Foundation to institution: 1. **Paynter, J.,** Keen, D., Trembath, D., Fordyce, K., Joosten, A., Hoppenbrouwers, G., DeBlassio, A., Ecker, U.,

	Australian Psychological Society (APS) Autism CRC Play Matters (Formerly playgroup Queensland) Advance Queensland/Queensland Government	& Imms, C. (2016-2019). Debunking Autism Treatment Myths (Early Intervention Staff). Department of Social Services (DSS) Autism Specific Early Learning and Care Centre Research Funding, Department of Social Security, $89,445.43. 2. Trembath, D., Tucker, M., **Paynter, J**…..Dissanayake, C. (2017-2019). Supporting Best Practice in the Assessment and Treatment of Minimally Verbal Children with Autism. DSS Autism Specific Early Learning and Care Centre Research Funding, $232,821. Funded consultancy for Education Queensland (presentations, workshops) to institution Funded consultancy to institution and personally (workshops paid to me personally)- APS CI on funded grants outside of guidelines, payments made to institution. 1. Roberts, J., Keen, D., Trembath, D., Westerveld, M., Simpson, K., **Paynter, J.**, Adams, D., Howlin, P. (2016-2021). *Longitudinal Study of Australian Students with Autism (LASA).* Autism Cooperative Research Centre (Autism CRC), Strategic Project Funding, $661,989. 2. Westerveld, M., McCartney, D., **Paynter, J.,** Simpson, K., Ward, I., & Hurley, A. (2017-2020). Providing early literacy sessions in libraries to

		preschoolers on the autism spectrum and their parents. Autism CRC Utilisation Grant Application. $77,350. Funded consultancy to institution from Playgroup Queensland 1. **Paynter, J.** (2021-2022). Active Inclusion Evaluation. Playgroup Queensland Consultancy. $39, 749.60. Funded research grant to institution from Queensland Government. 1. **Paynter, J.** (2020-2022). Griffith University – Dr Jessica Paynter – Maternity Funding. Women's Research Assistance Program (Advance Queensland/Queensland Government). $15, 600.
Royalties or licenses	None	
Consulting fees	None	
Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	Education Queensland/Department of Education	Payment for presentations from 2018 to present.
Payment for expert testimony	None	
Support for attending meetings and/or travel	None	
Patents planned, issued or pending	None	
Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	Australian Society for Autism Research Australian Psychological Society	Vice President (2021-present) Committee Member (2018-present). Unpaid position. Chair Gold Coast Branch (2018-present) Committee Member Psychology of Intellectual Disability and Autism. Unpaid positions.
Grants or contracts from any entity (if not indicated in item #1 above).	None	
Royalties or licenses	None	

Consulting fees	None	
Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	Children's Health Queensland	Payment for presentation at conference (2022) to institution.
Payment for expert testimony	None	
Support for attending meetings and/or travel	None	
Patents planned, issued or pending	None	
Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	None	
Stock or stock options	None	
Receipt of equipment, materials, drugs, medical writing, gifts or other services	None	

3. Relevant other activities or relationships, including non-financial relationships (no time limit)

Are there other relationships or activities that readers could be perceived to have influenced, or that could give the appearance of potentially influencing, your involvement in the guideline? If so, please specify.

	Specifications/comments (e.g., description of the relationship/activity/organisations involved)
Development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	Jessica Paynter is a clinical psychologist who maintains her own private practice renting rooms from Griffith University operating out of the psychology clinic. She offers diagnostic and therapy services to clients on the autism spectrum. Interventions draw from behavioural and cognitive-behavioural strategies. She receives private fees paid directly by clients, NDIS funding, and/or medicare rebates. Jessica Paynter is an author on evaluations of Early Start Denver Model (ESDM)/La Trobe research and AEIOU Foundation program/AEIOU Foundation. She has published a number of articles on evidence-based practice in autism. For full list, please see: https://scholar.google.com.au/citations?user=9VT4bfQAAAAJ&hl=en&oi=ao
A personal relationship with another person (e.g., spouse, family member) involved in the development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	None

Development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	Yes. Jessica Paynter is a senior lecturer in the School of Applied Psychology at Griffith University and she teaches into the clinical psychology and professional psychology masters programs.
A personal relationship with another person (e.g., spouse, family member) involved in the development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
Personal and/or family member experience of accessing therapies and/or support that may be covered in the guideline	None
Other	None

Declaration

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Autism CRC National Practice Guideline

Disclosure of Interests

Date:	11 July 2022
First Name:	Nicole
Surname:	Rogerson

Origin of Form

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Please add more rows if necessary.

	Name all entities that provided support (or indicate none)	**Description of support (e.g., amount of funding, time in lieu)**
Grant	None	
Consulting fee or honorarium	None	
Support for travel to meetings for the guideline or other purposes	None	
Other	None	

2. Relevant financial activities outside the guideline (2019-2022)

This section asks about your financial relationships with entities in the field of autism that could be perceived to influence, or that give the appearance of potentially influencing, your involvement in the guideline. These relationships may include clinical service providers; companies that sell products that autistic people, their families, or service providers may purchase; and organisations that represent and/or advocate for autistic people, their families, and/or service providers. You should disclose interactions with ANY entity that could be considered broadly relevant to the work. Report all sources of revenue paid (or promised to be paid) directly to you or your institution on your behalf over the 36 months prior to commencing work on the guideline, and up until the point it is submitted to Autism CRC (i.e., 2019-2022). This should include all monies from sources with relevance to the guideline, not just monies from Autism CRC which sponsored the research. Please note that your interactions with Autism CRC that are outside the guideline should also be listed here. If there is any question, please disclose the relationship. For grants you have received for work outside the guideline, you should disclose support only from entities that could be perceived to be affected financially by the published work, such as Government departments and agencies (e.g., National Disability Insurance Scheme), service providers, companies, business (including where self-employed), or foundations supported by entities that could be perceived to have a financial stake in the outcome.

	Name all entities with whom you have this relationship or indicate none (add rows as needed)	**Specifications/comments (e.g., description of support, if payments were made to you or your institution)**
Grants or contracts from any entity (if not indicated in item #1 above).	None	1.
Royalties or licenses	None	
Consulting fees	None	
Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	None	
Payment for expert testimony	None	
Support for attending meetings and/or travel	None	
Patents planned, issued or pending	None	

Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	None	
Grants or contracts from any entity (if not indicated in item #1 above).	None	
Royalties or licenses	None	
Consulting fees	None	
Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	None	
Payment for expert testimony	None	
Support for attending meetings and/or travel	None	
Patents planned, issued or pending	None	
Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	None	
Stock or stock options	None	
Receipt of equipment, materials, drugs, medical writing, gifts or other services	None	

3. Relevant other activities or relationships, including non-financial relationships (no time limit)

Are there other relationships or activities that readers could be perceived to have influenced, or that could give the appearance of potentially influencing, your involvement in the guideline? If so, please specify.

	Specifications/comments (e.g., description of the relationship/activity/organisations involved)
Development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	None
A personal relationship with another person (e.g., spouse, family member) involved in the development, delivery, and/or evaluation of	None

therapies and/or supports that may be covered within the scope of the guideline	
Development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
A personal relationship with another person (e.g., spouse, family member) involved in the development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
Personal and/or family member experience of accessing therapies and/or support that may be covered in the guideline	None
Other	None

Declaration

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Autism CRC National Practice Guideline

Disclosure of Interests

Date:	21/06/2022
First Name:	Frances
Surname:	Scodellaro

Origin of Form

This form has been adapted (including direct replication of text where relevant) from:

- The International Committee of Medical Journal Editors (ICMJE) disclosure of interest form (https://www.icmje.org/disclosure-of-interest/)
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Did you or your institution at any time receive payment or services from a third party for any aspect of your involvement in the development of the guideline?

Please add more rows if necessary.

	Name all entities that provided support (or indicate none)	**Description of support (e.g., amount of funding, time in lieu)**
Grant	None	NA
Consulting fee or honorarium	None	NA
Support for travel to meetings for the guideline or other purposes	None	NA
Other	None	NA
Member of an organisation that received an honorarium of $1000 for membership of the Reference Group	None	NA

2. Relevant financial activities outside the guideline (2019-2022)

This section asks about your financial relationships with entities in the field of autism that could be perceived to influence, or that give the appearance of potentially influencing, your involvement in the guideline. These relationships may include clinical service providers; companies that sell products that autistic people, their families, or service providers may purchase; and organisations that represent and/or advocate for autistic people, their families, and/or service providers. You should disclose interactions with ANY entity that could be considered broadly relevant to the work. Report all sources of revenue paid (or promised to be paid) directly to you or your institution on your behalf over the 36 months prior to commencing work on the guideline, and up until the point it is submitted to Autism CRC (i.e., 2019-2022). This should include all monies from sources with relevance to the guideline, not just monies from Autism CRC which sponsored the research. Please note that your interactions with Autism CRC that are outside the guideline should also be listed here. If there is any question, please disclose the relationship. For grants you have received for work outside the guideline, you should disclose support only from entities that could be perceived to be affected financially by the published work, such as Government departments and agencies (e.g., National Disability Insurance Scheme), service providers, companies, business (including where self-employed), or foundations supported by entities that could be perceived to have a financial stake in the outcome.

	Name all entities with whom you have this relationship or indicate none (add rows as needed)	**Specifications/comments (e.g., description of support, if payments were made to you or your institution)**
Grants or contracts from any entity (if not indicated in item #1 above).	None	
Royalties or licenses	None	
Consulting fees	None	
Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	None	

Payment for expert testimony	None	
Support for attending meetings and/or travel	Autism Qld	Ref group members' time to participate in meetings and related activities in undertaken whilst employed by AQ
Patents planned, issued or pending	None	
Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	None	
Grants or contracts from any entity (if not indicated in item #1 above).	None	
Royalties or licenses	None	
Consulting fees	None	
Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	None	
Payment for expert testimony	None	
Support for attending meetings and/or travel	None	
Patents planned, issued or pending	None	
Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	None	
Stock or stock options	None	
Receipt of equipment, materials, drugs, medical writing, gifts or other services	None	

3. Relevant other activities or relationships, including non-financial relationships (no time limit)

Are there other relationships or activities that readers could be perceived to have influenced, or that could give the appearance of potentially influencing, your involvement in the guideline? If so, please specify.

	Specifications/comments (e.g., description of the relationship/activity/organisations involved)
Development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	Autism Qld (employer) develops and delivers therapy services and supports for children and their parents and carers, Autism Qld has engaged in research independently and in partnership with universities, the CRC and other institutions.

	Autism Qld provides information to parents, autistic people, professionals, schools, etc about autism supports and services.
A personal relationship with another person (e.g., spouse, family member) involved in the development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	None
Development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	AQ has a dedicated Professional Learning and Development services that develops and delivers professional and parent education throughout Qld and occasionally interstate and internationally. AQ also coordinates the national Early Days Workshop program.
A personal relationship with another person (e.g., spouse, family member) involved in the development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
Personal and/or family member experience of accessing therapies and/or support that may be covered in the guideline	None
Other	None

Declaration

If your answer is different from 'No' to any of the questions above, you may have a competing interest which should be declared. These will be reviewed by the co-Chairs of the Guideline Development Group. If the co-Chairs have answered other than ‘none’ to any of the questions above, these will be reviewed by Dr Gary Allen, Senior Policy Officer Human Research Ethics and Research Integrity at Griffith University. In each case, appropriate processes will be put in place to management any conflicts arising. Team members should not be concerned about answering 'yes' to any of the questions. 'Yes' answers do not indicate good or bad, but are simply something to declare on the form and consider for inclusion in the declarations section of the guideline.

Autism CRC National Practice Guideline

Disclosure of Interests

Date:	21/06/2022
First Name:	Jess
Surname:	Styles

Origin of Form

This form has been adapted (including direct replication of text where relevant) from:

- The International Committee of Medical Journal Editors (ICMJE) disclosure of interest form (https://www.icmje.org/disclosure-of-interest/)
- The Cochrane Collaboration Disclosure of Potential Conflicts of Interest form (https://community.cochrane.org/sites/default/files/uploads/EPPR/Cochrane-COI-disclosure-form.pdf)

Instructions

The purpose of this form is to provide readers of your review with information about your other interests that could influence how they receive and understand your work. We ask you to disclose all relationships/activities/interests listed below that are related to your involvement in the development of the National Practice Guideline (herein referred to as the *guideline*). "Related" means any relation with for-profit or not-for-profit third parties whose interests may be affected by the content of the guideline. Disclosure represents a commitment to transparency and does not necessarily indicate a bias. Please think broadly when disclosing all relationships/activities/interests that may be relevant to your involvement in the guideline. If you are in doubt about whether to list a relationship/activity/interest, it is preferable that you do so.

Each person will be asked to complete their own form and you are responsible for the accuracy and completeness. In submitting this form, you certify that you have answered every question and have not altered the wording of any of the questions on this form.

If new interests arise during the project, you are required to submit an updated form.

1. Support for your involvement in the development of the guideline.

This section asks for information about your role in the development of the guideline. The time frame for this reporting is that of the work itself, from the initial conception and planning to the present. The requested information is about resources that you received, either directly or indirectly (via your institution), to enable you to complete the work. Writing "None" means that you did the work without receiving any financial support from any third party -- that is, the work was supported by funds from the same institution that pays your salary and that institution did not receive third-party funds with which to pay you. If you or your institution received funds from a third party to support the work, such as a government granting agency, charitable foundation or commercial sponsor, then provide the details. For example, if you received an honorarium from Autism CRC in relation to your involvement, you would name Autism CRC and then indicate the amount of funds received.

Did you or your institution at any time receive payment or services from a third party for any aspect of your involvement in the development of the guideline?

Please add more rows if necessary.

	Name all entities that provided support (or indicate none)	**Description of support (e.g., amount of funding, time in lieu)**
Grant	Autism CRC	Member of an organisation that received an honorarium of $1000 for membership of the Reference Group
Consulting fee or honorarium	None	
Support for travel to meetings for the guideline or other purposes	None	
Other	None	

2. Relevant financial activities outside the guideline (2019-2022)

This section asks about your financial relationships with entities in the field of autism that could be perceived to influence, or that give the appearance of potentially influencing, your involvement in the guideline. These relationships may include clinical service providers; companies that sell products that autistic people, their families, or service providers may purchase; and organisations that represent and/or advocate for autistic people, their families, and/or service providers. You should disclose interactions with ANY entity that could be considered broadly relevant to the work. Report all sources of revenue paid (or promised to be paid) directly to you or your institution on your behalf over the 36 months prior to commencing work on the guideline, and up until the point it is submitted to Autism CRC (i.e., 2019-2022). This should include all monies from sources with relevance to the guideline, not just monies from Autism CRC which sponsored the research. Please note that your interactions with Autism CRC that are outside the guideline should also be listed here. If there is any question, please disclose the relationship. For grants you have received for work outside the guideline, you should disclose support only from entities that could be perceived to be affected financially by the published work, such as Government departments and agencies (e.g., National Disability Insurance Scheme), service providers, companies, business (including where self-employed), or foundations supported by entities that could be perceived to have a financial stake in the outcome.

	Name all entities with whom you have this relationship or indicate none (add rows as needed)	**Specifications/comments (e.g., description of support, if payments were made to you or your institution)**
Grants or contracts from any entity (if not indicated in item #1 above).	None	
Royalties or licenses	None	
Consulting fees	None	
Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	None	
Payment for expert testimony	None	
Support for attending meetings and/or travel	None	

Patents planned, issued or pending	None	
Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	None	
Grants or contracts from any entity (if not indicated in item #1 above).	None	
Royalties or licenses	None	
Consulting fees	None	
Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events	None	
Payment for expert testimony	None	
Support for attending meetings and/or travel	None	
Patents planned, issued or pending	None	
Participation on a Data Safety Monitoring Board or Advisory Board	None	
Leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid	None	
Stock or stock options	None	
Receipt of equipment, materials, drugs, medical writing, gifts or other services	None	

3. Relevant other activities or relationships, including non-financial relationships (no time limit)

Are there other relationships or activities that readers could be perceived to have influenced, or that could give the appearance of potentially influencing, your involvement in the guideline? If so, please specify.

	Specifications/comments (e.g., description of the relationship/activity/organisations involved)
Development, delivery, and/or evaluation of therapies and/or supports that may be covered within the scope of the guideline	None
A personal relationship with another person (e.g., spouse, family member) involved in the development, delivery, and/or evaluation of therapies	None

and/or supports that may be covered within the scope of the guideline	
Development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
A personal relationship with another person (e.g., spouse, family member) involved in the development and/or delivery of professional preparation programs that may be relevant to the guideline (e.g., allied health professional preparation programs)	None
Personal and/or family member experience of accessing therapies and/or support that may be covered in the guideline	None
Other	None

Declaration

If your answer is different from 'No' to any of the questions above, you may have a competing interest which should be declared. These will be reviewed by the co-Chairs of the Guideline Development Group. If the co-Chairs have answered other than ‘none’ to any of the questions above, these will be reviewed by Dr Gary Allen, Senior Policy Officer Human Research Ethics and Research Integrity at Griffith University. In each case, appropriate processes will be put in place to management any conflicts arising. Team members should not be concerned about answering 'yes' to any of the questions. 'Yes' answers do not indicate good or bad, but are simply something to declare on the form and consider for inclusion in the declarations section of the guideline.

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Appendix 4.1	Existing Guidelines review - Included Guidelines

Existing Guidelines review - included Guidelines

Academy of Medicine Singapore-Ministry of Health Clinical Practice Guidelines Workgroup on Autism Spectrum Disorders. (2010). Autism Spectrum Disorders in pre-school children. https://www.moh.gov.sg/hpp/all-healthcare-professionals/guidelines

Barthélémy, C., Fuentes, J., Howlin, P., & and Jan van der Gaag, R. (2019). People with autism spectrum disorder: Identification, understanding, intervention (3rd ed.). Autism-Europe. https://www.autismeurope.org/blog/2019/09/16/people-with-autism-spectrum-disorder-identification-understanding-intervention-third-edition/

Dubai Health Authority (2021). Dubai Clinical Practice Guidelines for Autism Spectrum Disorder (ASD) in Children and Adolescents (from Birth to 18 Years of Age). https://www.dha.gov.ae/uploads/112021/f5d3aa75-37c3-4237-ba9a-d9e4fba52531.pdf

Ministries of Health and Education. (2016). New Zealand Autism Spectrum Disorder Guideline (2nd ed.). New Zealand Ministries of Health. https://www.health.govt.nz/publication/new-zealand-autism-spectrum-disorder-guideline

Ministry of Health Malaysia (2014). Clinical practice guidelines: management of autism spectrum disorder in children and adolescents. https://www.moh.gov.my/moh/attachments/CPG%202014/CPG%20Management%20of%20Autism%20Spectrum%20Disofer%20in%20Children%20and%20Adolescents.pdf

Ministry of Public Health Qatar. (2019). National Clinical Guideline: The Diagnosis and Management of Autism Spectrum Disorder.

Missouri Autism Guidelines Initiative. (2012). Autism spectrum disorders: Guide to evidence-based interventions. https://autismguidelines.dmh.mo.gov/

National Institute for Health and Care Excellence (2021). Autism spectrum disorder in under 19s: support and management. https://www.nice.org.uk/guidance/cg170

New York State Department of Health, Bureau of Early Intervention. (2017). Clinical practice guideline on assessment and intervention services for young children with autism spectrum disorders (ASD): 2017 update report of recommendations. https://www.health.ny.gov/community/infants_children/early_intervention/disorders/autism/

Roberts, J., & Williams, K. J. (2016). Autism spectrum disorder: Evidence-based/evidence-informed good practice for supports provided to preschool children, their families and carers. https://www.ndis.gov.au/media/863/download

Scottish Intercollegiate Guidelines Network (SIGN). (2016). Assessment, diagnosis and interventions for autism spectrum disorders: A national clinical guideline. https://www.sign.ac.uk/our-guidelines/assessment-diagnosis-and-interventions-for-autism-spectrum-disorders/

Subramanyam AA, Mukherjee A, Dave M, Chavda K. (2019). Clinical Practice Guidelines for Autism Spectrum Disorders. Indian Journal of Psychiatry. doi: 10.4103/psychiatry.IndianJPsychiatry_542_18.

Veereman, G., Holdt Henningsen, K., Eyssen, M., Benahmed, N., Christiaens, W., Bouchez, M-H., De Roeck, A., Deconinck, N., De ligne, G., Dewitte, G., Gheysen, T., Hendrix, M., Kagan, C., Magerotte, G., Moonen, M., Roeyers, H., Schelstraete, S., Soncarrieu, M-V., Steyaert, J., Tolfo, F., Vrancken, G., Willaye, E., Wintgens, A., Wouters, S., Croonenberghs, J. (2014). Management of autism in children and young people: A good clinical practice guideline. Belgian Health Care Knowledge Centre (KCE). https://kce.docressources.info/index.php?lvl=notice_display&id=3465

Washington Department of Health. (2010, April 12). Defining Autism. In Autism guidebook for Washington State (Chapter 3). Retrieved April 16, 2011, from Autism Task Force website: http://www.doh.wa.gov/cfh/mch/autism/Documents/Guidebook/Chapter3.pdf

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Appendix 5.1	Umbrella review - Outcomes included

Appendix 5.1 - Umbrella review - Outcomes included

Outcome category ***Specific outcome***	**Operationalised definition**	**Examples of terms used to describe these outcomes in included systematic reviews.**
Communication *Overall communication*	Please note the differentiation between 'social communication' and 'communication' categories described in the 'social communication' entry. 'Communication' was coded where: (a) the term was used to describe the outcome; and/or (b) The outcome refers to a set of behaviours that together enhance the child's capacity to understand, and/or be understood by others. This latter definition was based on that described in Volkmar (2013).	Child communication; communication; communication-language; communication and language skill; composite language; general language; gestures; joint language; language; qualitative impairment in communication;
Communication *Social-communication*	The following definition was used to guide coding for measures of social communication (Volkmar, 2013): "Social communication is a broad term that describes the vast amount of verbal and nonverbal behaviors used to interact with other people. Examples of the verbal and nonverbal behaviors are (but are not limited to) speech, prosody, gestures, and facial expressions. These behaviors can be used to initiate or respond to joint attention, to share emotion with others, or to signal when an individual wants the attention of another person, along with many other uses." The term 'social communication' emphasises the pragmatic (functional) use of language. Accordingly, variables that relate primarily to children expressing a pragmatic function (e.g., requesting, commenting, sharing) were coded as 'social communication'. Measures were coded under other communication related categories ('communication', 'expressive language', 'receptive language'), where: (a) these terms were used explicitly and/or (b) the outcome emphasises the proficiency of expressive or receptive language (e.g., syntax, grammar, morphology) in comparison to other children of similar age.	Child initiations; interpersonal; joint attention; non-verbal behaviours; pragmatic language; qualitative impairment in social interaction; reciprocity of social interaction towards others; shared engagement; socialisation; social-communication; social and emotional development; social adaptation; social skills.
Communication *Expressive language*	Please note the differentiation between 'social communication' and 'expressive language' categories described in the 'social communication' entry. 'Expressive language' was coded where: (a) the term was used to describe the outcome; and/or (b) The	Expression; expressive language; speech or vocalisation; speech outcomes; spoken language; words produced.

	outcome referred to a skill that enhances a child's capacity to be understood by others via a range of modalities such as vocalisations, speech, gesture, and augmentative communication. This latter definition was based on that described in Volkmar (2013).	
Communication *Receptive language*	Please note the differentiation between 'social communication' and 'receptive language' categories described in the 'social communication' entry. 'Receptive language' was coded where: (a) the term was used to describe the outcome; and/or (b) The outcome referred to a skill that enhances a child's capacity to understand others' vocalisations, speech, and gestures. This latter definition was based on that described in Volkmar (2013).	Comprehension; receptive language.
Sensory development	The following definition was used to guide coding for measures of sensory behaviours (Volkmar, 2013): **Sensory seeking:** "Sensation-seeking is the tendency to pursue sensory stimulation and excitement. **Sensory avoiding:** "Sensation avoiding is the tendency to avoid sensory stimulation."	Sensory or emotion regulation; sensory skills; sensory-related outcomes.
Cognitive development	The following definition was used to guide coding for measures of cognition (Volkmar, 2013): "The term "cognition" refers to mental processes or forms of information processing. These processes include attention, memory, learning, decision making, reasoning, and problem solving. In the study of autism, a distinction often is drawn between social and/or non-social forms of cognition...."	Child cognitive or educational strengths; cognition; cognitive; cognitive development; developmental quotient; developmental/intellectual gains; full scale IQ; higher cognitive functioning; non-verbal cognitive skills; non-verbal IQ; visual reception.
Social-emotional development	The following definition was used to guide coding for measures of social-emotional development: **Social-Emotional:** "Behavioural and emotional strengths and ability to adapt and deal with daily challenges (resilience and coping skills) and respond positively to adversity while leading a fulfilling life" (AIHW 2012). **'Challenging behaviour':** "Challenging behavior refers to certain behaviors that a person engages in which negatively affect his/her daily functioning. These behaviors are often recognized as being culturally abnormal and occur at such an intensity, frequency, or duration that the safety of the person and/or others is placed in jeopardy. Challenging behaviors may be related to social,	Adaptive/maladaptive behaviour; behaviour; behavioural skills; challenging/interfering behaviour; classroom behaviour; disruptive behaviour; hyperactivity; maladaptive behaviour; problem behaviour; self-regulation; social emotional/challenging behaviour.

	academic, communicative, cognitive, vocational, or physical domains, may serve various functions, and should be examined systematically in order to identify these functions." (Volkmar, 2013)	
Motor development	The following definition was used to guide coding for measures of motor (Volkmar, 2013): "Fine motor skills are also termed hand skills, fine motor coordination, object manipulation, or dexterity. Components of fine motor development include reach, grasp, release, in-hand manipulation, and bimanual coordination" "Gross motor abilities entail the use of large muscle groups that coordinate body movements to perform activities such as maintaining balance, walking, sitting upright, jumping, throwing objects, etc."	Fine motor; gross motor performance; motor; motor and fine motor; motor skills.
Academic Skills	The following definition was used to guide coding for measures of academic skills (Volkmar, 2013): "Academic skills ….refer to skills in subject areas that form the academic curriculum, available to all children in that country."	Academic/s.
School/Learning Readiness	The following definition was used to guide coding for measures of school/learning readiness (UNICEF, 2012): "School readiness is a combination of three domains: learned behaviours such as knowing colours and shapes, counting numbers and saying letters of the alphabet; attitude and emotional competence, as in listening to directions, being interested in learning and behaving in a socially acceptable manner; and developmental maturation, including fine and gross motor development and sitting still for an appropriate period of time."	Academic placement; learning readiness; placement; school readiness.
Daily activities and participation *Adaptive behaviour*	The following definition was used to guide coding for measures of adaptive behaviour (Volkmar, 2013): "The collection of conceptual, social, and practical skills that have been learned by people in order to function in everyday lives. Adaptive behavior is best understood as the degree to which individuals are able to function and maintain themselves independently and meet cultural expectations for personal and social responsibility at various ages."	Adaptive behaviour; adaptive/self-help; daily living skills; functional skills; personal responsibility.

Daily activities and participation *Play skills*	The following definition was used to guide coding for measures of play skills: A set of behaviours referred to as 'play' by the study authors and encompassing various characteristics including exploratory, functional, parallel, sensorimotor, and pretend. The investigators of the current review formulated this definition based on definitions for a range of play activities provided in Volkmar (2013).	Play.
Daily activities and participation *Participation*	The following definition was used to guide coding for measures of participation: A child's ability to participate in activities within the community. The investigators of the current review formulated this definition.	Academic placement (percentage of time spent with typical peers); functional participation.
General child outcomes	This outcome was coded where authors did not specify a specific outcome, but provided a global measure of the effect of a support.	Condition specific outcomes; child behavioural functioning and development; efficacy outcomes; functioning and participation; outcomes.
Overall autism characteristics	This outcome was coded where authors provided a global measure of autism symptoms or characteristics.	ASD/autism symptom severity; autism general symptoms; diagnostic characteristics of autism; general symptoms; severity of autism; symptoms associated with autism/ASD.
Restricted and repetitive interests and behaviours	The following definition was used to guide coding for measures of restricted and repetitive interests and behaviours (Volkmar, 2013): **Repetitive behaviours:** "The term "repetitive behaviors" refers to abnormal behaviors that are characterized by repetition, rigidity, inappropriateness, and lack of adaptability. They include motor stereotyped behaviors, self-stimulatory behaviors, self-injurious behaviors, compulsive or sameness behaviors, and verbal repetitive behaviors such as echolalia." **Restricted interest:** "A limited set or limited number of interests and/or activities…… Restrictive interests may be repetitious (i.e., spinning a wheel) and/or limited in scope or range (i.e., a narrow or limited range of items that hold the individual's interest)." **Stereotypies:** "Stereotypies are repetitive, persistent, non-goal, and apparently purposeless motor actions and speech patterns which are carried out in a rhythmic and uniform way that serves no obvious adaptive functioning."	Repetitive behaviours; Repetitive and maladaptive behaviours; Restrictive and repetitive behaviours; Restricted, repetitive, non-functional patterns of behaviour, interests, or activity.

	A separate category for social-emotional developments was also included in the current review. Measures were coded according to the context in which the authors of a systematic review used the term.	
Family wellbeing and satisfaction *Child quality of life*	The following definition was used to guide coding for measures of quality of life (WHO, : “An individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns.”	Joy; quality of life.
Family wellbeing and satisfaction *Child satisfaction with support*	The following definition was used to guide coding for measures of child satisfaction with support: Children’s’ views regarding the appropriateness and acceptability of support goals, methods, and/or outcomes. The investigators of the current review formulated this definition.	Child distress.
Family wellbeing and satisfaction *Parent knowledge and skills*	The following definition was used to guide coding for measures of caregiver communication and interaction strategies: Caregiver behaviour proposed by the authors to be beneficial to promoting communication and interaction abilities in children on the autism spectrum. The investigators of the current review formulated this definition.	Fidelity; knowledge acquisition; parental responsiveness; parental synchrony; parents’ use of intervention strategies
Family wellbeing and satisfaction *Parent social emotional wellbeing*	The following definition was used to guide coding for measures of caregiver social emotional wellbeing (AIHW, 2012): ”Behavioural and emotional strengths and ability to adapt and deal with daily challenges (resilience and coping skills) and respond positively to adversity while leading a fulfilling life”.	Parent behaviours; Parenting efficacy; parental stress; parental distress; parental self-efficacy; parent-child relationship; parents’ confidence; quality of family relationships.
Family wellbeing and satisfaction *Parent financial wellbeing*	The following definition was used to guide coding for measures of caregiver financial impact: Direct or indirect consequence to caregivers of accessing a support measured in monetary terms. The investigators of the current review formulated this definition.	Cost of intervention; reduced costs.
Family wellbeing and satisfaction *Parent satisfaction with support*	The following definition was used to guide coding for measures of caregiver financial impact: Caregivers’ views regarding the appropriateness and acceptability of support goals, methods, and/or outcomes.	Customer satisfaction; satisfaction and acceptability; social validity.

	The investigators of the current review formulated this definition.	
Child related adverse effects	The following definition was used to guide coding for measures of child-related adverse effects Undesired and/or harmful effects of the support on the child. These can be immediate effects or longer-term effects. The investigators of the current review formulated this definition.	Adverse effects; deterioration; increases in stereotypy and problem behaviour.

References:

Australian Institute of Health and Welfare. Australia's children. Cat. no. CWS 69. Canberra: AIHW; 2020/
UNICEF. School readiness: A conceptual framework. New York: United Nations Children's Fund; 2012.
Volkmar F. (Ed). Encyclopedia of Autism Spectrum Disorders. New York: Springer-Verlag; 2013.
World Health Organisation. World Health Organisation Definition of Quality of Life. Accessed 1st July 2020 from: https://www.who.int/healthinfo/survey/whoqol-qualityoflife/en/

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Appendix 5.2	Umbrella review - Database search strategy

Appendix 5.2 - Umbrella review - Database search strategy

CINAHL
S1 (MH"Asperger Syndrome") OR (MH"Autistic Disorder") OR (MH"Pervasive Development Disorder-Not Otherwise Specified")
S2 Autis* OR ASD* OR Asperger* OR "pervasive developmental disorder*" OR PDD* OR "pervasive child development disorder*" OR "pervasive childhood developmental disorder*" OR PCDD* OR "disintegrative disorder*"
S3 intervention* OR therap* OR treat* OR teach* OR program* OR package*
S4 "systematic review*" OR "systematic literature review*" OR "evidence synthes*" OR "meta-analy*" OR "meta-regression*"
S5 S1 OR S2
S6 S3 AND S4 AND S5
S7 Limiters – Published Date: 20200107-20211119

Cochrane
#1 MeSH descriptor: [Child Development Disorders, Pervasive] explode all trees
#2 Autis* OR ASD* OR Asperger* OR "pervasive developmental disorder*" OR PDD* OR "pervasive child development disorder*" OR "pervasive childhood developmental disorder*" OR PCDD* OR "disintegrative disorder*"
#3 #1 OR #2
#4 intervention* OR therap* OR treat* OR teach* OR program* OR package*
#5 "systematic review*" OR "systematic literature review*" OR "evidence synthes*" OR "meta-analy*" OR "meta-regression"
#6 #3 AND #4 AND #5
#7 Limit: Cochrane Library publication date from July 2020 to present

Education Source
S1 Autis* OR ASD* OR Asperger* OR "pervasive developmental disorder*" OR PDD* OR "pervasive child development disorder*" OR "pervasive childhood developmental disorder*" OR PCDD* OR "disintegrative disorder*"
S2 intervention* OR therap* OR treat* OR teach* OR program* OR package*
S3 "systematic review*" OR "systematic literature review*" OR "evidence synthes*" OR "meta-analy*" OR "meta-regression"
S4 S1 AND S2 AND S3
S5 Limiters – Published Date: 20200107-20211119

EMBASE
#1 'autism'/exp
#2 Autis* OR ASD* OR Asperger* OR "pervasive developmental disorder*" OR PDD* OR "pervasive child development disorder*" OR "pervasive childhood developmental disorder*" OR PCDD* OR "disintegrative disorder*"
#3 #1 OR #2
#4 intervention* OR therap* OR treat* OR teach* OR program* OR package*

#5 “systematic review*” OR “systematic literature review*” OR “evidence synthes*” OR “meta-analy*” OR “meta-regression”
#6 #3 AND #4 AND #5
#7 #6 AND (2010:py OR 2011:py OR 2012:py OR 2013:py OR 2014:py OR 2015:py OR 2016:py OR 2017:py OR 2018:py OR 2019:py OR 2020:py)

Epistemonikos
(title:(Autis* OR ASD* OR Asperger* OR "pervasive developmental disorder*" OR PDD* OR "pervasive child development disorder*" OR "pervasive childhood developmental disorder*" OR PCDD* OR "disintegrative disorder*") OR abstract:(Autis* OR ASD* OR Asperger* OR "pervasive developmental disorder*" OR PDD* OR "pervasive child development disorder*" OR "pervasive childhood developmental disorder*" OR PCDD* OR "disintegrative disorder*")) AND (title:(intervention* OR therap* OR treat* OR teach* OR program* OR package*) OR abstract:(intervention* OR therap* OR treat* OR teach* OR program* OR package*)) AND (title:("systematic review*" OR "systematic literature review*" OR "evidence synthes*" OR meta-analy* OR meta-regression*) OR abstract:("systematic review*" OR "systematic literature review*" OR "evidence synthes*" OR meta-analy* OR meta-regression*)) Limit: 2020 - 2021

ERIC
S1 su(autism)
S2 Autis* OR ASD* OR Asperger* OR “pervasive developmental disorder*” OR PDD* OR “pervasive child development disorder*” OR “pervasive childhood developmental disorder*” OR PCDD* OR “disintegrative disorder*”
S3 S1 OR S2
S4 intervention* OR therap* OR treat* OR teach* OR program* OR package*
S5 “systematic review*” OR “systematic literature review*” OR “evidence synthes*” OR “meta-analy*” OR “meta-regression”
S6 S3 AND S4 AND S5
S7 Limits applied: 2020-07-01 - 2020

Medline

1. exp Child Development Disorders, Pervasive/
2. (Autis* OR ASD* OR Asperger* OR “pervasive developmental disorder*” OR PDD* OR “pervasive child development disorder*” OR “pervasive childhood developmental disorder*” OR PCDD* OR “disintegrative disorder*”).mp.[mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
3. 1 OR 2
4. (intervention* OR therap* OR treat* OR teach* OR program* OR package*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]

5. (“systematic review*” OR “systematic literature review*” OR “evidence synthes*” OR “meta-analy*” OR “meta-regression”).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
6. 3 and 4 and 5
7. Limit 6 to yr=”2020-current”

PsycInfo

1. exp autism spectrum disorders/
2. (Autis* OR ASD* OR Asperger* OR “pervasive developmental disorder*” OR PDD* OR “pervasive child development disorder*” OR “pervasive childhood developmental disorder*” OR PCDD* OR “disintegrative disorder*”).mp.[mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]
3. 1 or 2
4. (intervention* OR therap* OR treat* OR teach* OR program* OR package*).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]
5. (“systematic review*” OR “systematic literature review*” OR “evidence synthes*” OR “meta-analy*” OR “meta-regression”).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]
6. 3 and 4 and 5
7. Limit 6 to yr=”2020-current”

PubMed

(((child development disorders, pervasive[MeSH Terms] OR (Autis* OR ASD* OR Asperger* OR “pervasive developmental disorder*” OR PDD* OR “pervasive child development disorder*” OR “pervasive childhood developmental disorder*” OR PCDD* OR “disintegrative disorder*”)) AND (intervention* OR therap* OR treat* OR teach* OR program* OR package*)) AND (“systematic review*” OR “systematic literature review*” OR “evidence synthes*” OR “meta-analy*” OR “meta-regression”) Filters: from 2020 - 2021

Scopus

(TITLE-ABS-KEY (Autis* OR ASD* OR Asperger* OR “pervasive developmental disorder*” OR PDD* OR “pervasive child development disorder*” OR “pervasive childhood developmental disorder*” OR PCDD* OR “disintegrative disorder*”) AND TITLE-ABS-KEY (intervention* OR therap* OR treat* OR teach* OR program* OR package*) AND TITLE-ABS-KEY (“systematic review*” OR “systematic literature review*” OR “evidence synthes*” OR “meta-analy*” OR “meta-regression”)) AND (LIMIT-TO (PUBYEAR, 2020))

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Appendix 5.3	Umbrella review - Consensus on the eligibility of each type of support

Appendix 5.3 - Umbrella review - Consensus on the eligibility of each type of support

Type of support	Explicitly listed for exclusion	Not an practice/ category of support i.e. assessment	Not a practice/ category of support i.e. technique	Does not meet eligibility criteria	Include
Acceptance and Commitment Therapy					X
Acupuncture	X				
Animal-assisted Therapy					X
Antecedent-Based Interventions			X		
Art therapy				X	
Auditory Integration Training					X
Augmentative and Alternative Communication (AAC)					X
Behavioral intervention					X
Behavioral Momentum Intervention			X		
Behavioural skills training					X
Chelation	X				
Child-centred play therapy					X
Chiropractic	X				
Client Feedback			X		
Cognitive bias modification				X	
Cognitive Behavioral/ Instructional Strategies					X
Cognitive Orientation to Daily Occupational Performance (CO-OP)					X
Cognitive Remediation/Cognitive training					X
Comprehensive Behavioral Treatment for Young Children					X
Computer-based intervention					X
Concept Mapping			X		
Creative arts programs				X	
Dance	X				
Developmental Relationship-based Treatment					X

Differential Reinforcement of Alternative, Incompatible, or Other Behavior			X		
DIR/Floortime					X
Direct Instruction (DI)			X		
Discrete Trial Training (DTT)					X
Emotion Recognition Training				X	
Enhanced Milieu Training					X
Exercise and Movement	X				
Exposure Package					X
Extinction			X		
Facial Emotion Training/ Emotion Recognition Training				X	
Facilitated Communication					X
Family therapy				X	
Feeding				X	
Fluency intervention					X
Functional Communication Training (FCT)					X
Functional Behavioral Assessment (FBA)		X			
Gamification/Serious games					X
Gluten-free/Casein-free diet	X				
Holding therapy					X
Hydrotherapy	X				
Hyperbaric oxygen therapy interventions	X				
Imitation-based Intervention					X
Inclusion of circumscribed/special interests			X		
Initiation Training					X
Intensive Interaction					X
‘Interactive social interventions’					X
Joint control training/Joint stimulus control			X		
Kinesiology	X				
Language Training (Production & Understanding)					X
Language Training (Production)					X
Lego therapy					X
Mand training			X		
Martial arts	X				
Massage Therapy	X				
Matrix training			X		

Mind-body therapies *(yoga, meditation, Nei Yang Gong, acceptance and commitment therapy)*	X				
Mindfulness					X
Modelling			X		
Motivating Operations			X		
Multi-component Package					X
Music-Mediated Intervention (MMI)					X
Narrative intervention				X	
Natural Language Paradigm					X
Naturalistic Intervention					X
Neurofeedback	X				
Neurostimulation	X				
Oral health				X	
Parent Child Interaction Therapy					X
Parent verbal responsiveness			X		
Parent-Implemented Intervention					X
Peer-Based Instruction and Intervention (PBII)					X
Picture Exchange Communication System					X
Pivotal Response Treatment®					X
Precision teaching					X
Prompting (PP)			X		
Psychodynamic psychotherapy				X	
Psychomotor therapy					X
Punishment			X		
Rapid Prompting Method (RPM)					X
Reductive Package					X
Reflexology	X				
Reinforcement			X		
Response Interruption/Redirection			X		
Responsivity interventions					X
Role play			X		
Schedules			X		
Scripting			X		
Self-controlled technology					X
Self-Management (SM)			X		
SENSE Theatre Intervention				X	

Sensory Integration® (SI)					X
Shared reading					X
Shock Therapy	X				
Sign Instruction					X
Social Behavioral Learning Strategy					X
Social Cognition Intervention					X
Social communication intervention					X
Social Narratives (SN)			X		
Social Robots					X
Social Skills Training (SST)					X
Social Thinking Intervention-					X
Speaker/Listener instruction					X
Structured teaching					X
Systemic therapy					X
Task Analysis (TA)			X		
Task interspersal			X		
Technology-Aided Instruction and Intervention (TAII)					X
The listening programme					X
Theory of Mind Training-					X
Therapeutic surfing	X				
Theraplay					X
Time Delay (TD)			X		
Toileting				X	
Transcranial magnetic stimulation	X				
UCLA PEERS					X
Verbal behaviour intervention					X
Video Modeling			X		
Video-based instruction			X		
Virtual/augmented/mixed reality					X
Visual Supports			X		
Water Safety				X	
Weighted vests					X
Supports targeting inappropriate masturbation				X	

Note: The names of these supports were taken verbatim from the articles.

Appendix 5.4	Umbrella review - Items for extraction

Appendix 5.4 - Umbrella review - Items for extraction

Items for extraction at the systematic review level

1. Review title
2. Review authors
3. Year of publication
4. Type of review (meta-analysis or narrative synthesis)
5. Aims/objectives as stated in the review
6. Databases searched
7. Start and end year for search
8. Number of studies included
9. Number of autism-specific studies included
10. Design of eligible studies
    - Randomised controlled trial
    - Non-randomised with comparison
    - Non-randomised without comparison
    - Single case experimental designs
    - Other designs
11. Design of included studies
    - Randomised controlled trial
    - Non-randomised with comparison
    - Non-randomised without comparison
    - Single case experimental designs
    - Other designs
    - Designs not specified
12. Comparison groups for included studies
    - Wait list control
    - Treatment-as-usual
    - Another support (includes minimal support and eclectic)
    - The individual's own baseline (single case experimental designs)
    - Other comparison group
    - No comparison group
13. Continents in which included studies were conducted
    - Africa
    - Asia
    - Australia
    - Pacific
    - Europe
    - South America/Caribbean
    - North America
14. Eligible and included autism diagnoses

- Children diagnosed with autism were eligible for inclusion (yes/no)
- Children at increased likelihood for a diagnosis of autism were eligible for inclusion (yes/no)
- Children diagnosed with autism were included (yes/no)
- Children at increased likelihood for a diagnosis of autism were included (yes/no)
- Autism diagnoses of included children

15. Number of included participants
    - Number of participants in the total sample
    - Number of participants in the support group
    - Number of participants in the comparison group
16. Eligible and included participant age
    - Minimum age of eligible participants
    - Maximum age of eligible participants
    - Minimum age of included participants
    - Maximum age of included participants
    - Mean age of participants in the total sample
    - Mean age of participants in the support group
    - Mean age of participants in the comparison group
17. Sex of included participants
    - Mean percentage male
    - Mean percentage female
    - Minimum percentage male
    - Maximum percentage male
    - Minimum percentage female
    - Maximum percentage female
18. Specified cooccurring conditions for included participants
    - ADHD
    - Sleep
    - Anxiety
    - Depression
    - Language delay
    - Minimal verbal (descriptive term, used with language delay)
    - Cognitive impairment (including ID, IQ <70)
    - Global developmental delay
    - Genetic syndrome (e.g. Down Syndrome, Fragile X)
    - Challenging behaviour
    - Physical disability
    - Other cooccurring conditions
19. Included categories and practices
20. Appraisal instrument used
21. Appraisal ratings
22. Sources of funding
23. Conflict(s) of interest reported by the author(s)

Outcome-level data for extraction

1. Review authors
2. Year of publication
3. Type of review (practice/category focussed, outcome focussed, delivery focussed
4. Name of category (Behavioural, Developmental, NDBI, Sensory, Technology, CBT, Animal-assisted, Other)
5. Name of practice
6. Name of delivery characteristic
7. Setting(s) for included studies
    - Clinic
    - Home
    - Educational settings (schools, early childhood)
    - Other settings
8. Format(s) for included studies
    - Delivered to individuals
    - Delivered to groups
9. Agent(s) (type of people delivering the support) for included studies
    - Parent(s)/caregiver(s)
    - Peer(s)/sibling(s)
    - School or early childhood staff (e.g. teacher, TA)
    - Clinician(s)/researcher(s)
    - Other agents
10. Mode(s) for included studies
    - Face-to-face
    - Telehealth
    - Other modes
11. Amount of support
12. Mean amount
13. Minimum amount
14. Maximum amount
15. Term used by SR to describe overall outcome
16. Outcomes that contributed to the overall effect measure
17. Specify the overall effect size including confidence intervals
18. Specify the types of effect size (e.g. Cohen's d or Hedge's g)
19. Meta-analysis - direction of the therapeutic effect.
20. Effect size specified
21. Heterogeneity statistic type
22. Heterogeneity statistic value
23. For qualitative studies, copy the author's terminology to describe the summary of outcomes verbatim.
24. General child outcomes from meta-analyses
    - Term used by review to describe this outcome
    - Specific outcomes that contributed to the 'general outcomes' effect

  - Number of studies evaluating this outcome
  - Overall effect size and confidence intervals
  - Type(s) of effect size (e.g., Cohen's d or Hedge's g)
  - Direction of the effect (positive effect of support, negative effect of support, null effect of support)
  - Heterogeneity statistic type
  - Heterogeneity statistic value
  - Verbatim summary of outcomes
25. Overall autism characteristics outcomes from meta-analyses
    - Term used by review to describe this outcome
    - Number of studies evaluating this outcome
    - Overall effect size and confidence intervals
    - Type(s) of effect size (e.g., Cohen's d or Hedge's g)
    - Pooled direction of the effect (positive effect of support, negative effect of support, null effect of support)
    - Heterogeneity statistic type
    - Heterogeneity statistic value
    - Verbatim summary of outcomes
26. Social-communication outcomes from meta-analyses
    - Term used by review to describe this outcome
    - Number of studies evaluating this outcome
    - Overall effect size and confidence intervals
    - Type(s) of effect size (e.g., Cohen's d or Hedge's g)
    - Pooled direction of the effect (positive effect of support, negative effect of support, null effect of support)
    - Heterogeneity statistic type
    - Heterogeneity statistic value
    - Verbatim summary of outcomes
27. Restricted and repetitive behaviour outcomes from meta-analyses
    - Term used by review to describe this outcome
    - Number of studies evaluating this outcome
    - Overall effect size and confidence intervals
    - Type(s) of effect size (e.g., Cohen's d or Hedge's g)
    - Pooled direction of the effect (positive effect of support, negative effect of support, null effect of support)
    - Heterogeneity statistic type
    - Heterogeneity statistic value
    - Verbatim summary of outcomes
28. Sensory outcomes from meta-analyses
    - Term used by review to describe this outcome
    - Number of studies evaluating this outcome
    - Overall effect size and confidence intervals
    - Type(s) of effect size (e.g., Cohen's d or Hedge's g)

- Pooled direction of the effect (positive effect of support, negative effect of support, null effect of support)
- Heterogeneity statistic type
- Heterogeneity statistic value
- Verbatim summary of outcomes

29. Overall communication outcomes from meta-analyses
    - Term used by review to describe this outcome
    - Number of studies evaluating this outcome
    - Overall effect size and confidence intervals
    - Type(s) of effect size (e.g., Cohen's d or Hedge's g)
    - Pooled direction of the effect (positive effect of support, negative effect of support, null effect of support)
    - Heterogeneity statistic type
    - Heterogeneity statistic value
    - Verbatim summary of outcomes
30. Expressive language outcomes from meta-analyses
    - Term used by review to describe this outcome
    - Number of studies evaluating this outcome
    - Overall effect size and confidence intervals
    - Type(s) of effect size (e.g., Cohen's d or Hedge's g)
    - Pooled direction of the effect (positive effect of support, negative effect of support, null effect of support)
    - Heterogeneity statistic type
    - Heterogeneity statistic value
    - Verbatim summary of outcomes
31. Receptive language outcomes from meta-analyses
    - Term used by review to describe this outcome
    - Number of studies evaluating this outcome
    - Overall effect size and confidence intervals
    - Type(s) of effect size (e.g., Cohen's d or Hedge's g)
    - Pooled direction of the effect (positive effect of support, negative effect of support, null effect of support)
    - Heterogeneity statistic type
    - Heterogeneity statistic value
    - Verbatim summary of outcomes
32. Cognitive development outcomes from meta-analyses
    - Term used by review to describe this outcome
    - Number of studies evaluating this outcome
    - Overall effect size and confidence intervals
    - Type(s) of effect size (e.g., Cohen's d or Hedge's g)
    - Pooled direction of the effect (positive effect of support, negative effect of support, null effect of support)
    - Heterogeneity statistic type

- Heterogeneity statistic value
- Verbatim summary of outcomes

33. Motor outcomes from meta-analyses
    - Term used by review to describe this outcome
    - Number of studies evaluating this outcome
    - Overall effect size and confidence intervals
    - Type(s) of effect size (e.g., Cohen's d or Hedge's g)
    - Pooled direction of the effect (positive effect of support, negative effect of support, null effect of support)
    - Heterogeneity statistic type
    - Heterogeneity statistic value
    - Verbatim summary of outcomes
34. Social emotional development outcomes from meta-analyses
    - Term used by review to describe this outcome
    - Number of studies evaluating this outcome
    - Overall effect size and confidence intervals
    - Type(s) of effect size (e.g., Cohen's d or Hedge's g)
    - Pooled direction of the effect (positive effect of support, negative effect of support, null effect of support)
    - Heterogeneity statistic type
    - Heterogeneity statistic value
    - Verbatim summary of outcomes
35. Play outcomes from meta-analyses
    - Term used by review to describe this outcome
    - Number of studies evaluating this outcome
    - Overall effect size and confidence intervals
    - Type(s) of effect size (e.g., Cohen's d or Hedge's g)
    - Pooled direction of the effect (positive effect of support, negative effect of support, null effect of support)
    - Heterogeneity statistic type
    - Heterogeneity statistic value
    - Verbatim summary of outcomes
36. Adaptive behaviour outcomes from meta-analyses
    - Term used by review to describe this outcome
    - Number of studies evaluating this outcome
    - Overall effect size and confidence intervals
    - Type(s) of effect size (e.g., Cohen's d or Hedge's g)
    - Pooled direction of the effect (positive effect of support, negative effect of support, null effect of support)
    - Heterogeneity statistic type
    - Heterogeneity statistic value
    - Verbatim summary of outcomes
37. School/learning readiness outcomes from meta-analyses

  - Term used by review to describe this outcome
  - Number of studies evaluating this outcome
  - Overall effect size and confidence intervals
  - Type(s) of effect size (e.g., Cohen's d or Hedge's g)
  - Pooled direction of the effect (positive effect of support, negative effect of support, null effect of support)
  - Heterogeneity statistic type
  - Heterogeneity statistic value
  - Verbatim summary of outcomes

38. Academic outcomes from meta-analyses
    - Term used by review to describe this outcome
    - Number of studies evaluating this outcome
    - Overall effect size and confidence intervals
    - Type(s) of effect size (e.g., Cohen's d or Hedge's g)
    - Pooled direction of the effect (positive effect of support, negative effect of support, null effect of support)
    - Heterogeneity statistic type
    - Heterogeneity statistic value
    - Verbatim summary of outcomes
39. Child quality of life outcomes from meta-analyses
    - Term used by review to describe this outcome
    - Number of studies evaluating this outcome
    - Overall effect size and confidence intervals
    - Type(s) of effect size (e.g., Cohen's d or Hedge's g)
    - Pooled direction of the effect (positive effect of support, negative effect of support, null effect of support)
    - Heterogeneity statistic type
    - Heterogeneity statistic value
    - Verbatim summary of outcomes
40. Community participation outcomes from meta-analyses
    - Term used by review to describe this outcome
    - Number of studies evaluating this outcome
    - Overall effect size and confidence intervals
    - Type(s) of effect size (e.g., Cohen's d or Hedge's g)
    - Pooled direction of the effect (positive effect of support, negative effect of support, null effect of support)
    - Heterogeneity statistic type
    - Heterogeneity statistic value
    - Verbatim summary of outcomes
41. Parent knowledge and skill outcomes from meta-analyses
    - Term used by review to describe this outcome
    - Number of studies evaluating this outcome
    - Overall effect size and confidence intervals

- Type(s) of effect size (e.g., Cohen's d or Hedge's g)
- Pooled direction of the effect (positive effect of support, negative effect of support, null effect of support)
- Heterogeneity statistic type
- Heterogeneity statistic value
- Verbatim summary of outcomes

42. Parent social-emotional wellbeing outcomes from meta-analyses
    - Term used by review to describe this outcome
    - Number of studies evaluating this outcome
    - Overall effect size and confidence intervals
    - Type(s) of effect size (e.g., Cohen's d or Hedge's g)
    - Pooled direction of the effect (positive effect of support, negative effect of support, null effect of support)
    - Heterogeneity statistic type
    - Heterogeneity statistic value
    - Verbatim summary of outcomes
43. Parent financial wellbeing outcomes from meta-analyses
    - Term used by review to describe this outcome
    - Number of studies evaluating this outcome
    - Overall effect size and confidence intervals
    - Type(s) of effect size (e.g., Cohen's d or Hedge's g)
    - Pooled direction of the effect (positive effect of support, negative effect of support, null effect of support)
    - Heterogeneity statistic type
    - Heterogeneity statistic value
    - Verbatim summary of outcomes
44. Parent satisfaction
    - Term used for the measure of parent satisfaction
    - Number of studies evaluating this outcome
    - Verbatim summary of outcomes
    - Summarised direction of the effect (consistent positive effect of support; consistently negative effect of support, consistently null effect of support, inconsistent effect of support)
45. Parent dissatisfaction
    - Term used for the measure of parent satisfaction
    - Number of studies evaluating this outcome
    - Verbatim summary of outcomes
    - Summarised direction of the effect (consistent positive effect of support; consistently negative effect of support, consistently null effect of support, inconsistent effect of support)
46. Child satisfaction
    - Term used for the measure of parent satisfaction
    - Number of studies evaluating this outcome
    - Verbatim summary of outcomes

- Summarised direction of the effect (consistent positive effect of support; consistently negative effect of support, consistently null effect of support, inconsistent effect of support)

47. Child dissatisfaction
    - Term used by review to describe this outcome
    - Number of studies evaluating this outcome
    - Verbatim summary of outcomes
    - Summarised direction of the effect (consistent positive effect of support; consistently negative effect of support, consistently null effect of support, inconsistent effect of support)
48. Child distress/harm related to the support (Adverse effects)
    - Evidence for child distress or harm
    - Description of type of harm/distress related to the support
49. General child outcomes from narrative syntheses
    - Term used by review to describe this outcome
    - Number of studies evaluating this outcome
    - Verbatim summary of outcomes
    - Summarised direction of the effect (positive effect of support, negative effect of support, null effect of support, inconsistent effect of support)
50. Overall autism characteristics outcomes from narrative syntheses
    - Term used by review to describe this outcome
    - Number of studies evaluating this outcome
    - Verbatim summary of outcomes
    - Summarised direction of the effect (positive effect of support, negative effect of support, null effect of support, inconsistent effect of support)
51. Social-communication outcomes from narrative syntheses
    - Term used by review to describe this outcome
    - Number of studies evaluating this outcome
    - Verbatim summary of outcomes
    - Summarised direction of the effect (positive effect of support, negative effect of support, null effect of support, inconsistent effect of support)
52. Restricted and repetitive behaviour outcomes from narrative syntheses
    - Term used by review to describe this outcome
    - Number of studies evaluating this outcome
    - Verbatim summary of outcomes
    - Summarised direction of the effect (positive effect of support, negative effect of support, null effect of support, inconsistent effect of support)
53. Sensory outcomes from narrative syntheses
    - Term used by review to describe this outcome
    - Number of studies evaluating this outcome
    - Verbatim summary of outcomes
    - Summarised direction of the effect (positive effect of support, negative effect of support, null effect of support, inconsistent effect of support)
54. Overall communication outcomes from narrative syntheses
    - Term used by review to describe this outcome

- Number of studies evaluating this outcome
- Verbatim summary of outcomes
- Summarised direction of the effect (positive effect of support, negative effect of support, null effect of support, inconsistent effect of support)

55. Expressive language outcomes from narrative syntheses
    - Term used by review to describe this outcome
    - Number of studies evaluating this outcome
    - Verbatim summary of outcomes
    - Summarised direction of the effect (positive effect of support, negative effect of support, null effect of support, inconsistent effect of support)
56. Receptive language outcomes from narrative syntheses
    - Term used by review to describe this outcome
    - Number of studies evaluating this outcome
    - Verbatim summary of outcomes
    - Summarised direction of the effect (positive effect of support, negative effect of support, null effect of support, inconsistent effect of support)
57. Cognitive development outcomes from narrative syntheses
    - Term used by review to describe this outcome
    - Number of studies evaluating this outcome
    - Verbatim summary of outcomes
    - Summarised direction of the effect (positive effect of support, negative effect of support, null effect of support, inconsistent effect of support)
58. Motor outcomes from narrative syntheses
    - Term used by review to describe this outcome
    - Number of studies evaluating this outcome
    - Verbatim summary of outcomes
    - Summarised direction of the effect (positive effect of support, negative effect of support, null effect of support, inconsistent effect of support)
59. Social emotional development outcomes from narrative syntheses
    - Term used by review to describe this outcome
    - Number of studies evaluating this outcome
    - Verbatim summary of outcomes
    - Summarised direction of the effect (positive effect of support, negative effect of support, null effect of support, inconsistent effect of support)
60. Play outcomes from narrative syntheses
    - Term used by review to describe this outcome
    - Number of studies evaluating this outcome
    - Verbatim summary of outcomes
    - Summarised direction of the effect (positive effect of support, negative effect of support, null effect of support, inconsistent effect of support)
61. Adaptive behaviour outcomes from narrative syntheses
    - Term used by review to describe this outcome
    - Number of studies evaluating this outcome

- Verbatim summary of outcomes
- Summarised direction of the effect (positive effect of support, negative effect of support, null effect of support, inconsistent effect of support)

62. School/learning readiness outcomes from narrative syntheses
    - Term used by review to describe this outcome
    - Number of studies evaluating this outcome
    - Verbatim summary of outcomes
    - Summarised direction of the effect (positive effect of support, negative effect of support, null effect of support, inconsistent effect of support)
63. Academic outcomes from narrative syntheses
    - Term used by review to describe this outcome
    - Number of studies evaluating this outcome
    - Verbatim summary of outcomes
    - Summarised direction of the effect (positive effect of support, negative effect of support, null effect of support, inconsistent effect of support)
64. Child quality of life outcomes from narrative syntheses
    - Term used by review to describe this outcome
    - Number of studies evaluating this outcome
    - Verbatim summary of outcomes
    - Summarised direction of the effect (positive effect of support, negative effect of support, null effect of support, inconsistent effect of support)
65. Community participation outcomes from narrative syntheses
    - Term used by review to describe this outcome
    - Number of studies evaluating this outcome
    - Verbatim summary of outcomes
    - Summarised direction of the effect (positive effect of support, negative effect of support, null effect of support, inconsistent effect of support)
66. Parent knowledge and skill outcomes from narrative syntheses
    - Term used by review to describe this outcome
    - Number of studies evaluating this outcome
    - Verbatim summary of outcomes
    - Summarised direction of the effect (positive effect of support, negative effect of support, null effect of support, inconsistent effect of support)
67. Parent social-emotional wellbeing outcomes from narrative syntheses
    - Term used by review to describe this outcome
    - Number of studies evaluating this outcome
    - Verbatim summary of outcomes
    - Summarised direction of the effect (positive effect of support, negative effect of support, null effect of support, inconsistent effect of support)
68. Parent financial wellbeing outcomes from narrative syntheses
    - Term used by review to describe this outcome
    - Number of studies evaluating this outcome
    - Verbatim summary of outcomes

- Summarised direction of the effect (positive effect of support, negative effect of support, null effect of support, inconsistent effect of support)

69. Moderators
    - Term used by review to describe the moderator
    - Term used for moderator in the current umbrella review
    - Term used by review to describe outcome
    - Term used for the outcome in the current umbrella review
    - Direction of moderation effect
    - Verbatim summary of moderation effect
    - Summary of moderation effect for the current umbrella review

Appendix 5.5	Umbrella review - Quality appraisal form

Appendix 5.5 - Umbrella review - Quality appraisal form

adapted from the Critical Appraisal Checklist for SRs and Research Syntheses created by the Joanna Briggs institute (2020)

NB: A 'Yes' decision requires all checkboxes under a single item to be met, unless the criteria specifically state otherwise (i.e., use an 'OR' qualifier). If all checkboxes are not met, a 'No' decision should be specified.

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1. **Is the review question clearly and explicitly stated?**
    - ☐ The review question(s) or aim(s)/objectives explicitly state(s) the population, intervention, and outcomes of interest PI(C)O.

2. **Were the inclusion criteria appropriate for the review question?**
    - ☐ The PICO elements and design were clearly defined in the inclusion and/or exclusion criteria.
    - ☐ The PICO elements were relevant to the objectives of the review and/or the research questions

3. **Was the search strategy appropriate?**
    - ☐ The search strategy included key words and/or index terms that specified PI(C)O
    - ☐ Date and language limits appropriate and/or justified

4. **Were the sources and resources used for the study adequate?**
    - ☐ Included at least two major bibliographic databases relevant to the review question, from the following list: Medline, CINAHL, PsycINFO, PubMed, EMBASE, Scopus, Web of Science, and ERIC
    - ☐ Attempt to search for grey literature (e.g. websites relevant to the review question, thesis repositories, trial registries)

5. **Were criteria for appraising the studies appropriate?**
    - ☐ Clear statement that critical appraisal was conducted
    - ☐ Details of the items that were used to assess the included studies (within methods, appendix, or further reference) were outlined and appropriate for the relevant study design

6. **Was critical appraisal conducted by two or more reviewers independently?**
    - ☐ Critical appraisal was conducted by two reviewers working independently from each other and conferring when needed to make a decision; OR
    - ☐ Two reviewers conducted critical appraisal with at least 10% of eligible studies and achieved good agreement (at least 80% or Cohen's kappa = 0.6 or greater), with the remainder extracted by one reviewer.

7. Were there methods to minimise errors in data extraction?

☐ All data extraction was conducted by two reviewers working independently OR

☐ Two reviewers extracted data with a sample of eligible studies and achieved good agreement (at least 80% or Cohen's kappa = 0.6 or greater), with the remainder extracted by one reviewer.

8. Were the methods used to combine studies appropriate?

- Meta-analyses
  - ☐ A statement about the extent to which the studies were appropriate to be combined
  - ☐ Assessment of heterogeneity
  - ☐ Explanation for heterogeneity that may be present
- Narrative synthesis
  - ☐ Methods for data synthesis are congruent with the stated methodology
  - ☐ Adequate information is provided to support the synthesised findings
- Meta-analyses and narrative synthesis
  - ☐ Summary/extraction tables were structured to provide sufficient information to ascertain PICO elements and design for each included study.

9. Was the likelihood of publication bias assessed? (meta-analyses only)

☐ Publication bias was assessed (e.g. a funnel plot for 10 or more studies or Egger's test Begg test, Harbord test)

☐ N/A

10. Were recommendations for policy and/or practice supported by the reported data?

☐ Clear link made between the results of the review and recommendations for policy and practice.

☐ The strengths of the findings and the quality of the research considered in the formulation of the review recommendations

11. Were the specific directives for new research appropriate?

☐ Indication of directions for further research

Appendix 5.6	Umbrella review - Excluded articles

Appendix 5.6 - Umbrella review - Excluded articles

Articles excluded during full-text screening with reasons

*****Indicates an article identified in the ancestral search

Exclusion reason: Duplicate (n = 4)

Boster, J. B., Spitzley, A. M., Castle, T. W., Jewell, A. R., Corso, C. L., & McCarthy, J. W. (2021). Music Improves Social and Participation Outcomes for Individuals With Communication Disorders: A Systematic Review. *Journal of Music Therapy*, *58*(1), 12-42.

Moore, D. M., Baggett, K. M., & Barger, B. (2021). Measuring parent positive support of social communication among toddlers with autism: a systematic review. *Psychosocial Intervention*, *30*(1), 57-66.

Sandgreen, H., Frederiksen, L. H., & Bilenberg, N. (2021). Digital interventions for autism spectrum disorder: a meta-analysis. *Journal of Autism and Developmental Disorders*, *51*(9), 3138-3152.

Valentine, A. Z., Hall, S. S., Young, E., Brown, B. J., Groom, M. J., Hollis, C., & Hall, C. L. (2021). Implementation of telehealth services to assess, monitor, and treat neurodevelopmental disorders: systematic review. *Journal of Medical Internet Research, 23*(1), e22619.

Exclusion reason: Not systematic (n = 33)

Aspiranti, K. B., Larwin, K. H., & Schade, B. P. (2020). iPads/tablets and students with autism: A meta-analysis of academic effects. *Assistive Technology*, *32*(1), 23-30.

Bene, K., & Lapina, A. (2021). A Meta-Analysis of Sibling-Mediated Intervention for Brothers and Sisters Who Have Autism Spectrum Disorder. *Review Journal of Autism and Developmental Disorders*, *8*, 186-194.

Birnschein, A. M., Paisley, C. A., & Tomeny, T. S. (2021). Enhancing social interactions for youth with autism spectrum disorder through training programs for typically developing peers: A systematic review. *Research in Autism Spectrum Disorders*, *84*, e101784.

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Exclusion reason: No (separate analysis of) children diagnosed with autism (n = 8)

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Exclusion reason: Excluded publication type (n = 10)

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Correll, C. U., Cortese, S., Croatto, G., Monaco, F., Krinitski, D., Arrondo, G., ... & Solmi, M. (2021). Efficacy and acceptability of pharmacological, psychosocial, and brain stimulation interventions in children and adolescents with mental disorders: an umbrella review. *World Psychiatry*, *20*(2), 244-275.

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Zhang, D., Lee, E. K., Mak, E. C., Ho, C. Y., & Wong, S. Y. (2021). Mindfulness-based interventions: an overall review. *British Medical Bulletin*, *138*(1), 41-57.

Exclusion reason: No (separate analysis of) relevant age range (n = 11)

Bailey, B., Bryant, L., & Hemsley, B. (2021). Virtual Reality and Augmented Reality for Children, Adolescents, and Adults with Communication Disability and Neurodevelopmental Disorders: a Systematic Review. *Review Journal of Autism and Developmental Disorders*, advance online publication.

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Garcia, Y., Keller-Collins, A., Andrews, M., Kurumiya, Y., Imlay, K., Umphrey, B., & Foster, E. (2021). Systematic Review of Acceptance and Commitment Therapy in Individuals with Neurodevelopmental Disorders, Caregivers, and Staff. *Behavior Modification*, advance online publication.

Healy, S., Obrusnikova, I., & Getchell, N. (2021). Fundamental Motor Skill Interventions in Children with Autism Spectrum Disorder: A Systematic Review of the Literature Including a Methodological Quality Assessment. *Research in Autism Spectrum Disorders*, *81*, advance online publication.

Lian, X., & Sunar, M. S. (2021). Mobile Augmented Reality Technologies for Autism Spectrum Disorder Interventions: A Systematic Literature Review. *Applied Sciences*, *11*(10), 4550-4770.

Lichtlé, J., Downes, N., Engelberg, A., & Cappe, E. (2020). The effects of parent training programs on the quality of life and stress levels of parents raising a child with autism spectrum disorder: A systematic review of the literature. *Review Journal of Autism and Developmental Disorders*, *7*(3), 242-262.

Mosher, M. A., & Carreon, A. C. (2021). Teaching social skills to students with autism spectrum disorder through augmented, virtual and mixed reality. *Research in Learning Technology*, *29*, 1-22.

Mosher, M. A., Carreon, A. C., Craig, S. L., & Ruhter, L. C. (2021). Immersive Technology to Teach Social Skills to Students with Autism Spectrum Disorder: a Literature Review. *Review Journal of Autism and Developmental Disorders*, advance online publication.

Nieforth, L. O., Schwichtenberg, A. J., & O'Haire, M. E. (2021). Animal-Assisted Interventions for Autism Spectrum Disorder: A Systematic Review of the Literature from 2016 to 2020. *Review Journal of Autism and Developmental Disorders*, advance online publication.

Silva, G. M., Souto, J. J. D. S., Fernandes, T. P., Bolis, I., & Santos, N. A. (2021). Interventions with Serious Games and Entertainment Games in Autism Spectrum Disorder: A Systematic Review. *Developmental Neuropsychology*, *46*(7), 463-485.

Exclusion reason: No relevant intervention (n = 5)

Akers, J. S., Davis, T. N., Gerow, S., & Avery, S. (2020). Decreasing motor stereotypy in individuals with autism spectrum disorder: A systematic review. *Research in Autism Spectrum Disorders*, *77*, advance online publication.

Byrne, G., Ghráda, Á. N., O'Mahony, T., & Brennan, E. (2021). A systematic review of the use of acceptance and commitment therapy in supporting parents. *Psychology and Psychotherapy: Theory, Research and Practice*, *94*, 378-407.

Chua, J. Y. X., & Shorey, S. (2021). The Effect of Mindfulness-Based and Acceptance Commitment Therapy-Based Interventions to Improve the Mental Well-Being Among Parents of Children with Developmental Disabilities: A Systematic Review and Meta-Analysis. *Journal of Autism and Developmental Disorders*, advance online publication.

Juvin, J., Sadeg, S., Julien-Sweerts, S., & Zebdi, R. (2021). A Systematic Review: Acceptance and Commitment Therapy for the Parents of Children and Adolescents with Autism Spectrum Disorder. *Journal of Autism and Developmental Disorders*, *52*, 124–141.

Osborn, R., Dorstyn, D., Roberts, L., & Kneebone, I. (2021). Mindfulness therapies for improving mental health in parents of children with a developmental disability: a systematic review. *Journal of Developmental and Physical Disabilities*, *33*(3), 373-389.

Exclusion reason: No full-text in English (n = 5)

da Costa Carneiro, A. C., Brassolatti, I. M., Nunes, L. F. S., Damasceno, F. C. A., & Cortez, M. D. (2020). Ensino de Pais via Telessaúde para a Implementação de Procedimentos Baseados em ABA: Uma Revisão de Literatura e Recomendações em Tempos de COVID-19. *Revista Brasileira de Análise do Comportamento*, *16*(2), 148-173.

Jung, S. I., Lim, S., Jo, E., Sim, H. S., Sung, J. E., & Kim, Y. T. (2020). The efficacy of telepractice intervention for children & adolescents with speech, language & hearing impairments: a meta-analysis. *Communication Sciences & Disorders*, *25*(4), 976-986.

Moral Pérez, M. E. D., & López Bouzas, N. (2021). Augmented reality and stimulation of social and communicative abilities in people with ASD: research review. *RED-Revista de Educación a Distancia*, *22*(66), 1-13.

Rojas Torres, L., Alonso Esteban, Y., & Alcantud-Marín, F. (2020). Revisión de evidencias de las técnicas de DIR/Floortime™ para la intervención en niños y niñas con Trastornos del Espectro del Autismo. *Siglo Cero, 51*(2), 7-32

Shiri, E., Pouratemad, H., Fathabadi, J., & Narimani, M. (2021). Parent-mediated behavioural intervention for treatment behavioural excesses in children with autism spectrum disorder. *Journal of Arak University of Medical Sciences (JAMS), 24*(4), 422-437.

Exclusion reason: Did not name all practices and categories (n = 2)

*Beaudoin, A. J., Sébire, G., & Couture, M. (2014). Parent training interventions for toddlers with autism spectrum disorder. *Autism Research and Treatment*, *2014,* 1-15.

Musetti, A., Manari, T., Dioni, B., Raffin, C., Bravo, G., Mariani, R., ... & Corsano, P. (2021). Parental Quality of Life and Involvement in Intervention for Children or Adolescents with Autism Spectrum Disorders: A Systematic Review. *Journal of Personalized Medicine*, *11*(9), 894-910.

Exclusion reason: No useable combination of practices and categories (n = 3)

*Ledbetter-Cho, K., Lang, R., Watkins, L., O'Reilly, M., & Zamora, C. (2017). Systematic review of collateral effects of focused interventions for children with autism spectrum disorder. *Autism & Developmental Language Impairments*, 2, 1-22.

McDaniel, J., Brady, N. C., & Warren, S. F. (2021). Effectiveness of Responsivity Intervention Strategies on Prelinguistic and Language Outcomes for Children with Autism Spectrum Disorder: A Systematic Review and Meta-Analysis of Group and Single Case Studies. *Journal of Autism and Developmental Disorders*, advance online publication.

O’Keeffe, C., & McNally, S. (2021). A systematic review of play-based interventions targeting the social communication skills of children with Autism Spectrum Disorder in educational contexts. *Review Journal of Autism and Developmental Disorders*, advance online publication.

Articles excluded during extraction with reasons

Exclusion reason: No relevant (useable summary of) outcomes (n = 7)

de Nocker, Y. L., & Toolan, C. K. (2021). Using Telehealth to Provide Interventions for Children with ASD: a Systematic Review. *Review Journal of Autism and Developmental Disorders*, 1-31.

Ellison, K. S., Guidry, J., Picou, P., Adenuga, P., & Davis, T. E. (2021). Telehealth and autism prior to and in the age of COVID-19: a systematic and critical review of the last decade. *Clinical Child and Family Psychology Review,* 24(3), 599-630.

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Pacia, C., Holloway, J., Gunning, C., & Lee, H. (2021). A systematic review of family-mediated social communication interventions for young children with autism. *Review Journal of Autism and Developmental Disorders*, advance online publication.

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Short, C. A., & Vital, P. (2021). A Systematic Review of Social Maintenance Behavior Outcomes of Interactive Social Interventions for Children With Autism Spectrum Disorders. *Focus on Autism and Other Developmental Disabilities*, *36*(2), 108-120.

Valentine, A. Z., Hall, S. S., Young, E., Brown, B. J., Groom, M. J., Hollis, C., & Hall, C. L. (2021). Implementation of telehealth services to assess, monitor, and treat neurodevelopmental disorders: Systematic review. *Journal of Medical Internet Research*, *23*(1), e22619.

Exclusion reason: Publication corresponding to included report (n = 1; excluded during extraction)

Hume, K., Steinbrenner, J. R., Odom, S. L., Morin, K. L., Nowell, S. W., Tomaszewski, B., ... & Savage, M. N. (2021). Evidence-based practices for children, youth, and young adults with autism: Third generation review. *Journal of Autism and Developmental Disorders*, *51*, 4013–4032.

Articles excluded from the original umbrella review with reasons (n = 28)

Exclusion reason: Final literature search conducted > 10 years ago (n = 6)

Flippin, M., Reszka, S., & Watson, L. R. (2010). Effectiveness of the picture exchange communication system (PECS) on communication and speech for children with autism spectrum disorders: a meta-analysis. *American Journal of Speech-Language Pathology, 19*(2), 178-195. doi:10.1044/1058-0360(2010/09-0022)

Lang, R., O'Reilly, M., Healy, O., Rispoli, M., Lydon, H., Streusand, W., . . . Giesbers, S. (2012). Sensory integration therapy for autism spectrum disorders: A systematic review. *Research in Autism Spectrum Disorders, 6*(3), 1004-1018. doi:10.1016/j.rasd.2012.01.006

Makrygianni, M. K., & Reed, P. (2010). A meta-analytic review of the effectiveness of behavioural early intervention programs for children with autistic spectrum disorders. *Research in Autism Spectrum Disorders, 4*(4), 577-593. doi:10.1016/j.rasd.2010.01.014

Peters-Scheffer, N., Didden, R., Korzilius, H., & Sturmey, P. (2011). A meta-analytic study on the effectiveness of comprehensive ABA-based early intervention programs for children with autism spectrum disorders. *Research in Autism Spectrum Disorders, 5*(1), 60-69. doi:10.1016/j.rasd.2010.03.011

Treurnicht Naylor, K., Kingsnorth, S., Lamont, A., McKeever, P., & Macarthur, C. (2011). The effectiveness of music in pediatric healthcare: a systematic review of randomized controlled trials. *Evidence-Based Complementary and Alternative Medicine, 2011*, 464759. doi:10.1155/2011/464759

Virués-Ortega, J. (2010). Applied behavior analytic intervention for autism in early childhood: Meta-analysis, meta-regression and dose-response meta-analysis of multiple outcomes. *Clinical Psychology Review, 30*(4), 387-399. doi:10.1016/j.cpr.2010.01.008

Exclusion reason: No relevant (useable summary of) outcomes (n = 17)

Akemoglu, Y., Muharib, R., & Meadan, H. (2020). A systematic and quality review of parent-implemented language and communication interventions conducted via telepractice. *Journal of Behavioral Education*, 29(2), 282-316.

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Exclusion reason: Did not name all practices and categories (n = 3)

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National guideline for supporting the learning, participation, and wellbeing of autistic children and their families in Australia

Appendix 5.7	Umbrella review - Included articles

Appendix 5.7 - Umbrella review - Included articles

Articles excluded during full-text screening with reasons

*****Indicates an article from the original 2020 umbrella review

*Bejarano-Martín, Á., Canal-Bedia, R., Magán-Maganto, M., Fernández-Álvarez, C., Lóa-Jónsdóttir, S., Saemundsen, E., ... & Posada, M. (2020). Efficacy of focused social and communication practices for young children with autism spectrum disorder: A meta-analysis. *Early Childhood Research Quarterly*, *51*, 430-445.

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Valentine, A. Z., Brown, B. J., Groom, M. J., Young, E., Hollis, C., & Hall, C. L. (2020). A systematic review evaluating the implementation of technologies to assess, monitor and treat neurodevelopmental disorders: A map of the current evidence. *Clinical psychology review*, *80*, 101870.

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National guideline for supporting the learning, participation, and wellbeing of autistic children and their families in Australia

Appendix 5.8	Umbrella review - Characteristics of included systematic reviews

Appendix 5.8 - Umbrella review - Characteristics of included systematic reviews

Author (year)	Characteristics of Systematic Review	Characteristics of Included Studies
Bejarano-Martín et al. (2020)	**Type:** Meta-analysis **Objectives:** “to ascertain the overall effectiveness of [focused practices] in children with [autism spectrum disorder] 6 years of age and younger.” **Number of included studies:** 43 **Search limit (years):** 2000 – 2018 **Locations of included studies:** Not specified **Study designs:** Randomised controlled trials, non-randomised with comparison, single-case experimental designs (inclusion criteria). **Quality (systematic review):** High (9/11) **Quality appraisal tool (included studies):** EBP Update Workgroup Reviewer Training criteria (Wong et al., 2015) of the National Professional Development Centre on Autism Spectrum Disorders. **Quality (included studies):** Included high quality/low risk of bias only. **Sources of funding:** Specified - Funded **Conflict of interest:** Specified - No conflicts	**Participant characteristics** **Number of participating children:** 1402 (785 support, 617 comparison) **Age:** 25 – 72 months, M = 41.6 months **Sex**: 75 – 91.7% male **Description:** Autism spectrum disorder (inclusion criteria) **Increased likelihood of ASD:** Not eligible (inclusion criteria) **Other conditions:** None **Support(s):** Focused practices - Discrete trial training (DTT); Pivotal Response Training (PRT), Contingent imitation; discrete trial training (DTT) plus social interaction, mediated learning with active engagement; picture exchange communication system (PECS); video modelling; prompting and reinforcement; physical and verbal cues; token economy and prompting; photographic schedules. **Comparison:** Not specified **Outcomes:** Social-communication (social-communication, imitation, joint attention, play).
Binns & Oram Cardy (2019)	**Type:** Narrative synthesis **Objectives:** to “systematically review studies examining the impact of developmental social pragmatic interventions in supporting (a) foundational social communication and language skills of preschool children with autism spectrum disorder and (b) caregiver interaction style.” **Number of included studies:** 10 **Search limit (years):** Database inception – 2018 **Locations of included studies:** Not specified **Study designs:** Randomised controlled trials **Quality (systematic review):** High (9/10) **Quality appraisal tool (included studies):** Critical Appraisal Skills Programme tool (CASP, 2018); Dollaghan’s (2007) scale. **Quality (included studies):** Included low quality/high risk of bias.	**Participant characteristics** **Number of participating children:** 716 **Age:** 1 year, 3 months - 6 years, M = 37.8 months **Sex**: Not specified **Description:** Autism spectrum disorder **Increased likelihood of ASD:** Not included **Other conditions:** None **Support(s):** Developmental social pragmatic interventions - Child Talk; Hanen More than Words; Developmental Individual-Difference Relationship-Based (DIR); Milton and Ethel Harris Research Initiative Treatment (MEHRIT) - DIR based; Pediatric Autism and Communication Therapy (PACT); Joint attention mediated learning; Play and Language for Autistic Youngsters (PLAY) project - DIR based; Social communication, emotion regulation, transactional support (SCERTS).

	Sources of funding: Specified - Funded **Conflict of interest:** Specified - No conflicts	**Comparison:** Wait list, treatment as usual, another support. **Outcomes:** Social communication (social interaction and social communication); Communication (language capacities).
Crank et al. (2021)	**Type:** Meta-analysis **Objectives: "**We examined the quality of evidence supporting the effects of Naturalistic Developmental Behavioral Interventions (NBDIs) for facilitating change in young children with autism. We also investigated whether effects varied as a function of specific features of the intervention, samples, and outcomes measured." **Number of included studies:** 27 **Search limit (years):** 1970-2018 **Locations of included studies:** Not specified **Study designs:** Randomised controlled trials, non-randomised with comparison **Quality (systematic review):** Low (8/11) **Quality appraisal tool (included studies):** Quality indicators, including their risk of selection bias, detection bias, and attrition bias, as well as their proximity to intervention targets, their boundedness to the context of intervention, and their risk of parent/teacher training CME. **Quality (included studies):** Not specified **Sources of funding:** Not specified **Conflict of interest:** Not specified	**Participant characteristics** **Number of participating children:** Not specified **Age:** 18.2 – 75.4 months (M = 39 months) **Sex**: Not specified **Description:** Autism spectrum disorder (inclusion criteria) **Increased likelihood of autism:** Not specified **Other conditions:** Not specified **Support(s):** Naturalistic developmental behavioural interventions - Advancing Social Communication and Play (ASAP); Caregiver-based intervention program in community day-care centers; Denver Model; Early Social Interaction Project (SCERTS); Early Start Denver Mode (ESDM); Home-based Building Blocks Program; home-based intervention program; ImPACT Online; Interpersonal Synchrony; Joint Attention Intervention; Joint Attention Symbolic Play Engagement Regulation (JASPER); Joint Engagement Intervention; Joint Engagement Intervention with Creative Movement Therapy; Parent-Early Start Denver Model (P-ESDM); Parent-training intervention; Pivotal Response Treatment (PRT); Reciprocal Imitation Training; Social ABCs Cognitive behaviour therapy (CBT). **Comparison:** Not specified **Outcomes:** General outcomes.
Deb et al. (2020)	**Type:** Meta-analysis **Objectives:** "We carried out a systematic review and meta-analyses to assess effectiveness of parental training for children with autism on their symptoms and parental stress." **Number of included studies:** 17 **Search limit (years):** Database inception – 2020 **Locations of included studies:** Not specified **Study designs:** Randomised controlled trials **Quality (systematic review):** High (9/11) **Quality appraisal tool (included studies):** Cochrane Risk of Bias (RoB) **Quality (included studies):** Not specified **Sources of funding:** Specified - Funded **Conflict of interest:** Specified – No conflicts	**Participant characteristics** **Number of participating children:** 975 **Age:** 20 months – 10 years **Sex**: M = 84% male **Description:** Autism spectrum disorder **Increased likelihood of autism:** Not included **Other conditions:** Co-occurring sleep difficulties, cognitive impairment **Support(s):** Parent-mediated support - Social pragmatic joint attention parent training; Pivotal Response Treatment; Developmental, Individualised, Relationship oriented DIR/Floor Time intervention; parent focussed training; Early start denver model (ESDM); Parent education and behaviour management (PEBM) training; Sleep study curriculum; Primary Care Stepping Stones Triple P (PCSSTP); Parent

		Training to manage behaviours; generic parent training; Autism Preschool Programme. **Comparison:** Wait list, treatment as usual, another support **Outcomes:** General outcomes (treatment effect).
Dimolareva & Dunn (2021)	**Type:** Meta-analysis **Objectives:** "The current meta-analysis assesses the effectiveness of Animal Assisted Interventions (AAIs) on social interaction, communication and global autism symptoms." **Number of included studies:** 16 **Search limit (years):** Database inception – 2020 **Locations of included studies:** Not specified **Study designs:** Non-randomised without comparison, other designs not specified **Quality (systematic review):** Low (8/11) **Quality appraisal tool (included studies):** Cochrane collaboration tool for assessing risk of bias (Higgins and Green 2014). **Quality (included studies):** Not specified **Sources of funding:** Not specified **Conflict of interest:** Not specified	**Participant characteristics** **Number of participating children:** 489 **Age:** 4 – 18 years (inclusion criteria) **Sex**: Not specified **Description:** Autism spectrum disorder **Increased likelihood of autism:** Not included **Other conditions:** Not specified **Support(s):** Equine therapy **Comparison:** Wait list, treatment as usual, another support, no comparison **Outcomes:** Overall autism characteristics (global measures of ASD); Social-communication (social interaction); Language (communication).
Ferguson et al. (2019)	**Type:** Narrative synthesis **Objectives:** "to systematically review the literature researching telehealth and [applied behaviour analysis to individuals with autism spectrum disorder]." **Number of included studies:** 28 **Search limit (years):** Not specified – 2018 **Locations of included studies:** Not specified **Study designs:** Randomised controlled trials, non-randomised with comparison, non-randomised without comparison, single-case experimental designs, other **Quality (systematic review):** High (9/10) **Quality appraisal tool (included studies):** Evaluative method for evaluating and determining evidence-based practices in autism (Reichow et al., 2008). **Quality (included studies):** Included low quality/high risk of bias **Sources of funding:** Specified – Funded **Conflict of interest:** Specified – No conflicts	**Participant characteristics** **Number of participating children:** 307 (231 support, 76 comparison) **Age:** 1.75 - 16 years, M = 4.73 years (of studies reporting age) **Sex**: Not specified **Description:** Autism spectrum disorder, pervasive developmental disorder not otherwise specified **Increased likelihood of ASD:** Not included **Other conditions:** None **Support(s):** Telehealth interventions with behavioural principle - functional analysis (FA); functional communication training (FCT); naturalistic and incidental teaching; behaviour support strategies (e.g., positive behaviour support); preference assessments; Early Start Denver Model (ESDM); Improving Parents as Communication Teachers (imPACT). **Comparison:** Wait list, treatment as usual, another support, the individual's own baseline, no comparison group **Outcomes:** General outcomes (efficacy outcomes).

Fuller et al. (2020)	**Type:** Meta-analysis **Objectives:** to examine “the effects of the Early Start Denver Model (ESDM) for young children with autism on developmental outcome measures.” **Number of included studies:** 12 **Search limit (years):** Not specified – 2019 **Locations of included studies:** Asia, Australia, Europe, North America **Study designs:** Randomised controlled trials, non-randomised with comparison **Quality (systematic review):** High (10/11) **Quality appraisal tool (included studies):** Study quality indicators (random assignment, use of assessors who were blind or naïve of the group assignment). Measurement–quality variables were coded based on Sandbank et al. (2020). **Quality (included studies):** Not specified **Sources of funding:** Specified – Funded **Conflict of interest:** Specified – Conflicts	**Participant characteristics** **Number of participating children:** 640 (286 support, 354 comparison) **Age:** 9 months – 5 years, M = 2.51 years **Sex**: 65.63 - 100% male, M = 80.6% male **Description:** Autism spectrum disorder (inclusion criteria) **Increased likelihood of ASD:** Eligible (inclusion criteria) **Other conditions:** None **Support(s):** Early Start Denver Model (ESDM). **Comparison:** Wait list, treatment as usual, another support **Outcomes:** General outcomes (child outcomes); overall autism characteristics (autism symptoms); Social-communication; Restricted and repetitive interests and behaviours (repetitive behaviours); Communication (language); Cognitive developement; Adaptive behaviour (adaptive functioning).
Geretsegger et al. (2014)	**Type:** Meta-analysis **Objectives:** “to review the effects of music therapy, or music therapy added to standard care, for individuals with [autism spectrum disorder].” **Number of included studies:** 10 **Search limit (years):** Database inception – 2013 **Locations of included studies:** Australia, South America/Caribbean, North America **Study designs:** Randomised controlled trials, non-randomised with comparison (inclusion criteria) **Quality (systematic review):** High (11/11) **Quality appraisal tool (included studies):** Cochrane risk of bias tool (Higgins, 2011). **Quality (included studies):** Not specified **Sources of funding:** Specified – Funded **Conflict of interest:** Specified – No conflicts	**Participant characteristics** **Number of participating children:** 165 **Age:** 2 – 12 years **Sex**: 80 – 100% **Description:** Autism spectrum disorder **Increased likelihood of ASD:** Not included **Other conditions:** None **Support(s):** Music therapy. **Comparison:** Treatment as usual, another support, other comparison group **Outcomes:** Social-communication (social adaptation); Communication (non-verbal, verbal); Caregiver social emotional wellbeing (quality of family relationships).
Griffith et al. (2020)	**Type:** Narrative synthesis **Objectives:** to “present a narrative synthesis of studies examining whether children < 6 years can learn from interactive apps.” **Number of included studies:** 35 (3 autism-specific) **Search limit (years):** 2008 – 2019	**Participant characteristics** **Number of participating children:** 4639 (164 ASD) **Age range (mean age):** 0 - 71 months (inclusion criteria) **Sex**: 40 – 90% male **Description:** Autism spectrum disorder

	Locations of included studies: Asia, Australia, Europe, North America **Study designs:** Randomised controlled trials, non-randomised with comparison **Quality (systematic review):** High (8/10) **Quality appraisal tool (included studies):** Adapted Cochrane risk of bias tool. **Quality (included studies):** Included low quality/high risk of bias **Sources of funding:** Specified – Not funded **Conflict of interest:** Specified – No conflicts	**Increased likelihood of ASD:** Not included **Other conditions:** Not specified **Support(s):** Interactive apps. **Comparison:** Treatment as usual, another support **Outcomes:** Social-communication.
Hampton & Kaiser (2016)	**Type:** Meta-analysis **Objectives:** to examine "the effects of early interventions on spoken language in children with [autism spectrum disorder]." **Number of included studies:** 26 **Search limit (years):** Not specified – 2014 **Locations of included studies:** Australia, Europe, North America **Study designs:** Randomised controlled trials, non-randomised with comparison **Quality (systematic review):** High (10/11) **Quality appraisal tool (included studies):** Cochrane Collaboration (Higgins et al., 2011). **Quality (included studies):** Included low quality/high risk of bias **Sources of funding:** Not specified **Conflict of interest:** Not specified	**Participant characteristics** **Number of participating children:** 1738 **Age:** 1.75 – 4.18 years, M = 3.33 years **Sex:** 69 – 91% male **Description:** Autism spectrum disorder **Increased likelihood of ASD:** Not included **Other conditions:** None **Support(s):** Early interventions - Early Intensive Behavioural Intervention (EIBI); Early Intervention Preschool (EIP); Early Start Denver Model (ESDM); Joint Attention Mediated Learning (JAML); Joint Attention; Structured Play Engagement; and Regulation (JAML); Learning Experiences and Alternative Program (LEAP); Milton and Ethel Harris Research Initiative Treatment (MEHRIT); More Than Words (MTW); Pediatric Autism and Communication Therapy (PACT); Play and Language for Autistic Youngsters; PRT, Pivotal Response Training (Play and Language for Autistic Youngsters); Treatment and Education of Autistic and Related Communication Handicapped Children (TEACCH); Scottish Early Intervention Preschool; Parent training model (PSwA); Focused playtime (FPI); Speech remediation; Teach Town basics; Early Social Interaction (ESI); Parent training, Behaviour analytic. **Comparison:** Not specified **Outcomes:** Expressive language (spoken language).
Hardy & Weston (2020)	**Type:** Narrative synthesis **Objectives:** to examine "the current state of literature on canine-assisted therapy (CAT) for children with [autism spectrum disorder] based on peer-reviewed articles." **Number of included studies:** 5 **Search limit (years):** Not specified – 2017	**Participant characteristics** **Number of participating children:** 66 **Age:** 3 – 14 years **Sex**: 66.7 - 87.5% male **Description:** Autism spectrum disorder **Increased likelihood of ASD:** Not included

	Locations of included studies: Not specified **Study designs:** Not specified **Quality (systematic review):** Low (6/10) **Quality appraisal tool (included studies):** Adapted from Jarde et al. (2013). **Quality (included studies):** Not specified **Sources of funding:** Not specified **Conflict of interest:** Specified – No conflicts	**Other conditions:** None **Support(s):** Canine-assisted therapy. **Comparison:** Not specified **Outcomes:** Social-communication (social behaviour).
Ho et al. (2014)	**Type:** Meta-analysis **Objectives:** to examine "studies reporting on randomised controlled trials of the use of cognitive-behavioural approaches to intervention for children with autism spectrum disorder." **Number of included studies:** 10 **Search limit (years):** Not specified – 2012 **Locations of included studies:** Not specified **Study designs:** Randomised controlled trials **Quality (systematic review):** Low (7/11) **Quality appraisal tool (included studies):** Gersten et al. (2005). **Quality (included studies):** Not specified **Sources of funding:** Not specified **Conflict of interest:** Not specified	**Participant characteristics** **Number of participating children:** 402 (199/372 completed support, 173/372 comparison) **Age:** 4.5 – 16 years, M = 10.5 years **Sex**: Not specified **Description:** Asperger's syndrome, high functioning autistic disorder/autism spectrum disorder, pervasive developmental disorder not otherwise specified, portion of sample without sub-type diagnoses specified **Increased likelihood of ASD:** Not included **Other conditions:** None **Support(s):** Cognitive behavioural intervention - Cool Kids; Building Confidence Family Cognitive Behaviour Therapy (FCBT); Social Skills Training for Children and Adolescents with Asperger Syndrome and Social-Communications Problems; Thinking about you, thinking about me; Coping Cat CBT program; Facing your fears; Group Cognitive Behaviour Therapy (CBT). **Comparison:** Not specified **Outcomes:** Social-communication (social skills).
Jiménez-Muñoz et al. (2022)	**Type:** Narrative synthesis **Objectives: "**The aim of the present study is to systematically review the evidence about the use of video games as therapeutic tools in children diagnosed with ASD." **Number of included studies:** 24 **Locations of included studies:** Asia, Australia, Europe, South America/Caribbean, North America **Search limit (years):** Database inception - 2021 **Study designs:** Randomised controlled trial, non-randomised with comparison non-randomised without comparison, other study designs. **Quality (systematic review):** Low (7/10) **Quality appraisal tool (included studies):** Cochrane	**Participant characteristics** **Number of participating children:** 803 **Age:** M = 6.8 – 17.7 years **Sex**: 60 – 100% male **Description:** Autism spectrum disorder, Asperger syndrome **Increased likelihood of autism:** Not included **Other conditions:** Attention deficit hyperactivity disorder, other conditions not specified. **Support(s):** Video games. **Comparison:** Treatment as usual, another support, no comparison, other comparisons not specified **Outcomes:** General outcomes (main findings).

	Collaboration's tool for assessing risk of bias. **Quality (included studies):** Not specified **Sources of funding:** Specified - Funded **Conflict of interest:** Specified – No conflicts	
Kent et al. (2020)	**Type:** Meta-analysis **Objectives:** to examine "the efficacy of play-based interventions to address the play skills of children with [autism spectrum disorder]… [and] to summarize key characteristics of a range of play-based interventions for children with [autism spectrum disorder] and assess the quality of published [randomised controlled trials]." **Number of included studies:** 19 narrative synthesis; 11 meta-analysis **Search limit (years):** Not specified – 2017 **Locations of included studies:** Not specified **Study designs:** Randomised controlled trials **Quality (systematic review):** High (10/11) **Quality appraisal tool (included studies): T**he QualSyst critical appraisal tool (Kmet et al., 2004). **Quality (included studies):** Included moderate quality/moderate risk of bias **Sources of funding:** Specified – Funded **Conflict of interest:** Specified – No conflicts	**Participant characteristics** **Number of participating children:** 1149 **Age:** 2 – 12 years **Sex**: Not specified **Description:** Autism spectrum disorder **Increased likelihood of ASD:** Not included **Other conditions:** None **Support(s):** Play-based interventions - [Generic] play intervention; Joint Attention, Symbolic Play, Engagement, and Regulation (JASPER); Lego therapy; Social stories; behavioural approaches; peer training; teacher training; Social Emotional NeuroScience Endocrinology (SENSE) Theater principles; video modelling. **Comparison:** Wait list, another support **Outcomes:** Play.
Khan et al. (2019)	**Type:** Meta-analysis **Objectives:** "to review the effectiveness of randomized controlled trials (RCTs) of Web-based interventions delivered to children and young people with neurodevelopmental disorders." **Number of included studies:** 10 narrative review (5 autism-specific); 5 meta-analysis (3 autism-specific) **Search limit (years):** 2000 – 2018	**Participant characteristics** **Number of participating children:** 523 in analysis (545 in review, of which 289 were diagnosed with ASD) **Age:** 2 – 17 years, M range= 3.32 – 12.16 years **Sex**: 62.5 – 94% male **Description:** Autism spectrum disorder **Increased likelihood of ASD:** Not included

	Locations of included studies: Australia, Europe, South America/Caribbean, North America **Study designs:** Randomised controlled trials **Quality (systematic review):** High (9/11) **Quality appraisal tool (included studies):** Joanna Briggs Institute Critical Appraisal Checklist for RCTs. **Quality (included studies):** Included moderate quality/moderate risk of bias **Sources of funding:** Specified – Funded **Conflict of interest:** Specified – No conflicts	**Other conditions:** Tic disorders or chronic tic disorders, attention deficit hyperactivity disorder, specific learning disorder, dyscalculia **Support(s):** Web-based interventions - apps; serious games; videoconferencing; virtual environment with playable games; Web-based cognitive behavioural therapy (CBT) intervention. **Comparison:** Wait list, treatment as usual, another support **Outcomes:** General outcomes (condition-specific outcomes or reducing comorbid psychological symptoms).
Leung et al. (2021)	**Type:** Narrative synthesis **Objectives:** **"**The objective of this review was to evaluate previous evidence, obtained in randomized controlled trials (RCTs), on the effectiveness of using mobile devices as the medium of intervention targeting social and cognitive skills among individuals with ASD.**"** **Number of included studies:** 10 **Search limit (years):** 2000 – 2019 **Locations of included studies:** Not specified **Study designs:** Randomised controlled trials **Quality (systematic review):** Low (7/10) **Quality appraisal tool (included studies):** Cochrane risk of bias tool **Quality (included studies):** Not specified **Sources of funding:** Not specified **Conflict of interest:** Specified – No conflicts	**Participant characteristics** **Number of participating children:** Not specified **Age:** Not specified **Sex**: Not specified **Description:** Autism spectrum disorder **Increased likelihood of autism:** Not included **Other conditions:** Not specified **Support(s):** Mobile technology. **Comparison:** Wait list, treatment as usual, another support **Outcomes:** General outcomes (effectiveness).
Mayer-Benarous et al. (2021)	**Type:** Narrative synthesis **Objectives:** **"**We aimed to review the evidence examining the use of music therapy in youths with ASD and/or other NDDs." **Number of included studies:** 39 (22 autism specific) **Search limit (years):** 1970 – 2020 **Locations of included studies:** Not specified **Study designs:** Randomised controlled trial, non-randomised with comparison, non-randomised without comparison, other study designs **Quality (systematic review):** High (8/10) **Quality appraisal tool (included studies):** Risk of Bias In Non randomized Studies—of Interventions (ROBINS-I) tool and the Revised Cochrane risk-of-bias tool for randomized trials (RoB 2). **Quality (included studies):** Included low quality/high risk of	**Participant characteristics** **Number of participating children:** Not specified **Age:** 1 – 20 years **Sex**: Not specified **Description:** Autism spectrum disorder **Increased likelihood of autism:** Not included **Other conditions:** Attention deficit hyperactivity disorder, anxiety, language delay, minimally verbal, cognitive impairment, global developmental delay, dyslexia, severe and multiple disabilities, sensory impairment and neurological disorders, specific learning disorders/disabilities, emotional disturbance, post-traumatic stress disorder **Support(s):** Music therapy. **Comparison:** Wait list, treatment as usual, another support, no

	bias. **Sources of funding:** Specified - Funded **Conflict of interest:** Specified – No conflicts	comparison **Outcomes:** Social-communication (joint attention).
Mazon et al. (2019)	**Type:** Narrative synthesis **Objectives:** "to update the previous [reviews of technology-based interventions] with a focus on clinical-quality studies; to examine reliability, consistency, durability and generalisation of measurements; and to compare the methodology of two cores of studies according to two dimensions: Therapeutic Effectiveness (TE) and Technology Usability (TU)." **Number of included studies:** 31 **Search limit (years):** 2000 – 2016 **Locations of included studies:** Not specified **Study designs:** Randomised controlled trials, non-randomised with comparison **Quality (systematic review):** Low (6/10) **Quality appraisal tool (included studies):** SIGN ratings for levels of evidence (SIGN, 2008); Jadad Score for methodological quality (Jadad et al., 1996). **Quality (included studies):** Not specified **Sources of funding:** Specified – Funded **Conflict of interest:** Specified – No conflicts	**Participant characteristics** **Number of participating children:** 796 (576 with ASD) **Age:** 3 – 18 years **Sex**: M = 82% male **Description:** Autism spectrum disorder **Increased likelihood of ASD:** Not included **Other conditions:** Down Syndrome, Speech and Language impairment (also included typically developing children) **Support(s):** Technology based interventions including (but not limited to) computer and robot-based interventions. **Comparison:** Not specified **Outcomes:** General outcomes (statistical significance).
Moon et al. (2020)	**Type:** Meta-analysis **Objectives:** "to assess the evidence for effects of therapeutic intervention with mobile device applications (apps) for individuals with autism spectrum disorder (ASD)." **Number of included studies:** 7 **Search limit (years):** 2009 – 2019 **Study designs:** Randomised controlled trials **Locations of included studies:** Australia, Europe, North America **Quality (systematic review):** Cochrane risk of bias (RoB)-2 tool**.** **Quality appraisal tool (included studies):** High (10/11) **Quality (included studies):** Included low quality/high risk of bias **Sources of funding:** Specified – Not funded **Conflict of interest:** Specified – No conflicts	**Participant characteristics** **Number of participating children:** 328 **Age:** 39 – 120 months **Sex**: Not specified **Description:** Autism spectrum disorder (inclusion criteria) **Increased likelihood of ASD:** Not eligible (inclusion criteria) **Other conditions:** None **Support(s):** Mobile device applications - including (but not limited to) FindMe game app, Therapy Outcomes By You (TOBY), Camp Discovery. **Comparison:** Wait list, treatment as usual, other comparison group **Outcomes:** Social-communication; Communication (gestures, symbolic); Expressive language (expressive language, words produced); Receptive language; Cognitive developement (visual reception); Motor (fine motor).
Murza et al. (2016)	**Type:** Meta-analysis **Objectives:** "to provide a quantitative assessment of the	**Participant characteristics** **Number of participating children:** 694 (410 support; 284

	effectiveness of joint attention interventions aimed at improving joint attention abilities in children with [autism spectrum disorder].” **Number of included studies:** 16 narrative synthesis, 12 meta-analysis **Search limit (years):** Database inception – 2015 **Locations of included studies:** Not specified **Study designs:** Randomised controlled trials (inclusion criteria) **Quality (systematic review):** High (9/11) **Quality appraisal tool (included studies):** Cochrane Collaboration’s Tool for Assessing Risk of Bias (Higgins et al., 2011). **Quality (included studies):** Included low quality/high risk of bias **Sources of funding:** Not specified **Conflict of interest:** Specified – No conflicts	comparison) **Age:** 11 – 152 months, M = 55 months **Sex**: Not specified **Description:** Autism spectrum disorder **Increased likelihood of ASD:** Not eligible (inclusion criteria) **Other conditions:** None **Support(s):** Joint attention interventions - Assessment, Evaluation and Programming System (AEPS) for Infants and Children; Caregiver Education Model (CEM); Caregiver Mediated Model (CMM); Hanen More Than Words (HMTW); Joint Attention Mediated Learning (JAML); Joint Attention Symbolic Play Engagement and Regulation (JASPER); Milton and Ethel Harris Research Initiative (MEHRI); Preschool Autism Communication Trial (PACT); parent training modules; and workshop training. **Comparison:** Not specified **Outcomes:** Social-communication (joint attention).
Naveed et al. (2019)	**Type:** Meta-analysis **Objectives:** to “a) assess the effectiveness of non-specialist delivered or mediated interventions in autism spectrum disorder (ASD); b) systematically evaluate relevant implementation processes involved in these non-specialists delivered interventions for autism spectrum disorder, and c) and to rate the quality of evidence across different outcomes using the World Health Organization’s recommended Grading of Recommendations Assessment, Development and Evaluation (GRADE) criteria.” **Number of included studies:** 33 **Search limit (years):** Database inception - 2018 **Locations of included studies:** Asia, Australia, Europe, North America **Study designs:** Randomised controlled trials **Quality (systematic review):** High (9/11) **Quality appraisal tool (included studies):** Cochrane Collaboration tool for randomized controlled trials (Higgins et al., 2011). **Quality (included studies):** Included low quality/high risk of bias **Sources of funding:** Specified – Not funded **Conflict of interest:** Specified – No conflicts	**Participant Characteristics** **Number of participating children:** Not specified **Age:** 16 months – 17 years **Sex**: Not specified **Description:** autism spectrum disorder, Asperger’s syndrome, childhood disintegrative disorder (inclusion criteria) **Increased likelihood of ASD:** Not included **Other conditions:** None **Support(s):** Cognitive behavioural strategies (CBT); Social emotional NeuroScience Endocrinology (SENSE) theatre; Preschool Autism Communication Trial (PACT); Parent mediated intervention for Autism Spectrum Disorders in South Asia (PASS); Project Impact; Peer interventions; Qigong Sensory Treatment (QST); Qigong massage; Joint Attention, Symbolic Play, Engagement, and Regulation programme (JASPER); Play project; LEAP project i.e. Learning Experiences and Alternative Program for Preschoolers and Their Parents; Hanen’s more than words (HMTW) intervention program; Peer network intervention procedure; family centered music therapy; The Managing Repetitive Behaviours Programme; psychoeducation program; autism preschool program; Video-feedback Intervention to promote Positive Parenting adapted for Autism; Social ABCs; Parent mediated intervention for Autism Spectrum Disorders in South Asia (PASS) plus; enhancing

		interactions tutorial; Social Tools And Rules for Teens socialization (START); COMPASS for Hope; Program for the Education and Enrichment of Relational Skills (PEERS) curriculum; Therapeutic Outcome By You (TOBY) application. **Comparison:** Not specified **Outcomes:** General outcomes; overall autism characteristics (autism symptom severity); social-communication (social skills, joint engagement, joint attention); Restricted and repetitive interests and behaviours (repetitive behaviours); Communication; Expressive language; Receptive language; Cognitive developement (visual reception); Motor (motor skills); Social emotional/challenging behaviour (self-regulation); Adaptive behaviour; Caregiver social emotional wellbeing (parent distress, parental self-efficacy, parent-child relationship); Child satisfaction (child distress).
Nevill et al. (2018)	**Type:** Meta-analysis **Objectives:** to review "randomised clinical trials of parent-mediated interventions for children with autism spectrum disorder between the ages of 1 and 6 years and [conduct] a meta-analysis on their efficacy." **Number of included studies:** 19 **Search limit (years):** 2000 – 2015 **Locations of included studies:** Asia, Australia, Europe, North America **Study designs:** Randomised controlled trials **Quality (systematic review):** Low (7/11) **Quality appraisal tool (included studies):** Grading of Recommendations Assessment, Development and Evaluation (Guyatt et al., 2011). **Quality (included studies):** Not specified **Sources of funding:** Specified – Not funded **Conflict of interest:** Not specified	**Participant Characteristics** **Number of participating children:** 1205 (608 support, 597 comparison) **Age:** 15 – 72 months, M = 42 months **Sex**: Not specified **Description:** Autism spectrum disorder **Increased likelihood of ASD:** Not included **Other conditions:** None **Support(s):** Parent-mediated interventions - Child's Talk Project; Hanen's More than Words (HMTW); DIR/Floortime; Parent Focus Training; Joint Attention Symbolic Play Engagement and Regulation (JASPER); Pivotal Response Training (PRT); Video Intervention to promote Positive Parenting for children with Autism (VIPP-AUTI); Home-based program; Building Blocks; Focused Playtime Intervention; Play and Language for Autistic Youngsters (PLAY) Project; Preschoolers with Autism; Treatment and Education of Autistic and Related Communication Handicapped Children (TEACCH); Social Communication, Emotion Regulation, and Transactional Supports (SCERTS); Parent-mediated Communication-focused Treatment (PACT). **Comparison:** Treatment as usual, another support **Outcomes:** Overall autism characteristics (autism symptom severity); Social-communication (socialisation); Communication (language); Cognitive developement.
O'Donovan et al., 2019	**Type:** Narrative synthesis **Objectives:** "This literature review examines the existing	**Participant characteristics** **Number of participating children:** Not specified

	evidence for group-based parent training interventions that support parents of children with autism.**”** **Number of included studies:** 13 **Search limit (years):** Database inception – 2016 **Locations of included studies:** Not specified **Study designs:** Randomised controlled trial, non-randomised with comparison, non-randomised without comparison, other study designs **Quality (systematic review):** Low (6/10) **Quality appraisal tool (included studies):** The Scientific Merit Rating Scale (SMRS) (Green et al. 2009). **Quality (included studies):** Included low quality/high risk of bias **Sources of funding:** Not specified **Conflict of interest:** Specified - No conflicts	**Age:** 3 – 18 years (inclusion criteria) **Sex**: Not specified **Description:** Autism **Increased likelihood of autism:** Not included (inclusion criteria) **Other conditions:** Sleep issues, other conditions not specified **Support(s):** Group-based parent training interventions - The National Autistic Society (NAS) EarlyBird and EarlyBird Plus Programme (EBPP); ‘Understanding autism and understanding my child with autism’ (UA); TEACCH-based; Incredible Years; Generic support group; Parent management training (PMT); Sleep education workshops; ‘Riding the Rapids: Living with Autism or Disability’; Psychoeducation groups; ‘Riding the Rapids: Living with Autism or Disability’; Parent Education and Behaviour Management (PEBM)**.** **Comparison:** Wait list, treatment as usual, another support, no comparison **Outcomes:** Social emotional/ challenging behaviour (problematic behaviours); Caregiver communication and interaction (parental skills).
Ona et al. (2020)	**Type:** Meta-analysis **Objectives:** “to compile evidence examining the effectiveness of [pivotal response treatment] (PRT) on social communication, social interaction, and repetitive behaviour for children with autism spectrum disorder.” **Number of included studies:** 5 **Search limit (years):** Database inception - 2017 **Study designs:** Randomised controlled trials **Locations of included studies:** Not specified **Quality (systematic review):** Low (8/11) **Quality appraisal tool (included studies):** Modified version of the guidelines from the Cochrane Consumers and Communication Review Group (Ryan et al., 2007). **Quality (included studies):** Included low quality/high risk of bias **Sources of funding:** Not specified **Conflict of interest:** Specified – No conflicts	**Participant Characteristics** **Number of participating children:** 181 (91 support, 90 comparison) **Age:** 2.4 - 9.2 years, M = 5.3 years **Sex**: Not specified **Description:** Autism spectrum disorder **Increased likelihood of ASD:** Not included **Other conditions:** None **Support(s):** Pivotal Response Treatment (PRT). **Comparison:** Wait list, treatment as usual, another support **Outcomes:** Communication; Expressive language.
Oono et al. (2013)	**Type:** Meta-analysis **Objectives: “**To assess the effectiveness of parent-mediated early interventions in terms of the benefits for both children with autism spectrum disorder (ASD) and their parents and to explore some potential moderators of treatment effect.”	**Participant Characteristics** **Number of participating children:** 919 **Age:** 17 months – 6 years **Sex**: Not specified **Description:** Autism, autism spectrum disorder

	Number of included studies: 17 narrative synthesis; 10 meta-analysis. **Search limit (years):** 2002 – 2012 **Locations of included studies:** Asia, Australia, Europe, North America **Study designs:** Randomised controlled trials **Quality (systematic review):** High (11/11) **Quality appraisal tool (included studies):** Cochrane Collaboration tool for assessing risk of bias (Higgins 2011). **Quality (included studies):** Not specified **Sources of funding:** Specified – Funded **Conflict of interest:** Specified – No conflicts	**Increased likelihood of ASD:** Not included **Other conditions:** None **Support(s):** Parent mediated interventions – Developmental Individual-Difference Relationship-Based (DIR) techniques; massage intervention; management of challenging behaviour; early intensive behavioural intervention; Pivotal Response Treatment (PRT). **Comparison:** Wait list, treatment as usual, another support, other comparison group **Outcomes:** Overall autism characteristics (severity of autism characteristics); Social-communication (shared or joint attention, child initiations); Communication (communication, joint language); Expressive language (expression); Receptive language (comprehension); Cognitive (developmental/intellectual gains); Social-emotional development (maladaptive behaviour); Adaptive behaviour; Caregiver communication and interaction (parental synchrony); Caregiver social emotional wellbeing (parents' level of stress, parental confidence).
Parsons, Cordier, Munro et al. (2017)	**Type:** Meta-analysis **Objectives:** "to conduct a systematic review and meta-analysis of pragmatic language interventions for children with autism spectrum disorder (ASD)." **Number of included studies:** 21 narrative synthesis; 15 meta-analysis **Search limit (years):** Database inception - 2016 **Locations of included studies:** Asia, Australia, Europe, North America **Study designs:** Randomised controlled trials **Quality (systematic review):** Low (7/10) **Quality appraisal tool (included studies):** Standard quality assessment (Kmet et al. 2004). **Quality (included studies):** Included low quality/high risk of bias **Sources of funding:** Specified – Not funded **Conflict of interest:** Specified – No conflicts	**Participant Characteristics** **Number of participating children:** 925 **Age:** 21 months – 14 years **Sex**: Not specified **Description:** Autism spectrum disorder **Increased likelihood of ASD:** Not included **Other conditions:** None **Support(s):** Pragmatic language interventions - The Junior detective Program; Milton and Ethel Harris Research Initiative Treatment (MEHRIT); Building Blocks Program; Social Emotional NeuroScience Endocrinology (SENSE) theatre; Social Skills Group Intervention- High Functioning Autism; FindMe App; Therapeutic Horse Riding; FaceSay; Joint Attention, Symbolic Play, Engagement, and Regulation (JASPER); Improvisational music therapy; SummerMAX; Mind Reading; Skillstreaming; Emotion Recognition Training; Seaver-NETT. **Comparison:** Wait list, treatment as usual, another support **Outcomes:** Social-communication (pragmatic language).
Parsons, Cordier, Vaz et al. (2017)	**Type:** Narrative synthesis **Objectives:** "to (1) systematically review the existing evidence presented by studies on parent-mediated intervention training, delivered remotely for parents having children with autism spectrum disorder and living outside of urban areas; (2) provide an overview of current parent training interventions used with	**Participant Characteristics** **Number of participating children:** Not specified **Age:** 0 - < 18 years (inclusion criteria) **Sex**: Not specified **Description:** Autism spectrum disorder **Increased likelihood of ASD:** Not included

	this population; (3) and provide an overview of the method of delivery of the parent training interventions used with this population." **Number of included studies:** 7 **Search limit (years):** 2014 – 2016 **Locations of included studies:** Australia, North America **Study designs:** Randomised controlled trials, non-randomised with comparison, non-randomised without comparison, single-case experimental designs **Quality (systematic review):** High (9/11) **Quality appraisal tool (included studies):** Standard quality assessment (Kmet et al. 2004). **Quality (included studies):** Included moderate quality/moderate risk of bias **Sources of funding:** Specified – Not funded **Conflict of interest:** Specified – No conflicts	**Other conditions:** None **Support(s):** Parent-mediated interventions delivered remotely - Web-based training in behavioural interventions; Online and Applied System for Intervention Skills (OASIS) training intervention Research-to-practice; Improving Parents as Communication Teachers (ImPACT) on the Web; Implementation discrete-trial instructions using video training materials; Parent Early Start Denver Model (P-EDSM) training; Functional communication training. **Comparison:** Another support, the individual's own baseline, no comparison group **Outcomes:** Caregiver communication and interaction (parental knowledge acquisition).
Pi et al. (2021)	**Type:** Meta-analysis **Objectives:** "This meta-analysis aimed to examine the effectiveness of technology-based interventions in assisting parents to deliver interventions for their children with ASD based only on RCTs." **Number of included studies:** 16 **Search limit (years):** Database inception – 2021 **Locations of included studies:** Asia, Australia, Europe, North America **Study designs:** Randomised controlled trials **Quality (systematic review):** Low (8/11) **Quality appraisal tool (included studies):** Standards set by Reichow et al. (Reichow et al., 2008). **Quality (included studies):** Included low quality/high risk of bias **Sources of funding:** Specified - Not funded **Conflict of interest:** Specified – No conflicts	**Participant characteristics** **Number of participating children:** 748 **Age:** 0 – 12 years (inclusion criteria) **Sex**: 68 – 100% male **Description:** Autism spectrum disorder, high-functioning autism spectrum disorder **Increased likelihood of autism:** Not included **Other conditions:** Not specified **Support(s):** Technology assisted parent-mediated intervention - App-based interventions, online/web based, computer based, DVD-based. **Comparison:** Wait list, treatment as usual, another support **Outcomes:** Social-communication (social-communication; socialisation); Language (language total score, gestures); Expressive language (expressive speech); Receptive language.
Postorino et al. (2017)	**Type:** Meta-analysis **Objectives:** to summarise "the essential elements of parent training (PT) for disruptive behaviour in children with autism spectrum disorder (ASD) and [evaluate] the available evidence for parent training using both descriptive and meta-analytic procedures."	**Participant Characteristics** **Number of participating children:** 653 (343 support, 310 comparison) **Age:** 2 – 14 years **Sex**: 76.9 – 87.8% male **Description:** Autism spectrum disorder

	Number of included studies: 8 **Search limit (years):** 1980 – 2016 **Locations of included studies:** Australia, North America **Study designs:** Randomised controlled trials, non-randomised with comparison **Quality (systematic review):** Low (7/11) **Quality appraisal tool (included studies):** Cochrane risk of bias assessment tool (Higgins 2013). **Quality (included studies):** Included low quality/high risk of bias **Sources of funding:** Not specified **Conflict of interest:** Specified – Conflict	**Increased likelihood of ASD:** Not included **Other conditions:** None **Support(s):** Parent training for disruptive behaviour. **Comparison:** Wait list, treatment as usual, another support, other comparison group **Outcomes:** Social-emotional development (disruptive behaviour).
Reichow et al. (2018)	**Type:** Meta-analysis **Objectives: "**to systematically review the evidence for the effectiveness of early intensive behavioural intervention (EIBI) in increasing functional behaviours and skills, decreasing autism severity, and improving intelligence and communication skills for young children with autism spectrum disorder (ASD)." **Number of included studies:** 5 **Search limit (years):** Database inception - 2017 **Locations of included studies:** Europe, North America **Study designs:** Randomised controlled trials, non-randomised with comparison **Quality (systematic review):** High (11/11) **Quality appraisal tool (included studies):** Cochrane Collaboration's tool for assessing risk of bias (Higgins, 2017). **Quality (included studies):** Not specified **Sources of funding:** Specified – Funded **Conflict of interest:** Specified – Conflict	**Participant Characteristics** **Number of participating children:** 219 (116 support, 103 comparison) **Age:** 0 - <6 years (inclusion criteria), M range = 30.2 – 42.5 months **Sex**: Not specified **Description:** Autism spectrum disorder, autistic disorder, pervasive developmental disorder not otherwise specified **Increased likelihood of ASD:** Not included **Other conditions:** None **Support(s):** Early intensive behavioural intervention (EIBI). **Comparison:** Treatment as usual, another support **Outcomes:** Overall autism characteristics (autism symptoms); Social-Communication (social competence); Communication; Expressive language; Receptive language; Cognitive development (intelligence quotient); Social-emotional/ challenging behaviour (problem behaviour); Adaptive behaviour (adaptive behaviour, daily living skills).
Rodgers et al. (2020)	**Type:** Meta-analysis **Objectives:** "To evaluate the clinical effectiveness and cost-effectiveness of early intensive applied behaviour analysis-based interventions for autistic children based on current evidence." **Number of included studies:** 20 **Search limit (years):** Database inception – 2017 **Locations of included studies:** Asia, Australia, Europe, North America	**Participant characteristics** **Number of participating children:** 669 **Age:** Med. = 37.4 months **Sex**: M = 86% male **Description:** autism, autism spectrum disorder, pervasive developmental disorder not otherwise specified **Increased likelihood of autism:** Not included **Other conditions:** Cognitive impairment

	Study designs: Randomised controlled trial; non-randomised with comparison **Quality (systematic review):** High (10/11) **Quality appraisal tool (included studies):** Cochrane Risk of Bias 2.0 tool; Risk Of Bias In Non-randomised Studies – of Interventions (ROBINS-I) tool. **Quality (included studies):** Not specified **Sources of funding:** Specified - Funded **Conflict of interest:** Specified – No conflicts	**Support(s):** Early intensive applied behaviour analysis. **Comparison:** Treatment as usual, another support **Outcomes:** Overall autism characteristics (autism symptom severity); Cognitive development (cognitive ability); Adaptive behaviour.
Sandbank et al. (2020)	**Type:** Meta-analysis **Objectives:** to review "group design studies of non-pharmacological early interventions designed for young children with autism spectrum disorder (ASD)." **Number of included studies:** 130 **Search limit (years):** Not specified **Locations of included studies:** Not specified **Study designs:** Randomised controlled trials, non-randomised with comparison **Quality (systematic review):** High (10/11) **Quality appraisal tool (included studies):** Cochrane Collaboration's tool for assessing risk of bias (Higgins, 2011), plus additional indicators proposed by Yoder et al. (2013). **Quality of studies:** Not specified **Sources of funding:** Specified – Funded **Conflict of interest:** Specified – Conflict	**Participant Characteristics** **Number of participating children:** 6240 **Age:** 0 – 8 years, M = 54.21 months **Sex**: M = 84% male **Description:** Autism spectrum disorder (inclusion criteria) **Increased likelihood of ASD:** Not included **Other conditions:** None **Support(s):** Animal-assisted therapy - Canine Assistance; Presence of a Therapeutic Service Dog; Therapeutic Horseback Riding. Behavioural - Behavioral Parent Training; Discrete Trial Training with Motor Vocal Imitation Assessment; Early Intensive Behavioral Treatment; Functional Behavior Skills Training; Home-based behavioral treatment; Home-based Early Intensive Behavioral; Intervention (EIBI); Intensive Applied Behaviour Analysis (ABA); Intensive Early Intervention; Low Intensity Behavioral Treatment; Managing Repetitive Behaviors; Picture Exchange Communication System (PECS); Peer-Mediated Intervention; Rapid Motor Imitation Antecedent; Regular Intensive Learning for Young Children with Autism; Schedules, Tools, and Activities for Transitions (STAT); Social Skills Group; Stepping Stones Triple P Positive Parenting Program; Strategies for Teaching Based on Autism Research (STAR). Developmental - Adapted Hanen More Than Words; Developmental, Individual-Difference, Relationship-Based (DIR)-Floortime; Hanen More Than Words; Joint Attention Mediated Learning (JAML); MEHRIT (Milton and Ethel Harris Research Initiative Treatment); Parent-Mediated Communication Focused Treatment; Parent-mediated intervention for autism spectrum disorder in South Asia (PASS); Play and Language For Autistic Youngsters (PLAY)/ DIR Floortime; Scottish Early Intervention Program; Social Communication Intervention for Children with Autism and Pervasive Developmental Disorder; Video-feedback Intervention to Promote Positive Parenting

		adapted to autism (VIPP-AUTI). Naturalistic developmental behavioural intervention (NDBI) - Advancing Social-Communication and Play (ASAP); Caregiver-based intervention program in community day-care centers; Denver Model; Early Social Interaction Project (SCERTS); Early Start Denver Mode (ESDM); Home-based Building Blocks Program; home-based intervention program; ImPACT Online; Interpersonal Synchrony; Joint Attention Intervention Joint Attention Symbolic Play Engagement Regulation (JASPER); Joint Engagement Intervention; Joint Engagement Intervention with Creative Movement Therapy; Parent-Early Start Denver Model (P-ESDM); Parent-training intervention; Pivotal Response Treatment (PRT); Reciprocal Imitation Training; Social ABCs Cognitive behaviour therapy (CBT). Sensory based - Developmental Speech and Language Training through Music; Family-Centered Music Therapy; Improvisational Music Therapy; Music Therapy; Qigong (QST) Massage Treatment; Qigong Massage Treatment; Rhythm Intervention Sensorimotor Enrichment; Sensory Enrichment; Thai Traditional Massage; Tomatis Sound Therapy; Vestibular Stimulation via a Platform Swing. Technology based - ABRACADABRA; Emotiplay Serious Game; FaceSay; FindMe iPad App; Gaming Open Library for Intervention in Autism at Home (GOLIAH); Gaze-contingent attention training; Social Skills Training using a robotic behavioral intervention system;The Transporters animated series; Therapy Outcomes By You (TOBY) App; Transporters DVD; Transporters Program for Children with Autism. Treatment and Education of Autistic and related Communications Handicapped Children (TEACCH) Other - "Autism 123"; Balance Training Intervention; Circle of Friends; Cognitive Method; Colloborative Model for Promoting Competence and Success (COMPASS); Comprehensive Inclusion Program; Group Psychoeducational Program for Mothers; Home-based intervention; Hyperbaric Oxygen Therapy; Individual Parent Sleep Education; Interactive Book Reading; LEAP (Learning Experiences and Alternative Program for Preschoolers); NeuroModulation Technique (NMT); Outdoor Adventure Program; Parent Education and Counselling (PEAC); Parent-Child Interaction Therapy (PCIT) or Child-directed interaction therapy (CDIT); Positive Family Intervention (Positive Behavior Support +parent optimism training); Primary Care Stepping Stones Triple P; Professionally supported intervention; Psychoeducation

		Intervention; Psychomotor Intervention Program; Reading Mastery; Sleep Education Pamphlet; Sung computer-based intervention; Thought-bubble Training for Theory of Mind; Water Exercise Swimming Program. **Comparison:** Not specified **Outcomes:** Overall autism characteristics (diagnostic characteristics); Restricted and repetitive interests and behaviours; Social-Communication; Communication (language); Cognitive development; Motor; Social-emotional development; Adaptive behaviour; Play.
Sandgreen et al. (2021)	**Type:** Meta-analysis **Objectives: "**This study aimed to review digital interventions in the treatment of autism spectrum disorder (ASD).**"** **Number of included studies:** 19 **Search limit (years):** Not specified – 2019 **Locations of included studies:** Not specified **Study designs:** Randomised controlled trials, non-randomised with comparison **Quality (systematic review):** Low (8/11) **Quality appraisal tool (included studies):** Revised Cochrane risk-of-bias tool for randomized trials (RoB 2) (Sterne et al. 2019). **Quality (included studies):** Included low quality/high risk of bias **Sources of funding:** Specified - Not funded **Conflict of interest:** Specified – No conflicts	**Participant characteristics** **Number of participating children:** 815 **Age:** No age limit (inclusion criteria) **Sex**: M = 19.5% female **Description:** Autism spectrum disorder **Increased likelihood of autism:** Not included **Other conditions:** Cognitive impairment **Support(s):** Technology-based supports - computer programs, tablet apps, robots, interactive DVD. **Comparison:** Wait list, treatment as usual, another support **Outcomes:** General outcomes.
Shi et al. (2021)	**Type:** Meta-analysis **Objectives:** "The current meta-analysis reviewed studies reporting broader outcomes in children with ASD who had ever participated in a [comprehensive treatment model] CTM and examined the predictors of developmental gains." **Number of included studies:** 18 **Search limit (years):** Database inception – 2019 **Locations of included studies:** Australia, Europe, North America **Study designs:** Randomised controlled trial, non-randomised with comparison, non-randomised without comparison, other designs **Quality (systematic review):** High (11/11) **Quality appraisal tool (included studies):** Evaluative Method for Determining Evidence-Based Practices in Autism (Reichow	**Participant characteristics** **Number of participating children:** 495 **Age:** M = 24 - 49 months **Sex**: 71 - 95% male **Description:** autism, autism spectrum disorder, autism disorder, pervasive developmental disorder pervasive developmental disorder not otherwise specified **Increased likelihood of autism:** Not included **Other conditions:** Cognitive impairment **Support(s):** Early intensive behavioural intervention - UCLA, early start Denver model, "other" interventions. **Comparison:** Treatment as usual, another support, no comparison, other comparisons not specified **Outcomes:** Social-communication (VABS Social); Communication (VABS communication); Expressive language; Receptive language;

	et al., 2008). **Quality (included studies):** Included low quality/high risk of bias **Sources of funding:** Specified - Funded **Conflict of interest:** Specified - No conflicts	Cognitive development (IQ); Adaptive behaviour (VABS composite); Adaptive behaviour (daily living skills).
Soares et al. (2021)	**Type:** Meta-analysis **Objectives:** "The aim of this study is to conduct a meta-analysis comparing RCTs of [face-to-face social skills training] and [behavioural intervention technologies social skills training] interventions for children and adolescents with ASD to compare their efficacy." **Number of included studies:** 18 **Locations of included studies:** Asia, Australia, Europe, North America **Search limit (years):** Database inception - 2020 **Study designs:** Randomised controlled trials **Quality (systematic review):** High (9/11) **Quality appraisal tool (included studies):** Revised Cochrane Risk-of-Bias Tool for Randomized Trials (Sterne et al. 2019). **Quality (included studies):** Included moderate quality/moderate risk of bias **Sources of funding:** Not specified **Conflict of interest:** Specified – No conflicts	**Participant characteristics** **Number of participating children:** 1266 **Age:** 4 – 19 years **Sex**: 69 – 100% male **Description:** autism spectrum disorder **Increased likelihood of autism:** Not included (inclusion criteria) **Other conditions:** Not specified **Support(s):** Technology-based - Social skills training **Comparison:** Wait list, treatment as usual, another support **Outcomes:** Social-communication (social functioning).
Sutherland et al. (2018)	**Type:** Narrative synthesis **Objectives:** "to examine the nature and outcomes of studies examining telehealth assessment and/or intervention in autism spectrum disorder (ASD)." **Number of included studies:** 14 **Search limit (years):** Database inception - 2016 **Locations of included studies:** North America **Study designs:** Randomised controlled trials, single-case experimental designs, other **Quality (systematic review):** Low (7/10) **Quality appraisal tool (included studies):** Scientific Merit Rating Scale (SMRS; National Autism Center, 2015). **Quality (included studies):** Included low quality/high risk of bias **Sources of funding:** Not specified **Conflict of interest:** Specified – No conflicts	**Participant Characteristics** **Number of participating individuals:** 284 **Age:** 19 months – upper age not specified **Sex**: Not specified **Description:** Autism, autism spectrum disorder, pervasive developmental disorder not otherwise specified **Increased likelihood of ASD:** Not included **Other conditions:** None **Support(s):** Telehealth - Program Improving Parents as Communication Teachers (imPACT); internet-based Parent Implemented Communication Strategies (iPICS); general communication intervention; imitation training; Telehealth diagnostic services; 'Telehealth Facing Your Fears' Intervention'; functional behaviour assessment and functional communication training; school age intervention using web-based education; language intervention. **Comparison:** Wait list, treatment as usual, another support, the individual's own baseline, no comparison group

		Outcomes: Caregiver satisfaction (satisfaction and acceptability); Caregiver communication and interaction (fidelity).
Tachibana et al. (2018)	**Type:** Meta-analysis **Objectives:** "to investigate the effectiveness of individual and group interventions for children with autism spectrum disorder (ASD) and to compare the effectiveness of these two types if possible." **Number of included studies:** 30 studies analysis II, IV; 14 studies Analysis I and III **Search limit (years):** Not Specified – 2014 **Study designs:** Randomised controlled trials **Locations of included studies:** Asia, Australia, Europe, North America **Quality (systematic review):** High (11/11) **Quality appraisal tool (included studies):** Cochrane Collaboration's Tool for Assessing Risk of Bias (Higgins et al., 2011). **Quality (included studies):** Included moderate quality/moderate risk of bias **Sources of funding:** Specified – Funded **Conflict of interest:** Specified – No conflicts	**Participant Characteristics** **Number of participating children:** 1220 **Age:** 1 – 6 years **Sex:** Not specified **Description:** Autism, autism spectrum disorder **Increased likelihood of ASD:** Not included **Other conditions:** None **Support(s):** Social communication supports - Hanen's More Than Words; Early Start Denver Model (ESDM); Parent training; Joint Attention Symbolic Play Engagement and Regulation (JASPER); Preschool Autism Communication Trial (PACT); Treatment and Education of Autistic and related Communications Handicapped Children (TEACCH)-based group social skills; Reciprocal Imitation Training; Caregiver-based intervention program in community day-care centers; Preschool-based joint attention intervention; Caregiver Mediated Joint Engagement Intervention; Improvisational music therapy; intervention targeting development of socially synchronous engagement; Developmental, Individual-Difference, Relationship-Based(DIR)/ Floortime intervention; Functional Behavior Skills Training (FBST); Building Blocks; Parent delivery of the Early Start Denver Model (P-ESDM); Joint Attention Mediated Learning (JAML) intervention; Focused Playtime Intervention (FPI); Education and Skills Training Program for Parents; Parent education and behaviour management (PEBM) Skills training intervention or comparison for the non-specific aspects of the PEBM parent education and counselling intervention; Home TEACCHing Program. **Comparison:** Wait list, treatment as usual, another support **Outcomes:** Overall autism characteristics (autism general symptoms); Social-communication (qualitative impairment in social interaction, reciprocity of social interaction towards others, responding to joint attention, initiating joint attention; imitation); Restricted and repetitive interests and behaviours (restricted repetitive and stereotyped patterns, behaviours, interests and activities); Communication (qualitative impairment in communication); Expressive language; Receptive language; Cognitive development (developmental quotient); Adaptive behaviour; Caregiver communication and interaction (parental synchrony); Caregiver social emotional wellbeing (parenting stress).

Tan-MacNeill et al. (2021)	**Type:** Narrative synthesis **Objectives:** This systematic review identified and evaluated the quality of evidence for the efficacy of online parent-implemented interventions for children with Autism Spectrum Disorder (ASD), Attention-Deficit/Hyperactivity Disorder (ADHD), Cerebral Palsy (CP), and Fetal Alcohol Spectrum Disorder (FASD). **Number of included studies:** 17 (9 autism-specific) **Search limit (years):** Database inception – 2020 **Locations of included studies:** Not specified **Study designs:** Randomised controlled trial, non-randomised with comparison, non-randomised without comparison, single case experimental design **Quality (systematic review):** High (8/10) **Quality appraisal tool (included studies):** Quality index for randomized and non-randomized studies proposed by Downs and Black (1998). **Quality (included studies):** Not specified **Sources of funding:** Specified - Funded **Conflict of interest:** Specified – No conflicts	**Participant characteristics** **Number of participating children:** Not specified **Age:** 20 months – 16 years **Sex**: Not specified **Description:** Autism spectrum disorder **Increased likelihood of autism:** Not specified **Other conditions:** Attention deficit hyperactivity disorder, sleep issues, anxiety, language delay, cognitive impairment, sensory processing, learning disability, epilepsy, oppositional defiant disorder, disruptive behaviour disorder, Tourette Syndrome, conduct disorder. **Support(s):** Online parent implemented interventions - ImPACT online, POWR Online Communication Training; Pivotal response treament (PRT); enhancing interactions; reciprocal imitation training (RIT); ABA Web-Based Training; Enhancing Interactions; FASD Education and Training; Triple P online (TPOL); Project CHASE (children with autism supported to exercise); parent sleep education intervention; promoting engagement for ADHD pre-Kindergarteners (PEAK), blended behavioural parent training (BPT). **Comparison:** Wait list, another support, the individual's own baseline, no comparison, other comparisons not specified **Outcomes:** Social-communication (communication behaviours and language targets).
Tarver et al. (2019)	**Type:** Meta-analysis **Objectives:** to assess the "evidence for the efficacy of behavioural parent interventions for disruptive and hyperactive child behaviour in autism spectrum disorders, as well as parenting efficacy and stress." **Number of included studies:** 11 **Search limit (years):** Database inception - 2017 **Locations of included studies:** Australia, North America **Study designs:** Randomised controlled trials **Quality (systematic review):** Low (8/11) **Quality appraisal tool (included studies):** Cochrane risk of bias tool (Higgins et al., 2011). **Quality (included studies):** Included low quality/high risk of bias **Sources of funding:** Specified – Funded **Conflict of interest:** Not specified	**Participant Characteristics** **Number of participating children:** 764 (396 supports, 368 comparison) **Age:** 2 – 14 years **Sex**: 21 – 100% male **Description:** Autism spectrum disorder, Asperger's **Increased likelihood of ASD:** Not included **Other conditions:** None **Support(s):** Behavioural parent interventions – Research Units in Behavioural Intervention (RUBI) Parent Training Manual; Child directed interaction therapy (CDIT); Compass for help (C-HOPE); Parent management training; parent-child interaction therapy (PCIT); Primary care stepping stones Tripe P (PCSSTP); Stepping stones triple P (SSTP). **Comparison:** Wait list, treatment as usual, another support, other comparison group

		Outcomes: Social-emotional development; Caregiver social emotional wellbeing (parenting stress, parenting efficacy).
Tiede & Walton (2019)	**Type:** Meta-analysis **Objectives:** to conduct "a meta-analysis of outcomes of group-design studies testing interventions using naturalistic developmental behavioural intervention strategies [for children with autism spectrum disorder]." **Unique included studies:** 27 **Search limit (years):** Not Specified – 2018 **Locations of included studies:** Not specified **Study designs:** Randomised controlled trials, non-randomised with comparison (inclusion criteria) **Quality (systematic review):** High (10/11) **Quality appraisal tool (included studies):** Evaluative Method for Determining Evidence-Based Practice in Autism (Reichow et al., 2008). **Quality (included studies):** Included low quality/high risk of bias **Sources of funding:** Specified – Not funded **Conflict of interest:** Not specified	**Participant characteristics** **Number of participating children:** Not specified **Age:** Mean age < 6 (inclusion criteria) **Sex**: Not specified **Description:** Autism spectrum disorder (inclusion criteria) **Increased likelihood of ASD:** Eligible (inclusion criteria) **Other conditions:** None **Support(s):** Naturalistic Developmental Behavioural Interventions - Early Start Denver Model (ESDM); Early Social Interaction Project (ESI); intervention emphasizing joint attention and imitation skill-building (JA/Imitation); Joint Attention, Symbolic Play, Engagement, and Regulation (JASPER); Learning Experiences Alternative Program (LEAP); Pivotal Response Treatment (PRT); Reciprocal Imitation Training (RIT); Focus parent training program; parent training. **Comparison:** Not specified **Outcomes:** Overall autism characteristics (symptoms of ASD); Social-communication (joint attention, social engagement); Expressive language; Receptive language; Cognitive development (cognitive development, non-verbal IQ); Play; Adaptive behaviour.
Trzmiel et al. (2019)	**Type:** Meta-analysis **Objectives:** "to assess the effectiveness of Equine-Assisted Activities and Therapies (EAAT) in autism spectrum disorder (ASD) patients." **Number of included studies:** 15 narrative synthesis; 3 meta-analysis **Search limit (years):** 2000 – 2017 **Locations of included studies:** Not specified **Study designs:** Not specified **Quality (systematic review):** Low (7/11) **Quality appraisal tool (included studies):** Quality Assessment Tool for Quantitative Studies (QATQS; National Collaborating Centre for Methods and Tools, 2008). **Quality (included studies):** Included low quality/high risk of bias **Sources of funding:** Not specified **Conflict of interest:** Specified – No conflicts	**Participant Characteristics** **Number of participating children:** 390 **Age:** 3 – 16 years, M range = 5.14 – 10.2 years **Sex**: M = 79% male, 21% female **Description:** Autism spectrum disorder **Increased likelihood of ASD:** Not included **Other conditions:** None **Support(s):** Equine-assisted therapy - hippotherapy, therapeutic riding. **Comparison:** Not specified **Outcomes:** Social-communication (social); Communication; Adaptive behaviour.
Tupou et al. (2019)	**Type:** Narrative synthesis **Objectives:** "to identify studies involving the provision of early	**Participant characteristics** **Number of participating children:** 809 (517 support,

	intervention to children with autism spectrum disorder (ASD) who were attending inclusive preschool settings. We also sought to appraise the quality of the identified studies and evaluate their effects on child outcomes. The strategies used in training teaching staff to implement these interventions with fidelity were a particular focus of the review as well." **Number of included studies:** 16 **Search limit (years):** 2000 – 2017 **Locations of included studies:** Not specified **Study designs:** Randomised controlled trials, non-randomised with comparison, non-randomised without comparison, single-case experimental designs **Quality (systematic review):** High (9/10) **Quality appraisal tool (included studies):** Modified version of Goldstein et al.'s (2014) framework. **Quality (included studies):** Included low quality/high risk of bias **Sources of funding:** Specified – Funded **Conflict of interest:** Specified – No conflicts	292 comparison) **Age:** 12 – 72 months (inclusion criteria), M = 46 months **Sex**: Not specified **Description:** Autism/autism spectrum disorder, pervasive developmental disorder not otherwise specified, Asperger's syndrome **Increased likelihood of ASD:** Included **Other conditions:** None **Support(s):** Comprehensive treatment programmes - Developmentally Appropriate Treatment for Autism (DATA); Treatment and Education of Autistic and Related Communication Handicapped Children (TEACCH); Early Intensive Behavioural Intervention (EIBI); Learning Experiences and Alternative Program for Preschoolers (LEAP); Comprehensive Autism Program (CAP); EIBI intervention described as being based on Lovaas' UCLA model. Skills focused interventions targeting - communication, play skills, peer interaction, and reading skills. **Comparison:** Not specified **Outcomes:** Overall autism characteristics (autism severity and/or symptoms); Social-communication (social skills); Communication (communication and/or language); Social-emotional development (adaptive/maladaptive behaviour); Adaptive behaviour (functional skills).
Valentine et al. (2020)	**Type:** Narrative synthesis **Objectives:** "This review provides an evidence map describing how technology is implemented in the assessment/diagnosis and monitoring/ treatment of NDD." **Number of included studies**: 47 (32 autism-specific) **Search limit (years):** 2014 – 2019 **Locations of included studies:** Not specified **Study designs:** Randomised controlled trial, non-randomised with comparison, single case experimental designs, other designs **Quality (systematic review):** High (9/10) **Quality appraisal tool (included studies):** Oxford Centre for Evidence Based Medicine (OCEBM) **Quality (included studies):** Included low quality/high risk of bias **Sources of funding:** Specified – Funded **Conflict of interest:** Specified – Conflicts	**Participant characteristics** **Number of participating children:** Not specified **Age:** 17 months – 44 years **Sex**: Not specified **Description:** All autism spectrum disorders included pervasive Developmental delay not otherwise specified and Retts **Increased likelihood of autism:** Not specified **Other conditions:** Attention deficit hyperactivity disorder, anxiety, cognitive impairment, communication disorders, specific learning disorder, oppositional defiance disorder/conduct disorder **Support(s):** Technology-assisted - tablet, Mobile App, Gaming, Video/DVD/Video modelling, Robots, Virtual Reality**.** **Comparison:** Wait list, treatment as usual, the individual's own baseline, no comparison, other comparisons not specified **Outcomes:** General outcomes (clinical effectiveness).

Verschuur et al. (2014)	**Type:** Narrative synthesis **Objectives:** "to analyse the research on [Pivotal Responses Treatment] (PRT) in order to (a) document the range of skills that have been targeted for improvement with PRT, (b) assess the success of PRT for improving the skills of children with autism spectrum disorder (i.e., pivotal skills and untargeted skills), (c) assess the success of PRT for improving the skills of caregivers and staff, (d) evaluate the certainty of evidence arising from these studies, (e) identify limitations of the existing evidence base, and (f) suggest directions for future research." **Number of included studies:** 43 **Search limit (years):** Database inception – 2013 **Locations of included studies:** Not specified **Study designs:** Randomised controlled trials, non-randomised with comparison, non-randomised without comparison, single-case experimental designs, other **Quality (systematic review):** Low (6/10) **Quality appraisal tool (included studies):** Certainty of evidence rated using the classification system described by Lang et al. (2012), Palmen et al. (2012), Ramdoss et al. (2011) and Ramdoss et al. (2012). **Quality (included studies):** Included low quality/high risk of bias **Sources of funding:** Not specified **Conflict of interest:** Specified – No conflicts	**Participant characteristics** **Number of participating children:** 420 **Age:** 1 – 12 years, 7 months, M = 4 years, 7 months **Sex**: M = 71% male, 15.4% female, remainder not reported **Description:** Autism spectrum disorder, autism, pervasive developmental disorder not otherwise specified, Asperger's syndrome. **Increased likelihood of ASD:** Included **Other conditions:** None **Support(s):** Pivotal Response Treatment (PRT); Natural Language Paradigm; facilitated social play training; and socio-dramatic play training. **Comparison:** Wait list, another support, the individual's own baseline, no comparison group **Outcomes:** General outcomes (child behaviours); Caregiver social emotional wellbeing (caregiver behaviours).
Waddington et al. (2021)	**Type:** Narrative synthesis **Objectives: "**This systematic literature review examined the effects of Joint Attention, Symbolic Play, Engagement, and Regulation (JASPER) intervention and its components on child, parent and educator outcomes." **Number of included studies:** 19 **Search limit (years):** 2006 – 2020 **Locations of included studies:** Europe, North America **Study designs:** Randomised controlled trials **Quality (systematic review):** High (9/10) **Quality appraisal tool (included studies):** Quality indicators outlined by the Council of Exceptional Children (Cook et al., 2015). **Quality (included studies):** Not specified	**Participant characteristics** **Number of participating children:** 619 (346 support, 273 comparison) **Age:** M = 30 – 60 months **Sex**: Not specified **Description:** Autism spectrum disorder, pervasive developmental disorder not otherwise specified **Increased likelihood of autism:** Included **Other conditions:** Minimally verbal, other conditions not specified **Support(s):** Joint Attention, Symbolic Play, Engagement, and Regulation (JASPER) intervention. **Comparison:** Wait list, treatment as usual, another support **Outcomes:** Overall autism characteristics (core characteristics of ASD); Social-communication (joint attention and engagement);

	Sources of funding: Specified – Funded **Conflict of interest:** Specified – No conflicts	Communication (child communication skills); Expressive language (overall expressive language); Receptive language; Play.
Wang et al. (2021a)	**Type:** Meta-analysis **Objectives:** "To examine and analyse the intervention effects of the Early Start Denver Model (ESDM) on children with autism spectrum disorder (ASD)." **Number of included studies:** 11 **Search limit (years):** Not specified – 2020 **Locations of included studies:** Asia, Australia, North America **Study designs:** Randomised controlled trials **Quality (systematic review):** Low (8/11) **Quality appraisal tool (included studies):** Cochrane risk of bias **Quality (included studies):** Included high quality **Sources of funding:** Specified - Funded **Conflict of interest:** Specified - No conflicts	**Participant characteristics** **Number of participating children:** 624 **Age:** M = 1.72 – 3.96 years **Sex**: Not specified **Description:** Not specified **Increased likelihood of autism:** Not specified **Other conditions:** Not specified **Support(s):** Early Start Denver Model. **Comparison:** Not specified **Outcomes:** Overall autism characteristics (autism symptoms); Social-communication; Communication (language); Cognitive development (cognition).
Wang et al. (2021b)	**Type:** Meta-analysis **Objectives:** To evaluate the effectiveness of [cognitive behavioural therapy] on the symptoms of ASD and social-emotional problems in children or adolescents with ASD by using a meta-analytic approach. **Number of included studies:** 51 **Search limit (years):** Database inception – 2019 **Locations of included studies:** Asia, Australia, Europe, North America **Study designs:** Randomised controlled trials, other designs **Quality (systematic review):** High (9/11) **Quality appraisal tool (included studies):** the Jadad scale (Jadad et al., 1996) **Quality (included studies):** Included low quality/high risk of bias **Sources of funding:** Specified – Not funded **Conflict of interest:** Specified – No conflicts	**Participant characteristics** **Number of participating children:** 2485 **Age:** 0 – 17 years (inclusion criteria) **Sex**: Not specified **Description:** Autism spectrum disorder **Increased likelihood of autism:** Not included **Other conditions:** Not specified **Support(s):** Cognitive behavioural therapy. **Comparison:** Not specified **Outcomes:** Overall autism characteristics (symptoms related to ASD); Social emotional/challenging behaviour (symptoms of social-emotional problems).
Zheng et al. (2021)	**Type:** Meta-analysis **Objectives:** "We synthesized current research evidence on the PEERS program to evaluate the treatment effect on four commonly used outcome measures." **Number of included studies:** 12 **Search limit (years):** 2000 – 2020	**Participant characteristics** **Number of participating children:** 441 (245 intervention, 196 comparison) **Age:** 11 – 21 years (M = 12.9 – 18.8 years) **Sex**: 64 – 93% male **Description:** Autism spectrum disorder **Increased likelihood of autism:** Not included **Other conditions:** Cognitive impairment, other conditions not

	Locations of included studies: Asia, North America **Study designs:** Randomised controlled trials, non-randomised without comparison **Quality (systematic review):** Low (8/11) **Quality appraisal tool (included studies):** an adapted version of Risk of Bias In Non-Randomized Studies-of Interventions (ROBINS-I) **Quality (included studies):** Included low quality/high risk of bias **Sources of funding:** Not specified **Conflict of interest:** Specified – No conflicts	specified **Support(s):** UCLA Program for the Education and Enrichment of Relational Skills (PEERS). **Comparison:** Wait list, another support, no comparison **Outcomes:** Social-communication.

Footnote: "(inclusion criteria)" indicates that the given information was taken from the SR inclusion criteria as it was not possible to determine based on the included studies; "number of included studies" refers to the number of studies included in overall analysis within each SR; "quality of included studies" refers to the overall quality of all studies included in the SR; "M" indicates mean age; M range indicates the range of mean ages (minimum – maximum) reported by SR authors; "increased likelihood of autism" refers to whether or not individuals with an increased likelihood of autism, but without an autism diagnosis, were eligible for inclusion, or included, in the SR; the names of all supports were taken verbatim from each SR; "Outcomes ()" the first term refers to the outcome categories defined for this umbrella review, the term in parenthesis refers to the author's term(s) for the outcome, where there is no term in brackets, the systematic review author's outcome classification matched that of the current umbrella review.

National guideline for supporting the learning, participation, and wellbeing of autistic children and their families in Australia

Appendix 5.9	Umbrella review - Summary of findings from practice/category-focused systematic reviews

Appendix 5.9 - Umbrella review - Summary of findings from practice/category-focused systematic reviews

Behavioural Supports

	Characteristics of supports included in the systematic review	Findings from the systematic review	Study designs	Quality (systematic review)
Systematic reviews at the category level				
Sandbank et al. (2020)	**Label:** Behavioural supports. **Setting:** Not specified. **Format:** Not specified. **Agent:** Not specified. **Mode:** Not specified. **Amount of support:** Not specified. **Practices:** Behavioral Parent Training; Discrete Trial Training with Motor Vocal Imitation Assessment; Early Intensive Behavioral Treatment; Functional Behavior Skills Training Home-based behavioral treatment; Home-based Early Intensive Behavioral Intervention (EIBI); Intensive ABA; Intensive Early Intervention; Low Intensity Behavioral Treatment; Managing Repetitive Behaviors; Picture Exchange Communication System (PECS); Peer-Mediated Intervention; Rapid Motor Imitation Antecedent; Regular	**Overall autism characteristics (diagnostic characteristics): Positive pooled effect*.** **Social-communication: Positive pooled effect*.** **Communication (language): Positive pooled effect*.** **Cognitive development: Positive pooled effect*.** **Motor: Positive pooled effect*.** **Social-emotional development: Positive pooled effect*.** **Adaptive behaviour: Positive pooled effect*.** **Adverse effects:** Not reported.	RCTs, non-randomised with comparison	High (10/11)

	Intensive Learning for Young Children with Autism; Schedules, Tools, and Activities for Transitions (STAT); Social Skills Group; Stepping Stones Triple P Positive Parenting Program; Strategies for Teaching Based on Autism Research (STAR).			
Systematic reviews at the practice level				
Early Intensive Behavioural Intervention (EIBI)				
Reichow et al. (2018)	**Setting:** Not specified. **Format:** Individual. **Agent:** Not specified. **Mode:** Face-to-face. **Amount of support:** Not specified.	**Overall autism characteristics (autism symptoms): Null pooled effect*.** **Social-Communication (social competence):** Positive pooled effect. **Communication:** Positive pooled effect. **Expressive language:** Positive pooled effect. **Receptive language:** Positive pooled effect. **Cognitive development (intelligence quotient):** Positive pooled effect. **Social-emotional development (problem behaviour): Null pooled effect*.** **Adaptive behaviour:** Positive pooled effect. **Adaptive behaviour (daily living skills):** Positive pooled effect. **Adverse effects:** Considered, and none identified.	RCTs, non-randomised with comparison	High (11/11)
Rodgers et al. (2020)	**Setting:** Clinics, homes, educational settings, other. **Format:** Individuals, groups. **Agent:** Parents/caregivers, early childhood staff, clinicians/researchers, other. **Mode:** Face-to-face. **Amount of support:** Not specified.	**Overall autism characteristics (autism symptom severity): Null pooled effect*.** **Cognitive development (cognitive ability – 1 year):** Positive pooled effect. **Cognitive development (cognitive ability – 2 years):** Positive pooled effect. **Adaptive behaviour (1 year):** Null pooled effect. **Adaptive behaviour (2 years):** Positive pooled effect.	RCTs; non-randomised with comparison	High (10/11)

		Child age: The child's age (age at recruitment) was not related to the effect of support on cognitive development or adaptive behaviour. **Cognitive development:** The child's cognitive development (IQ at baseline) was not related to the effect of support on cognitive development or adaptive behaviour. **Adaptive behaviour:** The child's adaptive behaviour (VABS at baseline) was not related to the effect of support on Cognitive development or adaptive behaviour. **Adverse effects:** Not reported.		
Shi et al. (2021)	**Setting:** Not specified. **Format:** Not specified. **Agent:** Parents/caregivers, clinicians/researchers. **Mode:** Face-to-face. **Amount of support:** Not specified.	**Social-communication (VABS Social): Positive pooled effect*.** **Communication (VABS communication): Positive pooled effect*.** **Expressive language: Null pooled effect*.** **Receptive language: Null pooled effect*.** **Cognitive development (IQ): Positive pooled effect*.** **Adaptive behaviour (VABS composite): Positive pooled effect*.** **Adaptive behaviour (daily living skills): Null pooled effect*.** **Adverse effects:** Not reported.	RCTs, non-randomised with comparison, non-randomised without comparison, other designs	High (11/11)

* This effect is presented in the summary table in Appendix 6.13 (Effect of type of support on child and family outcomes).

Developmental Supports

	Characteristics of supports included in the systematic review	**Findings form the systematic review**	**Study designs**	**Quality (systematic review)**

Systematic reviews at the category level				
Binns & Oram Cardy (2019)	**Label:** Developmental social pragmatic supports. **Setting:** Clinic, home. **Format:** Individual, group. **Agent:** Parents/caregivers, educators, clinicians/researchers. **Mode:** Face-to-face. **Amount of support:** Not specified. **Practices:** Child Talk; Hanen More than Words; Developmental Individual-Difference Relationship-Based (DIR); Milton and Ethel Harris Research Initiative Treatment (MEHRIT)-DIR based; Pediatric Autism and Communication Therapy (PACT); Joint attention mediated learning; Play and Language for Autistic Youngsters (PLAY) project - DIR based; Social communication, emotion regulation, transactional support (SCERTS).	**Social-communication (social interaction and social-communication):** Positive summarised effect. **Communication (language capacities):** Inconsistent summarised effect. **Adverse effects:** Not reported.	RCTs only	High (9/10)
Sandbank et al. (2020)	**Label:** Developmental supports. **Setting:** Not specified. **Format:** Not specified. **Agent:** Not specified. **Mode:** Not specified. **Amount of support:** Not specified. **Practices:** Adapted Hanen More Than Words; DIR-Floortime;	**Social-communication: Positive pooled effect*.** **Communication (language): Null pooled effect*.** **Adverse effects:** Not reported.	RCTs, non-randomised with comparison	High (10/11)

	Hanen More Than Words; Joint Attention Mediated Learning (JAML); MEHRIT (Milton and Ethel Harris Research Initiative Treatment); Parent-Mediated Communication Focused Treatment; Parent-mediated intervention for autism spectrum disorder in South Asia (PASS); Play and Language For Autistic Youngsters (PLAY)/DIR Floortime; Scottish Early Intervention Program; Social Communication Intervention for Children with Autism and Pervasive Developmental Disorder; Video-feedback Intervention to Promote Positive Parenting adapted to autism (VIPP-AUTI)			
Systematic reviews at the practice level				
DIR/Floortime (parent mediated only)				
Deb et al. (2020)[1]	**Setting:** Home, educational settings, other. **Format:** Individuals, groups. **Agent:** Parents/caregivers, early childhood staff, clinicians/researchers, other. **Mode:** Face-to-face, telehealth, other. **Amount of support:** Not specified.	**General Outcomes (treatment effect):** Positive pooled effect. **Adverse effects:** Not reported.	RCTs	High (9/11)

* This effect is presented in the summary table in Appendix 6.13 (Effect of type of support on child and family outcomes).

[1] This summary of findings is also presented within the 'Delivery Characteristics table' (Appendix 6.11) under 'Agent (parent-mediated, DIR/Floortime)'

Naturalistic Developmental Behavioural Interventions

	Characteristics of supports included in the systematic review	Findings form the systematic review	Study designs	Quality (systematic review)
Systematic reviews at the category level				
Tiede & Walton (2019)	**Label:** Naturalistic developmental behavioural interventions. **Setting:** Clinic, home, educational, community. **Format:** Individual. **Agent:** Parents/caregivers, educators, clinicians/researchers. **Mode:** Face-to-face. **Amount of support:** 6 – 1581 hours. **Practices:** Early Start Denver Model (ESDM); Early Social Interaction Project (ESI); intervention emphasizing joint attention and imitation skill-building (JA/Imitation); Joint Attention, Symbolic Play, Engagement, and Regulation (JASPER); Learning Experiences Alternative Program (LEAP); Pivotal Response Treatment (PRT); Reciprocal Imitation Training (RIT); Focus parent	**Overall autism characteristics (symptoms of ASD): Positive pooled effect*.** **Social-communication (joint attention): Null pooled effect*.** **Social-communication (social engagement): Positive pooled effect*.** **Expressive language: Positive pooled effect*.** **Receptive language: Positive pooled effect*.** **Cognitive development: Positive pooled effect*.** **Play: Positive pooled effect*.** **Adaptive behaviour: Null pooled effect*.** **Amount of support:** Greater amount of support (total hours) related to greater effect of support on social-communication (joint attention). Amount of support (total hours) not related to effect of support on adaptive behaviour, expressive or receptive language, Cognitive development, overall autism characteristics, social-communication (social engagement), or play. **Adverse effects:** Not reported.	RCTs, non-randomised with comparison (inclusion criteria)	High (10/11)

	training program; parent training.			
Sandbank et al. (2020)	**Label:** Naturalistic developmental behavioural interventions. **Setting:** Not specified. **Format:** Not specified. **Agent:** Not specified. **Mode:** Not specified. **Amount of support:** Not specified. **Practices:** Advancing Social-Communication and Play (ASAP); Caregiver-based intervention program in community day-care centers; Denver Model; Early Social Interaction Project (SCERTS); Early Start Denver Model (ESDM); Home-based Building Blocks Program; home-based intervention program; ImPACT Online; Interpersonal Synchrony; Joint Attention Intervention; Joint Attention Symbolic Play Engagement Regulation (JASPER); Joint Engagement Intervention; Joint Engagement Intervention with Creative Movement Therapy; Parent-Early Start Denver Model (P-ESDM); Parent-training intervention; Pivotal Response Treatment (PRT); Reciprocal Imitation Training; Social ABCs	**Overall autism characteristics (diagnostic characteristics):** Null pooled effect. **Social-communication:** Positive pooled effect. **Restricted and repetitive interests and behaviours: Null pooled effect*.** **Communication (language):** Positive pooled effect. **Cognitive development:** Positive pooled effect. **Social-emotional development: Null pooled effect*.** **Play:** Positive pooled effect. **Adaptive behaviour:** Null pooled effect. **Adverse effects:** Not reported.	RCTs, non-randomised with comparison	High (10/11)

Crank et al. (2021)	**Setting:** Not specified **Format:** Not specified **Agent:** Parents/caregivers, early childhood staff, clinicians/researchers, other agents **Mode:** Not specified **Amount of support:** M = 556 hours (8 – 3276 hours) **Practices:** Naturalistic developmental behavioural interventions: Advancing Social Communication and Play (ASAP); Caregiver-based intervention program in community day-care centers; Denver Model; Early Social Interaction Project (SCERTS); Early Start Denver Model (ESDM); Home-based Building Blocks Program; home-based intervention program; ImPACT Online; Interpersonal Synchrony; Joint Attention Intervention; Joint Attention Symbolic Play Engagement Regulation (JASPER); Joint Engagement Intervention; Joint Engagement Intervention with Creative Movement Therapy; Parent-Early Start Denver Model (P-ESDM); Parent-training intervention; Pivotal Response Treatment (PRT); Reciprocal Imitation Training; Social ABCs;	**Child age:** The child's age (chronological age) was not related to the effect of support on general outcomes. **Communication:** The child's communication (language age) was not related to the effect of support on general outcomes. **Amount of support:** The amount of support (cumulative intensity) was not related to the effect of support on general outcomes. **Agent:** The agent (clinicians, educators, caregivers, combination) was not related to the effect of support on general outcomes. **Adverse effects:** Not reported.	RCTs, non-randomised with comparison	Low (8/11)

	Cognitive behaviour therapy (CBT).			
Systematic reviews at the practice level				
Early Start Denver Model				
Fuller et al. (2020)	**Setting:** Not specified. **Format:** Individual, group. **Agent:** Parents/caregivers, clinicians/researchers. **Mode:** Face-to-face. **Amount of support:** Not specified.	**Overall autism characteristics (autism symptoms):** Null pooled effect. **Social-communication:** Null pooled effect. **Restricted and repetitive interests and behaviours (repetitive behaviours): Null pooled effect*.** **Communication (language):** Positive pooled effect. **Cognitive development:** Positive pooled effect. **Adaptive behaviour (adaptive functioning): Null pooled effect*.** **Amount of support:** Amount of support (total hours) not related to the effect of support on general outcomes (child outcomes). **Adverse effects:** Not reported.	RCTs, non-randomised with comparison	High (10/11)
Wang et al. (2021a)	**Setting:** Not specified. **Format:** Individuals, groups. **Agent:** Parents/caregivers, other. **Mode:** Not specified. **Amount of support:** Not specified.	**Overall autism characteristics (autism symptoms): Positive pooled effect*.** **Social-communication: Null pooled effect*.** **Communication (language): Positive pooled effect*.** **Cognitive development: Positive pooled effect*.** **Agent:** The agent (parents, professionals) was not related to the effect of support on overall autism characteristics or communication. **Format:** The format (individual, group) was not related to the effect of support on overall autism characteristics or communication. **Adverse effects:** Not reported.	RCTs	Low (8/11)

Pivotal Response Treatment				
Verschuur et al. (2014)	**Setting:** Clinic, home, educational. **Format:** Individual, group. **Agent:** Parents/caregivers, peers/siblings, educators, clinicians/researchers. **Mode:** Face-to-face, self-directed learning. **Amount of support:** Not specified.	**General outcomes (child behaviours): Inconsistent summarised effect*.** **Caregiver social emotional wellbeing (caregiver behaviours): Inconsistent summarised effect*.** **Adverse effects:** Not reported.	RCTs, non-randomised with comparison, non-randomised without comparison, single-case experimental designs, other	Low (6/10)
Ona et al. (2020)	**Setting:** Clinic, home. **Format:** Individual, group. **Agent:** Parents/caregivers, clinicians/researchers. **Mode:** Face-to-face. **Amount of support:** Not specified.	**Communication: Null pooled effect*.** **Expressive language: Positive pooled effect*.** **Adverse effects:** Not reported.	RCTs only	Low (8/11)
Pivotal response treatment (parent-mediated only)				
Deb et al. (2020)[1]	**Setting:** Home, educational settings, other. **Format:** Individuals, groups. **Agent:** Parents/caregivers, early childhood staff, clinicians/researchers, other. **Mode:** Face-to-face, telehealth, other. **Amount of support:** Not specified.	**General Outcomes (treatment effect):** Positive pooled effect. **Adverse effects:** Not reported.	RCTs	High (9/11)

JASPER				
Waddington et al. (2021)	**Setting:** Clinics, homes, educational settings, other. **Format:** Individuals, groups. **Agent:** Parents/caregivers, early childhood staff, clinicians/researchers. **Mode:** Face-to-face. **Amount of support:** Not specified.	**Overall autism characteristics (core characteristics of ASD): Null summarised effect*.** **Social-communication (joint attention and engagement): Positive summarised effect*.** **Communication (child communication skills): Positive summarised effect*.** **Expressive language (overall expressive language): Inconsistent summarised effect*.** **Receptive language: Inconsistent summarised effect.** **Play: Positive summarised effect*.** **Adverse effects:** Not reported.	RCTs	High (9/10)

* This effect is presented in the summary table in Appendix 6.13 (Effect of type of support on child and family outcomes).

[1] This summary of findings is also presented in the 'Delivery Characteristics table' (Appendix 6.11) under 'Agent (parent mediated, pivotal response treatment)'

Sensory-based Supports

	Characteristics of supports included in the systematic review	Findings form the systematic review	Study designs	Quality (systematic review)
Systematic reviews at the category level				
Sandbank et al. (2020)	**Label:** Sensory-based supports. **Setting:** Not specified. **Format:** Not specified. **Agent:** Not specified. **Mode:** Not specified. **Amount of support:** not specified **Practices:** Developmental Speech and Language Training through Music; Family-Centered Music	**Communication (language): Null pooled effect*.** **Adverse effects:** Not reported.	RCTs, non-randomised with comparison	High (10/11)

	Therapy; Improvisational Music Therapy; Music Therapy; Qigong (QST) Massage Treatment; Qigong Massage Treatment; Rhythm Intervention Sensorimotor Enrichment; Sensory Enrichment; Thai Traditional Massage; Tomatis Sound Therapy; Vestibular Stimulation via a Platform Swing			
Systematic reviews at the practice level				
Music therapy				
Geretsegger at al. (2014)	**Setting:** Clinic, home, educational, hospital. **Format:** Individual, group with family. **Agent:** Clinicians/researchers. **Mode:** Face-to-face. **Amount of support:** Not specified.	**Social-communication (social adaptation – overall): Positive pooled effect*.** **Communication (non-verbal, overall): Positive pooled effect*.** **Communication (verbal, overall): Positive pooled effect*.** **Caregiver social emotional wellbeing (quality of family relationships): Positive pooled effect*.** **Adverse effects:** Considered, and none identified.	RCTs, non-randomised with comparison (inclusion criteria)	High (11/11)
Mayer-Benarous et al. (2021)	**Setting:** Home. **Format:** Individuals, groups. **Agent:** Not specified. **Mode:** Face-to-face. **Amount of support:** Not specified.	**Social-communication (joint attention):** Null summarised effect. **Adverse effects:** Not reported.	RCTs, non-randomised with comparison, non-randomised without comparison, other study designs	High (8/10)

* This effect is presented in the summary table in Appendix 6.13 (Effect of type of support on child and family outcomes).

Treatment and Education of Autistic and related Communications Handicapped Children (TEACCH)

	Characteristics of supports included in the systematic review	Findings form the systematic review	Study designs	Quality (systematic review)
Systematic reviews at the category level				
Sandbank et al. (2020)	**Label: TEACCH** **Setting:** Not specified. **Format:** Not specified. **Agent:** Not specified. **Mode:** Not specified. **Amount of support:** Not specified. **Practices:** TEACCH.	**Social communication: Null pooled effect*.** **Adverse effects:** Not reported.	RCTs, non-randomised with comparison	High (10/11)

* This effect is presented in the summary table in Appendix 6.13 (Effect of type of support on child and family outcomes).

Technology-based supports

	Characteristics of supports included in the systematic review	Findings form the systematic review	Study designs	Quality (systematic review)
Systematic reviews at the category level				
Mazon et al. (2019)	**Label:** Technology-based support. **Setting:** Clinic, home, educational, therapeutic centre, overtime clinic **Format:** Individual. **Agent:** Not specified. **Mode:** Face-to-face, computer assisted, robot. **Amount of support:** Not specified. **Practices:** Technology based supports including (but not	**General outcomes (statistical significance):** Inconsistent summarised effect. **Adverse effects:** Considered and identified: "6 participants were excluded due to refusal or distress" (p. 243-244 of the original article).	RCTs, non-randomised with comparison	Low (6/10)

	limited to) computer and robot-based supports.			
Khan et al. (2019)	**Label:** Web-Based Supports. **Setting:** Clinic, home, educational, hospital. **Format:** Individual. **Agent:** Parents/caregivers, clinicians/researchers. **Mode:** Face-to-face, apps, serious games, online. **Amount of support:** Not specified. **Practices:** Apps; serious games; videoconferencing; virtual environment with playable games; Web-based cognitive behavioural therapy (CBT).	**General outcomes (condition-specific outcomes or reducing comorbid psychological symptoms): Inconsistent summarised effect*.** **Adverse effects:** Considered, and none identified.	RCTs only	High (9/11)
Sandbank et al. (2020)	**Label:** Technology-based supports. **Setting:** Not specified. **Format:** Not specified. **Agent:** Not specified. **Mode:** Not specified. **Amount of support:** Not specified. **Practices:** ABRACADABRA; Emotiplay Serious Game; FaceSay; FindMe iPad App; Gaming Open Library for Intervention in Autism at Home (GOLIAH); Gaze-contingent attention training; Social Skills Training using a robotic behavioral intervention system;	**Social-communication: Null pooled effect*.** **Social-emotional development: Null pooled effect*.** **Adverse effects:** Not reported.	RCTs, non-randomised with comparison	High (10/11)

	The Transporters animated series; Therapy Outcomes By You (TOBY) App; Transporters DVD; Transporters Program for Children with Autism			
Sandgreen et al. (2021)	**Setting:** Not specified. **Format:** Individuals. **Agent:** Early childhood staff, clinician/researcher. **Mode:** Online contact with a therapist, computer, tablet app, DVD, robot. **Amount of support:** Not specified. **Practices:** Computer programs, tablet apps, robots, interactive DVD.	**Child age:** The child's age (age group <5 years, 5-10 years, >10-15 years) was not related to the effect of support on general outcomes. **Adverse effects:** Not reported.	RCTs, non-randomised with comparison	Low (8/11)
Systematic reviews at the practice level				
Apps				
Moon et al. (2019)	**Setting:** Clinic, home, educational. **Format:** Individual. **Agent:** Not specified. **Mode:** Face-to-face. **Amount of support:** Not specified.	**Social-communication: Null pooled effect*.** **Communication (gestures): Null pooled effect*.** **Communication (symbolic): Null pooled effect*.** **Expressive language: Null pooled effect*.** **Expressive language (words produced): Null pooled effect*.** **Receptive language: Null pooled effect*.** **Cognitive development (visual reception): Positive pooled effect*.** **Motor (fine motor): Positive pooled effect*.** **Adverse effects:** Not reported.	RCTs only	High (10/11)

Griffith et al. (2020)	**Setting:** Home, educational. **Format:** Individual. **Agent:** Not specified. **Mode:** Face-to-face, apps. **Amount of support:** not specified	**Social-communication:** Null summarised effect. **Adverse effects:** Not reported.	RCTs, non-randomised with comparison	High (8/10)
Valentine et al. (2020)	**Setting:** Home. **Format:** Not specified. **Agent:** Not specified. **Mode:** Tablet/mobile apps. **Amount of support:** Not specified.	**General outcomes (clinical effectiveness): Inconsistent summarised effect*.** **Adverse effects:** Not reported.	RCTs, non-randomised with comparison, single case experimental designs, other designs	High (9/10)
Computer programmes and robots (social skills training)				
Soares et al. (2021)[1]	**Setting:** Educational settings **Format:** Not specified. **Agent:** Early childhood staff, clinicians/researchers. **Mode:** Computers and robots. **Amount of support:** Not specified.	**Social-communication (social functioning): Positive pooled effect*.** **Adverse effects:** Not reported.	RCTs.	High (9/11)
Gaming				
Valentine et al. (2020)	**Setting:** Home. **Format:** Not specified. **Agent:** Not specified. **Mode:** Gaming **Amount of support:** Not specified.	**General outcomes (clinical effectiveness): Positive summarised effect*.** **Adverse effects:** Not reported.	RCTs, non-randomised with comparison, single case experimental designs, other designs	High (9/10)
Mobile technology				
Leung et al. (2021)	**Setting:** Not specified. **Format:** Not specified.	**General outcomes (effectiveness): Inconsistent summarised effect*.**	RCTs	Low (7/10)

	Agent: Peers/siblings, early childhood staff. **Mode:** Mobile/tablet **Amount of support:** Not specified.	**Adverse effects:** Not reported.		
Video games (social training)				
Jiménez-Muñoz et al. (2022)[2]	**Setting:** Homes, early childhood settings, other. **Format:** Individuals. **Agent:** Not specified. **Mode:** Video games. **Amount of support:** Not specified.	**General outcomes (main findings): Positive summarised effect*.**	RCTs, non-randomised with comparison non-randomised without comparison, other study designs.	Low (7/10)
Video/DVD/Video modelling				
Valentine et al. (2020)	**Setting:** Home. **Format:** Not specified. **Agent:** Not specified. **Mode:** Video/DVD/Video modelling**.** **Amount of support:** Not specified.	**General outcomes (clinical effectiveness): Positive summarised effect*.** **Adverse effects:** Not reported.	RCTs, non-randomised with comparison, single case experimental designs, other designs	High (9/10)

* This effect is presented in the summary table in Appendix 6.13 (Effect of type of support on child and family outcomes).

[1] This summary of findings is also presented under ‘Other supports (social skills training, delivered by computer programmes and robots)’

[2] This summary of findings is also presented under ‘Other supports (social skills, video games)’

Animal-assisted supports

	Characteristics of supports included in the systematic review	Findings form the systematic review	Study designs	Quality (systematic review)
Systematic reviews at the practice level				

Equine assisted therapy				
Dimolareva & Dunn (2021)	**Setting:** Not specified. **Format:** Not specified. **Agent:** Not specified. **Mode:** Animal-assisted. **Amount of support:** Not specified. **Practices:** Hippotherapy, Equine assisted therapy, therapeutic horse-riding, equine assisted activity.	**Overall autism characteristics (global measures of ASD): Null pooled effect*.** **Social-communication (social interaction): Positive pooled effect*.** **Language (communication): Positive pooled effect***. **Amount of support:** The amount of support (minutes engaged in therapy) was not related to the effect of support on overall autism characteristics, social-communication, or communication (language). **Adverse effects:** Not reported.	Non-randomised without comparison, other designs not specified	Low (8/11)
Trzmiel et al. (2019)	**Setting:** Not specified. **Format:** Individual. **Agent:** Not specified. **Mode:** Face-to-face, equine. **Amount of support:** Not specified.	**Social-communication (social):** Null pooled effect. **Communication:** Null pooled effect. **Adaptive behaviour: Null pooled effect*.** **Adverse effects:** Not reported.	Not specified	Low (7/11)
Canine assisted therapy				
Hardy & Weston (2020)	**Setting:** Not specified. **Format:** Individual. **Agent:** Not specified. **Mode:** Face-to-face, canine. **Amount of support:** Not specified.	**Social communication (social behaviour): Positive summarised effect*.** **Adverse effects:** Not reported.	Not specified	Low (6/10)

* This effect is presented in the summary table in Appendix 6.13 (Effect of type of support on child and family outcomes).

Cognitive behavioural therapy

	Characteristics of supports included in the systematic review	Findings form the systematic review	Study designs	Quality (systematic review)

Ho et al. (2014)	**Label:** Cognitive behavioural approaches. **Setting:** Clinic. **Format:** Individual, group. **Agent:** Parents/caregivers, peers/siblings, clinicians/researchers. **Mode:** Face-to-face. **Amount of support:** M = 10.8 hours (7 – 18 hours)	**Social-communication (social skills): Positive pooled effect*.** **Adverse effects:** Not reported.	RCT only	Low (7/11)
Wang et al. (2021b)	**Setting:** Other. **Format:** Individuals, groups. **Agent:** Parents/caregivers, early childhood staff, other. **Mode:** Face-to-face. **Amount of support:** Not specified.	**Overall autism characteristics (Symptoms related to ASD- self-reported outcomes): Null pooled effect*.** **Overall autism characteristics (Symptoms related to ASD – informant reported outcomes): Positive pooled effect*.** **Overall autism characteristics (Symptoms related to ASD – clinician reported outcomes): Negative pooled effect*.** **Overall autism characteristics (Symptoms related to ASD – task-based outcomes): Positive pooled effect*.** **Social emotional/challenging behaviour (Symptoms of social-emotional problems – self reported outcomes): Null pooled effect*.** **Social emotional/challenging behaviour (Symptoms of social-emotional problems – informant reported outcomes): Positive pooled effect*.** **Child age:** The relationship between the child's age (mean age: <10, ≥10) and both overall autism characteristics and social emotional/challenging behaviour was inconsistent. The child's age was not related to the effect of support on self-report, clinician	RCTs	High (9/11)

		ratings, and task-based ratings of overall autism characteristics. The child's age was positively associated with the effect of support on informant-reported overall autism characteristics. Children aged ≥10 showed greater reductions than those aged <10. The child's age was not related to the effect of support on self-report and informant report ratings of social emotional/challenging behaviour. The child's age was negatively associated with the effect of support on clinician rated social emotional/challenging behaviour. Children aged <10 showed greater reductions than those aged ≥ 10. **Format:** The format (group based, individual based) was not related to the effect of support on self-reported, informant reported, or clinician ratings of overall autism characteristics or social-emotional development or task-based ratings of overall autism characteristics. **Adverse effects:** Not reported.		

* This effect is presented in the summary table in Appendix 6.13 (Effect of type of support on child and family outcomes).

Other Supports

	Characteristics of supports included in the systematic review	Findings form the systematic review	Study designs	Quality (systematic review)
Social skills training (Delivered by computer programmes and robots)				
Soares et al. (2021)[1]	**Setting:** Educational settings **Format:** Not specified. **Agent:** Early childhood staff, clinicians/researchers.	**Social-communication (social functioning): Positive pooled effect*.** **Adverse effects:** Not reported.	RCTs.	High (9/11)

	Mode: Computers and robots. **Amount of support:** Not specified.			
Social skills (video games)				
Jiménez-Muñoz et al. (2022)[2]	**Setting:** Homes, early childhood settings, other. **Format:** Individuals. **Agent:** Not specified. **Mode:** Video games. **Amount of support:** Not specified.	**General outcomes (main findings): Positive summarised effect*.** **Adverse effects:** Not reported.	RCTs, non-randomised with comparison non-randomised without comparison, other study designs.	Low (7/10)
UCLA Program for the Education and Enrichment of Relational Skills (PEERS)				
Zheng et al. (2021)	**Setting:** Clinics, educational settings, other. **Format:** Groups. **Agent:** Parents/caregivers, early childhood staff, clinican/researcher. **Mode:** Face-to-face. **Amount of support:** Not specified.	**Social-communication (Self-reported social knowledge – TASSK): Positive pooled effect*.** **Social-communication (Parent-reported social knowledge – SSiS): Positive pooled effect.** **Social-communication (SRS - parent-reported social knowledge): Positive pooled effect*.** **Community participation (Get togethers - self-report QSQ): Positive pooled effect*.** **Community participation (Get togethers - parent-report QSQ): Positive pooled effect*.** **Adverse effects:** Not reported.	RCTs, non-randomised without comparison.	Low (8/11)

[1] This summary of findings is also presented under 'Technology-based supports (computer programmes and robots, social skills training)'

[2] This summary of findings is also presented under 'Technology-based supports (social skills, video games)'

Footnote: "Label" refers to the term used by the authors of the systematic review to describe the category of supports being examined; "Practices" refers to the practices described verbatim by the authors as being included in the systematic review; participants in the support group of a systematic review generally only received one practice, though this was not always specified; "pre-support" refers to child characteristics measured prior to the delivery of support; Only outcomes for which evidence was available are included; "Outcomes ()" the first term refers to the outcome categories defined for this umbrella review, the term in parenthesis refers to the author's term(s) for the outcome, where there is no term in brackets, the systematic review author's outcome classification matched that of the current umbrella review; "risk of bias (included studies)” refers to the risk of bias, as assessed by the authors of the systematic review and appraised by current authors during data extraction, the rating indicates the lower bound of quality/risk of bias for studies included in the review.

National guideline for supporting the learning, participation, and wellbeing of autistic children and their families in Australia

Appendix 5.10	Umbrella review - Summary of findings from outcome-focussed systematic reviews

Appendix 5.10 - Umbrella review - Summary of findings from outcome-focussed systematic reviews

	Characteristics of supports included in the systematic review	Findings form the systematic review	Study designs	Quality (systematic review)
Social communication				
Murza et al. (2016)	**Setting:** Clinic, home, educational. **Format:** Individual, group. **Agent:** Parents/caregivers, educators, clinicians/researchers. **Mode:** Face-to-face. **Amount of support:** 12 – 1196 hours **Practices:** Joint attention interventions - Assessment, Evaluation and Programming System (AEPS) for Infants and Children; Caregiver Education Model (CEM); Caregiver Mediated Model (CMM); Hanen More Than Words (HMTW); Joint Attention Mediated Learning (JAML); Joint Attention Symbolic Play Engagement and Regulation (JASPER); Milton and Ethel Harris Research Initiative (MEHRI); Preschool Autism Communication Trial (PACT); parent training modules; and workshop training.	**Social-Communication (joint attention):** Positive pooled effect. **Adverse effects:** Not reported.	RCT only	High (9/11)
Parsons, Cordier, Munro et al. (2017)	**Setting:** Clinic, home, educational. **Format:** Individual, group. **Agent:** Parents/caregivers, peers/siblings, educators,	**Social-communication (pragmatic language):** Positive pooled effect.	RCT only	Low (7/10)

	clinicians/researchers, certified therapeutic riding instructor. **Mode:** Face-to-face, computer assisted. **Amount of support:** 4 – 1092 hours. **Practices:** Pragmatic language interventions - The Junior detective Program; Milton and Ethel Harris Research Initiative Treatment (MEHRIT); Building Blocks Program; Social Emotional NeuroScience Endocrinology (SENSE) theatre; Social Skills Group Intervention- High Functioning Autism; FindMe App; Therapeutic Horse Riding; FaceSay; Joint Attention, Symbolic Play, Engagement, and Regulation (JASPER); Improvisational music therapy; SummerMAX; Mind Reading; Skillstreaming; Emotion Recognition Training; Seaver-NETT.	**Child age:** Age not related to the effect of support on social communication. **Setting:** Setting not related to the effect of support on social communication. **Format:** Format (individual, group) not related to the effect of support on social communication. **Agent:** Positive effect of support for supports with active parent involvement, but not for supports with parent education alone. **Adverse effects:** Not reported.		
Bejarano-Martín et al. (2020)	**Setting:** Not specified. **Format:** Individual. **Agent:** Parents/caregiver, peers/siblings, educators, clinicians/researchers. **Mode:** Face-to-face. **Amount of support:** Not specified. **Practices:** Focused practices - Discrete trial training (DTT); Pivotal Response Training (PRT), Contingent imitation; discrete trial training (DTT) plus social interaction, mediated learning with	**Social-communication:** Positive pooled effect. **Social-communication (imitation):** Positive pooled effect. **Social-communication (joint attention):** Positive pooled effect. **Social-communication (play):** Positive pooled effect.	RCTs, non-randomised with comparison, single-case experimental designs (inclusion criteria)	High (9/11)

	active engagement; picture exchange communication system (PECS); video modelling; prompting and reinforcement; physical and verbal cues; token economy and prompting; photographic schedules.	**Child age:** Age negatively associated with the effect of support on social-communication. **Communication:** Child communication skills prior to support not related to the effect of support on social-communication. **Cognitive development:** Child cognitive development prior to support not related to the effect of support on social-communication. **Amount of support:** Amount of support (total hours) not related to the effect of support on social-communication. **Agent:** Agent (caregivers, teachers, clinicians) not related to effect of support on social-communication. **Adverse effects:** Not reported.		
Expressive language				
Hampton & Kaiser (2016)	**Setting:** Not specified. **Format:** Individual. **Agent:** Parents/caregivers, clinicians/researchers. **Mode:** Face-to-face. **Amount of support:** Not specified.	**Expressive language (spoken language):** Positive pooled effect. **Child age:** Age not related to the effect of support on	Randomised controlled trials, non-randomised with comparison	High (10/11)

	Practices: Early interventions- Early Intensive Behavioural Intervention (EIBI); Early Intervention Preschool (EIP); Early Start Denver Model (ESDM); Joint Attention Mediated Learning (JAML); Joint Attention; Structured Play Engagement; and Regulation (JAML); Learning Experiences and Alternative Program (LEAP); Milton and Ethel Harris Research Initiative Treatment (MEHRIT); More Than Words (MTW); Pediatric Autism and Communication Therapy (PACT); Play and Language for Autistic Youngsters; PRT, Pivotal Response Training (Play and Language for Autistic Youngsters); Treatment and Education of Autistic and Related Communication Handicapped Children (TEACCH); Scottish Early Intervention Preschool; Parent training model (PSwA); Focused playtime (FPI); Speech remediation; Teach Town basics; Early Social Interaction (ESI); Parent training, Behaviour analytic.	expressive language (spoken language). **Amount of support:** Amount of support (total hours) not related to the effect of support on expressive language (spoken language). **Agent:** Supports involving clinicians and caregivers related to greater effect of support on expressive language (spoken language) than clinicians or caregivers alone. **Adverse effects:** Not reported.		
Play				
Kent et al. (2020)	**Setting:** Clinic, home, educational, community (theatre group). **Format:** Individual, group. **Agent:** Parents/caregivers, peers/siblings, educators, clinicians/researchers, unfamiliar adults. **Mode:** Face-to-face.	**Play:** Positive pooled effect. **Format**: Format (individual, group) did not relate to the effect of support on play.	RCT only	High (10/11)

	Amount of support: Not specified. **Practices:** Play-based interventions- [Generic] play intervention; Joint Attention, Symbolic Play, Engagement, and Regulation (JASPER); Lego therapy; Social stories; behavioural approaches; peer training; teacher training; Social Emotional NeuroScience Endocrinology (SENSE) Theater principles; video modelling.	**Setting**: Setting (clinic, home) not related to the effect of support on play skills. **Adverse effects:** Not reported.		

Footnote: "Outcomes ()" the first term refers to the outcome categories defined for this umbrella review, the term in parenthesis refers to the author's term(s) for the outcome, where there is no term in brackets, the systematic review author's outcome classification matched that of the current umbrella review.

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Appendix 5.11	Umbrella review - Summary of findings from delivery-focussed systematic reviews

Appendix 5.11 - Umbrella review - Summary of findings from delivery-focussed systematic reviews

Setting

	Characteristics of supports included in the systematic review	Findings form the systematic review	Study designs	Quality (systematic review)
Inclusive school setting				
Tupou et al. (2019)	**Setting:** Educational. **Format:** Individual, group. **Agent:** Educators. **Mode:** Face-to-face. **Amount of support:** Not specified. **Practices:** Comprehensive treatment programmes - Developmentally Appropriate Treatment for Autism (DATA); Treatment and Education of Autistic and Related Communication Handicapped Children (TEACCH); Early Intensive Behavioural Intervention (EIBI); Learning Experiences and Alternative Program for Preschoolers (LEAP); Comprehensive Autism Program (CAP); EIBI intervention described as being based on Lovaas' UCLA model; Skills focused interventions targeting -	**Overall autism characteristics (autism severity and/or symptoms):** Positive summarised effect. **Social communication (social skills):** Positive summarised effect. **Communication (communication and/or language):** Positive summarised effect. **Social-emotional development (adaptive/maladaptive behaviour):** Positive summarised effect. **Adaptive behaviour (functional skills):** Positive summarised effect. **Adverse effects:** Not reported.	Randomised controlled trials, non-randomised with comparison, non-randomised without comparison, single-case experimental designs	High (9/10)

	communication, play skills, peer interaction, and reading skills.			

Format

	Characteristics of supports included in the systematic review	Findings form the systematic review	Study designs	Quality (systematic review)
Individual, group				
Tachibana et al. (2018)	**Setting:** Clinic, home, educational. **Format:** Individual, group. **Agent:** Parents/caregivers, educators, clinicians/researchers. **Mode:** Face-to-face. **Amount of support:** Not specified. **Practices:** Social communication intervention - Hanen's More Than Words; Early Start Denver Model (ESDM); Parent training; Joint Attention Symbolic Play Engagement and Regulation (JASPER); Preschool Autism Communication Trial (PACT); Treatment and Education of Autistic and related Communications Handicapped Children (TEACCH)-based group social skills; Reciprocal Imitation Training; Caregiver-based intervention program in community day-care centers; Preschool-based joint attention intervention; Caregiver Mediated Joint Engagement Intervention; Improvisational music therapy; intervention targeting development of socially synchronous engagement; Developmental, Individual-Difference, Relationship-Based(DIR)/Floortime interventio	**Overall autism characteristics (autism general symptoms – individual intervention):** Null pooled effect. **Social communication (qualitative impairment in social interaction – individual intervention)**: Null pooled effect. **Social communication (reciprocity of social interaction towards others – individual intervention):** Positive pooled effect. **Social communication (reciprocity of social interaction towards others – group intervention):** Positive pooled effect. **Social communication (initiating joint attention– individual intervention):** Null pooled effect.	RCT only	High (11/11)

	n; Functional Behavior Skills Training (FBST); Building Blocks; Parent delivery of the Early Start Denver Model (P-ESDM); Joint Attention Mediated Learning (JAML) intervention; Focused Playtime Intervention (FPI); Education and Skills Training Program for Parents; Parent education and behaviour management (PEBM) Skills training intervention or comparison for the on specific aspects of the PEBM parent education and counselling intervention; Home TEACCHing Program.	**Social communication (initiating joint attention – group intervention):** Null pooled effect. **Social communication (imitation):** Null pooled effect. **Social communication (responding to joint attention – individual intervention):** Null pooled effect. **Restricted and repetitive interests and behaviours (restricted repetitive and stereotyped patterns behaviours, interests and activities- individual intervention):** Null pooled effect. **Communication (qualitative impairment in communication – individual intervention)**: Null pooled effect. **Expressive language (individual intervention):** Null pooled effect. **Expressive language (group intervention):** Null pooled effect. **Receptive language (individual intervention):** Null pooled effect.		

		Receptive language (group intervention): Null pooled effect. **Cognitive development (developmental quotient – individual intervention):** Positive pooled effect. **Adaptive behaviour (individual intervention):** Null pooled effect. **Adaptive behaviour (group intervention):** Null pooled effect. **Caregiver communication and interaction (parental synchrony-individual intervention):** Positive pooled effect. **Caregiver social emotional wellbeing (parenting stress – individual intervention):** Null pooled effect. **Caregiver social emotional wellbeing (parenting stress – group intervention):** Null pooled effect. **Format:** Format (individual, group) did not relate to the effect of support on overall autism characteristics, social-communication, expressive language, receptive language, Cognitive development, or adaptive behaviour.		

		Adverse effects: Not reported.		
Group-based (parent training)				
O'Donovan et al. (2019)[1]	**Setting:** Homes. **Format:** Individuals, groups. **Agent:** Parents/caregivers, early childhood staff. **Mode:** Not specified. **Amount of support:** Not specified. **Practices:** Group-based parent training interventions: The National Autistic Society (NAS) EarlyBird and EarlyBird Plus Programme (EBPP); 'Understanding autism and understanding my child with autism' (UA); TEACCH-based; Incredible Years; Generic support group; Parent management training (PMT); Sleep education workshops; 'Riding the Rapids: Living with Autism or Disability'; Psychoeducation groups; 'Riding the Rapids: Living with Autism or Disability'; Parent Education and Behaviour Management (PEBM).	**Social emotional/challenging behaviour (problematic behaviours):** Positive summarised effect. **Caregiver communication and interaction (parental skills):** Positive summarised effect. **Adverse effects:** Not reported	Randomised controlled trial, non-randomised with comparison, non-randomised without comparison, other study designs	Low (6/10)

[1] This summary of findings is also presented under 'Agent (parent training, group based)'

Agent

	Characteristics of supports included in the systematic review	Findings form the systematic review	Study designs	Quality (systematic review)
Non-specialist implemented/mediated				
Naveed et al. (2019)	**Setting:** Clinic, home, educational, community. **Format:** Individual. **Agent:** Parents/caregivers, siblings/peers, educators. **Mode:** Face-to-face, telepractice.	**Overall autism characteristics (autism symptom severity):** Positive pooled effect. **Social communication (social skills):** Positive pooled effect. **Social communication (joint engagement):** Positive pooled effect.	RCT only	High (9/11)

	Amount of support: Not specified. **Practices:** Cognitive behavioural strategies (CBT); Social Emotional NeuroScience Endocrinology (SENSE) theatre; Preschool Autism Communication Trial (PACT); Parent mediated intervention for Autism Spectrum Disorders in South Asia (PASS); Project Impact; Peer interventions; Qigong Sensory Treatment (QST); Qigong massage; Joint Attention, Symbolic Play, Engagement, and Regulation programme (JASPER); Play project; LEAP project i.e. Learning Experiences and Alternative Program for Preschoolers and Their Parents; Hanen's more than words (HMTW) intervention program; Peer network intervention procedure; family centered music therapy; The Managing Repetitive Behaviours Programme; psychoeducation program; autism preschool program; Video-feedback Intervention to promote Positive Parenting adapted for Autism; Social ABCs; Parent-mediated intervention for Autism Spectrum Disorders in South Asia (PASS) plus; enhancing interactions tutorial;	**Social communication (joint attention):** Null pooled effect. **Restricted and repetitive interests and behaviours (repetitive behaviours):** Positive pooled effect. **Communication:** Positive pooled effect. **Expressive language:** Positive pooled effect. **Receptive language:** Null pooled effect. **Cognitive development (visual reception):** Positive pooled effect. **Motor (motor skills):** Positive pooled effect. **Social-emotional development (self-regulation):** Positive pooled effect. **Adaptive behaviour:** Null pooled effect. **Caregiver social emotional wellbeing (parental distress):** Positive pooled effect. **Caregiver social emotional wellbeing (parental self-efficacy):** Positive pooled effect. **Caregiver social emotional wellbeing (parent-child relationship):** Positive pooled effect. **Child satisfaction (child distress):** Positive pooled effect. **Child age:** Age not related to the effect of support. **Amount of support:** Number of support sessions not related to the effect of support. **Adverse effects:** Not reported.		

	Social Tools And Rules for Teens socialization (START); COMPASS for Hope; Program for the Education and Enrichment of Relational Skills (PEERS) curriculum; Therapeutic Outcome By You (TOBY) application.			
Parent-implemented/mediated				
Oono et al. (2013)	**Setting:** Clinic, home, out of home locations. **Format:** Individual, group. **Agent:** Parents/caregivers. **Mode:** Face-to-face, self-training with a manual and videotapes. **Amount of support:** Not specified. **Practices:** Developmental Individual-Difference Relationship-Based (DIR) techniques; massage intervention; management of challenging behaviour; early intensive behavioural intervention; Pivotal Response Treatment (PRT).	**Overall autism characteristics (severity of autism characteristics):** Positive pooled effect. **Social communication (shared or joint attention):** Positive pooled effect. **Social communication (child initiations):** Null pooled effect. **Communication:** Null pooled effect. **Communication (joint language):** Null pooled effect. **Expressive language (expression - direct or independent assessment):** Null pooled effect. **Receptive language (comprehension - direct or independent assessment):** Null pooled effect. **Cognitive development (developmental/intellectual gains):** Positive summarised effect. **Social-emotional development (maladaptive behaviour):** Null summarised effect. **Adaptive behaviour:** Null pooled effect. **Caregiver communication and interaction (parental**	RCT only	High (11/11)

		synchrony): Positive pooled effect. **Caregiver social emotional wellbeing (parents' level of stress):** Null pooled effect. **Adverse effects:** Not reported.		
Nevill et al. (2018)	**Setting:** Clinic, home, community. **Format:** Individual, group. **Agent:** Parents/caregivers. **Mode:** Face-to-face. **Amount of support:** Not specified. **Practices:** Child's Talk Project; Hanen's More than Words (HMTW); DIR/Floortime; Parent Focus Training; Joint Attention Symbolic Play Engagement and Regulation (JASPER); Pivotal Response Training (PRT); Video Intervention to promote Positive Parenting for children with Autism (VIPP-AUTI); Home-based program; Building Blocks; Focused Playtime Intervention; Play and Language for Autistic Youngsters (PLAY) Project; Preschoolers with Autism; Treatment and Education of Autistic and Related Communication Handicapped Children (TEACCH); Social Communication, Emotion Regulation, and Transactional Supports	**Overall autism characteristics (autism symptom severity):** Positive pooled effect. **Social communication (socialisation):** Positive pooled effect. **Communication (language):** Positive pooled effect. **Cognitive development:** Positive pooled effect. **Amount of support:** Amount of support (total hours) not related to the effect of support on overall autism characteristics (symptom severity), social-communication (socialisation), communication (language), or cognitive development. **Adverse effects:** Not reported.	RCT only	Low (7/11)

	(SCERTS); Parent-mediated Communication-focused Treatment (PACT).			
Tarver et al. (2019)	**Setting:** Not specified. **Format:** Individual, group, workshops. **Agent:** Parents/caregivers. **Mode:** Face-to-face. **Amount of support:** Not specified. **Practices:** Behavioural parent interventions – Research Units in Behavioural Intervention (RUBI) Parent Training Manual; Child directed interaction therapy (CDIT); Compass for help (C-HOPE); Parent management training; parent-child interaction therapy (PCIT); Primary care stepping stones Tripe P (PCSSTP); Stepping stones triple P (SSTP).	**Social-emotional development (parent-reported disruptive behaviour):** Positive pooled effect. **Social-emotional development (parent-reported hyperactivity):** Positive pooled effect. **Caregiver social emotional wellbeing (parenting stress):** Positive pooled effect. **Caregiver social emotional wellbeing (parenting efficacy):** Null pooled effect. **Adverse effects:** Not reported.	RCT only	Low (8/11)
Parent training				
Postorino et al. (2017)	**Setting:** Clinic. **Format:** Individual, group. **Agent:** Parents/caregivers. **Mode:** Face-to-face, telepractice. **Amount of support:** Not specified. **Practices:** Parent training for disruptive behaviour	**Social-emotional development (disruptive behaviour):** Positive pooled effect. **Adverse effects:** Not reported.	Randomised controlled trials, non-randomised with comparison	Low (7/11)
Parent focussed training				
Deb et al., 2020	**Setting:** Home, educational settings, other. **Format:** Individuals, groups.	**General Outcomes (treatment effect):** Positive pooled effect. **Adverse effects:** Not reported.	Randomised controlled trials	High (9/11)

	Agent: Parents/caregivers, early childhood staff, clinicians/researchers, other. **Mode:** Face-to-face, telehealth, other. **Amount of support:** Not specified. **Practices:** Parent focussed training.			
Parent training (group based)				
O'Donovan et al. (2019)[1]	**Setting:** Homes. **Format:** Individuals, groups. **Agent:** Parents/caregivers, early childhood staff. **Mode:** Not specified. **Amount of support:** Not specified. **Practices:** Group-based parent training interventions: The National Autistic Society (NAS) EarlyBird and EarlyBird Plus Programme (EBPP); 'Understanding autism and understanding my child with autism' (UA); TEACCH-based; Incredible Years; Generic support group; Parent management training (PMT); Sleep education workshops; 'Riding the Rapids: Living with Autism or Disability'; Psychoeducation groups; 'Riding the Rapids: Living with Autism or Disability'; Parent Education and Behaviour Management (PEBM).	**Social emotional/challenging behaviour:** Positive summarised effect. **Caregiver communication and interaction (parental skills):** Positive summarised effect. **Adverse effects:** Not reported	Randomised controlled trial, non-randomised with comparison, non-randomised without comparison, other study designs	Low (6/10)

Parent training (delivered by apps or DVDs)				
Pi et al. (2021)[2]	**Setting:** Not specified. **Format:** Groups. **Agent:** Parents/caregivers. **Mode:** Telehealth, apps, DVDs **Amount of support:** Not specified. **Practices:** Technology assisted parent-mediated intervention: App-based interventions, online/web based, computer based, DVD-based.	**Social-communication:** Null summarised effect. **Social-communication (socialisation):** Null summarised effect. **Communication (language total score):** Null summarised effect. **Communication (gestures):** Null summarised effect. **Expressive language (expressive speech):** Null summarised effect. **Receptive language:** Null summarised effect. **Adverse effects:** Not reported	Randomised controlled trials	Low (8/11)
Parent training (delivered by website or online platform)				
Tan-MacNeill et al. (2021)[3]	**Setting:** Not specified. **Format:** Not specified. **Agent:** Not specified. **Mode:** Website or online platform. **Amount of support:** Not specified. **Practices:** Online parent implemented intervention: ImPACT online, POWR Online Communication Training; Pivotal response treament (PRT); enhancing interactions; reciprocal imitation training (RIT); ABA Web-Based Training; Enhancing Interactions; FASD Education and Training; Triple P online (TPOL); Project CHASE (children with autism supported to exercise); parent sleep education intervention;	**Social-communication (communication behaviours and language targets):** Positive summarised effect. **Adverse effects:** Not reported	Randomised controlled trial, non-randomised with comparison, non-randomised without comparison	High (8/10)

	promoting engagement for ADHD pre-Kindergarteners (PEAK), blended behavioural parent training (BPT).			
Parent mediated (DIR/Floortime)				
Deb et al. (2020)[4]	**Setting:** Home, educational settings, other. **Format:** Individuals, groups. **Agent:** Parents/caregivers, early childhood staff, clinicians/researchers, other. **Mode:** Face-to-face, telehealth, other. **Amount of support:** Not specified.	**General outcomes (treatment effect):** Positive pooled effect. **Adverse effects:** Not reported.	RCTs	High (9/11)
Parent mediated (pivotal response treatment)				
Deb et al. (2020)[5]	**Setting:** Home, educational settings, other. **Format:** Individuals, groups. **Agent:** Parents/caregivers, early childhood staff, clinicians/researchers, other. **Mode:** Face-to-face, telehealth, other. **Amount of support:** Not specified.	**General outcomes (treatment effect):** Positive pooled effect. **Adverse effects:** Not reported.	RCTs	High (9/11)

[1] This summary of findings is also presented under ‘Format (group-based, parent training)’

[2] This summary of findings is also presented under ‘Mode (apps or DVDs, parent training)’

[3] This summary of findings is also presented under ‘Mode (website or online platform, parent training)’

[4] This summary of findings is also presented within the ‘Categories and Practices table’ (Appendix 6.9) under ‘Developmental Supports’

[5] This summary of findings is also presented within the ‘Categories and Practices table’ (Appendix 6.9) under ‘Naturalistic Developmental Behavioural Interventions’

Mode

	Characteristics of supports included in the systematic review	**Findings form the systematic review**	**Study designs**	**Quality (systematic review)**
Telepractice				
Parsons, Cordier, Vaz et al. (2017)	**Setting:** Home. **Format:** Individual. **Agent:** Parents/caregivers. **Mode:** Telepractice, videoconferencing, DVD, online modules. **Amount of support:** Not specified. **Practices:** Web-based training in behavioural interventions; Online and Applied System for Intervention Skills (OASIS) training intervention Research-to-practice; Improving Parents as Communication Teachers (ImPACT) on the Web; Implementation discrete-trial instructions using video training materials; Parent Early Start Denver Model (P-EDSM) training; Functional communication training.	**Caregiver communication and interaction (parental knowledge acquisition):** Positive summarised effect. **Adverse effects:** Not reported.	Randomised controlled trials, non-randomised with comparison, non-randomised without comparison, single-case experimental designs.	High (9/11)
Ferguson et al. (2019)	**Setting:** Clinic, home. **Format:** Individual, group. **Agent:** Parents/caregivers, peers/siblings, educators, clinicians/researchers, other associated professionals working in the field. **Mode:** Telehealth, written instructions,	**General outcomes (efficacy outcomes):** Positive summarised effect. **Adverse effects:** Not reported.	Randomised controlled trials, non-randomised with comparison, non-randomised without comparison, single-case experimental	High (9/10)

	videoconferencing, websites, DVDs. **Amount of support:** Not specified. **Practices:** Telehealth interventions with behavioural principles-functional analysis (FA); functional communication training (FCT); naturalistic and incidental teaching; behaviour support strategies (e.g., positive behaviour support); preference assessments; Early Start Denver Model (ESDM); Improving Parents as Communication Teachers (imPACT).		designs, other.	
Sutherland et al. (2018)	**Setting:** Clinic. **Format:** Individual. **Agent:** Parents/caregivers, educators. **Mode:** Telepractice, online training. **Amount of support:** Not specified. **Practices:** Program Improving Parents as Communication Teachers (imPACT); internet-based Parent Implemented Communication Strategies (iPICS); general communication intervention; imitation training; Telehealth diagnostic services; 'Telehealth Facing Your Fears' Intervention'; functional behaviour assessment and functional communication training;	**Caregiver satisfaction (satisfaction and acceptability):** Positive summarised effect. **Caregiver communication and interaction (fidelity):** Positive summarised effect. **Adverse effects:** Not reported.	Randomised controlled trials, single-case experimental designs, other.	Low (7/10)

	school age intervention using web-based education; language intervention.			
Apps or DVDs (parent training)				
Pi et al. (2021)[1]	**Setting:** Not specified. **Format:** Groups. **Agent:** Parents/caregivers. **Mode:** Telehealth, apps, DVDs **Amount of support:** Not specified. **Practices:** Technology assisted parent-mediated intervention: App-based interventions, online/web based, computer based, DVD-based.	**Social-communication:** Null summarised effect. **Social-communication (socialisation):** Null summarised effect. **Communication (language total score):** Null summarised effect. **Communication (gestures):** Null summarised effect. **Expressive language (expressive speech):** Null summarised effect. **Receptive language:** Null summarised effect. **Adverse effects:** Not reported	Randomised controlled trials	Low (8/11)
Website or online platform (parent training)				
Tan-MacNeill et al. (2021)[2]	**Setting:** Not specified. **Format:** Not specified. **Agent:** Not specified. **Mode:** Website or online platform. **Amount of support:** Not specified. **Practices:** Online parent implemented intervention: ImPACT online, POWR Online Communication Training; Pivotal response treament (PRT); enhancing interactions; reciprocal imitation training (RIT); ABA Web-Based Training; Enhancing Interactions; FASD Education and Training; Triple P online (TPOL); Project CHASE (children	**Social-communication (communication behaviours and language targets):** Positive summarised effect. **Adverse effects:** Not reported	Randomised controlled trial, non-randomised with comparison, non-randomised without comparison	High (8/10)

	with autism supported to exercise); parent sleep education intervention; promoting engagement for ADHD pre-Kindergarteners (PEAK), blended behavioural parent training (BPT).			

[1] This summary of findings is also presented under ‘Agent (parent training, delivered by apps or DVDs)’
[2] This summary of findings is also presented under ‘Agent (parent training, delivered by website or online platform)’

Footnote: “Outcomes ()” the first term refers to the outcome categories defined for this umbrella review, the term in parenthesis refers to the author’s term(s) for the outcome, where there is no term in brackets, the systematic review author’s outcome classification matched that of the current umbrella review

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Appendix 5.12	Umbrella review - Quality appraisal ratings

Appendix 5.12 - Umbrella review - Quality appraisal ratings

Item-level and total quality appraisal ratings for each included systematic review

	1. Review question stated	**2. Inclusion criteria appropriate**	**3. Search strategy appropriate**	**4. Sources and resources adequate**	**5. Quality appraisal appropriate**	**6. Independent critical appraisal**	**7. Minimised errors in data extraction**	**8. Methods to combine studies appropriate**	**9. Publication bias assessed (meta-analyses)**	**10. Policy and/or practice recommendations**	**11. Directives for new research appropriate**	**Total**	**Overall Quality**
Bejarano-Martìn et al., 2020	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Yes	Yes	Yes	9/11	H
Binns & Oram Cardy, 2019	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	-	Yes	Yes	9/10	H
Crank et al., 2021	Yes	No	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	8/11	L
Deb et al., 2020	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No	Yes	Yes	9/11	H
Dimolareva & Dunn, 2020	Yes	No	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Yes	8/11	L
Ferguson et al., 2019	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	-	Yes	Yes	9/10	H
Fuller et al., 2020	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	10/11	H
Geretsegger et al., 2014	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	11/11	H
Griffith et al., 2020	Yes	Yes	Yes	No	Yes	Yes	No	Yes	-	Yes	Yes	8/10	H
Hampton & Kaiser, 2016	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	10/11	H
Hardy & Weston, 2020	Yes	No	Yes	No	Yes	Yes	No	No	-	Yes	Yes	6/10	L
Ho et al. 2014	Yes	No	Yes	No	Yes	No	Yes	No	Yes	Yes	Yes	7/11	L
Jiménez-Muñoz et al., 2021	Yes	Yes	Yes	Yes	No	Yes	No	Yes	-	No	Yes	7/10	L
Kent et al., 2020	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	10/11	H
Khan et al., 2019	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Yes	9/11	H
Leung et al., 2021	Yes	No	Yes	No	Yes	No	Yes	Yes	-	Yes	Yes	7/10	L
Mayer-Benarous, 2021	Yes	Yes	Yes	No	Yes	No	Yes	Yes	-	Yes	Yes	8/10	H
Mazon et al., 2019	Yes	Yes	Yes	No	Yes	No	No	No	-	Yes	Yes	6/10	L
Moon et al., 2020	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	10/11	H
Murza et al., 2016	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	9/11	H
Naveed et al., 2019	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Yes	Yes	Yes	9/11	H
Nevill et al., 2018	Yes	Yes	Yes	No	Yes	No	No	Yes	No	Yes	Yes	7/11	L
O'Donovan et al., 2019	Yes	Yes	No	No	Yes	Yes	No	No	-	Yes	Yes	6/10	L

Ona et al., 2020	Yes	Yes	Yes	Yes	Yes	No	No	Yes	No	Yes	Yes	8/11	L
Oono et al., 2013	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	11/11	H
Parsons, Cordier, Munro et al., 2017	Yes	Yes	Yes	No	Yes	Yes	No	No	-	Yes	Yes	7/10	L
Parsons, Cordier, Vaz et al., 2017	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	9/11	H
Pi et al., 2021	Yes	Yes	Yes	No	Yes	Yes	No	Yes	No	Yes	Yes	8/11	L
Postorino et al., 2017	Yes	Yes	Yes	No	Yes	No	Yes	No	Yes	Yes	No	7/11	L
Reichow et al., 2018	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	11/11	H
Rodgers et al., 2020	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	10/11	H
Sandbank et al., 2020	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	10/11	H
Sandgreen et al., 2020	Yes	Yes	Yes	No	Yes	No	No	Yes	Yes	Yes	Yes	8/11	L
Shi et al., 2021	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	11/11	H
Soares et al., 2020	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Yes	9/11	H
Sutherland et al., 2018	Yes	Yes	Yes	No	Yes	No	No	Yes	-	Yes	Yes	7/10	L
Tachibana et al., 2018	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	11/11	H
Tan-MacNeill et al., 2021	Yes	Yes	Yes	Yes	Yes	No	No	Yes	-	Yes	Yes	8/10	H
Tarver et al., 2019	Yes	Yes	Yes	No	Yes	Yes	No	Yes	No	Yes	Yes	8/11	L
Tiede & Walton, 2019	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	10/11	H
Trzmiel et al., 2019	Yes	Yes	No	Yes	Yes	Yes	No	No	Yes	No	Yes	7/11	L
Tupou et al., 2020	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	-	Yes	Yes	9/10	H
Valentine et al., 2020	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	-	Yes	Yes	9/10	H
Vershuur et al., 2014	Yes	No	Yes	No	Yes	No	No	Yes	-	Yes	Yes	6/10	L
Waddington et al., 2021	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	-	Yes	Yes	9/10	H
Wang et al., 2021a	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes	No	Yes	8/11	L
Wang et al., 2021b	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Yes	Yes	Yes	9/11	H
Zheng et al., 2021	No	No	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	8/11	L

Note: L = Low Quality <80%; H = High Quality ≥80%

Appendix 5.13	Umbrella review - Effect of type of support on child and family outcomes

Appendix 5.13 - Umbrella review - Effect of type of support on child and family outcomes

Summary of the effect of types of support on child and family outcomes.

Type of support	Number of Systematic reviews	Communication				Sensory development	Cognitive development	Social-emotional wellbeing	Motor	Academic skills	School/ learning readiness	Overall autism characteristics	Restricted and repetitive interests and behaviours	General child outcomes	Daily activities and participation			Family wellbeing and satisfaction					
		Overall communication	Expressive language	Receptive language	Social-communication										Adaptive behaviour	Play	Participation	Child quality of life	Child satisfaction with support	Parent knowledge and skills	Parent social emotional wellbeing	Parent financial wellbeing	Parent satisfaction with support
Behavioural supports (variety of practices)	1	**+** **H^1**			**+** **H^1**		**+** **H^1**	**+** **H^1**	**+** **H^1**			**+** **H^1**			**+** **H^1**								
Early intensive behavioural intervention	3	**+** **H^2**	**O** **H^2**	**+** **H^2**	**+** **H^2**		**+** **H^2**	**o** **H^3**				**O** **$H^{3,4}$**			**?** **H^2**								
Developmental supports (variety of practices)	2	**o** **H^1**			**+** **H^1**																		
Naturalistic developmental behavioural interventions (variety of practices)	2	**+** **H^1**	**+** **H^5**	**+** **H^5**	**?** **H^5**		**+** **H^5**	**o** **H^1**				**+** **H^5**	**o** **H^1**		**o** **H^5**	**+** **H^5**							

Early Start Denver Model	2	**+** **L[6]**			**o** **L[6]**		**+** **L[6]**					**+** **L[6]**	**o** **H[7]**		**o** **H[7]**								
Pivotal Response Treatment	2	**o** **L[8]**	**+** **L[8]**											*?* *L[9]*						*?* *L[9]*			
JASPER	1	*+* *H[10]*	*?* *H[10]*	*?* *H[10]*	*+* *H[10]*							*o* *H[10]*				*+* *H[10]*							
Sensory-based supports (variety of practices)	1	**o** **H[1]**																					
Music therapy	2	**+** **H[11]**			**+** **H[11]**															**+** **H[11]**			
TEACCH (variety of practices)	1				**o** **H[1]**																		
Technology based supports (variety of practices)	3				**o** **H[1]**			**o** **H[1]**						*?* *H[12]*									
Apps	3	**o** **H[13]**	**o** **H[13]**	**o** **H[13]**	**o** **H[13]**		**+** **H[13]**		**+** **H[13]**					*?* *H[14]*									
Gaming	1													*+* *H[14]*									
Mobile technology	1													*?* *H[15]*									
Videos/DVDs/Video modelling	1													*+* *H[14]*									
Animal-assisted supports (variety of practices)																							
Equine assisted therapy	2	**+** **L[16]**			**+** **L[16]**							**o** **L[16]**			**o** **L[17]**								
Canine assisted therapy	1				*+* *L[18]*																		
Cognitive behavioural therapy (variety of practices)	2				**+** **L[19]**			**?** **H[20]**				**?** **H[20]**											
Other supports																							

Social skills training (computers + robots)	1				**+** **H**[21]																		
Social training (video games)	1													*+* *H*[15]									
UCLA PEERS	1				**+** **L**[22]												**+** **L**[22]						

+ = positive therapeutic effect
? = inconsistent therapeutic effect
o = null effect
L = Low quality systematic review
H = High quality systematic review
Blank cells = no therapeutic evidence
Effects in **bold** font are drawn from meta-analyses
Effects in *italicised* font are drawn from narrative syntheses

[1] Sandbank et al. (2020)
[2] Shi et al. (2021)
[3] Reichow et al. (2018)
[4] Rodgers et al. (2020)
[5] Tiede & Walton (2019)
[6] Wang et al. (2021a)
[7] Fuller et al. (2020)
[8] Ona et al. (2020)
[9] Vershuur et al. (2014)
[10] Waddington et al. (2020)
[11] Geretsegger et al. (2014)
[12] Khan et al. (2019)
[13] Moon et al. (2020)
[14] Valentine et al. (2020)
[15] Jiménez-Muñoz et al. (2022)
[16] Dimolareva & Dunn (2021)
[17] Trzmiel et al. (2019)
[18] Hardy & Weston (2020)
[19] Ho et al. (2014)
[20] Wang et al. (2021b)
[21] Soares et al. (2021)
[22] Zheng et al. (2021)

National guideline for supporting the learning, participation, and wellbeing of autistic children and their families in Australia

Appendix 5.14	Umbrella review - Raw data and summary statements

Appendix 5.14 - Umbrella review - Raw data and summary statements

Raw data and summary statements from each included systematic review for all categorised outcomes in the current umbrella review.

Bejarano-Martín et al. (2020)- Meta-analysis

Outcome	Context	Studies included	Effect size	Heterogeneity	Categorised outcome
Social-communication	Overall (group studies)	18	g = 0.51, 95CI [0.37, 0.65]	I^2 = 23.01	Positive pooled effect
Social-communication (Imitation)	Group studies	4	g = 0.43, 95CI [0.10, 0.75]	I^2 = 6.62	Positive pooled effect
Social-communication (Joint attention)	Group studies	14	g = 0.55, 95CI [0.39, 0.70]	I^2 = 19.83	Positive pooled effect
Social-communication (Play)	Group studies	6/7[1]	g = 0.47, 95CI [0.25, 0.70]	I^2 = 73.56	Positive pooled effect

Moderators	Context	Outcome	Studies Included	Verbatim summary from systematic review	Categorised outcome
Child age	Group	Social-communication	24 group	Group: "did prove to be significant, Q (1) = 6.95, p = 0.008. Effect sizes were greater when participants' preintervention ages were lower (see Appendix H for more information)."	Age negatively associated with the effect of support on social-communication.
Child characteristics	Group	Social-communication	14 group	"nonsignificant for group" "All the descriptive moderators (overall cognitive ability, verbal ability…) were nonsignificant."	Child communication skills and cognitive ability prior to support not related to the effect of support on social-communication.
Amount of support	Group	Social-communication	16 group	Group: "were nonsignificant… Treatment amount increased with increasing participants' age, although this relationship	Amount of support (total hours) not

				was not significant (r = 0.271, p = 0.076). In addition, when we eliminated the two studies where treatment amount was much higher than the rest of the studies, the relationship between the amount and the effect was significantly positive (see Fig. 6 in Appendix I)."	related to the effect of support on social-communication.
Agent	Overall	Social-communication	9 group	Group: "The effect sizes… ranged from g = 0.11 to g = 1.02. Fig. 4 shows the individual effect size for this analysis (g = 0.50, K = 9, 95% [CI 0.32, 0.68], Z = 5.39, p < 0.001). This was a medium effect. The sample of studies was not sufficiently large and the I^2 statistic (0.00) did not meet the criteria to proceed with moderator or publication bias analyses."	Agent (caregivers, teachers, clinician) not related to the effect of support on social-communication.

[1] Both numbers reported.

Binns & Oram Cardy (2019) – Narrative synthesis

Outcome	Studies included	Verbatim summary from systematic review	Categorised outcome
Social-communication (social interaction and social-communication)	4	"Each of the four studies evaluating social interaction capacities or overall social-communication reported positive results, with moderate (Solomon et al., 2014; Wetherby et al., 2014) to large effects (Aldred et al., 2004; Green et al., 2010; Pajareya & Nopmaneejumruslers, 2011). Aldred et al. (2004) included both social interaction and communication outcome measures, and reported positive results in the social interaction domain of the ADOS, but no significant change on the communication domain."	Positive summarised effect
Communication (language capacities)	6	"Six studies used standardized language tests as outcome measures (e.g. Preschool Language Scale; Zimmerman, Steiner, & Pond, 2006). Of these, three reported mixed results across different language tests (Green et al., 2010; Schertz et al., 2013;Wetherby et al., 2014) and three reported no effects (Aldred et al., 2004; Casenhiser et al., 2013; Solomon et al., 2014). Two of the studies that reported mixed results found small to moderate positive effects in children's receptive language, but not in expressive language (Schertz et al., 2013; Wetherby et al., 2014). Green et al. (2010) found no effects using assessor rated measures of language."	Inconsistent summarised effect

Crank et al. (2021)- Meta-analysis

Outcome	Context	Studies included	Effect size	Heterogeneity	Categorised outcome
Overall autism characteristics (ASD symptomology)*	-	8	RVE = 0.05, 95%CI (-0.38, 0.48)	-	Null pooled effect

Social-communication*	-	>10	RVE = 0.35, 95%CI (0.18, 0.53)	-	Positive pooled effect
Restricted and repetitive interests and behaviours*	-	8	RVE = -0.01, 95%CI (-0.34, 0.32)	-	Null pooled effect
Language*	-	>10	RVE = 0.20, 95%CI (0.03, 0.38)	-	Positive pooled effect
Cognitive development*	-	>10	RVE = 0.26, 95%CI (0.01, 0.51)	-	Positive pooled effect
Social emotional/ challenging behaviour*	-	6	RVE = 0.17, 95%CI (-0.28, 0.61)	-	Null pooled effect
Play skills*	-	7	RVE = 0.33, 95%CI (0.13, 0.54)	-	Positive pooled effect
Adaptive behaviour*	-	7	RVE = 0.16, 95%CI (-0.24, 0.56)	-	Null pooled effect

Moderators	**Context**	**Outcome**	**Studies Included**	**Verbatim summary from systematic review**	**Categorised outcome**
Child age	-	General outcomes	27	"The results of meta-regression models indicated that neither the mean chronological age (B = −0.06, P = 0.256), nor the mean language age of samples at study entry (B = −0.02, P = 0.758)...moderated NDBI intervention effects."	The child's age (chronological age) was not related to the effect of support on general outcomes.
Communication	-	General outcomes	10		The child's communication (language age) was not related to the effect of support on general outcomes.
Amount of support	-	General outcomes	12	"Effect sizes did not significantly vary as a function of cumulative intensity of support in hours (B = 0.09, P = 0.563)."	The amount of support (cumulative intensity) was not related to the effect of support on general outcomes.
Agent	Clinician, caregiver, educator, combination	General outcomes	27	"Effect sizes did not significantly vary as a function of...the type of interventionist that implemented the intervention (clinician B = 0.12, P = 0.539; combination B = −0.26, P = 0.215; educator B = 0.01, P = 0.931; reference category = caregiver)."	The agent (clinicians, educators, caregivers, combination) was not related to the effect of support on general outcomes.

* These effects are identical to those originally reported in Sandbank et al. (2020). Thus, they are reported under Sandbank et al. (2020) only in the summary tables.

Deb et al. (2020)- Meta-analysis

Outcome	**Context**	**Studies included**	**Effect size**	**Heterogeneity**	**Categorised outcome**
General outcomes (treatment effect)	DIR/Floortime	2	SMD = 0.98, 95%CI (0.41, 1.55)	Tau^2 = 0 Chi^2 = 0.55 I^2 = 0%	Positive pooled effect
General outcomes (treatment effect)	Parent-focussed training	2	SMD = 0.38, 95%CI (0.08, 1.67)	Tau^2 = 0 Chi^2 = 0.94 I^2 = 0%	Positive pooled effect
General outcomes (treatment effect)	Pivotal response treatment	2	SMD = 0.73, 95%CI (0.24, 1.21)	Tau^2 = 0 Chi^2 = 0.27 I^2 = 0%	Positive pooled effect

Dimolareva & Dunn (2021)- Meta-analysis

Outcome	**Context**	**Studies included**	**Effect size**	**Heterogeneity**	**Categorised outcome**
Overall autism characteristics (global measures of ASD)	-	7	SMC = -0.19, 95%CI (-0.39, 0.02)	I^2= 0% Q= 13.48	Null pooled effect
Social-communication (social interaction)	-	9	SMC = 0.21, 95%CI (0.07, 0.35)	I^2= 0% Q= 6.73	Positive pooled effect
Communication (language)	-	9	SMC = 0.26, 95%CI (0.08, 0.44)	I^2= 30.1% Q= 11.02	Positive pooled effect

Moderators	**Context**	**Outcome**	**Studies Included**	**Verbatim summary from systematic review**	**Categorised outcome**
Amount of support	Minutes engaged in therapy	Overall autism characteristics	-	"The meta-regression results showed no significant relationship between dosage (approximate mins engaged in therapy) and improvement in social interaction (β = 0.00, SE = 0.00, z = 0.68, Q = 0.47, p = 0.49), communication (β = 0.00, SE = 0.00, z = 0.11, Q = 0.01, p = 0.91), or Global ASD symptoms (β = -− 0.00, SE = 0.00, z = − 0.42, Q = 0.17, p = 0.67)."	The amount of support (minutes engaged in therapy) was not related to the effect of support on overall autism characteristics.
		Social-communication	9		The amount of support (minutes engaged in therapy) was not related to the effect of

					support on social-communication.
		Communication (language)	-		The amount of support (minutes engaged in therapy) was not related to the effect of support on communication (language).

Ferguson et al. (2019) – Narrative synthesis

Outcome	Studies included	Verbatim summary from systematic review	Categorised outcome
General outcomes (efficacy outcomes)	28	"Results of efficacy (Fig. 3) show that 61% (n=17) of studies were rated as 'positive' in which improvements were achieved by all participants across all dependent variables…Overall, 32% (n=9) of studies received a 'mixed' efficacy rating (Barkaia et al. 2017; Bearss et al. 2017; Machalicek et al. 2016; Meadan et al. 2016; Suess et al. 2014; Vismara et al. 2013, 2016; Wainer and Ingersoll 2015; Wilczynski et al. 2017). For example, 44% (n=4) of these studies found improvements in interventionist treatment fidelity across all participants but failed to increase scores of social-communication or imitation behaviours consistently across participants (Meadan et al. 2016; Wainer and Ingersoll 2015; Vismara et al. 2013). None of the 28 studies included in this review received a 'negative' rating."	Positive summarised effect

Fuller et al. (2020) – Meta-analysis

Outcome	Context	Studies included	Effect size	Heterogeneity	Categorised outcome
Overall autism characteristics (autism symptoms)	-	9	g = 0.070 (-)	$I^2 = 48.90\%$ $\tau^2 = 0.073$	Null pooled effect
Social-communication	-	8	g = 0.209 (-)	$I^2 = 72.53\%$ $\tau^2 = 0.176$	Null pooled effect
Restricted and repetitive interests and behaviours (repetitive behaviours)	-	5	g = -0.016 (-)	-	Null pooled effect
Communication (language)	-	11	g = 0.408 (-)	$I^2 = 52.70\%$ $\tau^2 = 0.088$	Positive pooled effect
Cognitive development (cognition)	-	9	g = 0.412 (-)	$I^2 = 66.30\%$	Positive pooled effect

				τ^2 = 0.145	
Adaptative behaviour (adaptive functioning)	-	6	g = 0.121 (-)	I^2 = 49.03% τ^2 = 0.062	Null pooled effect

Moderators	**Context**	**Outcome**	**Studies Included**	**Verbatim summary from systematic review**	**Categorised outcome**
Amount of support	-	General outcomes (Child outcomes)	Not specified	"The studies used a wide range of amount of supports both in intensity and in length, ranging in intensity from one hour per week to 20 hours per week, and ranging in length from six weeks to 156 weeks. This resulted in total hours of intervention ranging from 12 hours to 2080 hours. However, a meta-regression showed that child outcomes were not significantly related to the length of intervention (B = −0.01, p = 0.46), to the hours per week of intervention (B = −0.02, p = 0.73), or to the total number of hours (B = 0.004, p = 0.66)."	Amount of support (total hours) not related to the effect of support on general outcomes (child outcomes).

Geretsegger et al. (2014) – Meta-analysis

Outcome	**Context**	**Studies included**	**Effect size**	**Heterogeneity**	**Categorised outcome**
Social-communication (social adaptation)	Overall	4	SMD = 0.41, 95CI [0.21, 0.60]	Chi^2 = 15.34 I^2 = 80%	Positive pooled effect
Communication (non-verbal)	Overall	Not specified	SMD = 0.47, 95CI [0.21, 0.73]	Chi2 = 1.32 I^2 = 0%	Positive pooled effect
Communication (verbal)	Overall	6	SMD = 0.33, 95CI [0.16, 0.49]	Chi^2 = 0.72 I^2 = 0%	Positive pooled effect
Caregiver social emotional wellbeing (quality of family relationships)	-	2	SMD = 0.82, 95CI [0.13, 1.52]	Chi^2 = 0.03 I^2 = 0%	Positive pooled effect

Griffith et al. (2020) – Narrative synthesis

Outcome	**Studies included**	**Verbatim summary from systematic review**	**Categorised outcome**

Social-communication	3	"None of the 3 studies reported significant improvement in the primary social-communication skills outcome measures for the app treatment group compared with the comparison group. Effect sizes for gains in the app groups on social-communication outcomes ranged from 0 to 0.40."	Null summarised effect

Hampton & Kaiser (2016) – Meta-analysis

Outcome	**Context**		**Studies included**	**Effect size**	**Heterogeneity**	**Categorised outcome**
Expressive language (spoken language)	-		26	g = 0.26, 95CI [0.11, 0.42]	τ^2 = 0.083 Q = 59.08 I^2 = 57.7%	Positive pooled effect
Moderators	**Context**	**Outcome**	**Studies Included**	**Verbatim summary from systematic review**		**Categorised outcome**
Child age	-	Expressive language (spoken language)	26	"The second meta-regression moderator analysis examined the impact of age of participants and included the same 26 studies and comparison variables. The null hypothesis could not be rejected: the effect of interventions on spoken-language for younger and older participants did not differ significantly (β= 0.092,SE=0.096). This analysis accounted for none of the heterogeneity (R2=0.00%), indicating that interventions delivered at different ages resulted in similar outcomes."		Age not related to the effect of support on expressive (spoken) language.
Amount of support	-	Expressive language (spoken language)	26	"The first meta-regression included all 26 studies. The results indicated the total intervention dose (β=0.008,SE =0.010; total hours of intervention computed as length of treatment x hours per week), and number of indicators of bias (β=0.027,SE=0.027) did not significantly predict the magnitude of spoken-language outcomes."		Amount of support (total hours) not related to the effect of support on expressive (spoken) language.
Agent	-	Expressive language	26	"The random effects ANOVA model for the sub-group analysis of implementers		Supports involving clinicians

		(spoken language)		(clinician only, parent only or parent plus clinician) summarises the outcomes within types of implementers (Fig.2). There was a significant difference among the sub-groups [Q=59.08(25),P<0.001]. None of the heterogeneity was explained within the parent-only group, the parent plus clinician group explained 36.4%, and77.1% was explained by the clinician-only group. The sub-group analysis indicated a significantly better effect on language outcomes for parent plus clinician delivered interventions (g=0.42)as compared with parent-only (g=0.11) or clinician-only (g=0.08) delivered interventions."	and parents related to greater effect of support on expressive (spoken) language than clinicians or parents alone.

Hardy & Weston (2020) – Narrative synthesis

Outcome	**Studies included**	**Verbatim summary from systematic review**	**Categorised outcome**
Social-communication (social behaviour)	5	"Results of the five studies indicated positive effects of CAT on the frequency and duration of social behavior of children with ASD (Becker et al. 2017; Fung and Leung 2014; Grigore and Rusu 2014; Martin and Farnum 2002; Redefer and Goodman 1989)...However, due to the methodological weaknesses of these studies, it would be unfitting to make any assertions about the degree to which CAT impacts social behavior."	Positive summarised effect

Ho et al. (2014) – Meta-analysis

Outcome	**Context**	**Studies included**	**Effect size**	**Heterogeneity**	**Categorised outcome**
Social-communication (social skills)	-	3	g = 0.98, 95CI [0.47, 1.49]	-	Positive pooled effect

Jiménez-Muñoz et al. (2022)- Narrative analysis

Outcome	**Studies Included**	**Verbatim summary from systematic review**	**Categorised outcome**
General outcomes (main findings)	5	"[Four] of the five studies that focused on social training found significant improvement in the outcomes explored (Beaumont et al. 2021; Ben-Sasson et al. 2013; Chung et al. 2016; Wang et al. 2018), while one failed to find statistically significant changes after the intervention (Bernardini et al. 2014)."	Positive summarised effect

Kent et al. (2020) – Meta-analysis

Outcome	**Context**	**Studies included**	**Effect size**	**Heterogeneity**	**Categorised outcome**
Play	Pre/post within group analysis of intervention groups	11	g = 0.439, 95CI [0.209, 0.669]	Q = 17.210 I^2 = 41.9%	Positive pooled effect
	Between-group analysis	8	g = 0.335, 95CI [0.083, 0.586]	-	Positive pooled effect

Moderators	**Context**	**Outcome**	**Studies Included**	**Verbatim summary from systematic review**	**Categorised outcome**
Format	Individual, group	Play	8	"Following the subgroup analysis of intervention characteristics, a meta-regression analysis was performed on eight studies to further explain variability of the results (Chang et al. 2016, b; Goods et al. 2013, b; Kasari et al. 2006, b, 2012, b, 2014, b, 2015, b; Poslawsky et al. 2015, b; Quirmbach et al. 2009, b). The analysis of intervention characteristics indicated that setting and group vs individual [Table 5: Q = 1.06, df= 2, p = 0.5897] were not significant mediators of intervention effects (see Table 5). However, focus of the intervention (i.e., child, parent, peer or teacher) was found to be a significant mediator of play outcomes (Q(3) = 8.52, p = 0.036)."	The format (individual, group) did not relate to the effect of support on play.
Setting	Clinic, home, school	Play	Not specified	"No effect size for the clinic, home, or school setting was significant (clinic z(2) = 1.221,p= 0.222, Hedges' g=0.887,95%CI[−0.537, 2.311]; home: z(2) = 1.402,p= 0.161, Hedges' g= 0.286, 95% CI [−0.114, 0.685]; school: z(4) = 1.469,p= 0.142, Hedges' g=0.259, 95% CI [−0.087, 0.605])… The analysis of intervention characteristics indicated that setting and group vs individual were not significant mediators of	Setting not related to the effect of support on play skills.

				intervention effects (see Table5)."	

Khan et al. (2019) – Meta-analysis (relevant outcomes based on narrative synthesis only)

Outcome	Studies included	Verbatim summary from systematic review	Categorised outcome
General outcomes (condition-specific outcomes or reducing comorbid psychological symptoms)	10	"Primary outcomes: Of 10 interventions, 4 interventions in the included studies were aimed at a youth population with ASD; however, just one [25] of these trials found that Web-based interventions were effective. In the study by Fridenson-Hayo et al [25], children with ASD who received an internet-based serious game improved in ER tasks compared with the WLC group who received TAU. A total of 3 studies [23,24,26] comparing iPad or tablet apps with WLC/TAU groups for children with ASD found no difference in outcome between the groups."	Inconsistent summarised effect

Leung et al. (2021)- Narrative synthesis

Outcome	Studies Included	Verbatim summary from systematic review	Categorised outcome
General outcomes (effectiveness)	6	"...the effectiveness was less robust among younger children, as shown in Table 2 (2 effective, 2 partially effective, and 2 ineffective)."	Inconsistent summarised effect

Mayer-Benarous et al. (2021)- Narrative synthesis

Outcome	Studies Included	Verbatim summary from systematic review	Categorised outcome
Social-communication (joint attention)	4	"Four studies evaluated the benefit of educational music therapy on joint attention (23, 25, 26, 32)…None of these studies reported a statistically significant effect of these interventions on the joint attention of children with ASD."	Null summarised effect

Mazon et al. (2019) – Narrative synthesis

Outcome	Included studies	Verbatim summary from systematic review	Categorised outcome
General outcomes (statistical significance)	23	"Overall, TE studies reported inconsistent results concerning the TBI effect, i.e., 7 with highly-positive, 8 with slightly-positive, and 8 with limited evidence. Fewer of the TBI effects reported in RCT studies were highly-positive (N = 3/14) than in controlled studies (N = 4/8, Table 5). Although there were fewer TU studies, all controlled trials, the TBI effects reported were mostly slightly-positive (N = 4/6). Hence, the highly-positive evidence for TBI was dependent on the study design, irrespective of its aim (TE vs. TU): the more robust the study design, the less consistent the results."	Inconsistent summarised effect

Moon et al. (2020) – Meta-analysis

Outcome	Context	Studies included	Effect size	Heterogeneity	Categorised outcome

Social-communication	3-month follow-up	2	SMD = 0.18, 95CI [-0.20, 0.56]	I^2 = 0%	Null pooled effect
	6-month follow-up	2	SMD = 0.00, 95CI [-0.55, 0.55]	I^2 = 0%	Null pooled effect
Communication (gestures)	3-month follow-up	2	SMD = 0.32, 95CI [-0.05, 0.69]	I^2 = 0%	Null pooled effect
Communication (symbolic)	3-month follow-up	2	SMD = 0.05, 95CI [-0.33, 0.43]	I^2 = 0%	Null pooled effect
Expressive language	-	2	SMD = 0.25, 95CI [-0.36, 0.86]	I^2 = 60.99%	Null pooled effect
Expressive language (words produced)	-	2	SMD = -0.23, 95CI [-0.68, 0.22]	I^2 = 32.56%	Null pooled effect
Receptive language	-	2	SMD = 0.24, 95CI [-0.13, 0.61]	I^2 = 0%	Null pooled effect
Cognitive development (visual reception)	-	2	SMD = 0.41, 95CI [0.03, 0.80]	I^2 = 0%	Positive pooled effect
Motor (fine motor)	-	2	SMD = 0.44, 95CI [0.06, 0.81]	I^2 = 5.2%	Positive pooled effect

Murza et al. (2016) – Meta-analysis

Outcome	**Context**	**Studies included**	**Effect size**	**Heterogeneity**	**Categorised outcome**
Social-communication (joint attention)	Joint attention versus control group	9	g = 0.660 (0.395, 0.925)	Not specified	Positive pooled effect
	Joint attention versus symbolic play	2	g = 0.527 (0.077, 0.978)	Not specified	Positive pooled effect
	Joint attention versus control group: treatment administered by parent	5	g = 0.678 (0.313, 1.043)	Not specified	Positive pooled effect
	Joint attention versus control group: discrete trial training plus social interactive approach	5	g = 0.762 (0.337, 1.187)	Not specified	Positive pooled effect
	Joint attention versus control group: social interactive approach only	4	g = 0.589 (0.194, 0.983)	Not specified	Positive pooled effect

Naveed et al. (2019) – Meta-analysis

Outcome	**Context**	**Studies included**	**Effect size**	**Heterogeneity**	**Categorised outcome**
Overall autism characteristics (autism symptom severity)	-	7 trials, 10 studies[1]	SMD = 0.44, 95CI [0.27, 0.60]	I^2 = 0% Chi^2 = 5.42	Positive pooled effect
Social-communication (social skills)	-	10 trials, 18 studies[1]	SMD = 0.53, 95CI [0.34, 0.73]	I^2 = 48.59% Chi^2 = 31.12	Positive pooled effect

Social-communication (joint engagement)	-		4 trials, 7 studies[1]	SMD = 0.63, 95CI [0.21, 1.06]	I^2 = 75.88% Chi^2 = 24.87	Positive pooled effect
Social-communication (joint attention)	-		7 trials, 8 studies[1]	SMD = 0.16, 95CI [-0.22, 0.54]	I^2 = 76.13% Chi^2 = 29.32	Null pooled effect
Restricted and repetitive interests and behaviours (repetitive behaviours)	-		2 trials, 3 studies[1]	SMD = 0.33, 95CI [0.05, 0.62]	I^2 = 0% Chi^2 = 0.17	Positive pooled effect
Communication	-		15 trials, 13 studies[1]	SMD = 0.23, 95CI [0.03, 0.42]	I^2 = 37.96% Chi^2 = 17.73	Positive pooled effect
Expressive language	-		15 trials, 6 studies[1]	SMD = 0.47, 95CI [0.22, 0.72]	I^2 = 53.59% Chi^2 = 8.62	Positive pooled effect
Receptive language	-		15 trials, 4/5 studies[1]	SMD = 0.16, 95CI [-0.24, 0.55]	I^2 = 53.34% Chi^2 = 7.38	Null pooled effect
Cognitive development (visual reception)	-		3	SMD = 0.29, 95CI [0.01, 0.57]	I^2 = 0% Chi^2 = 1.22	Positive pooled effect
Motor (motor skills)	-		5 trials, 6 studies[1]	SMD = 0.25, 95CI [0.02, 0.48]	I^2 = 0% Chi^2 = 4.18	Positive pooled effect
Social emotional/challenging behaviour (self-regulation)	-		3	SMD = 0.54, 95CI [0.06, 1.03]	I^2 = 55.91% Chi^2 = 4.36	Positive pooled effect
Adaptive behaviour	-		6 trials, 7 studies[1]	SMD = 0.26, 95CI [-0.001, 0.52]	I^2 = 41.44% Chi^2 = 10.25	Null pooled effect
Caregiver social emotional wellbeing (parental distress)	-		7	SMD = 0.33, 95CI [0.09, 0.57]	I^2 = 52.01% Chi^2 = 18.75	Positive pooled effect
Caregiver social emotional wellbeing (parental self-efficacy)	-		4	SMD = 0.42, 95CI [0.23, 0.62]	I^2 = 0% Chi^2 = 4.64	Positive pooled effect
Caregiver social emotional wellbeing (parent-child relationship)	-		6	SMD = 0.67, 95CI [0.23, 1.10]	I^2 = 76.0% Chi^2 = 20.83	Positive pooled effect
Child satisfaction (child distress)	-		2	SMD= 0.55, 95CI [0.25, 0.85]	I^2 = 0% Chi^2 = 1.76	Positive pooled effect
Moderators	**Context**	**Outcome**	**Studies Included**	**Verbatim summary from systematic review**		**Categorised outcome**

Child age	-	General outcomes	-	"Initially, meta-regression analysis was run inclusive for all outcomes. It did not reveal any significant effects of age, year of publication or duration of program and session or number of sessions or quality of trials on the significance of these interventions."	Age not related to the effect of support.
Amount of support	-	General outcomes	-		Number of support sessions not related to the effect of support.

[1] Both numbers reported

Nevill et al. (2018) – Meta-analysis

Outcome	**Context**	**Studies included**	**Effect size**	**Heterogeneity**	**Categorised outcome**
Overall autism characteristics (autism symptom severity)	-	6	g = 0.22, 95CI [0.03, 0.41]	Q = 3.79 $I^2 = 0\%$	Positive pooled effect
Social-communication (socialisation)	-	13	g = 0.23, 95CI [0.09, 0.36]	Q = 35.90 $I^2 = 66.57\%$	Positive pooled effect
Communication (language)	-	13	g = 0.16, 95CI [0.02, 0.31]	Q = 11.50 $I^2 = 0\%$	Positive pooled effect
Cognitive development (cognition)	-	6	g = 0.24, 95CI [0.03, 0.46]	Q = 1.86 $I^2 = 0\%$	Positive pooled effect

Moderators	**Context**	**Outcome**	**Studies Included**	**Verbatim summary from systematic review**	**Categorised outcome**
Amount of support	<20h parent training vs 20 hours or higher of parent training	Overall autism characteristics (symptom severity), social-communication (socialisation), communication (language), cognitive development (cognition)	Overall autism characteristics (symptom severity): <20h n=2 ≥ 20h n=4 Social-communication (socialisation): <20 h n=5 ≥ 20h n=8 Communication (language): <20h n=6 ≥ 20h n=7	"Effect of intervention by dose of parent training. Dose of active intervention ranged from 2.3 to 104 h. Studies were coded as providing less than 20h (k=9) or 20h or more (k=10) of parent training while in the active treatment group. Results of subgroup meta-analyses based on dose are shown in Table 8. For studies with less than 20 h of parent training, socialization [Table 8: weighted g = 0.25, 95%CI (−0.004, 0.51] and communication language [Table 8: weighted g = 0.25, 95%CI (0.01 to 0.49)] was associated with small treatment effects. Analyses were not performed for cognition or ASD symptom severity because there was only one study assessing change in cognitive development and two studies assessing change in	Amount of support (total hours) not related to the effect of support on overall autism characteristics (symptom severity), social-communication (socialisation), communication (language), or cognitive development.

			Cognitive development: $<$20h n=1 $\geq$ 20h n=5	ASD symptom severity. Across studies with doses at or above 20h, small effects were observed for socialization [Table 8: weighted g = 0.22, 95%CI (0.06 to 0.38)] and cognition [Table 8: weighted g = 0.24, 95%CI (0.02, 0.46)], and trivial non-significant effects were observed for ASD symptom severity [Table 8: weighted g = 0.14, 95%CI (-0.07, 0.35)] and communication-language [Table 8: weighted g = 0.14, 95%CI (-0.04, 0.31)]. Outcomes were not significantly different based on dose of treatment. Hedges' Q homogeneity tests were non-significant across outcomes."	

O'Donovan et al. (2019)- Narrative synthesis

Outcome	**Studies Included**	**Verbatim summary from systematic review**	**Categorised outcome**
Social emotional/ challenging behaviour (problematic behaviours)	4	"Problematic behaviours were measured in three studies (Roberts and Pickering 2010; Sofronoff and Farbotko 2002; Stuttard et al. 2014) by the Eyberg Child Behaviour Inventory (ECBI) and by Todd et al. (2010) using an alternative service-specific measure. All four studies found a reduction in the frequency of children's problematic behaviours post-intervention"	Positive summarised effect
Caregiver communication and interaction (parental skills)	2	"Clubb (2012) and Probst and Glen (2011) report improvements in parental skills following interventions."	Positive summarised effect

Ona et al. (2020) – Meta-analysis

			Effect size	**Heterogeneity**	
Communication	-	2	SMD = 1.12, 95CI [-0.49, 2.73]	$I^2 = 89\%$ $\tau^2 = 1.2$	Null pooled effect
Expressive language	-	2	SMD = 0.48, 95CI [0.04, 0.93]	$I^2 = 0\%$ $\tau^2 = 0.0$	Positive pooled effect

Oono et al. (2013) – Meta-analysis

Outcome	**Context**	**Studies included**	**Effect size**	**Heterogeneity**	**Categorised outcome**

Overall autism characteristics (severity of autism characteristics)	-	6	SMD = -0.30, 95CI [-0.52, -0.08]	I^2 = 0%	Positive pooled effect
Social-communication (shared or joint attention)	-	3	SMD = 0.41, 95CI [0.14, 0.68]	I^2 = 0%	Positive pooled effect
Social-communication (child initiations)	-	4	SMD = 0.38, 95CI [-0.07, 0.82]	I^2 = 60%	Null pooled effect
Communication	Parent or teacher report	3	SMD = 5.31, 95CI [-6.77, 17.39]	I^2 = 75%	Null pooled effect
Communication (joint language)	Direct or independent assessment	2	SMD = 0.45, 95CI [-0.05, 0.95]	I^2 = 0%	Null pooled effect
Expressive language (expression)	Direct or independent assessment	3	SMD = 0.14, 95CI [-0.16, 0.45]	I^2 = 29%	Null pooled effect
Receptive language (comprehension)	Direct or independent assessment	2	SMD = 0.29, 95CI [-0.20, 0.78]	I^2 = 57%	Null pooled effect
			Verbatim summary from systematic review		
Cognitive (developmental/intellectual gains)	-	-	"five studies (Smith 2000; Drew 2002; Rickards 2007; Dawson 2010; Tonge 2012) with varying theoretical basis and methods for assessing developmental/intellectual gains reported on this outcome. Dawson 2010 and Rickards 2007 suggest that small gains were made in this domain following intervention. However, Drew 2002 and Tonge 2012 (individual and group intervention, respectively) did not report any difference in this domain between intervention and control groups following intervention. Smith 2000 found greater gains for the intensive therapist-delivered intervention condition. Evidence for gains from parent-mediated intervention therefore may be suggested. However, gains in formal assessment may in part reflect child co-operation."		Positive summarised effect
Social-emotional development (maladaptive behaviour)	-	-	"Four studies (Smith 2000; Tonge 2006/Tonge 2012; Rickards 2007; Roberts 2011) reported on this outcome. Due to significant and important differences between these studies in theoretical basis and outcome measures used, a meta-analysis could not be conducted. None found a		Null summarised effect

			significant difference in maladaptive behaviour in favour of the intervention group, even where that was the focus of intervention (Tonge 2012)."		
			Effect size	**Heterogeneity**	
Adaptive behaviour	-	2	SMD = 1.06, 95CI [-2.95, 5.06]	I^2 = 86%	Null pooled effect
Caregiver communication and interaction (parental synchrony)	-	3	SMD = 0.90, 95CI [0.56, 1.23]	I^2 = 27%	Positive pooled effect
Caregiver social emotional wellbeing (parents' level of stress)	-	2	SMD = -0.17, 95CI [-0.70, 0.36]	I^2 = 0%	Null pooled effect

Parsons, Cordier, Munro et al. (2017) – Meta-analysis

Outcome	**Context**		**Studies included**	**Effect size**	**Heterogeneity**	**Categorised outcome**
Social-communication (pragmatic language)	Compared to controls		17 intervention groups from 15 studies	g = 0.274, 95CI [0.088, 0.460]	Q = 19.413 I^2 = 17.570%	Positive pooled effect
	Intervention effect (i.e., within intervention group, pre/post comparison)		17 intervention groups from 15 studies	g = 0.500, 95CI [0.352, 0.647]		Positive pooled effect
Moderators	**Context**	**Outcome**	**Studies Included**	**Verbatim summary from systematic review**		**Categorised outcome**
Child age	-	Social-communication (pragmatic language)	17 intervention groups from 15 studies	"No differences were detected in outcomes as a result of participant age or method of pragmatic language measurement (i.e., parent report, observation, or lab task)...Lastly, as there was a concordance between increased age and receiving intervention in a group, participant age was examined in relation to mode. This did not produce a significant result, indicating age did not mediate the effect of mode of delivery (i.e., individual, group, or both)."		Age not related to the effect of support on social-communication.
Setting	Home, school, clinic	Social-communication (pragmatic language)	17 intervention groups from 15 studies	"Interventions set in the clinic demonstrated a significant, moderate effect size (z(12) = 5.758, p < 0.001, Hedge's g = 0.535, 95%CI = 0.353–0.718), which was the largest effect		Setting not related to the effect of support on social-

				size calculated as a function of setting. Interventions set in the school were approaching significance, with a small effect (z(3) = 1.925, p = 0.054, Hedge's g = 0.408, 95%CI = -0.007–0.824), Interventions set in the clinic demonstrated a significant, moderate effect size (z (12) = 5.758, p < 0.001, Hedge's g = 0.535, 95%CI = 0.353–0.718), which was the largest effect and interventions set in the home did not have a significant effect on improving pragmatic language skills when compared to the other settings (z(2) = 1.846, p = 0.065). However, these results should be interpreted with caution as only two studies were set in the home and just one at school compared to 12 in the clinic setting group."	communication.
Format	Individual, group	Social-communication (pragmatic language)	17 intervention groups from 15 studies	"Whether interventions were administered to a group, the individual or both, effects were significant and moderate in size. Group interventions produced the largest effect of the three modalities (z(5) = 3.811, p < 0.001, Hedge's g = 0.553, 95%CI = 0.269–0.838). The analysis of intervention characteristics indicated that setting and mode were not significant mediators of intervention effect."	Format (individual, group) not related to the effect of support on social-communication.
Agent	Child, parent, children and parent	Social-communication (pragmatic language)	17 intervention groups from 15 studies	"Approaches that integrated a caregiver into the program via education and/or coaching in intervention techniques demonstrated a significant, moderate-large effect (z(4) = 5.265, p < 0.001, Hedge's g = 0.760, 95%CI = 0.477–1.043), while the intervention that focused on parent education only had no significant impact on the pragmatic language skills of children with ASD (z(1) = 0.341, p = 0.733).The majority of studies focused on administering the intervention directly to the children with ASD, and these interventions	Positive effect of support for supports with active parent involvement, but not for supports with parent education alone.

				demonstrated a significant, moderate effect (z(12) = 5.842,p < 0.001, Hedge's g = 0.482, 95%CI = 0.320–0.644). Again, caution is required in interpreting these results as there is only one study in the parent focused group, and 12 and 4 in the child focused and combined child and parent focused groups respectively...intervention focus (e.g. child, parent or child and parent) was found to be a significant mediator of pragmatic language outcomes (F(2) = 4.17, p = 0.0381), accounting for all of the between study variance in the model (R2 = 100%)."	

Parsons, Cordier, Vaz et al. (2017) – Narrative synthesis

Outcome	**Studies included**	**Verbatim summary from systematic review**	**Categorised outcome**
Caregiver communication and interaction (parental knowledge acquisition)	5	"Parents' skills in implementing the acquired therapy techniques were investigated by Heitzman-Powell et al [50], St. Peter et al [46], Vismara et al [12,48], Wacker et al [47], and in the study by Ingersoll and Berger [43], Ingersoll et al [44], and Pickard et al [45]. All of the studies reported statistically significant improvements in parents' skills in administering skills learnt through the interventions. These findings present evidence that parents who received the appropriate training could gain skills in the delivery of interventions, thus improving the skills in social-communication and behavior of their children with ASD."	Positive summarised effect

Pi et al. (2021)- Meta-analysis

Outcome	**Context**	**Studies included**	**Effect size**	**Heterogeneity**	**Categorised outcome**
Social-communication	-	6	MD = 0.75, 95%CI (-0.16, 1.68)	I^2 = 39%	Null summarised effect
Social-communication (socialisation)	VABS	2	MD = 1.83, 95%CI (-2.01, 5.68)	I^2 = 0%	Null summarised effect
Communication (language total score)	-	3	MD = -0.06, 95%CI (-2.76, 2.64)	I^2 = 43%	Null summarised effect
Communication (gestures)	-	2	MD = 1.71, 95%CI (-1.24, 4.66)	I^2 = 0%	Null summarised effect
Expressive language (expressive speech)	-	2	MD = 0.03, 95%CI (-0.36, 0.42)	I^2 = 0%	Null summarised effect

Receptive language	-	3	MD = 10.49, 95%CI (-13.11, 34.09)	I^2 = 59%	Null summarised effect

Postorino et al. (2017) – Meta-analysis

Outcome	**Context**	**Studies included**	**Effect size**	**Heterogeneity**	**Categorised outcome**
Social emotional/challenging behaviour (disruptive behaviour)	-	8	SMD = -0.59, 95CI [-0.88, -0.30]	Q = 16.77 I^2 = 57.8%	Positive pooled effect

Reichow et al. (2018) – Meta-analysis

Outcome	**Context**	**Studies included**	**Effect size**	**Heterogeneity**	**Categorised outcome**
Overall autism characteristics (autism symptoms)	EIBI vs treatment as usual	2	SMD = -0.34, 95CI [-0.79, 0.11]	Q = 0.23 I^2 = 0% Tau^2 = 0.00	Null pooled effect
Social-communication (social competence)		5	MD = 6.56, 95CI [1.52, 11.61]	Q = 5.25 I^2 = 23.87% Tau^2 = 7.94	Positive pooled effect
Communication		5	MD = 11.22, 95CI [5.39, 17.04]	Q = 1.86 I^2 = 0% Tau^2 = 0.00	Positive pooled effect
Expressive language		4	SMD = 0.51, 95CI [0.12, 0.90]	Q = 4.46 I^2 = 32.77% Tau^2 = 0.05	Positive pooled effect
Receptive language		4	SMD = 0.55, 95CI [0.23, 0.87]	Q = 1.52 I^2 = 0% Tau^2 = 0.00	Positive pooled effect
Cognitive development (intelligence quotient)		5	MD = 15.44, 95CI [9.29, 21.59]	Q = 1.16 I^2 = 0% Tau^2 = 0.00	Positive pooled effect
Social emotional/challenging behaviour (problem behaviour)		2	SMD = -0.58, 95CI [-1.24, 0.07]	Q = 1.71 I^2 = 41.37% Tau^2 = 0.09	Null pooled effect
Adaptive behaviour		5	MD = 9.58, 95CI [5.57, 13.60]	Q = 2.43 I^2 = 0% Tau^2 = 0.00	Positive pooled effect

Adaptive behaviour (daily living skills)		5	MD = 7.77, 95CI [3.75, 11.79]	Q = 1.73 I^2 = 0% Tau^2 = 0.00	Positive pooled effect

Rodgers et al. (2020)- Meta-analysis

Outcome	**Context**		**Studies included**	**Effect size**	**Heterogeneity**	**Categorised outcome**
Overall autism characteristics (autism symptom severity)	1 year		2	MD = 0.27, 95%CI (-0.19, 0.73)	I^2 = 0%	Null pooled effect
Cognitive development (cognitive ability)	1 year		5	MD = 10.12, 95%CI (5.81, 14.44)	I^2 = 0%	Positive pooled effect
Cognitive development (cognitive ability)	2 years		6	MD = 11.97, 95%CI (6.74, 17.20)	I^2 = 15%	Positive pooled effect
Adaptive behaviour	1 year		8	MD = 1.82, 95%CI (-2.79, 6.43)	I^2 = 80%	Null pooled effect
Adaptive behaviour	2 years		7	MD = 7.74, 95%CI (1.87, 13.61)	I^2 = 72%	Positive pooled effect
Moderators	**Context**	**Outcome**	**Studies Included**	**Verbatim summary from systematic review**		**Categorised outcome**
Child age		Cognitive development	-	“There is no clear evidence of any interaction between these factors [age at recruitment, sex, age at baseline, IQ at baseline] and either IQ or VABS score (e.g. no evidence that older children gain greater benefit from early intensive ABA-based interventions than with alternative interventions than younger children).” From table 5: Age at recruitment, MD = 0.08 95%CI (-0.26, 0.42).		The child's age (age at recruitment) was not related to the effect of support on cognitive development.
Cognitive development		Cognitive development	-	“There is no clear evidence of any interaction between these factors [age at recruitment, sex, age at baseline, IQ at baseline] and either IQ or VABS score (e.g. no evidence that older children gain greater benefit from early intensive ABA-based interventions than with alternative interventions than younger children).” From table 5: IQ at baseline, MD = 0.09 95%CI (-0.13, 0.31).		The child's cognitive development (IQ at baseline) was not related to the effect of support on cognitive development.
Adaptive behaviour		Cognitive	-	“There is no clear evidence of any interaction between these factors [age at recruitment, sex,		The child's adaptive behaviour

		development		age at baseline, IQ at baseline] and either IQ or VABS score (e.g. no evidence that older children gain greater benefit from early intensive ABA-based interventions than with alternative interventions than younger children).” From table 5: VABS at baseline, MD = -0.11 95% CI (-0.58, 0.35).	(VABS at baseline) was not related to the effect of support on cognitive development.
Child age		Adaptive behaviour	-	“There is no clear evidence of any interaction between these factors [age at recruitment, sex, age at baseline, IQ at baseline] and either IQ or VABS score (e.g. no evidence that older children gain greater benefit from early intensive ABA-based interventions than with alternative interventions than younger children).” From table 5: Age at recruitment, MD = -0.05 95% CI (-0.29, 0.18).	The child's age (age at recruitment) was not related to the effect of support on adaptive behaviour.
Cognitive development		Adaptive behaviour	-	“There is no clear evidence of any interaction between these factors [age at recruitment, sex, age at baseline, IQ at baseline] and either IQ or VABS score (e.g. no evidence that older children gain greater benefit from early intensive ABA-based interventions than with alternative interventions than younger children).” From table 5: IQ at baseline, MD = 0.09 95%CI (-0.06, 0.23).	The child's cognitive development (IQ at baseline) was not related to the effect of support on adaptive behaviour.
Adaptive behaviour		Adaptive behaviour	-	“There is no clear evidence of any interaction between these factors [age at recruitment, sex, age at baseline, IQ at baseline] and either IQ or VABS score (e.g. no evidence that older children gain greater benefit from early intensive ABA-based interventions than with alternative interventions than younger children).” From table 5: VABS at baseline, MD = -0.05 95%CI (-0.28, 0.18).	The child's adaptive behaviour (VABS at baseline) was not related to the effect of support on adaptive behaviour.
Setting		Cognitive development	-	“Table 6 presents a summary of these subgroup analyses for outcomes at 2 years. For IQ, all p-values are > 0.05 and there are	The setting (delivery setting- home, school, specialist centre)

				no clear patterns of variation in treatment effect across analyses. For VABS composite score, all p-values are < 0.1, but these are a consequence of extreme results in a single subgroup, driven by extreme results in a single trial,85,95 and are unlikely to represent genuine differences between subgroups.” Table 6; p-value of interaction = 0.62.	was not related to the effect of support on cognitive development.
Agent		Cognitive development (cognition)	-	“Table 6 presents a summary of these subgroup analyses for outcomes at 2 years. For IQ, all p-values are > 0.05 and there are no clear patterns of variation in treatment effect across analyses. For VABS composite score, all p-values are < 0.1, but these are a consequence of extreme results in a single subgroup, driven by extreme results in a single trial,85,95 and are unlikely to represent genuine differences between subgroups.” Table 6: P-value of interaction = 0.52, 95% CI for all effect sizes positive.	The agent (4 hours/week, encouraged, some) was not related to the effect of support on cognitive development.
Setting	Home, school, specialist centre	Adaptive behaviour	-	“Table 6 presents a summary of these subgroup analyses for outcomes at 2 years. For IQ, all p-values are > 0.05 and there are no clear patterns of variation in treatment effect across analyses. For VABS composite score, all p-values are < 0.1, but these are a consequence of extreme results in a single subgroup, driven by extreme results in a single trial,85,95 and are unlikely to represent genuine differences between subgroups.” Table 6: P <0.01, mean for school is highest, mean for specialist centre is lowest, no post-hoc testing.	The setting (delivery setting-home, school, specialist centre) was not associated with the effect of support on adaptive behaviour.
Agent		Adaptive behaviour	-	“Table 6 presents a summary of these subgroup analyses for outcomes at 2 years. For IQ, all p-values are > 0.05 and there are no clear patterns of variation in treatment effect across analyses. For VABS composite score, all p-values are < 0.1, but these are a consequence of extreme	The agent (parental involvement 10 hours/week, 4 hours/week, encouraged, some) was not related to the effect of support

				results in a single subgroup, driven by extreme results in a single trial,85,95 and are unlikely to represent genuine differences between subgroups.” Table 6: p = 0.1.	on adaptive behaviour.
Amount of support	Home, school, specialist centre	Cognitive development (cognition)	3	“Three studies compared high-intensity EIBI (> 15 hours/week) with lower-intensity EIBI.26,90,91,98,103 IQ was the only outcome recorded consistently in all three studies. A repeated measures meta-analysis of IQ comparing high- with low-intensity early ABA-based intervention is shown in Figure 14. This suggests that high-intensity ABA-based interventions produced much larger improvements in IQ than low-intensity ABA-based interventions, with differences of between 10 and 20 points from 1 to 4 years after recruitment, although results are not statistically significant at 1 and 3 years.”	The amount of support (high intensity versus low intensity) was positively associated with the effect of support on cognitive development. Children in high intensity ABA conditions had larger improvements in cognitive development at 4 and 7 years after recruitment but there were no differences at 1 and 3 years.

Sandbank et al. (2020) – Meta-analysis

Outcome	**Context**	**Studies included**	**Effect size**	**Heterogeneity**	**Categorised outcome**
Behavioural Supports					
Overall autism characteristics (diagnostic characteristics)	All studies	8	g = 0.45, 95CI [0.26, 0.63]	Not specified	Positive pooled effect
Social-communication	All studies	20	g = 0.40, 95CI [0.18, 0.61]	Not specified	Positive pooled effect
Communication (language)	All studies	14	g = 0.24, 95CI [0.01, 0.47]	Not specified	Positive pooled effect
Cognitive development	All studies	21	g = 0.29, 95CI [0.05, 0.54]	Not specified	Positive pooled effect
Motor	All studies	8	g = 0.42, 95CI [0.13, 0.72]	Not specified	Positive pooled effect
Social emotional/challenging behaviour	All studies	13	g = 0.46, 95CI [0.27, 0.66]	Not specified	Positive pooled effect

Adaptive behaviour	All studies	21	g = 0.38, 95CI [0.19, 0.56]	Not specified	Positive pooled effect
Developmental Supports					
Social-communication	All studies	14	g = 0.30, 95CI [0.11, 0.50]	Not specified	Positive pooled effect
Communication (language)	All studies	8	g = 0.06, 95CI [-0.08, 0.21]	Not specified	Null pooled effect
Naturalistic developmental behavioural interventions (NDBIs)					
Overall autism characteristics (diagnostic characteristics)	All studies	6	g = 0.05, 95CI [-0.38, 0.48]	Not specified	Null pooled effect
Social-communication	All studies	24	g = 0.35, 95CI [0.18, 0.53]	Not specified	Positive pooled effect
Restricted and repetitive interests and behaviours	All studies	7	g = -0.01, 95CI [-0.34, 0.32]	Not specified	Null pooled effect
Communication (language)	All studies	19	g = 0.20, 95CI [0.03, 0.38]	Not specified	Positive pooled effect
Cognitive development	All studies	9	g = 0.26, 95CI [0.01, 0.51]	Not specified	Positive pooled effect
Social emotional/challenging behaviour	All studies	6	g = 0.17, 95CI [-0.28, 0.61]	Not specified	Null pooled effect
Play	All studies	6	g = 0.33, 95CI [0.13, 0.54]	Not specified	Positive pooled effect
Adaptive behaviour	All studies	6	g = 0.16, 95CI [-0.24, 0.56]	Not specified	Null pooled effect
Sensory-based Supports					
Communication (language)	All studies	7	g = 0.28, 95CI [-0.19, 0.76]	Not specified	Null pooled effect
Treatment and Education of Autistic and related Communications Handicapped Children (TEACCH)					
Social-communication	All studies	6	g = -0.11, 95CI [-0.93, 0.71]	Not specified	Null pooled effect
Technology-based Supports					
Social-communication	All studies	9	g = 0.05, 95CI [-0.18, 0.27]	Not specified	Null pooled effect
Social emotional/challenging behaviour	All studies	7	g = 0.42, 95CI [-0.19, 1.03]	Not specified	Null pooled effect

Sandgreen et al. (2021)- Meta-analysis

Moderators	**Context**	**Outcome**	**Studies Included**	**Verbatim summary from systematic review**	**Categorised outcome**
Child age	<5 years, 5-10 years, >10-15 years	General outcomes	-	"The meta regression analysis revealed no significant associations between Cohen's d and any of the variables	The child's age (age group <5 years, 5-10

				tested. These were...age group between subgroups (< 5 years: $\beta = -0.35$, p = 0.24; 5–10 years: $\beta = 0$ (baseline); > 10–15 years: $\beta = -0.25$, p = 0.36...)."	years, >10-15 years) was not related to the effect of support on general outcomes.

Shi et al. (2021)- Meta-analysis

Outcome	Context	Studies included	Effect size	Heterogeneity	Categorised outcome
Social-communication (VABS Social)	-	5	SMD = 0.38, 95%CI (0.03, 0.73)	I^2= 20.8%	Positive pooled effect
Communication (VABS communication)	-	5	SMD = 0.38, 95%CI (0.03, 0.73)	I^2 = 21%	Positive pooled effect
Expressive language	-	4	SMD = 0.46, 95%CI (-0.08, 1.00)	I^2 = 56.1%	Null pooled effect
Receptive language	-	4	SMD = 0.42, 95%CI (-0.06, 0.91)	I^2 = 45.5%	Null pooled effect
Cognitive development (IQ)	-	6	SMD = 0.53, 95%CI (0.16, 0.90)	I^2 = 41.3%	Positive pooled effect
Adaptive behaviour (VABS composite)	-	5	SMD = 0.47, 95%CI (0.11, 0.83)	I^2 = 24.2%	Positive pooled effect
Adaptive behaviour (daily living skills)	-	4	SMD = 0.18, 95%CI (-0.16, 0.53)	I^2 = 0%	Null pooled effect

Soares et al. (2021)- Meta-analysis

Outcome	Context	Studies included	Effect size	Heterogeneity	Categorised outcome
Social-communication (social functioning)	-	4	g = 0.93, 95%CI (0.57, 1.29)	χ^2 = 4.32 I^2 = 7.31	Positive pooled effect

Sutherland et al. (2018) – Narrative synthesis

Outcome	Studies included	Verbatim summary from systematic review	Categorised outcome
Caregiver satisfaction (satisfaction and acceptability)	9	"Satisfaction and acceptability. Parent satisfaction was a reported outcome for nine of the 14 studies (Baharav & Reiser, 2010; Hepburn et al., 2016; Ingersoll & Berger, 2015; Meadan et al., 2016; Pickard et al., 2016; Reese, Braun, et al., 2015; Schutte et al., 2015; Suess et al., 2016; Wainer & Ingersoll, 2015). All studies reported high levels of programme acceptability and parent satisfaction with the telehealth component of the intervention or assessment. In addition, two studies that involved direct telehealth involvement with individuals on the spectrum (Hepburn et al., 2016; Schutte et al., 2015) reported high participant satisfaction with the methods used."	Positive summarised effect
Caregiver communication	7	"Measurement of fidelity of parent implementation of tasks was a focus of seven of the 14 studies (Hepburn, et al., 2016; Ingersoll & Berger, 2015; Ingersoll et al., 2016; Meadan et al., 2016; Reese,	Positive summarised effect

and interaction (fidelity)		Jamison, et al., 2013; Suess et al., 2016; Wainer & Ingersoll, 2015). The fidelity of parent administration of assessment tasks in the diagnosis study (Reese, Jamison, et al., 2013) was described as ‘adequate’’, while parent fidelity in the behaviour study of Suess et al. (2016) varied across the coached and independent trials “The remaining studies reported high levels of parent fidelity for interventions provided via telehealth (Hepburn et al., 2016; Ingersoll et al., 2016), with a number reporting that the fidelity of programmes taught to parents online was improved when telehealth coaching was provided (Ingersoll & Berger, 2015; Meadan et al., 2016; Wainer & Ingersoll, 2015).”	

Tachibana et al. (2018) – Meta-analysis

Outcome	**Context**	**Studies included**	**Effect size**	**Heterogeneity**	**Categorised outcome**
Overall autism characteristics (autism general symptoms)	Individual intervention (Analysis I)	3	SMD = −0.31, 95CI [−0.63, 0.01]	$I^2 = 0\%$	Null pooled effect
Social-communication (qualitative impairment in social interaction)	Individual intervention (Analysis I)	2	SMD = −0.15, 95CI [−0.40, 0.10]	$I^2 = 0\%$	Null pooled effect
Social-communication (reciprocity of social interaction towards others)	Individual intervention (Analysis I)	5	SMD = 0.59, 95CI [0.25, 0.93]	$I^2 = 18\%$	Positive pooled effect
	Group intervention (Analysis I)	3	SMD = 0.45, 95CI [0.02, 0.88]	$I^2 = 0\%$	Positive pooled effect
Social-communication (initiating joint attention)	Individual intervention (Analysis I)	4	SMD = 0.48, 95CI [-0.14, 1.10]	$I^2 = 78\%$	Null pooled effect
	Group intervention (Analysis I)	2	SMD = 0.15, 95CI [-0.38, 0.68]	$I^2 = 15\%$	Null pooled effect
Social-communication (imitation)	Individual intervention (Analysis I)	Not specified	SMD = 0.54, 95CI [−0.25,1.33]	$I^2 = 62\%$	Null pooled effect
Social-communication (responding to joint attention)	Individual intervention (Analysis I)	3	SMD = 0.63, 95CI [−0.14,1.39]	$I^2 = 97\%$	Null pooled effect
Restricted and repetitive interests and behaviours (restricted repetitive and stereotyped patterns behaviours, interests and activities)	Individual intervention (Analysis I)	3	SMD = −0.21, 95CI [−0.52, 0.09]	$I^2 = 39\%$	Null pooled effect
Communication (qualitative impairment in communication)	Individual intervention (Analysis I)	1	SMD = −0.03, 95CI [−0.35, 0.29]	N/A	Null pooled effect
Expressive language	Individual intervention (Analysis I)	7	SMD = 0.13, 95CI [−0.06, 0.33]	$I^2 = 0\%$	Null pooled effect
	Group intervention (Analysis I)	1	SMD = -0.03, 95CI [−0.54, 0.48]	N/A	Null pooled effect
Receptive language	Individual intervention (Analysis I)	7	SMD = 0.17, 95CI [−0.09, 0.42]	$I^2 = 28\%$	Null pooled effect

	Group intervention (Analysis I)	1	SMD = 0.14, 95CI [−0.65, 0.37]	N/A	Null pooled effect
Cognitive development (developmental quotient)	Individual intervention (Analysis I)	4/5[1]	SMD = 0.36, 95CI [0.05, 0.66]	$I^2 = 20\%$	Positive pooled effect
Adaptive behaviour	Individual intervention (Analysis I)	7	SMD = −0.05, 95CI [-0.25, 0.14]	$I^2 = 39\%$	Null pooled effect
	Group intervention (Analysis I)	1	SMD = 0.44, 95CI [-0.07, 1.65]	N/A	Null pooled effect
Caregiver communication and interaction (parental synchrony)	Individual Intervention (Analysis I)	3	SMD = 0.99 [0.70, 1.29]	Not specified	Positive pooled effect
Caregiver social emotional wellbeing (parenting stress)	Individual intervention (Analysis I)	2	SMD = -0.30, 95CI [-0.93, 0.32]	$I^2 = 0\%$	Null pooled effect
	Group intervention (Analysis I)	2	SMD = -0.29, 95CI [-0.81, 0.22]	$I^2 = 0\%$	Null pooled effect

Moderators	**Context**	**Outcome**	**Studies Included**	**Verbatim summary from systematic review**	**Categorised outcome**
Format	Individual, group	Overall autism characteristics (autism general symptoms), social-communication (reciprocity of social interaction towards others), expressive language, receptive language, cognitive development (developmental quotient), adaptive behaviour	Not specified	"There were no significant differences between the individual and group intervention studies on the outcomes reviewed."	Format (individual, group) did not relate to the effect of support on overall autistm characteristics, social-communication, expressive language, receptive language, cognitive development, or adaptive behaviour.

[1] Both numbers reported

Tan-MacNeill et al. (2021)- Narrative synthesis.

Outcome	**Studies included**	**Verbatim Summary from Systematic Review**	**Categorised outcome**
Social-communication (communication behaviours and language targets)	3	"All three of the social-communication interventions improved children's communication behaviors and language targets (Douglas et al., 2018; Ingersoll et al., 2016; McGarry et al., 2019)."	Positive summarised effect

Tarver et al. (2019) – Meta-analysis

Outcome	**Context**	**Studies included**	**Effect size**	**Heterogeneity**	**Categorised outcome**
Social emotional/challenging behaviour	Parent-reported disruptive behaviour	9	SMD = 0.67, 95CI [0.49, 0.85]	I^2 = 0%	Positive pooled effect
	Parent-reported hyperactivity	3	SMD = 0.31, 95CI [0.07, 0.56]	I^2 = 0%	Positive pooled effect
Caregiver social emotional wellbeing (parenting stress)	-	7	SMD = 0.37, 95CI [0.17, 0.57]	I^2 = 0%	Positive pooled effect
Caregiver social emotional wellbeing (parenting efficacy)	-	5	SMD = 0.39, 95CI [−0.17, 0.95]	I^2 = 81%	Null pooled effect

Tiede & Walton (2019) – Meta-analysis

Outcome	**Context**	**Studies included**	**Effect size**	**Heterogeneity**	**Categorised outcome**
Overall autism characteristics (symptoms of ASD)	-	9	g = -0.38, 95CI [−0.71, −0.04]	Q = 26.1 I^2 = 67%	Positive pooled effect
Social-communication (joint attention)	Initiating joint attention	15	g = 0.14, 95CI [−0.01, 0.28]	Q = 16.0 I^2 = 7%	Null pooled effect
Social-communication (social engagement)	-	12	g = 0.65, 95CI [0.37, 0.93]	Q = 34.2 I^2 = 64%	Positive pooled effect
Expressive language	-	12	g = 0.32, 95CI [0.07, 0.56]	Q = 22.9 I^2 = 54%	Positive pooled effect
Receptive language	-	10	g = 0.28, 95CI [−0.02, 0.58]	Q = 24.9 I^2 = 64%	Positive pooled effect
Cognitive development	Composite IQ	5	g = 0.48, 95CI [0.22, 0.74]	Q = 5.3 I^2 = 30%	Positive pooled effect
Cognitive development (nonverbal IQ)	-	7	g = 0.21, 95CI [0.01, 0.41]	Q = 6.1 I^2 = <1%	Positive pooled effect
Play	-	8	g = 0.23, 95CI [0.04, 0.41]	Q = 7.7 I^2 = 11%	Positive pooled effect
Adaptive behaviour	-	5	g = 0.09, 95CI [−0.24, 0.42]	Q = 9.1 I^2 = 56%	Null pooled effect

Moderators	**Context**	**Outcome**	**Studies Included**	**Verbatim summary from systematic review**	**Categorised outcome**

Amount of support	-	Social-communication (joint attention, social engagement), expressive language, receptive language, cognitive development (cognition), adaptive behaviour, overall autism characteristics, play	Not specified	[Social-communication – joint attention]: "Dosage significantly moderated the results such that increased hours of professional contact resulted in more positive joint attention outcomes (β = 0.17 p = 0.02, 95% CI = 0.02 to 0.32)." [Expressive Language]: "Dosage did not moderate effects (β = 0.09, p = 0.35, 95% CI = −0.10 to 0.29)." [Receptive Language]: "When study quality and dosage were added as moderators, neither dosage (β = 0.15, p = 0.35, 95% CI = −0.16 to 0.46) nor study quality (β = −0.28, p = 0.36, 95% CI = −0.87 to 0.32) significantly moderated the effects." [Cognitive development]: "for composite IQ/cognitive development… Dosage (β = 0.06, p = 0.79, 95% CI = −0.36 to 0.47) and study quality (β = −0.09, p = 0.80, 95% CI = −0.82 to 0.63) did not significantly moderate the effects. For nonverbal IQ… Neither study quality (β = 0.24, p = 0.25, 95% CI = −0.17 to 0.65) nor dosage significantly moderated the effects (β = 0.18, p = 0.14, 95% CI = −0.06 to 0.42)." [Adaptive behaviour]: "A marginally significant effect was found for dosage; more professional contact hours were associated with more positive findings (β = 0.30, p = 0.06, 95% CI = −0.02 to 0.62)." [Overall autism characteristics]: "Neither dosage (β = 0.13, p = 0.54, 95% CI = −0.28 to 0.54) nor study quality (β = −0.07, p =	Greater amount of support (total hours) related to greater effect of support on social-communication (joint attention). Amount of support (total hours) not related to effect of support on adaptive behaviour, expressive or receptive language, cognition, overall autism characteristics, social-communication (social engagement), or play.

				0.86, 95% CI = −0.89 to 0.74) moderated the results.” [Social-communication – social engagement]: “Neither dosage (β = 0.17, p = 0.20, 95% CI = −0.09 to 0.44) nor study quality (β = 0.25, p = 0.42, 95% CI = −0.36 to 0.85) moderated the results.” [Play]: “Dosage did not significantly moderate the results (β = −0.11, p = 0.21, 95% CI = −0.27 to 0.06; see Figure 2(h)).”	

Trzmiel et al. (2019) – Meta-analysis

Outcome	Context	Studies included	Effect size	Heterogeneity	Categorised outcome
Social-communication (social)	-	3	SMD = .220, 95CI [-.130, .580]	Chi^2 = 0.55 I^2 = 0.0%	Null pooled effect
Communication	-	3	SMD = .191, 95CI [-.165, .547]	Chi^2 = 0.48 I^2 = 0.0%	Null pooled effect
Adaptive behaviour	-	3	SMD = .742, 95CI [-.010, 1.494]	Chi^2 = 5.87 I^2 = 66.0%	Null pooled effect

Tupou et al. (2019) – Narrative synthesis

Outcome	Studies included	Verbatim summary from systematic review	Categorised outcome
Overall autism characteristics (autism severity and/or symptoms)	4	[group design studies only] “Four (57%) of the seven group studies reported on measures of autism severity and/or symptoms (D’Elia et al. 2014; Eikeseth et al. 2012; Strain and Bovey 2011; Young et al. 2016) using the Autism Diagnostic Observation Schedule (ADOS; Lord et al.2008), or the Childhood Autism Rating Scale (CARS; Schopleretal. 2002). D’Elia et al. (2014) reported decreases in autism diagnoses across both EGs and CGs, as measured by the ADOS, with a larger decrease observed in the EG. Similarly, in the study by Strain and Bovey (2011), the EG demonstrated a greater decrease in CARS scores than the CG. The Eikeseth study (2012) reported a significant decrease in CARS scores for the EG, but did not report comparison data for the CG. The authors of the final study (Young et al.2016) did not report any significant change in CARS scores.”	Positive summarised effect

Social-communication (social skills)	2	[group design studies only] “Two (29%) of the group studies (Strain and Bovey 2011; Young et al. 2016) reported on social skills, which were measured via the Social Skills Rating System (SSRS; Gresham and Elliott 1990) and the Autism Screening Instrument for Educational Planning (ASIEP; Krug et al.2008). Both studies reported positive results, with the EG making greater improvements than the CG in both cases.”	Positive summarised effect
Communication (communication and/or language)	5	[group design studies only] “Child communication and/or language was measured in five (71%) of the group studies (Boulware et al. 2006; D’Elia et al. 2014; Fleury and Schwartz 2017; Strain and Bovey 2011; Young et al. 2016) via a range of different instruments including (a) Communication, Social, and Symbolic Behavior Scales (CSBS; Wetherby and Prizant 2002); (b) MacArthur Communication Developmental Inventories (CDI; Fenson et al. 1993; Fenson et al. 1994); (c) Preschool Language Scale (PLS; Zimmerman et al. 1991); (d) Expressive One Word Picture Vocabulary Test (EOWPVT; Brownell 2000a); (e) Receptive One Word Picture Vocabulary Test (ROWPVT; Brownell2000b); and (f) a researcher-delivered book vocabulary assessment (Fleury and Schwartz 2017). Participants demonstrated improvement on at least one communication/language outcome across all five of these studies.”	Positive summarised effect
Social emotional/challenging behaviour (adaptive/maladaptive behaviour)	5	[group design studies only] “Five (71%) of these group design studies that measured adaptive/maladaptive behavior reported positive results (Boulware et al. 2006; D’Elia et al. 2014; Eikeseth et al. 2012; Eldevik et al. 2012; Strain and Bovey 2011), while the remaining study was coded as having no effect because there were no significant changes in participant scores for the EG (Young et al. 2016).”	Positive summarised effect
Adaptive behaviour (functional skills)	2	[group design studies only] “Functional skills were measured as outcomes in two (29%) of the group studies (Boulware et al. 2006; Schwartz et al. 2004) and were assessed using (a) Bayley Scales of Infant Development (Bayley 2006); (b) Assessment, Evaluation, and Programming System for Infants and Children (AEPS; Bricker 1994); (c) a researcher-developed functional outcomes index (Schwartz et al. 2004); and (d) a researcher developed functional outcomes scale (Boulware et al. 2006). Participating children from both studies demonstrated gains across at least one functional outcome, and participants from the Schwartz et al. (2004) study made gains across all six of the functional outcomes measured.”	Positive summarised effect

Valentine et al. (2020)- Narrative synthesis

Outcome	**Studies included**	**Context**	**Verbatim summary from systematic review**	**Categorised outcome**
General outcomes (clinical effectiveness)	6	Gaming	“Five papers reported gaming to be clinically effective and one reported a lack of clinical effectiveness.”	Positive summarised effect

General outcomes (clinical effectiveness)	9	Tablet/mobile apps	“Tablet / Mobile phone applications (apps). Clinical effectiveness: As seen in Table 7, nine papers focussed on treatment in an ASD sample. Five of these papers reported the tablet/mobile app to be clinically effective/partially effective.”	Inconsistent summarised effect
General outcomes (clinical effectiveness)	5	Video/DVD/ Video modelling	“Clinical effectiveness: Most papers (5/6) reported on clinical efficacy, however, sample sizes were small with four papers reporting three or fewer participants (Kern Koegel, Ashbaugh, Navab, & Koegel, 2016; Kourassanis, Jones, & Fienup, 2014; Radley et al., 2015; Stewart & Umeda, 2014). Three of these papers reported positive clinical effectiveness and video-modelling was found to increase empathic communication (Kern Koegel et al., 2016), improve social game behaviours (Kourassanis et al., 2014) and social skills accuracy (Radley et al., 2015). The findings of Stewart and Umeda (2014) were more mixed, reporting that it was effective in teaching motor imitation only in some children. In a larger study with 38 participants, Dai et al. (2018) used a DVD to deliver an ASD parenting intervention reporting mixed results, with parents' confidence about their parenting abilities significantly increasing, knowledge increasing slightly, but self-efficacy remaining constant.”	Positive summarised effect

Verschuur et al. (2014) – Narrative synthesis

Outcome	**Studies included**	**Verbatim summary from systematic review**	**Categorised outcome**
General outcomes (child behaviours)	35	“Of the 35 studies targeting child behaviors, 15 studies (42.9 %) reported positive outcomes and 20 studies (57.1 %) reported mixed outcomes.” [Outcomes include communication and language skills; play skills; adaptive functioning; maladaptive behaviours; autism symptoms]	Inconsistent summarised effect
Caregiver social emotional wellbeing (caregiver behaviours)	13	“Of the 13 studies targeting caregiver behaviors, 7 studies (53.8 %) reported positive outcomes and 5 studies (38.5 %) reported mixed outcomes.” [Outcomes include caregiver fidelity of implementation of PRT/NLP; parental stress; parental affect; parental self-efficacy; parent verbalisations]	Inconsistent summarised effect

Waddington et al. (2021)- Narrative synthesis

Outcome	**Studies included**	**Verbatim summary from systematic review**	**Categorised outcome**
Overall autism characteristics (core characteristics of ASD)	2	“Autism characteristics: Several studies measured the effect of intervention on core characteristics of ASD. These studies reported that there was no significant post-treatment difference in restricted and repetitive behaviours (Harrop et al., 2017), or ‘global autism symptoms’ (Nordahl-Hansen et al., 2016) between the intervention and comparison groups at any timepoint.”	Null summarised effect
Social-communication (joint attention	13	“Table 2 indicates the effects of intervention on children’s joint attention and engagement skills. All 13 studies reported at least one positive effect of intervention on at least one outcome.”	Positive summarised effect

and engagement)			
Communication (child communication skills)	7	“Table 3 also indicates the effects of intervention on child communication skills, for the seven studies that assessed this outcome. Five of these studies reported positive effects for at least one outcome.”	Positive summarised effect
Expressive language (overall expressive language)	6	“Two of six studies reported positive effects for overall expressive language.”	Inconsistent summarised effect
Receptive language	4	“Only one of four studies reported a positive intervention effect for receptive language.”	Inconsistent summarised effect
Play	9	“Table 3 indicates the effects of intervention on child play skills, for the nine studies which assessed this outcome. All but one study (Wong, 2013) reported positive effects for at least one outcome.”	Positive summarised effect

Wang et al. (2021a)- Meta-analysis

Outcome	**Context**	**Studies included**	**Effect size**	**Heterogeneity**	**Categorised outcome**
Overall autism characteristics (autism symptoms)	-	8	g = 0.272, 95%CI (0.018, 0.526)	I^2 = 53.06%	Positive pooled effect
Social communication	-	7	g = 0.010, 95%CI (-0.184, 0.204)	I^2 = 47.48%	Null pooled effect
Communication (language)	-	7	g = 0.278, 95%CI (0.002, 0.555)	I^2 = 70.82%	Positive pooled effect
Cognitive development (cognition)	-	7	g = 0.278, 95%CI (0.108, 0.449)	I^2 = 1.38%	Positive pooled effect

Moderators	**Context**	**Outcome**	**Studies Included**	**Verbatim summary from systematic review**	**Categorised outcome**
Agent	Parent, professional	Overall autism characteristics	9	“The primary implementer and the format were independent of the heterogeneity in the effect sizes.” From table 2: Q between = 2.46; p = 0.12	The agent (parents, professionals) was not related to the effect of support on overall autism characteristics.
Format	Group, individual	Overall autism characteristics	9	“The primary implementer and the format were independent of the heterogeneity in the effect sizes.” From table 2: Q between 0.07, p = .80	The format (individual, group) was not related to

					the effect of support on overall autism characteristics.
Amount of support	Intensity of support	Overall autism characteristics	-	“Table 3 shows that the results of the regression model were not significant, and the length and intensity of the intervention could not predict the results. In other words, increasing the length and intensity of the intervention does not produce significant effects on autism symptoms.” From table 3: Tau squared = 0.10, p =0.74.	The amount of support (intensity) was not related to the effect of support on overall autism characteristics.
Agent	Parent, professional	Communication	13	“The primary implementer and the format were independent of the heterogeneity in the effect sizes.” From Table 4: Q between = 6.82, p = 0.12.	The agent (parents, professionals) was not related to the effect of support on communication.
Format	Group, individual	Communication	13	“The primary implementer and the format were independent of the heterogeneity in the effect sizes.” From table 4: Q between = 0.22, p = 0.64.	The format (individual, group) was not related to the effect of support on communication.

Wang et al. (2021b)- Meta-analysis

Outcome	**Context**	**Studies included**	**Effect size**	**Heterogeneity**	**Categorised outcome**
Overall autism characteristics (symptoms related to ASD)	Self-reported outcomes	10	SMD = -0.09, 95%CI (-0.42, 0.24)	I^2 = 69.3%	Null pooled effect
Overall autism characteristics (symptoms related to ASD)	Informant-reported outcomes	23	SMD = -0.57, 95%CI (-0.90, -0.24)	I^2 = 87.8%	Positive pooled effect
Overall autism characteristics (symptoms related to ASD)	Clinician reported outcomes	5	SMD = 0.75, 95%CI (0.10, 1.41)	I^2 = 55.1%	Negative pooled effect
Overall autism characteristics (symptoms related to ASD)	Task-based outcomes	11	SMD = -0.41, 95%CI (-0.75, -0.08)	I^2 = 70.9%	Positive pooled effect
Social emotional/challenging behaviour (symptoms of social-emotional problems)	Self-reported outcomes	9	SMD = -0.42 95%CI (-0.90, 0.07)	I^2 = 78.6%	Null pooled effect
Social emotional/challenging behaviour (symptoms of social-emotional problems)	Informant reported outcomes	19	SMD = -0.71, 95%CI (-1.04, -0.38)	I^2 = 77.3%	Positive pooled effect

Social emotional/challenging behaviour (symptoms of social-emotional problems)	Clinician reported outcomes		9	SMD = 1.02, 95%CI (0.58, 1.46)	I^2 = 68.6%	Negative pooled effect *Note: Described as positive by the authors contradictory to the direction of the effect so excluded from summary tables.*
Moderators	**Context**	**Outcome**	**Studies Included**	**Verbatim summary from systematic review**		**Categorised outcome**
Child age	≥10, <10 years	Overall autism characteristics (self-reported)	10	Table 1: Between subgroups p-value = 0.479		The child's age (mean age: <10, ≥10) was not related to the effect of support on self-reported overall autism characteristics.
Child age	≥10, <10 years	Overall autism characteristics (informant-reported)	23	Table 1: Between subgroups p-value = 0.007; ≥10 = -0.76 (-1.3,-0.22); <10 = -0.4 (-0.79, -0.02)		The child's age (mean age: <10, ≥10) was positively associated with the effect of support on informant-reported overall autism characteristics. Children aged ≥10 showed greater reductions than those aged <10.
Child age	≥10, <10 years	Overall autism characteristics	5	Table 1. Between subgroups p-value = .136		The child's age (mean age: <10, ≥10) was not related to the

		(clinician reported)			effect of support on clinician ratings of overall autism characteristics.
Child age	≥10, <10 years	Overall autism characteristics (task-based)	11	Table 1: Between subgroups p-value = 0.237	The child's age (mean age: <10, ≥10) was not related to the effect of support on task-based ratings of overall autism characteristics.
Format	Group, individual	Overall autism characteristics (self-reported)	10	Table 1: Between subgroups p-value = 0.696	The format (group based, individual based) was not related to the effect of support on self-reported overall autism characteristics.
Format	Group, individual	Overall autism characteristics (informant-reported)	23	Table 1: Between subgroups p-value = 0.815	The format (group based, individual based) was not related to the effect of support on informant reported overall autism characteristics.
Format	Group, individual	Overall autism characteristics (clinician-reported)	5	Table 1: Between groups p-value = 0.610	The format (group based, individual based) was not related to the effect of support on clinician ratings of overall

					autism characteristics.
Format	Group, individual	Overall autism characteristics (task-based)	11	Table 1: Between subgroups p-value = 0.110	The format (group based, individual based) was not related to the effect of support on task-based ratings of overall autism characteristics.
Child age	≥10, <10 years	Social-emotional and challenging behaviour (self-reported)	9	Table 1: Between groups p-value = 0.255	The child's age (mean age: <10, ≥10) was not related to the effect of support on self-reported social emotional/ challenging behaviour.
Child age	≥10, <10 years	Social-emotional and challenging behaviour (informant-reported)	19	Table 1: Between groups p-value = 0.391	The child's age (mean age: <10, ≥10) was not related to the effect of support on informant reported social emotional/ challenging behaviour.
Child age	≥10, <10 years	Social-emotional and challenging behaviour (clinician-reported)	9	Table 1: Between groups p-value = 0.018; ≥10 = 0.80 (0.40, 1.19); <10 = 1.64 (0.1,3.19)	The child's age was negatively associated with the effect of support on clinician rated social emotional/ challenging behaviour. Children aged <10 showed

					greater reductions than those aged ≥ 10.
Format	Group, individual	Social-emotional and challenging behaviour (self-reported)	9	Table 1: Between groups p-value = 0.069	The format (group based, individual based) was not related to the effect of support on self-reported social emotional/ challenging behaviour.
Format	Group, individual	Social-emotional and challenging behaviour (informant-reported)	19	Table 1: Between groups p-value = 0.481	The format (group based, individual based) was not related to the effect of support on informant reported social emotional/ challenging behaviour.
Format	Group, individual	Social-emotional and challenging behaviour (clinician-reported)	9	Table 1: Between groups p-value = 0.335	The format (group based, individual based) was not related to the effect of support on clinician reported social emotional/ challenging behaviour.

Zheng et al. (2021)- Meta-analysis

Outcome	**Context**	**Studies included**	**Effect size**	**Heterogeneity**	**Categorised outcome**
Social-communication	Self-reported social knowledge - TASSK	9	g = 2.15, 95%CI (1.54, 2.77)	I^2 = 71%	Positive pooled effect
Social-communication	Parent-reported social knowledge - SSiS	5	g = 0.71, 95%CI (0.26, 1.15)	I^2 = 4%	Positive pooled effect

Social-communication	SRS - parent-reported social knowledge	5	g = 0.72, 95%CI (0.33, 1.10)	I^2 = 0%	Positive pooled effect
Community participation	Get togethers (self-report QSQ)	9	g = 0.60, 95CI (0.27,0.93)	I^2 = 49%	Positive pooled effect
Community participation	Get togethers (parent-report QSQ)	6	g = 0.55, 95%CI (0.16,0.93)	I^2 = 12%	Positive pooled effect

Footnote: ES = Effect size; MD = mean difference; NS = Not stated; SMD = standardised mean difference; SMC = standard mean change; RVE = Robust Variance Estimation

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Appendix 5.15	Umbrella review - Adverse effects

Appendix 5.15 - Umbrella review - Adverse effects

Information on the influence of different support delivery characteristics on the effect of support.

Focus of Systematic Review	Frequency of consideration and identification	Evidence for adverse effects	
		Systematic review	**Author statement (verbatim quote)**
Behavioural supports	Considered in 1/4 systematic reviews (identified in 0)	-	-
Developmental supports	Considered in 0/3 systematic reviews	-	-
Naturalistic developmental behavioural interventions	Considered in 0/8 systematic reviews	-	-
Sensory-based supports	Considered in 1/3 systematic reviews (identified in 0)	-	
TEACCH	Considered in 0/1 systematic reviews	-	

Technology-based supports	Considered in 2/10 systematic reviews (identified in 1)	Mazon et al. (2019)	“Sample sizes across studies ranged from 5 to 23 participants per group, with an average around 10 participants per group. According to the Jadad scale, 5 of out the 6 studies scored 0 and the remaining study scored 1, thanks to the inclusion of a statement about dropouts (6 participants were excluded due to refusal or distress; Bekele et al., 2014).” (p.243-244)
Animal-assisted supports	Considered in in 1/3 systematic reviews (identified in 0)		
Cognitive behaviour therapy	Considered in 0/2 systematic reviews	-	-
Other supports	Considered in 0/3 systematic reviews	-	-
Child outcomes	Considered in 0/5 systematic reviews	-	-
Delivery characteristics	Considered in 0/13 systematic reviews	-	-

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Appendix 5.16	Umbrella review - Influence of delivery characteristics on child and family support outcomes

Appendix 5.16 - Umbrella review - Influence of delivery characteristics on child and family support outcomes

Characteristic	**Systematic review**	**Summary of evidence**
Setting	Parsons, Cordier, Munro et al. (2017)	**Social communication outcomes:** Setting not related to the effect of support on social-communication.
	Kent et al. (2020)	**Play outcomes:** Setting (clinic, home) not related to the effect of support on play.
Format	Wang et al. (2021a)	**Early Start Denver Model (practice):** Format (individual, group) not related to the effect of support on overall autism characteristics or communication.
	Wang et al. (2021b)	**Cognitive behavioural therapy (category):** Format (individual, group) not related to the effect of support on overall autism characteristics or social-emotional development.
	Parsons, Cordier, Munro et al. (2017)	**Social communication outcomes:** Format (individual, group) not related to the effect of support on social-communication.
	Kent et al. (2020)	**Play outcomes:** Format (individual, group) not related to the effect of support on play.
	Tachibana et al., (2018)	**Effect of format:** Format (individual, group) was not related to the effect of support on overall autism characteristics, social-communication, expressive language, receptive language, cognitive development, or adaptive behaviour.
Agent	Crank et al. (2021).	**Naturalistic developmental behavioural intervention (category):** Agent (clinicians, educators, caregivers, combination) was not related to the effect of support on general outcomes.
	Wang et al. (2021a)	**Early Start Denver Model (practice):** Agent (parents, professionals) was not related to the effect of support on overall autism characteristics or communication.

	Bejarano-Martín et al. (2020)	**Social communication outcomes:** Agent (caregivers, teachers, clinicians) not related to effect of support on social-communication.
	Parsons, Cordier, Munro et al. (2017)	**Social communication outcomes:** Positive effect of support for supports with active caregiver involvement, but not for supports with parent education alone.
	Hampton & Kaiser (2016)	**Expressive language outcomes:** Supports involving clinicians and caregivers related to greater effect of support on expressive language (spoken language) than clinicians or caregivers alone.

Appendix 5.17	Umbrella review - Influence of amount of support on child and family support outcomes

Appendix 5.17 - Umbrella review - Influence of amount of support on child and family support outcomes

Systematic review	**Focus of systematic review** **(specific focus)**	**Summary of evidence**
Tiede & Walton (2019)	Practice/category (NDBI category)	Greater effect of support on social-communication (joint attention), but not on outcomes relating to overall autism characteristics, social-communication (social engagement), expressive or receptive language, cognitive development (cognition), play, or adaptive behaviour.
Crank et al. (2021)	Practice/category (NDBI category)	Cumulative intensity not related to the effect of support on general outcomes.
Fuller et al. (2020)	Practice/category (Early Start Denver Model practice)	Total hours of support not related to general outcomes (child outcomes).
Dimolareva & Dunn (2021)	Animal assisted (category)	Minutes engaged in therapy not related to the effect of support on overall autism characteristics, social-communication, or communication (language).
Bejarano-Martín et al. (2020)	Outcomes (Social-communication)	Total hours not related to the effect of support on social-communication.
Hampton & Kaiser (2016)	Outcomes (Expressive language)	Total hours not related to the effect of support on expressive language (spoken language).
Naveed et al. (2019)	Delivery characteristics (Non-specialist mediated)	Number of intervention sessions not related to the effect of support.
Nevill et al. (2018)	Delivery characteristics (Parent-mediated)	Total hours not related to the effect of support on overall autism characteristics, social-communication (socialisation), communication (language), or cognitive development (cognition).

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Appendix 5.18	Umbrella review - Influence of child characteristics on child and family support outcomes

Appendix 5.18 - Umbrella review - Influence of child characteristics on child and family support outcomes

Child characteristic	**Systematic review**	**Summary of evidence**
Age	Rodgers et al. (2020)	**Early intensive behavioural intervention (practice):** Age (at recruitment) was not related to the effect of support on cognitive development (cognition) or adaptive behaviour.
	Crank et al. (2021)	**Naturalistic developmental behavioural intervention (category):** Age not related to the effect of support on general outcomes.
	Sandgreen et al. (2021)	**Technology-based supports (category):** age (<5 years, 5-10 years, >10-15 years) not related to the effect of support on general outcomes.
	Wang et al. (2021b)	**Cognitive behavioural therapy (category):** Age inconsistently related to the effect of support on overall autism characteristics and social emotional/challenging behaviour.
	Bejarano-Martín et al. (2020)	**Social-communication outcomes:** Age negatively related to the effect of support on social-communication.
	Parsons, Cordier, Munro et al. (2017)	**Social-communication outcomes:** Age not related to the effect of support on social-communication.
	Hampton & Kaiser (2016)	**Expressive language:** Age not related to the effect of support on expressive language (spoken language).
	Naveed et al. (2019)	**Effect of non-specialist mediated support:** Age not related to the effect of support.
Communication	Bejarano-Martín et al. (2020)	**Social-communication outcomes:** Communication skills prior to support not related to the effect of support on social-communication.

	Crank et al. (2021)	**Naturalistic developmental behavioural intervention (category):** Communication (language age) was not related to the effect of support on general outcomes.
Cognitive development	Bejarano-Martín et al. (2020)	**Social-communication outcomes:** Cognitive development (cognition) prior to support not related to the effect of support on social-communication.
	Rodgers et al. (2020)	**Early intensive behavioural intervention (practice):** Cognitive development (IQ at baseline) not related to the effect of support on cognitive development or adaptive behaviour.
Adaptive behaviour	Rodgers et al. (2020)	**Early intensive behavioural intervention (practice):** Adaptive behaviour (at baseline) was not related to the effect of support on cognitive development or adaptive behaviour.

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Appendix 6w.1	Individual and family experiences review - Database search strings

Individual and family experiences review - Database search strings

Searches conducted 14.12.21

CINAHL (via EBSCO)
(((MH "Asperger Syndrome") OR (MH "Autistic Disorder") OR (MH "Pervasive Developmental Disorder-Not Otherwise Specified")) AND (Autis* OR ASD* OR Asperger* OR "pervasive developmental disorder*" OR PDD* OR "pervasive child development disorder*" OR "pervasive childhood developmental disorder*" OR PCDD* OR ("disintegrative disorder"))) AND (intervent* OR therap* OR treat* OR teach* OR program* OR package*) AND (experien* OR feedback* OR social validity* OR view* OR opinion* OR accept* OR satisfaction* OR criticis* OR perception*) AND Australia*)

= 65 results

EBSCO Education Source
(((MH "Asperger Syndrome") OR (MH "Autistic Disorder") OR (MH "Pervasive Developmental Disorder-Not Otherwise Specified")) AND (Autis* OR ASD* OR Asperger* OR "pervasive developmental disorder*" OR PDD* OR "pervasive child development disorder*" OR "pervasive childhood developmental disorder*" OR PCDD* OR ("disintegrative disorder"))) AND (intervent* OR therap* OR treat* OR teach* OR program* OR package*) AND (experien* OR feedback* OR social validity* OR view* OR opinion* OR accept* OR satisfaction* OR criticis* OR perception*) AND Australia*)))

= 0 results

Education Resources Information Centre (ERIC, via ProQuest)
(((Autism* OR ASD* OR Asperger* OR "pervasive developmental disorder*" OR PDD* OR "pervasive child development disorder*" OR "pervasive childhood developmental disorder*" OR PCDD* OR ("disintegrative disorder")) AND (intervent* OR therap* OR treat* OR teach* OR program* OR package*) AND (experien* OR feedback* OR social validity* OR view* OR opinion* OR accept* OR satisfaction* OR criticis* OR perception*) AND Australia*))

= 93 results

EMBASE
(Autism* OR ASD* OR Asperger* OR "pervasive developmental disorder*" OR PDD* OR "pervasive child development disorder*" OR "pervasive childhood developmental disorder*" OR PCDD* OR "disintegrative disorder") AND (intervent* OR therap* OR treat* OR teach* OR program* OR package*) AND (experien* OR feedback* OR (social AND validity) OR view* OR opinion* OR accept* OR satisfaction* OR criticis* OR perception*) AND Australia*

= 950 results

Epistemonikos.
(autism* OR asd* OR asperger* OR "pervasive developmental disorder*" OR pdd* OR "pervasive child development disorder*" OR "pervasive childhood developmental disorder*" OR pcdd* OR "disintegrative disorder*") AND (intervent* OR therap* OR treat* OR teach* OR program* OR package*) AND (

experien* OR feedback* OR social AND validity* OR view* OR opinion* OR accept* OR satisfaction* OR criticis* OR perception*) AND Australia*

= 13 results

Medline (via Ovid)
((Autism* or ASD or Asperger* or "pervasive developmental disorder*" or PDD* or "pervasive child development disorder*" or "pervasive childhood developmental disorder*" or PCDD* or "disintegrative disorder*") and (intervent* or therap* or treat* or teach* or program* or package*) and (experien* or feedback* or social validity* or view* or opinion* or accept* or satisfaction* or criticis* or perception*) and Australia*)

= 72 results

PsycINFO
((Autism* or ASD* or Asperger* or "pervasive developmental disorder*" or PDD* or "pervasive child development disorder*" or "pervasive childhood developmental disorder*" or PCDD* or "disintegrative disorder*") and (intervent* or therap* or treat* or teach* or program* or package*) and (experien* or feedback* or social validity* or view* or opinion* or accept* or satisfaction* or criticis* or perception*) AND Australia*)

= 117 results

PubMed
(Child Development Disorders, Pervasive [Mesh]) AND (Autism OR ASD OR Asperger OR Aspergers OR "pervasive developmental disorder" OR PDD OR PCDD OR "disintegrative disorder") AND (intervention OR interventions OR therapy OR therapies OR treatment OR treatments OR teach OR program OR programs OR package OR packages) AND (experience OR feedback OR "social validity" OR view OR opinion OR acceptance OR satisfaction OR perception OR criticism) AND Australia*

= 401 results

Scopus

(ALL (australia*) AND TITLE-ABS-KEY ((autism* OR asd* OR asperger* OR "pervasive developmental disorder*" OR pdd* OR "pervasive child development disorder*" OR "pervasive childhood developmental disorder*" OR pcdd* OR "disintegrative disorder*") AND (intervent* OR therap* OR treat* OR teach* OR program* OR package*) AND (experien* OR feedback* OR social AND validity* OR view* OR opinion* OR accept* OR satisfaction* OR criticis* OR perception*)))

= 658 results

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Appendix 6.2	Individual and family experiences review - Standardised data extraction form

Individual and family experiences review - Standardised data extraction form

Data Extraction Template

Field label	Field Description/Response Options
General information	
Author	
Title	
Year	
Country of Publication	[take from method, if country where study conducted not explicitly stated, enter NS {not specified)]
Characteristics of Publication	
Study Abstract	Copied directly from text
Aim of study/viewpoint	[direct quote from abstract or introduction]
Publication type	[free text or from a selection] e.g., qualitative study of…
Design/Method	e.g., focus groups, survey etc.
Study participants	[who are the participants] e.g., parents of children enrolled in an early intervention service
No of participants	
Evidence that study refers to children	[outline age range of children in study/in question if original research or highlight statement from commentary/viewpoint which supports author reflecting on experiences as a young child]
Types/category/name of supports (interventions) experienced	[from a selection or intervention categories? Or free text with intervention names]
Setting/s supports were delivered in	[copied from article]
Format	[copied from article]
Mode	[copied from article]
Agent	[copied from article]
Amount	[copied from article]
Sample questions	[copied from article]

National guideline for supporting the learning, participation, and wellbeing of autistic children and their families in Australia

Appendix 6.3	Individual and family experiences review - Study characteristics and exemplar quotes

Individual and family experiences review - Study characteristics and exemplar quotes

Author and Year of Publication	Study aim (Taken verbatim from abstract, or first place mentioned in article)	Participants	Principles coded (n = no. times coded in each paper)	Examples
Aeurt et al., 2012	The aim of this study was to explore the expectations, awareness, and experiences of parents in their efforts to access evidence-based speech-language pathology (SLP) services for their children with autism spectrum disorders (ASD).	Parents (n = 17 mothers and 3 fathers)	Affirming (1)	*The most common priority expressed by participants in this study was to find a SLP who could relate to their children on a personal level. More specifically, Lina sought an SLP who could build rapport with her children, and with whom she and her children felt comfortable*
			Child and family centred (6)	*Other participants suggested that the SLP 's role should extend to supplying parents with information, including relevant research literature, and involving them in the therapy process*
			Empirically supported (5)	In support of this principle: *Ron, for example, said that he wanted a SLP who knows and understands the research evidence for the treatments she provides.*
				Contrary to this principle: *Not all participants believed that the research evidence was a crucial factor in determining which treatments to use*
			Holistic (1)	*Several participants explained that they also sought SLPs who showed empathy and understanding for their individual needs. Marley, for example, spoke positively about the empathy, time, and support she was given by a SLP at the time her child was first diagnosed*
			Informed consent (2)	*the extent to which the participants had been given clear information regarding their children's therapy programs (e.g., through integrated education plans) and the rationales for treatment decisions (e.g., by being given references and written information) appeared to have direct bearing on their ability to make informed decisions as partners in the therapy process.*

			Personalised (1)	*As illustrated by the following dialogue, participants initially turned to intuition about their children ’ s capacity to concentrate in order to respond to the question… “it all has to be based on individual needs and their capacity”*
			Supported (3)	*Emad, for example, suggested that SLPs should help parents to not only understand the role of the SLP in delivering the therapy, but also their own role as parents in the therapy process.*
			Qualified practitioners (6)	*There was consensus among the participants that finding a SLP that had knowledge and experience working with children with ASD was, in their opinion, a key factor in achieving successful therapy outcomes.*
Donato et al., 2014	To explore the views of key stakeholders on using visual supports for children with developmental disabilities in early intervention group settings. Specifically, this study aimed to determine stakeholders’ views on the barriers to and facilitators for the use of visual supports in these settings to inform the feasibility of implementing an immersive Visual Language in Autism program.	Parents (n = 4), educators (n = 4), and health professionals (n = 5)*	Affirming (2)	*Participants also agreed that there was a lack of awareness of the purpose of visual supports broader community, and some reported feeling uncomfortable at being ‘stared at’ when they used visual supports with their children. They tried to ignore this, particularly when children were exhibiting challenging behaviours*
			Coordinated (4)	*Across focus groups, participants viewed consistency in the use of visual supports across settings as being an important facilitator for children learning use of the visual supports to communicate. Parents agreed that ‘routine and consistency is the most important thing’.*
			Empirically supported (1)	*Participants agreed that if they had been provided with positive parental reports and ‘evidence’ to the use of visual supports they might have invested earlier in the idea of using visual supports for their child.*
			Equity (2)	*They reported having limited access to allied health professionals such as occupational therapists and speech pathologists. Their need for multi-disciplinary services increased funding demands.*
			Holistic (2)	*Parents were also enabled by encouragement and support to persist with the difficulties (e.g., increased demands on time) and they also provided this to other parents.*
			Personalised (2)	*Many expressed a preference for mobile technologies over low technology (e.g., multiple card sets) to use visual supports and discussed their children’s interest and interaction with digital media, including children’s television programs and video games*

Edwards et al., 2016	To explore parental perspectives on the EI message.	Parents (n = 17 mothers and fathers, n = 3 assisted in interview guide preparation, n = 14 participated in interviews)	Equity (1)	*Several of the parents reported that they were unwilling to wait for services, given that they believed that intervention needed to be implemented as early as possible in order for it to be effective. To this end, some parents selected intervention programmes based purely on availability.*
			Lifespan perspective (2)	*In some cases, parents were surprised to find that therapies implemented once their children were older were more effective than EI programmes had been.*
			Personalised (1)	Contrary to this principle: *Other participants reported that their decision-making was influenced by the perceived need to have intensive therapy, as opposed to just accessing therapy to address their child's specific needs.*
Edwards et al., 2018	The aim of the current study was to explore how parents of children with ASD make decisions about which intervention approaches to access.	Parents (n = 17 mothers and fathers, n = 3 assisted in interview guide preparation, n = 14 participated in interviews)	Affirming (2)	*As time progressed post-diagnosis, the parents in this study reported feeling that they had a better understanding of ASD as a neuro-developmental disorder. With increased understanding, some of parents in this study started to accept the lifelong nature of ASD. Where parents were previously aiming for a cure, parents then focused on achieving more functional goals.*
			Child and family centred (6)	In support of this principle: *The parents in this study identified that with time and experience, they trusted their own decision-making to the point that they felt that they understood the needs of their child better than any professional.*
				Contrary to this principle: *Parents felt unqualified to make the decisions that they were faced with, and that they were parents trying to make decisions that should be made by experts*
			Equity (2)	*At all stages of the journey, parents had to filter their decision-making through the reality of logistics, for example, the cost and availability of services. This tended to be influenced by external factors (e.g. availability of funding) as well as factors related to the family (i.e. family income).*
			Holistic (1)	*For the majority of the families in this study during the 'Experience and Evaluate' stage, there was an increasing recognition of the needs of the family, not just the needs of the child. With time, most of the parents in this study*

				identified that prioritizing the needs of the family was actually in the child's best interest.
			Personalised (4)	*The parents in this study reported that with experience, they started to gain a better understanding of their child's needs and learning style, which informed their subsequent decision-making.*
			Supported (1)	*During this stage, a number of the parents in this study started to make connections with other parents of children with ASD, and therefore were able to gain information regarding service providers and intervention approaches.*
Grant et al., 2015	This study explores parents' (n= 23) intervention decision making processes and information preferences following the diagnosis of ASD for their child.	Parents (n = 23)	Child and family centred (2)	*Parents reported that their confidence was generally low to begin with, but improved as they became more familiar with their child's diagnosis, had opportunities to speak to a number of clinicians*
			Empirically supported (3)	In contrast to this principle: *Typically, parents assumed and trusted that mainstream interventions such as occupational therapy and speech therapy were based on evidence as they are readily available.*
				Contrary to this principle: *Parents usually did not consider whether an intervention had research to support its effectiveness and no participant accurately explained the term 'evidence-based'.*
			Equity (1)	*Of greater priority when selecting interventions were logistical issues such as access to funding, and availability and location of services.*
			Evidence-based approach (1)	Contrary to this principle: *Pragmatically, parents described a journey from the point of diagnosis that involved seeking information on ASD interventions from a number of sources, and a 'trial and error' approach to choosing and evaluating these interventions*
			Qualified practitioners (2)	*Participants appeared to seek advice from trusted professionals in the absence of other reliable sources or perceived lack of decision-making support from other sources.*
Gray, 1993	This study examines the relationship between parents of autistic children and the	Parents (n = 35 mothers and fathers)	Developmental perspective (1)	*Two other factors seemed to reconcile parents to the eventual institutionalisation of their child. One was the illness. The failure of the child to overcome his or her autistic symptoms by adolescence...convinced many parents that their child could not remain with the family indefinitely.*

	treatment centre staff at a state autistic association.		Equity (1)	*Given the high costs involved, the hope for a 'halfway house' placement is unlikely to be fulfilled.*
			Holistic	*Another related factor was the family's exhaustion…in that most parents with older children accepted that their child would eventually be institutionalised.*
			Lifespan perspective (1)	*However, most parents recognised that their child was likely to outlive them and few wanted their other children to be endlessly burdened by caring for an autistic sibling.*
Iacono et al., 2016	Our aim was to explore parent and practitioner uses of technology, and views about telehealth, including perceived barriers, for autism early intervention service delivery in a regional town in Australia.	Parents (n = 15 mothers)	Equity (2)	*Some mothers provided reasons for responses about their willingness to receive telehealth services (Table 1), including concerns about internet access or quality and the need for practitioners to directly interact with their children.*
Iacono et al., 2018	We sought to understand the real world translation context for interventions that are evidence-based or reflect best practice.	Parents (n = 13 mothers), autism service provider managers* (n = 15), frontline practitioners* (n = 19)	Equity (3)	*One respondent commented on the difficulties in obtaining assistance for behavioural problems, noting "It's pathetic trying to get help in [town name] for behaviour issues and psychologists [sic].*
			Holistic (1)	*Most respondents reported that the travel resulted in some form of interruption (Table 2): One mother noted having to leave her employment because of the care requirements for her child, while another missed time from her studies.*
Jones et al., 2021	This paper presents two studies that explored community attitudes to autism in Australia; and autistic people and their families' perspectives of community attitudes.	Study 2 analysed only: Autistic people and their families (n = 1297 analysed in final sample, 68.4% family member,	Equity (2)	*Of those currently receiving services, 42.8% (n = 389) reported that the level of support is inadequate and a further 9.4% (n = 85) were unsure.*

		49.4% carer of autistic person, 5.8% as autistic person)		
MacKintosh et al., 2012	in the current study, we sought to learn more about parents' experiences seeking and using treatments for their children with ASD by asking the open-ended question "What do you like/dislike about the treatment(s) you are currently using?"	Parents (n=486 parents, 2.4% of sample were Australian)		Note: only 2 responses were linked to Australian participants in this sample and these were not linked to principles.
Valentine, 2010	This paper reports on a qualitative study of parents' experience of diagnosis and treatment, conducted in four states in Australia in 2008.	Parents (n = 32) and early intervention service providers* (n = 2, who also identified as parents)	Child and family centred (4)	In support of this principle: *These parents have become experts not only in their child's symptoms, but also in the research literature and practices of treating autism. They describe taking on the responsibility of choice and engagement*
				Contrary to this principle: *However, parents are often required to make decisions when they do not feel that they have sufficient information to do so, and to act as clinical experts rather than expert in their knowledge of their children.*
			Empirically Supported (1)	*A number of parents who had chosen ABA also talked about no other choice being plausible, and they drew on the logic of evidence based medicine to do so.*
			Equity (5)	*Very active parents construe their choices as necessity, not as choice. By their account, decisions and consequences are left 'up to the parents' and the*

				services that exist are unsatisfactory: schools are ill-equipped, doctors ill-informed.
			Supported (1)	*Parents also described a range of other responses, including very active engagement in treatment, and investing significant resources in assisting other parents or lobbying for services.*
			Qualified practitioners (1)	*Parents reported frustration at the reluctance of diagnosing clinicians and peak bodies to make specific recommendations about treatment.*
Wilson et al., 2021	The aim of the current study was to explore parent-reported influences on decisions.	Parents (n = 14)	Coordinated (1)	*Some parents raised the importance of collaboration between their child's supports (e.g., school and therapists).*
			Developmental perspective (1)	*Child age and developmental readiness was also an influence on therapy and intervention decisions*
			Empirically supported (1)	*Consideration of research evidence was raised by a parent discussing behavioural therapy (i.e., ABA)*
			Equity (1)	*The logistics of accessing therapies (e.g., costs, funding, wait lists, availability and location) was raised by all participants.*
			Holistic (3)	*Issues regarding the intensity, frequency and comprehensiveness of therapies were raised by parents. Some parents were reluctant to utilise therapies that were too intensive (i.e., too many hours), other parents indicated that sufficient hours are a necessary aspect of early intervention.*
			Lifespan perspective (1)	*Some parents expressed that their child had used a strategy (e.g., sensory approach or communication system) that they no longer required since they had outgrown the need.*
			Personalised (3)	*Child qualities and preferences were often considered. Parents reported pursuing strategies that fit their child's interests and preferences.*
			Qualified practitioners (2)	*The importance of finding clinicians who were a good fit with regard to experience, expertise and rapport, was raised by most parents.*

Appendix 7.1	Online survey – Adults

Community Survey

AutismCRC

Supporting Children National Guideline

Information Statement for the Research Project:

Development of a National Practice Guideline for Supporting Children on the Autism Spectrum and their Families: Community Consultation Online Survey
(GU ref no:2021/843)

Part 1: Participation Information

What is this project about?
Autism CRC is leading the development of a National Practice Guideline for supporting children on the autism spectrum and their families in Australia. The Guideline will be developed based on both research and consultation with the community. The result will be a set of recommendations to guide the delivery of therapy and support services for children on the autism spectrum and their families.

Why are you being invited to participate?
We want to hear the voices of all community members with an interest in the Guideline. We are inviting you to participate, by completing an online survey. We anticipate it will take approximately 60 minutes to complete if you answer all questions. However, it could be shorter (as little as 15 minutes) or longer, depending on how much information you would like to provide.

Who can participate in the research?
We would like to hear from the following community members;

Adults and young people on the autism spectrum. Parents or caregivers of a child/children on the autism spectrum (this can be an adult child). Family members of children on the autism spectrum. Practitioners who provide supports to children on the autism spectrum. Other members of the autism community (e.g., service providers, researchers). You do not need to have had previous experience or involvement in the development of Practice Guidelines to participate.

What would I need to do?
If you agree to complete the survey, it will appear on your screen after you provide informed consent (below). As specified above, the survey may take up to 60 minutes to complete. The survey will ask you to provide your views and perspectives on how therapies and supports should be planned, delivered, and their outcomes assessed. We will invite you to reflect on your experiences.

Do I have to participate?
Participation in this research is entirely your choice. Only information collected from those who give consent will be included in this project. If you decide not to participate, this decision will not disadvantage you or impact your relationship with Griffith University or any other institutions affiliated with this research.

What happens if I change my mind?
If you begin the survey and decide that you would like to withdraw consent, there is a button at the end of the survey you can select to indicate that you no longer want the information you provided to be used in the project. If you decide to withdraw consent after submitting the survey, your individual responses will not be able to identified, due to the anonymous nature of data collection.

What are the benefits of participating?
We hope that it will be a positive experience for you, in helping to inform the Guideline. While you may not receive any direct benefits from participating in this research, the benefits of the research more broadly include an increase in knowledge and understanding regarding the most important factors relevant to the delivery of therapies and supports for young children on the autism spectrum.

Are there any potential risks?
We do not believe there are any direct risks associated with participation in this research. However, we understand that for some people thinking and talking about their experiences, can lead to a mixture of emotions, including sadness. If you, or anyone close to you, participates in this research and experiences any distress, we ask that you contact Lifeline on 13 11 14.

Who are the researchers?
Professor Andrew Whitehouse, Angela Wright Bennett Professor of Autism & Director, CliniKids, Telethon Kids Institute
A/Professor David Trembath, Menzies Health Institute Queensland, Griffith University
Dr Kandice Varcin, Research Fellow, Menzies Health Institute Queensland, Griffith University
Dr Rhylee Sulek, Research Fellow, School of Health Sciences and Social Work, Griffith University
Dr Hannah Waddington, Lecturer, School of Education, Victoria University of Wellington
Ms Sarah Pillar, Integration Project Manager, CliniKids, Telethon Kids Institute

Who can I contact for further information?

You might be unsure if you are able to participate or unsure about how the research process works. We encourage you to contact the research team at supportingchildren@griffith.edu.au to discuss this and anything else you might wish to talk about in relation to the project.

How can I receive information about the research results?
Regular updates regarding the progress of the Guideline including a summary of the outcomes of this survey, will be provided on the Supporting Children National Guideline web pages on the Autism CRC website. Participants will be able to access a copy of the Guideline, once published. If you would like to discuss this further with the research team, you can do so via email.

How can I trust this research is safe for me?
This research is being conducted by skilled research staff and supported by a Guideline Development Group that includes people with a range of knowledge and experience, including autistic adults and parents raising children on the autism spectrum. The team has carefully selected the questions, considered how they are presented in the survey, and has made available different options for you and other people to share your thoughts. Only anonymous, summarised and combined survey data will be used and reported.

Part 2: Ethical Information we must provide you.

What will be done with the data?
We will use the information you and others provide to help develop a set of draft recommendations for supporting children and their families, and then share these with the community for feedback.

When we share our findings, we will:

Present a summary of de-identified information about who participated (e.g., the variety of professionals, broad geographical areas represented). Present the themes that emerge from responses, and use direct quotes from participants to help explain what the themes are about. Any quotes will be presented anonymously, not using your real name. It is possible that if you read the findings or see them presented at a workshop or seminar that you might recognise your own quotes, but we will never attach real names to these quotes. How will privacy be protected? The conduct of this research involves the collection, access, storage and/or use of your deidentified personal information. The information collected is confidential and will not be disclosed to third parties without your consent, except to meet government, legal or other regulatory authority requirements. Your anonymity will at all times be safeguarded. For further information consult the University's Privacy Plan at http://www.griffith.edu.au/about-griffith/plans-publications/griffith-university-privacy-plan or telephone (07) 3735 4375.

To further explain how your privacy will be protected, all of the data that is collected through the survey will be completely confidential. All data will be stored securely on an encrypted and password protected storage drive that will be accessible only by the members of the research team. This data will be stored securely for five years.

The ethical conduct of this research
Griffith University conducts research in accordance with the National Statement on Ethical Conduct in Human Research. Please feel free to contact the researchers if you have any questions (supportingchildren@griffith.edu.au). If you have any additional questions or concerns about ethical issues, please contact the Manager, Research Ethics, at Griffith University Human Research Ethics Committee (research-ethics@griffith.edu.au; 07 3735 4375).

THIS SURVEY WILL CLOSE AT 5pm ON THE 29th MARCH, 2022.

[Attachment: "Online survey_Participant Information statement.docx"]

[Attachment: "Voice-to-text instructions.doc"]

Consent to Participate

Consent Form for the Research Project:
Development of a National Practice Guideline for Supporting Children on the Autism Spectrum and their Families: Community Consultation Online Survey
(GU ref no:2021/843)

By selecting the check box below, I confirm that I have read and understood the information sheet and I have noted that:

I understand that my participation in this research will include: Completing a survey, which we anticipate may take up to 60 minutes to complete I understand that the responses to the survey will be used to inform the development of National Practice Guideline for supporting children on the autism spectrum and their families in Australia I have read the Information Statement, or someone has read it to me in a language that I understand I understand why this research is being conducted and how I can participate I understand any risks as described above I have had an opportunity to ask questions and I am satisfied with the answers I have received I understand that I am free to withdraw at any time during the project without comment or consequence I understand that I can contact the Manager, Research Ethics, at Griffith University Human Research Ethics Committee if I have any concerns about the ethical conduct of this project I agree to participate in the research

I agree to participate in this research	○ No ○ Yes

Thank you again for your interest in this research.

As a reminder, you will have the opportunity to save your responses and return at a later time to complete this survey. To assist us in our data collection, we ask that you please finalise your responses within one week of starting the survey. We will not analyse any additional answers provided after this time.

Which of the following best describes you?	○ Autistic individual/Person on the autism spectrum ○ Parent/primary caregiver of someone on the autism spectrum ○ Family member of person on the autism spectrum ○ An individual who provides services to children (0-12 years) on the autism spectrum ○ A member of an organisation or service which provides services to children (0-12 years) on the autism spectrum and their families ○ Other
Please indicate if you are:	○ Completing this yourself ○ Completing this on behalf of an autistic individual/someone on the autism spectrum
Please specify your relationship to the person on the autism spectrum (e.g., grandparent, sibling)	______________________
Please indicate if you are:	○ Completing this survey as an individual member of the organisation ○ Completing this survey as the nominated representative of the organisation (e.g., you are making a submission on behalf of the organisation as a whole)
Please specify if other	______________________

Please indicate any additional perspectives you bring to this survey (select all that apply)	☐ Autistic individual/person on the autism spectrum ☐ Parent/primary caregiver of someone on the autism spectrum ☐ Family member of person on the autism spectrum ☐ An individual who provides services to children (0-12 years) on the autism spectrum ☐ A member of an organisation or service which provides services to children (0-12 years) on the autism spectrum and their families ☐ Other
Please specify your relationship to the person on the autism spectrum (e.g., grandparent, sibling)	__________________________________
Please specify if other	__________________________________
With which gender do you identify?	○ Female ○ Male ○ Non-binary ○ Prefer not to say ○ Other
Please specify if other	__________________________________
Which state or territory of Australia do you currently reside in?	○ Australian Capital Territory ○ New South Wales ○ Northern Territory ○ Queensland ○ South Australia ○ Tasmania ○ Victoria ○ Western Australia ○ Do not currently reside in Australia
Which of the following best describes where you live?	○ Major city ○ Regional and/or remote area
Do you self-identify as Aboriginal and/or Torres Strait Islander?	○ No ○ Yes, Aboriginal ○ Yes, Torres Strait Islander ○ Yes, both Aboriginal and Torres Strait Islander
Are you of Aboriginal and/or Torres Strait Islander heritage?	○ No ○ Yes, Aboriginal ○ Yes, Torres Strait Islander ○ Yes, both Aboriginal and Torres Strait Islander
Were you born in Australia?	○ No ○ Yes
In what country were you born?	__________________________________
Do you speak one or more languages other than English in the home?	○ No ○ Yes

How many languages, including English, do you speak at home?	________________________________
What is your age?	○ 0-17 years ○ 18-20 years ○ 21-30 years ○ 31-40 years ○ 41-50 years ○ 51-60 years ○ 61-70 years ○ 71-80 years ○ 81-90 years ○ 91-100 years ○ 100+ years
Are you happy to tell us more about your experience of autism, in terms of diagnosis?	○ Yes ○ No
Which of the following best describes your circumstances?	○ I have been given a formal diagnosis of autism (or a related diagnosis e.g., Asperger's, Pervasive Developmental Disorder) by one or more qualified health practitioners (e.g., paediatrician, clinical psychologist, psychiatrist) ○ I am currently being assessed for a possible diagnosis of autism ○ I self-identify as autistic, but have not been given a formal diagnosis by a health professional.
At what age did you receive a formal diagnosis? Please specify in years	________________________________
What was your diagnosis?	________________________________
Did you receive or access autism specific therapies and supports between the ages of 0-6 years?	○ No ○ Yes
Did you receive or access autism specific therapies and supports between the ages of 7-12 years?	○ No ○ Yes

The below table outlines the three levels of support required within the autism spectrum as described in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5).

Level

Social communication

Restricted, repetitive behaviors

Level 3 "Requiring very substantial support"

Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning, very limited initiation of social interactions, and minimal response to social overtures from others. For example, a person with few words of intelligible speech who rarely initiates interaction and, when he or she does, makes unusual approaches to meet needs only and responds to only very direct social approaches

Inflexibility of behavior, extreme difficulty coping with change, or other restricted/repetitive behaviors markedly interfere with functioning in all spheres. Great distress/difficulty changing focus or action.

Level 2 "Requiring substantial support"

Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal responses to social overtures from others. For example, a person who speaks simple sentences, whose interaction is limited to narrow special interests, and how has markedly odd nonverbal communication.

Inflexibility of behavior, difficulty coping with change, or other restricted/repetitive behaviors appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress and/or difficulty changing focus or action.

Level 1 "Requiring support"

Without supports in place, deficits in social communication cause noticeable impairments. Difficulty initiating social interactions, and clear examples of atypical or unsuccessful response to social overtures of others. May appear to have decreased interest in social interactions. For example, a person who is able to speak in full sentences and engages in communication but whose to- and-fro conversation with others fails, and whose attempts to make friends are odd and typically unsuccessful.

Inflexibility of behavior causes significant interference with functioning in one or more contexts. Difficulty switching between activities. Problems of organization and planning hamper independence.

If you were diagnosed as a child under the DSM-5, please indicate which support level was associated with your diagnosis.	○ Level 1 - Requires support ○ Level 2 - Requires substantial support ○ Level 3 - Required very substantial support ○ I am unsure ○ I would prefer not to say
If you were not diagnosed as a child under the DSM-5, or you received a diagnosis in adulthood, please indicate which level would have best represented your support needs as a child.	○ Level 1 - Requires support ○ Level 2 - Requires substantial support ○ Level 3 - Required very substantial support ○ I am unsure ○ I would prefer not to say

Are you happy to tell us more about your child(ren) on the autism spectrum? This includes your children who are now teenagers or adults. We will ask you to focus on just one child at a time.	○ Yes ○ No
How old is your child (years)	________________________________
How old is your child (months)	________________________________
Has your child received a formal diagnosis of autism (or a related disorder e.g., Asperger's, Pervasive Developmental Disorder)?	○ No ○ Yes
At what age was your child diagnosed (please round to the nearest year)?	________________________________
Did you access therapies and/or supports for your child at some stage between the ages of 0-6 years?	○ No ○ Yes
Did you access therapies and/or supports for your child at some stage between the ages of 7-12 years?	○ No ○ Yes

The below table outlines the three levels of support required within the autism spectrum as described in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5).

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If your child was diagnosed under the DSM-5, please indicate which support level is associated with their diagnosis.	○ Level 1 - Requires support ○ Level 2 - Requires substantial support ○ Level 3 - Required very substantial support ○ I am unsure ○ I would prefer not to say
If your child has not yet received a formal diagnosis or was not diagnosed as a child under the DSM-5, please indicate which level you feel would have best represented their support needs as a child.	○ Level 1 - Requires support ○ Level 2 - Requires substantial support ○ Level 3 - Required very substantial support ○ I am unsure ○ I would prefer not to say
Do you wish to provide details for another child on the autism spectrum?	○ No ○ Yes
How old is your child (years)	________________________
How old is your child (months)	________________________
Has your child received a formal diagnosis of autism (or a related disorder e.g., Asperger's, Pervasive Developmental Disorder)?	○ No ○ Yes
At what age was your child diagnosed (please round to the nearest year)?	________________________
Did you access therapies and/or supports for your child at some stage between the ages of 0-6 years?	○ No ○ Yes
Did you access therapies and/or supports for your child at some stage between the ages of 7-12 years?	○ No ○ Yes

The below table outlines the three levels of support required within the autism spectrum as described in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5).

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If your child has not yet received a formal diagnosis or was not diagnosed as a child under the DSM-5, please indicate which level you feel would have best represented their support needs as a child.	○ Level 1 - Requires support ○ Level 2 - Requires substantial support ○ Level 3 - Required very substantial support ○ I am unsure ○ I would prefer not to say
Do you wish to provide details for another child on the autism spectrum?	○ No ○ Yes

How old is your child (years)	______________________
How old is your child (months)	______________________
Has your child received a formal diagnosis of autism (or a related disorder e.g., Asperger's, Pervasive Developmental Disorder)?	○ No ○ Yes
At what age was your child diagnosed (please round to the nearest year)?	______________________
Did you access therapies and/or supports for your child at some stage between the ages of 0-6 years?	○ No ○ Yes
Did you access therapies and/or supports for your child at some stage between the ages of 7-12 years?	○ No ○ Yes

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Do you wish to provide details for another child on the autism spectrum?	○ No ○ Yes
How old is your child (years)	________________________________
How old is your child (months)	________________________________
Has your child received a formal diagnosis of autism (or a related disorder e.g., Asperger's, Pervasive Developmental Disorder)?	○ No ○ Yes
At what age was your child diagnosed (please round to the nearest year)?	________________________________
Did you access therapies and/or supports for your child at some stage between the ages of 0-6 years?	○ No ○ Yes
Did you access therapies and/or supports for your child at some stage between the ages of 7-12 years?	○ No ○ Yes

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If your child has not yet received a formal diagnosis or was not diagnosed as a child under the DSM-5, please indicate which level you feel would have best represented their support needs as a child.	○ Level 1 - Requires support ○ Level 2 - Requires substantial support ○ Level 3 - Required very substantial support ○ I am unsure ○ I would prefer not to say

The following questions ask about your work in providing therapies and supports to young children on the autism spectrum.

What is your profession (select all that apply)?	☐ Aboriginal and Torres Strait Islander Health Worker or Health Practitioner ☐ Aboriginal and Torres Strait Islander Health Advocate ☐ Art therapist ☐ Behaviour Therapist (not Board Certified) ☐ Board Certified Behaviour Analyst ☐ Developmental Educator ☐ Drama therapist ☐ Educator (early childhood) ☐ Educator (primary school) ☐ Educator (high school) ☐ Exercise Scientist ☐ General Practitioner ☐ Music therapist ☐ Nurse ☐ Occupational Therapist ☐ Paediatrician ☐ Physiotherapist ☐ Play therapist ☐ Psychiatrist ☐ Psychologist ☐ Researcher ☐ Social Worker ☐ Speech Pathologist ☐ Support worker ☐ Other
Please specify if other	______________________________
How are you currently involved in the delivery of services for children on the autism spectrum? (select all that apply)	☐ I provide therapy and support to children on the autism spectrum ☐ I provide advocacy for children on the autism spectrum and their families ☐ I supervise others who deliver therapy and support to children on the autism spectrum ☐ I conduct research on therapy and support for children on the autism spectrum ☐ I am responsible for staff and/or business processes that result in the provision of therapy and support to children on the autism spectrum ☐ Other
Please specify if other	______________________________
In which of the following service settings do you currently provide therapies and supports for children on the autism spectrum and their families (select all that apply)?	☐ Private, including non-government organisations ☐ Government organisation

In which of the following service settings to do you currently provide therapies and supports for children on the autism spectrum and their families? (select all that apply)	☐ Child's home ☐ Hospital (inpatient/outpatient) ☐ Community clinic (including private practice) ☐ University clinic (includes providing services as part of student training and research) ☐ Early childhood education centre (prior to formal schooling, and commonly referred to as day care/childcare) ☐ Early childhood education centre in a specialised setting (prior to formal school and catering only to children with additional learning needs) ☐ Mainstream school ☐ Support class/unit within a mainstream school ☐ School specifically for children on the autism spectrum ☐ School specifically for children with additional learning needs, that includes children on the autism spectrum ☐ Other
Please specify if other	________________________________
How many years of experience do you have working in clinical practice with children on the autism spectrum?	________________________________
In 2021, approximately what proportion of your caseload were children on the autism spectrum?	○ 0-25% ○ 26-50% ○ 51-75% ○ 76-100%
In 2021, what age groups did you provide therapies and supports for children on the autism spectrum (select all that apply)?	☐ 0-3 years ☐ 4-6 years ☐ 7-9 years ☐ 10-12 years ☐ 13-15 years ☐ 16-18 years ☐ 19 years and older
As part of your practice, do you see children on the autism spectrum who have any of the following co-occurring conditions (Select all that apply):	☐ Physical disability (e.g., cerebral palsy) ☐ Cognitive impairment (e.g., Intellectual Disability) ☐ Health conditions (e.g., asthma, metabolic conditions) ☐ Mental health conditions (e.g., anxiety, depression) ☐ Genetic conditions (e.g., Fragile X, Down syndrome) ☐ Sensory impairment (vision/hearing) ☐ Other (please specify)
Please specify if other	________________________________

In which state/territory do you currently practice? (select all that apply)	☐ Australian Capital Territory ☐ New South Wales ☐ Northern Territory ☐ Queensland ☐ South Australia ☐ Tasmania ☐ Victoria ☐ Western Australia
In which areas do you conduct your work with children on the autism spectrum and their families? (Select all that apply)	☐ Major cities ☐ Regional and remote areas
Please indicate how children and families access your services (select all that apply):	☐ Face to face delivery ☐ Telepactice/videoconferencing delivery
In 2021, did you provide therapies and supports for children on the autism spectrum and their families who were from non-English speaking countries and speak languages other than English in the home (i.e., families who are culturally and linguistically diverse [CALD])?	○ No ○ Yes
In 2021, did you provide therapies and supports for children on the autism spectrum and their families who identify as being Aboriginal and/or Torres Strait Islander peoples?	○ No ○ Yes

The following questions ask about your work in providing services to young children on the autism spectrum.

What is the name of your organisation/service? ________________________________

If available, please provide a link to your organisation's webpage. ________________________________

In 20-30 words, please provide a description of your organisation. ____

Please explain how your organisation is relevant to supporting the learning and participation of children on the autism spectrum, aged 0-12, and their families. ____

Approximately how many staff work at your organisation in either a paid or voluntary capacity? ________________________________

If relevant, approximately how many members are registered with your organisation? ________________________________

For example, if you are a peak registration body for a profession, approximately how many people are registered with your organisation?

In which states/territories does your organisation provide services? (select all that apply)

☐ Australian Capital Territory
☐ New South Wales
☐ Northern Territory
☐ Queensland
☐ South Australia
☐ Tasmania
☐ Victoria
☐ Western Australia

In which areas does your organisation conduct work with children on the autism spectrum and their families? Select all that apply

☐ Major cities
☐ Regional and remote areas

Which of the following represents individuals involved with your organisation? (select all that apply)	☐ Aboriginal and Torres Strait Islander Health Worker or Health Practitioner ☐ Aboriginal and Torres Strait Islander Health Advocate ☐ Art therapist ☐ Behaviour Therapist (not Board Certified) ☐ Board Certified Behaviour Analyst ☐ Developmental Educator ☐ Drama therapist ☐ Educator (early childhood) ☐ Educator (primary school) ☐ Educator (high school) ☐ Exercise Scientist ☐ General Practitioner ☐ Music therapist ☐ Nurse ☐ Occupational Therapist ☐ Paediatrician ☐ Physiotherapist ☐ Play therapist ☐ Psychiatrist ☐ Psychologist ☐ Researcher ☐ Social Worker ☐ Speech Pathologist ☐ Support worker ☐ Other
Please specify if other	__________________________________
In which of the following settings does your organisation provide services for children on the autism spectrum and their families? (select all that apply)	☐ Child's home ☐ Hospital (inpatient/outpatient) ☐ Community clinic (including private practice) ☐ University clinic (includes providing services as part of student training and research) ☐ Early childhood education centre (prior to formal schooling, and commonly referred to as day care/childcare) ☐ Early childhood education centre in a specialised setting (prior to formal school and catering only to children with additional learning needs) ☐ Mainstream school ☐ Support class/unit within a mainstream school ☐ School specifically for children on the autism spectrum ☐ School specifically for children with additional learning needs, that includes children on the autism spectrum ☐ Other
Please specify if other	__________________________________
Would you like to tell us your story about getting support for your child?	○ Yes ○ No - skip to next section ○ No - exit survey
Type your answers to the questions below, or upload a three (3) minute video file answering them here.	

When thinking about getting autism specific support for your child: What has been good?	__________________________________
What has been bad?	__________________________________
What should have been done better?	__________________________________
Would you like to tell us your story about getting support?	○ Yes ○ No - skip to next section ○ No - exit survey
Type your answers to the questions below, or upload a three (3) minute video file answering them here.	
When thinking about getting autism specific support: What has been good?	__________________________________
What has been bad?	__________________________________
What should have been done better?	__________________________________
2. Your thoughts about the development of the guideline	
What do you think are the three most important things that should be addressed in the guideline?	__________________________________
What are the potential benefits of having a guideline?	__________________________________
What concerns, if any, do you have about the development of a guideline?	__________________________________
At the moment, where do you get information about therapies and supports for children on the autism spectrum (select all that apply)?	☐ Online searches ☐ Social media ☐ Family and friends ☐ Autistic people (e.g., personal accounts published online) ☐ Teachers ☐ Medical practitioners ☐ Allied health practitioners ☐ Word of mouth ☐ Research articles ☐ Other

Please specify if other. __________________________________

3. Language preferences in relation to autism

The following questions ask about language preferences in relation to autism. Would you like to provide responses to these questions?	○ Yes ○ No - skip to next section ○ No - exit survey

Autism CRC understands that different people have different views and preferences about terminology used to describe autism and people on the autism spectrum (see here for Autism CRC statement).

For this guideline, we will make decisions about language and terminology based on feedback from you and other members of the community, collected in this survey.

Our goal is to choose terminology that:

Is preferred by the majority of the autistic community. Is acceptable to the majority of parents/caregivers and practitioners, in that the term/s used would not stop them making use of the practice guideline. We are talking here only about the use of terminology in the guideline document itself, and when Autism CRC and the project team are communicating about the guideline. We understand that people may have different preferences about terminology, depending on the situation (for example when referring to themselves versus others), but we are focusing only on the guideline in this survey.

To help us choose terminology, please answer the following questions.

1. Please tell us what term/s you would like to see used in the guideline by giving each a rating.

	Strongly dislike	Dislike	Somewhat dislike	Neutral	Somewhat like	Like	Strongly like
Autistic	○	○	○	○	○	○	○
Autistic person (e.g., autistic children)	○	○	○	○	○	○	○
Person with autism (e.g., children with autism)	○	○	○	○	○	○	○
Person on the autism spectrum (e.g., children on the autism spectrum)	○	○	○	○	○	○	○
Person with autism spectrum disorder (e.g., children with ASD)	○	○	○	○	○	○	○
Person with autism spectrum condition (e.g., children with ASC)	○	○	○	○	○	○	○

2. Please now tell us if you think each of these terms are acceptable for use in the guideline.

When we say acceptable, we mean that the term would not stop you supporting and/or using the guideline, even if it is not your personal preference.

	Unacceptable: I would not support and/or use the guideline if this term is used	Acceptable: I would support and/or use the guideline if this term is used, even if it is not my personal preference
Autistic	○	○
Autistic child	○	○

Child with autism	○	○
Child on the autism spectrum	○	○
Child with autism spectrum disorder (child with ASD)	○	○
Child with autism spectrum condition (child with ASC)	○	○

4. Underlying Principles

The following set of questions ask you to provide your thoughts on principles that are important to the delivery of therapies and supports for children on the autism spectrum and their families. Would you like to provide responses to these questions?	○ Yes ○ No - skip to next section ○ No - exit survey

The following statements describe principles that have been identified by research as having importance for all aspects of providing therapies and supports for children and their families on the autism spectrum. While some principles refer to both children and their families in the same item to acknowledge the family unit, we do so noting that the individual preferences, needs, and rights of each person are always to be considered and maintained.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Holistic: When providing therapy and supports, we should consider an individual's life history, culture, strengths and challenges, goals and preferences, and environmental factors that impact their learning, participation, and quality of life.	○	○	○	○	○
Child and family-centred: The child and their family members should be considered equal partners with practitioners in the therapy process.	○	○	○	○	○
Supported: The child and their family should be supported to include people they feel are relevant in the therapy process, including for advocacy and support.	○	○	○	○	○
Lifespan perspective: When providing therapies and supports, decision making should account for the current stage of life of the child, as well as appropriate planning for both the short and longer term.	○	○	○	○	○
Developmental perspective: Decision-making should account for, and be responsive to, the individual, family and social changes that occur through childhood.	○	○	○	○	○

Empirically-supported: Therapies and supports should be underpinned by published, peer-reviewed scientific evidence demonstrating their effectiveness and safety.	○	○	○	○	○
Evidence-based practice approach: Decision-making should draw on and combine research and clinical evidence alongside the preferences and values of the child and their family.	○	○	○	○	○
Ethical practice: The provision of therapies and supports should be underpinned by an ethical framework that follows the principles of beneficence, non-maleficence, autonomy and fairness.	○	○	○	○	○
Culturally aware and responsive: The values, knowledge, preferences and cultural perspectives of the child and family should be sought, respected, and evident in the provision of therapies and supports.	○	○	○	○	○
Equity: All children and families, regardless of age, gender, cultural background, socioeconomic status or geographical location should be able to access timely, safe, desirable and effective therapies and supports.	○	○	○	○	○
Strengths-focused: Therapies and supports should focus on understanding, embracing and developing the strengths of an individual and their family.	○	○	○	○	○
Coordinated: A coordinated approach across practitioners, organisations, and agencies should be taken.	○	○	○	○	○

Personalised: Therapies and supports should be tailored to the unique strengths, needs, and preferences of each child and family.	○	○	○	○	○
Accessible: The process of planning, delivering, and monitoring therapies and support, including interactions and documentation, should be accessible.	○	○	○	○	○
Informed consent (parents): Informed parental consent should be obtained for therapies and supports provided.	○	○	○	○	○
Assent (children): Children's assent (expression of approval) should be obtained, wherever possible, for therapies and supports provided.	○	○	○	○	○
Qualified practitioners: People involved in the provision of therapies and supports should have relevant qualifications and professional regulation, and only engage in goal setting and the delivery of therapies and supports that are within their scope of practice.	○	○	○	○	○

What other principles not listed above, are important to the delivery of therapies and supports?

____

5a. Understanding the child, family, and context

The following set of questions ask you to provide your thoughts on understanding children, their family, and their context, in the provision of therapies and supports. Would you like to:	○ Skip this section ○ Provide your general thoughts on this ○ Answer our specific questions ○ Exit the survey

In clinical practice, assessment involves collecting information that helps the practitioner understand the child, their family, and the broader context. Assessment may involve a range of people (e.g., the child, family, other practitioners), include the use of a range of tools (e.g., observation, interviewing, functional assessment, dynamic assessments), and draw on both current and historical information.

From your perspective, what are the most important considerations for practitioners trying to understand the child, family, and their context?	________________________________
How important do you think it is to understand the child, their family, and their context when making decisions about therapies and supports for children on the autism spectrum?	○ Not at all important ○ Slightly important ○ Moderately important ○ Very important ○ Extremely important
What information do you think is most important to collect to understand the child, their family, and their context?	________________________________
What would you suggest practitioners (i.e., people working directly with the child on the autism spectrum) do to ensure they understand the child, their family, and their context? Provide up to three suggestions.	________________________________

5b. Goal Setting

The following questions ask about the process of planning, selecting and prioritising goals for therapy for young children on the autism spectrum. Would you like to :	○ Skip this section ○ Provide your general thoughts on this ○ Answer our specific questions ○ Exit the survey
From your perspective, what are the most important considerations for practitioners when planning, selecting, and prioritising goals for children?	__________________________________
How important do you think it is to select appropriate goals for therapy when working with children on the autism spectrum and their families?	○ Not at all important ○ Slightly important ○ Moderately important ○ Very important ○ Extremely important
Who is important to involve (e.g., child, parents, practitioners, others) in planning, selecting, and prioritising goals to support the learning and participation of children on the autism spectrum and their families?	__________________________________
What types of goals are likely to be relevant to supporting the learning and participation of children on the autism spectrum and their families?	__________________________________
What can practitioners do to ensure appropriate goals are selected? Provide up to three suggestions.	__________________________________

5c. Selecting Therapies and Supports

The following questions ask about the process of planning and selecting specific therapies and supports for young children on the autism spectrum. Would you like to:	○ Skip this section ○ Provide your general thoughts on this ○ Answer our specific questions ○ Exit the survey
From your perspective, what are the most important considerations for practitioners when planning and selecting therapies and supports for children?	__________________________________
How important do you think it is to select appropriate therapies and supports when working with children on the autism spectrum and their families?	○ Not at all important ○ Slightly important ○ Moderately important ○ Very important ○ Extremely important
Who is important to involve (e.g., parents, practitioners, the child) in selecting therapies and supports for children on the autism spectrum and their families? If your response is the same as goal setting, please type "See previous section" here.	__________________________________
What types of therapies and supports are relevant to supporting the learning and participation of children on the autism spectrum and their families?	__________________________________
What can practitioners do to ensure that appropriate therapies and supports are selected? Provide up to three suggestions. If your response is the same as for goal setting, please type "see previous section".	__________________________________

5d. Delivering Therapies and Supports

The following questions ask about decisions related to the delivery of therapies and supports (i.e., the setting, the format [individual, group], the people involved [practitioner, parents, siblings/peers, others], the amount). Would you like to:	○ Skip this section ○ Provide your general thoughts on this ○ Answer our specific questions ○ Exit the survey
From your perspective, what are the most important considerations for practitioners when delivering therapies and supports for children on the autism spectrum?	__________________________________
How important do you think it is to deliver therapies and supports in ways that are appropriate for children on the autism spectrum and their families?	○ Not at all important ○ Slightly important ○ Moderately important ○ Very important ○ Extremely important
Is there a standard amount of practitioner-delivered therapy and support that you think children on the autism spectrum should have access to? This includes therapies and supports provided directly to the child, supports provided to upskill parents/caregivers to support the child, and supports to upskills other members of the community (e.g., a child's teacher) to support the child.	○ Yes ○ No
What is this standard amount of therapy?	____________________________
What is an appropriate amount of practitioner-delivered therapy and support you think that children on the autism spectrum should have access to?	__________________________________
In what settings do you think it is appropriate to deliver therapies and supports?	__________________________________
Who is important to involve (e.g., parents, practitioners, the child) in the delivery of therapies and supports? If your response is the same as previous sections (goal setting, planning), please indicate "see previous sections" here.	__________________________________
What can practitioners do to ensure that appropriate therapies and supports are delivered? Provide up to three suggestions. If your response is the same as previous sections (goal setting, planning), please indicate "see previous sections" here.	__________________________________

5e. Monitoring of therapies and supports

The following questions ask about monitoring progress and outcomes of therapies and supports. By this we mean the things that those working with the child and family do to evaluate how the service is delivered and the child and family's experience and outcomes. Would you like to:	○ Skip this section ○ Provide your general thoughts on this ○ Answer our specific questions ○ Exit the survey
From your perspective, what are the most important considerations for practitioners when monitoring progress and outcomes of therapies and supports for children on the autism spectrum?	________________________________
How important do you think it is to monitor the delivery of therapies and supports for children on the autism spectrum and their families? This includes ensuring the goals, therapies, and supports continue to be appropriate.	○ Not at all important ○ Slightly important ○ Moderately important ○ Very important ○ Extremely important
What aspects of therapies and supports provided, and the child and family's experience, should be monitored by practitioners?	________________________________
What can practitioners do to ensure the appropriate monitoring of goals, therapies and supports? Please provide up to three suggestions.	________________________________

5f. Safety and wellbeing

The following questions ask about how the safety and wellbeing of children on the autism spectrum and their families can be ensured. Would you like to?	○ Skip this section ○ Provide your general thoughts on this ○ Answer our specific questions ○ Exit the survey
From your perspective, what are the most important things for practitioners to consider in order to ensure the safety and wellbeing of children on the autism spectrum and their families	______________________________
How important to do you think it is to ensure that the safety and wellbeing of children on the autism spectrum and their families is ensured when accessing therapies and supports?	○ Not at all important ○ Slightly important ○ Moderately important ○ Very important ○ Extremely important
How can practitioners support the safety and wellbeing of children on the autism spectrum and their families when accessing therapies and supports?	______________________________
Please describe any risks you see for children and families in accessing therapies and supports.	______________________________
Before you go, did you complete the whole survey?	○ Yes ○ No
Are you happy for us to use the information you provided?	○ Yes ○ No
If you are willing, please tell us why you did not complete the whole survey? Select all that apply	☐ It was too long ☐ I did not understand the questions ☐ It was not relevant to me ☐ I have other things I need to do ☐ I prefer not to say ☐ Other

A note from the research team

Thank you very much for answering the questions. The information that you and others provide will directly inform the recommendations in the guideline.

The next step for the research team will be to analyse all of the information provided. The Guideline Development Group will then formulate recommendations.

If you have not already done so, please register with Autism CRC to receive updates about the guideline. You can do so here.

Before we finish, we want to take a moment to acknowledge the time it takes to complete surveys like this. While we are not able to send a personal response to each person who completes it, please know that we genuinely value the information you have provided and will be reading every word.

We also acknowledge that if you are an autistic person, a parent, or other family member of a child on the autism spectrum, you will have shared in the survey insights from your own life, your experience, and your expertise. It is likely that you will have been asked to do this many times before, and we warmly thank you for being willing to do so again here, to help make the guideline the best it can be. We simply could not do this piece of important work, without your insights. Thank you.

If you have any final comments, please feel welcome to share them below.

We look forward to sharing updates, and the guideline in due course, via Autism CRC's website.

Sincerely,

Rhylee, Kandice, Hannah, Sarah, David, and Andrew, on behalf of the Guideline Development Group.

Please provide any final comments below.

Appendix 7.2	Online survey – Young people

Online Survey - Young People

AutismCRC

Supporting Children National Guideline

[Attachment: "Online Survey - Explanation for Young People - Transcipt.docx"]

[Attachment: "Voice-to-text instructions.doc"]

Thank you again for your interest in this research.

As a reminder, you will have the opportunity to save your responses and return at a later time to complete this survey. To assist us in our data collection, we ask that you please finalise your responses within one week of starting the survey. We will not analyse any additional answers provided after this time.

THIS SURVEY WILL CLOSE AT 11:59 PM ON 30TH APRIL, 2022.

Please indicate if you are:	○ Completing this yourself ○ Completing this with the help of a parent or caregiver
Would you like to tell us your story about getting support?	○ Yes ○ No - skip to next section

Type your answers to the questions below, or upload a three (3) minute video file answering them here.

When thinking about getting autism specific support:

What has been good? ______________________________

What has been bad? ______________________________

What should have been done better? ______________________________

2. Your thoughts about the development of the Guideline

What do you think are the three most important things that should be addressed in the Guideline? ______________________________

What are the possible benefits of having a Guideline? ______________________________

What concerns, if any, do you have about the development of a Guideline? ______________________________

At the moment, where do you get information about therapies and supports (select all that apply)?

☐ Online searches
☐ Social media
☐ Family and friends
☐ Autistic people (e.g., personal accounts published online)
☐ Teachers
☐ Medical practitioners
☐ Allied health practitioners
☐ Word of mouth
☐ Research articles
☐ Other

Please specify if other. ______________________________

3. Language preferences in relation to autism

The following questions ask about language preferences in relation to autism. Would you like to provide responses to these questions?	○ Yes ○ No - skip to next section ○ No - exit survey

Autism CRC understands that different people have different views and preferences about terminology used to describe autism and people on the autism spectrum (see here for Autism CRC statement).

For this guideline, we will make decisions about language and terminology based on feedback from you and other members of the community, collected in this survey.

Our goal is to choose terminology that:

Is preferred by the majority of the autistic community. Is acceptable to the majority of parents/caregivers and practitioners, in that the term/s used would not stop them making use of the Practice Guideline. We are talking here only about the use of terminology in the Guideline document itself, and when Autism CRC and the project team are communicating about the Guideline. We understand that people may have different preferences about terminology, depending on the situation (for example when referring to themselves versus others), but we are focusing only on the Guideline in this survey.

To help us choose terminology, please answer the following questions.

1. Please tell us what term/s you would like to see used in the Guideline by giving each a rating.

	Strongly dislike	Dislike	Somewhat dislike	Neutral	Somewhat like	Like	Strongly like
Autistic	○	○	○	○	○	○	○
Autistic person (e.g., autistic children)	○	○	○	○	○	○	○
Person with autism (e.g., children with autism)	○	○	○	○	○	○	○
Person on the autism spectrum (e.g., children on the autism spectrum)	○	○	○	○	○	○	○
Person with autism spectrum disorder (e.g., children with ASD)	○	○	○	○	○	○	○
Person with autism spectrum condition (e.g., children with ASC)	○	○	○	○	○	○	○

2. Please now tell us if you think each of these terms are acceptable for use in the Guideline.

When we say acceptable, we mean that the term would not stop you supporting and/or using the Guideline, even if it is not your personal preference.

	Unacceptable: I would not support and/or use the guideline if this term is used	Acceptable: I would support and/or use the guideline if this term is used, even if it is not my personal preference
Autistic	○	○
Autistic child	○	○

Child with autism	○	○
Child on the autism spectrum	○	○
Child with autism spectrum disorder (child with ASD)	○	○
Child with autism spectrum condition (child with ASC)	○	○

4. Underlying Principles

The following set of questions ask you to provide your thoughts on principles that are important to the delivery of therapies and supports for children on the autism spectrum and their families. Would you like to provide responses to these questions?	○ Yes ○ No - skip to next section ○ No - exit survey

The following statements describe principles that have been identified by research as having importance for all aspects of providing therapies and supports for children and their families on the autism spectrum. While some principles refer to both children and their families in the same item to acknowledge the family unit, we do so noting that the individual preferences, needs, and rights of each person are always to be considered and maintained.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Holistic: When providing therapy and supports, we should consider an individual's life history, culture, strengths and challenges, goals and preferences, and environmental factors that impact their learning, participation, and quality of life.	○	○	○	○	○
Child and family-centred: The child and their family members should be considered equal partners with practitioners in the therapy process.	○	○	○	○	○
Supported: The child and their family should be supported to include people they feel are relevant in the therapy process, including for advocacy and support.	○	○	○	○	○
Lifespan perspective: When providing therapies and supports, decision making should account for the current stage of life of the child, as well as appropriate planning for both the short and longer term.	○	○	○	○	○
Developmental perspective: Decision-making should account for, and be responsive to, the individual, family and social changes that occur through childhood.	○	○	○	○	○

Empirically-supported: Therapies and supports should be underpinned by published, peer-reviewed scientific evidence demonstrating their effectiveness and safety.	○	○	○	○	○
Evidence-based practice approach: Decision-making should draw on and combine research and clinical evidence alongside the preferences and values of the child and their family.	○	○	○	○	○
Ethical practice: The provision of therapies and supports should be underpinned by an ethical framework that follows the principles of beneficence, non-maleficence, autonomy and fairness.	○	○	○	○	○
Culturally aware and responsive: The values, knowledge, preferences and cultural perspectives of the child and family should be sought, respected, and evident in the provision of therapies and supports.	○	○	○	○	○
Equity: All children and families, regardless of age, gender, cultural background, socioeconomic status or geographical location should be able to access timely, safe, desirable and effective therapies and supports.	○	○	○	○	○
Strengths-focused: Therapies and supports should focus on understanding, embracing and developing the strengths of an individual and their family.	○	○	○	○	○
Coordinated: A coordinated approach across practitioners, organisations, and agencies should be taken.	○	○	○	○	○

Personalised: Therapies and supports should be tailored to the unique strengths, needs, and preferences of each child and family.	○	○	○	○	○
Accessible: The process of planning, delivering, and monitoring therapies and support, including interactions and documentation, should be accessible.	○	○	○	○	○
Informed consent (parents): Informed parental consent should be obtained for therapies and supports provided.	○	○	○	○	○
Assent (children): Children's assent (expression of approval) should be obtained, wherever possible, for therapies and supports provided.	○	○	○	○	○
Qualified practitioners: People involved in the provision of therapies and supports should have relevant qualifications and professional regulation, and only engage in goal setting and the delivery of therapies and supports that are within their scope of practice.	○	○	○	○	○

What other principles not listed above, are important to the delivery of therapies and supports? ______________________________

5a. Understanding the child, family, and context

The following set of questions ask you to provide your thoughts on understanding children, their family, and their context, in the provision of therapies and supports. Would you like to:	○ Skip this section ○ Provide your general thoughts on this ○ Answer our specific questions ○ Exit the survey

In clinical practice, assessment involves collecting information that helps the practitioner understand the child, their family, and the broader context. Assessment may involve a range of people (e.g., the child, family, other practitioners), include the use of a range of tools (e.g., observation, interviewing, functional assessment, dynamic assessments), and draw on both current and historical information.

From your perspective, what are the most important considerations for practitioners trying to understand the child, family, and their context?	____
How important do you think it is to understand the child, their family, and their context when making decisions about therapies and supports for children on the autism spectrum?	○ Not at all important ○ Slightly important ○ Moderately important ○ Very important ○ Extremely important
What information do you think is most important to collect to understand the child, their family, and their context?	____
What would you suggest practitioners (i.e., people working directly with the child on the autism spectrum) do to ensure they understand the child, their family, and their context? Provide up to three suggestions.	____

5b. Goal Setting

The following questions ask about the process of planning, selecting and prioritising goals for therapy for young children on the autism spectrum. Would you like to:	○ Skip this section ○ Provide your general thoughts on this ○ Answer our specific questions ○ Exit the survey
From your perspective, what are the most important considerations for practitioners when planning, selecting, and prioritising goals for children?	______________________________
How important do you think it is to select appropriate goals for therapy when working with children on the autism spectrum and their families?	○ Not at all important ○ Slightly important ○ Moderately important ○ Very important ○ Extremely important
Who is important to involve (e.g., child, parents, practitioners, others) in planning, selecting, and prioritising goals to support the learning and participation of children on the autism spectrum and their families?	______________________________
What types of goals are likely to be relevant to supporting the learning and participation of children on the autism spectrum and their families?	______________________________
What can practitioners do to ensure appropriate goals are selected? Provide up to three suggestions.	______________________________

5c. Selecting Therapies and Supports

The following questions ask about the process of planning and selecting specific therapies and supports for young children on the autism spectrum. Would you like to:	○ Skip this section ○ Provide your general thoughts on this ○ Answer our specific questions ○ Exit the survey
From your perspective, what are the most important considerations for practitioners when planning and selecting therapies and supports for children?	________________________
How important do you think it is to select appropriate therapies and supports when working with children on the autism spectrum and their families?	○ Not at all important ○ Slightly important ○ Moderately important ○ Very important ○ Extremely important
Who is important to involve (e.g., parents, practitioners, the child) in selecting therapies and supports for children on the autism spectrum and their families? If your response is the same as goal setting, please type "See previous section" here.	________________________
What types of therapies and supports are relevant to supporting the learning and participation of children on the autism spectrum and their families?	________________________
What can practitioners do to ensure that appropriate therapies and supports are selected? Provide up to three suggestions. If your response is the same as for goal setting, please type "see previous section".	________________________

5d. Delivering Therapies and Supports

The following questions ask about decisions related to the delivery of therapies and supports (i.e., the setting, the format [individual, group], the people involved [practitioner, parents, siblings/peers, others], the amount). Would you like to:	○ Skip this section ○ Provide your general thoughts on this ○ Answer our specific questions ○ Exit the survey
From your perspective, what are the most important considerations for practitioners when delivering therapies and supports for children on the autism spectrum?	__________________________________
How important do you think it is to deliver therapies and supports in ways that are appropriate for children on the autism spectrum and their families?	○ Not at all important ○ Slightly important ○ Moderately important ○ Very important ○ Extremely important
Is there a standard amount of practitioner-delivered therapy and support that you think children on the autism spectrum should have access to? This includes therapies and supports provided directly to the child, supports provided to upskill parents/caregivers to support the child, and supports to upskills other members of the community (e.g., a child's teacher) to support the child.	○ Yes ○ No
What is this standard amount of therapy?	____________________________
What is an appropriate amount of practitioner-delivered therapy and support you think that children on the autism spectrum should have access to?	__________________________________
In what settings do you think it is appropriate to deliver therapies and supports?	__________________________________
Who is important to involve (e.g., parents, practitioners, the child) in the delivery of therapies and supports? If your response is the same as previous sections (goal setting, planning), please indicate "see previous sections" here.	__________________________________
What can practitioners do to ensure that appropriate therapies and supports are delivered? Provide up to three suggestions. If your response is the same as previous sections (goal setting, planning), please indicate "see previous sections" here.	__________________________________

5e. Monitoring of therapies and supports

The following questions ask about monitoring progress and outcomes of therapies and supports. By this we mean the things that those working with the child and family do to evaluate how the service is delivered and the child and family's experience and outcomes. Would you like to:	○ Skip this section ○ Provide your general thoughts on this ○ Answer our specific questions ○ Exit the survey
From your perspective, what are the most important considerations for practitioners when monitoring progress and outcomes of therapies and supports for children on the autism spectrum?	________________________________
How important do you think it is to monitor the delivery of therapies and supports for children on the autism spectrum and their families? This includes ensuring the goals, therapies, and supports continue to be appropriate.	○ Not at all important ○ Slightly important ○ Moderately important ○ Very important ○ Extremely important
What aspects of therapies and supports provided, and the child and family's experience, should be monitored by practitioners?	________________________________
What can practitioners do to ensure the appropriate monitoring of goals, therapies and supports? Please provide up to three suggestions.	________________________________

5f. Safety and wellbeing

The following questions ask about how the safety and wellbeing of children on the autism spectrum and their families can be ensured. Would you like to?	○ Skip this section ○ Provide your general thoughts on this ○ Answer our specific questions ○ Exit the survey
From your perspective, what are the most important things for practitioners to consider in order to ensure the safety and wellbeing of children on the autism spectrum and their families	__________________________________
How important to do you think it is to ensure that the safety and wellbeing of children on the autism spectrum and their families is ensured when accessing therapies and supports?	○ Not at all important ○ Slightly important ○ Moderately important ○ Very important ○ Extremely important
How can practitioners support the safety and wellbeing of children on the autism spectrum and their families when accessing therapies and supports?	__________________________________
Please describe any risks you see for children and families in accessing therapies and supports.	__________________________________
Before you go, did you complete the whole survey?	○ Yes ○ No
Are you happy for us to use the information you provided?	○ Yes ○ No
If you are willing, please tell us why you did not complete the whole survey? Select all that apply	☐ It was too long ☐ I did not understand the questions ☐ It was not relevant to me ☐ I have other things I need to do ☐ I prefer not to say ☐ Other
If you have any final comments, please feel welcome to share them here.	__________________________________

A note from the research team

Thank you very much for answering the questions. The information that you and others provide will directly inform the recommendations in the guideline.

The next step for the research team will be to analyse all of the information provided. The Guideline Development Group will then formulate recommendations.

If you have not already done so, please register with Autism CRC to receive updates about the guideline. You can do so here.

Before we finish, we want to take a moment to acknowledge the time it takes to complete surveys like this. While we are not able to send a personal response to each person who completes it, please know that we genuinely value the information you have provided and will be reading every word.

We look forward to sharing updates, and the guideline in due course, via Autism CRC's website.

Sincerely,

Rhylee, Kandice, Hannah, Sarah, David, and Andrew, on behalf of the Guideline Development Group.

Appendix 7.3	Code Book

Appendix 7.3 Code Book

Instructions for coders

1. Before starting coding for the day, please review the ‘*Coding Questions & Comments’* Tab in Teams to see if there have been any updates
2. Find the file you have been allocated in Teams. Your file will be located in your own Teams folder located in the *‘Data Files NVIVO*’ folder. Your files will be dated, so please take note to select the most recent file (This should be the file available)
3. Save the file in a folder on your computer that is safe and can be easily found and deleted when coding is complete.
4. Open NVIVO - (If you have not already setup your NVIVO settings, please ensure the settings are set to remind you to save the file at least every 15 minutes and add a two letter initials for identifying purposes. For example, David would add DT in the initial sections.)
5. Check which questions you are required to code (see colour coding below, the upload notification will confirm the questions requiring coding) and have a printed copy of the code book beside you for your reference.
6. Review the codes and definitions to clarify your understanding.
7. You might find coding one column (i.e., participants’ responses to a question) at a time to be easier, as each column will have a specific set of codes to consider within the coding framework. Therefore, double check you are coding each response to the correct codes assigned.
8. In situations where the participant’s response appears relevant to the question they were asked, but does not clearly meet the definition of one or more codes, then code as 'other.'
9. Please write a journal/reflection on the process, during each coding session. This should be done in NVIVO memo feature. Please reflect on any patterns you are seeing in the data (e.g., prominent themes); differences, contrasts, and/or contradictions in the responses; any challenges you experienced in assigning codes; suggestions for possible new or revised codes; reasons for why you may have coded a specific way or anything else that you, at that time, felt was important. These memos not only provide you with a great way to document the process and a source for recalling what you did and why, but are also a key aspect of the methodology and thus important to analysing and interpreting the data.
10. Once you have finished coding all responses in your file, save the file and upload into your Teams Data Files NVIVO Return folder. There is no need to change the file name.

11. Please notify Emma, in the Teams channel ‘*Data Management*' or in chat when you have completed and uploaded your assigned response. Likewise, this channel also notifies when a new data file for coding ready for each coder.
12. ***IMPORTANT*** – Please <u>DO NOT</u> change any of the comments and responses. Only assign codes, as any changes to the text will impact file merging.

If you have any questions with coding, please ask via the ‘‘*Coding Questions & Comments’* Tab in Teams in the first instance, as this will provide us with a central and consistent way of documenting and responding to these questions. You can share a chat message via the Teams chat or contact Emma/David directly if you want to alert them to the new question/comment. Please do not hesitate to any questions or share comments as this is an important part of the process.

Part A: Coding Guide

- The sections and corresponding questions to be coded are outlined below
- See column ‘D’ for codes to be applied to each section
- Codes are further described in Part B of this manual
- Please ensure you are coding the correct codes according to the coding framework to be applied (D) as they can and do change for most questions.

A. Section	**B. Question Number**	**C. Question Label**	**D. Coding framework to be applied**	**Coding Instructions**
Your Story (parents/ caregivers)	1	What has been good?	• Code for principles in first instance	Code these three questions at the same time for each participant
Your Story (parents/ caregivers)	2	What has been bad?	• Code for principles in first instance	

Your Story (parents/ caregivers)	3	What could have been done better?	- Code for principles in first instance	
Your Story (autistic adults)	1	What has been good?	- Code for principles in first instance	Code these three questions at the same time for each participant
Your Story (autistic adults)	2	What has been bad?	- Code for principles in first instance	
Your Story (autistic adults)	3	What could have been done better?	- Code for principles in first instance	
4: Underlying Principles	2	What other principles not listed above, are important to the delivery of therapies and supports?	- If responses to S4.2 align with an existing principle, code at principles node - If responses do not map to existing principles, code as “S4.2 Principles - other”	Code this question for all participants at one time
5a: Understanding the child, family, and context	1a	From your perspective, what are the most important considerations for practitioners trying to understand the child, family, and their context?	- Code for principles - If unsure, code as “S5 Understanding - other”	
5a: Understanding the child, family, and context	2	What information do you think is most important to collect to understand the child, their family, and their context?	- Code as either “S5 understanding - child”, “S5 understanding: family”, or “S5 understanding: context”	

			- If unsure, code as "S5Understanding - other"	
5a: Understanding the child, family, and context	3	What would you suggest practitioners (i.e., people working directly with the child on the autism spectrum) do to ensure they understand the child, their family, and their context? Provide up to three suggestions.	- Code as either "S5 understanding: child", "S5 understanding: family", or "S5 understanding: context" - If unsure, code as "S5Understanding - other"	
5b. Goal Setting	1a	From your perspective, what are the most important considerations for practitioners when planning, selecting, and prioritising goals for children?	- Code for principles - If unsure, code as "S5b Goal setting - other"	
5b. Goal Setting	2	Who is important to involve (e.g., child, parents, practitioners, others) in selecting goals to support the learning and participation of children on the autism spectrum and their families?	- Code at "who" nodes (detailed below) - If unsure, code as "S5b Goal setting - other"	
5b. Goal Setting	3	What types of goals are likely to be relevant to supporting the learning and participation of children on the autism spectrum and their families?	- Code as either "S5b.3 Child: mental/physical functions", "S5b.3 Child: activities/participation", or "S5b.3 Child: environment" - If unsure, code as "S5b Goal setting - other"	
5b. Goal Setting	4	What would you suggest practitioners do to ensure appropriate goals are selected? Provide up to three suggestions.	- Code at "suggestions" nodes (more details below) - If unsure, code as "S5b Goal setting - other"	

5c. Selecting Therapies and Supports	1a	From your perspective, what are the most important considerations for practitioners when planning and selecting therapies and supports for children?	- Code for principles - If unsure, code as “Q5c Selection - other”	
5c. Selecting Therapies and Supports	2	Who is important to involve (e.g., parents, practitioners, the child) in selecting therapies and supports for children on the autism spectrum and their families?	- Code at “who” nodes - If unsure, code as “S5c Selection - other”	
5c. Selecting Therapies and Supports	3	What types of therapies and supports are relevant to supporting the learning and participation of children on the autism spectrum and their families?	*Specific - Supported:* The respondent names a specific profession, technique, practice, or category of practices that they believe is appropriate to children and/or families *Specific* - Non-supported: The respondent names a specific profession, technique, practice, or category of practices that they believe is not appropriate for children and/or families *Non-Specific* - Supported: The respondent refers to a type and/or aspect of service delivery, that is general in nature (i.e., does not meet the specificity requirement to be coded above) that they believe is appropriate for children and/or families	

			Non-Specific - Non-supported: The respondent refers to a type and/or aspect of service delivery, that is general in nature (i.e., does not meet the specificity requirement to be coded above) that they believe is not appropriate for children and/or families	
5c. Selecting Therapies and Supports	4	What can practitioners do to ensure that appropriate therapies and supports are selected? Provide up to three suggestions.	• Code at "suggestions" nodes (more details below) • If unsure, code as "S5c Selection - other"	
5d. Delivering Therapies and Supports	1a	From your perspective, what are the most important considerations for practitioners when delivering therapies and supports for children?	• Code for principles • If unsure, code as "Q5d Delivery - other"	
5d. Delivering Therapies and Supports	2a	What is this standard amount of therapy?	• Code as "S5d.2a Delivery – amount" • New breakdown list is included below	

5d. Delivering Therapies and Supports	3	What is an appropriate amount of practitioner-delivered therapy and support you think that children on the autism spectrum should have access to?	• Code as "S5d.3 Delivery – amount"
			  • New breakdown list is included below
			  • 2a and 3 use the same codes	

5d. Delivering Therapies and Supports	4	In what settings do you think therapies and supports should be delivered?	• Code as "S5d.4 Delivery – Clinic", "S5d.4 Delivery – home",	

			“S5d.4 Delivery – educational setting”, “S5d.4 Delivery – cultural setting”, “S5d.4 Delivery –social setting”, or “S5d.4 Delivery – recreational setting” • If unsure, code as “S5d Delivery – other”	
5d. Delivering Therapies and Supports	5	Who is important to involve (e.g., parents, practitioners, the child) in the delivery of therapies and supports?	• Code at “who” nodes • If unsure, code as “S5d Delivery - other”	
5d. Delivering Therapies and Supports	6	What would you suggest practitioners do to ensure that appropriate therapies and supports are delivered? Provide up to three suggestions.	• Code at “suggestions” nodes (more details below) • If unsure, code as “S5d Delivery - other”	
5e. Monitoring of therapies and supports	1a	From your perspective, what are the most important considerations for practitioners when monitoring progress and outcomes of therapies and supports for children?	• Code for principles • If unsure, code as “S5e Monitoring - other”	
5e. Monitoring of therapies and supports	2	What aspects of therapies and supports provided, and the child and family's experience, should be monitored?	• Code as either “S5e.2 Monitoring: fidelity”, “S5e.2 Monitoring: progress”, “S5e.2 Monitoring: impact”, “S5e.2 Monitoring: maintenance”, “S5e.2 Monitoring: Generalisation”, “S5e.2 Monitoring: costs/benefits”, or “S5e.2 Monitoring: unplanned outcomes”	

			• If unsure, code as “S5e Monitoring - other”	
5e. Monitoring of therapies and supports	3	What can practitioners do to ensure the appropriate monitoring of goals, therapies, and supports? Provide up to three suggestions.	• Code at “suggestions” nodes (more details below) • If unsure, code as “S5e Monitoring - other”	
5f. Safety and wellbeing	1a	From your perspective, what are the most important considerations for practitioners to ensure the safety and wellbeing of children on the autism spectrum and their families?	• Code for principles • If unsure, code as “S5f Safety - other”	
5f. Safety and wellbeing	2	How can practitioners support the safety and wellbeing of children on the autism spectrum and their families?	• Code as “S5f.2 Safety - Empirical Evidence”, “S5f.2 Safety – Experience”, “S5f.2 Safety- Supervision”, “S5f.2 Safety – Research”, “S5f.2 Safety – monitoring”, “S5f.2 Safety – assessment”, “S5f.2 Safety – rights”, “S5f.2 Safety – practice standards”, “S5f.2 Safety – concerns”, “S5f.2 Safety – communication” • If unsure, code as “S5f Safety - other”	
5f. Safety and wellbeing	3	Please describe any risks you see for children and families in accessing therapies and supports	• Code for principles • If unsure, code as “S5f Safety - other”	

Part B: Code descriptions

- The following tables provide additional descriptors for some of the above codes to be used
- Codes are bolded

Section 4. Principles

Note: Code below at each principle label (bolded)

Holistic: When providing therapy and supports, we should consider an individual's life history, culture, strengths and challenges, goals and preferences, and environmental factors that impact their learning, participation, and quality of life.
Child and family-centred: The child on the autism spectrum and their family members should be considered equal partners with practitioners in the therapy process.
Supported: The child and their family should be supported to include people they feel are relevant in the therapy process, including for advocacy and support.
Lifespan perspective: Decision making should account for the current stage of life of the child, as well as appropriate planning for both the short and longer term.
Developmental perspective: Decision-making should account for, and be responsive to, the individual, family and social changes that occur through childhood.
Empirically-supported: Therapies and supports should be underpinned by published, peer-reviewed scientific evidence demonstrating their effectiveness and safety.
Evidence-based practice approach: Decision-making should draw on and combine research and clinical evidence alongside the preferences and values of the child and their family.
Ethical practice: The provision of therapies and supports should be underpinned by an ethical framework that follows the principles of beneficence, non-maleficence, autonomy and fairness.
Culturally aware and responsive: The values, knowledge, preferences and cultural perspectives of the child and family should be sought, respected, and evident in the provision of therapies and supports.
Equity: All children and families, regardless of age, gender, cultural background, socioeconomic status or geographical location should be able to access timely, safe, desirable and effective therapies and supports.
Strengths focused:

Therapies and supports should focus on understanding, embracing and developing the strengths of an individual and their family.
Coordinated: A coordinated approach across practitioners, organisations, and agencies should be taken.
Personalised: Therapies and supports should be tailored to the unique strengths, needs, and preferences of each child and family.
Accessible: The process of planning, delivering, and monitoring therapies and support, including interactions and documentation, should be accessible.
Informed consent (parents): Informed parental consent should be obtained for therapies and supports provided.
Assent (children): Children's assent (expression of approval) should be obtained, wherever possible, for therapies and supports provided.
Qualified practitioners: People involved in the provision of therapies and supports should have relevant qualifications and professional regulation, and only engage in goal setting and the delivery of therapies and supports that are within their scope of practice.

Section 5a. Understanding the child, family, and context

S5a Understanding: child *(use above code for any responses related to below)*	
4.2a	The child's health (i.e., physical health, mental health, and health history).
4.2b	The child's developmental skills (i.e., gross and fine motor, social, emotional, cognitive, communication, and academic skills).
4.2c	The child's diagnostic characteristics (i.e., social communication skills, repetitive behaviours, focused/intense interests, and sensory behaviours).
4.2d	The child's activities and participation in home, educational, and community settings (this includes enablers and barriers to participation).
4.2e	The child's behaviour(s) of concern (including, (i) behaviours arising from the interaction of the person and their environment that risk the physical safety of the individual and/or others and (ii) behaviours that limit or deny participation in life activities).
4.2f	The child's perception of their quality of life (to the extent this is possible to obtain)
4.2g	The child's activity-related strengths and preferences (i.e., activities that bring the child joy and/or that they have expertise in).
4.2h	The child's preferences for therapies/supports (to the extent this is possible to obtain)

4.2i	The child’s expectations for the outcomes of therapy/support (to the extent this is possible to obtain)
4.2j	Other child factors

S5a Understanding: family *(use above code for any responses related to below)*	
a	The family’s physical and mental health (i.e., the presence of any conditions that may impact upon their capacity to participate, or need to be considered, in the provision of therapies/supports for their child).
b	The family’s social-emotional resources and supports (i.e., resilience factors and the capacity to deal with stressful situations in life, along with social support via family, friends, and support groups).
c	The family’s financial resources and supports (i.e., funding to pay for therapies and supports, capacity to purchase unfunded therapies and supports, and capacity to take time away from paid work to access therapies and supports).
d	The family’s activities (i.e., work, social, cultural, sport and recreational, and educational activities).
e	The family’s views, perspectives and preferences (i.e., views about their child’s learning, participation and quality of life now and in the future, views on disability, the relevance of therapies/supports for their child, cultural perspectives on therapies/supports, preferences for therapies/supports, and expectations for outcomes).
f	The family’s dynamics (i.e., the nature and strength of relationships between family members, the nature and distribution of roles and responsibilities, the positive and challenging impacts associated with the child’s disability).

S5a Understanding: context *(use above code for any responses related to below)*	
A	The nature of any services previously accessed, including goals and types of services (e.g., allied health, mainstream supports).
b	The child and family’s experience of previously accessed services, including their satisfaction with the service(s).
C	The child and family’s outcomes of accessing previous services, including the progress made towards goals.
D	Any arrangements that are in place to support the coordination of services and supports accessed by the child and family (e.g., nominated case coordinator, NDIS support coordination).
E	Family preferences for future arrangements to support the coordination of services and supports accessed by the child and family.

Section 5b. Goal Setting

S5b.3 Child: mental/physical functions *(use above code for any responses related to below)*	
A	Mental functions (e.g., executive functioning)
B	Physical functions (e.g., articulation of speech sounds, fine motor skills)
S5b.3 Child: activities/participation *(use above code for any responses related to below)*	
A	The acquisition of skills (e.g., social, communication, play, motor)
B	The generalised use of skills in daily activities with others (e.g., social skills used to help form relationships, communication skills used to have a conversation, play skills used to engage in play with peers).
C	The reduction of behaviours of concern (e.g., self-injurious behaviours)
D	Learning and applying knowledge (e.g., learning to count, learning to read)
E	Carrying out daily routines (relative to age expectations)
F	Supporting interpersonal interactions and relationships
G	Participation in community, social, and civic life (e.g., recreation, leisure, religion, spirituality)
S5b.3 Child: environment *(use above code for any responses related to below)*	
A	Accessibility in the physical environment (e.g., sensory-safe spaces)
B	Accessibility in the social environment (e.g., changing attitudes and increasing knowledge and skills of others')
C	Enhancement of services, systems, and policies (e.g., to improve coordination of services, changing policies that create barriers to participation).

Section 5c. Selecting and Planning

A	**S5c.3 Specific - Supported**	The respondent names a specific profession, technique, practice, or category of practices that they believe is appropriate to children and/or families
B	**S5c.3 Specific - Non-supported**	The respondent names a specific profession, technique, practice, or category of practices that they believe is not appropriate for children and/or families
C	**S5c.3 Non-Specific - Supported**	The respondent refers to a type and/or aspect of service delivery, that is general in nature (i.e., does not meet the specificity requirement to be coded above) that they believe is appropriate for children and/or families
D	**S5c.3 Non-Specific - Non-supported:**	The respondent refers to a type and/or aspect of service delivery, that is general in nature (i.e., does not meet the specificity requirement to be coded above) that they believe is not appropriate for children and/or families

Section 5d. Delivery

A	**S5d.4 Delivery – Clinic**	Clinic
B	**S5d.4 Delivery – home**	The child’s home
C	**S5d.4 Delivery – educational setting**	Educational settings (including school and early child education settings/day care)
D	**S5d.4 Delivery – cultural setting**	Cultural settings (e.g., places of worship)
E	**S5d.4 Delivery –social setting**	Social settings (e.g., other people’s homes, community spaces)
f	**S5d.4 Delivery – recreational setting**	Recreational settings (e.g., sports ovals, music/art/drama studios)
	S5d.2a and S5d.3: Delivery amount	Only allocate one code per the entire entry
	Specified amount	The respondent specifies an amount (minimum, maximum, range, and or mean) of therapy/support in quantitative terms (e.g., hours, days, sessions, occasions of service). The respondent does not indicate that the amount should be individualised.
	Individualised - Indicative amount.	People who can contribute to supporting the child’s participation in community activities (e.g., sports coaches, art teachers, community members the child interacts with regularly including retail environments, community groups, and cultural activities)
	Individualised - Amount not specified	The respondent indicates that amount should be individualised and does not specify an amount that children should receive. The respondent may imply that the amount should be individualised based on criticism of specific amount they mention (e.g., not XX hours).
	Not Applicable	The respondent's comments are inconsistent with each of the three codes.

Section 5e. Monitoring of Therapies and Supports

S5e.2 Monitoring: fidelity *(use above code for any responses related to below)*	
8.2 Fidelity of therapy/support delivery	
A	Type: The extent to which the planned type of therapy/support was delivered.
B	People: The extent to which the people who were intended to contribute to progress towards the goal contributed.

C	Settings: The extent to which the settings in which the goal was to be targeted were included.
D	Amount: The extent to which the intended amount of therapy/support was delivered.
S5e.2 Monitoring: progress *(use above code for any responses related to below)*	
8.3 Children's progress towards therapy/support goals	
A	Amount of progress made towards the goal
B	The child's satisfaction with progress towards the goal (to the extent possible)
C	Parents' satisfaction with the child's progress towards the goal
S5e.2 Monitoring: impact *(use above code for any responses related to below)*	
8.4 Impact of progress towards therapy/support goals	
A	Changes in the child's skills
B	Changes in the child's learning and participation
C	Changes in the child's wellbeing
D	Changes in the family's wellbeing
E	Changes in the environment that affect learning and participation
S5e.2 Monitoring: maintenance *(use above code for any responses related to below)*	
8.5 Maintenance	
A	Maintenance of change over the short term (i.e., 12 months – 2 years)
B	Maintenance of change over the medium term (i.e., 2-3 years)
C	Maintenance of change over the long term (i.e., 3+ years)
S5e.2 Monitoring: Generalisation *(use above code for any responses related to below)*	
A	Generalisation of change to interactions with other people
B	Generalisation of change to other activities
C	Generalisation of change to other settings
S5e.2 Monitoring: costs/benefits *(use above code for any responses related to below)*	
A	Costs for children (e.g., time, fatigue, not pursuing alternative goal or service option)
B	Costs for parents (e.g., time, financial)
C	Benefits for children
D	Benefits for family members
S5e.2 Monitoring: unplanned outcomes *(use above code for any responses related to below)*	
A	Positive unplanned outcomes that have arisen from the delivery of therapy/support
B	Adverse effects that have arisen from the delivery of the therapies/supports

Section 5f. Safety and Wellbeing

a.	**S5f.2 Safety - Empirical Evidence**	Ensuring practitioners have up-to-date knowledge of the empirical evidence for therapies/supports (including research on the views and preferences of autistic people)
b.	**S5f.2 Safety - Experience**	Ensuring practitioners have adequate experience and skills in the selection, delivery and assessment of therapies/supports
c.	**S5f.2 Safety- Supervision**	Ensuring that practitioners have access to clinical supervision
d.	**S5f.2 Safety - Research**	Ensuring the effectiveness and safety of therapies/supports being delivered by practitioners have been validated through well-designed research studies
e.	**S5f.2 Safety – monitoring**	Ongoing monitoring of therapy/support outcomes
f.	**S5f.2 Safety – assessment**	Ongoing assessment of support needs
g.	**S5f.2 Safety – rights**	Practitioners working in ways that are consistent with relevant conventions, including the United Nations Convention on the Rights of Persons with Disabilities and the United Nations Convention on the Rights of the Child
h.	**S5f.2 Safety – practice standards**	Practitioners following relevant practice/ professional processes and legislative requirements (e.g., Disability Discrimination Act, NDIS rules)
i.	**S5f.2 Safety – concerns**	Ensuring that children and their families have a clear method and pathway for raising concerns
j.	**S5f.2 Safety - communication**	Ensuring the provision of clear, appropriate, and accurate information between practitioners and families at all stages (including to ensure informed consent is validly obtained)

Across Section Codes

‘Who’ codes

2.1	**Who: family**	The child, family, and family-like people (i.e., family friends, peers)
2.2	**Who: support providers**	People who provide formal support for the child’s health and development (e.g., educators, medical and allied health practitioners)
2.3	**Who: participation**	People who can contribute to supporting the child’s participation in community activities (e.g., sports coaches, art teachers, community members the child interacts with

		regularly including retail environments, community groups, and cultural activities)
2.4	**Who: agencies**	Agencies that support the provision and/or access to services (e.g., NDIS planners, child safety officers)

‘Suggestion’ Codes

a.	**Suggestions - Theoretical Rationale**	A theoretical rationale for why the goal/therapy/support is likely to lead to an increase in the child’s learning and participation.
b.	**Suggestions – research evidence**	Research evidence (from published, peer-reviewed research) that the goal/therapy/support is likely to lead to an increase in the child’s learning and participation.
c.	**Suggestions – clinical evidence**	Clinical evidence gathered through practice that the goal/therapy/support is likely to lead to an increase in the child’s learning and participation, including evidence drawn from the experiences/outcomes of other children and families the practitioner has supported.
d.	**Suggestions – autistic perspectives**	Perspectives expressed by autistic people regarding the goal/therapy/support.
	Suggestions – about child/family/context *(use above code for any suggestions that relate to below (e through o)*	
e.	Information about the child, family, and their context that is relevant to this goal/therapy/support	
f.	Consideration of whether the child/family have the time required for the goal/therapy/support	
g.	Consideration of whether the child/family have the social support required for the goal/therapy/support (e.g., family members willing to assist).	
h.	Consideration of whether the child/family have the financial resources required for the goal/therapy/support	
i.	Consideration of whether the child/family have the emotional support required for the goal/therapy/support	
j.	Consideration of whether the goal/therapy/support is consistent with the child/family’s cultural background.	
k.	Consideration of whether the goal/therapy/support is consistent with the parent/s views on child-rearing.	
l.	Consideration of whether the goal/therapy/support is consistent with the parent/s views on child development.	
m.	Consideration of whether the goal/therapy/support is consistent with the parent/s views on disability (and the need to focus on the child versus the environment).	
n.	Consideration of whether the child supports the goal/therapy/support (to the extent possible).	

o.	Consideration of whether the parent/s support the goal/therapy/support	
p.	**Suggestions – benefits**	Consideration of the potential benefits associated with the goal/therapy/support.
q.	**Suggestions - risks**	Consideration of the potential risks associated with the goal/therapy/support.
r.	**Suggestions – alternatives**	Consideration of the alternative options to this goal/therapy/support.
s.	**Suggestions – enhance progress**	Consideration of how this goal/ /therapy/support may enhance progress towards other goals.
t.	**Suggestions – impede progress**	Consideration of how this goal/therapy/support may impede progress towards other goals.
u.	**Suggestions – relevance (current)**	Consideration of the relevance of this goal/therapy/support currently for the child and family.
v.	**Suggestions – relevance (future)**	Consideration of the relevance of this goal/therapy/support in the future for the child and family.

Appendix 8.1	Focus Group – Demographics survey

Community Survey

AutismCRC

Supporting Children National Guideline

Thank you for registering to participate in the Supporting Children Guideline focus groups.
The following short survey will ask for some basic information about you, which will help us describe the individuals who participated in the publication of the guideline.

While we do ask for your name and email address, this information will only be used for administrative purposes and will not be published in any format.

Please provide your first and last name. ________________________________

Please provide your contact email you used to register for the focus groups. ________________________________

Information About You

Please indicate which perspectives you bring to this focus group (select all that apply)	☐ Autistic individual/person on the autism spectrum ☐ Parent/primary caregiver of someone on the autism spectrum ☐ Family member of person on the autism spectrum ☐ An individual who provides services to children (0-12 years) on the autism spectrum ☐ A member of an organisation or service which provides services to children (0-12 years) on the autism spectrum and their families
With which gender do you identify?	○ Female ○ Male ○ Non-binary ○ Prefer not to say ○ Other
Please specify if other	______________________
Which state or territory of Australia do you currently reside in?	○ Australian Capital Territory ○ New South Wales ○ Northern Territory ○ Queensland ○ South Australia ○ Tasmania ○ Victoria ○ Western Australia ○ Do not currently reside in Australia
Which of the following best describes where you live?	○ Major city ○ Regional and/or remote area
Do you self-identify as Aboriginal and/or Torres Strait Islander?	○ No ○ Yes, Aboriginal ○ Yes, Torres Strait Islander ○ Yes, both Aboriginal and Torres Strait Islander
Are you of Aboriginal and/or Torres Strait Islander heritage?	○ No ○ Yes, Aboriginal ○ Yes, Torres Strait Islander ○ Yes, both Aboriginal and Torres Strait Islander
Were you born in Australia?	○ No ○ Yes
In what country were you born?	______________________
Do you speak one or more languages other than English in the home?	○ No ○ Yes
How many languages, including English, do you speak at home?	______________________

What is your age?	○ 0-17 years ○ 18-20 years ○ 21-30 years ○ 31-40 years ○ 41-50 years ○ 51-60 years ○ 61-70 years ○ 71-80 years ○ 81-90 years ○ 91-100 years ○ 100+ years
If you identify as an autistic adult, are you happy to tell us more about your experience of autism, in terms of your diagnosis?	○ No ○ Yes ○ Does not apply to me
Which of the following best describes your circumstances?	○ I have been given a formal diagnosis of autism (or a related diagnosis e.g., Asperger's, Pervasive Developmental Disorder) by one or more qualified health practitioners (e.g., paediatrician, clinical psychologist, psychiatrist) ○ I am currently being assessed for a possible diagnosis of autism ○ I self-identify as autistic, but have not been given a formal diagnosis by a health professional.
At what age did you receive a formal diagnosis? Please specify in years	__________________________________
What was your diagnosis?	__________________________________
Did you receive or access autism specific therapies and supports between the ages of 0-6 years?	○ No ○ Yes
Did you receive or access autism specific therapies and supports between the ages of 7-12 years?	○ No ○ Yes

The below table outlines the three levels of support required within the autism spectrum as described in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5).

Level

Social communication

Restricted, repetitive behaviors

Level 3 "Requiring very substantial support"

Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning, very limited initiation of social interactions, and minimal response to social overtures from others. For example, a person with few words of intelligible speech who rarely initiates interaction and, when he or she does, makes unusual approaches to meet needs only and responds to only very direct social approaches

Inflexibility of behavior, extreme difficulty coping with change, or other restricted/repetitive behaviors markedly interfere with functioning in all spheres. Great distress/difficulty changing focus or action.

Level 2 "Requiring substantial support"

Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal responses to social overtures from others. For example, a person who speaks simple sentences, whose interaction is limited to narrow special interests, and how has markedly odd nonverbal communication.

Inflexibility of behavior, difficulty coping with change, or other restricted/repetitive behaviors appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress and/or difficulty changing focus or action.

Level 1 "Requiring support"

Without supports in place, deficits in social communication cause noticeable impairments. Difficulty initiating social interactions, and clear examples of atypical or unsuccessful response to social overtures of others. May appear to have decreased interest in social interactions. For example, a person who is able to speak in full sentences and engages in communication but whose to- and-fro conversation with others fails, and whose attempts to make friends are odd and typically unsuccessful.

Inflexibility of behavior causes significant interference with functioning in one or more contexts. Difficulty switching between activities. Problems of organization and planning hamper independence.

If you were diagnosed as a child under the DSM-5, please indicate which support level was associated with your diagnosis.	○ Level 1 - Requires support ○ Level 2 - Requires substantial support ○ Level 3 - Required very substantial support ○ I am unsure ○ I would prefer not to say
If you were not diagnosed as a child under the DSM-5, or you received a diagnosis in adulthood, please indicate which level would have best represented your support needs as a child.	○ Level 1 - Requires support ○ Level 2 - Requires substantial support ○ Level 3 - Required very substantial support ○ I am unsure ○ I would prefer not to say
If you identify as a parent, are you happy to tell us more about your child(ren) on the autism spectrum? This includes your children who are now teenagers or adults. We will ask you to focus on just one child at a time.	○ No ○ Yes ○ This does not apply to me
How old is your child (years)	________________________
How old is your child (months)	________________________
Has your child received a formal diagnosis of autism (or a related disorder e.g., Asperger's, Pervasive Developmental Disorder)?	○ No ○ Yes
At what age was your child diagnosed (please round to the nearest year)?	________________________
Did you access therapies and/or supports for your child at some stage between the ages of 0-6 years?	○ No ○ Yes
Did you access therapies and/or supports for your child at some stage between the ages of 7-12 years?	○ No ○ Yes

The below table outlines the three levels of support required within the autism spectrum as described in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5).

Level

Social communication

Restricted, repetitive behaviors

Level 3 "Requiring very substantial support"

Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning, very limited initiation of social interactions, and minimal response to social overtures from others. For example, a person with few words of intelligible speech who rarely initiates interaction and, when he or she does, makes unusual approaches to meet needs only and responds to only very direct social approaches

Inflexibility of behavior, extreme difficulty coping with change, or other restricted/repetitive behaviors markedly interfere with functioning in all spheres. Great distress/difficulty changing focus or action.

Level 2 "Requiring substantial support"

Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal responses to social overtures from others. For example, a person who speaks simple sentences, whose interaction is limited to narrow special interests, and how has markedly odd nonverbal communication.

Inflexibility of behavior, difficulty coping with change, or other restricted/repetitive behaviors appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress and/or difficulty changing focus or action.

Level 1 "Requiring support"

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Inflexibility of behavior causes significant interference with functioning in one or more contexts. Difficulty switching between activities. Problems of organization and planning hamper independence.

If your child was diagnosed under the DSM-5, please indicate which support level is associated with their diagnosis.	○ Level 1 - Requires support ○ Level 2 - Requires substantial support ○ Level 3 - Required very substantial support ○ I am unsure ○ I would prefer not to say
If your child has not yet received a formal diagnosis or was not diagnosed as a child under the DSM-5, please indicate which level you feel would have best represented their support needs as a child.	○ Level 1 - Requires support ○ Level 2 - Requires substantial support ○ Level 3 - Required very substantial support ○ I am unsure ○ I would prefer not to say
Do you wish to provide details for another child on the autism spectrum?	○ No ○ Yes

How old is your child (years)	________________________________
How old is your child (months)	________________________________
Has your child received a formal diagnosis of autism (or a related disorder e.g., Asperger's, Pervasive Developmental Disorder)?	○ No ○ Yes
At what age was your child diagnosed (please round to the nearest year)?	________________________________
Did you access therapies and/or supports for your child at some stage between the ages of 0-6 years?	○ No ○ Yes
Did you access therapies and/or supports for your child at some stage between the ages of 7-12 years?	○ No ○ Yes

The below table outlines the three levels of support required within the autism spectrum as described in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5).

Level

Social communication

Restricted, repetitive behaviors

Level 3 "Requiring very substantial support"

Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning, very limited initiation of social interactions, and minimal response to social overtures from others. For example, a person with few words of intelligible speech who rarely initiates interaction and, when he or she does, makes unusual approaches to meet needs only and responds to only very direct social approaches

Inflexibility of behavior, extreme difficulty coping with change, or other restricted/repetitive behaviors markedly interfere with functioning in all spheres. Great distress/difficulty changing focus or action.

Level 2 "Requiring substantial support"

Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal responses to social overtures from others. For example, a person who speaks simple sentences, whose interaction is limited to narrow special interests, and how has markedly odd nonverbal communication.

Inflexibility of behavior, difficulty coping with change, or other restricted/repetitive behaviors appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress and/or difficulty changing focus or action.

Level 1 "Requiring support"

Without supports in place, deficits in social communication cause noticeable impairments. Difficulty initiating social interactions, and clear examples of atypical or unsuccessful response to social overtures of others. May appear to have decreased interest in social interactions. For example, a person who is able to speak in full sentences and engages in communication but whose to- and-fro conversation with others fails, and whose attempts to make friends are odd and typically unsuccessful.

Inflexibility of behavior causes significant interference with functioning in one or more contexts. Difficulty switching between activities. Problems of organization and planning hamper independence.

If your child was diagnosed under the DSM-5, please indicate which support level is associated with their diagnosis.	○ Level 1 - Requires support ○ Level 2 - Requires substantial support ○ Level 3 - Required very substantial support ○ I am unsure ○ I would prefer not to say
If your child has not yet received a formal diagnosis or was not diagnosed as a child under the DSM-5, please indicate which level you feel would have best represented their support needs as a child.	○ Level 1 - Requires support ○ Level 2 - Requires substantial support ○ Level 3 - Required very substantial support ○ I am unsure ○ I would prefer not to say
Do you wish to provide details for another child on the autism spectrum?	○ No ○ Yes
How old is your child (years)	________________________
How old is your child (months)	________________________
Has your child received a formal diagnosis of autism (or a related disorder e.g., Asperger's, Pervasive Developmental Disorder)?	○ No ○ Yes
At what age was your child diagnosed (please round to the nearest year)?	________________________
Did you access therapies and/or supports for your child at some stage between the ages of 0-6 years?	○ No ○ Yes
Did you access therapies and/or supports for your child at some stage between the ages of 7-12 years?	○ No ○ Yes

The below table outlines the three levels of support required within the autism spectrum as described in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5).

Level

Social communication

Restricted, repetitive behaviors

Level 3 "Requiring very substantial support"

Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning, very limited initiation of social interactions, and minimal response to social overtures from others. For example, a person with few words of intelligible speech who rarely initiates interaction and, when he or she does, makes unusual approaches to meet needs only and responds to only very direct social approaches

Inflexibility of behavior, extreme difficulty coping with change, or other restricted/repetitive behaviors markedly interfere with functioning in all spheres. Great distress/difficulty changing focus or action.

Level 2 "Requiring substantial support"

Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal responses to social overtures from others. For example, a person who speaks simple sentences, whose interaction is limited to narrow special interests, and how has markedly odd nonverbal communication.

Inflexibility of behavior, difficulty coping with change, or other restricted/repetitive behaviors appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress and/or difficulty changing focus or action.

Level 1 "Requiring support"

Without supports in place, deficits in social communication cause noticeable impairments. Difficulty initiating social interactions, and clear examples of atypical or unsuccessful response to social overtures of others. May appear to have decreased interest in social interactions. For example, a person who is able to speak in full sentences and engages in communication but whose to- and-fro conversation with others fails, and whose attempts to make friends are odd and typically unsuccessful.

Inflexibility of behavior causes significant interference with functioning in one or more contexts. Difficulty switching between activities. Problems of organization and planning hamper independence.

If your child was diagnosed under the DSM-5, please indicate which support level is associated with their diagnosis.	○ Level 1 - Requires support ○ Level 2 - Requires substantial support ○ Level 3 - Required very substantial support ○ I am unsure ○ I would prefer not to say
If your child has not yet received a formal diagnosis or was not diagnosed as a child under the DSM-5, please indicate which level you feel would have best represented their support needs as a child.	○ Level 1 - Requires support ○ Level 2 - Requires substantial support ○ Level 3 - Required very substantial support ○ I am unsure ○ I would prefer not to say

A note from the research team

Thank you very much for providing answers to these questions.

Following the completion of the focus groups, the next step for the research team will be to analyse all of the information provided. The Guideline Development Group will then formulate recommendations.

If you have not already done so, please register with the Autism CRC to receive updates about the guideline. You can do so here.

Before we finish, we want to take a moment to acknowledge, and thank you for the time you are committing to participate in these focus groups.

We also acknowledge that we are asking you to share insights during focus groups from your own life, your experience, and your expertise as an autistic person and/or a parent or caregiver of a child on the autism spectrum. It is likely that you will have been asked to do this many times before, and we warmly thank you for being willing to do so again here, to help make the guideline the best it can be. We simply could not do this piece of important work, without your insights. Thank you.

We look forward to sharing updates, and the guideline in due course, via the Autism CRC website.

Sincerely,

Rhylee, Kandice, Hannah, Sarah, David, and Andrew, on behalf of the Guideline Development Group.

Appendix 8.2	Focus Group – Presentation

Supporting Children National Guideline Community Consultation

Focus Groups

AutismCRC

Acknowledgement of Country

Overview

- Housekeeping
- Introduction to guideline and focus groups
- Understanding and expectations

This focus group is being recorded so that we can transcribe and analyse the information the group provides.

The recording ***will not*** be used for any other purpose.

We ***will not*** use anyone's name or other identifying information when share the findings in the National Guideline.

AutismCRC

Housekeeping

- Introducing the facilitators
- Schedule
  - Introduction and house keeping (10 mins)
  - Focus questions (90 mins)
  - Summary and next steps (10 mins)
- Video/audio/chat options
- Tech Support
- Key ethical considerations (consent, privacy, seeking support)

AutismCRC

Introducing the Guideline

1. Why do we need a guideline?
2. How is it being developed?
3. How will my involvement today help?
4. What if I have other questions about the Guideline?

AutismCRC

Why do we need a Guideline?

- Therapies and supports during childhood can support children’s early development, minimise disability, and maximise each child’s strengths and opportunities.

- However, a wide variety are available, which differ according to:
  - Nature
  - How they are support to work
  - The goals they target
  - The places/settings in which they are delivered
  - The people who deliver them
  - Evidence for their effectiveness
  - And many other ways…

AutismCRC

Why do we need a Guideline

- Despite the complexity, there is not a yet a national guideline for the selection, delivery, and monitoring of therapies and supports for children on the autism spectrum and their families.

- The Autism CRC is addressing this need, and your involvement today will help shape the recommendations in the Guideline.

How is it being developed?

Research evidence for effects

Focus Groups

Community survey

Expression through art

Review of existing Guidelines

Reflection

Delphi Survey

Review of research about experiences

Short survey

Reference Group

How will my involvement today help?

We will pose a series of questions

We warmly invite you to share your insights, views, and experiences

We will write down everything everyone says (including a copy of the chat)

We will then review all of the information and identify themes

It is these themes that will then help shape the recommendations in the guideline

AutismCRC

How will my involvement today help?

We will pose a series of questions

We warmly invite you to share your insights, views, and experiences

We will write down everything everyone says (including a copy of the chat)

We will then review all of the information and identify themes

It is these themes that will then help shape the recommendations in the guideline

How will my involvement today help?

We will pose a series of questions

We warmly invite you to share your insights, views, and experiences

We will write down everything everyone says (including making a copy of the online chat)

We will then review all of the information and identify themes

It is these themes that will then help shape the recommendations in the guideline

AutismCRC

How will my involvement today help?

We will pose a series of questions

We warmly invite you to share your insights, views, and experiences

We will write down everything everyone says (including a copy of the chat)

We will then review all of the information and identify themes

It is these themes that will then help shape the recommendations in the guideline

AutismCRC

How will my involvement today help?

We will pose a series of questions

We warmly invite you to share your insights, views, and experiences

We will write down everything everyone says (including a copy of the chat)

We will then review all of the information and identify themes

These themes will help to shape the recommendations

What if I have questions about the Guideline?

Website:

https://www.autismcrc.com.au/supporting-children

Email:

supportingchildren@autismcrc.com.au

AutismCRC

Understanding and Expectations

You have volunteered your time because you want to make a difference

We are privileged to have people with diverse views and experiences joining

We want to ensure that everyone has the opportunity contribute and feels safe and supported

AutismCRC

A positive and productive focus group

- As facilitators we will ensure:
  - On topic
  - On time
  - Everyone has a chance to share

- As participants, we ask that you please:
  - Stay on topic
  - Keep your comments relatively brief, so that more people have a chance to talk/share
  - Help us create a safe and supportive space
  - Avoid naming specific people, practitioners, and service providers
  - Maintain the privacy of others during and following the group

AutismCRC

The questions we will ask

Understanding	Understanding the child, family, and their context?
Goal setting	Planning, selecting, and prioritising goals for children?
Selecting therapies and supports	Planning and selecting therapies and supports for children?
Delivering therapies and supports	Delivering therapies and supports for children?
Monitoring	Monitoring progress and outcomes of therapies and supports for children?
Quality and Safeguards	Ensuring the safety and wellbeing of children on the autism spectrum and their families?

AutismCRC

Key Terms

- **Parent(s):** Refers to any individuals with parenting or caregiving responsibilities for a child (e.g., guardians, kinship, foster carers).
- **Family:** Refers to the child’s parents/caregivers, siblings and any extended family (e.g., grandparents, aunts, uncles, cousins) involved in the child’s care.
- **Therapies**: Refers to services that focus on **supporting children to acquire or enhance functional skills** aimed at ensuring their learning, participation, and quality of life in the community.
- **Support:** Refers to services that focus on **adjustments, modifications, and enhancements to the environment** aimed at ensuring their learning, participation, and quality of life in the community.
- **Practitioners:** People who are paid to provide services to children and families.

AutismCRC

Question 1 of 6:

What are the most important considerations for practitioners trying to **understand the child, family, and their context**?

Question 2 of 6:

From your perspective, what are the most important considerations for practitioners when **planning, selecting, and prioritising goals** for children?

AutismCRC

Question 3 of 6:

From your perspective, what are the most important considerations for practitioners when **planning and selecting therapies and supports** for children?

AutismCRC

Question 4 of 6:

From your perspective, what are the most important considerations for practitioners when **delivering therapies and supports** for children?

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Question 5 of 6:

From your perspective, what are the most important considerations for practitioners when **monitoring progress and outcomes** of therapies and supports for children?

AutismCRC

Question 6 of 6:

From your perspective, what are the most important considerations for practitioners to ensure the **safety and wellbeing** of children on the autism spectrum and their families?

AutismCRC

Summary and Next Steps

- Reflections on discussion
- Next steps
- Acknolwedgements

AutismCRC

AutismCRC

autismcrc.com.au

Appendix 9.1	Delphi Survey – Round 1

Supporting Children Guideline - Delphi Survey (Round 1)

In this survey, we are interested in your views, as a practitioner, about the planning and delivery of therapies and supports aimed at enhancing the learning, participation, and quality of life of children on the autism spectrum (aged 0-12 years) and their families in community settings.

Part 1 of the survey will ask about your professional affiliation, your experience and practice working with children on the autism spectrum and their families, and the types and location of your current service setting(s). Part 2 of the survey (which contains nine sections) asks you to rate your agreement with various statements on what you consider to be best practice when supporting children on the autism spectrum and their families. You will also have the opportunity within each section of Part 2 to provide additional (optional) comments.

PLEASE NOTE: The survey will close at 11:59pm on March 20th (AEST)

For the purpose of this survey:

'Parent(s)' refers to any individuals with parenting or caregiving responsibilities for a child (e.g., guardians, kinship, foster carers)'Family' refers to the child's parents/caregivers, siblings and any extended family (e.g., grandparents, aunts, uncles, cousins) involved in the child's care'Therapies' refers to services that focus on supporting the children to acquire or enhance functional skills aimed at ensuring their learning, participation, and quality of life in the community'Support' refers to services that focus on adjustments, modifications, and enhancements to the environment aimed at ensuring their learning, participation, and quality of life in the community

---

Please provide your first name: ______________________

Please provide your last name: ______________________

Please provide the most appropriate email address to follow-up with your Round 2 survey: ______________________

You have been invited to participate in this survey through your links with a professional organisation.

Which professional organisation invited you to participate in this survey?	○ Australian Psychological Society ○ Australian Physiotherapy Association ○ Neurodevelopmental and Behavioural Paediatrics Society of Australasia ○ Occupational Therapy Australia ○ Speech Pathology Australia
What is your profession (select all that apply)?	☐ General Practitioner ☐ Occupational Therapist ☐ Paediatrician ☐ Physiotherapist ☐ Psychiatrist ☐ Psychologist ☐ Speech Pathologist ☐ None of the above
How are you currently involved in clinical practice for children on the autism spectrum? (select all that apply)	☐ I provide therapies and supports to children and families on the autism spectrum ☐ I supervise others who provide therapies and supports to children on the autism spectrum ☐ I conduct research into clinical practice for children on the autism spectrum ☐ Other
As you selected 'other', please specify how you are currently involved in clinical practice for children on the autism spectrum.	__________________________________
How many years experience do you have working in clinical practice with children on the autism spectrum?	____________________________
In 2021, approximately what proportion of your caseload were children on the autism spectrum?	○ 0-25% ○ 26-50% ○ 51-75% ○ 76-100%
In 2021, what age groups of individuals on the autism spectrum did you provide therapies and supports to (select all that apply)?	☐ 0-3 years ☐ 4-6 years ☐ 7-9 years ☐ 10-12 years ☐ 13-15 years ☐ 16-18 years ☐ 19 years and older ☐ I did not provide any therapies or supports to individuals on the autism spectrum in 2021
Across your career to date, what age groups of individuals on the autism spectrum have you predominately provided therapies and supports to (select all that apply)?	☐ 0-3 years ☐ 4-6 years ☐ 7-9 years ☐ 10-12 years ☐ 13-15 years ☐ 16-18 years ☐ 19 years and older
In 2021, did you provide therapies and supports for children on the autism spectrum and their families who identify as being Aboriginal and/or Torres Strait Islander peoples?	○ Yes ○ No

In 2021, did you provide therapies and supports for children on the autism spectrum and their families who were not born in Australia?	○ Yes ○ No
In 2021, did you provide therapies and supports for children on the autism spectrum and their families who did not speak English?	○ Yes ○ No
In which state/territory do you currently practice? (select all that apply)	☐ Australian Capital Territory ☐ New South Wales ☐ Northern Territory ☐ Queensland ☐ South Australia ☐ Tasmania ☐ Victoria ☐ Western Australia
In which areas do you conduct your work with children on the autism spectrum and their families?	☐ Major cities ☐ Regional and remote areas
In which of the following service settings do you currently provide therapies and supports for children on the autism spectrum and their families (select all that apply)?	☐ Private, including non-government organisations ☐ Government organisation
In which of the following settings do you currently provide therapies and supports for children on the autism spectrum and their families? (select all that apply)	☐ Child's home ☐ Hospital (inpatient/outpatient) ☐ Community clinic (including private practice) ☐ University clinic (includes providing services as part of student training and research) ☐ Early childhood education centre (prior to formal schooling, and commonly referred to as day care/childcare) ☐ Early childhood education centre in a specialised setting (prior to formal schooling and catering only to children with additional learning needs) ☐ Mainstream school ☐ Support class/unit within a mainstream school ☐ School specifically for children on the autism spectrum ☐ School specifically for children with additional learning needs, that includes children on the autism spectrum ☐ Other
Please specify the 'other' type(s) of settings that you currently provide therapies and supports for children on the autism spectrum.	__________________________________
Please indicate how children on the autism spectrum and their families access your service (select all that apply)	☐ Face to face delivery ☐ Telepractice delivery

SURVEY PART 2

There are nine sections to this survey.

First, we will ask you to reflect on overarching principles that should be adhered to at all stages of the clinical process when working with children on the autism spectrum and their families (Section 1).

We will then ask (i) who should be involved in the provision of therapies and supports (Section 2), and (ii) what sources of information should be considered when making decisions about therapies and supports (Section 3).

We will next ask you to offer your views across various stages of working with children on the autism spectrum and their families, which we have divided into (a) understanding the child, family and their context (Section 4), (b) goal setting (Section 5), (c) selecting therapies and supports (Section 6), (d) delivering therapies and supports (Section 7), and (e) monitoring outcomes (Section 8).

At the end, we will also ask you to offer your views about how quality and safety can be assured (Section 9).

PLEASE NOTE: the survey takes approximately 45-60 minutes to complete. At any stage, you can select the 'Save and Return Later' icon if you would prefer to complete the survey over multiple sittings.

The data you enter will be automatically saved on the Griffith University research server (via REDCap), so do not be concerned about it being lost. If you have any difficulties re-commencing the survey, you can contact the research team for help (k.varcin@griffith.edu.au).

The survey will close at 11:59pm on March 20th (AEST)

Section 1 of 9.

Principles

1.1 Please indicate the extent to which you agree each of the following are principles that are important to all aspects of providing therapies and supports to children on the autism spectrum.

***While some principles refer to both children and their families to acknowledge the family unit, we do so noting that the individual preferences, needs, and rights of each person are always to be considered and maintained.**

		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
1.1a	Holistic: The provision of therapies and supports should involve consideration of an individual's life history, culture, strengths and challenges, goals and preferences, and environmental factors that act as facilitators or barriers to learning, participation, and quality of life.	○	○	○	○	○
1.1b	Child and family-centred: The child and their family members should be considered equal partners with practitioners in the therapy process.	○	○	○	○	○
1.1c	Supported: The child and their family should be supported to include people they feel are relevant in the therapy process, including for advocacy and support.	○	○	○	○	○
1.1d	Lifespan perspective: Clinical decision-making regarding the provision of therapies and supports should account for the current stage of life of the individual, as well as appropriate planning for both the short and longer term.	○	○	○	○	○
1.1e						

	Developmental perspective: Clinical decision-making regarding the provision of therapies and supports should account for, and be responsive to, the individual, family and social changes that occur through childhood.	○	○	○	○	○
1.1f	Empirically supported: Therapies and supports should be underpinned by the best available published, peer-reviewed scientific evidence demonstrating their effectiveness and safety.	○	○	○	○	○
1.1g	Evidence-based practice approach: Clinical decision-making regarding the provision of therapies and supports should draw on, and integrate, research and clinical evidence alongside the preferences and values of the child and their family.	○	○	○	○	○
1.1h	Ethical practice: The provision of therapies and supports should be underpinned by an ethical framework that follows the principles of beneficence (i.e., to act for the benefit of others), non-maleficence (i.e., do no harm), autonomy and fairness.	○	○	○	○	○
1.1i	Culturally aware and responsive: The values, knowledge, preferences and cultural perspectives of the child and family should be sought, respected, and evident in the provision of therapies and supports.	○	○	○	○	○
1.1j						

	Equity: All children and families, regardless of age, gender, cultural background, socioeconomic status or geographical location should be able to access timely, safe, desirable and effective therapies and supports.	○	○	○	○	○
1.1k	Strengths-focused: Therapies and supports should focus on understanding, embracing and developing the strengths of an individual and their family.	○	○	○	○	○
1.1l	Coordinated: A coordinated approach to the provision of therapies and supports for the child and family across practitioners, organisations, and agencies should be taken.	○	○	○	○	○
1.1m	Personalised: Therapies and supports should be tailored to the unique strengths, needs, and preferences of each child and family.	○	○	○	○	○
1.1n	Accessible: The process of planning, delivering, and monitoring therapies and supports, including interactions and documentation, should be accessible.	○	○	○	○	○
1.1o	Informed consent (parents): Informed parental consent should be obtained for the provision of therapies and supports.	○	○	○	○	○
1.1p	Assent (children): Children's assent (expression of approval) should be obtained, wherever possible, for the provision of therapies and supports.	○	○	○	○	○
1.1q						

Qualified practitioners: People involved in the provision of therapies and supports should have relevant qualifications and professional regulation, and only engage in goal setting and the delivery of therapies and supports that are within their scope of practice.	○	○	○	○	○

1.2. Are there other overarching principles that are relevant to the provision of therapies and supports for children on the autism spectrum?	○ Yes ○ No
To help us understand your suggestion, please provide the name of the principle that has not been covered. Principle name:	__________________________
Please explain why this principle is important, as we have done in the table above. Principle explanation:	________________________________
Are there other overarching principles that are relevant to the provision of therapies and supports for children on the autism spectrum?	○ Yes ○ No
To help us understand your suggestion, please provide the name of the principle that has not been covered. Principle name:	__________________________
Please explain why this principle is important, as we have done in the table above. Principle explanation:	________________________________
Are there other overarching principles that are relevant to the provision of therapies and supports for children on the autism spectrum?	○ Yes ○ No
To help us understand your suggestion, please provide the name of the principle that has not been covered. Principle name:	__________________________
Please explain why this principle is important, as we have done in the table above. Principle explanation:	________________________________

Are there other overarching principles that are relevant to the provision of therapies and supports for children on the autism spectrum?	○ Yes ○ No
To help us understand your suggestion, please provide the name of the principle that has not been covered. Principle name:	__________________________
Please explain why this principle is important, as we have done in the table above. Principle explanation:	________________________________
Are there other overarching principles that are relevant to the provision of therapies and supports for children on the autism spectrum?	○ Yes ○ No
To help us understand your suggestion, please provide the name of the principle that has not been covered. Principle name:	__________________________
Please explain why this principle is important, as we have done in the table above. Principle explanation:	________________________________

Section 2 of 9.

Who should be involved in the provision of therapies and supports?

We are interested to know who you think should be involved in the provision of therapies and supports for children on the autism spectrum. This includes when:

Working to understand the child, family, and context Setting goals Selecting therapies and supports Delivering therapies and supports Monitoring outcomes Below, we have indicated a range of people who might be involved in the provision of therapies and supports.

Please tell us the extent to which you agree with these statements.

2.1. The child, family, and family-like people (i.e., family friends, peers) should be involved in:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
2.1a Working to understand the child, family, and their context	○	○	○	○	○
2.1b Setting goals	○	○	○	○	○
2.1c Selecting therapies and supports	○	○	○	○	○
2.1d Delivering therapies and supports	○	○	○	○	○
2.1e Monitoring outcomes	○	○	○	○	○

2.2. People who provide formal support for the child's health and development (e.g., educators, medical and allied health practitioners) should be involved in:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
2.2a Working to understand the child, family, and their context	○	○	○	○	○
2.2b Setting goals	○	○	○	○	○
2.2c Selecting therapies and supports	○	○	○	○	○
2.2d Delivering therapies and supports	○	○	○	○	○
2.2e Monitoring outcomes	○	○	○	○	○

2.3. People who can contribute to supporting the child's participation in community activities (e.g., sports coaches, art teachers, community members the child interacts with regularly including retail environments, community groups, and cultural activities) should be involved in:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
2.3a Working to understand the child, family, and their context	○	○	○	○	○
2.3b Setting goals	○	○	○	○	○
2.3c Selecting therapies and supports	○	○	○	○	○
2.3d Delivering therapies and supports	○	○	○	○	○
2.3e Monitoring outcomes	○	○	○	○	○

2.4. Agencies that support the provision and/or access to services (e.g., NDIS planners, child safety officers) should be involved in:

		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
2.4a	Working to understand the child, family, and their context	○	○	○	○	○
2.4b	Setting goals	○	○	○	○	○
2.4c	Selecting therapies and supports	○	○	○	○	○
2.4d	Delivering therapies and supports	○	○	○	○	○
2.4e	Monitoring outcomes	○	○	○	○	○

2.5. Are there any other people or agencies that should be involved in service delivery?

○ Yes
○ No

Please indicate (i) any other people or agencies who/that should be involved in service delivery, (ii) in what aspect(s) of service delivery they should be involved in (e.g., assessment, goal setting, selecting and delivering therapies/supports, monitoring), and (iii) to what extent they should be involved.

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Section 3 of 9.

Sources of information

We are interested to know what factors are important for practitioners to consider when making recommendations for goals, and the selection and delivery of therapies and supports when working with children on the autism spectrum and their families.

3.1 Please indicate the extent to which you believe the following factors are important:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
3.1a A theoretical rationale for why the chosen goal/therapy/support is likely to lead to an increase in the child's learning and participation.	○	○	○	○	○
3.1b Research evidence (from published, peer-reviewed research) that the goal/therapy/support is likely to lead to an increase in the child's learning and participation.	○	○	○	○	○
3.1c Clinical evidence gathered through practice that the goal/therapy/support is likely to lead to an increase in the child's learning and participation, including evidence drawn from the experiences/outcomes of other children and families the practitioner has supported.	○	○	○	○	○
3.1d Perspectives expressed by autistic people regarding the goal/therapy/support.	○	○	○	○	○
3.1e Information about the child, family, and their context that is relevant to the goal/therapy/support.	○	○	○	○	○
3.1f Consideration of whether the child/family have the time required for the goal/therapy/support	○	○	○	○	○
3.1g Consideration of whether the child/family have the social support required for the goal/therapy/support (e.g., family members willing to assist).	○	○	○	○	○
3.1h Consideration of whether the child/family have the financial resources required for the goal/therapy/support.	○	○	○	○	○

3.1i

	Consideration of whether the child/family have the emotional support required for the goal/therapy/support.	○	○	○	○	○
3.1j	Consideration of whether the goal/therapy/support is consistent with the child/family's cultural background.	○	○	○	○	○
3.1k	Consideration of whether the goal/therapy/support is consistent with the parent/s views on child-rearing.	○	○	○	○	○
3.1l	Consideration of whether the goal/therapy/support is consistent with the parent/s views on child development.	○	○	○	○	○
3.1m	Consideration of whether the goal/therapy/support is consistent with the parent/s views on disability (and the need to focus on the child versus the environment).	○	○	○	○	○
3.1n	Consideration of whether the child supports the goal/therapy/support (to the extent possible).	○	○	○	○	○
3.1o	Consideration of whether the parent/s supports the goal/therapy/support.	○	○	○	○	○
3.1p	Consideration of the potential benefits associated with the goal/therapy/support.	○	○	○	○	○
3.1q	Consideration of the potential risks associated with the goal/therapy/support.	○	○	○	○	○
3.1r	Consideration of the alternative options to this goal/therapy/support.	○	○	○	○	○
3.1s	Consideration of how this goal/therapy/support may enhance progress towards other goals.	○	○	○	○	○

3.1t

	Consideration of how this goal/therapy/support may impede progress towards other goals.	○	○	○	○	○
3.1u	Consideration of the relevance of this goal/therapy/support currently for the child and family.	○	○	○	○	○
3.1v	Consideration of the relevance of this goal/therapy/support in the future for the child and family.	○	○	○	○	○

3.1w Are there any other factors that decisions regarding goal setting and therapy/support selection and delivery, should be based on?	○ Yes ○ No

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Please describe any other factors that decisions regarding goal setting and therapy/support selection and delivery should be based on. ______________________________

Section 4 of 9.

Understanding the child, family and their context

In clinical practice, assessment involves collecting information that helps the practitioner understand the child, their family, and the broader context. Assessment may involve a range of people (e.g., the child, family, other practitioners), include the use of a range of tools (e.g., observation, interviewing, functional assessment, dynamic assessments), and draw on both current and historical information.

	Not at all important	Slightly important	Moderately important	Very important	Extremely important
4.1 How important do you think it is to understand the child, their family, and their context when making decisions about therapies and supports for children on the autism spectrum?	○	○	○	○	○

4.2 Please indicate the extent to which you agree that the planning of therapies and supports should be informed by assessment of the following aspects of children's health, development, and wellbeing:

		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
4.2a	The child's health (i.e., physical health, mental health, and health history).	○	○	○	○	○
4.2b	The child's developmental skills (i.e., gross and fine motor, social, emotional, cognitive, communication, and academic skills).	○	○	○	○	○
4.2c	The child's diagnostic characteristics (i.e., social communication skills, repetitive behaviours, focused/intense interests, and sensory behaviours).	○	○	○	○	○
4.2d	The child's activities and participation in home, educational, and community settings (this includes enablers and barriers to participation).	○	○	○	○	○
4.2e	The child's behaviour(s) of concern (including, (i) behaviours arising from the interaction of the person and their environment that risk the physical safety of the individual and/or others and (ii) behaviours that limit or deny participation in life activities).	○	○	○	○	○
4.2f	The child's perception of their quality of life (to the extent this is possible to obtain).	○	○	○	○	○
4.2g	The child's activity-related strengths and preferences (i.e., activities that bring the child joy and/or that they have expertise in).	○	○	○	○	○
4.2h	The child's preferences for therapies/supports (to the extent this is possible to obtain).	○	○	○	○	○

4.2i

The child's expectations for the outcomes of therapy/support (to the extent this is possible to obtain).	○	○	○	○	○

4.2j Are there any other child-related factors that should inform the planning of therapies and supports?	○ Yes ○ No
Please describe any other child-related factors that should be assessed to inform the planning of therapies and supports.	__________________________________

4.3 Please indicate the extent to which you agree that the planning of therapies and supports should be informed by assessment of the following aspects of the family:

		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
4.3a	The family's physical and mental health (i.e., the presence of any conditions that may impact upon their capacity to participate, or need to be considered, in the provision of therapies/supports for the child).	○	○	○	○	○
4.3b	The family's social-emotional resources and supports (i.e., resilience factors and the capacity to deal with stressful situations in life, along with social support via family, friends, and support groups).	○	○	○	○	○
4.3c	The family's financial resources and supports (i.e., funding to pay for therapies and supports, capacity to purchase unfunded therapies and supports, and capacity to take time away from paid work to access therapies and supports).	○	○	○	○	○
4.3d	The family's activities (i.e., work, social, cultural, sport and recreational, and educational activities).	○	○	○	○	○
4.3e	The family's views, perspectives, and preferences (i.e., views about their child's learning, participation, and quality of life now and in the future, views on disability, the relevance of therapies/supports for their child, cultural perspectives on therapies/supports, preferences for therapies/supports, and expectations for outcomes).	○	○	○	○	○
4.3f						

The family's dynamics (i.e., the nature and strength of relationships between family members, the nature and distribution of roles and responsibilities, and the positive and challenging impacts associated with the child's disability).	○	○	○	○	○

4.3g Are there any other family-related factors that should inform the planning of therapies and supports?	○ Yes ○ No

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Please describe any other family-related factors that should be assessed to inform the planning of therapies and supports. ____________________________________

4.4 Please indicate the extent to which you agree that the planning of therapies and supports should be informed by assessment of the following aspects of a family's PREVIOUS engagement with other services:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
4.4a The nature of any services previously accessed, including goals and types of services (e.g., allied health, mainstream supports).	○	○	○	○	○
4.4b The child and family's experience of previously accessed services, including their satisfaction with the service(s).	○	○	○	○	○
4.4c The child and family's outcomes of accessing previous services, including the progress made towards goals.	○	○	○	○	○

4.5 Please indicate the extent to which you agree that the planning of therapies and supports should be informed by assessment of the following aspects of a family's CURRENT engagement with other services:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
4.5a The nature of any services and funding/support (e.g., NDIS plan, education department) currently accessed, including goals and types of services (e.g., allied health, mainstream supports)	○	○	○	○	○
4.5b The child and family's experience of currently accessed services, including their satisfaction with the service(s).	○	○	○	○	○
4.5c The child and family's outcomes of accessing current services, including the progress made towards goals.	○	○	○	○	○
4.5d Any arrangements that are in place to support the coordination of services and supports accessed by the child and family (e.g., nominated case coordinator, NDIS support coordination)	○	○	○	○	○
4.5e Family preferences for future arrangements to support the coordination of services and supports accessed by the child and family	○	○	○	○	○

4.5f Are there any other factors related to the family's engagement with services that should inform the planning of therapies and supports?

○ Yes
○ No

Please describe any other factors related to the family's engagement with services that should inform the planning of therapies and supports.

____

[OPTIONAL] 4.6 Please provide any further information you would like to help explain your responses, or that you believe is relevant to consider in understanding a child, their family and their context prior to the provision of therapies/supports.

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Section 5 of 9.

Goal-setting

In this section we ask you to rate your agreement with statements about goal setting, including what the goals should target, and how decisions about goal setting should be made.

	Not at all important	Slightly important	Moderately important	Very important	Extremely important
5.1 How important do you think it is to select appropriate goals for therapy when working with children on the autism spectrum and their families?	○	○	○	○	○

5.2 When relevant, goals for children on the autism spectrum and their families should consider focusing on the child's:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
5.2a Mental functions (e.g., executive functioning)	○	○	○	○	○
5.2b Physical functions (e.g., articulation of speech sounds, fine motor skills)	○	○	○	○	○

5.3 When relevant, goals for children on the autism spectrum and their families should consider focusing on the following skills/behaviours related to the child's activities and participation:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
5.3a The acquisition of skills (e.g., social, communication, play, motor).	○	○	○	○	○
5.3b The generalised use of skills in daily activities with others (e.g., social skills used to help form relationships, communication skills used to have a conversation, play skills used to engage in play with peers).	○	○	○	○	○
5.3c The reduction of behaviours of concern (e.g., self-injurious behaviours).	○	○	○	○	○
5.3d Learning and applying knowledge (e.g., learning to count, learning to read).	○	○	○	○	○
5.3e Carrying out daily routines (relative to age expectations).	○	○	○	○	○
5.3f Supporting interpersonal interactions and relationships.	○	○	○	○	○
5.3g Participation in community, social, and civic life (e.g., recreation, leisure, religion, spirituality).	○	○	○	○	○

5.4 When relevant, goals for children on the autism spectrum and their families should consider focusing on the following aspects of the child's environment:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
5.4a Accessibility in the physical environment (e.g., sensory-safe spaces).	○	○	○	○	○
5.4b Accessibility in the social environment (e.g., changing attitudes and increasing knowledge and skills of others).	○	○	○	○	○
5.4c Enhancement of services, systems, and policies (e.g., to improve coordination of services, changing policies that create barriers to participation).	○	○	○	○	○

5.5 Are there any other domains that goals should be focused on for children on the autism spectrum and their families?	○ Yes ○ No
Please describe any other domains that goals should be focused on for children on the autism spectrum and their families.	________________________________

5.6 In working with children and families to set goals, practitioners should:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
5.6a Ensure goals are specific	○	○	○	○	○
5.6b Ensure goals are measureable	○	○	○	○	○
5.6c Ensure goals are achievable	○	○	○	○	○
5.6d Ensure goals are relevant to the child, family and their context	○	○	○	○	○
5.6e Ensure goals are understood by the family and relevant stakeholders	○	○	○	○	○
5.6f Ensure goals are documented	○	○	○	○	○
5.6g Ensure goals have a clear timeframe	○	○	○	○	○

5.7 Therapy/support goals should be selected in relation to how they support the child's functioning, activities, and participation over the:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
5.7a Short-term i.e., for goal attainment over 12 months-2 years.	○	○	○	○	○
5.7b Medium term i.e., for goal attainment over 2-3 years.	○	○	○	○	○
5.7c Long-term i.e., for goal attainment over 3+ years.	○	○	○	○	○

5.7d Are there other timeframes that therapy/support goals should cover?

○ Yes
○ No

Please describe any other timeframes that therapy/support goals should cover.

____

[OPTIONAL] 5.8 Please provide any further information you would like to help explain your responses, or that you believe is relevant to consider in the formulation and selection of goals.

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Section 6 of 9.

Selecting therapies and supports

	Not at all important	Slightly important	Moderately important	Very important	Extremely important
6.1 How important do you think it is to select appropriate therapies and supports when working with children on the autism spectrum and their families?	○	○	○	○	○

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
6.2 The selection of therapies and supports should be informed by the goals for therapy	○	○	○	○	○

[OPTIONAL] 6.3 Earlier in the survey, we asked about who should be involved in selecting therapies and supports and what information should be considered. Please provide any further information you would like to help explain your responses, or that you believe is relevant to consider in the selection of therapies/supports that has not been covered.

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Section 7 of 9.

Delivering therapies and supports

The following items focus on decisions about therapy/support delivery (e.g., settings, amount, timing).

	Not at all important	Slightly important	Moderately important	Very important	Extremely important
7.1 How important do you think it is to deliver therapies and supports in ways that are appropriate for children on the autism spectrum and their families?	○	○	○	○	○

In what settings should therapies/supports be delivered?

7.2 Where relevant, the following settings may be appropriate for the delivery of therapies/supports:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
7.2a Clinic	○	○	○	○	○
7.2b The child's home	○	○	○	○	○
7.2c Educational settings (including school and early child education settings/day care)	○	○	○	○	○
7.2d Cultural settings (e.g., places of worship)	○	○	○	○	○
7.2e Social settings (e.g., other people's homes, community spaces)	○	○	○	○	○
7.2f Recreational settings (e.g., sports ovals, music/art/drama studios)	○	○	○	○	○

7.2g Are there any other settings that may be appropriate for the delivery of therapies and supports?	○ Yes ○ No
Please describe any other settings that may be appropriate for the delivery of therapies and supports.	__________________________________

In what amount(s) should therapies/supports be delivered?

In this section we will ask you for your views regarding the amount of therapy/support children on the autism spectrum should receive.

First, we want to acknowledge that children's learning and participation may be supported through a combination of mainstream services (e.g., health and education), practitioner services (e.g., allied health therapies), and upskilling parents and other family members to deliver therapies and supports. We provide an opportunity to comment on the relevance of mainstream services and parent-mediated therapies and supports in other sections.

Here, we want to focus on your views about the amount of practitioner-delivered support children and families should receive.

7.3 When relevant, children should have access to:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
7.3a Child-directed services (i.e., a practitioner working primarily with the child as 1:1 or in a small group)	○	○	○	○	○
7.3b Parent-directed services (i.e., a practitioner working primarily to upskill the parent(s) to support the child's learning and participation)	○	○	○	○	○
7.3c Community-directed services (i.e., a practitioner working primarily to upskill other members of the community [e.g., educators] to support the child's learning and participation)	○	○	○	○	○

7.4 Please rate your agreement with the following statements:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
7.4a Services provided to children should be predominately child-directed (i.e., a practitioner working primarily with the child as 1:1 or in a small group)	○	○	○	○	○
7.4b Services provided to children should be predominately parent-directed (i.e., a practitioner working primarily to upskill the parent/s)	○	○	○	○	○
7.4c Services provided to children should be predominately community-directed (i.e., a practitioner working primarily to upskill other members of the community [e.g., educators])	○	○	○	○	○
7.4d The proportion of child-directed, parent-directed, and community-directed services should be personalised	○	○	○	○	○

7.5 Please rate your agreement with the following statements:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
7.5a There is a minimum number of practitioner-delivered therapy/support hours that all children on the autism spectrum should receive	○	○	○	○	○
7.5b There is a maximum number of practitioner-delivered therapy/support hours that all children on the autism spectrum should receive	○	○	○	○	○
7.5c All children on the autism spectrum should receive a set number of hours per week of practitioner-delivered therapy/support services	○	○	○	○	○
7.5d The amount of therapy/support hours should be based on individual factors related to the child and family, including the child's functional difficulties, the therapy goals, and the broader family needs.	○	○	○	○	○
7.5e The number of hours of practitioner-delivered therapy/support a child receives should be personalised	○	○	○	○	○

As you agreed that there should be a minimum number of practitioner-delivered therapy/support hours for children, please indicate the minimum number of hours per week you think children on the autism spectrum should receive. ______________________________

As you agreed that there should be a maximum number of practitioner-delivered therapy/support hours for children, please indicate the maximum number of hours per week you think children on the autism spectrum should receive. ______________________________

As you agreed that all children on the autism spectrum should receive a set number of hours per week of practitioner-delivered therapy/support services, please (i) indicate the number of hours per week you would recommend, and (ii) provide your reasoning. ______________________________

Please provide your reasoning as to why you disagree that all children on the autism spectrum should receive a set number of hours per week of practitioner-delivered therapy/support services. ______________________________

Please provide your reasoning as to why you agree that the amount of therapy/support hours should be based on individual factors related to the child and family.

____

Please provide your reasoning as to why you disagree that the amount of therapy/support hours should be based on individual factors related to the child and family.

____

When should therapies and supports be delivered?

7.6 Please rate your agreement with the following statement:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Therapies/supports should be made available as soon as a support need is identified	○	○	○	○	○

[OPTIONAL] 7.7 Please provide any further information you would like to help explain your responses, or that you believe is relevant to consider in the delivery of therapies/supports. ____

Section 8 of 9.

Monitoring

In this section we seek your views on how progress towards goals and the broader impacts of therapies and supports should be monitored, including who should be consulted; what sources of information should be considered; and how, and how often, the findings should be shared with child, family, and key stakeholders.

	Not at all important	Slightly important	Moderately important	Very important	Extremely important
8.1 How important do you think it is to monitor the delivery of therapies and supports for children on the autism spectrum and their families? This includes ensuring the goals, therapies, and supports continue to be appropriate.	○	○	○	○	○

8.2 When relevant, progress and the outcomes of therapy/support provision should include monitoring of the following aspects of therapy fidelity/support delivery:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
8.2a Type: the extent to which the planned type of therapy/support was delivered	○	○	○	○	○
8.2b People: the extent to which the people who were intended to contribute to progress towards the goal, contributed	○	○	○	○	○
8.2c Settings: the extent to which the settings in which the goal was to be targeted were included	○	○	○	○	○
8.2d Amount: the extent to which the intended amount of therapy/support was delivered	○	○	○	○	○

8.3 When relevant, progress and the outcomes of therapy/support provision should include monitoring of children's progress towards therapy/support goals across the following domains:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
8.3a Amount of progress made towards the goal	○	○	○	○	○
8.3b The child's satisfaction with progress towards the goal (to the extent possible)	○	○	○	○	○
8.3c Parent's satisfaction with the child's progress towards the goal	○	○	○	○	○

8.4 When relevant, progress and the outcomes of therapy/support provision should include monitoring of:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
8.4a Changes in the child's skills	○	○	○	○	○
8.4b Changes in the child's learning and participation	○	○	○	○	○
8.4c Changes in the child's wellbeing	○	○	○	○	○
8.4d Changes in the family's wellbeing	○	○	○	○	○
8.4e Changes in the environment that affect learning and participation	○	○	○	○	○

8.5 When relevant, progress and the outcomes of therapy/support provision should include monitoring of:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
8.5a Maintenance of change over the short-term (i.e., 12 months-2 years)	○	○	○	○	○
8.5b Maintenance of change over the medium term (i.e., 2-3 years)	○	○	○	○	○
8.5c Maintenance of change over the long-term (i.e., 3+ years)	○	○	○	○	○

8.6 When relevant, progress and the outcomes of therapy/support provision should include monitoring of:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
8.6a Generalisation of change to interactions with other people	○	○	○	○	○
8.6b Generalisation of change to other activities	○	○	○	○	○
8.6c Generalisation of change to other settings	○	○	○	○	○

8.7 When relevant, progress and the outcomes of therapy/support provision should include monitoring of:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
8.7a Costs for children (e.g., time, fatigue, not pursuing alternative goal or service option)	○	○	○	○	○
8.7b Costs for parents (e.g., time, financial)	○	○	○	○	○
8.7c Benefits for children	○	○	○	○	○
8.7d Benefits for family members	○	○	○	○	○

8.8 When relevant, progress and the outcomes of therapy/support provision should include monitoring of:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
8.8a Positive unplanned outcomes that have arisen from the delivery of therapies/supports	○	○	○	○	○
8.8b Adverse effects that have arisen from the delivery of therapies/supports	○	○	○	○	○

8.9 The following assessment/evaluation tools and sources of information should be considered when monitoring therapy/support progress and outcomes: OBSERVATIONS

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
8.9a Observations of the child's progress towards goals during the delivery of therapy/support	○	○	○	○	○
8.9b Observations of the child's progress towards goals in contexts outside of those in which the therapy/support is being delivered	○	○	○	○	○
8.9c Observations of the child's reaction (positive, negative, mixed) to engaging in the therapy/support	○	○	○	○	○

8.10 The following assessment/evaluation tools and sources of information should be considered when monitoring therapy/support progress and outcomes: DIRECT AND PARENT REPORT

		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
8.10a	Direct report from the child about progress towards goals (to the extent possible)	○	○	○	○	○
8.10b	Parent report of the child's progress towards the goals	○	○	○	○	○
8.10c	Direct report from the child about their experience (positive, negative, mixed) of engaging with the therapy/support (to the extent possible)	○	○	○	○	○
8.10d	Parent report of what they perceive to be the child's experience (positive, negative, mixed) of engaging with the therapy/support	○	○	○	○	○

8.11 The following assessment/evaluation tools and sources of information should be considered when monitoring therapy/support progress and outcomes: REPORTS FROM OTHERS

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
8.11a Reports from people who are involved in the delivery of the therapy/support	○	○	○	○	○
8.11b Reports from people who can provide insight into the child's progress towards the goals and/or general learning, participation, and wellbeing	○	○	○	○	○

8.12 The following assessment/evaluation tools and sources of information should be considered when monitoring therapy/support progress and outcomes: PROGRESS DATA

		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
8.12a	Clinician collected progress data	○	○	○	○	○
8.12b	Child collected progress data (to the extent possible) (e.g. self-report)	○	○	○	○	○
8.12c	Parent-collected progress data	○	○	○	○	○
8.12d	Progress data collected from other stakeholders (e.g. teacher checklist)	○	○	○	○	○

8.13 The following assessment/evaluation tools and sources of information should be considered when monitoring therapy/support progress and outcomes: ASSESSMENT TOOLS

		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
8.13a	Norm-referenced assessments comparing a child's skills and functioning with neurotypical children of the same age	○	○	○	○	○
8.13b	Norm-referenced assessments comparing a child's skills and functioning with a cohort of children on the autism spectrum	○	○	○	○	○
8.13c	Criterion-referenced assessment comparing a child's skills and functioning with pre-defined criteria such as developmental milestones	○	○	○	○	○
8.13d	Curriculum-based assessments comparing a child's progress towards a pre-specified set of goals	○	○	○	○	○
8.13e	Ethnographic interviewing to gather child/family views regarding progress and outcomes	○	○	○	○	○
8.13f	Naturalistic sampling (e.g., recording and analysis of communication interactions, change in self-injurious behaviour)	○	○	○	○	○

8.14 Therapy/support GOALS should be reviewed:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
8.14a At each occasion of service	○	○	○	○	○
8.14b Every month	○	○	○	○	○
8.14c Every 2 months	○	○	○	○	○
8.14d Every 3 months	○	○	○	○	○
8.14e Every 6 months	○	○	○	○	○
8.14f Every 12 months	○	○	○	○	○

8.14g Are there other time intervals that are appropriate for reviewing therapy/support goals?	○ Yes ○ No
Please describe other time intervals that are more appropriate for reviewing therapy/support goals.	__________________________________

8.15 Therapy/support goals should be reviewed if/when:

		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
8.15a	The child achieves a goal	○	○	○	○	○
8.15b	The child and/or their family request new goals	○	○	○	○	○
8.15c	The practitioner identifies new goals relevant to the child and/or their family	○	○	○	○	○
8.15d	There are significant changes in the life of the child and/or family (e.g., transition to school, parental supervision, moving house)	○	○	○	○	○
8.15e	At a frequency, and in a manner, specified by the child and family	○	○	○	○	○
8.15f	At a frequency, and in a manner, that is sufficient for the practitioner delivering the therapy/support to make evidence-based decisions and recommendations	○	○	○	○	○
8.15g	There is a change in the funding for services for the child and family	○	○	○	○	○

8.15h Are there other occasions/events that should lead to a review of therapy/support goals?

○ Yes
○ No

Please describe other occasions/events that should lead to a review of therapy/support goals.

____

8.16 At a minimum, the monitoring of therapy/support PROGRESS AND OUTCOMES should occur:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
8.16a At each occasion of service	○	○	○	○	○
8.16b Every month	○	○	○	○	○
8.16c Every 2 months	○	○	○	○	○
8.16d Every 3 months	○	○	○	○	○
8.16e Every 6 months	○	○	○	○	○
8.16f Every 12 months	○	○	○	○	○

8.16g Are there other time intervals that are appropriate for monitoring therapy/support progress and outcomes?	○ Yes ○ No
Please describe other time intervals that are appropriate for monitoring therapy/support progress and outcomes	______________________________

8.17 The information gained through monitoring should:

***It is assumed that people providing services will adhere to relevant rules and legislation (e.g., privacy, freedom of information)**

		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
8.17a	Be shared and discussed with the child receiving the therapies/supports, if appropriate	○	○	○	○	○
8.17b	Be shared and discussed with the parents of the child receiving the therapies/supports*	○	○	○	○	○
8.17c	Be shared and discussed with other community members (nominated by the family) as the basis for supporting the child and/or family*	○	○	○	○	○
8.17d	Be shared with other practitioners/specialists that support the child, as the basis for informing them of progress and/or inviting consultation*	○	○	○	○	○
8.17e	Be shared with other organisations that support the child, as the basis for informing them of progress and/or inviting consultation (e.g., schools/day care)*	○	○	○	○	○
8.17f	Not be disclosed	○	○	○	○	○

***Responses will only appear to this item if you agreed, in the previous item, that information should be shared**

8.18 The focus of this item is on the mode by which monitoring information may be shared. The manner in which this would then occur would account for individual and cultural preferences regarding the nature of the interaction.

The outcome of monitoring should:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
8.18a Be shared during a telephone conversation	○	○	○	○	○
8.18b Be shared during a face-to-face conversation	○	○	○	○	○
8.18c Be shared during a videoconference conversation	○	○	○	○	○
8.18d Be shared in a written report	○	○	○	○	○
8.18e Be shared via a graphical mode (i.e., drawing, art)	○	○	○	○	○
8.18f Be shared and discussed in the manner preferred by the child and/or family	○	○	○	○	○
8.18g Be shared by a combination of different modes preferred by the child and/or family	○	○	○	○	○

8.18h Are there other modes in which monitoring information should be shared?

○ Yes
○ No

Please describe other modes by which monitoring information should be shared. ________________________________

[OPTIONAL] 8.19 Please provide any further information you would like to help explain your responses, or that you believe is relevant to consider in the monitoring of therapies/supports. ________________________________

Section 9 of 9.

Quality and Safeguards

In this section, we are seeking your views about how the safety, comfort, and wellbeing of individuals on the autism spectrum can be best supported. This includes approaches for acknowledging and maintaining people's rights and reducing the risk of adverse effects that can occur any time therapies and supports are delivered.

	Not at all important	Slightly important	Moderately important	Very important	Extremely important
9.1 How important do you think it is that the safety of children on the autism spectrum and their families is ensured when accessing therapies and supports?	○	○	○	○	○

9.2 Please indicate the extent to which you agree each of the following are approaches that should be incorporated in clinical practice to ensure the safety, comfort, and wellbeing of individuals on the autism spectrum and their families:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
9.2a Ensuring practitioners have up-to-date knowledge of the empirical evidence for therapies/supports (including research on the views and preferences of autistic people)	○	○	○	○	○
9.2b Ensuring practitioners have adequate experience and skills in the selection, delivery and assessment of therapies/supports	○	○	○	○	○
9.2c Ensuring that practitioners have access to clinical supervision	○	○	○	○	○
9.2d Ensuring the effectiveness and safety of therapies/supports being delivered by practitioners have been validated through well-designed research studies	○	○	○	○	○
9.2e Ongoing monitoring of therapy/support outcomes	○	○	○	○	○
9.2f Ongoing assessment of support needs	○	○	○	○	○
9.2g Practitioners working in ways that are consistent with relevant conventions, including the United Nations Convention on the Rights of Persons with Disabilities and the United Nations Convention on the Rights of the Child	○	○	○	○	○
9.2h Practitioners following relevant practice/ professional processes and legislative requirements (e.g., Disability Discrimination Act, NDIS rules)	○	○	○	○	○
9.2i Ensuring that children and their families have a clear method and pathway for raising concerns	○	○	○	○	○
9.2j					

Ensuring the provision of clear, appropriate, and accurate information between practitioners and families at all stages (including to ensure informed consent is validly obtained)	○	○	○	○	○

9.2k Are there other approaches that should be incorporated into clinical practice to ensure the safety, comfort, and wellbeing of individuals on the autism spectrum and their families?

○ Yes
○ No

Please describe other approaches that should be incorporated into clinical practice to ensure the safety, comfort, and wellbeing of individuals on the autism spectrum and their families.

____

[OPTIONAL] 9.3 Please provide any further information you would like to help explain your responses, or that you believe is relevant to consider for how the safety and quality of therapy/support provision can be ensured.

____

Appendix 9.2	Delphi Survey – Round 2

Supporting Children Guideline Delphi Round 2

Thank you for your participation in the Round 1 Delphi Survey. The outcomes of this Delphi process will directly inform the recommendations in the National Practice Guideline for supporting children on the autism spectrum and their families in Australia.

The results of the Round 1 survey showed strong consensus amongst practitioners for most items. This Round 2 survey presents the results from Round 1 for all items. For those items that did achieve consensus, we have presented the results for your information. For those items that did not achieve consensus, we are presenting the item again for you to rate your agreement/disagreement. Some of the items are being presented exactly as they appeared in Round 1. Others have been modified slightly according to the qualitative feedback provided from practitioners in Round 1.

In addition, there are three new items that did not appear in Round 1 for you to rate your agreement. These new items were informed by feedback from our community consultation process, including focus groups, an online survey, and qualitative feedback provided on the Delphi Round 1 survey.

For this Round 2 survey, we are once again interested in your views, as a practitioner, about the planning and delivery of therapies and supports aimed at enhancing the learning, participation, and quality of life of children on the autism spectrum (aged 0-12 years) and their families in community settings.

The Round 2 survey contains ten sections. However, since consensus was achieved on most items in the Round 1 survey, there are only six sections with items to rate your agreement on what you consider to be best practice when supporting children on the autism spectrum and their families.

Please note: the survey will close at 11:59pm on May 5th (AEST).

As a reminder, for the purpose of this survey:

‘Parent(s)’ refers to any individuals with parenting or caregiving responsibilities for a child (e.g., guardians, kinship, foster carers).‘Family’ refers to the child’s parents/caregivers, siblings and any extended family (e.g., grandparents, aunts, uncles, cousins) involved in the child’s care.‘Therapies’ refers to services that focus on supporting children to acquire or enhance functional skills aimed at ensuring their learning, participation, and quality of life in the community.‘Support’ refers to services that focus on adjustments, modifications, and enhancements to the environment aimed at ensuring their learning, participation, and quality of life in the community.

Please provide your first name: ________________________________

Please provide your last name: ________________________________

Please provide the most appropriate email address to follow-up with feedback from Round 2: ________________________________

Survey Part 1

Overview of practitioners participating in Round 1

Seventy-two practitioners representing six professions, from five professional organisations, participated in the Round 1 Delphi survey for the National Practice Guideline.

Practitioners had, on average, 15 years’ experience in working in clinical practice with children on the autism spectrum (Mean = 15 years, SD = 9.60; Range: 1.5 – 41 years).

All states and territories were represented in the Round 1 survey. The distribution of practitioners working in major cities versus regional/remote areas was broadly consistent with the distribution of the Australian population (ABS 2019) whereby 70% of practitioners worked with families in major cities, and 30% worked with families in regional/remote areas.

The pdf below contains a breakdown of:

The number of practitioners from each professional organisation Professions represented The broad geographical distribution of practitioners that participated in Round 1

[Attachment: "Round 1_practitioners.pdf"]

Survey Part 2

There are ten sections to this survey, however, there are only six sections that contain items for you to rate. The first nine sections are the same as those in Round 1. In this version, there is also one new section (Section 10). For some sections, consensus was achieved across all items in Round 1. For those sections, we have presented the results for your information, even if there are no items to rate in Round 2.

Below is a table of all ten sections in the survey, including if the section contains items for you to rate.

Section	Section Name	Outcome
1	Principles	Consensus achieved
2	Who should be involved in the provision of therapies and supports?	Items to rate
3	Sources of information	Items to rate
4	Understanding the child, family, and their context	Consensus achieved
5	Goal setting	Consensus achieved
6	Selecting therapies and supports	Items to rate
7	Delivering therapies and supports	Items to rate
8	Monitoring outcomes	

Items to rate

9

Quality and safeguards

Consensus achieved

10

Knowledge, skills, and/or experience of practitioners providing therapies and supports

Items to rate

Items in Round 1 were rated on a scale from 1 (Strongly Disagree) to 5 (Strongly Agree).

To determine if consensus had been achieved for items, two criteria were applied:

For agreement with statements, we used a median rating of ≥4 (i.e., agree or strongly agree) and an interquartile range (IQR) of ≤1 for agreement with the item; for disagreement with statements, we used median ≤2 (i.e., disagree or strongly disagree) and an interquartile range (IQR) of ≤1 for disagreement with the item For agreement with statements, ≥70% of practitioners rated the item as ≥4 (i.e., agree or strongly agree) for agreement with the item; for disagreement with statements, ≥70% of practitioners rated the item as median ≤2 (i.e., disagree or strongly disagree) for disagreement with the item Consensus agreement or consensus disagreement was achieved if both of the above criteria were met. If only one of the criteria was met, it was considered to be partial consensus agreement/disagreement and the item was retained for the Round 2 survey. If neither criteria were met, the item was considered to not have consensus agreement or consensus disagreement and it was retained for the Round 2 survey. For those items without consensus agreement/disagreement, the item was reviewed and, where relevant, revised based on the qualitative feedback you provided in Round 1.

Please note: the survey takes approximately 20-40 minutes to complete. At any stage, you can select the ‘Save and Return Later’ icon if you would prefer to complete the survey over multiple sittings. The data you enter will be automatically saved on the Griffith University research server (via REDCap), so do not be concerned about it being lost, and if you have any difficulties re-commencing the survey, you can contact the research team for help (k.varcin@griffith.edu.au).

The survey will close at 11:59pm on May 5th (AEST).

The first section of this survey refers to 'Principles' that are relevant to all aspects of therapy/support provision. There was consensus agreement for all items in this section in Round 1. As such, what would you like to do?	○ See the feedback from Round 1 ○ Skip to the next section

Section 1 of 10.

Principles

Round 1: Items with consensus achieved

There was consensus agreement amongst practitioners in Round 1 that all of the below principles are important to all aspects of providing therapies and supports to children on the autism spectrum. Consensus agreement was reached on all items. Data are provided below for your interest.

*Agreement = the proportion of practitioners who rated their agreement for the statement as 4 (agree) or 5 (strongly agree).

1.1 Please indicate the extent to which you agree each of the following are principles that are important to all aspects of providing therapies and supports to children on the autism spectrum:

Outcome

Median (IQR)

a.

Holistic: The provision of therapies and supports should involve consideration of an individual's life history, culture, strengths and challenges, goals and preferences, and environmental factors that act as facilitators or barriers to learning, participation, and quality of life.

100% agreement

5 (0)

b.

Child and family-centred: The child and their family members should be considered equal partners with practitioners in the therapy process.

99%

agreement

5 (0)

c.

Supported: The child and their family should be supported to include people they feel are relevant in the therapy process, including for advocacy and support.

100% agreement

5 (0)

d.

Lifespan perspective: Clinical decision-making regarding the provision of therapies and supports should account for the current stage of life of the individual, as well as appropriate planning for both the short and longer term.

99%

agreement

5 (0)

e.

Developmental perspective: Clinical decision-making regarding the provision of therapies and supports should account for, and be responsive to, the individual, family and social changes that occur through childhood.

100% agreement

5 (0)

f.

Empirically supported: Therapies and supports should be underpinned by the best available published, peer-reviewed scientific evidence demonstrating their effectiveness and safety.

90%

agreement

5 (1)

g.

Evidence-based practice approach: Clinical decision-making regarding the provision of therapies and supports should draw on, and integrate, research and clinical evidence alongside the preferences and values of the child and their family.

98%

agreement

5 (0)

h.

Ethical practice: The provision of therapies and supports should be underpinned by an ethical framework that follows the principles of beneficence (i.e., to act for the benefit of others), non-maleficence (i.e., do no harm), autonomy and fairness.

100% agreement

5 (0)

i.

Culturally aware and responsive: The values, knowledge, preferences and cultural perspectives of the child and family should be sought, respected, and evident in the provision of therapies and supports.

100% agreement

5 (0)

j.

Equity: All children and families, regardless of age, gender, cultural background, socioeconomic status or geographical location should be able to access timely, safe, desirable and effective therapies and supports.

100% agreement

5 (0)

k.

Strengths-focused: Therapies and supports should focus on understanding, embracing and developing the strengths of an individual and their family.

97%

agreement

5 (0)

l.

Coordinated: A coordinated approach to the provision of therapies and supports for the child and family across practitioners, organisations, and agencies should be taken.

97%

agreement

5 (0)

m.

Personalised: Therapies and supports should be tailored to the unique strengths, needs, and preferences of each child and family.

96%

agreement

5 (0)

n.

Accessible: The process of planning, delivering, and monitoring therapies and support, including interactions and documentation, should be accessible.

100% agreement

5 (0)

o.

Informed consent (parents): Informed parental consent should be obtained for the provision of therapies and supports.

96%

agreement

5 (0)

p.

Assent (children): Children’s assent (expression of approval) should be obtained, wherever possible, for the provision of therapies and supports.

89%

agreement

5 (1)

q.

Qualified practitioners: People involved in the provision of therapies and supports should have relevant qualifications and professional regulation, and only engage in goal setting and the delivery of therapies and supports that are within their scope of practice.

99%

agreement

5 (0)

Section 2 of 10.

Who should be involved in the provision of therapies and supports?

Round 1: Items with conensus achieved

Items 2.1, 2.2: There was consensus agreement amongst practitioners in Round 1 that (i) the child, family, and family-like people (i.e., family, friends, peers), and (ii) people who provide formal support to the child's health and development (e.g., educators, medical and allied health practitioners) should be involved in all aspects of therapy/support provision for children on the autism spectrum.

*Agreement = the proportion of practitioners who rated their agreement for the statement as 4 (agree) or 5 (strongly agree).

2. Below, we have indicated a range of people who might be involved in therapy/support provision. Please tell us the extent to which you agree with these statements.

Outcome

Mdn (IQR)

2.1 The child, family, and family-like people (i.e., family, friends, peers)

a. Working to understand the child, family, and their context

100% agreement

5 (0)

b. Setting goals

100% agreement

5 (0)

c. Selecting therapies and supports

91% agreement

5 (1)

d. Delivering therapies and supports

86% agreement

5 (1)

e. Monitoring outcomes

92% agreement

4.5 (1)

2.2. People who provide formal support to the child's health and development (e.g., educators, medical and allied health practitioners)

a. Working to understand the child, family, and context

100% agreement

5 (0)

b. Setting goals

99% agreement

5 (1)

c. Selecting therapies and supports

90% agreement

5 (1)

d. Delivering therapies and supports

100% agreement

5 (1)

e. Monitoring outcomes

97% agreement

5 (0)

Who should be involved in the provision of therapies and supports? (continued)

Please read the below statement and view the attached file, as it is relevant for the next item we will ask you to rate.

Item 2.3 - With regard to people who can contribute to supporting the child’s participation in community activities (e.g., sports coaches, art teachers, community members the child interacts with regularly including retail environments, community groups, and cultural activities), there was no consensus agreement or consensus disagreement for their involvement in all aspects of therapy/support provision.

The results from Round 1 for these items are presented in the attached file.

[Attachment: "Round 1 results_Item 2.3.pdf"]

Based on the quantitative ratings and qualitative feedback provided in Round 1, we have revised item 2.3. A key change relates to the use of 'may' where 'should' was used previously. Please tell us the extent to which you now agree with this statement:

2.3. Where relevant and desired by the child and family, people who can contribute to supporting the child's participation in community activities (e.g., sports coaches, art teachers, community members the child interacts with regularly including retail environments, community groups, and cultural activities) may be involved in one or more aspects of:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
(i) Working to understand the child, family, and their context, (ii) setting goals, (iii) selecting therapies and supports, (iv) delivering therapies and supports, (v) monitoring outcomes	○	○	○	○	○

Who should be involved in the provision of therapies and supports? (continued)

Please read the below statement and view the attached file, as it is relevant for the next item we will ask you to rate.

Item 2.4 - With regard to agencies that support the provision and/or access to services (e.g., NDIS planners, safety officers), there was no consensus agreement or consensus disagreement for their involvement in all aspects of therapy/support provision. The results from Round 1 for these items are presented in the attached pdf.

[Attachment: "Round 1 results_Item 2.4.pdf"]

Based on the quantitative ratings and qualitative feedback provided in Round 1, we have revised this item. A key change relates to the use of 'may' where 'should' was used previously. Please tell us the extent to which you agree with this statement:

2.4. Where relevant and desired by the child and family, staff in agencies that support the provision and/or access to services (e.g., NDIS planners, child safety officers) may be involved in one or more aspects of:

		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
2.4	(i) Working to understand the child, family, and their context, (ii) setting goals, (iii) selecting therapies and supports, (iv) delivering therapies and supports, (v) monitoring outcomes	○	○	○	○	○

Section 3 of 10.

Sources of information

Round 1: Items with conensus achieved

Item 3.1 There was consensus agreement amongst practitioners in Round 1 that the factors listed below are important for practitioners to consider when making recommendations for goals and the selection and delivery of therapies and supports when working with children on the autism spectrum and their families.

*Agreement = the proportion of practitioners who rated their agreement for the statement as 4 (agree) or 5 (strongly agree).

3.1 Please indicate the extent to which you believe the following factors are important:

Outcome

Mdn (IQR)

a.

A theoretical rationale for why the goal/therapy/support is likely to lead to an increase in the child's learning and participation.

86% agreement

4 (1)

b.

Research evidence (from published, peer-reviewed research) that the goal/therapy/support is likely to lead to an increase in the child's learning and participation.

85% agreement

4 (1)

c.

Clinical evidence gathered through practice that the goal/therapy/support is likely to lead to an increase in the child's learning and participation, including evidence drawn from the experiences/outcomes of other children and families the practitioner has supported.

94% agreement

5 (1)

d.

Perspectives expressed by autistic people regarding the goal/therapy/support.

90% agreement

5 (1)

e.

Information about the child, family, and their context that is relevant to this goal/therapy/support.

100% agreement

5 (0)

f.

Consideration of whether the child/family have the time required for the goal/therapy/support

98% agreement

5 (1)

g.

Consideration of whether the child/family have the social support required for the goal/therapy/support (e.g., family members willing to assist).

99% agreement

5 (1)

h.

Consideration of whether the child/family have the financial resources required for the goal/therapy/support.

90% agreement

5 (1)

i.

Consideration of whether the child/family have the emotional support required for the goal/therapy/support,

100% agreement

5 (0)

j.

Consideration of whether the goal/therapy/support is consistent with the child/family’s cultural background.

97% agreement

5 (1)

m.

Consideration of whether the goal/therapy/support is consistent with the parent/s views on disability (and the need to focus on the child versus the environment).

76% agreement

4 (1)

n.

Consideration of whether the child supports the goal/therapy/support (to the extent possible).

89% agreement

5 (1)

o.

Consideration of whether the parent/s support the goal/therapy/support.

98% agreement

5 (1)

p.

Consideration of the potential benefits associated with the goal/therapy/support.

100% agreement

5 (1)

q.

Consideration of the potential risks associated with the goal/therapy/support.

98% agreement

5 (1)

r.

Consideration of the alternative options to this goal/therapy/support.

97% agreement

4 (1)

s.

Consideration of how this goal/ /therapy/support may enhance progress towards other goals.

96% agreement

5 (1)

t.

Consideration of how this goal/therapy/support may impede progress towards other goals.

90% agreement

5 (1)

u.

Consideration of the relevance of this goal/therapy/support currently for the child and family.

98% agreement

5 (1)

v.

Consideration of the relevance of this goal/therapy/support in the future for the child and family.

95% agreement

5 (1)

Sources of information (continued)

Please read the below statements and view the attached file, as it is relevant for the next item we will ask you to rate.

Consensus was not achieved on two items.

Item 3k - ‘Consideration of whether the goal/therapy/support is consistent with the parent/s views on child-rearing’ - showed partial consensus agreement amongst practitioners.

Item 3l - ‘Consideration of whether the goal/therapy/support is consistent with the parent/s views on child development’ - did not meet consensus agreement or consensus disagreement thresholds amongst practitioners.

The distributions of ratings for these items is presented in the attached image.

[Attachment: "Round 1 results_3k_l.png"]

Having reviewed these results from Round 1, we would like to ask you to rate these items again. We are interested to know what factors are important for practitioners to CONSIDER when making recommendations for goals and the selection and delivery of therapies and supports when working with children on the autism spectrum and their families.

3.1 Please indicate the extent to which you believe the following factors are important:

		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
3.1k	Consideration of whether the goal/therapy/support is consistent with the parent/s views on child-rearing.	○	○	○	○	○
3.1l	Consideration of whether the goal/therapy/support is consistent with the parent/s views on child development.	○	○	○	○	○

The next section of this survey refers to 'Understanding the child, family, and their context'. There was consensus agreement for all items in this section in Round 1. As such, what would you like to do?	○ See the feedback from Round 1 ○ Skip to the next section

Section 4 of 10.

Understanding the child, family, and their context

Round 1: Items with consensus achieved

Item 4.1 There was consensus agreement amongst practitioners in Round 1 that it is important to understand the child, their family, and their context when making decisions about therapies and supports.

*Agreement = the proportion of practitioners who rated the statement as 4 (important) or 5 (very important).

Outcome

Mdn (IQR)

How important do you think it is to understand the child, their family, and their context when making decisions about therapies and supports for children on the autism spectrum?

98% agreement

5 (0)

Item 4.2 There was consensus agreement amongst practitioners in Round 1 that the planning of therapies and supports should be informed by assessment of the following aspects of children's health, development, and wellbeing:

*Agreement = the proportion of practitioners who rated their agreement for the statement as 4 (agree) or 5 (strongly agree).

4.2 Please indicate the extent to which you agree that the planning of therapies and supports should be informed by assessment of the following aspects of children's health, development, and wellbeing:

Outcome

Mdn (IQR)

a

The child's health (i.e., physical health, mental health, and health history).

100% agreement

5 (1)

b

The child's developmental skills (i.e., gross and fine motor, social, emotional, cognitive, communication, and academic skills).

97% agreement

5 (0)

c

The child's diagnostic characteristics (i.e., social communication skills, repetitive behaviours, focused/intense interests, and sensory behaviours).

92% agreement

5 (1)

d

The child’s activities and participation in home, educational, and community settings (this includes enablers and barriers to participation).

100% agreement

5 (1)

e

The child’s behaviour(s) of concern (including, (i) behaviours arising from the interaction of the person and their environment that risk the physical safety of the individual and/or others and (ii) behaviours that limit or deny participation in life activities).

98% agreement

5 (1)

f

The child’s perception of their quality of life (to the extent this is possible to obtain)

90% agreement

5 (1)

g

The child’s activity-related strengths and preferences (i.e., activities that bring the child joy and/or that they have expertise in).

97% agreement

5 (1)

h

The child’s preferences for therapies/supports (to the extent this is possible to obtain)

95% agreement

4 (1)

i

The child’s expectations for the outcomes of therapy/support (to the extent this is possible to obtain)

86% agreement

4 (1)

Item 4.3 There was consensus agreement amongst practitioners in Round 1 that the planning of therapies and supports should be informed by assessment of the following aspects of the family:

*Agreement = the proportion of practitioners who rated their agreement for the statement as 4 (agree) or 5 (strongly agree).

4.3 Please indicate the extent to which you agree that the planning of therapies and supports should be informed by assessment of the following aspects of the family:

		Outcome	Mdn (IQR)
a	The family’s physical and mental health (i.e., the presence of any conditions that may impact upon their capacity to participate, or need to be considered, in the provision of therapies/supports for their child).	98% agreement	5 (1)
b	The family’s social-emotional resources and supports (i.e., resilience factors and the capacity to deal with stressful situations in life, along with social support via family, friends, and support groups).	99% agreement	5 (1)
c	The family’s financial resources and supports (i.e., funding to pay for therapies and supports, capacity to purchase unfunded therapies and supports, and capacity to take time away from paid work to access therapies and supports).	89% agreement	5 (1)
d	The family’s activities (i.e., work, social, cultural, sport and recreational, and educational activities).	90% agreement	4 (1)
e	The family’s views, perspectives and preferences (i.e., views about their child’s learning, participation and quality of life now and in the future, views on disability, the relevance of therapies/supports for their child, cultural perspectives on therapies/supports, preferences for therapies/supports, and expectations for outcomes).	92% agreement	5 (1)
f	The family’s dynamics (i.e., the nature and strength of relationships between family members, the nature and distribution of roles and responsibilities, the positive and challenging impacts associated with the child’s disability).	96% agreement	4.5 (1)

Item 4.4 There was consensus agreement amongst practitioners in Round 1 that the planning of therapies and supports should be informed by assessment of the following aspects of a family’s previous engagement with other services:

*Agreement = the proportion of practitioners who rated their agreement for the statement as 4 (agree) or 5 (strongly agree).

4.4 Please indicate the extent to which you agree that the planning of therapies and supports should be informed by assessment of the following aspects of a family’s previous engagement with other services:

Outcome

Mdn (IQR)

a

The nature of any services previously accessed, including goals and types of services (e.g., allied health, mainstream supports).

73% agreement

4 (1)

b

The child and family’s experience of previously accessed services, including their satisfaction with the service(s).

86% agreement

4 (1)

c

The child and family’s outcomes of accessing previous services, including the progress made towards goals.

83% agreement

4 (1)

Item 4.5 There was consensus agreement amongst practitioners in Round 1 that the planning of therapies and supports should be informed by assessment of the following aspects of a family’s current engagement with other clinical services and mainstream supports:

*Agreement = the proportion of practitioners who rated their agreement for the statement as 4 (agree) or 5 (strongly agree).

4.5 Please indicate the extent to which you agree that the planning of therapies and supports should be informed by assessment of the following aspects of a family’s current engagement with other clinical services and mainstream supports:

Outcome

Mdn (IQR)

a

The nature of any services and funding/support (e.g., NDIS plan, education department) currently accessed, including goals and types of services (e.g., allied health, mainstream supports).

93% agreement

4 (1)

b

The child and family’s experience of currently accessed services, including their satisfaction with the service(s).

96% agreement

4 (1)

c

The child and family’s outcomes of accessing current services, including the progress made towards goals.

94% agreement

4 (1)

d

Any arrangements that are in place to support the coordination of services and supports accessed by the child and family (e.g., nominated case coordinator, NDIS support coordination).

86% agreement

4 (1)

e

Family preferences for future arrangements to support the coordination of services and supports accessed by the child and family.

87% agreement

4 (1)

The next section of this survey refers to 'Goal-setting'. There was consensus agreement for all items in this section in Round 1.

As such, what would you like to do?

○ See the feedback from Round 1
○ Skip to the next section

Section 5 of 10.

Goal-setting

Round 1: Items with consensus achieved

Iten 5.1 There was consensus agreement amongst practitioners in Round 1 that it is important to select appropriate goals for therapy when working with children on the autism spectrum and their families.

*Agreement = the proportion of practitioners who rated the statement as 4 (important) or 5 (very important).

Outcome

Mdn (IQR)

How important do you think it is to select appropriate goals for therapy when working with children on the autism spectrum and their families?

96% agreement

5 (0)

Items 5.2-5.4 There was consensus agreement amongst practitioners in Round 1 that, when relevant, goals for children on the autism spectrum and their families should consider focusing on the following:

*Agreement = the proportion of practitioners who rated their agreement for the statement as 4 (agree) or 5 (strongly agree).

Items 5.2-5.4. When relevant, goals for children on the autism spectrum and their families should consider focusing on:

Outcome

Mdn (IQR)

5.2 Child’s mental and physical functions

a

Mental functions (e.g., executive functioning)

95% agreement

5 (1)

b

Physical functions (e.g., articulation of speech sounds, fine motor skills)

92% agreement

4 (1)

5.3 Child’s activities and participation

a

The acquisition of skills (e.g., social, communication, play, motor)

94% agreement

5 (1)

b

The generalised use of skills in daily activities with others (e.g., social skills used to help form relationships, communication skills used to have a conversation, play skills used to engage in play with peers).

96% agreement

5 (1)

c

The reduction of behaviours of concern (e.g., self-injurious behaviours)

89% agreement

5 (1)

d

Learning and applying knowledge (e.g., learning to count, learning to read)

78% agreement

4 (1)

e

Carrying out daily routines (relative to age expectations)

96% agreement

5 (1)

f

Supporting interpersonal interactions and relationships

94% agreement

5 (1)

g

Participation in community, social, and civic life (e.g., recreation, leisure, religion, spirituality)

95% agreement

5 (1)

5.4 Child’s environment

a

Accessibility in the physical environment (e.g., sensory-safe spaces)

96% agreement

4.5 (1)

b

Accessibility in the social environment (e.g., changing attitudes and increasing knowledge and skills of others’)

98% agreement

5 (1)

c

Enhancement of services, systems, and policies (e.g., to improve coordination of services, changing policies that create barriers to participation).

91% agreement

5 (1)

Item 5.6 There was consensus agreement amongst practitioners in Round 1 that, when working with children and families to set goals, practitioners should do the following:

*Agreement = the proportion of practitioners who rated their agreement for the statement as 4 (agree) or 5 (strongly agree).

5.6 In working with children and families to set goals, practitioners should:

Outcome

Mdn (IQR)

a

Ensure goals are specific

93% agreement

5 (1)

b

Ensure goals are measurable

95% agreement

5 (1)

c

Ensure goals are achievable

96% agreement

5 (1)

d

Ensure goals are relevant to the child, family and their context

100% agreement

5 (0)

e

Ensure goals are understood by the family and relevant stakeholders

100% agreement

5 (0)

f

Ensure goals are documented

97% agreement

5 (1)

g

Ensure goals have a clear timeframe

81% agreement

4 (1)

Item 5.7 There was consensus agreement amongst practitioners in Round 1 that, therapy/support goals should be selected in relation to how they support the child’s functioning, activities, and participation over the following timeframes:

*Agreement = the proportion of practitioners who rated their agreement for the statement as 4 (agree) or 5 (strongly agree).

5.7 Therapy/support goals should be selected in relation to how they support the child’s functioning, activities, and participation over the:

		Outcome	Mdn (IQR)
a	Short-term i.e., for goal attainment over 12 months – 2 years.	90% agreement	5 (1)
b	Medium term i.e., for goal attainment over 2 – 3 years.	77% agreement	4 (0)
c	Long-term i.e., for goal attainment over 3+ years	71% agreement	4 (1)

Section 6 of 10.

Selecting therapies and supports

Round 1: Items with consensus achieved

Item 6.1 There was consensus agreement amongst practitioners in Round 1 that it is important to select appropriate therapies and supports when working with children on the autism spectrum and their families.

*Agreement = the proportion of practitioners who rated the statement as 4 (important) or 5 (very important).

	Outcome	Mdn (IQR)
How important do you think it is to select appropriate therapies and supports when working with children on the autism spectrum and their families?	95% agreement	5 (1)

Item 6.2 There was consensus agreement amongst practitioners in Round 1 that the selection of therapies and supports should be informed by the goals for therapy.

*Agreement = the proportion of practitioners who rated their agreement for the statement as 4 (agree) or 5 (strongly agree).

	Outcome	Mdn (IQR)
The selection of therapies and supports should be informed by the goals for therapy.	93% agreement	5 (1)

Selecting therapies and supports (continued)

New item in Round 2

This section contains one new item that was developed based on qualitative feedback from the Round 1 Delphi and our additional community consultations activities, including focus groups and an online survey.

We are interested in your views on how therapies and supports should be selected. In this question, we ask about practices and techniques. We have defined what we mean by ‘practice’ and ‘technique’ in the below table. To do that, we also refer to ‘categories’. Please familiarise yourself with these definitions.

Term	Category	Example
Category	One or more practices that share similar theoretical underpinnings.	‘Behavioural interventions’
Practice	A combination of techniques evaluated and implemented together to target the acquisition of one or more skills	Early Intensive Behavioural Intervention; the Picture Exchange Communication System
Technique	A discrete clinical strategy, targeting the acquisition of a discrete skill	Prompting; modelling; shaping

6.3 - NEW ITEM: Please rate your agreement with the following statements.

Where relevant, and assuming that the therapy program is tailored to the individual child and their family, practitioners may:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
6.3a Select and deliver a single intervention practice	○	○	○	○	○
6.3b Select and deliver a range of practices or techniques (i.e., a so called 'eclectic approach').	○	○	○	○	○

Section 7 of 10.

Delivering therapies and supports

Round 1: Items with consensus achieved

Item 7.1 There was consensus agreement amongst practitioners in Round 1 that it is important to deliver therapies and supports in ways that are appropriate for children on the autism spectrum and their families.

*Agreement = the proportion of practitioners who rated the statement as 4 (important) or 5 (very important).

Outcome

Mdn (IQR)

How important do you think it is to deliver therapies and supports in ways that are appropriate for children on the autism spectrum and their families?

97% agreement

5 (0)

In what settings should therapies/supports be delivered?

Item 7.2 There was consensus agreement amongst practitioners in Round 1 that an array of settings may be appropriate for the delivery of therapies/supports.

*Agreement = the proportion of practitioners who rated their agreement for the statement as 4 (agree) or 5 (strongly agree).

7.2 Where relevant, the following settings may be appropriate for the delivery of therapies/supports:

Outcome

Mdn (IQR)

a

Clinic

77% agreement

4 (0)

b

The child’s home

96% agreement

5 (1)

c

Educational settings (including school and early child education settings/day care)

97% agreement

5 (1)

e

Social settings (e.g., other people’s homes, community spaces)

81% agreement

4 (0)

f

Recreational settings (e.g., sports ovals, music/art/drama studios)

79% agreement

4 (1)

In what settings should therapies/supports be delivered? (continued)

Please read the below statement and view the attached file, as it is relevant for the next item we will ask you to rate.

Consensus was not achieved on one item in this sub-section.

Item 7.2d - ‘Cultural settings (e.g., places of worship)’ - did not meet consensus agreement or consensus disagreement thresholds amongst practitioners in Round 1. The distribution of ratings is presented in the attachment below.

[Attachment: "Round 1 results_7.2d.png"]

We would like to ask you to rate this item again. However, please note that the preceding phrase 'where relevant' implies that a setting may be appropriate depending on the individual child, their family, and their context. It does not require this setting to be part of the provision of all therapies/supports for all children and their families.

7.2 Where relevant, the following setting may be appropriate for the delivery of therapies/supports:

		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
7.2d	Cultural settings (e.g., places of worship)	○	○	○	○	○

In what amount(s) should therapies/supports be delivered?

Item 7.3 There was consensus agreement amongst practitioners in Round 1 that, when relevant, children should have access to the following services:

*Agreement = the proportion of practitioners who rated their agreement for the statement as 4 (agree) or 5 (strongly agree).

7.3 When relevant, children should have access to:

Outcome

Mdn (IQR)

a

Child-directed services (i.e., a practitioner working primarily with the child as 1:1 or in a small group)

92% agreement

5 (1)

b

Parent-directed services (i.e., a practitioner working primarily to upskill the parent(s) to support the child’s learning and participation)

98% agreement

5 (1)

c

Community-directed services (i.e., a practitioner working primarily to upskill other members of the community [e.g., educators] to support the child’s learning and participation)

94% agreement

5 (1)

For item 7.4, there was consensus agreement amongst practitioners (based on both quantitative ratings and qualitative feedback) that the proportion of child-directed, parent-directed, and community-directed services should be personalised.

7.4 Please rate your agreement with the following statements:

Outcome

Mdn (IQR)

d

The proportion of child-directed, parent-directed, and community-directed services should be personalised

95% agreement

5 (0)

As such, we have not presented items 7.4a-c for rating again in Round 2.

The distributions of ratings for items 7.4a-d are presented in the attached file.

[Attachment: "Round 1 results_7.4a-d.png"]

In what amount(s) should therapies/supports be delivered? (continued)

Round 1: Items with consensus achieved

Item 7.5 The majority of practitioners in Round 1 disagreed with the statement that all children on the autism spectrum should receive a set number of hours per week of practitioner-delivered therapy/support services.

There was consensus agreement amongst practitioners in Round 1 that (i) the amount of therapy/support hours a child received should be based on individual factors related to the child and family and (ii) the number of hours of practitioner-delivered therapy/support a child receives should be personalised.

*Agreement = the proportion of practitioners who rated their agreement for the statement as 4 (agree) or 5 (strongly agree).

*Disagreement = the proportion of practitioners who rated their agreement for the statement as 1 (strongly disagree) or 2 (disagree).

7.5 Please rate your agreement with the following statements:

Outcome

Mdn (IQR)

c

All children on the autism spectrum should receive a set number of hours per week of practitioner-delivered therapy/support services.

87% disagreement

2 (1)

d

The amount of therapy/support hours should be based on individual factors related to the child and family, including the child’s functional difficulties, the therapy goals, and broader family needs.

100% agreement

5 (0)

e

The number of hours of practitioner-delivered therapy/support a child receives should be personalised.

100% agreement

5 (0)

In what amount should therapies/supports be delivered? (continued)

Please read the below statement and view the attached file, as it is relevant for the next item we will ask you to rate.

Two items achieved partial consensus disagreement.

Item 7.5a - 'There is a minimum number of practitioner-delivered therapy/support hours that all children on the autism spectrum should receive' - showed partial consensus disagreement amongst practitioners.

Item 7.5b - 'There is a maximum number of practitioner-delivered therapy/support hours that all children on the autism spectrum should receive' - showed partial consensus disagreement amongst practitioners.

The distributions of ratings are presented in the attached file.

[Attachment: "Round 1 results_7.5a-b.png"]

Having reviewed these results from Round 1, including the qualitative feedback provided, we have revised these items and would like to ask you to rate these items again.

7.5 Please rate your agreement with the following statements:

		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
7.5a	All children on the autism spectrum should receive a minimum number of practitioner-delivered therapy/support hours, irrespective of child and family contextual factors.	○	○	○	○	○
7.5b	All children on the autism spectrum should receive a maximum number of practitioner-delivered therapy/support hours, irrespective of child and family contextual factors.	○	○	○	○	○

When should therapies and supports be delivered?

Round 1: Items with consensus achieved

Item 7.6 There was consensus agreement amongst practitioners in Round 1 that therapies/supports should be made available as soon as a support need is identified.

*Agreement = the proportion of practitioners who rated their agreement for the statement as 4 (agree) or 5 (strongly agree).

7.6 Please rate your agreement with the following statement:

Outcome

Mdn (IQR)

Therapies/supports should be made available as soon as a support need is identified.

92% agreement

5 (1)

Section 8 of 10.

Monitoring

In this section we sought your views on how progress towards goals and the broader impacts of therapies and supports should be monitored, including who should be consulted; what sources of information should be considered; and how, and how often, the findings should be shared with child, family, and key stakeholders.

Round 1: Items with consensus achieved

Item 8.1 There was consensus agreement amongst practitioners in Round 1 that it is important to monitor the delivery of therapies and supports for children on the autism spectrum and their families.

*Agreement = the proportion of practitioners who rated the statement as 4 (important) or 5 (very important).

	Outcome	Mdn (IQR)
How important do you think it is to monitor the delivery of therapies and supports for children on the autism spectrum and their families? This includes ensuring the goals, therapies, and supports continue to be appropriate.	95% agreement	5 (1)

Item 8.2-8.8 There was consensus agreement amongst practitioners in Round 1 that, when relevant, progress and the outcomes of therapy/support provision should include monitoring of the following aspects:

*Agreement = the proportion of practitioners who rated their agreement for the statement as 4 (agree) or 5 (strongly agree).

8.2-8.8 When relevant, progress and the outcomes of therapy/support provision should include monitoring of the following aspects:

		Outcome	Mdn (IQR)
8.2 Fidelity of therapy/support delivery			
a	Type: The extent to which the planned type of therapy/support was delivered.	94% agreement	4 (1)

b

People: The extent to which the people who were intended to contribute to progress towards the goal contributed.

92% agreement

4 (1)

c

Settings: The extent to which the settings in which the goal was to be targeted were included.

91% agreement

4 (1)

d

Amount: The extent to which the intended amount of therapy/support was delivered.

90% agreement

4 (1)

8.3 Children’s progress towards therapy/support goals

a

Amount of progress made towards the goal

94% agreement

4 (1)

b

The child’s satisfaction with progress towards the goal (to the extent possible)

95% agreement

5 (1)

c

Parents’ satisfaction with the child’s progress towards the goal

97% agreement

5 (1)

8.4 Impact of progress towards therapy/support goals

a

Changes in the child’s skills

96% agreement

5 (1)

b

Changes in the child’s learning and participation

97% agreement

5 (1)

c

Changes in the child’s wellbeing

100% agreement

5 (0)

d

Changes in the family’s wellbeing

99% agreement

5 (1)

e

Changes in the environment that affect learning and participation

97% agreement

5 (1)

8.5 Maintenance

a

Maintenance of change over the short term (i.e., 12 months – 2 years)

91% agreement

5 (1)

b

Maintenance of change over the medium term (i.e., 2-3 years)

72% agreement

4 (1)

8.6 Generalisation

a

Generalisation of change to interactions with other people

86% agreement

4 (1)

b

Generalisation of change to other activities

87% agreement

4 (1)

c

Generalisation of change to other settings

91% agreement

4 (1)

8.7 Costs and Benefits

a

Costs for children (e.g., time, fatigue, not pursuing alternative goal or service option)

94% agreement

4 (1)

b

Costs for parents (e.g., time, financial)

94% agreement

4 (1)

c

Benefits for children

100% agreement

5 (1)

d

Benefits for family members

96% agreement

5 (1)

8.8 Unplanned Outcomes

a

Positive unplanned outcomes that have arisen from the delivery of therapy/support

93% agreement

4 (1)

b

Adverse effects that have arisen from the delivery of the therapies/supports

100% agreement

5 (1)

Monitoring (continued)

Please read the below statement and view the attached file, as it is relevant for the next item we will ask you to rate.

One item did not achieve consensus.

This item was item 8.5c - ‘Maintenance of change over the long term (i.e., 3+ years)’.

The distribution of ratings for this item is presented in the attached file.

[Attachment: "Round 1 results_8.5c.png"]

We would like to ask you to rate this item again. However, please note that the preceding phrase 'when relevant' implies that the monitoring of maintenance over this timeframe should only be considered when it is feasible and appropriate.

8.5 When relevant, progress and the outcomes of therapy/support provision should include monitoring of:

		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
8.5c	Maintenance of change over the long-term (i.e., 3+ years)	○	○	○	○	○

Monitoring (continued)

Items 8.9-8.13 There was consensus agreement amongst practitioners in Round 1 that the following assessment/evaluation tools and sources of information should be considered when monitoring therapy/support progress and outcomes:

*Agreement = the proportion of practitioners who rated their agreement for the statement as 4 (agree) or 5 (strongly agree).

8.9-8.13 The following assessment/evaluation tools and sources of information should be considered when monitoring therapy/support progress and outcomes.

Outcome

Mdn (IQR)

8.9 Observations

a

Observations of the child’s progress towards goals during the delivery of the therapy/support

94% agreement

4 (1)

b

Observations of the child’s progress towards goals in contexts outside of those in which the therapy/support is being delivered

90% agreement

4 (1)

c

Observations of the child’s reaction (positive, negative, mixed) to engaging in the therapy/support

90% agreement

4 (1)

8.10 Direct and Parent report

a

Direct report from the child about progress towards goals (to the extent possible)

94% agreement

5 (1)

b

Parent report of the child’s progress towards the goals

96% agreement

5 (1)

c

Direct report from the child about their experience (positive, negative, mixed) of engaging with the therapy/support (to the extent possible)

96% agreement

5 (1)

d

Parent report of what they perceive to be the child’s experience (positive, negative, mixed) of engaging with the therapy/support

95% agreement

5 (1)

8.11 Reports from others

a

Reports from people who are involved in the delivery of the therapy/support

97% agreement

4 (1)

b

Reports from people who can provide insight into the child’s progress towards the goals and/or general learning, participation, and wellbeing.

98% agreement

4 (1)

8.12 Progress data

a

Clinician collected progress data

94% agreement

4 (1)

b

Child collected progress data (to the extent possible) (e.g. self-report)

93% agreement

4 (1)

c

Parent-collected progress data

94% agreement

4 (1)

d

Progress data collected from other stakeholders (e.g., teacher checklist)

91% agreement

4 (1)

8.13 Assessment tools

e

Ethnographic interviewing to gather child/family views regarding progress and outcomes

71% agreement

4 (1)

f

Naturalistic sampling (e.g., recording and analysis of communication interactions, change in self-injurious behaviour)

83% agreement

4 (1)

Monitoring (continued)

Please read the below statement and view the attached file, as it is relevant for the next item we will ask you to rate.

Four items (regarding Assessment tools) did not have clear consensus agreement from practitioners in Round 1. These items were:

Item 8.13a - ‘Norm-referenced assessments comparing child’s skills and functioning with neurotypical children of the same age’ - did not meet consensus agreement or consensus disagreement thresholds. Item 8.13b - ‘Norm-referenced assessments comparing child’s skills and functioning with a cohort of children on the autism spectrum’ - had only partial consensus agreement from practitioners in Round 1. Item 8.13c - ‘Criterion-references assessments comparing child’s skills and functioning with pre-defined criteria such as developmental milestones’ - had only partial consensus agreement from practitioners in Round 1. Item 8.13d - ‘Curriculum-based assessments comparing child’s progress towards a pre-specified set of goals’ - had only partial consensus agreement from practitioners in Round 1. The distributions of ratings for these items is presented in the attached file.

[Attachment: "Round 1 results_8.13a-d.png"]

We would like to ask you to rate these items again. Please note that these statements refer to POSSIBLE options that practitioners can select as a way of monitoring therapy/support progress and outcomes. It is not expected that these assessments would be required on every occasion or with every child.

8.13 The following assessment/evaluation tools and sources of information should be considered when monitoring therapy/support progress and outcomes: ASSESSMENT TOOLS

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
8.13a Norm-referenced assessments comparing a child's skills and functioning with neurotypical children of the same age	○	○	○	○	○
8.13b Norm-referenced assessments comparing a child's skills and functioning with a cohort of children on the autism spectrum	○	○	○	○	○
8.13c Criterion-referenced assessment comparing a child's skills and functioning with pre-defined criteria such as developmental milestones	○	○	○	○	○
8.13d Curriculum-based assessments comparing a child's progress towards a pre-specified set of goals	○	○	○	○	○

Monitoring (continued)

Round 1: Items with consensus achieved

Item 8.14 There was consensus agreement amongst practitioners in Round 1 that therapy/support goals should be reviewed every 6 months (8.14e) and every 12 months (8.14f).

*Agreement = the proportion of practitioners who rated their agreement for the statement as 4 (agree) or 5 (strongly agree).

8.14 Therapy/support goals should be reviewed:

Outcome

Mdn (IQR)

e

Every 6 months

87% agreement

4 (1)

f

Every 12 months

89% agreement

5 (1)

Monitoring (continued)

Please read the below statement and view the attached file, as it is relevant for the next item we will ask you to rate.

While there was clear consensus agreement that therapy/support goals should be reviewed every 6-12 months, there was no clear consensus over shorter timeframes.

Specifically, four items did not achieve consensus:

Item 8.14a – 'At each occasion of service' – did not achieve consensus agreement or disagreement Item 8.14b – 'Every month' - did not achieve consensus agreement or disagreement Item 8.14c – 'Every 2 months' - did not achieve consensus agreement or disagreement Item 8.14d – 'Every 3 months' – had partial consensus agreement The distributions of ratings for these items are presented in the attached file.

[Attachment: "Round 1 results_8.14.png"]

Having reviewed these results from Round 1, we would like to ask you to rate these items again.

8.14 Therapy/support goals should be reviewed:

		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
8.14a	At each occasion of service	○	○	○	○	○
8.14b	Every month	○	○	○	○	○
8.14c	Every 2 months	○	○	○	○	○
8.14d	Every 3 months	○	○	○	○	○

Monitoring (continued)

Round 1: Items with consensus achieved

Item 8.15 There was consensus agreement amongst practitioners in Round 1 that therapy/support goals should be reviewed if/when the following occur:

*Agreement = the proportion of practitioners who rated their agreement for the statement as 4 (agree) or 5 (strongly agree).

8.15 Therapy/support goals should be reviewed if/when:

Outcome

Mdn (IQR)

a

The child achieves a goal

94% agreement

4 (1)

b

The child and/or their family request new goals

95% agreement

4 (1)

c

The practitioner identifies new goals relevant to the child and/or their family

91% agreement

4 (1)

d

There are significant changes in the life of the child and/or family (e.g., transition to school, parental supervision, moving house)

95% agreement

4 (1)

f

At a frequency, and in a manner, that is sufficient for the practitioner delivering the therapy/support to make evidence-based decisions and recommendations.

77% agreement

4 (1)

Monitoring (continued)

Please read the below statement and view the attached file, as it is relevant for the next item we will ask you to rate.

Two items did not achieve consensus.

Item 8.15e - ‘At a frequency, and in a manner, specified by the child and family’ – had partial consensus agreement from practitioners.
Item 8.15g - ‘There is a change in the funding for services for the child and family’ - had only partial consensus agreement from practitioners.

The distributions of ratings for these items are presented in the attached file.

[Attachment: "Round 1 results_8.15e-g.png"]

Having reviewed these results from Round 1, including the qualitative feedback, we have revised these items and would like to ask you to rate them again.

8.15 Therapy/support goals should be reviewed:

		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
8.15e	At a frequency, and in a manner, that is appropriate to the child and family.	○	○	○	○	○
8.15g	If/when there is a change in the family's financial capacity to access services, including changes in available funding.	○	○	○	○	○

Monitoring (continued)

Round 1: Items with consensus achieved

Item 8.16 There was consensus agreement amongst practitioners in Round 1 that monitoring of therapy/support progress and outcomes should occur every 6 months (8.16e) and every 12 months (8.16f).

*Agreement = the proportion of practitioners who rated their agreement for the statement as 4 (agree) or 5 (strongly agree).

8.16 At a minimum, the monitoring of therapy/support progress and outcomes should occur:

Outcome

Mdn (IQR)

e.

Every 6 months

77% agreement

4 (1)

f.

Every 12 months

76% agreement

4 (1)

Monitoring (continued)

Please read the below statement and view the attached file, as it is relevant for the next item we will ask you to rate.

While there was consensus agreement that monitoring of therapy/support progress and outcomes should occur every 6-12 months, there was no clear consensus over shorter timeframes.

Specifically, four items did not achieve consensus agreement disagreement amongst practitioners in Round 1:

Item 8.16a – ‘At each occasion of service’
Item 8.16b – ‘Every month’
Item 8.16c – ‘Every 2 months’
Item 8.16d – ‘Every 3 months’

The distributions of ratings for these items are presented in the attached file.

[Attachment: "Round 1 results_8.16a-d.png"]

Having reviewed these results from Round 1, we would like to ask you to rate these items again.

8.16 At a minimum, the monitoring of therapy/support progress and outcomes should occur:

		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
8.16a	At each occasion of service	○	○	○	○	○
8.16b	Every month	○	○	○	○	○
8.16c	Every 2 months	○	○	○	○	○
8.16d	Every 3 months	○	○	○	○	○

Monitoring (continued)

Round 1: Items with consensus achieved

Item 8.17 There was consensus agreement amongst practitioners that the information gained through monitoring should be shared and discussed with the child, parents, other community members, other practitioners/specialists, and other organisations (8.17a-e). The majority of practitioners in Round 1 disagreed with the statement that information gained through monitoring should not be shared.

*Agreement = the proportion of practitioners who rated their agreement for the statement as 4 (agree) or 5 (strongly agree).

*Disagreement = the proportion of practitioners who rated their agreement for the statement as 1 (strongly disagree) or 2 (disagree).

8.17 The information gained through monitoring should:

Outcome

Mdn (IQR)

a.

Be shared and discussed with the child receiving the therapies/supports, if appropriate

98%

agreement

5 (1)

b.

Be shared and discussed with the parents of the child receiving the therapies/supports*

100%

agreement

5 (1)

c.

Be shared and discussed with other community members (nominated by the family) as the basis for supporting the child and/or family.

81%

agreement

4 (1)

d.

Be shared with other practitioners/specialists that support the child, as the basis for informing them of progress and/or inviting consultation*

92%

agreement

4 (1)

e.

Be shared with other organisations that support the child, as the basis for informing them of progress and/or inviting consultation (e.g., schools/day care)*

84%

agreement

4 (1)

f.

Not be disclosed

83% disagreement

2 (1)

*At all times, it is assumed that people providing services will adhere to relevant rules and legislation (e.g., privacy, freedom of information).

Item 8.18 There was consensus agreement amongst practitioners in Round 1 that the information gained through monitoring may be shared during a face-to-face conversation (8.18b), in a written report (8.18d), in the manner preferred by the child and/or family (8.18f), and by a combination of different modes preferred by the child and/or family (8.18g).

8.18 The outcome of monitoring should:

Outcome

Mdn (IQR)

b.

Be shared during a face-to-face conversation

73% agreement

4 (1)

d.

Be shared in a written report

72% agreement

4 (1)

f.

Be shared and discussed in the manner preferred by the child and/or family

89% agreement

5 (1)

g.

Be shared by a combination of different modes preferred by the child and/or family

94% agreement

5 (1)

Monitoring (continued)

Please read the below statement and view the attached file, as it is relevant for the next item we will ask you to rate.

Three items did not achieve consensus.

Item 8.18a – ‘Be shared during a telephone conversation’ – achieved partial consensus agreement Item 8.18c – ‘Be shared during a videoconference conversation’ – achieved partial consensus agreement Item 8.18e – ‘Be shared via graphical mode (i.e., drawing, art)’ – did not achieve consensus agreement or disagreement The distributions of ratings for these items are presented in the attached file.

[Attachment: "Round 1 results_8.18a c e.png"]

Having reviewed these results from Round 1, including the qualitative feedback, we have reviewed these items and would like to ask you to rate these items again. Please note that these are listed as potential options that should be considered for sharing monitoring information - the manner in which information is ultimately shared would be tailored to the particular circumstances of the child and family.

8.18 The focus of this item is on the mode by which monitoring information may be shared. The manner in which this would then occur would account for individual and cultural preferences regarding the nature of the interaction.

The outcome of monitoring should:

		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
8.18a	Be shared during a telephone conversation	○	○	○	○	○
8.18c	Be shared during a videoconference conversation	○	○	○	○	○
8.18e	Be shared in other ways that may be meaningful to the child and/or family (e.g., graphical mode such as drawing, art)	○	○	○	○	○

The next section of this survey refers to 'Quality and Safeguards'. There was consensus agreement for all items in this section in Round 1. As such, what would you like to do?	○ See the feedback from Round 1 ○ Skip to the next section

Section 9 of 10.

Quality and Safeguards

Round 1: Items with consensus achieved

Item 9.1 There was consensus agreement amongst practitioners in Round 1 that it is important that the safety of children on the autism spectrum and their families is ensured when accessing therapies and supports.

*Agreement = the proportion of practitioners who rated the statement as 4 (important) or 5 (very important).

Outcome

Mdn (IQR)

How important do you think it is that the safety of children on the autism spectrum and their families is ensured when accessing therapies and supports?

100% agreement

5 (0)

Item 9.2 There was consensus agreement amongst practitioners in Round 1 that each of the below are approaches that should be incorporated in clinical practice to ensure the safety, comfort, and wellbeing of individual on the autism spectrum and their families:

*Agreement = the proportion of practitioners who rated their agreement for the statement as 4 (agree) or 5 (strongly agree)

9.2 Please indicate the extent to which you agree each of the following are approaches that should be incorporated in clinical practice to ensure the safety, comfort, and wellbeing of individuals on the autism spectrum and their families:

		Outcome	Mdn (IQR)
a.	Ensuring practitioners have up-to-date knowledge of the empirical evidence for therapies/supports (including research on the views and preferences of autistic people)	100% agreement	5 (0)
b.	Ensuring practitioners have adequate experience and skills in the selection, delivery and assessment of therapies/supports	98.5% agreement	5 (0)
c.	Ensuring that practitioners have access to clinical supervision	97% agreement	5 (0)
d.	Ensuring the effectiveness and safety of therapies/supports being delivered by practitioners have been validated through well-designed research studies	89% agreement	5 (1)
e.	Ongoing monitoring of therapy/support outcomes	97% agreement	

5 (1)

f.

Ongoing assessment of support needs

96% agreement

5 (1)

g.

Practitioners working in ways that are consistent with relevant conventions, including the United Nations Convention on the Rights of Persons with Disabilities and the United Nations Convention on the Rights of the Child

100% agreement

5 (0)

h.

Practitioners following relevant practice/ professional processes and legislative requirements (e.g., Disability Discrimination Act, NDIS rules)

98.5% agreement

5 (0)

i.

Ensuring that children and their families have a clear method and pathway for raising concerns

100% agreement

5 (0)

j.

Ensuring the provision of clear, appropriate, and accurate information between practitioners and families at all stages (including to ensure informed consent is validly obtained)

100% agreement

5 (0)

Section 10 of 10.

Knowledge, skills and/or experiences of practitioners providing therapies and supports

This section contains two new questions that were developed based on qualitative feedback from the Round 1 Delphi and our additional community consultations activities, including focus groups and an online survey.

In this section, we ask you to rate your agreement with statements about what knowledge, skills, and/or experience you believe are required of practitioners who provide therapies and supports to children on the autism spectrum and their family.

NEW ITEM

10.1 It is important that practitioners providing therapies and supports to children on the autism spectrum and their families obtain relevant knowledge, skills and/or experience in the following areas:

		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
10.1a	Typical and atypical development across the age ranges of children with whom they conduct their clinical work	○	○	○	○	○
10.1b	The impact of other important considerations, such as intellectual and/or communication capacity, culturally, linguistically and/or socioeconomically diverse background, regional or remote location, or complex psychosocial factors, on the provision of therapy/support	○	○	○	○	○
10.1c	The range of therapies and supports appropriate for children on the autism spectrum and other neurodevelopmental disorders, within their scope of practice	○	○	○	○	○
10.1d	The theoretical principle(s) underpinning the therapies and supports that that they provide ('Theoretical principles' refers to the purported reasons that the therapies and supports deliver the intended therapeutic effect, i.e., how and why the therapy/support works).	○	○	○	○	○
10.1e	The current best available research that the therapies and supports they provide delivers the intended therapeutic effect	○	○	○	○	○
10.1f	The circumstances when therapies and supports may and may not be appropriate for a given child and family	○	○	○	○	○
10.1g						

	Clinical reasoning in evaluating evidence, integrating information and decision-making	○	○	○	○	○
10.1h	Clinical documentation and reporting	○	○	○	○	○
10.1i	Communicating with children on the autism spectrum and their family members	○	○	○	○	○
10.1j	Understanding of neurodiversity affirming practices ('Neurodiversity affirming' here refers to practices that affirm the child's neurodivergent identity, rather than seeking to fix or cure their neurotype.)	○	○	○	○	○

10.1k Are there other areas in which practitioners providing therapies and supports to children on the autism spectrum and their families should have relevant training, expertise, and knowledge?	○ Yes ○ No
Please describe the other areas in which you feel practitioners providing therapies and supports to children on the autism spectrum and their families should have relevant training, expertise, and knowledge.	__________________________________

NEW ITEM

10.2 In addition to the foundation qualification(s) relevant to their professional discipline, it is important that practitioners providing therapies and supports to children on the autism spectrum and their families obtain and/or maintain their skills and expertise through:

		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
10.2a	Peer observation	○	○	○	○	○
10.2b	Peer supervision	○	○	○	○	○
10.2c	Peer mentoring	○	○	○	○	○
10.2d	Formal training courses	○	○	○	○	○
10.2e	Further qualifications	○	○	○	○	○

10.2f Are there other types of relevant training and expertise practitioners should obtain when providing therapies and supports to children on the autism spectrum and their families?

○ Yes
○ No

Please describe the other types of relevant training and expertise practitioners should obtain when providing therapies and supports to children on the autism spectrum and their families.

____

Appendix 10.1	Brief Online Survey

Brief Survey

AutismCRC

Supporting Children National Guideline

[Attachment: "Brief Survey Video Script.docx"]

Development of a National Practice Guideline for Supporting Children on the Autism Spectrum and their Families: Three Questions about Therapies and Supports

(GU ref no:2021/843)

Part 1: Participation Information

What is this project about?

The Autism CRC is leading the development of a National Practice Guideline for supporting children on the autism spectrum and their families in Australia. The Guideline will be developed based on both research and consultation with the community. The result will be a set of recommendations to guide the delivery of therapy and support services for children on the autism spectrum and their families.

Why are you being invited to participate?

We want to hear the voices of all community members with an interest in the Guideline, including those of children and young people, as well as those of adults who communicate mainly in ways other than speech. We are inviting you to give consent for your child, young person, or adult person to complete a three-question survey about their views on accessing therapies and supports.

Who can participate in the research?

We want to hear from:

Parents of children, young people, and adult people on the autism spectrum. The children, young people, and adults themselves.

What is this activity? It is a set of three questions that you would ask your child, young person, or adult person. They can write their response or you can write down what they say. The questions ask for their opinion about their most and least favourite things about accessing therapies and supports, and what they think could be done better.

Who is it designed for? We have designed this activity with children, young people, and adults who are able to ask and answer questions in mind.

How long will it take? This should take between 5-15 minutes to complete, depending on how much information they want to share.

What will you need to do? We will provide you with the questions on screen, and the child, young person, or adult person (with or without your help) can type in their responses. It is important to note that although you can help with typing, the answers for this activity need to be their own words (a voice to text option may be available to you, depending on the device you use).

Can you have a look first? Yes, you can click on the pdf link below to see the instructions and questions you will be asked.

Do you have to participate?

Participation is voluntary for you and your child. If you decide not to participate, this decision will not disadvantage you or impact your relationship with Griffith University or any other institutions affiliated with this research.

What happens if you/they have a change of mind?

If you and your child begin participating but then change your mind:

There is a button at the end of the questionnaire that you/your child can select to indicate that you no longer want the information you provided to be used in the project. If you decide to withdraw consent after submitting the survey, your individual responses will not be able to identified, due to the anonymous nature of data collection. If you are unsure, you can contact the research team at supportingchildren@griffith.edu.au What are the benefits of participating?

We hope that it will be a positive experience for you and your child, young person, or adult person in helping to inform the Guideline. While you may not receive any direct benefits from participating in this research, the benefits of the research more broadly include an increase in knowledge and understanding regarding the most important factors relevant to the delivery of therapies and supports for young children on the autism spectrum.

Are there any potential risks?

We do not believe there are any direct risks associated with participation in this research. However, we understand that for some people thinking and talking about their experiences, can lead to a mixture of emotions, including sadness. There is also the possibility that the person completing the survey may respond in ways that you were not expecting, such as sharing negative experiences about accessing therapies and supports. If you, the person completing the survey, or anyone close to you, participates in this research and experiences any distress, we ask that you contact Lifeline on 13 11 14 and Kidshelpline on 1800 55 1800. If the person answering the survey raises any issues that require further investigation, please contact the relevant authorities such as the police or Government department responsible for services and safety in your State or Territory.

Who are the researchers?

A/Professor David Trembath, Menzies Health Institute Queensland, Griffith University

Professor Andrew Whitehouse, Bennett Chair of Autism & Director, CliniKids, Telethon Kids Institute

Dr Kandice Varcin, Research Fellow, Menzies Health Institute Queensland, Griffith University

Dr Rhylee Sulek, Research Fellow, School of Health Sciences and Social Work, Griffith University

Dr Hannah Waddington, Lecturer, School of Education, Victoria University of Wellington

Ms Sarah Pillar, Integration Project Manager, CliniKids, Telethon Kids Institute

Who can you contact for further information?

You might be unsure if you are able to participate or unsure about how the research process works. We encourage you to contact A/Prof David Trembath at supportingchildren@griffith.edu.au

to discuss this and anything else you might wish to talk about in relation to the project.

How can you receive information about the research results?

Regular updates regarding the progress of the Guideline including a summary of the outcomes of this set of consultation activities, will be provided on the National Practice Guideline Community Hub website. Participants will be able to access a copy of the Guideline, once published. If you would like to discuss this further with the research team, you can do so via email.

How can you trust this research is safe for me and/or my child/young person/adult person?

This research is being conducted by skilled research staff and supported by a Guideline Development Group that includes people with a range of knowledge and experience, including autistic adults and parents raising children on the autism spectrum. The team has carefully designed the activities to include only questions that are relevant and to ensure that different activities can cater for all children, young people, and adults who communicate mainly in ways other than speech. Only anonymous, summarised and combined information will be used and reported.

Part 2: Ethical Information we must provide you.

What will be done with the information collected?

We will use the information you and others provide to help develop a set of draft recommendations for supporting children and their families, and then share these with the community for feedback. The information will be published and presented in public, including through the Guideline document but also potentially in presentations, academic journals, online newspapers and newsletters, and social media.

When we share our findings, we will:

Present a summary of de-identified information about who participated (e.g., ages, communication skills). Present the themes that emerge from responses, and use direct quotes from participants to help explain what the themes are about. Any quotes will be presented anonymously, not using their real name. It is possible that if you or the person who completes the survey reads the findings or sees them presented at a workshop or seminar they might recognise their quotes, but we will never attach real names to these quotes.

How will privacy be protected?

The conduct of this research involves the collection, access, storage and/or use of your identified personal information. The information collected is confidential and will not be disclosed to third parties without your consent, except to meet government, legal or other regulatory authority requirements. Your anonymity will at all times be safeguarded. For further information consult the University's Privacy Plan at http://www.griffith.edu.au/about-griffith/plans-publications/griffith-university-privacy-plan or telephone (07) 3735 4375.

To further explain how your privacy will be protected, all of the data that is collected through the survey will be completely confidential. All data will be stored securely on an encrypted and password protected storage drive that will be accessible only by the members of the research team. This data will be stored securely for five years.

The ethical conduct of this research

Griffith University conducts research in accordance with the National Statement on Ethical Conduct in Human Research. Please feel free to contact the researchers if you have any questions (A/Prof David Trembath, supportingchildren@griffith.edu.au). If you have any additional questions or concerns about ethical issues, please contact the Manager, Research Ethics, at Griffith University Human Research Ethics Committee (research-ethics@griffith.edu.au; 07 3735 4375).

THIS SURVEY WILL CLOSE AT 11:59 PM ON 30TH APRIL, 2022.

[Attachment: "Brief survey_Participant Information statement.docx"]

Please click on the pdf attachment if you would like to view a copy of the instructions and survey before deciding to participate.

[Attachment: "Brief survey_activity and questions.pdf"]

[Attachment: "Voice-to-text instructions.doc"]

Consent to Participate

Consent Form for the Research Project:

Development of a National Practice Guideline for Supporting Children on the Autism Spectrum and their Families: Three Questions about Therapies and Supports

(GU ref no:2021/843)

By selecting the check box below, I confirm that I have read and understood the information sheet and I have noted that:

I understand that my child's/young person's/adult person's participation in this research will involve them completing a three question survey about therapies and supports. I understand that I will be responsible for providing informed consent, and then sharing/facilitating their access to or completion of the task. I understand that the information collected will be used to inform the development of National Practice Guideline for supporting children on the autism spectrum and their families in Australia. I understand that written responses they provide in this activity may be reproduced in the Guideline and related research activities (e.g., community presentations, research articles, online news and newsletters, social media), provided they contain no personally identifying information. I have read the Information Statement, or someone has read it to me in a language that I understand. I understand why this research is being conducted and what participating will involve. I understand any risks as described above. I have had an opportunity to ask questions and I am satisfied with the answers I have received. I understand that I am free, and my child/young person/adult person is free, to withdraw at any time during the project without question or consequence. I understand that I can contact the Manager, Research Ethics, at Griffith University Human Research Ethics Committee if I have any concerns about the ethical conduct of this project I agree to participate in the research.

I agree for my child and/or young person to take part in this research	○ No ○ Yes

Thank you again for your interest in this research.

As a reminder, you will have the opportunity to save your responses and return at a later time to complete this survey. To assist us in our data collection, we ask that you please finalise your responses within one week of starting the survey. We will not analyse any additional answers provided after this time.

Your young person's first and last name: (Note: this information is only collected to obtain consent and is not used in the research)	________________________
Your first and last name: (Note: this information is only collected to obtain consent and is not used in the research)	________________________

Parent and Child Demographics

Please answer the following questions so that we can describe, in general terms, children and adults who participated in this aspect of the study. All questions are optional, but it is very helpful to us if you complete them as this helps us interpret the information provided.

About you: Are you the parent/primary caregiver/legal guardian of a child on the autism spectrum?	○ Yes ○ No
About your child: How old is your child (years)	________________________
With what gender does you child identify?	○ Female ○ Male ○ Non-binary ○ Prefer not to say ○ Other
Please specify if other	________________________
Are they of Aboriginal and/or Torres Strait Islander origin?	○ No ○ Yes, Aboriginal ○ Yes, Torres Strait Islander ○ Yes, both Aboriginal and Torres Strait Islander
Were they born in Australia?	○ No ○ Yes
Are they living in a home where a language other than English is spoken?	○ No ○ Yes
Has your child received a formal diagnosis of autism (or a related condition e.g., Asperger's, Pervasive Developmental Disorder)?	○ No ○ Yes
At what age was your child diagnosed (please round to the nearest year)?	________________________
Did you access therapies and/or supports for your child at some stage between the ages of 0-6 years?	○ No ○ Yes
Did you access therapies and/or supports for your child at some stage between the ages of 7-12 years?	○ No ○ Yes

The below table outlines the three levels of support required within the autism spectrum as described in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5).

Level

Social communication

Restricted, repetitive behaviors

Level 3 "Requiring very substantial support"

Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning, very limited initiation of social interactions, and minimal response to social overtures from others. For example, a person with few words of intelligible speech who rarely initiates interaction and, when he or she does, makes unusual approaches to meet needs only and responds to only very direct social approaches

Inflexibility of behavior, extreme difficulty coping with change, or other restricted/repetitive behaviors markedly interfere with functioning in all spheres. Great distress/difficulty changing focus or action.

Level 2 "Requiring substantial support"

Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal responses to social overtures from others. For example, a person who speaks simple sentences, whose interaction is limited to narrow special interests, and how has markedly odd nonverbal communication.

Inflexibility of behavior, difficulty coping with change, or other restricted/repetitive behaviors appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress and/or difficulty changing focus or action.

Level 1 "Requiring support"

Without supports in place, deficits in social communication cause noticeable impairments. Difficulty initiating social interactions, and clear examples of atypical or unsuccessful response to social overtures of others. May appear to have decreased interest in social interactions. For example, a person who is able to speak in full sentences and engages in communication but whose to- and-fro conversation with others fails, and whose attempts to make friends are odd and typically unsuccessful.

Inflexibility of behavior causes significant interference with functioning in one or more contexts. Difficulty switching between activities. Problems of organization and planning hamper independence.

If your child was diagnosed under the DSM-5, please indicate which support level is associated with their diagnosis.	○ Level 1 - Requires support ○ Level 2 - Requires substantial support ○ Level 3 - Required very substantial support ○ I am unsure ○ I would prefer not to say
If your child has not yet received a formal diagnosis or was not diagnosed as a child under the DSM-5, please indicate which level you feel would have best represented their support needs as a child.	○ Level 1 - Requires support ○ Level 2 - Requires substantial support ○ Level 3 - Required very substantial support ○ I am unsure ○ I would prefer not to say

Three Questions – Task Instructions/Survey
Development of a National Practice Guideline for Supporting Children on the Autism Spectrum and their Families:

Three Questions about Therapies and Supports

Instructions

Please explain this activity to your child, young person, or adult person in a way that matches their understanding and gives you confidence that they are comfortable to be involved.

If your child or young person is 0-12 years of age, please ask them to talk/write about therapies and supports they are currently accessing.

If the young person or adult person is older than 12 years, please ask them to talk/write about what it was like accessing therapies and supports when they were under 12 years of age.

They can complete the survey independently or with help. For example, they can type their answers, they can use a voice-to-text option if your device allows it, or you can offer to type their responses. However, if you are typing, please type exactly what they say. Do not change, correct, or add words or ideas. For this survey, we really want to hear what they have to say in their own words, including any errors or profanities.

You can call the therapies or supports that your child, young person, or adult person has accessed and/or is accessing whatever will make the most sense to that person, and use any other materials that might be helpful. For example, some people refer to ‘speech therapy’ while others refer to the name of the person of the speech pathologist. Some people may be able to respond based just on the name, but others may find it helpful to refer to a picture of the person, the organisation’s website, a visual support, or any other object or artefact that is helpful to them.

They can answer the questions for one or more therapies and supports, either by talking about them together in one response or by answering the questions multiple times (up to 5 times).

Question for you, the parent/caregiver

What type of therapies/supports will you ask about? ______________________________

Questions for the autistic child, young person, or adult person on the autism spectrum:

---

1. What was/is your most favourite thing about.... [please use the name of the therapy/support that will make the most sense to the person] ______________________________

For example, you might ask "What is your most favourite thing about going to occupational therapy?" Alternatively, you could say the name of the person they see, such as "What is your most favourite thing about seeing Jessica?" (the occupational therapist)

2. What was/is your least favourite thing about.... [please use the name of the therapy/support that will make the most sense to the person] For example, you might ask, “What is your least favourite thing about going to occupational therapy?” Alternatively, you could say the name of the person they see, such as “What is your least favourite thing about seeing Jessica?” (the occupational therapist)	__________________________________
3. What could make it better?.... [please use the name of the therapy/support that will make the most sense to the person] For example, you might ask, “What could make going to occupational therapy better?” Alternatively, you could say the name of the person they see, such as “What could make seeing Jessica (the occupational therapist) better?"	__________________________________
Would you like to enter another response	○ Yes ○ No
1. What was/is your most favourite thing about.... [please use the name of the therapy/support that will make the most sense to the person] For example, you might ask "What is your most favourite thing about going to occupational therapy?" Alternatively, you could say the name of the person they see, such as "What is your most favourite thing about seeing Jessica?" (the occupational therapist)	__________________________________
2. What was/is your least favourite thing about.... [please use the name of the therapy/support that will make the most sense to the person] For example, you might ask, “What is your least favourite thing about going to occupational therapy?” Alternatively, you could say the name of the person they see, such as “What is your least favourite thing about seeing Jessica?” (the occupational therapist)	__________________________________

3. What could make it better?.... [please use the name of the therapy/support that will make the most sense to the person] For example, you might ask, “What could make going to occupational therapy better?” Alternatively, you could say the name of the person they see, such as “What could make seeing Jessica (the occupational therapist) better?"	__________________________________
Would you like to enter another response	○ Yes ○ No
1. What was/is your most favourite thing about.... [please use the name of the therapy/support that will make the most sense to the person] For example, you might ask "What is your most favourite thing about going to occupational therapy?" Alternatively, you could say the name of the person they see, such as "What is your most favourite thing about seeing Jessica?" (the occupational therapist)	__________________________________
2. What was/is your least favourite thing about.... [please use the name of the therapy/support that will make the most sense to the person] For example, you might ask, “What is your least favourite thing about going to occupational therapy?” Alternatively, you could say the name of the person they see, such as “What is your least favourite thing about seeing Jessica?” (the occupational therapist)	__________________________________
3. What could make it better?.... [please use the name of the therapy/support that will make the most sense to the person] For example, you might ask, “What could make going to occupational therapy better?” Alternatively, you could say the name of the person they see, such as “What could make seeing Jessica (the occupational therapist) better?"	__________________________________
Would you like to enter another response	○ Yes ○ No

1. What was/is your most favourite thing about.... [please use the name of the therapy/support that will make the most sense to the person]

For example, you might ask "What is your most favourite thing about going to occupational therapy?" Alternatively, you could say the name of the person they see, such as "What is your most favourite thing about seeing Jessica?" (the occupational therapist)

____

2. What was/is your least favourite thing about.... [please use the name of the therapy/support that will make the most sense to the person]

For example, you might ask, “What is your least favourite thing about going to occupational therapy?” Alternatively, you could say the name of the person they see, such as “What is your least favourite thing about seeing Jessica?” (the occupational therapist)

____

3. What could make it better?.... [please use the name of the therapy/support that will make the most sense to the person]

For example, you might ask, “What could make going to occupational therapy better?” Alternatively, you could say the name of the person they see, such as “What could make seeing Jessica (the occupational therapist) better?"

____

Would you like to enter another response

○ Yes
○ No

1. What was/is your most favourite thing about.... [please use the name of the therapy/support that will make the most sense to the person]

For example, you might ask "What is your most favourite thing about going to occupational therapy?" Alternatively, you could say the name of the person they see, such as "What is your most favourite thing about seeing Jessica?" (the occupational therapist)

____

2. What was/is your least favourite thing about.... [please use the name of the therapy/support that will make the most sense to the person]

For example, you might ask, “What is your least favourite thing about going to occupational therapy?” Alternatively, you could say the name of the person they see, such as “What is your least favourite thing about seeing Jessica?” (the occupational therapist)

____

3. What could make it better?.... [please use the name of the therapy/support that will make the most sense to the person] For example, you might ask, “What could make going to occupational therapy better?” Alternatively, you could say the name of the person they see, such as “What could make seeing Jessica (the occupational therapist) better?"	__________________________________
Questions for you, the parent/caregiver:	
What type of therapies/supports was your child, young person, or adult person talking about? (if different to above)	__________________________________
Which do you think they are reflecting on? The whole time they accessed these therapies and supports Just part of the time they accessed these therapies and supports (e.g., at the start, more recently, at one point in time)	__________________________________
Final questions for you, the parent/caregiver:	
1. How was the survey completed?	○ By the autistic child, young person, or adult person on the autism spectrum ○ With the help of a parent/caregiver
2. Is there anything else you would like to share to help us understand their responses?	__________________________________
We would like to ask you again, now that you have provided information: Are you happy for us to use the information you provided? Please note: all information collected through the survey will be completely confidential.	○ Yes ○ No
If you have any final comments, please feel welcome to share them here.	__________________________________

A note from the research team

Thank you very much for answering the questions. The information that you and others provide will directly inform the recommendations in the guideline.

The next step for the research team will be to analyse all of the information provided. The Guideline Development Group will then formulate recommendations.

If you have not already done so, please register with Autism CRC to receive updates about the guideline. You can do so here.

Before we finish, we want to take a moment to acknowledge the time it takes to complete surveys like this. While we are not able to send a personal response to each person who completes it, please know that we genuinely value the information you have provided and will be reading every word.

We also acknowledge that if you are an autistic person, a parent, or other family members of a child on the autism spectrum, you will have shared in the survey insights from your own life, your experience, and your expertise. It is likely that you will have been asked to do this many times before, and we warmly thank you for being willing to do so again here, to help make the guideline the best it can be. We simply could not do this piece of important work, without your insights. Thank you.

We look forward to sharing updates, and the guideline in due course, via Autism CRC's website.

Sincerely,

Rhylee, Kandice, Hannah, Sarah, David, and Andrew, on behalf of the Guideline Development Group.

Appendix 11.1	Parent Reflection Survey

Parent Observations and Reflections

Development of a National Practice Guideline for Supporting Children on the Autism Spectrum and their Families: Sharing Experiences through Observation and Reflection

(GU ref no:2021/843)

Part 1: Participation Information

What is this project about?

The Autism CRC is leading the development of a National Practice Guideline for supporting children on the autism spectrum and their families in Australia. The Guideline will be developed based on both research and consultation with the community. The result will be a set of recommendations to guide the delivery of therapy and support services for children on the autism spectrum and their families.

Why are you being invited to participate?

We want to hear the voices of all community members with an interest in the Guideline, including those of children and young people, as well as those of adults who communicate mainly in ways other than speech. We are inviting you to reflect on your child’s experiences of accessing therapies and supports when they are/were between the ages of 0-12 years, based on your observation.

Who can participate in the research?

This activity caters for:

Parents of children who communicate/d mostly in ways other than speech during the ages 0-12 years, as they access/ed therapies and supports. The children and young people, whose experiences will be reflected on. What is it?

We would ask parents to share their observations of their child or young person accessing therapies and supports. These may be current experiences, or reflections on the past. We want to learn from your observations of their emotions and actions, that can give insights into how they may have been feeling, what they may have been thinking, and what they may have been experiencing. We understand that many children, young people, and adults communicate mainly in ways other than speech, and that all emotions and actions are communication. Our goal here is to try to gain an understanding of their experiences, based on the insights of people who know them best.

Who is it designed for?

We have designed this activity with children and young people who communicate mainly in ways other than speech in mind. We are focusing on therapies and supports received when they were 0-12 years of age, but the reflections can be current or from the past.

How long will it take?

We anticipate that sharing this will take between 5-15 minutes, depending on how much you would like to tell us.

What will you need to do?

We will give you some instructions about what to reflect on, and a set of questions we would like you to answer.

Can you have a look first?

Yes, you can click on the pdf link below to see a copy of the instructions and questions you will be asked.

Do you have to participate?

Participation is voluntary. If you decide not to participate, this decision will not disadvantage you or impact your relationship with Griffith University or any other institutions affiliated with this research.

What happens if you/they have a change of mind?

If you and your child/young person/adult person begin participating but then change your mind, there is a button at the end of the questionnaire that you/your child can select to indicate that you no longer want the information you provided to be used in the project. If you decide to withdraw consent after submitting the survey, your individual responses will not be able to identified, due to the anonymous nature of data collection. If you are unsure you can contact the research team at supportingchildren@griffith.edu.au

What are the benefits of participating?

We hope that it will be a positive experience for you and your child in helping to inform the Guideline. While you may not receive any direct benefits from participating in this research, the benefits of the research more broadly include an increase in knowledge and understanding regarding the most important factors relevant to the delivery of therapies and supports for young children on the autism spectrum.

Are there any potential risks?

We do not believe there are any direct risks associated with participation in this research. However, we understand that for some people thinking and talking about their experiences, can lead to a mixture of emotions, including sadness. If you or anyone close to you, participates in this research and experiences any distress, we ask that you contact Lifeline on 13 11 14.

Who are the researchers?

A/Professor David Trembath, Menzies Health Institute Queensland, Griffith University

Professor Andrew Whitehouse, Bennett Chair of Autism & Director, CliniKids, Telethon Kids Institute

Dr Kandice Varcin, Research Fellow, Menzies Health Institute Queensland, Griffith University

Dr Rhylee Sulek, Research Fellow, School of Health Sciences and Social Work, Griffith University

Dr Hannah Waddington, Lecturer, School of Education, Victoria University of Wellington

Ms Sarah Pillar, Integration Project Manager, CliniKids, Telethon Kids Institute

Who can you contact for further information?

You might be unsure if you are able to participate or unsure about how the research process works. We encourage you to contact A/Prof David Trembath at supportingchildren@griffith.edu.au

to discuss this and anything else you might wish to talk about in relation to the project.

How can you receive information about the research results?

Regular updates regarding the progress of the Guideline including a summary of the outcomes of this set of consultation activities, will be provided on the National Practice Guideline Community Hub website. Participants will be able to access a copy of the Guideline, once published. If you would like to discuss this further with the research team, you can do so via email.

How can you trust this research is safe for me?

This research is being conducted by skilled research staff and supported by a Guideline Development Group that includes people with a range of knowledge and experience, including autistic adults and parents raising children on the autism spectrum. The team has carefully designed the activities to include only questions that are relevant and to ensure that different activities can cater for all children. Only anonymous, summarised and combined information will be used and reported.

Part 2: Ethical Information we must provide you.

What will be done with the information collected?

We will use the information you and others provide to help develop a set of draft recommendations for supporting children and their families, and then share these with the community for feedback. The information will be published and presented in public, including through the Guideline document but also potentially in presentations, academic journals, online newspapers and newsletters, and social media.

When we share our findings, we will:

Present a summary of de-identified information about who participated (e.g., the children’s ages, their communication skills). Present the themes that emerge from the information you and other parents share, and use direct quotes to help explain what the themes are about. Any quotes will be presented anonymously, not using your child’s real name. It is possible that if you read the findings or see them presented at a workshop or seminar that you might recognise your own quotes/artwork, but we will never attach real names to these quotes or drawings. How will privacy be protected?

The conduct of this research involves the collection, access, storage and/or use of your identified personal information. The information collected is confidential and will not be disclosed to third parties without your consent, except to meet government, legal or other regulatory authority requirements. Your anonymity will at all times be safeguarded. For further information consult the University's Privacy Plan at http://www.griffith.edu.au/about-griffith/plans-publications/griffith-university-privacy-plan or telephone (07) 3735 4375.

To further explain how your privacy will be protected, all of the data that is collected through the survey will be completely confidential. All data will be stored securely on an encrypted and password protected storage drive that will be accessible only by the members of the research team. This data will be stored securely for five years.

The ethical conduct of this research

Griffith University conducts research in accordance with the National Statement on Ethical Conduct in Human Research. Please feel free to contact the researchers if you have any questions (A/Prof David Trembath, supportingchildren@griffith.edu.au). If you have any additional questions or concerns about ethical issues, please contact the Manager, Research Ethics, at Griffith University Human Research Ethics Committee (research-ethics@griffith.edu.au; 07 3735 4375).

THIS SURVEY WILL CLOSE AT 11:59 PM ON 30TH APRIL, 2022.

[Attachment: "Child Parent Observation and Reflection_Participant Information statement.docx"]

Please click on the pdf attachment if you would like to view a copy of the survey before deciding to participate.

[Attachment: "Parent Observation and Reflection_activity & questions.pdf"]

[Attachment: "Voice-to-text instructions.doc"]

Consent Form for the Research Project:

Development of a National Practice Guideline for Supporting Children on the Autism Spectrum and their Families: Sharing Experiences through Observation and Reflection

(GU ref no:2021/843)

By selecting the check box below, I confirm that I have read and understood the information sheet and I have noted that:

I understand that my/my child's participation in this research will involve me sharing observations about my child's experiences accessing therapies and supports when they are/were between the ages of 0-12 years. I understand that I will be responsible for providing informed consent, and then sharing/facilitating my child's access to or completion of the task. I understand that the information collected will be used to inform the development of a National Practice Guideline for supporting children on the autism spectrum and their families in Australia. I understand that written responses I provide in this activity may be reproduced in the Guideline and related research activities (e.g., community presentations, research articles, online news and newsletters, social media), provided they contain no personally identifying information. I have read the Information Statement, or someone has read it to me in a language that I understand. I understand why this research is being conducted and how I and my child can participate I understand any risks as described above. I have had an opportunity to ask questions and I am satisfied with the answers I have received. I understand that I am free, and my child is free, to withdraw at any time during the project without comment or consequence. I understand that I can contact the Manager, Research Ethics, at Griffith University Human Research Ethics Committee if I have any concerns about the ethical conduct of this project. I agree to participate in the research.

Your child's first and last name: __________________________________

(Note: this information is only collected to obtain consent and is not used in the research)

Your first and last name: __________________________________

(Note: this information is only collected to obtain consent and is not used in the research)

Contact email: __________________________________

(Note: this information is only collected to obtain consent and is not used in the research)

I agree to participate in this research project and for my child to participate in this research project.

○ No
○ Yes

Thank you again for your interest in this research.

As a reminder, you will have the opportunity to save your responses and return at a later time to complete this survey. To assist us in our data collection, we ask that you please finalise your responses within one week of starting the survey. We will not analyse any additional answers provided after this time.

Parent/child demographic survey – Parents Please answer the following questions so that we can describe, in general terms, children and adults who participated in this aspect of the study. All questions are optional, but it is very helpful to us if you complete them as this helps us interpret the information provided.

About you: Are you the parent/primary caregiver/legal guardian of a child on the autism spectrum?	○ Yes ○ No
About your child: What is their age? (in years)	__________________________________
With what gender does you child identify?	○ Female ○ Male ○ Non-binary ○ Prefer not to say ○ Other
Please specify if other	__________________________________
Are they of Aboriginal and/or Torres Strait Islander origin?	○ No ○ Yes, Aboriginal ○ Yes, Torres Strait Islander ○ Yes, both Aboriginal and Torres Strait Islander
Were they born in Australia?	○ No ○ Yes
Are they living in home where a language other than English is spoken?	○ No ○ Yes
Has your child received a formal diagnosis of autism (or a related condition e.g., Asperger's, Pervasive Developmental Disorder)?	○ No ○ Yes
At what age was your child diagnosed (please round to the nearest year)?	__________________________________
Did you access therapies and/or supports for your child at some stage between the ages of 0-6 years?	○ No ○ Yes
Did you access therapies and/or supports for your child at some stage between the ages of 7-12 years?	○ No ○ Yes

The below table outlines the three levels of support required within the autism spectrum as described in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5).

Level

Social communication

Restricted, repetitive behaviors

Level 3 "Requiring very substantial support"

Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning, very limited initiation of social interactions, and minimal response to social overtures from others. For example, a person with few words of intelligible speech who rarely initiates interaction and, when he or she does, makes unusual approaches to meet needs only and responds to only very direct social approaches

Inflexibility of behavior, extreme difficulty coping with change, or other restricted/repetitive behaviors markedly interfere with functioning in all spheres. Great distress/difficulty changing focus or action.

Level 2 "Requiring substantial support"

Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal responses to social overtures from others. For example, a person who speaks simple sentences, whose interaction is limited to narrow special interests, and how has markedly odd nonverbal communication.

Inflexibility of behavior, difficulty coping with change, or other restricted/repetitive behaviors appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress and/or difficulty changing focus or action.

Level 1 "Requiring support"

Without supports in place, deficits in social communication cause noticeable impairments. Difficulty initiating social interactions, and clear examples of atypical or unsuccessful response to social overtures of others. May appear to have decreased interest in social interactions. For example, a person who is able to speak in full sentences and engages in communication but whose to- and-fro conversation with others fails, and whose attempts to make friends are odd and typically unsuccessful.

Inflexibility of behavior causes significant interference with functioning in one or more contexts. Difficulty switching between activities. Problems of organization and planning hamper independence.

If your child was diagnosed under the DSM-5, please indicate which support level is associated with their diagnosis.	○ Level 1 - Requires support ○ Level 2 - Requires substantial support ○ Level 3 - Required very substantial support ○ I am unsure ○ I would prefer not to say
If your child has not yet received a formal diagnosis or was not diagnosed as a child under the DSM-5, please indicate which level you feel would have best represented their support needs as a child.	○ Level 1 - Requires support ○ Level 2 - Requires substantial support ○ Level 3 - Required very substantial support ○ I am unsure ○ I would prefer not to say

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Sharing Experiences through Observation and Reflection

– Task Instructions/Survey

Development of a National Practice Guideline for Supporting Children on the Autism Spectrum and their Families: Sharing Experiences through Observation and Reflection

Instructions

Please explain this activity to your child, young person, or adult person in a way that matches their understanding and gives you confidence that they are comfortable to be involved.

Reflect on your experiences observing your child or young person as they access/ed therapies and supports. This can be before, during, and/or after they access/ed them. If your child or young person is 0-12 years of age, please reflect on their experiences of therapies and supports they are currently accessing. Alternatively, you can reflect on the experiences of your young person or adult person accessing services in the past, when they were 0-12 years of age.

Please share your reflections by answering the questions below

---

Questions for you, the parent/caregiver:

---

1. What types of therapies and supports are you reflecting on? ______________________________

---

2. Over what period of time are you reflecting (e.g., a particular day, a number of weeks, a number of months, a number of years)? ______________________________

You can answer the following questions based on what is happening now or happened in the past:

---

1. What do you think they currently like (or did like if in the past) about accessing these therapies and supports? How do/did they show you through their emotions and actions? ______________________________

---

2. What do you think they do not like (or did not like if in the past) about accessing these therapies and supports? How do/did they show you through their emotions and actions? ______________________________

---

3. What do you think they would like to change about accessing these therapies and supports? How do/did they show you through their emotions and actions? ______________________________

---

4. Is there anything else you would like to share to help us understand their experiences of accessing therapies and supports. ______________________________

We would like to ask you again, now that you have provided information: Are you happy for us to use the information you provided? Please note: all information collected through the survey will be completely confidential.	○ Yes ○ No

A note from the research team

Thank you very much for completing the activity. The information that you and others provide will directly inform the recommendations in the guideline.

The next step for the research team will be to analyse all of the information provided. The Guideline Development Group will then formulate recommendations.

If you have not already done so, please register with Autism CRC to receive updates about the guideline. You can do so here.

Before we finish, we want to take a moment to acknowledge the time it takes to participate in research projects like this. While we are not able to send a personal response to each person who completes it, please know that we genuinely value the information you have provided and will be reading every word.

We simply could not do this piece of important work without your insights. Thank you. We look forward to sharing updates, and the guideline in due course, via Autism CRC's website

Sincerely, David, Rhylee, Kandice, Hannah, Sarah, and Andrew, on behalf of the Guideline Development Group.

Appendix 12.1	Expression through art – Young people

Expression through Art

[Attachment: "Expressing through Art Video Script.docx"]

[Attachment: "Voice-to-text instructions.doc"]

Development of a National Practice Guideline for Supporting Children on the Autism Spectrum and their Families:

Expression through Art

Instructions for Completing with Consent and Support of Parent

Instructions

Please explain this activity to your child, young person, or adult person in way that matches their understanding and gives you confidence that they are comfortable to be involved.
Invite them to produce a piece of art (e.g., do a drawing, painting or other artwork) about their experiences and/or feelings of accessing therapies and supports.
If your child or young person is 0-12 years of age, please ask them to think about therapies and supports they are currently accessing.
If the young person or adult person is older than 12 years, please ask them to think about what it was like accessing therapies and supports when they were under 12 years of age.
Take a photo/scan the artwork and upload it via the link provided.
Answer three brief questions about the artwork to help us understand it.

Please upload your artwork here. If you have any issues uploading your artwork via this link, please email supportingchildren@griffith.edu.au for assistance.	
Questions for your child, young person, or adult person. If they are able to answer, please ask them: What is the artwork about? You can ask further questions to help such as: Who is in the picture? What are they doing? How are they feeling? What is good? What is bad? What would make it better? Please write down exactly what they say, in their own words, even if there are mistakes or you disagree.	______________________________
2. Is there anything else they would like to share to help us understand their artwork?	______________________________
3. How were the answers to these questions entered?	○ By the autistic child, young person, or adult person on the autism spectrum ○ With the help of a parent/caregiver
Questions for you, the parent/caregiver:	
1. Please share your own thoughts about the artwork. What do you think it tells us about their experiences and/or feelings about accessing therapies and supports?	______________________________
2. What type of therapies/supports do you think are being represented in the artwork? If you are not sure, please say so.	______________________________
3. Have they accessed any other therapies and supports in addition to these?	○ Yes ○ No
4. Which do you think they are reflecting on?	○ The whole time they accessed these therapies and supports ○ Just part of the time they accessed these therapies and supports (e.g., at the start, more recently, one point in time)
5. Is there anything else you would like to share to help us understand their artwork?	______________________________

We would like to ask you again, now that you have provided information: Are you happy for us to use the information you provided? Please note: all information collected through the survey will be completely confidential.	○ Yes ○ No
If you have any final comments, please feel welcome to share them here.	________________________________

A note from the research team

Thank you very much for completing the activity. The information that you and others provide will directly inform the recommendations in the guideline.

The next step for the research team will be to analyse all of the information provided. The Guideline Development Group will then formulate recommendations.

If you have not already done so, please register with Autism CRC to receive updates about the guideline. You can do so here: https://www.autismcrc.com.au/supporting-children

Before we finish, we want to take a moment to acknowledge the time it takes to participate in research projects like this. While we are not able to send a personal response to each person who completes it, please know that we genuinely value the information you have provided and will be reading every word.

We simply could not do this piece of important work without your insights. Thank you. We look forward to sharing updates, and the guideline in due course, via Autism CRC's website.

Sincerely, David, Rhylee, Kandice, Hannah, Sarah, and Andrew, on behalf of the Guideline Development Group.

Appendix 12.2	Expression through art - Adults

Expression through Art

[Attachment: "Expressing through Art Video Script.docx"]

[Attachment: "Voice-to-text instructions.doc"]

Development of a National Practice Guideline for Supporting Children on the Autism Spectrum and their Families:

Expression through Art

Instructions for People who are Self-Completing

Instructions

Please produce a piece of art (e.g., do a drawing, painting or other artwork) about your experience and/or feelings of accessing therapies and supports when you were a child, aged 0-12 years.

Take a photo/scan the artwork and upload it via the link provided.

Answer the following questions about the artwork to help us understand it.

Please upload your artwork here. If you have any issues uploading your artwork via this link, please email supportingchildren@griffith.edu.au for assistance.	
Questions for you. What does the artwork tell us about your experience of accessing therapies and supports as a child (0-12 years)?	__________________________________
2. What type of therapies/supports are represented in the artwork?	__________________________________
3. Did you access any other therapies and supports in addition to these when you were between the ages of 0-12 years?	○ Yes ○ No
4. Does the artwork reflect on:	○ The whole time you accessed these therapies and supports ○ Just part of the time you accessed these therapies and supports (e.g., at the start, more recently, one point in time)
5. Is there anything else you would like to share to help us understand your artwork?	__________________________________
We would like to ask you again, now that you have provided information: Are you happy for us to use the information you provided? Please note: all information collected through the survey will be completely confidential.	○ Yes ○ No
If you have any final comments, please feel welcome to share them here.	__________________________________

A note from the research team

Thank you very much for completing the activity. The information that you and others provide will directly inform the recommendations in the guideline.

The next step for the research team will be to analyse all of the information provided. The Guideline Development Group will then formulate recommendations.

If you have not already done so, please register with Autism CRC to receive updates about the guideline. You can do so here.

Before we finish, we want to take a moment to acknowledge the time it takes to participate in research projects like this. While we are not able to send a personal response to each person who completes it, please know that we genuinely value the information you have provided and will be reading every word.

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Sincerely, David, Rhylee, Kandice, Hannah, Sarah, and Andrew, on behalf of the Guideline Development Group.

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Our values

Inclusion

Working together with those with the lived experience of autism in all we do

Innovation

New solutions for long term challenges

Evidence

Guided by evidence-based research and peer review

Independence

Maintaining autonomy and integrity

Cooperation

Bringing benefits to our partners; capturing opportunities they cannot capture alone