Occupational Therapy Australia

SELECT COMMITTEE ON FOUNDATIONAL AND DISABILITY SUPPORTS AVAILABLE FOR CHILDREN AND YOUNG PEOPLE IN NEW SOUTH WALES

April 2025



Introduction

Occupational Therapy Australia

OTA is the professional association and peak representative body for occupational therapists in Australia. There are more than 30,000 registered occupational therapists (OTs) working across the government, non-government, private and community sectors in Australia[1]. Occupational therapists are allied health professionals whose role is to enable their clients to engage in meaningful and productive activities.

Occupational therapy is a person-centred health profession concerned with promoting health and wellbeing through participation in occupation (activities). Occupational therapists achieve this by working with people with disability, including children with developmental delays and/or disability, to enhance their ability to engage in the occupations they want, need, or are expected to do; or by modifying the occupation or the environment to better support their occupational engagement. Occupational therapists provide services across both clinical and non-clinical settings across the lifespan and have a valuable role in supporting children with developmental disorders including physical, intellectual, chronic and/or progressive disability.

Occupational therapists work in a diverse range of settings including small, medium and large private practice, rehabilitation settings, paediatric services, and community services.

Overview of OTA Submission

OTA welcomes the opportunity to provide input to the NSW Government's approach to development of foundation supports for children and young people with disability, developmental delay or concerns.

OTA supports the recommendations of the NDIS Review to develop foundational supports for children with developmental delay or disability. Current early childhood practice under the NDIS has become too dependent on ongoing one-on-one therapy with children and young people, which is not generally considered to be best practice. Best practice involves a range of approaches including working with families and caregivers, working directly with the child, and parent and peer-based activities. Services may also lack professionals with the necessary skill, practice scope and experience to deliver early childhood interventions that meet the needs of children and families, and align with best practice. For those who are not able to access the NDIS, there are very limited options for support, leaving many families resorting to funding private therapies or not accessing any services at all.

It is clear that there is a need to recalibrate what and how governments fund services, based on the most up-to-date evidence and the input provided by children and families, professionals such as occupational therapists, and the broader early childhood sector. There is also a clear need to better define the skills and experience required for effective and safe early childhood practice and for governments to work with professional bodies to set minimum training and experiential requirements associated with different roles. This is also required for systems of Governance and quality controls to ensure maintenance of high quality services and supports.

[1] Occupational Therapy Board of Australia (Australian Health Practitioner Regulation Agency), 2024; https://www.occupationaltherapyboard.gov.au/News/Annual-report.aspx

OTA's submission will have a particular focus on

- Workforce issues (Term of Reference G)
- Best practice child development and early childhood intervention service models and programs (Term of Reference F)
- Access to early childhood intervention and supports (Term of Reference B)

Principles for Foundational Supports for Children and Young people

OTA proposes the following key principles, which underpin access to occupational therapy and other early childhood supports:

1. Occupational therapists and other allied health professionals must be involved in early identification and tiered, multidisciplinary assessments that support access to programs and supports, as well as the design and delivery of those supports.
2. New early childhood intervention service models should allow for a range of different employment and contracting models, in order to: account for the differences in how individual states and territories, as well as rural and regional localities, provide support in mainstream settings; enable the different foundational support models that are likely to be implemented; and, recognise the high proportion of the workforce with the necessary skills and experience now situated in private practice.
3. Coordination of services will be key. This requires a commitment to supporting collaboration between different providers and services working across different funding programs and settings. Funding must be available across all programs to support collaboration and coordination and must be flexible enough to accommodate for different combinations of service delivery; funding individual coordination roles will not create collaboration without enabling participation by all providers.
4. Barriers to accessibility of supports that exist in early childhood settings such as early childhood education and care settings, as well as schools, must be addressed. One approach may involve funding for a registration portal for all schools. This could streamline entry requirements to schools, thereby increasing the capacity of external occupational therapists to work with educators to develop and adapt settings and educational approaches, and provide specialist intervention and support.

OTA's recommendations for the delivery of Foundational Supports in NSW

OTA calls on the NSW government to accept and implement the following recommendations when developing foundational supports to ensure an effective, contemporary and evidence-based model is accessible to children and young people and their families:

Workforce

1. Develop a consistent foundational supports model for NSW drawing on the upcoming Best Practice Framework for Early Childhood Intervention currently being developed on behalf of the Commonwealth Department of Social Services.
2. Undertake additional work to establish the workforce skills, scope, and experience required to deliver early childhood supports and how these relate to evidence-based practice and the ability to successfully deliver different supports and services.

3. Recognise the role and expertise of occupational therapists in supporting mainstream, and foundational supports for children and young people with developmental delay and disability by establishing clearly defined roles for occupational therapists across future services models.
4. Fund targeted foundational supports for children and young people with developmental delay and disability at a level that reflects evidence and supports access to an appropriately skilled and trained workforce.
5. Undertake formal, ongoing engagement with occupational therapists and other key allied health and early childhood professions to design and implement commissioning models for mainstream and foundational supports, that enable participation by private sector allied health organisations of all sizes with demonstrated early childhood expertise.

Early Identification and Assessment (ToR F)

6. Develop a rigorous early identification and access process for early childhood supports that ensures streamlined and coordinated access to all appropriate mainstream and foundational supports, and NDIS supports if required.

Best practice child development and early childhood intervention service models (ToR B)

7. Lead Practitioner or key worker models should be recognised as a means of providing coordinated supports for children and families that is sometimes appropriate but may not best align with evidence and needs. This model of delivery should be an option available for practitioners and families to consider rather than a default approach.
8. Funding should be provided to employ occupational therapists in NSW public schools and preschools. Funding models and resourcing for these positions should support best practice, equal access and early intervention and prevention, and collaboration with practitioners outside of school settings.
9. As part of the development of more inclusive education settings, occupational therapy roles are introduced at all three tiers of the multi-tiered approach.

The Role of Occupational Therapy in Foundational Supports for Children

Occupational therapists work with children, their families and caregivers, and other members of multidisciplinary teams, to assess support needs, identify meaningful goals, and develop and deliver appropriate supports and services that promote independence, participation, social connection, and protect and sustain physical and mental health. They deliver highly skilled interventions including:

- functional capacity assessments, understanding the complex interplay between an individual's current skills and developmental challenges, task and environmental barriers, and access to resources and supports;
- Comprehensive developmental assessments identifying specific skill-based challenges as well as underlying developmental challenges impacting on developmental progress;

- Clinical reasoning for the development and implementation of targeted capacity building interventions where this is indicated within assessments;
- Assessment, prescription and implementation of task adaptation, assistive technology and/or environmental modifications;
- Comprehensive assessment of environmental, neurodevelopmental, relational, sensory and sensorimotor contributions to behaviour where this is deemed 'challenging or concerning';
- targeted, goal-focused capacity building, for example, activities of daily living (ADL), or ADL training with children with physical, neurological and behavioural concerns or disability.

The evidence review and consultation findings emerging from the development of the best practice framework[2] funded by Department of Social Services, heavily endorse and support occupational therapy practice, referring extensively to evidence and examples from occupational therapy practice and the principles that underpin the work of the profession. Occupational therapy practice is rooted in occupational models such as the Model of Human Occupation (MOHO)[3], the Person Environment Occupation (PEO)[4] model, and Canadian Model of Occupational Performance & Engagement (CMOP-E)[5].

These models emphasise the important need to understand the child, their environment (physical, sensory, social, cultural, relational environments), and their occupations, where occupations represent everyday activities and routines. Occupational therapists draw on these models to work with children and families to develop collaborative goals, develop contextualised interventions that fit into the child's everyday environments, and ensure that areas of developmental need are practiced and reinforced where they are needed most. This approach and focus is unique to occupational therapy, practice and training.

[2] All reports are available from: https://healthy-trajectories.com.au/eci-review/. Last access on April 3, 2025.
[3] Taylor, R. and Kielhofner, G. (2017). *Kielhofner's model of human occupation theory and application*. 5th ed. Philadelphia Wolters Kluwer
[4] Taylor, R. and Kielhofner, G. (2017). *Kielhofner's model of human occupation theory and application*. 5th ed. Philadelphia Wolters Kluwer
[5] Polatajko, H.J., Townsend, E.A. & Craik, J. 2007. Canadian Model of Occupational Performance and Engagement (CMOP-E). In Enabling Occupation II: Advancing an Occupational Therapy Vision of Health, Well-being, & Justice through Occupation. E.A. Townsend & H.J. Polatajko, Eds. Ottawa, ON: CAOT Publications ACE. 22-36.

Occupational Therapy Australia

OTA's Input to NSW Select Committee Consultation on Foundational Supports for Children and Young People

1. Workforce

The early childhood workforce consists of a broad range of professions with varying levels of training, scope, experience, and regulatory requirements. These qualifications range from Australian Qualifications Framework (AQF) 3 and 4 certificate or diploma level training for the majority of Early Childhood Education and Care workforce[6] to allied health professions such as occupational therapy with training at AQF 7 (bachelor's degree) or higher.

A key division in early childhood workforces is between those with clearly defined scopes, competencies, and discipline boundaries (a key foundation for transdisciplinary practice), as well as clearly defined capabilities and experiential or training requirements associated with paediatric and early childhood practice, and those without. Educators are a key workforce in early childhood but often have little specific training or experience in developmental delay and disability. A defined scope of practice, supported by defined competencies, is a key foundation for the ability to provide safe and effective early childhood interventions as well as understanding how to work effectively as part of a multidisciplinary team and when to refer to other workforces with particular skills and experience.

Parents and other caregivers are also recognised as an important informal workforce in early childhood but there is a need to recognise the different levels of capacity that parents and caregivers may have, including differences in home, financial and relationship contexts that may impact capacity. Parents also identify the importance of 'remaining parents in a role' rather than a need to overly focus on therapy, ensuring capacity to concurrently prioritise their own mental health and wellbeing needs. Parents have an important role in supporting developmental outcomes, but only when appropriately supported. OTs are uniquely trained to guide parent and caregivers' roles in supporting developmental outcomes, drawing on their understanding of not only the child's needs and capacity, but also that of the parent.

In developing frameworks to guide early childhood practice, governments, and those working on their behalf, have chosen not to reference specific workforces or professionals. Instead, guidance has focused on evidence-based tools, approaches, or models without reference to the professions, and associated skills and training that have contributed to the outcomes referenced in academic literature. This poses significant risks. The current work on the Best Practice Framework is an example of this, where principles and practices are described without referring to specific professional capabilities required to implement and use a tool in order to effect intended developmental outcomes. Effective early childhood practice requires that all workforces are subject to minimum standards and

[6] Shaping our Future: A ten-year strategy to ensure a sustainable, high-quality children's education and care workforce 2022–2031. From: https://www.acecqa.gov.au/sites/default/files/2021-10/ShapingOurFutureChildrensEducationandCareNationalWorkforceStrategy-September2021.pdf

focus on ongoing development of knowledge and expertise. These requirements apply particularly when early childhood professionals step into transdisciplinary roles such as key worker/ lead practitioner roles.

OTA strongly argues that there is a need to undertake additional work to define the skills and scope of practice required to provide safe and effective interventions in different areas of early childhood intervention. This work should cover the whole multidisciplinary team, and identify where role substitution can occur and where services should only be delivered by occupational therapists or allied health professionals.

In addition, there is a need to recognize that individual professions are likely to have minimum training and experience requirements associated with developing early childhood capabilities. Early childhood practice is just one component of the core training of many early childhood professions, particularly in relation to the more specific needs of children with developmental needs and disability.

OTA recognises that despite the rigorous nature of occupational therapy training, and that early childhood practice is within the scope of all occupational therapists, there is a need to support the profession in understanding and developing the skills and capabilities associated with high quality paediatric practice. OTA has invested significant resources into working with experts in paediatric early childhood practice to develop a capability framework that provides a basis for occupational therapists and those that may employ them to understand how capabilities develop with experience and training and how to support that development. OTA's Paediatric Capability Framework[7] was released in June 2024 to support evidence-based practice by occupational therapists. It outlines the skills and capabilities that practitioners will need to acquire for paediatric practice at different career stages. The Framework will be supported by the OTA Paediatric Endorsement program, which will assess and recognise the additional knowledge, skills and experience of occupational therapists focusing their scope of practice in this field. The endorsement program will set a high standard for the occupational therapy profession and provide an important signal to practitioners, funders, and users of occupational therapy services about what the profession considers the foundation for safe and effective practice. The profession considers the use of this framework an important foundation for early childhood practice.

Importantly, there is a clear need for other early childhood workforces to develop and maintain similar standards for their own professions when working in early childhood roles. To achieve this, NSW should work with professions to establish workforce quality standards and specific professional training requirements, including on-the-job support and supervision, as the foundation for key roles in early childhood models of foundational and other early childhood supports.

OTA notes that the evidence review undertaken to support the development of the Best Practice Framework specifically states that in order to support the '…implementation of evidence-based strategies and best practice, on-the-job support, coaching, and continuous learning strategies are needed.'[8] Similarly, we note the importance of funding that enables access to experienced clinicians as well as supporting the developmental needs of earlier

[7] https://otaus.com.au/resources/capability-framework-for-occupational-therapists-working-with-children-young-people-and-families

[8] From pages 54 and 55. https://healthy-trajectories.com.au/wp-content/uploads/2024/11/ECI-TAP-Deliverable-1-Desktop-Review-Full-Report-V1.0_Nov2024.pdf

career professionals in relation to supervision, support, and training. It is essential that this early career support is monitored and maintained through robust systems of quality control.

In relation to the frequency and intensity of service provision, there is clear evidence across different areas of developmental delay and disability that guide decisions about dosage. In particular OTA notes that occasional or one-off services do not align with current evidence and are unlikely to reduce demand on the NDIS.

In addition to these considerations, it is essential that the available workforce and expertise is recognised and incorporated into the models and funding arrangements for foundational supports.

A key principle in the design of new systems must be that new and expanded services will strengthen existing services and the effective working relationships that many communities have established. This should include prioritising access to in-person services in rural and remote communities and ensuring access to the expert early childhood workforce that is now predominantly in private practice. Failure to harness the expertise of the existing workforce may lead to knowledge loss and lower quality services.

Recommendations

1. **Develop a consistent foundational supports model for NSW drawing on the upcoming Best Practice Framework for Early Childhood Intervention currently being developed on behalf of the Commonwealth Department of Social Services.**
2. **Undertake additional work to establish the workforce skills, scope, and experience required to deliver early childhood supports and how these relate to evidence-based practice and the ability to successfully deliver different supports and services.**
3. **Recognise the role and expertise of occupational therapists in supporting mainstream, and foundational supports for children and young people with developmental delay and disability by establishing clearly defined roles for occupational therapists across future services models.**
4. **Fund targeted foundational supports for children and young people with developmental delay and disability at a level that reflects evidence and supports access to an appropriately skilled and trained workforce.**
5. **Undertake formal, ongoing engagement with occupational therapists and other key allied health and early childhood professions to design and implement commissioning models for mainstream and foundational supports, that enable participation by private sector allied health organisations of all sizes with demonstrated early childhood expertise.**

2. Early identification and assessment

Early identification has been clearly established in evidence and in policy reviews, frameworks and strategies as a foundation for maximising outcomes for children and families. Early identification of developmental delays is critical for optimising outcomes, as the brain exhibits heightened neuroplasticity during early childhood, making this period a crucial window for intervention.[9] For some areas of disability such as cerebral palsy, early identification has been shown as critical in order to allow interventions while the brain is most capable of adapting, improving outcomes across the lifespan.[10] Early intervention is also crucial to supporting relationship development and secure attachments between children and those around them, leading to better outcomes across a range of domains such as health, education, social cohesion and justice.[11]

The Early Childhood Targeted Action Plan, which forms part of the implementation of Australia's Disability Strategy 2021-2031 identified the need to enable 'early identification of disability or developmental concerns and develop clearer pathways and timely access to appropriate supports.'[12] The NDIS Review also acknowledged the need to improve capacity, recommending the establishment of universal health checks in mainstream services working with children including both health and education.

OTA notes the New South Wales Health and Department of Education partnership to deliver the Brighter Beginnings program in Early Childhood Education and Care (ECEC) settings across all NSW Health local health districts.[13] This program is providing a 4-year-old health and development screening program to check progress across a range of domains.

Despite positives with this program, there are several issues with the current approach. Senior early childhood practitioners have noted that, at least in some areas, checks are being carried out by early career staff with limited knowledge and experience, who are spending too little time with children and with ECEC staff, leading to potential misdiagnosis and over-referral.

OTA also notes that there are significant gaps in identification services for children aged between 18 months and 4 years due to the lack of immunisations, mandated developmental checks, and reductions in nurse check-ins. Workforce and access issues mean that there are also long waits and potentially significant expenses associated with trying to access paediatricians and allied health professionals.

At a policy level, the introduction of additional universal checks has value and should be commended. However, OTA notes that further consideration is needed about how to build a more comprehensive early identification and assessment approach with built-in pathways to mainstream and foundational supports that maximise access to

[9] Shonkoff, J. P., & Phillips, D. A. (Eds.). (2000). From neurons to neighborhoods: The science of early childhood development. National Academies Press.
[10] Morgan, C., Fahey, M., Roy, B., & Novak, I. (2018). Diagnosing cerebral palsy in full-term infants. Journal of Paediatrics and Child Health, 54(10), 1159-1164. https://doi.org/10.1111/jpc.14177.
[11] Cassidy J, Brett BE, Gross JT, Stern JA, Martin DR, Mohr JJ, Woodhouse SS. Circle of Security-Parenting: A randomized controlled trial in Head Start. Dev Psychopathol. 2017 May;29(2):651-673. doi: 10.1017/S0954579417000244. PMID: 28401843; PMCID: PMC5543687.
[12] https://www.disabilitygateway.gov.au/sites/default/files/documents/2024-11/4981-1-final-taps-report-fa3.pdf.
[13] https://www.wslhd.health.nsw.gov.au/Integrated-and-Community-Health/Child-Family-Health/brighter-beginnings.

evidence-based supports and minimise the need for formal diagnosis. A key focus for that work will need to be re-defining assessment by occupational therapists and other allied health professionals as a support for identifying and planning collaborative interventions for children and young people that maximise developmental and participatory outcomes rather than the basis for funding decisions. The connection between assessment and funding is one that has emerged largely from NDIS policy and is leading to a misunderstanding of the role of occupational therapists in assessments.

Having early identification and tools sit within universal services conducted by educators alone is likely to have poor outcomes, without consideration of these issues and ensuring access to skilled and qualified allied health professionals.

New approaches must carefully consider how ECEC and school staff can build capacity to identify potential concerns and have access to support from experienced occupational therapists and other allied health professionals who have the knowledge and skills to assess those children and young people and support decision-making about how to consider potential interventions. This requires specific skills and expertise. As the Desktop Review of Early Childhood Evidence notes:

> *'Improved screening is desirable both because it offers opportunities for intervention at earlier ages and because it can drive innovation and new knowledge. However, knowing how to intervene effectively with very young children is challenging – they are at their most developmentally plastic stage and their disabilities are still in a relatively undifferentiated state and have not yet evolved into a more distinct form for which proven interventions exist.'*[14]

OTA calls for early identification to be optimised at the earliest 'points of contact', within hospitals, mainstream maternal and child health services, GP settings, and ECEC settings. Alongside this, accessible and timely pathways to appropriately skilled and experienced professionals who can further discern multiple and nuanced indicators of potential developmental delay, differences or disability are required. This timely and comprehensive identification is the linchpin for commencement of Early Intervention within the critical developmental window. More formal assessment should involve a stepped and multidisciplinary model that supports access to funding and supports.

Recommendation

6. **Develop a rigorous early identification and access process for early childhood supports that ensures streamlined and coordinated access to all appropriate mainstream and foundational supports, and NDIS supports if required.**

[14] https://healthy-trajectories.com.au/wp-content/uploads/2024/11/ECI-TAP-Deliverable-1-Desktop-Review-Full-Report-V1.0_Nov2024.pdf.

3. Best practice child development and early childhood intervention service models

Collaborative practice

Collaborative, child- and family-centred practice is recognised as an important foundation for helping children and young people to thrive. Evidence shows that families benefit from professionals working together and empowering families to understand their child's developmental characteristics and their own role in supporting the child's development. Collaboration is seen as a key component of occupational therapy practice, naturally aligning with these roles.

Where parents or caregivers can act as active partners, parent coaching and relationship-focussed interventions are well-established as evidence-based, and a core component of occupational therapy practice. Occupational Performance Coaching (OPC) is an example of an approach commonly used by the profession that draws on both family- and occupation-centred approaches and a focus on collaboration and parent-initiated solution finding.[15,16] Evidence also shows that occupational therapists are skilled at drawing on other areas such as sensory integration as part of coaching approaches.[17,18] Caregiver roles, including those of educators or childcare staff in ECEC or school settings, should also be seen as a focus for capacity building through coaching, such as that provided by occupational therapists. There is evidence to show that coaching provided by occupational therapists to childcare providers enhances early childhood mental wellness by equipping them with essential skills in self-regulation, emotional regulation, and trauma-informed interactions.[19] This type of approach is best supported by occupational therapy roles in mainstream education settings.

OTA was pleased to see that documentation from DSS outlining a potential targeted foundational supports model noted the potential need for extra support where children have concerns across a number of developmental areas.[20] We welcomed the recognition that this role would involve a focus on the family, including capacity building and emotional support to facilitate parental and caregiver wellbeing and subsequently influence positive developmental outcomes for the child.

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[15] Graham, F., Rodger, S., & Ziviani, J. (2014). Coaching parents to enable children's participation: An approach for working with parents and their children. Australian Occupational Therapy Journal, 61(2), 145-152.
[16] Gagnon, M., Couture, M., Hui, C., Obradovic, N., Camden, C., Lemay, L., & Jasmin, E. (2022). Occupational Performance Coaching for Significant Adults of Preschoolers: Multiple Case Studies. Early Childhood Education Journal. https://doi.org/10.1007/s10643-022-01423-1
[17] Bundy, A., & Bulkeley, K. (2020). Using Sensory Integration Theory in Coaching. In A. Bundy & S. Lane (Eds.), *Sensory Integration: Theory and Practice* (3rd ed.). F.A. Davis Company
[18] Rush, D. D., & Shelden, M. L. L. (2020). The Early Childhood Coaching Handbook (Second Edition ed.). Paul H Brookes Publishing.
[19] Shetzler, C. L. (2024). Occupational therapy coaching of the childcare provider in early childhood mental wellness (Order No. 30819365). Available from ProQuest One Academic. (2910094852). Retrieved from https://www.proquest.com/dissertations-theses/occupational-therapy-coaching-childcare-provider/docview/2910094852/se-2
[20] Foundational supports for children with developmental concerns, delay and/or disability and their families, carers and kin. https://engage.dss.gov.au/wp-content/uploads/2024/10/Foundational-Supports-Consultation-Paper.pdf.

However, we are concerned about the lack of specificity about the qualifications of that workforce and its interaction with the essential component of credentials within complex developmental science, relationship-based approaches, and facilitating reflective practice and parent engagement. The specific components of the broader multidisciplinary allied health team that must be involved when a child requires support across multiple developmental domains, is also not defined and prioritised. There is a clear need for better understanding of how key worker and other models operate and the skills and experience that underpin those roles in order to effect desired early childhood intervention outcomes.

Key Worker Models

Key worker models, based around concepts of transdisciplinary practice and collaboration, are often classed as best practice and may be seen as a default method of providing early childhood services. However, there is evidence to suggest that current models may not align with the evidence for the approach due to poor understanding of when and how to implement key worker models. Key worker models have also been implemented indiscriminately, with a lack of nuanced decision making. Further, staff may lack the necessary credentials and professional characteristics to work effectively in transdisciplinary key worker or equivalent roles.

The Desktop Review of Best Practice in Early Childhood Intervention noted the scarcity of vigorous research.[21] The report states,

> *'none of the included RCTs examined outcomes of collaborative teamwork, or specific team-based approaches (e.g., interdisciplinary, key worker, team-around-the-child models), and this remains a gap in the evidence… while collaboration and team-based approaches to supporting children and families are understood to be an element of best practice, the success of implementation and outcomes of specific models of collaboration did not appear to be a key focus of the included studies and could be an area which requires further examination'.*

In some areas of early childhood intervention, such as for children with brain injuries and cerebral palsy, there is no evidence supporting key worker models. Instead, there is very strong evidence from randomised control trials for specialised occupational therapy.[22,23] Prioritising transdisciplinary approaches may be a response to budget constraints, as in the original UCP National Collaborative Infant Project, where the approach was a way for understaffed and under-funded teams to pool their knowledge and skills to provide "better, more cost-effective services", rather than reflecting best practice, or being a preferred a model.

Transdisciplinary key workers have reported workplace issues due to the complex and high family needs they encounter, including having inadequate time to fully support each family, the lack of a clearly defined role and its

[21] https://www.preci.org.au/wp-content/uploads/2024/12/ECI-TAP-Deliverable-1-Desktop-Review-Full-Report-V1.0_Nov2024.pdf

[22] Novak I, Honan I. Effectiveness of paediatric occupational therapy for children with disabilities: A systematic review. Aust Occup Ther J. 2019 Jun;66(3):258-273. doi: 10.1111/1440-1630.12573. Epub 2019 Apr 10. PMID: 30968419; PMCID: PMC6850210. https://pubmed.ncbi.nlm.nih.gov/30968419/

[23] Novak I, McIntyre S, Morgan C, Campbell L, Dark L, Morton N, Stumbles E, Wilson SA, Goldsmith S. A systematic review of interventions for children with cerebral palsy: state of the evidence. Dev Med Child Neurol. 2013 Oct;55(10):885-910. doi: 10.1111/dmcn.12246. Epub 2013 Aug 21. PMID: 23962350.

boundaries, recognised gaps in knowledge and skills, and the systemic lack of information and accessibility to other support services for families.[24]

Evidence also suggest that those working in key worker roles may not be confident working outside of their professional boundaries.[25] Where transdisciplinary practice works more effectively, it is typically associated with a strong understanding of the worker's own discipline, support from peers in other disciplines, and an alignment between the worker's disciplinary background and the child's needs.[26] Key workers should always be working in close collaboration with the relevant professions and have extensive experience working alongside other professions.

OTA suggests that any models utilising a 'key worker' should adopt a Lead Practitioner approach, where it is implied that someone within the existing team around the child becomes a Lead Practitioner as opposed to an additional and identified specific team member or person acting alone. Of prime importance is that key worker or lead practitioner models must involve collaborating through regular case reviews and discussion about the effectiveness of interventions, progress in achieving outcomes, and changes in child or family needs. Lead practitioner terminology better recognises the skillset and background required, such as an appropriate allied health qualification, to provide transdisciplinary support.

Recommendation

7. **Lead Practitioner or key worker models should be recognised as a means of providing coordinated supports for children and families that is sometimes appropriate but may not best align with evidence and needs. This model of delivery should be an option available for practitioners and families to consider rather than a default approach.**

Natural and everyday settings

Natural (also referred to as everyday settings) have been well-established as critical in children and young people's lives. Where children and young people experience developmental delay or disability, natural and everyday settings are rightly recognised as the areas in which outcomes must be achieved. Those settings can also be an important focus for interventions, both delivered by early childhood professionals such as occupational therapists, parents, families and caregivers.

OTA and occupational therapists have always recognised the importance of natural settings. Distributed practice models are commonly used by occupational therapists, which draw on methods to embed supports within natural

[24] Understanding key worker experiences at an Australian Early Childhood Intervention Service' 2020. Young D, Gibbs L, Gilson KM, Williams K, Reddihough D, Tracy J, Tonmukayakul U, Carter R. Understanding key worker experiences at an Australian Early Childhood Intervention Service. Health Soc Care Community. 2021 Nov;29(6):e269-e278. doi: 10.1111/hsc.13350. Epub 2021 Mar 24. PMID: 33761179

[25] Fitzmaurice, E., Richmond, J. E., & Wittorf, M. (2017). An investigation of service providers' understanding, perspectives and implementations of the transdisciplinary model in early intervention settings for children with disabilities. The Internet Journal of Allied Health Sciences
and Practice, 15, 5. Available from: http://nsuwo rks.nova.edu/ijahsp

[26] Understanding key worker experiences at an Australian Early Childhood Intervention Service' 2020. *Young D, Gibbs L, Gilson KM, Williams K, Reddihough D, Tracy J, Tonmukayakul U, Carter R.*

settings 'between' direct consultations in order to mobilise capacity building potential and effect change. Regardless of whether initial work may be undertaken in clinical settings, occupational therapists work with families to assess natural settings and provide support on ways to embed capacity building approaches into daily routines, relationship and environments. This includes but is not limited to consideration of familial, relational and cultural factors. It will also be essential to undertake observation and assessment of the environment and task components in order to develop and implement environmental modifications, task adaptations, and use of specialised equipment and everyday items. This will enable opportunities for engagement and participation, facilitating developmental outcomes in those natural settings.

In practice, there are a range of challenges associated with natural settings and there are real risks in mandating that services are delivered in natural rather than clinical settings as the DSS consultation paper on targeted foundational supports has recommended.[27] What may be considered natural settings, e.g., homes, schools or ECEC settings, may in practice be separate rooms where the therapist engages with the child in a setting that is less effectively set up to optimise the comfort of the child or their needs than a clinical setting. Education settings are for education and having effective targeted intervention occur in those settings has the unintended impact of disruption to the core business of ECEC and schools. Some home environments may be unsafe, impoverished, or present persistent barriers for the child or young person to meaningfully engage in the early intervention approaches, which they have a right to access as frequently as required and with access to adequate resources.

For children with physical disabilities such as cerebral palsy, clinicians need access to specialist equipment such as specialised seating, tables, toys, and standardised assessment kits that cannot easily be made available in home or school settings, especially in the early stages of therapy. If cost effectiveness is also a factor, often being in a controlled environment to trial strategies and tools and then being able to generalise these new skills to a natural setting is a more efficient and cost-effective model, particularly if time limited supports are to be provided. Many standardised developmental assessments require training, precise application and resources, and using these in some environments can compromise standardisation of assessment criteria.

A focus on natural settings also needs to consider the impacts of travel time associated with those settings on costs and service availability. In a metropolitan environment, in-clinic capacity might be six to seven children per day compared to three when services are provided in-home, with commensurate increases in costs for the family. This is exacerbated further when looking at rural and remote settings where a combination of clinic settings (requiring the family to travel), and tele-support, can provide the most effective outcomes and increase options for families. Decision making tools are required to ensure the Early Intervention provider, in partnership with the child and family, can use their clinical reasoning and skills to determine the most meaningful setting for various aspects of support and intervention, which may vary and alternate depending on need and broader contextual factors. If this is rigidly prescribed, service providers will be unable to effectively deliver child- and family-centred supports, as it also removes the family's contribution to decision making.

In addition, parents are often in full time employment which can limit opportunities for practitioners to engage in vital face-to-face parent collaboration. Providing essential supports in limited prescribed settings (e.g. only' natural settings) and disregarding the need to flexibly engage with the family in ways that are accessible to them, limits the ability of the practitioner to holistically implement the specific supports required to achieve positive developmental outcomes.

[27] https://engage.dss.gov.au/wp-content/uploads/2024/10/Foundational-Supports-Consultation-Paper.pdf

Access to Supports in Educational Settings

Occupational therapists play an important role in supporting the delivery of inclusive education, by working with children and young people of all abilities to support participation and providing collaborative capacity building and knowledge sharing with Educators to facilitate inclusion on a broader scale. Occupational therapists also provide mental health assessment and intervention for students with experience of trauma, anxiety, depression, and other psychological difficulties. Occupational therapists can add significant value in school-based settings including:

- Early intervention of students experiencing psychosocial difficulties or developmental concerns;
- Sharing knowledge of developmental frameworks for understanding developmental differences and meaningful approaches to facilitate participation in play and learning settings;
- Promoting social and emotional wellbeing and capacity building for developmental progress and learning;
- Strengthening accommodations and adaptations at a class and whole site level in collaboration with educators to facilitate participation and engagement for all children;
- Planning and implementation of nuanced and targeted supports and interventions for children with highly complex and specific needs requiring greater differentiation and individualised learning plans.

OTA notes that a number of reviews into the support of students with disability in schools, including The Disability Royal Commission[28], indicate there is a gap between research in the field and practice in schools. This suggests a need for the implementation of best practice approaches to be more rigorously planned and facilitated.

The Audit Office of New South Wales conducted an audit on the NSW Department of Education's support of students with disability in NSW public schools. Its report on Supporting students with disability was released in September 2024[29], and found that the Department of Education provided guidance and support on reasonable adjustments to support students, however:

- Reasonable adjustments usually relied on the views and capabilities of individual teachers;
- Information provided to families and disability advocates about the adjustments made for students by schools was often vague;
- The department did not independently verify evidence of adjustments provided to students or have a mechanism to check that adjustments made by schools were reasonable and effective.

The Audit Office also assessed student access to targeted supports,[30] which are available when an eligible student with disability cannot be supported from within the school's resources, and found:

- The process for providing targeted supports is convoluted and administratively burdensome for schools;

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[28] Australian Senate Standing Committee on Education and Employment, *Access to real learning: the impact of policy, funding and culture on students with disability, Final report*, January 2016, p. 67

[29] Audit Office of NSW, *Support students with disability*, September 2024, section 3.2

[30] These include integration funding support for students with diagnosed disability and moderate to high supports needs in mainstream classes, support classes in mainstream settings or Schools for Specific Purposes, distance education and support from specialist itinerant teachers.

- Integration funding support provided for students in mainstream classes does not clearly reflect functional needs;
- Support classes are not planned or distributed equally to reduce supply constraints and unmet need.[31]

OTA is particularly concerned that the role of OT in educational settings is not clearly recognised or embraced in all states and territories. NSW has lagged behind most other states when it comes to the promotion and acceptance of OTs within the school system. Student and educator access to occupational therapists in New South Wales schools has been extremely limited and inconsistent.

NSW occupational therapists support the NSW Audit Office's findings and are reporting increasing difficulties accessing schools to provide school-based services with many school principals declining access. Further if OTs are granted access to schools, they are often finding they are not welcomed into the classroom and there is a lack of collaboration between teachers and OTs.

There are, however, examples of where OTs are working in schools collaboratively with principals, teachers, students and families with positive outcomes reported. Unfortunately, too often these opportunities are school specific and usually rely heavily on the school principal seeing the value of OT in the school setting and choosing to use their Resource Allocation Model (RAM) funding to engage occupational therapists in the school setting. The use of this RAM funding for occupational therapists means that the principal has to make the difficult decision to not spend the RAM funding on other enhancements or resources for the school.

The establishment of the Specialist Allied Health and Behaviour Support Provider Scheme by the NSW Department of Education in June 2020 was meant to address allied health access to schools. This has to some extent streamlined the process for checking allied health practitioner requirements such as working-with-children check and insurance prior to accessing a school. However, the Scheme has not addressed the acceptance by schools to have occupational therapists visit or the funding of occupational therapists to provide services in schools.

In some jurisdictions OTs have been employed by the Education Department and have been shown to provide effective support to students and collaboration with external services and practitioners. This model should be considered for implementation in NSW to facilitate the provision of supports to the student and school community and streamline the contribution of external allied health professionals.

OTA suggests that funding models for OTs in educational settings be developed with consideration of the following:

- **Clients**: All school aged children that would benefit from these services should have access, not just those with a diagnosed disability or mental health condition. The full-time equivalent benchmark should be calculated according to the size and demographics of each educational setting.
- **Recruitment difficulties**: Telehealth and outreach models should be made available to address recruitment difficulties in rural, regional, and remote settings.
- **Interventions:** Interventions should range across multiple levels; from one-on-one assessments and interventions to school wide strategies and capacity building of teaching staff.
- **Multi-disciplinary practice**: As is best practice, collaboration between occupational therapists, other health professionals, teaching staff, parents, families, and students should be enabled.

[31] Audit Office of NSW, *Support students with disability*, September 2024, section 3.5

- **Collaboration**: The importance of supporting collaboration between those supporting a child within an ECEC or school setting, and those outside of the school setting, is recognised and supported.

OTA recognizes that in some areas, access to OT for in-house support and services may be more difficult, for example in rural and remote areas with smaller school and class sizes and greater distances between schools. Existing models drawing on provider panels or pre-approved private practitioners have been shown to be effective as a means of drawing on local workforces to provide multi-disciplinary support to students and parents, as well as teachers and school communities.

Recommendation

8. **Funding should be provided to employ occupational therapists in NSW public schools and preschools. Funding models and resourcing for these positions should support best practice, equal access and early intervention and prevention, and collaboration with practitioners outside of school settings.**

Multi-tiered approaches

Multi-tiered approaches are well-established in early childhood settings as a means of promoting inclusion and participation. While the number of tiers can vary, a common approach involves three tiers of support:

- **Tier 1** - universal supports.
- **Tier 2** - targeted supports. For example, this may include professional learning for school-based staff, funding education and other workforces to support inclusive education, as well as supporting purchase of resources and equipment.
- **Tier 3** - specialised and/or intensive supports. These are available where a student has severe functional capacity limitations and where extensive adjustments are necessary to provide specialised approaches such as differentiated teaching and support to manage behaviour regulation and safety.

Occupational therapists already work in many mainstream settings at all three tiers of support though approaches vary widely across Australian states and territories. Lack of consistency across the states and territories, and within different programs, can impact the availability of supports for inclusion as well as the role of occupational therapists in supporting early identification and assessment. The most effective approaches allow occupational therapists to work across multiple tiers, allowing them to build capacity and effect broader changes while also working to address the individual needs of a child and their educators and caregivers.

OTA proposes that as part of the development of more inclusive education settings, occupational therapy roles are introduced at all three tiers. We note that there is likely to be overlap between tier 3 supports and those funded either as targeted foundational supports or as NDIS supports and consideration is required to address barriers to collaborative and inclusive multidisciplinary practice in mainstream education settings.

OTA proposes a multi-tiered approach that supports access to occupational therapy:

- Tier 1: Employment and contracting of occupational therapists by departments of education to provide ongoing access within schools. The focus areas for these practitioners would include:
    a. Conduct school access audits, which may consider environmental sensory demands (e.g. lighting, noise, classroom set up) and physical barriers (e.g. stairs, furniture selection, playground equipment).
    b. Design and deliver professional development for staff on topics such as emotional and arousal regulation, sensory processing differences, motor skill development, continence and toileting.
    c. Contribute to whole school reviews of student inclusion policy.

- Tier 2: Employment and contracting of occupational therapists by ECEC providers and schools to support occupational therapists to:
    a. Work with children and educators to modify environments and adapt tasks to support the participation of all children in school environments.
    b. Develop and deliver group programs to address specific skill areas such as fine motor programs, handwriting intervention, regulation awareness, or social skills programs.
    c. Deliver evidence-based intervention programs for OTs to provide services in and around the school environment (e.g. tender to run a program through local kindergarten, etc.).
    d. Support transition to new schools and classrooms through environmental assessments and recommendations to meet individual need.
    e. Design individual student programs to support development in an identified area of need (e.g. to improve recording of schoolwork or to increase independence in organising belongings).
    f. Identify and recommend environmental modifications and/or accommodations such as universal access, assistive technology, and specialist equipment to meet individual student needs.
    g. Support participation in school excursions and camps by collaboratively planning with the student, school and family.

In addition, at the Tier 1 level, employment or contracting of occupational therapists by departments of health or social services to provide support to mainstream services such as those delivered by councils for children and young people would enable:

a. Assessment and adaptation of environments to make them more accessible to children and young people with developmental delay or disability.
b. Adaptation of tasks and activities offered by mainstream library or other programs for children with developmental delay or disability in conjunction with program staff.

This model should not be based on the employment arrangement or location of occupational therapists, noting that access to a skilled and experienced workforce with local experience and engagement will be best supported by the involvement of local providers, regardless of service size or sector. This can be realised through contracting or commissioning programs, provider panels, and other similar approaches.

Recommendation

9. As part of the development of more inclusive education settings, occupational therapy roles are introduced at all three tiers of the multi-tiered approach.

Conclusion

OTA welcomes the opportunity to provide input to the NSW Government's approach to development of foundation supports for children and young people with disability, developmental delay or concerns.

We look forward to liaising with the Select Committee on Foundational and Disability Supports Available for Children and Young People in New South Waleson, and contributing further to its deliberations, and to working with the NSW Government on the development of Foundational Supports for children and young people.

If you would like to discuss our submission, please contact OTA on policy@otaus.com.au



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