



Department of Communities and Justice
Foundational Supports and Thriving Kids Program Team
By email: procurement@dcj.nsw.gov.au

20 May 2026

Re: Submission on the Draft Thriving Kids Program Specifications (May 2026)

IN SHORT

We support the policy direction in the Draft Thriving Kids Program Specifications (May 2026). Universal early intervention without diagnostic gatekeeping is the right ambition for the cohort, and the program's emphasis on family-centred, evidence-based and neuro-affirming practice is appropriate.

This submission offers comments on six aspects of the draft that warrant further consideration before contracts commence:

1. The Central Intake and Allocation Service replaces a clinical-assessment-led front door with remote functional screening. The evidence base, screening tools, and inter-rater reliability arrangements should be transparent and validated before operational scale.
2. The low-to-moderate threshold is unresolved. This is the single most important variable for program scope, family expectations and provider planning. Resolution is needed before commissioning.
3. The service model dose, duration and review parameters are unspecified. Providers cannot bid credibly without bounds.
4. Provider eligibility framing treats employed-clinician multidisciplinary private providers as a thin-markets fallback. This understates the capacity already operating at the Section 8.4 governance standard.
5. The subcontracting restriction (Section 7.2.1), for the purposes of the program, reflects sound design. We support it without qualification.
6. Workforce supply is the binding constraint on every commissioning decision. The current Psychology Board of Australia consultation on the higher education pathway is materially relevant.

WHO WE ARE

Unbound Minds Psychology. Two operational sites in Western Sydney - Gledswood Hills (Camden/Macarthur LGA) and Kingswood (Penrith LGA, Nepean Health Hub). Over 32 employed psychologists working across the full lifespan, with significant volume in child and adolescent assessment and therapy.

Both catchments are confirmed psychology workforce shortage areas with high CALD density. The Nepean catchment also includes pockets of socioeconomic disadvantage and a growing Aboriginal and Torres Strait Islander population. We currently deliver NDIS-funded therapy and assessment to children with autism, developmental delay and neurodivergent needs - directly the Thriving Kids target group.

THE STRUCTURAL CHANGE THRIVING KIDS INTRODUCES

The most consequential design choice in the Program Specifications is also the least named: the replacement of clinical assessment as the front door of the early childhood developmental supports system.

Currently, families navigate developmental concerns via clinical assessment - paediatric, psychological or multidisciplinary - which establishes the presence of developmental delay or autism, characterises functional need, and informs intervention direction. This pathway is anchored in decades of validated clinical reasoning.

The Program Specifications propose to replace this pathway with non-diagnostic functional screening conducted via phone and webform by a multi-agency CIAS team, with allocation to commissioned providers based on the screening outcome. This is a deliberate, considered choice consistent with the program's intent to remove the cost barrier of diagnostic gatekeeping and broaden access. We support that intent.

The architectural shift is substantial. The remaining sections of this submission address its operational implications.

ON THE CIAS ARCHITECTURE (SECTION 5.3.1)

Unbound Minds supports the principle of a coordinated, lower-friction intake function. The architectural shift, however, warrants detailed design consideration in five areas.

- **Validity of remote functional screening for children aged 0–8.** Functional screening by phone and webform is not a validated equivalent of clinical assessment for this age range, and the published evidence base for remote screening accuracy in early childhood developmental and autism presentations is limited. Before this becomes the dominant access route, the screening tools, evidence base, workforce capability requirements, and inter-rater reliability data should be made transparent and validated. We recommend DCJ publish the screening framework and its evidence base before CIAS operations commence at scale.

- **Interface with the existing clinical assessment pathway.** Many families will continue to access paediatric, psychological or multidisciplinary developmental assessment outside the CIAS system - via private paediatric practice, and existing psychology services. The Program Specifications are silent on how those clinical findings flow into the CIAS allocation decision. We recommend the design clarify whether clinical assessment findings (a) bypass CIAS screening, (b) inform but do not replace screening, or (c) sit outside the CIAS process entirely. Without clarity, families risk duplicated work, conflicting recommendations between clinical and CIAS pathways, and reduced confidence in the access process - particularly for families who have already invested in private assessment before learning about Thriving Kids.
- **Allocation lag risk.** The performance measures contemplated in Section 5.3.1 include the time between allocation and initial clinical assessment, but do not appear to include the time between intake and allocation. Without measuring both stages, families may experience extended delays before reaching clinical assessment - undermining the early intervention rationale that underpins the program. We recommend intake-to-allocation time be added as a published performance measure.
- **Plan review capacity at scale.** Section 5.3.1 indicates the CIAS will provide quality assurance review of provider-developed plans. At program scale this will require substantial CIAS clinical capacity. We recommend the CIAS workforce model and plan review service levels be specified before commissioning, so providers can build operational expectations around realistic turnaround times.
- **Demand and capacity transparency.** The Program Specifications do not currently describe demand management arrangements where demand exceeds available allocation capacity. Without published demand-capacity reporting there is a risk that allocation queues form within the CIAS itself, replicating the access problems the program is designed to address. We recommend quarterly publication of demand and capacity data at district level.

ON THE LOW-TO-MODERATE THRESHOLD

The Program Specifications acknowledge that a definition of low to moderate needs is subject to further design work between the Commonwealth and states and territories in mid-2026. Until that threshold is set, every other design parameter - service dose, duration, demand modelling, workforce sizing, provider capacity bids, family expectations - operates on assumption.

Three points on the threshold work.

- **The threshold should be functional, not diagnostic.** Diagnosis poorly predicts support need at the early childhood stage, particularly in the 0–5 range where presentations are emerging. The Program Specifications correctly avoid diagnostic gatekeeping; the threshold definition should follow suit.
- **The threshold should sit alongside a defined NDIS interface.** Families and providers need a clear answer to the question: what triggers escalation to NDIS access consideration, and who is accountable for that conversation? Without clarity,

families risk falling between systems - particularly children whose functional needs become apparent only after first contact with Thriving Kids.

- **The threshold should be published with its evidence base.** Providers commissioning into the program cannot calibrate caseload composition, supervision needs or clinical risk profile without knowing what the threshold captures.

We recommend the threshold definition, NDIS interface protocols, and supporting evidence be published before commissioned contracts commence.

ON SERVICE MODEL DOSE AND DURATION

The Program Specifications describe Targeted Supports as time-limited and goal-focused, with structured review and progression toward agreed goals - but do not specify the dose, intensity or duration parameters within which providers are expected to operate.

This is consequential. The international evidence base for early intervention dose is not settled at any specific number. Research recommendations have historically ranged from 20 to 40 hours per week of structured intervention for high-intensity programs, while more recent work emphasises that quality, targeting and family-coaching density matter more than total hours. The Program Specifications correctly avoid prescribing one number. However, providers need bounds within which DCJ is commissioning.

Specifically:

- the expected range of total hours per child per support period
- the expected duration of a support period before review
- the expected proportion of direct clinical time relative to family coaching, modelling and capacity-building
- the criteria triggering plan review, plan extension, and plan exit

Without these bounds, providers cannot price bids accurately, families cannot calibrate expectations, and the CIAS quality assurance function cannot operate consistently. We recommend the dose and duration parameters be published as a service model framework - bounds rather than prescriptions - to enable consistent commissioning and review.

ON PROVIDER ELIGIBILITY AND THE PRE-QUALIFICATION SCHEME

Section 5.3.1 indicates that Targeted Supports is delivered predominantly by NGOs and Local Health Districts, with private allied health practitioners on a pre-qualification scheme to address gaps in disciplines and capacity, especially as Targeted Supports are being established.

The framing implicitly treats private practice as a thin-markets-and-specialisations fallback. This understates the operational capacity of one specific cohort: employed-clinician multidisciplinary private providers operating at the Section 8.4 governance standard.

This cohort already meets the program's clinical governance requirements: AQF 7+ workforce, AHPRA-registered or peak-body-accredited, structured documented supervision, established initial assessment workflows, multi-site delivery from a single clinical spine, outcome measurement and case management infrastructure. The barrier to commissioning is not capability; it is the design assumption that this cohort is not predominantly eligible.

Two recommendations follow.

- **Make eligibility for primary Targeted Supports commissioning capability-based, not sector-based.** NGO and LHD delivery should not be prioritised by entity type. The Section 8.4 standard should be the test, applied consistently across provider types.
- **Open the pre-qualification scheme architecture to multidisciplinary employee-based private providers** with the same governance and quality assurance requirements as commissioned providers. Restricting it to fill workforce gaps creates a two-tier system where capability-mature providers are excluded from primary commissioning solely on the basis of corporate structure.

This is not a request for privileged access. It is a request that the eligibility test be the capability requirements DCJ has already articulated, applied consistently.

ON SUBCONTRACTING (SECTION 7.2.1)

Unbound Minds supports the policy direction reflected in the subcontracting restriction. The concern Section 7.2.1 addresses is structural and operates at the contract-architecture level: where a commissioned provider passes delivery of contracted services to a third party - and potentially fourth or fifth - each degree of remove from the contracting authority dilutes accountability, supervision visibility, and consistency of service standards. The one-degree-removed distinction matters.

Our own workforce reflects this principle. Unbound Minds employs psychologists under structured supervision and shared clinical governance. Section 7.2.1 reflects a sound design choice for a program with the safety, consistency and quality requirements of Thriving Kids.

ON WORKFORCE SUPPLY

Workforce supply will determine the feasibility of every commissioning decision the program makes. The Program Specifications correctly require AQF 7+ qualifications and AHPRA registration or peak-body accreditation across the allied health workforce. The structural constraints on that workforce are well-documented and material.

Psychology specifically is now governed by ongoing reform. The Psychology Board of Australia is consulting on a redesign of the higher education pathway that would lower the qualification floor from AQF 9 (current 5+1) to AQF 8 (proposed 5-year pathway), remove the supervised internship year, and replace external examination with employer-led competency assessment.

Unbound Minds has submitted to that consultation in opposition to the design as drafted, on the grounds that lowering the qualification floor will compound - not resolve - the workforce shortage by producing graduates less prepared for independent practice, with consequent increases in notifications, indemnity claims, and early-career attrition. The full submission is available on request.

The workforce implication for Thriving Kids: if the Psychology Board proposal proceeds as drafted, the supply of practice-ready psychologists into Thriving Kids will become both less reliable and lower-quality from approximately 2030 onwards. DCJ should engage with the Board consultation as a stakeholder in workforce planning, and design the program's workforce model on a basis that does not assume Psychology Board reform will deliver the supply it currently does not.

WHAT WE'RE ASKING FOR

1. Publish the CIAS screening framework, evidence base, and inter-rater reliability data before operational scale.
2. Clarify how clinical assessment findings from outside the CIAS pathway flow into allocation decisions.
3. Add intake-to-allocation time as a published performance measure alongside the existing allocation-to-clinical-assessment measure.
4. Specify the CIAS workforce model and plan review service levels before commissioning.
5. Publish demand and capacity data at district level on a quarterly basis.
6. Finalise the low-to-moderate definition with supporting evidence and the NDIS interface protocol before contract commencement.
7. Publish a service model framework specifying dose, duration, and review parameters.
8. Apply Section 8.4 governance as the primary eligibility test, consistently across provider types, rather than prioritising NGO and LHD delivery by sector.
9. Open the pre-qualification scheme to employed-clinician multidisciplinary private providers meeting the governance standard.
10. Maintain Section 7.2.1 as drafted - no carve-outs for transitional subcontracting arrangements.
11. Engage with the Psychology Board of Australia consultation as a stakeholder in workforce supply, and model Thriving Kids workforce assumptions independently of the Board's current proposal.

CLOSING

The Thriving Kids program addresses a real and urgent gap in the early childhood developmental supports system. Universal early intervention without diagnostic gatekeeping is the right ambition for a country with the resources to deliver it. The design choices in the Program Specifications are largely sound, and the document reads as the work of a department that has thought carefully about the cohort it serves.

The recommendations in this submission are offered as design input from a provider committed to delivering Thriving Kids services through the EOI process. We are available to engage further with DCJ on any of the points raised and can provide practice-level evidence on workforce, service model, governance and operational delivery on request.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Justin Khoury', with a stylized flourish at the end.

Justin Khoury

Chief Executive Officer

Unbound Minds