Briefing for information

Enhancing assessment and management of neurodevelopmental conditions in children

Date due to MO:	4 February 2026	**Action required by:**	N/A
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To:	Hon Simeon Brown, Minister of Health		
Copy to:	Hon Matt Doocey, Minister for Mental Health		
Consulted:	Health New Zealand: ☒		
Proactive release:	This **title** is proposed by the Ministry of Health for proactive release: ☒		

Contact for telephone discussion

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Minister's office to complete:

☐ Noted	☐ Seen
☐ Needs change	☐ Withdrawn
☐ See Minister's Notes	☐ Overtaken by events

Comment:

Briefing for information

Enhancing assessment and management of neurodevelopmental conditions in children

Security level:	IN CONFIDENCE	**Date:**	03 February 2026
To:	Hon Simeon Brown, Minister of Health		

Purpose of report

1. This briefing provides further requested advice regarding how the health system can be enhanced for the assessment and management of neurodevelopmental conditions in children to help reduce demand and long wait times for paediatric medicine First Specialty Assessment (FSA).
2. This specifically includes advice about the roles of allied health professionals and primary care providers, as well as current and future initiatives within the education sector.

Summary

3. You recently received advice from both the Ministry of Health (the Ministry) and Health New Zealand (Health NZ) regarding paediatric specialist wait times [H2025068372 refers] and actions underway to reduce paediatric FSA waitlists [HNZ00094804 refers].
4. Children with neurodevelopmental conditions experience significant delays in accessing paediatric FSAs due to long waitlists and increased demand for specialist services.
5. There is potential to reduce delays to access by strengthening the roles of allied health professionals and other health professions across multiple service settings, enabling earlier intervention and more efficient use of specialist resources.
6. Current and proposed initiatives within the education sector aim to better support children with additional learning needs, including neurodevelopmental needs.
7. Next steps include:
    a. Continued progress through the New Zealand Child and Youth Clinical Networks to help standardise neurodevelopmental care and improve coordination across sectors.
    b. Health NZ will assess the effectiveness of the Heidi AI tool in the Northern region.
    c. The Ministry will monitor performance against health targets to enhance service access and outcomes.

Recommendations

We recommend you:

a) **Note** that there is agreement both within New Zealand and internationally that enhanced interprofessional models of care which utilise a broader range of health professionals are required to meet rising demand for assessment and support for neurodevelopmental conditions. **Yes/No**

b) **Note** that clinical networks focused on paediatric care within Health NZ are already focusing on improving access to assessment for neurodevelopmental conditions and are best placed to support and drive the standardisation of health services which support neurodevelopmental conditions. **Yes/No**

c) **Note** that there were significant investments in Learning Support Services within the education sector through Budget 2025. These investments will help improve access to support for children who have additional learning needs, including those with neurodevelopmental conditions. Improved coordination between health and education services remains critical to reducing demands on paediatric medicine specialists and ultimately improving access to support and better outcomes for neurodivergent children. **Yes/No**

Dr Martin Chadwick
Chief Allied Health Professions Officer
Strategy & Policy Group
Ministry of Health
Date: 03 February 2026

Hon Simeon Brwon
Minister of Health
Date:

Enhancing assessment and management of neurodevelopmental conditions in children

Background

8. Demand for paediatric assessment, diagnosis, and treatment has steadily grown in recent years. This is aligned with the rising prevalence of Attention-Deficit/Hyperactivity Disorder (ADHD), Autism Spectrum Disorder (ASD), and developmental delays, which comprise a significant proportion of referrals.

9. Meanwhile, system capacity has not kept pace with demand, leading to a significant increase in waitlist numbers and wait times, and subsequently affecting a child's development and ability to learn.

10. This trend is true in New Zealand as well as in many other countries, where demand for assessment and diagnosis of paediatric neurodevelopmental conditions is outstripping the availability of specialists to provide these services.[1]

11. s 9(2)(g)(i)

12. Although some support and early intervention services are available for neurodevelopmental issues, access is inconsistent. Often, a paediatrician's formal diagnosis may be required for access to wider support, including disability funding. This places further demand on paediatric medicine services.

Current settings

Cross-sector services for neurodiversity

13. Government agencies approach neurodiversity differently based on their specific roles, with common challenges including assessment delays, service gaps, workforce and funding pressures, and difficulties in identifying neurodiverse individuals in data systems.

14. While awareness of the need for neurodiversity-inclusive practices is growing, there is also interest in developing a more coordinated, cross-agency government response.

15. In April 2025, the Ministry completed a stocktake report at the request of Associate Minister of Health, Hon Matt Doocey, which summarised current activities underway across several government agencies to support neurodiversity. These agencies included:

    a. The Ministry

    b. Health NZ

[1] Smith, J. V., Menezes, M., Brunt, S., Pappagianopoulos, J., Sadikova, E., & O Mazurek, M. (2024). Understanding autism diagnosis in primary care: Rates of diagnosis from 2004 to 2019 and child age at diagnosis. *Autism*, *28*(10), 2637-2646. https://doi.org/10.1177/13623613241236112

c. Whaikaha – Ministry for Disabled People

d. Ministry of Education

e. Ministry of Social Development (including Disability Support Services which is a business unit within the Ministry of Social Development)

f. Oranga Tamariki

g. Accident Compensation Corporation

Ministry of Education (MoE) supports neurodivergent children and families via a range of learning supports

16. Learning support services are delivered by a range of practitioners, including early intervention teachers, speech language therapists, psychologists, Advisors on Deaf Children, and kaitakawaenga. [2]

17. Access to learning support services is not dependent on a diagnosis. MoE provides different levels of support (universal, targeted, and tailored) that are available based on the needs of learners. This is in the context of their whānau, kaiako, schools, kura, and early learning services. The MoE's learning supports are provided to meet identified learning support needs within an educational context. For some services, this is from birth up to 21 years of age.

18. Learning support specialist services are either provided by the MoE or contracted service providers. There can be regional variations in access, which are being addressed by Budget 2025 investments. Current variations include:

    a. regional differences in the coverage of Learning Support Coordinators (LSCs)

    b. urban-rural differences in access to Early Intervention Specialist Services, which provide learning support specialist and paraprofessional services (eg, Education Support Workers) to support children with high and complex learning needs

    c. regional differences in wait times to receive other supports, such as Behaviour Services and Communication Services. There are multiple factors which can lead to these wait times, including increased demand, recruitment, and retention issues.

19. Budget 2025 investments in learning support are designed to improve access to the right supports at the right time, including expanding the coverage of LSCs.

Disability Support Services (DSS) provide a range of supports and services to neurodiverse populations

20. Generally, people are eligible for DSS-funded support if they meet the criteria of a long-term intellectual, physical, or sensory disability that:

    a. arises before age 65, and

    b. which lasts longer than six months, and

    c. requires ongoing support to live independently.

[2] Kaitakawaenga work with Māori children, families, hapū and iwi, educators, and Learning Support colleagues to improve access to learning support services.

21. Currently, access to DSS requires a confirmed disability diagnosis, which could include a specific neurodiverse condition(s). This ensures public funding is directed toward individuals with a confirmed diagnosis.

22. Limitations of a diagnosis-based approach to support for children with neurodiversity include:

    a. high demand and limited capacity for specialist assessments, which can bottleneck the system

    b. some neurodiverse conditions, such as severe language disorders or Foetal Alcohol Spectrum Disorder (FASD), significantly impact a person's life but are not eligible for DSS – creating variation in support according to diagnosis

    c. some neurodiverse conditions emerge as children grow older and cannot be diagnosed at an early age. Some conditions, such as FASD, can never be fully diagnosed in a person, even if suspected.

Opportunities to enhance services for neurodevelopmental conditions

23. Representatives from education and health agencies agree there is opportunity and need for improved coordination of services across agencies to support children and young people with neurodevelopmental conditions and developmental delays. There are examples of effective coordination arrangements between MoE and Health NZ, and opportunities for further collaboration could be investigated.

Education settings

24. Budget 2025 allocated $645.8 million in operating funding and $100.9 million in capital funding to enhance learning support, addressing the increasing needs of children and young people. This investment will empower teachers and specialists to identify learning support requirements at an early stage and ensure that assistance is delivered promptly.[3]

25. Some of the key initiatives being implemented to improve access to learning support are the expansion to the Early Intervention Service (EIS) and provision of LSCs to all schools with students in Years One to Eight by 2028.

26. LSCs are experienced, registered teachers with a current full practising certificate. They support students to get the right help earlier, better support teachers to meet diverse learning needs, and make it easier for families to understand and access learning support at school.

27. The EIS is expanding from early childhood education to the end of Year One in schools and kura, supporting children with additional learning needs during their transition. This aims to provide smoother transitions and expands services to meet increased demand.

28. Recruitment is underway to reduce wait times and address regional variation in access to learning support. Through Budget 2025 there will ultimately be over 560 new learning support specialist staff over the next five years for the expanded EIS.

[3] https://web-assets.education.govt.nz/s3fs-public/2025-05/B25%20Factsheet%20-%20Learning%20Support.pdf?VersionId=vG36vIe5E85HxvmMsoSOp2Uj8FxtwhSv

Improving access through use of the broader health workforce

29. Many children who are referred to paediatric medicine for specialist assessment present with issues that could be improved by more timely access to allied health professionals. Conditions such as ASD, ADHD and Developmental Coordination Disorder can have significant overlap clinically. They also have the potential to be recognised and addressed prior to, or in addition to, referral to a paediatrician.

30. Other paediatric developmental issues, such as atypical bowel and bladder patterns, can benefit from early allied health intervention and often do not require direct paediatrician involvement, though paediatricians may remain part of the broader health team. Allied health professionals are also well equipped to address paediatric orthopaedic and pain conditions.

31. Allied health services can be accessed across both health and education settings. The planned investment in allied health professionals within education services as outlined in Budget 2025 will enable improved access to interprofessional allied health teams within education settings (eg, targeted increases in educational psychologist and speech-language therapist FTE). Establishing clearer and more consistent pathways between health and education will ensure that children and families requiring support for neurodevelopmental conditions can access assistance where and when it is most needed.

32. Other professions utilised in interprofessional models that have been implemented internationally include speech therapists, behavioural therapists, nurses and nurse practitioners, psychiatrists, social workers, physiotherapists, and occupational therapists.

33. Engagement with allied health and nursing paediatric experts in New Zealand has highlighted the potential for specific pathways whereby appropriately skilled allied health and nurse practitioner teams can act as the initial triaging entry point. If severity of presentation is identified, this can lead to an expedited paediatrician pathway and earlier intervention.

34. Once triaged, an allied health pathway would allow for a formative diagnosis to be decided and a treatment programme initiated – significantly reducing both FSA wait times and time to access treatment.

35. Health professionals based in primary care, such as general practitioners, nurse practitioners, and health improvement practitioners – who are often allied health professionals – also provide support for neurodivergent children and their families. These models are variable and dependent on local skills and resource. However, they provide alternative pathways to improve access to assessment and support for neurodevelopmental conditions and could be expanded.

36. In Australia, the United Kingdom, and the United States, implementation of these interprofessional assessment models have been associated with improved access and

shorter wait times and comparably high accuracy rates when compared to single-specialist models.[4] [5] [6]

Summary principles for improving access to support for neuro-developmental conditions

37. Our review of the international evidence and consultation with stakeholders across the health and education sectors has highlighted nine principles for improving access to child neurodevelopmental services:

    a. Alternative models of care outside traditional paediatric clinics are growing in some areas and expansion of such models is needed. These models should incorporate the broader health workforce, which is qualified and positioned across a variety of settings and sectors to improve access to assessment and support for neurodevelopmental conditions.

    b. It is important to ensure that in establishing new models of care, children are not simply being moved from one wait list to another.

    c. All health workforces should be enabled to work at the top of their scope, with development of neurodevelopmental assessment and intervention skills being supported across multiple professions.

    d. Efforts to reduce FSA wait times must also address follow-up care for neurodevelopmental issues to ensure ongoing support, and to prevent the bottleneck moving from FSA wait times to follow-up appointment wait times.

    e. Standardising clinical models of neurodevelopmental care across professional groups and districts can improve consistency and outcomes. New Zealand Child and Youth Clinical Networks and regional working groups are well positioned to coordinate and oversee standardisation of models across the health sector.

    f. Neurodevelopmental care should be accessible and flexible, allowing any point of entry for assessment and support, and should begin before formal diagnosis (where formal diagnosis is required) to reduce the impact of developmental difficulties.

    g. Improved coordination between services and sectors, especially health and education, is needed for effective support of neurodiversity.

    h. Priority should be given to children from groups with barriers to access, ensuring those most in need receive help.

    i. Lack of standardised outpatient data and coding for neurodevelopmental assessments complicates national tracking of wait lists, service delivery, and functional outcomes.

[4] https://assets.childrenscommissioner.gov.uk/wpuploads/2024/10/CCo-report-on-ND-waiting-times_final.pdf
[5] Williams-Arya, P., et al. (2019). Improving Access to Diagnostic Assessments for Autism Spectrum Disorder Using an Arena Model. *Journal of developmental and behavioral pediatrics*, 40(3): 161-169.
[6] Creen, J., Kennedy-Behr, A., Gee, K., Wilks, L., & Verdonck, M. (2020). Reducing time between referral and diagnosis in paediatric outpatient neurodevelopmental and behavioural clinics. *Journal of Paediatrics and Child Health*, *57*(1), 126-131. https://doi.org/10.1111/jpc.15156

Next steps

38. Health NZ will continue to report quarterly on the progress with reducing waiting lists and wait times for FSA and treatment. This will focus on the implementation of changes to paediatric medicine, ORL, and dental surgery by region.

39. s 9(2)(f)(iv)

40. The Ministry will continue to monitor the performance of Health NZ against health targets, including FSAs for paediatric medicine. Additionally, we will continue to monitor the contribution of the National Clinical Networks and their work to improve waitlists and access to services.

ENDS.