1. Does the new vision reflect what we all want for children and families?

Partially but missing key components/needs development. The Vision is positive but missing key elements including but not limited to:
Must embed early access and remove bottlenecks/referral barriers.
Supports must stay individualised and centralise families, not generic programs.
Codesign must be meaningful (Disabled people, First Nations, neurodivergent adults, current full range of ECI professionals - sole traders, medium business, large business, NGOs not for profits).

2. Are the two main outcomes what we should be working towards for children and families? Why/Why not? - Outcome 1: Parents and caregivers are empowered to raise healthy, resilient children - Outcome 2: Children are supported to grow into healthy, resilient adults.

Outcome 1 (Parent empowerment):

Yes but with careful consideration of what empowerment means in terms of best practice. This also requires timely access to specialists and potentially choice of provider based on scope of practice. This means choice of provider based on the goals of their child.

Needs culturally safe, neuro-affirming, practical support with a focus on parent coaching and capacity building. Generic programs do not support child and family centred outcomes which a shown to be best practice.

3. Will a single national program provide more flexibility for your organisation?

Yes — if flexible (i.e. evidence-based occupational therapy services), not uniform programs that don't cater to the needs and functional goals of individual child/family.
Must not exclude small or regional private practices who often offer niche areas of support or solely support a particular region or community (e.g. AAC, intellectual disability, equipment prescription).
Must avoid mandatory hubs or pre-selected programs.
Must allow multidisciplinary delivery that can be across different services or practices in order to address the child's goals appropriately.

4. Does the service or activity you deliver fit within one of the three funding streams? Do these streams reflect what children and families in your community need now – and what they might need in the future?

Broadly yes but will need to be strengthened.
Must fund clinic based support, home visiting, outreach, collaboration and care team planning, travel when required as part of intervention, Assistive technology.
Mixed delivery modes must be allowed.
Children with mild/moderate needs are at risk of being excluded despite often experiencing subtle but significant functional impacts that could make large gains quickly if accommodated.
All Allied health disciplines must be recognised (including Dietetics).

5. Are there other changes we could make to the program to help your organisation or community overcome current challenges?

Self-referral, no wrong door principals in place.
Remove GP-only gateways as this is prohibitive for so many families.
Fund collaboration and interprofessional practice.
Reduce admin burden for families and providers.
Invest in private practice workforce sustainability.
Support digital access while ensuring quality and safety.

6. Do you agree that the four priorities listed on Page 4 are right areas for investment to improve outcomes for children and families?

Yes — but need refinements.
Wellbeing must include physical, sensory, communication & emotional safety.
Co-location not not mean collaboration — requires time, structures, supervision to ensure carefully selected practitioners are able to collaborate with educators and the family to care plan and all work together towards common child-lead and family centred goals that optimise participation and functional outcomes.
“Greatest need” must consider transport and proximity, disengaged families, families with complex needs, cultural safety.
First Nations supports must be ACCO-led with real governance.

7. Are there any other priorities or issues you think the department should be focusing on?

True early support + prevention of future need is the priority.
Avoid workforce downgrading/substitution in the desire to streamline.
Trauma-informed, neuro-affirming practice should be front and centre.
Support neurodivergent parents + intergenerational needs.
Protect rural/regional private providers.

8. Do the proposed focus areas – like supporting families at risk of child protection involvement and young parents match the needs or priorities of your service?

Yes — but access must stay open.
Must fund outreach + home visiting and or telehealth.
Cannot depend on attendance schools/GPs.

9. Are there other groups in your community, or different approaches, that you think the department should consider to better support family wellbeing?

CALD families, LGBTQIA+ parents, neurodivergent parents
Kinship carers/grandparents
Newly arrived/refugee families
Children with complex health needs
Approaches: peer-led groups, cultural programs, soft-entry playgroups, ECI-supported parent groups with options for referral to more specialise and family centred supports.

10. What are other effective ways, beyond co-location, that you've seen work well to connect and coordinate services for families?

Shared care models or areas of scope e.g. working alongside speech clinics with a special interest in AAC when we are supporting children with complex support, learning and/or communication needs.
Funded case and care team meetings to plan effectively.
Digital warm handover systems.
Local interagency groups.
Clear collaborative protocols.

11. What would you highlight in a grant application to demonstrate a service is connected to the community it serves? What should applicants be assessed on?

Local community connection
Clear scope of practice that is clear for families engaging
PRECI Best Practice integration within service
Cultural safety
Goals and outcomes that are family and child centred
Workforce development & supervision
Collaboration evidence
Accessibility & flexibility of service delivery

12. Beyond locational disadvantage, what other factors should the department consider to make sure funding reflects the needs of communities?

Transport
Workforce shortages
Cultural safety needs
Digital exclusion
Developmental vulnerability rates
Families not attending ECEC/school

13. What's the best way for organisations to show in grant applications, that their service is genuinely meeting the needs of the community?

Consultation evidence
Lived experience involvement/survey results/consulting with families already engaged.
Partnerships with ACCOs + ECI providers
Demonstrated unmet need/waitlist data
Flexible, family-centred practice examples

14. How could the grant process be designed to support and increase the number of ACCOs delivering services to children and families?

Tailored grant support
Relational contracts
ACCO-led models prioritised
Cultural supervision funding
Simpler reporting

15. What else should be built into the program design to help improve outcomes for Aboriginal and Torres Strait Islander children and families?

First Nations governance
Funding for Elders + cultural practitioners
Language + cultural protocols
Trauma-aware, culturally grounded frameworks
Support for providers to build competencies

16. What types of data would help your organisation better understand its impact and continuously improve its services?

Time to access
Family experience & satisfaction
Cultural safety indicators
Participation outcomes
Workforce stability

17. What kinds of data or information would be most valuable for you to share, to show how your service is positively impacting children and families?

Functional outcomes
Family capacity improvements
Child/family voice
Cultural safety practice
Interagency collaboration examples

18. If your organisation currently reports in the Data Exchange (DEX), what SCORE Circumstances domain is most relevant to the service you deliver?

Family functioning
Health & wellbeing
Material wellbeing
Community participation
Safety

19. What kinds of templates or guidance would help you prepare strong case studies that show the impact of your service?

Headings to guide reporting such as:
Profile + family priorities
What was provided and why
Functional, participation-based outcomes
Family voice
Collaboration included
Cultural/access considerations

20. What does a relational contracting approach mean to you in practice? What criteria would you like to see included in a relational contract?

We recommend designing an Early Intervention system with less administrative burden and greater stability and flexibility for families and providers. Responsibility for outcomes should be shared, recognising that progress depends on coordinated effort across services, systems and environments, not on one provider alone.

The model should foster genuine partnership with all providers, including private practice and community-based clinicians, ensuring diverse expertise is represented and accessible. Innovation space must be protected, allowing services to trial models, adapt supports and respond to individual and community needs. Finally, cultural governance should be embedded, not added on, ensuring culturally safe, community-led decision-making from the outset.

21. What's the best way for the department to decide which organisations should be offered a relational contract?

Relational contracts should prioritise community-trusted providers with demonstrated cultural safety, strong supervision structures, ongoing workforce development and a proven record of collaboration, particularly those able to reach under-served families.

22. Is your organisation interested in a relational contracting approach? Why/why not?

Yes—but only if relational contracting is genuinely open to private providers rather than restricted to NGOs, if requirements are realistic for small businesses, and if the model supports true partnership and community-embedded care.

23. Is there anything else you think the department should understand or consider about this proposed approach?

Early Intervention reform should avoid workforce downgrading, use the ECI Best Practice framework nationally, and not mandate co-location. Programs must avoid generic predetermined models, leverage the existing private Early Childhood Intervention workforce, simplify administration and reporting, embed cultural safety and community governance, and ensure families retain the ability to self-refer.

Reform must prioritise early access without gatekeeping, ensuring children receive timely supports without unnecessary assessments or delays. Individualised approaches must be protected, recognising that children's developmental needs vary and cannot be met through one-size-fits-all programs. Any future model should recognise and leverage the expertise already present in the private Early Childhood Intervention workforce rather than replacing it.

Meaningful reform requires true co-design with families, Disabled people and First Nations communities, with cultural safety and trauma-informed practice

embedded from the start. Models must remain flexible rather than tied to hubs or prescribed programs, and equitable for small and regional practices who are vital to access and continuity of care.

Relational contracting should include private providers, enabling integrated service delivery across the full ECI ecosystem. Above all, DSS must commit to a system where no child or family is worse off as reforms are implemented.