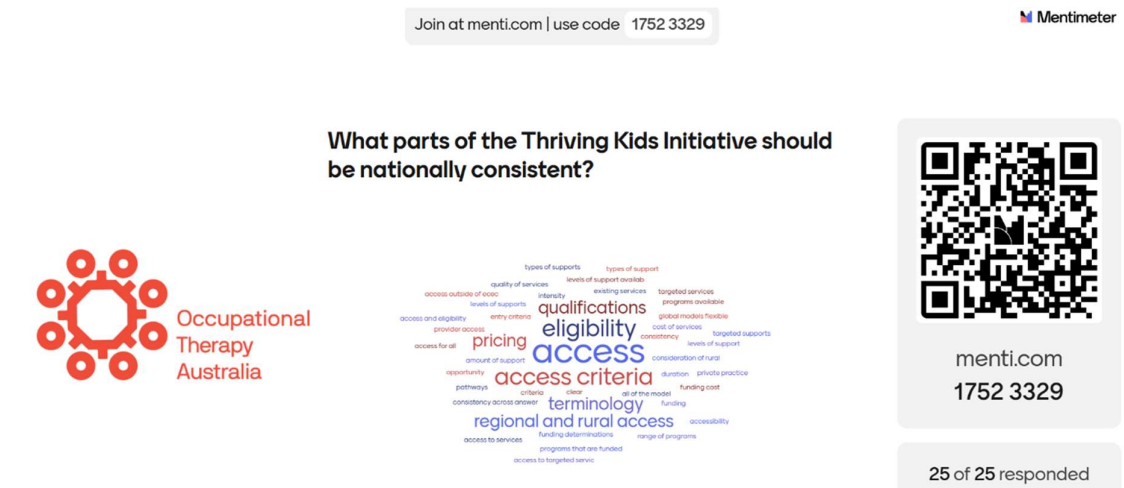
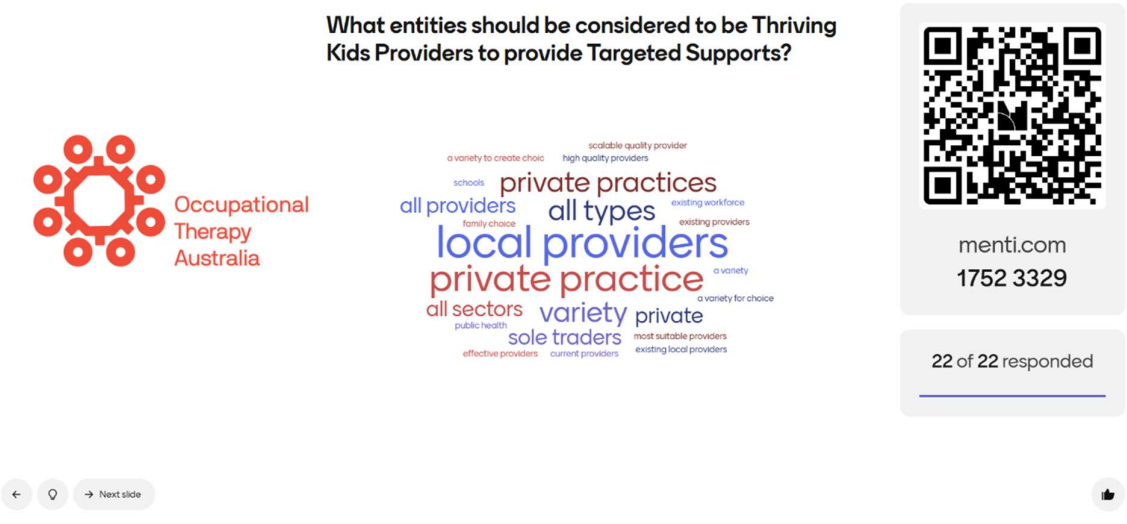
Appendix 1

Feedback from OTA Thriving Kids – Members Forums:







Join at menti.com with code 1752 3329

Mentimeter

What commissioning and funding models could work well in each State and Territory to enable flexibility?

Occupational Therapy Australia

simple tender process
open grant rounds
registered providers
funding for variability
eligible provider model
small tendering opps
capacity based
quality based
eligible provider list
equitable open tenders
meeting a grant criteria
use registered providers

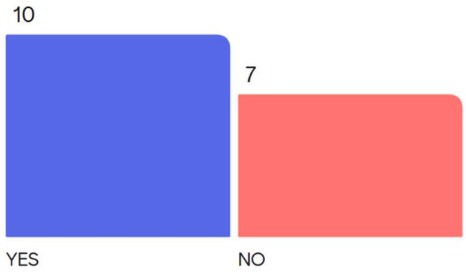
menti.com
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8 of 8 responded

Next slide

Mentimeter

Complex Neurodevelopmental disorder program under Medicare. Are OTs delivering services under this pathway?



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17 of 17 responded

End presentation



Support Effective & Emerging Models

OTA is calling on State & Territory Governments under Thriving Kids to support effective and emerging models: that demonstrate effective interventions for children with low to moderate support needs. During OTA consultations, occupational therapists highlighted effective programs operating across a range of settings. These are listed in Appendix 2.

Thriving Kids can and should build on and complement current government frameworks, strategies, reviews and policy documents. The newly endorsed and released National Best Practice Framework, should guide the design and delivery of future early childhood practice, services and supports.

There are several good international examples of early years support and wellbeing strategies and programs, that could be considered as providing best practice approaches:

- Partnering for Change (Canada) – Partnering for Change (PC4) was initially developed for occupational therapists working in the Ontario school system with children with motor coordination challenges. Since 2008, P4C has been developed, refined and continually evaluated through both qualitative and quantitative research involving key representatives from government, health care decision-makers, service provider organizations, clinicians, schools, and families working with the researchers.[1]

- The Child and Youth Strategy 2024-27 (NZ) – This Strategy has a focus on supporting children and their families and whānau in the first 2,000 days.[1]

- He Pikorua51 (NZ) – is the practice framework for Ministry and learning support practitioners. Both these key documents provide valuable pointers to working with indigenous communities to address early childhood support needs.[1]

- Getting it right for every child in Scotland – (GIRFEC) GIRFEC is both an approach and framework used by services across Scotland to improve and uphold the wellbeing of children and their families.[1]

- Eurlyaid. – The European Association on Early Childhood Intervention (EAECI). EAECI was implemented in Portugal under a legal framework that requires health, education and social services to collaborate in the design and delivery of best practice for young children with developmental concerns, delay or disability in the early years.[1]

- UNICEF Global Report on Children with Developmental Disabilities – This report proposes priority actions to accelerate individual-, family-, community-, and society-level changes to achieve inclusion and health equity. The report makes the case for greater investment and accountability to build inclusive and responsive multisectoral care systems for children and young people with developmental disabilities.[1]

- Head Start (US) – Head Start programs support children's growth from birth to age of five through services centered around early learning and development, health, and family well-being. It is a free program for families that meet low- income eligibility guidelines.[1]

OTA has received several examples from members about worthwhile case studies to consider, which include:

- School Readiness Program rolled out by the Victorian Department of Education - and delivered in South East Melbourne council areas through Monash Health during its early implementation stages. The program demonstrated strong potential as an effective model of care, particularly as relationships between allied health teams and kindergarten services strengthened over time and the program became more embedded each year.[1]

- Kids Care Clinics in Tasmania - The clinics provide community-based paediatric medical and short-term allied health services for vulnerable children facing access barriers, including multidisciplinary assessment and support focussed on health, development or behavioural needs. Clinics are held in natural environments and accessible locations like child and family centres and neighbourhood houses. No GP referral is required.[1]

- Sibling and Whole-Family Supports - Programs recognising that supporting the broader family system improves outcomes for children.
- Community Inclusion Programs - Programs delivered in real community settings where children build independence and participation skills.
- Early Childhood Educator Training – Occupational therapist led training programs that build educator capability to support inclusive practice in childcare and kindergarten settings.
- School Partnership Programs - Consultation and capacity-building models that support schools to implement inclusive practices and participation-focused strategies.
- Supported playgroups - Play-based developmental programs where allied health professionals support children and families in naturalistic settings.
- Inclusive practice training - Training and coaching for early childhood educators and schools to support participation of children with developmental differences.
- Integrated family-centred programs – Occupational therapist services are providing integrated family-centred intervention models, where support is delivered across multiple environments rather than through isolated therapy sessions.
- Peer and Community Based Participation Programs - Peer-based programs are an important model already operating across many allied health services and can act as a pathway to participation in community settings. These programs help children develop social participation, emotional regulation, confidence with peers, and problem-solving skills.
- Support Structures for a Contemporary Early Career Workforce - There are well-developed, formal workforce development models in place across the private paediatric allied health sector to support early-career clinicians entering paediatric practice. In the context of ongoing workforce shortages, the sector has, out of necessity, developed structured approaches to build the capability of early-career therapists more effectively and sustainably.
- Supporting early-career clinicians through structured development pathways - enables them to build the clinical confidence, capability, and professional judgement required to work effectively with young children and families in complex developmental contexts, while also strengthening long-term workforce retention. Importantly, many of these workforce support

systems are now well established and operational across the private allied health sector.

- PAIR Model - (Phased Approach to Including a Relational focus) helps establish the therapeutic alliance with parents, contracting around expectations, information gathering to determine whether starting with a focus on parent-child interactions will support goal attainment, and setting meaningful and collaborative goals. These shifts often make it easier to actively involve parents in sessions while sharing occupational therapist developmental knowledge in ways that truly fit for family routines and concerns.
- NEST Project - Through initiatives such as the NEST project, occupational therapists are working with GPs and families to improve early access to multidisciplinary/interdisciplinary screening, assessment and support. This program highlights how integrated, family-centred models can operate alongside education settings rather than within them.

In practice, many occupational therapy providers already deliver a diverse mix of intervention models, including peer and group programs, parent coaching, community-based supports, and capacity-building approaches that embed strategies within everyday environments. These models are intentionally designed to support participation in real-world settings and to extend the impact of therapy beyond the clinic.

Recognising and building on these existing, evidence-informed models of practice where they are working well, should be essential to the successful implementation of the Thriving Kids framework and to achieving the intended outcomes for children and families.

Occupational therapists play a key role in designing and facilitating these group interventions, ensuring activities and environments support meaningful participation. As children build confidence and skills in supported peer programs, this can transition to allied health assistants or disability support workers providing supported participation within community organisations and activities, with oversight from occupational therapists.

This stepped approach, from therapist-led peer programs to supported participation in real-world environments, aligns strongly with the Thriving Kids focus on building capacity and supporting children to participate where they live, learn, and play, but requires advanced systems and support structure to work effectively.

These models are underpinned by established practice frameworks and competency pathways, often aligned with the Occupational Therapy Australia Paediatric Capability Framework and the PRECI Best Practice Framework. They

typically include structured new graduate development programs, formal mentoring and supervision, and clearly defined competency progression.

OTA member feedback about commissioning includes:

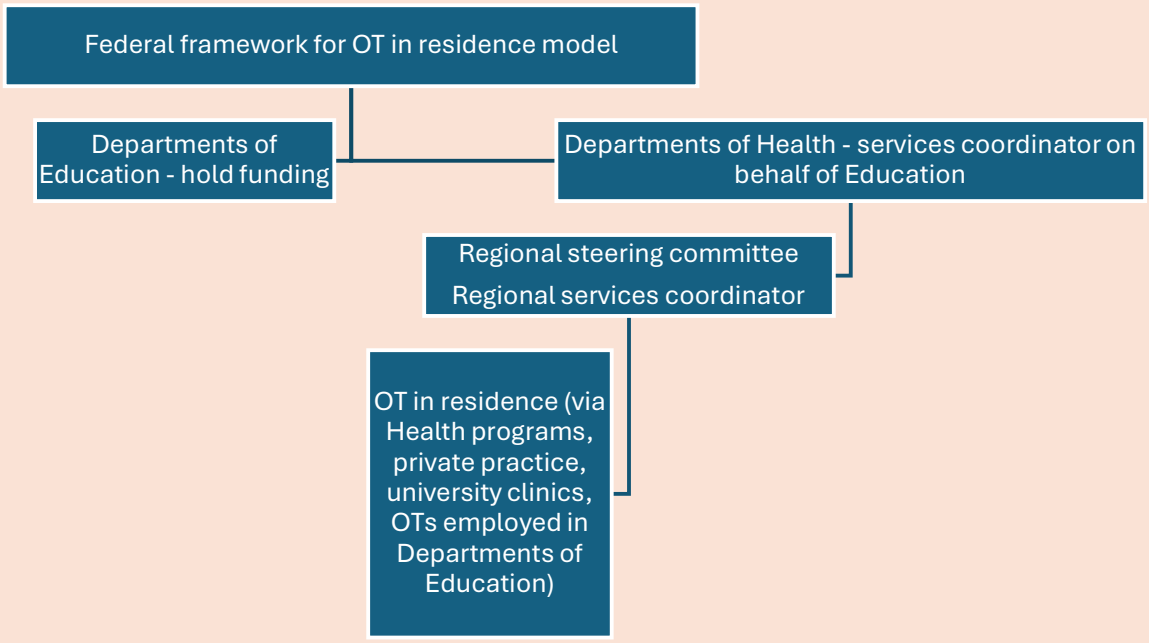
- "Funding and commissioning approaches should prioritise provider capability, workforce capacity, financial performance and quality of service delivery, rather than limiting eligibility based on organisational structure (e.g. NGO-only commissioning). Restricting commissioning to specific business structures risks significantly reducing the available workforce and excluding experienced providers who already have clinical governance systems, trained staff, and established service models ready to deliver at scale."
- "Across Australia, a significant proportion of paediatric occupational therapy services are delivered through small multidisciplinary practices and private allied health providers. These organisations already have:
    - trained paediatric workforce
    - established supervision structures specifically to support a contemporary, largely early career workforce
    - community partnerships and the trust and connection with local communities
    - service models operating in everyday environments such as homes, schools and community settings."
- "Collaborative consortium models (such as Yellow Ukulele) demonstrate how multiple smaller providers can work together to deliver coordinated services across regions, expanding workforce capacity without requiring large centralised organisations and creating cost-efficient delivery. This model allows for delivery of services at scale across regions while maintaining local expertise. Recognising and enabling a diverse provider ecosystem, including smaller allied health practices, possibly under a consortium model, alongside larger organisations, will help ensure the Thriving Kids system remains both financially sustainable and responsive to community needs."
- "Experience during COVID demonstrated the challenges that arise with different state-based rules. These differences can create confusion for families and providers and may limit access to services when people live close to jurisdictional boundaries. This issue is particularly significant in border communities. In more densely populated border regions, such as between New South Wales and Queensland, it is common for families to cross state borders regularly to access education, health, and therapy services that best meet their needs. Without careful coordination between

jurisdictions, there is a risk that children and families living in these areas may face barriers to accessing Thriving Kids supports, depending on where services are commissioned or funded. Clear national principles and mechanisms for cross-border service access and coordination will therefore be important to ensure equitable access for families regardless of where they live."

- "I'm concerned that in rural/regional areas, there are local occupational therapists embedded in local communities and they may be overlooked for provision of targeted supports in favour of larger metro providers (fly in fly out)."
- "While the states are going to be responsible for the design and implementation of TK at their local level, and need a degree of flexibility to align how services are delivered with their existing infrastructure and health services, all children and families, regardless of where they are, should go through a consistent assessment and eligibility process that ensures those with similar needs get similar levels of service. That assessment process begins when a child is referred into TK (e.g., by a maternal and child health nurse, GP, ECEC staff, or self-referred by the family). That will require a consistent assessment tool that is used by assessors in all states and territories, and work to ensure that those using the tool have the skills and training to use it."
- "The NDIA is also currently commissioning (or about to) the development of an assessment tool for under 16s that will be rolled out as of 1 July 2027 (one year later). Given this work is already underway, and the need to ensure we are delivering more consistency within and outside the NDIS, this work should be expanded to include the development of a TK tool. Consideration should be given to how children are assessed for, and access, not only TK, but also Education supports (which currently require a diagnosis) and the NDIS if they need more supports than TK can offer or age out of TK with ongoing needs."
- "The Commonwealth also has a crucial role in modelling and monitoring the impact of the introduction of TK for NDIS therapy providers. If, as is likely, an occupational therapy service currently delivering predominantly NDIS-funded EC supports but those shift to a state-funded program delivered by another provider, what does that do to the ongoing sustainability of that NDIS program, the employment of those staff, and the viability of that small to medium business. The impact of the shift to TK will profoundly impact employment and business viability, and access to services for participants. We cannot afford to go in blind to the impact of this change. Only the Commonwealth in conjunction with the NDIS can do this work."

OTA Member – Commissioning Idea

Commissioning framework recommendation: OT in residence in ECEC and schools



Key elements

- A nationally agreed, co-designed model for occupational therapist in residence service delivery (federal framework)
- State memoranda of understanding between Departments of Education and Departments of Health
- Education hold the funding for the occupational therapist in residence service
- Health funded to provide external service coordination on behalf Education
- State level steering committee with funded stakeholder representation including key community representatives
- Service coordination at state level – oversight regional coordinators, devolve decisions from state steering committee
- Service coordination at regional level – convene and coordinate local stakeholder group; appoint and oversight occupational therapist in residence including clinical governance

New South Wales approach

1. NSW Health community health should be included as potential occupational therapist in residence service providers. They already have clinical governance structures, child health programs and regional infrastructure. For example, Brighter Beginnings NSW Health provide 4-year-old health

screenings in partnership with DoE and could be expanded to an occupational therapist in residence role.

2. A service coordinator within each local health district sets up a regional steering committee governed by a memorandum of understanding (MOU) with their regional DoE office and local Aboriginal Medical Service and other local important stakeholders (eg school principals, family representatives).
3. Regional service coordinator oversites external service provider engagement if needed (e.g. university clinics, private practices) who apply through an expression of interest (EOI) to demonstrate their capacity.
4. Regional steering committee jointly decides which schools are prioritised, assesses external providers (if needed), and monitors delivery. Service coordinator is responsible for enacting the decisions of the committee.
5. Department of Education hold the money and bring school knowledge, Department of Health are service coordinator and bring expertise in clinical governance, stakeholders bring local context/ important ingredients of the model
6. The occupational therapist in residence EOI criteria must require genuine whole-school engagement across universal, and targeted supports and reflect the national framework
7. Codesign with schools needs to be a funded requirement within the occupational therapist in residence program
8. Families should be a valued part of any practice and involved in co-design at each stage of program development including any pilot schemes. For example, online or in person engagement with families when occupational therapist is visiting school, sharing of information about programs and ways to support at home, and engagement with family priorities. This point is particularly important for preschool and early primary years.
9. Clinical supervision and community of practice must also be funded within occupational therapist in residence contracts.
10. OTA could develop national professional standards for in-residence practice to guide the national framework that the local steering committees then use to assess and monitor providers. The 'in-residence practice' must have an evidence-based program that details activities that will be provided which work in step with DoE curriculum.

Here is a link for Brighter Beginnings explaining the preschool health checks in my LHD – this program is a Health/Education agreement and could potentially be expanded and adapted as per my previous email
https://www.nsw.gov.au/departments-and-agencies/hnelhd/services/child-and-family-health/brighter-beginnings

Also, most LHDs have a Child and Family Health Service directly delivered by LHD staff. LHDs have governance structures and clinical expertise. There is currently no sub-contracting of Child and Family Health as far as I am aware but there are other examples e.g. I believe in drug and alcohol and mental health the subcontracting model is more established (e.g. to NGOs). I think the clinical expertise and accountability available in health should be leveraged in any program under Thriving Kids.

States where occupational therapist is employed within DoE – the risk is the occupational therapist will be led by DoE priorities, not Thriving Kids priorities, so in these states a formal governance agreement between health, DoE and stakeholders could explicitly require the occupational therapist in DoE funded by TK work in the same way as all providers – same model requirements, outcome measurements etc. Employment stays with DoE but the clinical accountability sits with a joint group.

Another missing link is that NDIS operates independently of state health systems and is outside of what I have described for joint agreements. Perhaps NDIS should be represented in state and regional partnerships to address this structural gap between programs.

OTA Member – Case Study

Our team works in a consultative capacity with schools rather than providing direct therapy. This is as part of a multi-disciplinary team (including speech pathologists, psychologists and Teachers). The focus is on supporting participation and engagement in the school environment by working collaboratively with educators and school teams.

Our role typically includes:

- Observing students in their natural classroom and school environments
- Collaborating with teachers to understand barriers to participation
- Providing strategies and environmental adjustments to support regulation, engagement, and independence
- Supporting staff to embed strategies within everyday classroom routines
- Contributing to student support meetings and collaborative planning processes
- Delivering workshops and professional learning for school staff on topics such as sensory regulation, participation, and supporting student engagement
- Supporting schools to identify students who may have additional support needs and building staff knowledge about how to guide families toward

- appropriate pathways for further assessment and external supports where appropriate

The aim is to build capacity within the school so that supports can be implemented consistently in the learning environment, rather than relying on individual therapy sessions.

In practice this often involves supporting areas such as sensory regulation, classroom participation, transitions, self-care routines, and adapting environments or expectations to better support student engagement.