Submission

Inquiry into the Thriving Kids Initiative

Submission by the **Australian Physiotherapy Association**

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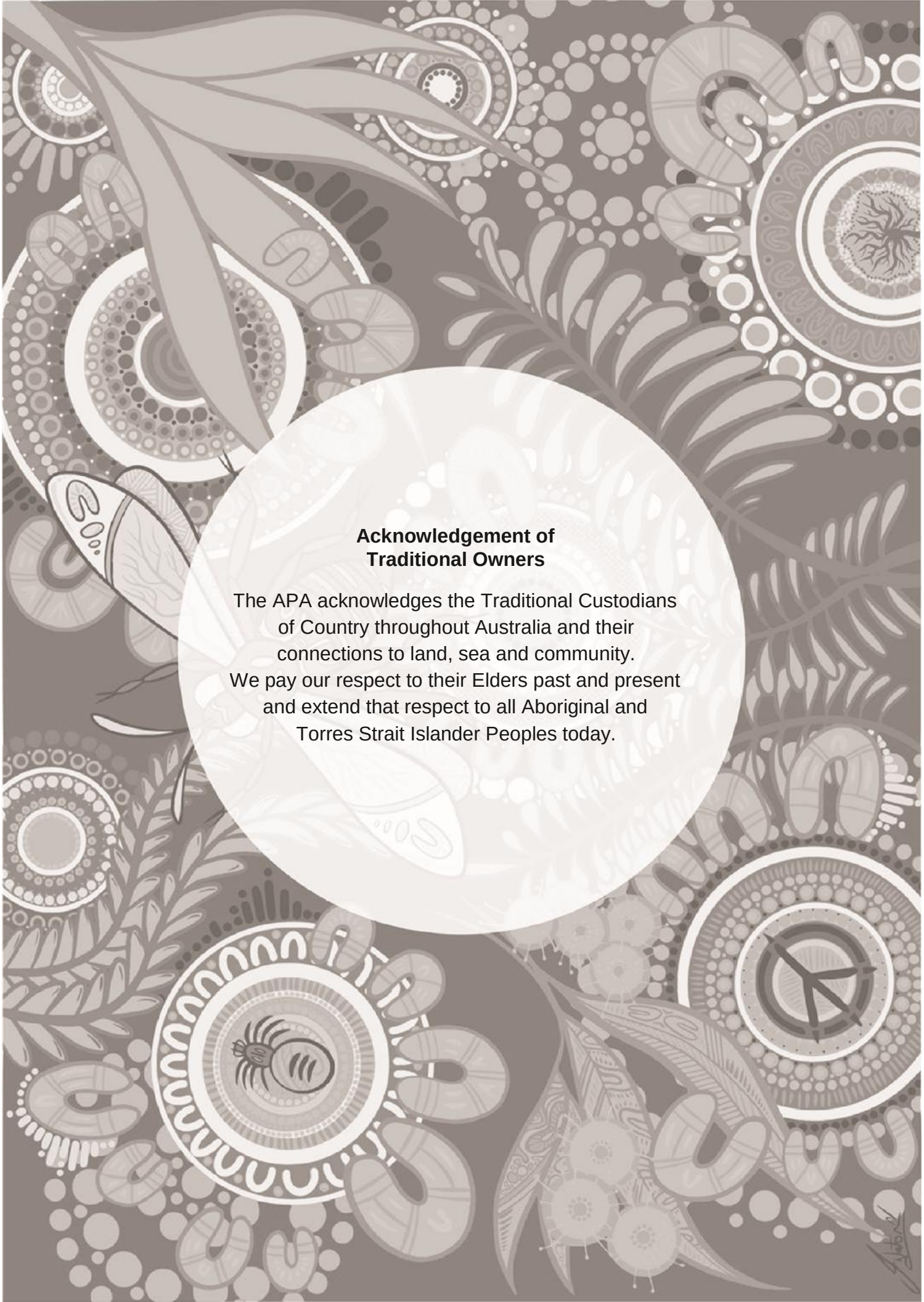

Acknowledgement of Traditional Owners

The APA acknowledges the Traditional Custodians of Country throughout Australia and their connections to land, sea and community. We pay our respect to their Elders past and present and extend that respect to all Aboriginal and Torres Strait Islander Peoples today.

About the Australian Physiotherapy Association

The Australian Physiotherapy Association's (APA) vision is that all Australians will have access to quality physiotherapy, when and where required, to optimise health and wellbeing, and that the community recognises the benefit of choosing physiotherapy. The APA is the peak body representing the interests of Australian physiotherapists and their patients. It is a national organisation with state and territory branches and specialty subgroups.

The APA represents more than 35,000 members. The APA corporate structure is one of a company limited by guarantee. The APA is governed by a Board of Directors elected by representatives of all stakeholder groups within the Association.

We are committed to professional excellence and career success for our members, which translates into better patient outcomes and improved health conditions for all Australians. Through our National Groups we offer advanced training and collegial support from physiotherapists working in similar areas.

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Executive Summary

The Australian Physiotherapy Association (APA) thanks the House Standing Committee on Health, Aged Care and Disability for the opportunity to contribute to the Inquiry into the Thriving Kids initiative. The APA further welcomes the Government's $2 billion investment to build a nationally consistent system of supports for children aged eight and under with mild to moderate developmental delay and autism, and their families.

Thriving Kids has the potential to transform early childhood development in Australia by enabling access to timely, appropriate supports in the places children live, learn and play.

This Inquiry is a rare and important opportunity to shape how Australia supports children in their early years. As Members of the Committee, you have the chance to help build a system that acts early, responds with evidence-based care, and reaches families where they are. **Physiotherapy is a vital part of that system.**

Physiotherapy is crucial to the success of Thriving Kids.

Movement is the earliest and most actionable indicator of developmental difference. Paediatric physiotherapists are first-contact movement experts with nationally recognised paediatric training and advanced practice credentialing. They deliver early detection, differential diagnosis and family-centred coaching that improve participation, co-regulation, language and social learning.

This scalable national workforce is embedded across neonatal intensive care units, tertiary early-intervention programs and community child-development services. Australian research leaders are extending this reach through tele-rehabilitation and digital tools, supporting families in rural and remote communities.

Physiotherapy in the first 1,000 days of life can alter developmental trajectories, improve school readiness, strengthen family confidence, and reduce reliance on higher-tier supports. Yet access outside the NDIS is inconsistent—low rebates, long waits and maldistribution of services disproportionately affect First Nations families, culturally and linguistically diverse communities, and those in rural and remote areas. Without explicit equity measures, Thriving Kids risks widening these gaps.

International models and best practice evidence outline how early identification and intervention that harness paediatric physiotherapy can be operationalised in Thriving Kids to build a world-leading national system of supports for children with mild to moderate developmental delay and autism, and their families.

By embedding physiotherapy within Thriving Kids, the initiative can deliver:

- Earlier identification and intervention
- Family-centred, participation-focused support
- Improved school readiness and inclusion
- Enhanced family wellbeing and workforce participation
- Greater system efficiency and equity
- Reduced long-term healthcare and disability costs.

We urge the Committee to ensure physiotherapy is explicitly named, funded and embedded in Thriving Kids. This will ensure children get the support they need, where and when it matters most.

Screening should begin in the first year, linked to national checks, with physiotherapists present at key motor-focused touchpoints including maternal health, primary care, early learning and schools. Equity starts with access but demands reach. Invest in culturally safe, community-led models, expand outreach and telehealth, and offer incentives to grow and retain the rural workforce. Fund shared assessments, coordinated care and physiotherapist-led parent coaching in soft-entry settings. Learn from global systems that treat physiotherapy as essential and build a workforce ready to deliver it.

This submission addresses the Inquiry's terms of reference and outlines practical, evidence-based recommendations. The APA welcomes the opportunity to provide further detail to the House Standing Committee as part of the upcoming public hearing on 20 October 2025. We are honoured to be included in this important conversation and look forward to contributing alongside our colleagues. This hearing is a chance to bring frontline expertise into the national conversation on early childhood reform.

Recommendations

Recommendation 1	**Fund physiotherapy within foundational support models and early childhood Medicare instruments.** Integrate paediatric physiotherapy into the Thriving Kids service framework, naming it explicitly in the guidance, service menus, and hub commissioning documents.
Recommendation 2	**Embed physiotherapy-led screening and early intervention within multidisciplinary teams across health, education, and community settings.** Establish physiotherapist-led screening and early intervention services within maternal and child health, primary care, early childhood education and care, and schools.
Recommendation 3	**Introduce nationally consistent developmental checks** with physiotherapists embedded—beginning in the first year and linked to the planned Medicare 3-year check. Nationally standardise early touchpoints with physiotherapists accessible for motor-focused screening.
Recommendation 4	**Invest in equity** through culturally safe, community-led models; outreach and telehealth; funded travel and targeted incentives for rural and remote workforce attraction and retention.
Recommendation 5	**Enable multidisciplinary care by funding case conferencing, non-face-to-face coordination, and shared assessments.** Facilitate case conferencing, shared assessments, and the use of My Health Record to reduce service duplication.
Recommendation 6	**Co-design parent resources with physiotherapists** to provide plain-language, visual and culturally adapted materials on early movement, play and participation
Recommendation 7	**Fund physiotherapist-led parent coaching through soft-entry settings.** Support physiotherapists in providing coaching through accessible community-based settings such as playgroups, toy libraries, and early childhood centres.
Recommendation 8	**Learn from international models that treat physiotherapy as core, publicly funded early-years support.** Draw on successful international models that embed physiotherapy within early years systems to create a robust, accessible framework for early intervention and support.
Recommendation 9	**Develop a sustainable, well-trained workforce for *Thriving Kids*.** Invest in workforce development, including the training of paediatric physiotherapists and other professionals in early childhood interventions. Ensure the workforce is equipped with the skills needed to provide high-quality, evidence-based care across diverse populations and settings.

Why physiotherapy is essential to Thriving Kids

The Early Childhood Targeted Action Plan, under Australia's Disability Strategy 2021-2031, highlights the need to enable early identification of disability or developmental concerns and develop clearer pathways and timely access to appropriate support.[1]

Movement is the earliest and most actionable indicator of developmental difference.

When motor divergence is identified and addressed early, it unlocks a cascade of gains in language, cognition and social participation.[2] [3] Paediatric physiotherapists are trained to detect these early motor signs and intervene before functional impairment becomes entrenched.[4] [5]

Physiotherapists bring clinical competence in differentiating typical variation vs early signs of motor divergence, such as asymmetry, low muscle tone, delayed milestones or inefficient movement patterns. This early discernment allows prompt referral and intervention before functional impairment deepens.

A workforce trained and ready to deliver

Paediatric physiotherapists are AHPRA-regulated experts in developmental movement qualified through advanced degree and specialist pathways as leaders in early detection and diagnostics. They treat developmental and physical conditions from infancy through adolescence, across hospital, community, private and telehealth settings. Their practice is distinct in its scope spanning neuromotor, orthopaedic and congenital conditions and uniquely positioned to both detect and address motor, biomechanical and participation limitations.

The physiotherapy profession is Australia's fourth-largest health workforce, with over 44,000 registered practitioners. All physiotherapists are trained in child development and developmental assessment at undergraduate level, and many progress to postgraduate qualifications in paediatrics. National professional competencies ensure they are trained to provide relationship-based caregiver coaching that can be embedded into daily routines in homes, early childhood education and care (ECEC), school and community settings. School-based physiotherapy interventions improve participation and function for children with developmental challenges, demonstrating both health and educational returns on investment.[6]

Physiotherapy can deliver support parents want in the settings Thriving Kids aims to strengthen.

The Thriving Kids initiative can leverage a large, scalable workforce that is already trained to detect and treat developmental concerns in infants, deliver systemic interventions such as capacity building for educators, and expand paediatric expertise through established training pathways.

1 Australian Government. (2021)

2 Bedford, R., Pickles, A., & Lord, C. (2016)

3 Wang, L. A. L., et al. (2022)

4 Lim, Y. H., et al. (2021).

5 Centre for Community Child Health (CCCH). (2017)

6 Alexander, K. E., Clutterbuck, G. L., & Johnston, L. M. (2024)

Harnessing the evidence

The first 1,000 days are a period of exceptional neuroplasticity. Evidence confirms that physiotherapy delivered in the first 1,000 days alters developmental trajectories for children with mild to moderate developmental delays and/or autism:

- **Cochrane evidence** confirms that early intervention including physiotherapy for infants at risk of developmental delay leads to better motor and cognitive outcomes. [7]
- **The Australian GAME** trial demonstrated that parent-coaching physiotherapy starting in infancy resulted in higher motor and cognitive scores at 12 months compared with standard care. [8]
- **The Centre for Community Child Health First 1000 Days Evidence Paper** highlights this period as a window of exceptional neuroplasticity, where timely, relationship-based intervention has lifelong benefits.[9]
- **Clinical practice guidelines** recommend initiating intervention for developmental risk in the first two years, even before a definitive diagnosis, to maximise developmental gains.[10]

Harnessing physiotherapy in Thriving Kids through national standardised screening and early intervention in the first 1,000 days will improve participation and reduce the need for intensive, ongoing supports, avoiding long-term system costs.

System value

Delays in providing developmental supports cost Australia $15.2 billion annually in avoidable expenditure.[11] Physiotherapists connect health, education and disability systems by embedding developmental screening, shared assessments and coordinated referrals into everyday settings. This integrated role reduces duplication, shortens wait times, and creates warm handovers between maternal and child health, paediatrics, early education and disability supports.

Paediatric physiotherapists bring advanced diagnostic skill in identifying what a child's body can do and what their context requires. Their assessments integrate psychosocial factors, family priorities and environmental realities, which are then translated into:

- Play-based, task-specific practice to accelerate motor and cognitive learning;
- Environmental adaptations and prescription of equipment or assistive technology; and
- Relationship-based caregiver coaching embedded into daily routines.

This family-centred, goal-directed approach produces immediate participation gains while strengthening resilience for the future.

As an example, Professor Alicia Spittle and Professor Angela Morgan have led pre-term infant tele-rehabilitation and Baby Moves, enabling parent video capture of General Movements Assessment for much earlier risk detection and remote triage. This is physiotherapy-led innovation that can facilitate greater equity. Low bandwidth tele-physiotherapy plus parent led video brings screening and early coaching to families beyond tertiary centres, to regional and remote communities, quickly and in natural settings.

7 Orton, J., Doyle, L. W., Tripathi, T., Boyd, R., Anderson, P. J., & Spittle, A. (2024)

8 Morgan, C., Novak, I., Dale, R. C., Guzzetta, A., & Badawi, N. (2016)

9 Centre for Community Child Health (CCCH). (2017)

10 Morgan, C., Fetters, L., Adde, L., et al. (2021).

11 O'Connell, M. (2025)

Terms of Reference

1. Evidence-based information and resources that could assist parents identify if their child has mild to moderate development delay and support parents to provide support to these children.

The co-design report for the National Early Childhood Program for Children with Disability or developmental concerns (NECP) documented 'remarkable consistency' in what caregivers want from early childhood supports, including enabling capabilities to improve confidence and capacity of families to facilitate participation.[12]

As gross motor difficulties are among the earliest observable signs of developmental delay, early physiotherapy screening, supported by co-designed education materials can give caregivers of children with developmental delay confidence through practical strategies and clear, timely pathways forward.

Australia already funds credible screening and information tools to help parents recognise concerns:

- **The Raising Children Network** provides plain-English information on developmental signs, milestones and next steps.[13]
- **ASDetect** (SACS based, 11–30 months), developed at La Trobe University, guides parent observations using the SACS approach and produces a 'low' or 'high' likelihood result for discussion with a GP or child-health nurse.[14]
- **Baby Moves** (GMA video in early infancy) from the University of Melbourne and the Murdoch Children's Research Institute, enables video capture of general movements at around 12–16 weeks corrected age for remote scoring by certified assessors, supporting earlier identification of risk for cerebral palsy.[15]
- **ASQ-3**(1–66 months)**, PEDS** (0–8 years)and **PARCA-R** (at 24 months) organise parental concern into clear next steps in primary care; **ASQ-TRAK** provides a culturally adapted, interview-based pathway for Aboriginal and Torres Strait Islander families. These are parent completed screeners in primary and community-care settings**.** *See Appendix B.*

These are screening and information tools; they do not deliver clinical diagnosis. While these resources support parents, they are not a substitute for guided, in-context early intervention.

The Targeted Motor Control (TMC) Screening Tool, developed by Australian physiotherapists to detect children at risk of or who have mild motor delay, is validated at age four against the NSMDA with an optimal cut-off < 9 (sensitivity 82.4%, specificity 66.7%, AUC ≈ 0.80).[16] TMC is quick, performance based and feasible for delivery by child health nurses, ECEC staff and allied health, which makes it ideal for universal checks. It only delivers value, however, if a positive result activates physiotherapy within weeks, a written plan and brief, relationship based caregiver coaching in the child's actual environments.

Raising Children Network, ENVISAGE Families (and ENVISAGE First Peoples), and PlayConnect+ are invaluable as starting supports. They provide evidence-based information, empowerment, peer connection, and practical ideas to help families feel less alone. They are not designed to deliver individualised, task-specific intervention for developmental delay; they do not prescribe or progress motor or participation goals based on clinical assessment; and they do not, on their own, embed connection, adaptation, inclusion and participation into a family's daily micro routines.

12 Department of Social Services (2021).

13 Raising Children Network.(2025)

14 Barbaro, J., & Yaari, M. (2020)

15 Alexander, C. F., Hall, S. E., Salt, A., Spittle, A. J., Morgan, C., Grisbrook, T., Ali, A., Amery, N., Davidson, S. A., Thornton, A., Sharp, M., Young, E., Ware, R. S., Silva, D., Ward, R., Badawi, N., Bora, S., Boyd, R. N., Woolfenden, S., Elliott, C., … Valentine, J. (2025).

16 Brown, L., Bacon, A., Pacey, V., & Ilhan, E. (2024)

Paediatric physiotherapists are the connector between identification and appropriate support, they:

- Match the right tool to the right age and concern (e.g., ASDetect in toddlerhood; Baby Moves in early infancy; ASQ-3 or PEDS in primary care; ASQ-TRAK with First Nations families);
- Help parents complete and understand results; and
- Issue plain language plans that supports caregiver coaching and embedding into daily routines.

These actions target participation in real routines, floor time, mealtimes, transitions, play, through graded, task-specific practice and simple environmental changes, reinforced by brief, relationship-based caregiver coaching delivered where children live and learn.

The informational programs remain in view, as repositories of credible content, communities of support and soft-entry touchpoints, but the dose, progression and fidelity that shift participation come from paediatric physiotherapy.

The evidence base is clear:

- Around 60 per cent of autistic children aged 2–7 years present with clinically significant motor impairment, often aligned with parent-reported concerns about sitting and walking.[17]
- Prospective infant data show motor difficulties are common at 9–14 months in infants with early behavioural signs of autism and persist over time.[18]
- Early gross-motor ability predicts later language[19]; meta-analysis confirms gross-motor deficits are consistently associated with social skills.[20]

The path forward: identify early, act early, and act through participation. To operationalise the evidence base, Thriving Kids should embed paediatric physiotherapists in maternal and child-health checks and ECEC multidisciplinary check-ins, using a standardised workflow:

Screen → Plan → Coach → Follow-up → Warm transfer

- Parents complete an appropriate screen with explanation.
- A one-page plan is issued quickly, linking to relevant Raising Children Network content and, where appropriate, referrals to ENVISAGE or PlayConnect+ for ongoing parental support.
- Brief coaching is delivered in natural settings to embed strategies.
- Progress (confidence and participation) is reviewed and the plan refined; only where indicated is a warm transfer made to multidisciplinary assessment, with support maintained while families wait.

The approach outlined above keeps the starting supports, Raising Children Network, ENVISAGE and PlayConnect+ where they add the most value, building on them in alignment with the evidence: individualised, clinically guided connection, adaptation, inclusion and participation in daily routines.

By keeping Raising Children Network, ENVISAGE and PlayConnect+ where they add the most value, and building on them with physiotherapy's individualised, clinically guided coaching, Thriving Kids can convert disparate resources into a coherent, equitable pathway. Public indicators such as time to first plan, caregiver confidence and participation gains should be used to measure success.

17 Reynolds, J. E., Whitehouse, A. J. O., Alvares, G. A., Waddington, H., Macaskill, E., & Licari, M. K. (2022)

18 Licari, M. K., Varcin, K., Hudry, K., Leonard, H. C., Alvares, G. A., Pillar, S. V., Stevenson, P. G., Cooper, M. N., Whitehouse, A. J., & AICES Team. (2021).

19 Bedford, R., Pickles, A., & Lord, C. (2016)

20 Wang, L. A. L., et al. (2022)

Case study 1

Five-year-old with developmental delay and Autism

Background
A five-year-old child with autism and developmental delay was referred to physiotherapy by their occupational therapist due to significant challenges with motor coordination. These difficulties meant the child was unable to participate fully in school playground games or sports activities, limiting their opportunities for friendship, confidence and belonging.

Best practice approach

- **Child-centred and rights-based:** The physiotherapist worked from the child's interests (love of bikes and playground games) to shape goals and sessions. The child was encouraged to make choices in activities and to evaluate their progress through play.
- **Family-centred:** Parents were recognised as experts and they set meaningful participation goals (bike riding, ball play at recess) and co-designed strategies.
- **Strengths-based:** Therapy built on the child's existing strengths – enjoyment of outdoor play, ability to run short distances – rather than focusing only on deficits.
- **Relationship-based:** Continuity with one therapist over six months built trust and a safe space for both child and family.
- **Everyday settings:** Sessions occurred in natural environments, at school, home and the playground, so that practice was embedded in the child's daily routines.
- **Capacity-building:** Caregivers and teachers were coached in practical, play-based strategies, ensuring skills were reinforced across home and classroom.
- **Evidence-informed:** Interventions drew on task-oriented and cognitive approaches for children with DCD/autism, focusing on functional, meaningful motor skills. Outcome measures to track impact at child, family, and service levels.

Intervention
The child received six months of **play-based, goal-focused physiotherapy**. Strategies targeted coordination, balance, bike riding, ball skills, and endurance, but always framed within activities the child enjoyed. Parents and educators were coached weekly to embed motor practice into daily life: playground routines, bike rides, weekend park visits, and classroom transitions.

Outcomes
A small, low-burden set of tools were chosen to capture outcomes for the child, the family, and the service system. These measures were selected because they are valid, reliable, feasible in everyday practice, and directly tied to participation and family confidence, the outcomes Thriving Kids should be assessed against.

- For the child, we used the MABC-2 to quantify motor coordination and the PEM-CY to show if skills transferred to home and school life. The Goal Attainment Scaling (GAS) captured what mattered most to this child and family—joining ball games and riding a bike, so we could measure progress against their own priorities.
- For the family, the Parenting Sense of Competence (PSOC) and Family Empowerment Scale (FES) measured confidence, reduced stress, and advocacy, critical Framework outcomes for parents and carers.
- For the service experience, the MPOC-20 assessed whether care felt coordinated, enabling, and empowering. We paired this with simple system KPIs, time-to-first contact and the proportion of sessions in natural environments, to show whether services were timely and ecologically based.

Together, these measures demonstrate not just that the child's motor skills improved, but that participation, family empowerment, and coordinated care were achieved, the outcomes that define best practice early intervention.

Child outcomes

- **MABC-2** percentile: 3rd → 9th → 16th over 6 months, showing clinically meaningful gains in motor coordination.
- **PEM-CY (School):** Participation in playground games improved from “seldom” to “often,” with involvement shifting from ‘low’ to ‘high’.
- **GAS:** Family-set goals (joining a recess ball game, bike riding 200m, completing a playground circuit) were achieved at or above expected levels.

Family outcomes

- **PSOC:** Parenting confidence increased from low-average to high-average range.
- **FES:** Parents reported greater empowerment in working with the school and advocating for inclusive play opportunities.
- Parents reported reduced stress and increased enjoyment in supporting their child’s development.

Service/practitioner outcomes

- **MPOC-20:** Ratings of “coordinated care” and “enabling partnership” improved by >1.5 points.
- Referral to physiotherapy achieved first contact within 9 days with 76% of sessions delivered in natural settings.

This case illustrates physiotherapy’s alignment with the National Best Practice Framework: **family-centred, child-centred, evidence-informed, and delivered in everyday settings.** By embedding strategies across home, school and community, physiotherapy enabled the child to **participate and feel they belong** alongside peers. The family grew in confidence and capability, and the school received practical strategies to support inclusion. Without timely physiotherapy, this child risked exclusion from sport and social play, with knock-on effects on confidence, friendships, and wellbeing. With Thriving Kids-style support, the outcomes were participation, confidence and thriving, exactly what the Framework expects.

Case study 2

Two-year-old with developmental delay diagnosis

Background
A 2-year-old with a developmental delay diagnosis had been receiving weekly joint occupational therapy and speech therapy. Despite this input, her gross motor progress began to plateau, and her occupational therapist noted emerging concerns about mobility. The occupational therapist (OT) referred her to physiotherapy for further assessment.

Best practice approach – teamwork in action

- **Team-centred referral:** The OT recognised that motor function was plateauing and referred for physiotherapy input. This reflects best practice teamwork: '*knowing when to refer, and trusting colleagues' expertise.'*
- **Whole-team view**: Physiotherapy identified red flags (hip dysplasia markers, calf spasticity) that could not have been managed by OT or speech alone. By sharing findings back with the team, each discipline adjusted their plan.
- **Coordinated responses:** The physiotherapist referred to orthopaedics and neurology and fitted ankle–foot orthoses (AFOs) to enable participation in standing play at early childhood education, mitigating the effects of spasticity. In parallel, the OT completed a sensory profile, identifying significant sensory integration concerns. The speech therapist adapted her positioning and strategies to accommodate the child's sensory sensitivities.
- **Family as team members:** Parents and early childhood educators were active partners, shaping goals around activities the child loved most.

Outcomes (qualitative)

- The child's safety and long-term independence were safeguarded by early detection of musculoskeletal and neurological issues.
- With the support of AFOs, the child was able to participate in her favourite activities, art time outdoors and dancing, which parents and ECE caregivers identified as her most valued routines.
- Parents reported increased confidence navigating health services and valued having "one team around the child" with clear, consistent communication.
- Educators reported they felt more equipped to include the child in group play, reducing isolation and increasing her sense of belonging.
- Practitioners reported reduced duplication and clearer role clarity: each discipline contributed their expertise while respecting others'.

This case shows the value of multidisciplinary teamwork when a child's progress plateaus and red flags emerge. Occupational therapy and speech therapy supported communication and play; physiotherapy identified and managed critical motor issues, fitted low-tech assistive technology to enable inclusion and participation, coached the family and educators in daily routines, and coordinated referrals. Together, the team delivered family-centred, child-centred, relationship-based care that enabled this child to join her favourite activities with peers and thrive in inclusive environments.

2. Examine the effectiveness of current (and previous) programs and initiatives that identify children with development delay, autism or both, with mild to moderate support needs and support them and their families.

The inclusion of physiotherapy in Thriving Kids responds directly to the shortcomings of past and current programs. Historically, Australia's mainstream services have struggled to effectively catch and support children with milder delays. Key for Thriving Kids is system design that converts identification into timely intervention and doesn't leave families waiting during the critical window.

NDIS pathways: Diagnosis-dependent access, administrative complexity and slow approval defer assistive technology and routine physiotherapy at the very point of maximum neuroplasticity.

State-based early intervention services: Before the NDIS, many states operated child development centres with multidisciplinary teams. With the NDIS rollout, these were reduced or absorbed, leaving children with milder delays outside eligibility thresholds unsupported.

ECEC health checks: NSW's Health and Development Checks in early learning centres demonstrate promise, but too often a 'positive' screen generates a referral slip into a queue, rather than immediate, in-situ support.

The last universal, MBS funded surveillance touchpoint, the Healthy Kids Check: abolished in 2015, removed a funded population wide opportunity to screen motor risk and warm transfer families to a paediatric physiotherapist.

Medicare architecture is the central reason Australia 'identifies without intervening' for children with mild–moderate needs.

The Chronic Disease Management pathway caps families at five allied health visits per calendar year (shared across professions), requires GP planning/referral, and reimburses against ≥20 minute consults. Best practice early intervention relies on 30–60 minute caregiver coaching sessions in homes and ECEC, coupled with educator liaison and simple environmental adaptations. The result is out of pocket costs, rationed care and deferred action.

The newer Complex Neurodevelopmental Disorders & Eligible Disabilities items have improved access for some but are diagnosis centred, administratively sequenced through medical items, and time limited (e.g., capped allied health assessment and treatment episodes). They do not create a funded route for early paediatric physiotherapy for children with emerging or mild needs. Nor do current items pay for the work that makes early paediatric physiotherapy effective - case conferencing with ECEC, in situ environmental adaptation, travel for outreach/rural service, or guarantee tele-paediatric physiotherapy parity.

The fix is not more screening; it is commissioning paediatric physiotherapists at the point of screening to translate results into a timely plan and actions.

What the evidence says about effective programs

Population-level impact: A Cochrane review of 25 early developmental programs (~3,600 preterm infants) reported cognitive benefits that persisted to preschool (SMD ≈ 0.43) and significant motor benefits in infancy.[21] Across diverse programs, the consistent finding is that coached practice shifts developmental trajectories when delivered early and embedded in daily care.[22]

21 Spittle, A., Orton, J., Anderson, P. J., Boyd, R., & Doyle, L. W. (2015)

22 Orton, J., Doyle, L. W., Tripathi, T., Boyd, R., Anderson, P. J., & Spittle, A. (2024)

Autism-specific gains: A 2025 meta-analysis of ~20 randomised trials (n≈671) showed that structured movement programs for autistic pre-schoolers - including gross motor play, ball skills and martial arts - produced significant improvements in motor coordination and social abilities, and moderate reductions in repetitive behaviours (SMD ≈ –0.37). These are exactly the types of 8–12 week blocks paediatric physiotherapists design and deliver in ECEC, transforming 'movement time' into classroom participation gains. [23]

START Play is a physiotherapist delivered, twice-weekly home programme over 12 weeks for infants with neuromotor disorders. In a multisite randomised clinical trial (n=112; PT + usual care vs usual care), infants with greater motor delay receiving START Play demonstrated short term gains in cognition, fine motor skill and problem solving play at three months, with persistence at 12 months. Infants with milder delay also showed an advantage in receptive communication (Bayley) over usual care.[24] This is a model that can be commissioned through mainstream child and family health to produce measurable motor, cognitive and early communication gains within a quarter.

Western Australia's LEaP (Learn, Engage and Play) is an 8-week, manualised, therapist run playgroup co-led by paediatric physiotherapy. In a single blind RCT (n=71; toddlers/preschoolers with developmental delay), LEaP produced between group advantages at 12 and 28 weeks on parent defined goal attainment (performance and function) and family support, with parenting distress reduced within group by 28 weeks.[25] The manualised design supports replication across community child development services. *See Appendices 3 and 4.*

If motor difference is often the first sign, physiotherapy is the first lever

Children need to sit to talk, and they need to move to explore. When infants achieve stable sitting, the hands are freed for exploration, visual horizons widen. When children can move through their environment, they encounter peers in natural play.

Posture → Exploration → Interaction → Language/Social learning

Paediatric physiotherapy is the discipline best placed to remove barriers to developmental delay. They bring specialist diagnostic and assessment skills to establish what a child's body can do and what their context demands. They then convert that insight into task specific, play-based practice, environmental adaptation (including assistive technology) and relationship-based caregiver coaching, delivered in natural settings and coordinated with primary care and ECEC. This is the mechanism that turns surveillance and information into measurable gains in participation, caregiver confidence and school readiness while diagnostic processes proceed.

Thriving Kids should fund three evidence-based archetypes as mainstream supports:

For infants with motor delay, commission a START Play–style 12-week, twice weekly home coaching block led by paediatric physiotherapists; the randomised trial shows motor, cognitive and receptive communication gains within the first year.

For toddlers and pre-schoolers with developmental delay, commission LEaP style manualised therapeutic playgroups co-led by physiotherapy through community child development services; the RCT shows improved goal attainment and family support with reduced parenting distress, outcomes families feel immediately.

For autistic pre-schoolers, embed 8–12 week physiotherapist designed fundamental movement units inside ECEC (ball skills, obstacle courses, gross motor play), drawing on meta analytic evidence for motor and social gains and reduced repetitive behaviours.

23 Wang, L. A. L., et al. (2022)

24 Harbourne, Regina T., Dusing, Stacey C., Lobo, Michele A., McCoy, Sarah W., Koziol, Natalie A., Hsu, Lin-Ya, Willett, Sandra, Marcinowski, Emily C., Babik, Iryna, Cunha, Andrea B., An, Hui-Ju, Chang, James A., Bovaird, Susan M., & Sheridan, James A. (2021)

25 Armstrong, J., Girdler, S., Davidson, E., et al. (2021).

3. Identify equity and intersectional issues, in particular, children who identify as First Nations and culturally and linguistically diverse.

The NDIS Review 2023 noted 'significant supports gaps across foundational supports for disadvantaged communities and cited a lack of available and appropriate supports for Aboriginal and Torres Strait Islander people, culturally and linguistically diverse (CALD) communities as well as gender and sexually diverse people with disability, [26] all acknowledged as priority audiences in the NECP co-design report.[27]

First Nations
Developmental vulnerability is not evenly distributed. Australian Early Development Census (AEDC) data highlights higher rates of developmental vulnerability in communities experiencing socioeconomic disadvantage and remoteness, with persistent gaps for First Nations children. First Nations children are further underrepresented in the uptake of disability services.[28]

The National Agreement on Closing the Gap sets an explicit target for 55 per cent of Aboriginal and Torres Strait Islander children to be developmentally on track by 2031.[29] In 2021, only 34 per cent of First Nations children were assessed as 'on track' across all five AEDC domains compared with 56 per cent of non-Indigenous children. Developmental difficulties have been identified as the primary cause of this gap.[30]

For First Nations communities, culturally safe, community-directed models are crucial. Research consistently emphasises that services must be holistic, family-cantered, flexible, and co-designed. A 2024 scoping review found significant gaps in culturally responsive disability supports for First Nations children in rural/remote areas, concluding that a family-centred approach tailored to community needs is needed to address those gaps. [31]

A review of child health services in remote Western Australia noted that services were fragmented and often not culturally safe. It recommended a unifying model of care developed in consultation with communities and greater investment in local Aboriginal Health Workers. [32] [33]

Universal tools and pathways can under-identify early concerns in Aboriginal and Torres Strait Islander children when instruments and delivery are not culturally adapted. The ASQ-TRAK/ASQ-TRAK2 co-designed with First Nations communities improves detection, enabling earlier support. [34] Screening and supports should be delivered with and through Aboriginal Community Controlled Organisations (ACCOs) and trusted local services, with clear funded pathways into allied health, including physiotherapy.

Remote Paediatric Therapy Program (RPTP) in the Northern Territory's Top End
Established in 2010, RPTP was a physiotherapy-inclusive, multidisciplinary outreach service targeting remote Indigenous communities with high rates of childhood disability. Initially, a fly-in/fly-out team (including paediatric physiotherapists, occupational therapists, etc.) travelled regularly across a large geographic area to provide intensive therapy to children with disabilities. Early evaluations of RPTP (2010 and 2012) revealed limited impact – the vast distances and infrequent visits meant direct therapy alone could not meet the high needs identified. In response, the program shifted its focus from purely providing therapy to building local capacity.

RPTP began training and supporting 'key community contacts' (e.g. community health workers, educators) who were continuously present in each community. By jointly visiting families, conducting case conferences, and using telehealth and mentoring between visits, the program empowered local partners to deliver day-to-day

26 Department of Social Services. (2023)
27 Department of Social Services. (2021).
28 Ibid
29 Australian Institute of Health and Welfare. (2025)
30 Ibid
31 D'Aprano, A., McRae, K., Dayton, S., Lloyd-Johnsen, C., & Gilroy, J. (2024)
32 Gosse, G., Kumar, S., Banwell, H., & Moran, A. (2025) Dossetor, P., Davies, J., Smith, R., & Johnson, L. (2019).
33 Dossetor, P., Davies, J., Smith, R., & Johnson, L. (2019).
34 D'Aprano, A., McRae, K., Dayton, S., Lloyd-Johnsen, C., & Gilroy, J. (2024)

therapeutic support. The most recent evaluation found this capacity-building approach successful – local staff reported increased confidence and skills in working with children with disabilities, leading to more consistent support on the ground.

RPTP's evolution underscores that partnering with community members and emphasising cultural safety and continuity can improve service effectiveness in remote First Nations contexts. Its lessons have been noted as valuable for the rollout of initiatives like the NDIS in the NT.[35]

State health services - **Paediatric outreach rehabilitation teams**
In Queensland (QLD) and New South Wales (NSW), specialist children's hospitals have developed outreach clinics and 'hub-and-spoke' networks where physiotherapists and other rehabilitation specialists periodically travel to regional centres and work with local providers.

An evidence check in NSW described models including specialist 'orbiting staff', short-term locums, and use of virtual clinics to reach children with complex developmental or physical rehabilitation needs. Evaluations of these services identify key success factors as engagement of local stakeholders, cultural competence, and securing continuity.[36]

Royal Far West's Telecare program
Telehealth is increasingly woven into outreach models and has enabled children in remote NSW and beyond to receive therapy (including physiotherapy and speech therapy) via videoconference at their school or home, reducing the need for travel. While more research is needed on long-term child outcomes, preliminary results suggest telehealth-supported outreach can improve families' access to specialist advice and maintain continuity of care between in-person visits. Studies caution that technology should be used in culturally sensitive ways to avoid widening the service gap for those who are hardest to reach.[37]

Closing the Gap Target 17 is that Aboriginal and Torres Strait Islander people have access to information and services enabling participation in informed decision-making regarding their own lives. Digital access disparities persist. While Thriving Kids initiatives must incorporate telehealth and digital resources for equity, they should be paired with devices/connectivity hubs and in-person options through ACCOs, ECEC etc.[38]

Child and Youth Assessment and Therapeutic Service (CYATS)
Established by The Central Australian Aboriginal Congress in Alice Springs, CYATS is an early childhood intervention program that offers multidisciplinary assessment and therapy for developmental conditions under one roof. CYATS is Aboriginal-led and holistic, combining medical specialists with allied health and operates as a 'one-stop' hub where families can receive a diagnosis and enter a network of health, education, and social supports.

An important outcome of this model has been community trust and high uptake: the service is 'widely trusted and easily accessed' by First Nations families in the region. By embedding physiotherapists and other therapists within an ACCO setting, CYATS and similar programs ensure care is delivered in a culturally safe environment, one that prioritises relationship-building, respects cultural perspectives on childrearing, and reduces the fear or distrust that many First Nations families experience with mainstream systems. While formal evaluations of CYATS are forthcoming (the service is expanding with new federal funding), its community-driven design aligns with best-practice principles identified in the literature.[39]

35 Johnston, H., & Pilkington, C. (2015)

36 Agency for Clinical Innovation. (2023)

37 Royal Far West. (2019).

38 Australian Institute of Health and Welfare. (2025)

39 SNAICC – National Voice for our Children. (2023)

Culturally and linguistically diverse

Evidence from NSW's Watch Me Grow and related studies shows reduced uptake of developmental screening and surveillance by culturally and linguistically diverse (CALD) families. They encounter barriers including awareness of checks, language, transport and referral complexity— 'slipping through the net' without guided navigation and interpreters.[40]

Delivering culturally safe care is about how care is provided, respecting each family's background and creating an environment where they feel respected and heard. By adopting these approaches, multidisciplinary teams have noted improved attendance and satisfaction among CALD parents, though formal outcome evaluations are still limited.

Studies have found that 'soft entry' points like playgroups or family hubs can greatly facilitate access for CALD communities. They serve as safe places where families can receive advice and referrals without the formality of appointments. Facilitators for CALD engagement include having culturally diverse staff, translation of information, and building trust over repeated visits. Conversely, identified barriers include social isolation and feeling overwhelmed by complex systems. [41] [42]

In Victoria and NSW, there are initiatives where maternal and child health nurses, together with visiting allied health professionals, run sessions at local multicultural playgroups or community hubs – providing developmental checks in a setting where parents feel comfortable.

- Partner physiotherapists and other therapists with bilingual community workers or using interpreter services to improve communication with families.
- Fund outreach through playgroups/libraries/ECEC where families already are rather than in intimidating clinical environments.
- Deliver services in familiar, welcoming community settings frequented by migrant families with embedded interpreters and active navigation.

Equitable access to early intervention for CALD families based in Sydney, reported that simplifying service pathways and improving cross-cultural communication led to more children being flagged for early intervention before school. In practice, this meant training health and early childhood staff in cultural competency, engaging ethnic community organisations to spread awareness about developmental milestones, and ensuring referral processes were easy to understand. [43]

Going forward, experts advocate for more robust evaluation of inclusive service models – for example, measuring developmental gains in children who receive interventions through culturally adapted programs versus standard care. Qualitative feedback and smaller studies consistently suggest that integrating cultural understanding into early childhood physiotherapy and allied health services leads to better engagement and earlier help for CALD children.

40 Garg, P., Ha, M. T., Eastwood, J., Harvey, S., Woolfenden, S., Murphy, E., Dissanayake, C., Jalaludin, B., Williams, K., McKenzie, A., Einfeld, S., Silove, N., Short, K., & Eapen, V. (2017) Australian Institute of Family Studies. (2017)

41 Australian Institute of Family Studies. (2017)

42 Warr, D., Mann, R., & Forbes, D. (2013).

43 Woolfenden, S., Posada, N., Krchnakova, R., Crawford, J., Gilbert, J., Jursik, B., Sarkozy, V., Perkins, D., & Kemp, L. (2015)

Rural and remote communities

The NDIS Review 2023 found significant barriers to accessing supports in rural and remote communities. In regional communities, disparities in access to healthcare can be seen across the board, from primary care to specialist medical services and community health initiatives. In 2024, regional, rural and remote Australia was home to 28 per cent of the total population.[44]

Reduced price limits for travel in the 2025-6 NDIS Pricing Arrangements and Price Limits has already resulted in service curtailment and withdrawal from regional and remote communities, undermining participant outcomes and inevitably transferring costs to hospitals and community health services. The impact of withdrawal of higher tier disability supports will further impact service accessibility for the Thriving Kids cohort.

Rural and remote access requires funded outreach, telehealth, and travel time, plus incentives to attract and retain the physiotherapy workforce outside metropolitan areas, so rural and remote families receive timely appropriate care.

Telehealth is a vital service delivery tool with which generalist physiotherapists working rural and remote can connect with specialist paediatric physiotherapists who can guide, supervise and mentor them, as well as facilitate direct consultations for the patient with paediatric physiotherapists. Telehealth caregiver-coaching models in the first three years are proven to improve child and family outcomes and reduce access barriers.[45]

During the COVID-19 pandemic especially, paediatric physiotherapists turned to telehealth to continue serving families remotely. Clinicians observed that tele-physiotherapy can confer benefits like reducing travel time for families and enabling more frequent contact, though it works best for certain 'right families' (those with adequate technology and support). Studies of allied health telehealth have found improved convenience and access for rural families, but also note that telehealth should complement, not fully replace, in-person services for young children.[46] [47] [48]

Multidisciplinary outreach programs like the Healthy Kids Bus Stop travel to rural communities to provide comprehensive health and developmental screening for children.

The Healthy Kids Bus Stop (HKBS) is a notable outreach model that integrated physiotherapy with other services in a mobile clinic. Operated by Royal Far West and partners in New South Wales, the HKBS is a specially outfitted bus that visits small towns to offer free screening assessments for 3–5 year olds. Over 2014–2022, this program visited multiple rural communities and screened over 4,200 children for oral health, hearing, speech and language, diet/nutrition, fine and gross motor skills, and social-emotional wellbeing. A multidisciplinary team conducted the screenings and then held a case conference for each child to coordinate follow-up care.

Outcomes from HKBS have been well documented: approximately 80 per cent of the children screened were found to have issues warranting referral for further assessment or intervention. The highest needs were in speech-language therapy, followed by occupational therapy – highlighting how this outreach identified hidden developmental delays before school entry. Program reports also noted significant benefits such as increased parental knowledge of child development and improved collaboration among local service providers.

By bringing services to the community, HKBS helped overcome access barriers and gaps in local services, prompting better linkage of families with ongoing supports. This model's success is underscored by its partnerships and its alignment with government initiatives to deliver universal preschool health checks. The HKBS demonstrates how co-location of multidisciplinary services in a mobile or 'pop-up' clinic can effectively identify needs and connect rural families to care, including physiotherapy for gross motor delays.[49]

44 Australian Institute of Health and Welfare. (2024).

45 Shin, Y., Park, E. J., & Lee, A. (2025)

46 Filbay, S. R., Bennell, K. L., Morello, R., Smith, L., Hinman, R. S., & Lawford, B. J. (2022)

47 Mathew, S., Fitts, M. S., Liddle, Z., Bourke, L., Campbell, N., Murakami-Gold, L., Russell, D. J., Humphreys, J. S., Mullholand, E., Zhao, Y., Jones, M. P., Boffa, J., Ramjan, M., Tangey, A., Schultz, R., & Wakerman, J. (2023)

48 Cottrell, M., Burns, C. L., Jones, A., Rahmann, A., Young, A., Sam, S., Cruickshank, M., & Pateman, K. (2021).

49 Royal Far West. (2022).

Key learning for Thriving Kids

Collaborative service delivery

Across both First Nations and CALD contexts, a recurring theme is the importance of collaboration and integration in service models. Multidisciplinary early childhood programs achieve the best outcomes when providers work in partnership and share care plans. Several Australian initiatives illustrate this principle.

In some states, Aboriginal Child and Family Centres have been established as one-stop hubs that co-locate early education, family support, and health services for Indigenous families. An evaluation of these centres noted that offering preschool programs on-site alongside allied health services (e.g. hearing and speech therapy) improved access to developmental support in a culturally safe environment.[50] Families could bring their child to the centre for childcare or playgroup and also see a visiting therapist or child health nurse without needing a separate appointment – a convenience that increased uptake of services. Co-location also fosters informal communication among professionals, reinforcing a team approach to each child's needs.

Integration with primary healthcare

Physiotherapists in early intervention often partner with child health nurses and general practitioners to form collaborative care pathways. E.g., a physiotherapist might run a joint clinic with a child and family health nurse for infants with motor delays, ensuring families get both developmental guidance and general health checks in one. In areas with integrated care programs, medical practitioners actively refer young children to allied health early, and multidisciplinary case conferences are held so that everyone is on the same page regarding the child's plan.

In one South Australian project, physiotherapists joined forces with early childhood educators in childcare centres to promote gross motor development, providing training to the educators and screening children in the centre. This kind of collaboration aligns with national guidelines that call for transdisciplinary early childhood intervention, where professionals share roles and focus collectively on family goals.[51]

A recent study from Flinders University piloted a nurse practitioner-led mobile paediatric clinic that visited preschools and childcare centres, bringing along allied health as part of the team. The focus of that project was interprofessional education, but it demonstrated a practical model: a nurse practitioner could lead a travelling clinic that does developmental screenings in early learning settings, while allied health team members (including physiotherapy) assess different domains of development. Such a model not only improves learning for future clinicians but also provides comprehensive checks for children in a familiar environment and facilitates referrals for any identified issues. The project reported enhanced interprofessional collaboration and found that even brief placements in the mobile service increased providers' readiness to work in teams. This suggests that training the workforce in team-based, community-outreach models can help sustain integrated services in the long run.[52]

Many of these integrated models show positive qualitative results (improved parental satisfaction, knowledge, and service access) and intermediate process outcomes (more referrals made, issues identified earlier, better provider collaboration).

The Healthy Kids Bus Stop noted improved school readiness and smoother transitions to kindergarten for participating children, as health issues were addressed before they started school. Parents reported feeling more knowledgeable and supported, and local health providers formed new networks to continue care for the referred children.

In First Nations communities, capacity-building models like RPTP have led to more consistent therapy input for children (through upskilled local staff) even when external specialists are not present. Families in those communities benefit from having someone on-site who can work on therapy activities with the child week-to-week, rather than waiting months between specialist visits.

50 Inside Policy. (2021)

51 Early Childhood Intervention Australia. (2016)

52 Lines, L. E., Bell, A., Hunter, S. C., Matwiejczyk, L., Williams, J., Kakyo, T. A., & Baldwin, C. (2024)

4. Identify gaps in workforce support and training required to deliver Thriving Kids

Delivering Thriving Kids effectively requires addressing critical workforce gaps in support, training and service models. Paediatric physiotherapy is central to meeting these challenges because it is both an early intervention service and a discipline skilled in building the capacity of families, educators, and other professionals to embed strategies in natural environments.

Undervalued multidisciplinary teamwork
Non-face-to-face activities such as case conferencing, resource development, shared planning and coordination are rarely funded. This creates pressure on physiotherapists to deliver evidence-based, team-based care without adequate resources or time allocation, undermining holistic best-practice early childhood intervention.[53] [54]

Unequal access across geographies
Limited rebates, lack of travel and outreach funding, and insufficient telehealth support create barriers especially in rural, regional, and outer-suburban communities. This delays timely intervention for vulnerable children with developmental delays or autism. [55]

Restrictive service delivery models
Funding schemes largely favour clinic-based care, despite evidence that early intervention is more effective when delivered in natural environments such as homes, day cares and schools. Current models limit physiotherapists' ability to work flexibly where children live and learn. [56] [57]

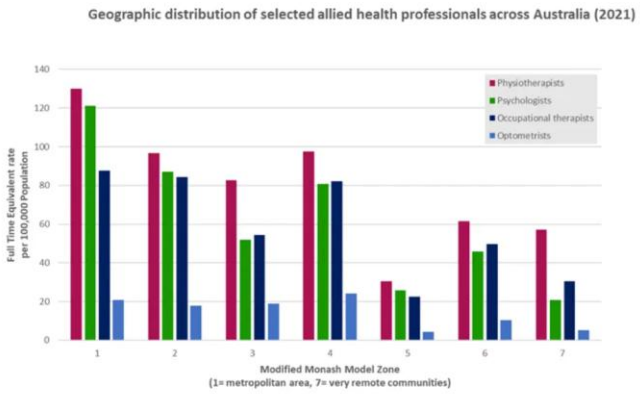
Challenges in rural workforce attraction and retention
Generic incentives have not fully addressed shortages of paediatric physiotherapists in rural and remote locations. Discipline-specific incentives, career development, mentoring and professional learning opportunities are essential to build local workforce capacity. [58]

How Physiotherapy can narrow these gaps

Physiotherapy is Australia's fourth largest and one of the fastest growing allied health professions, indicating readiness and capacity to meet demand for early childhood developmental supports.[59]

Paediatric physiotherapists are trained specialists with dedicated pathways focusing on the unique motor, sensory and functional challenges faced by children with developmental delay and autism. [60]

Geographic distribution of selected allied health professionals across Australia



The expanding physiotherapy workforce provides greater potential to scale services, including in regional and rural areas while championing team-based, collaborative practice supporting a multidisciplinary approach spanning health, education and community sectors to provide integrated targeted support, critical to Thriving Kids. Physiotherapists are skilled in delivering therapy across natural environments, matching the program's emphasis on supports embedded in everyday settings. Physiotherapists embrace family-cantered, culturally safe approaches tailored to diverse community needs inclusive of parents and caregivers.

53 NSW Ministry of Health. (2025)

54 NDIS Review. (2023)

55 Gosse, G., Kumar, S., Banwell, H., & Moran, A. (2025) Dossetor, P., Davies, J., Smith, R., & Johnson, L. (2019).

56 NSW Ministry of Health. (2025).

57 Early Start Australia. (2025)

58 Gosse, G., Kumar, S., Banwell, H., & Moran, A. (2025) Dossetor, P., Davies, J., Smith, R., & Johnson, L. (2019).

59 (**Image source**) Australian Government Department of Health. (2024)

60 Australian Physiotherapy Association. (2025)

How embedding physiotherapy value add to workforce supports

Paediatric physiotherapists do far more than provide one-on-one therapy, they are capacity builders and collaborators, empowering families and other professionals to support children's development in the child's natural environments (home, daycare, school) and enhancing the abilities of those in the child's daily life to implement therapeutic strategies. Physiotherapists act as teachers and mentors to parents, childcare staff, teachers, nurses, and others, not just as clinicians for the child.

In early intervention settings a physiotherapist might coach a parent on how to incorporate exercises into playtime or safe positioning techniques during every day routines like bathing and feeding. 'Caregiver coaching,' when practiced proficiently, has been shown to improve not only children's motor outcomes but also language and social-emotional development.[61] Paediatric physiotherapists help caregivers interpret the child's cues, manage regulation (e.g. calming strategies), and find the 'just-right' level of challenge in activities so the child can succeed and learn. By building parents' capacity, the physiotherapist ensures that therapeutic activities happen throughout the week, not just during clinic visits.

Physiotherapists also collaborate closely with other professionals. A paediatric physiotherapist might join a child health nurse on home visits for an infant flagged with gross motor delay, jointly assessing the baby and guiding the nurse (and parents) on activities to promote motor skills. In childcare or preschool, physiotherapists might spend time in the classroom ('on-floor' support) observing a child and then advise educators on inclusive strategies, adapting the playground for a child with mobility issues, or training the educator on exercises that can be embedded in play centres.

By mentoring frontline professionals, physiotherapists extend specialised knowledge into general practice. This is exactly the model anticipated in Thriving Kids, leveraging mainstream platforms for early support.

Families consistently report that having professionals collaborate and communicate clearly with each other (and with the family) is a huge benefit. By mentoring others, physiotherapists amplify their impact: a small number of physiotherapists can indirectly benefit many children by equipping parents and educators with the skills to help kids 'thrive' in their everyday life. This capacity-building ethos aligns perfectly with Thriving Kids' goal of delivering supports 'where children live, learn and play,' through existing community networks.

Training required

Paediatric physiotherapy training

Fostered by the Australian Physiotherapy Association (APA) and AHPRA, paediatric physiotherapists must engage in continuous professional development to effectively support children within Thriving Kids. Physiotherapists have access to graduate certificates and master's programs specialising in paediatric physiotherapy to deepen clinical expertise. In addition, paediatric physiotherapists have access to accredited professional development courses offered by the APA (Level 1 and 2 Paediatric courses), webinars and online lectures to maintain currency with evidence-based practices and emerging research. Finally, the APA titling and specialisation pathway is a high-level professional pathway completed via the Australian College of Physiotherapists, marking physiotherapists as expert clinicians in the field of paediatrics, for which the endorsement reflects a dedication to advanced practice, continual learning and leadership within paediatric physiotherapy.[62]

Compliance and safety training

Mandatory compliance training is essential for the safety of children and ethical practice. Completion of NDIS Quality and Safeguards Commission modules covering disability awareness, privacy, confidentiality and risk management, or some version of will be important. Child safeguarding and protection training, including mandatory reporting obligations and wellbeing policies; along with infection control, first aid, manual handling, and behaviour support would be important training to offer.

61 Morgan, C., Fetters, L., Adde, L., et al. (2021).

62 Australian Physiotherapy Association. (2024).

Thriving Kids-specific training elements

As Thriving Kids rolls out from July 2026, additional tailored training for allied health professionals, including physiotherapists will need to require the following: understanding new eligibility and referral pathways distinct from NDIS to navigate Thriving Kids access, and use of new Medicare items and billing processes supporting early developmental assessments and allied health interventions under Thriving Kids. While detailed Thriving Kids training curricula are still being finalised, these elements will build on and complement existing specialised paediatric physiotherapy education and mandatory compliance training, ensuring clinicians are fully equipped to contribute safely and effectively to this national initiative.

In conclusion, by addressing these workforce gaps through the expanding, well-trained and compliance certified paediatric physiotherapy workforce, augmented by program-specific training aligned to Thriving Kids' unique service and governance framework, the program can drive early childhood intervention that is accessible, integrated and evidence-based. This will maximise developmental gains and improve lifelong outcomes for children with mild to moderate developmental delay and autism across Australia.

5. Draw on domestic and international policy, experience and best practice.

England

Healthy Child Programme provides universal child health surveillance. Health visitors (public health nurses) conduct reviews at key ages (e.g. the 2–2½ year check using the ASQ-3 questionnaire) to identify developmental delays. Children not meeting expected milestones are referred to appropriate services (e.g. NHS paediatric physiotherapy, speech therapy, or specialist clinics). Specialist children's physiotherapists are available through the NHS, usually by referral from a health visitor or GP, to address motor delays as needed.[63]

Portage Home-Visiting Program is a home-based education service for pre-schoolers with developmental delays or mild disabilities. Portage home visitors (often part of local council early years SEN teams) make regular home visits to coach parents in play-based activities and 'small steps' skill-building tailored to the child.

The program is family-centred – parents' knowledge of their child is valued, and their active involvement in daily practice is key. Children with significant delay (e.g. >50% delay in at least two developmental areas) are eligible for Portage support.

Referrals commonly come via health professionals or early education providers, though parents can also access Portage through local family centres. Portage consultants also liaise with other professionals (such as physiotherapists or speech therapists) to ensure a coordinated plan.

This model has national reach across England and Wales under the guidance of the National Portage Association. Evaluations have found Portage can boost early developmental gains, especially when started early, although maintaining gains may require transition to robust nursery/school supports.[64]

Sure Start Children's Centres a government-led initiative creating integrated early childhood service hubs in disadvantaged areas. These centres provided a one-stop location for health services (e.g. health visitor clinics), parenting support, playgroups, and outreach home visits. While not limited to children with delays, Sure Start's multidisciplinary teams (including health visitors, early educators, and sometimes therapists) enabled early detection of issues and facilitated referrals to specialists.

Sure Start's holistic model combines health, early learning, and family support. Studies linked Sure Start participation to improved child social development and health as well as better parenting and fewer hospitalisations in later childhood.[65]

Early Support framework and SEN Services
The Early Support framework is a keyworker approach to help families of young children with additional needs navigate services. It promotes a single coordinated family service plan across health, education, and social care, often resulting in an integrated Education, Health and Care Plan (EHCP) for children with more significant or ongoing needs.

For mild to moderate delays without formal diagnoses, children can receive SEN Support in early years settings: this might involve early years area SENCOs (special needs coordinators) or inclusion teams working with nursery staff to implement interventions and access inclusion funding. Many local areas have Child Development Centres or multidisciplinary clinics where paediatricians, physiotherapists, occupational therapists, and speech-language therapists assess and treat children.

England's approach blends universal surveillance (to detect delays early) with targeted home-based programs like Portage and integrated service models to intervene and support development.

63 Council for Disabled Children. (2012)

64 National Portage Association. (2025).

65 Department of Education. (2025).

Scotland

Integrated child health reviews and family support

Scotland ensures early identification through its universal Child Health Programme. Health visitors perform routine developmental assessments at intervals (including a 27–30 month review) to flag any concerns in a child's motor, language, or social development. If delays are suspected, referrals are made to services such as physiotherapy or speech therapy provided by the NHS. [66]

Scotland's policy, Getting It Right for Every Child (GIRFEC) establishes a coordinated, multi-agency plan for any child with additional needs – a 'Team Around the Child' approach that unites health, education, and social care supports. Each family has a named contact (often the health visitor) to coordinate care, reflecting a whole-child, whole-family approach similar to England's Early Support principles.[67]

Evidence-based early childhood programs have been widely implemented. Notably, Scotland was the first country to scale the Family Nurse Partnership (FNP) nationally — a nurse-led home visiting program for first-time young mothers, which has strong evidence from trials in the US and UK.

Specially trained nurses visit caregivers from pregnancy until the child is age two, coaching on parenting, health, and development. Evaluations in Scotland show FNP families had improved early child development and health behaviours. Children who participated were more likely to meet developmental expectations in early schooling compared to similar families not in the program. While FNP isn't exclusive to children with delays, it exemplifies an early intervention that can prevent mild delays through proactive support and linkage to services.[68]

Scotland's early intervention ethos also extends to its early education system. Through GIRFEC, if a preschool child has mild developmental challenges, nursery staff and health professionals collaborate on a 'Child's Plan' to provide support such as therapist consultations. [69]

NHS Scotland's child development teams (including paediatric physiotherapists) serve as the clinical intervention arm – children may be seen at hospital-based Child Development Centres or through community therapy visits at home or nursery.

Scotland leverages universal services (health visitors and free nursery provision) plus evidence-based targeted programs (like FNP), under a unifying policy framework, to catch developmental issues early and intervene collaboratively.

Wales

Flying Start and early intervention in communities

Wales' flagship program Flying Start focuses on children 0–4 in disadvantaged areas, aiming to boost developmental outcomes through a multi-faceted, government-funded approach. Flying Start offers four core services:

Enhanced health visiting: Each Flying Start area maintains a low caseload ratio of roughly one full-time health visitor per 110 children. These health visitors conduct frequent home visits, monitoring child development and family needs closely. They provide parenting advice and developmental screenings, and they continually assess children's progress, making referrals to specialists (including physiotherapists) as needed. This intensive home-based support ensures early detection of delays and swift linkage to interventions.

Free high-quality childcare: Children aged 2–3 in Flying Start areas are entitled to part-time preschool placements (2.5 hours/day, 5 days/week) with qualified staff. Within these centres, emphasis is placed on learning through play, language development, and social skills. Children with emerging delays

66 Public Health Scotland. (2020)

67 Scottish Government. (2025).

68 Scottish Government. (2022).

69 Scottish Government. (2023).

can receive extra attention here, and staff work with Flying Start specialists to implement individual strategies.

Parenting programs: All families in the program are offered parenting support, ranging from informal drop-in advice to evidence-based group courses. Wales often delivers proven programs like 'Incredible Years' toddler parenting classes to help parents foster their child's language, motor, and social development at home.

Early language and play support: Many Flying Start teams include speech and language therapists or early language specialists who run language enrichment groups for toddlers and provide one-on-one support for children with communication delays. There is also funding for outreach play sessions and book-sharing initiatives to encourage cognitive and language skills.

A national evaluation of Flying Start found the program increased families' use of services and had positive effects on children's cognitive development and vocabulary by age three. Parents in Flying Start areas reported lower stress and improved confidence in supporting their children. The intensive health visiting component was particularly valued for catching issues early and guiding families to resources. [70] [71]

Flying Start's approach — combining home-based health support, high-quality early education, and parent coaching — offers a scalable model of community-based early intervention. Its focus on mild delays (like early language delay or borderline developmental concerns) within a disadvantaged population is especially relevant to policy designs targeting children who might otherwise 'fall through the cracks' until school age.

Northern Ireland

Sure Start

Sure Start in Northern Ireland is a targeted program for families in the most deprived areas, with children under four, jointly overseen by health and education departments. There are 38 local Sure Start projects across Northern Ireland, each offering an array of free services: home visiting and outreach support by early years workers, parenting programs and groups, playgroups for toddlers, and health clinics or advice sessions.

Health visitors and midwives are embedded in Sure Start teams to provide healthcare and developmental guidance to families. A key feature is support for children's social, emotional, and communication development – for example, some Sure Start projects employ speech and language therapists to run communication groups and drop-in speech clinics. While physiotherapy is not explicitly listed as a core service, Sure Start staff can refer families to the Health and Social Care (HSC) Trusts for paediatric physiotherapists or other specialist services.

Sure Start acts as a bridge, complementing statutory services and advising families how to access more specialised help if needed. Sure Start also runs a Developmental Programme for 2–3 year olds, a targeted playgroup to boost school readiness for children who might benefit most (e.g. those with slight delays or social needs). This structured program, with strong parental involvement, helps improve children's language, motor play, and self-help skills before preschool. Evaluations of Sure Start have noted improvements in child development and family well-being for those engaged, though reaching the most isolated families remains a challenge. [72] [73]

The Early Intervention Transformation Programme (EITP)

EITP is a system wide collaboration between government and philanthropic partners, aimed to embed evidence-based early interventions across services. Through EITP, Northern Ireland expanded parenting programs (like incredible Years for children with developmental or autism concerns), early screening initiatives, and the RISE NI service. [74]

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70 Welsh Government. (2013).

71 Welsh Government. (2019).

72 Department of Education Northern Ireland (2025) Department for Education. (2013)

73 Department for Education. (2013)

74 Social Change Initiative. (2020)

RISE NI (Regional Integrated Support for Education) is an early intervention therapy service that places multidisciplinary teams (including occupational therapists, speech-language therapists, and potentially physiotherapists) into preschool and primary school settings. They work preventatively to support children with mild difficulties in motor, speech, or social development, through school-based group interventions and teacher consultation.

This approach allows children who do not have a diagnosed condition (but are slightly behind in fine motor skills, balance, etc.) to get help in the natural learning environment. It also exemplifies how health and education sectors collaborate: health-employed therapists deliver services in educational settings to address low-level developmental issues before they escalate. [75]

Across the UK, early childhood intervention for mild to moderate delays relies on a mix of universal services and targeted supports. Multidisciplinary involvement is common – for instance, a child with motor delay might be simultaneously: identified by a health visitor, receiving home-based education via Portage, enrolled in a targeted nursery group, and seen periodically by an NHS physiotherapist. All UK nations emphasise integration – coordinating these supports so families have a seamless experience. This alignment of healthcare, early education, and family support around the child has been key in improving outcomes, and provides useful lessons for designing comprehensive early intervention policies elsewhere.

The United States of America

IDEA Part C

Early intervention: The United States operates a nationwide early intervention system under Part C of the Individuals with Disabilities Education Act (IDEA). Part C is a federal-state program that funds and mandates early intervention (EI) services for infants and toddlers (0–3 years) with developmental delays or disabilities.[76] Each state runs a Part C program but all adhere to certain core principles and entitlements:

Multidisciplinary services: Eligible children receive a range of services according to their needs, documented in an Individualised Family Service Plan (IFSP). Services must be delivered by qualified personnel and can include physical therapy. Notably, pediatric physical therapy is explicitly included as a Part C service – infants and toddlers with motor delays (e.g. delayed sitting, crawling, walking) can receive therapy from licensed pediatric physical therapists as part of their intervention plan. These professionals often work in tandem with other team members to address the whole child's development.

Natural environment and coaching model: Part C law requires that services be provided in natural environments to the maximum extent appropriate. This means most therapy sessions happen in the child's home or daycare, rather than clinics, so that skills are learned in everyday contexts. Providers use a coaching approach – teaching parents strategies to support the child's development during daily routines. For example, a physiotherapist might visit a family's home weekly to work on the child's motor skills by incorporating exercises into playtime or bath time, while training the parents on how to practice these activities between visits.

Eligibility and mild delays: Each state sets its criteria for what constitutes a 'developmental delay' eligible for Part C (commonly a 25 per cent delay in one or more domains, or a significant difference in standardized testing). Many states also serve children with milder delays or those 'at risk' of delay, at their discretion. In practice, Part C serves a broad spectrum – from children with diagnosed conditions (like Down syndrome or cerebral palsy) to children with moderate or even mild delays who would benefit from early therapy. If a child is not delayed enough to qualify, Part C programs typically refer families to other community resources (like parenting programs or public health services) to ensure they still receive support. Referrals into Part C come from pediatricians, hospitals (especially NICUs), child care providers, or directly from parents (Part C conducts public awareness so families can self-refer). Under the Child Find mandate, states must actively seek and identify infants with potential delays to enroll them early.

75 Southern Health & Social Care Trust. (2025.).

76 The Individuals with Disabilities Education Act (IDEA), Part C: Early Intervention for Infants and Toddlers with Disabilities. (2024). Hebbeler, K., Spiker, D., Scarborough, A., Mallik, S., Simeonsson, R., Singer, M., & Nelson, L. (2007). National early intervention longitudinal study (NEILS) final report. Menlo Park, CA: SRI International.

Scale and outcomes: The Part C early intervention system is available in all states and territories, making it highly scalable:

- In recent years about **7 per cent of U.S. children under age 3 receive Part C services.**
- In 2021, over **770,000 infants and toddlers received early intervention nationwide** – a figure that has grown as states broaden outreach. [77]
- According to federal outcome data, **a significant majority of children in Part C show improvements** in key developmental skills with about two-thirds making substantial progress and nearly half catching up to age expectations by the time they exit at age three.
- The landmark National Early Intervention Longitudinal Study (NEILS) found that **42 per cent of children who had received Part C did not need special education services by kindergarten**. [78]
- **Outcomes are most notable for children with mild/moderate delays** – timely intervention often means they enter school on par with peers.

Service structure: Each state's Part C program has a lead agency (often the state's health or education department) and a network of local early intervention providers. Services are typically delivered by either government-employed therapists or contracted agencies. An initial multidisciplinary evaluation (at no cost to families) determines eligibility and the child's needs. Then an IFSP team (including the family) sets goals and assigns appropriate services. Service coordination (case management) is provided to help families navigate multiple therapies and other supports.

Part C services are funded through a mix of federal funds, state funds, and often health insurance (including Medicaid for low-income children). For families, services must be free or low-cost; many states charge no fees at all for Part C. One challenge has been provider capacity – a recent GAO review noted many states face shortages of qualified therapists, especially in rural areas. Despite such challenges, Part C stands as a robust national model of early intervention that explicitly integrates paediatric therapies with developmental education in a family-centered way. It effectively targets children with mild to moderate delays in addition to those with disabilities, aligning closely with the goals of Australia's Thriving Kids initiative.

Preschool and early school-age supports (Ages 3–8:) After age 3, U.S. children with developmental needs transition into services under IDEA Part B (administered by local school districts). For ages 3–5, this is often called Preschool Special Education. This school-based system ensures that children identified in the 0–3 Part C program don't lose support; however, children with mild delays who were not in Part C can also be identified at preschool/kindergarten entry via screening and then receive services. [79]

Beyond the education system, the U.S. has several complementary programs that support early childhood development on a broader scale, often with federal funding and national reach:

Early Head Start and Head Start: Early Head Start (EHS) serves low-income pregnant women and children 0–3, while Head Start serves ages 3–5, providing comprehensive early education, health, and parent involvement services. These programs are not specific to developmental delays, but they include developmental and health screenings and must ensure that enrolled children with delays or disabilities get the services they need (often by coordinating with Part C or school special education).

Help Me Grow: Help Me Grow is an innovative model (originating in Connecticut, now spread to over 30 states) that focuses on developmental detection and connection rather than direct intervention. Typically run by a state or nonprofit, Help Me Grow establishes a centralized call line and outreach network to link families with young children to services if a developmental concern is identified. It works closely with pediatricians: for instance, when a doctor or parent has a concern but the child doesn't yet qualify for Part C, Help Me Grow can connect the family to community resources (like parent-child activity groups or developmental playgroups). The model also involves training doctors to use standardized screening tools (such as ASQ) and do 'developmental surveillance.' Evaluations of Help Me Grow have found it increases referrals to early intervention and other programs at younger ages and improves families' access to appropriate supports. [80]

77 U.S. Government Accountability Office (GAO). (2023).

78 Hebbeler, K., Spiker, D., Scarborough, A., Mallik, S., Simeonsson, R., Singer, M., & Nelson, L. (2007). U.S. Government Accountability Office (GAO). (2023).

79 The Individuals with Disabilities Education Act (IDEA), Part B: Key Statutory and Regulatory Provisions. (2024).

80 Administration for Children and Families. (2025.).

Evidence-based home visiting programs: The U.S. Maternal, Infant, and Early Childhood Home Visiting (MIECHV)[81] program funds states to implement evidence-based home visiting models for families at risk. Two prominent models are Nurse-Family Partnership (NFP) and Parents as Teachers (PAT).[82] NFP (also used in Scotland) employs nurses to make home visits from pregnancy until age two, focusing on health, parenting, and goal-setting. U.S. trials of NFP showed children of participant mothers had better cognitive and language scores in toddlerhood and reduced rates of child abuse and neglect. Parents as Teachers, on the other hand, uses parent educators to visit families from prenatal to kindergarten entry, providing child development guidance and periodic developmental screenings. A national evaluation of PAT demonstrated improvements in children's language and problem-solving skills and increased likelihood of identifying developmental delays early. These home visiting programs typically serve families who may not yet be in formal intervention systems – by coaching parents on activities to promote motor and cognitive skills, they can help mild delays from worsening and ensure referrals to formal early intervention if a delay is suspected. They are often implemented statewide (for example, Missouri and Oklahoma have PAT in many school districts, and NFP is available in dozens of states through health departments).[83]

Developmental Screening and Awareness Initiatives: Lastly, the U.S. has national initiatives like the CDC's 'Learn the Signs. Act Early.' [84] campaign, which improves early detection by educating parents and childcare providers about developmental milestones and warning signs of delay. There are also state laws in some places requiring childcare centers to conduct developmental checks or paediatricians to use specific screening tools at well-child visits. These efforts create a culture of early detection so that children with mild delays (with or without a diagnosis) are identified and then guided into the appropriate intervention program (whether Part C, Head Start, or other services).

Canada

In Canada, early childhood intervention is delivered primarily at the provincial level, leading to some variation across provinces and territories. Most provinces fund early intervention programs for 0–5 year olds that involve multidisciplinary supports (including physiotherapists) and emphasize family-centered delivery in natural settings. Below are key examples and structures reflective of Canadian practices:

Infant Development Programs (IDP): Many provinces have an Infant Development Program or equivalent serving children from birth to age 3 who have, or are at risk for, developmental delays. British Columbia's Infant Development Program (and a parallel Aboriginal IDP for Indigenous families) provides home-based early intervention services for infants/toddlers showing developmental concerns. Trained Infant Development consultants visit families regularly at home to coach parents on stimulating their child's development through play and daily routines. They monitor the child's progress, teach families activities to enhance skills and help them access other community resources. [85]

If a child in IDP needs more specific therapies, the consultant will link families with specialists – for instance, referring to an Early Intervention Therapy service for physiotherapy or speech therapy. IDP is voluntary and free, and referrals come from hospitals, public health nurses, doctors, or parents can self-refer.

This model has operated in British Columbia for decades and has counterparts elsewhere. Research in Canada has found that infants who receive such early developmental interventions show improved cognitive and social outcomes compared to those who do not.

Early Intervention Therapy Services: Alongside general developmental home-visiting, provinces usually provide therapeutic services for young children with developmental delays. In British Columbia, the Early Intervention Therapy (EIT) Program delivers physiotherapy, occupational therapy, speech-language pathology, and family support for children from birth to school entry who have developmental delays or disabilities. These are community-based services, often delivered by regional Child Development Centres or health authority teams. Importantly, EIT services are offered in flexible settings – therapists might see the child at home, at a community health centre, or in the child's preschool or daycare. The EIT programs accept referrals from any source (parents can refer directly, as can pediatricians, family

81 Administration for Children and Families (ACF). (2024).

82 McCombs-Thornton, K., Wang, Y., & Sturmfels, N. (2023).

83 Michalopoulos, C., Faucetta, K., Hill, C. J., Portilla, X. A., Burrell, L., Lee, H., Duggan, A., & Knox, V. (2019).

84 Centers for Disease Control and Prevention (2025).

85 Government of British Columbia. (2024).

doctors, or child care providers). A child can receive a mix of direct therapy sessions, caregiver coaching, group therapy (like toddler gym groups run by physiotherapists), and consultation where the therapist works with the daycare staff to adapt activities. Similar therapy programs exist countrywide: for instance, Ontario's Children's Treatment Centres provide physiotherapy and other rehab services for young children with developmental needs; Alberta's health system offers early childhood rehabilitation through community health clinics; and Nova Scotia has an Early Intensive Intervention Service for preschoolers with special needs. Access is generally universal within the province – children with mild to moderate delays (not just severe disabilities) are seen, though wait times can be an issue if resources are limited. These therapy services often coordinate with IDP or similar programs, as well as with medical services (e.g. developmental pediatricians), forming a continuum of care.

Inclusive early childhood education and childcare support: Another pillar of early intervention in Canada is ensuring children with developmental delays can participate in regular ECEC settings with appropriate supports. Many provinces fund inclusion support programs. In British Columbia, the Supported Child Development (SCD) program provides consultation, training, and sometimes extra staffing or funding to child care centers so they can include children with extra support needs. For instance, if a four-year-old with mild cerebral palsy (mild motor delays) is in a community daycare, the SCD program might fund a part-time aide or adaptive equipment and have an SCD consultant (often an early childhood educator) visit to help the staff with strategies. Similar programs exist in other provinces Evaluations of inclusive early childhood programs in Canada show positive outcomes in terms of children's social inclusion and developmental progress, as well as benefits to families.[8687]

Screening and Referral Pathways: Detection of developmental issues in Canada often occurs through the healthcare system. All provinces have a schedule of well-child visits and immunizations in the early years, during which basic developmental surveillance is done. Ontario pioneered the 18-Month Enhanced Well-Baby Visit, encouraging physicians to use standardized developmental checklists and engage parents in discussing their child's development. This has led to more referrals around that age for children with suspected delays. [88]

Public Health units in many regions also offer drop-in clinics or fairs where nurses or other professionals screen toddlers for issues (using tools like ASQ). Once a potential delay is noted, referral options include the provincial early intervention programs (IDP, therapy centers) or, if the delay seems more severe, directly to a hospital's developmental clinic.

Families do not need a diagnosis to access these services – a noted delay in development is sufficient. For example, a child doesn't need a diagnosis of autism or cerebral palsy to start receiving help; they might be labeled as having 'global developmental delay' or 'motor delay' and still get therapy before any definitive diagnosis.

Scalability and Reach: Canada's approach is not a single national program but rather a network of provincial programs, many of which have near-universal reach within their jurisdiction. Federal initiatives also play a role in scalability for specific groups: Jordan's Principle, for example, is a federal commitment that ensures First Nations children can access necessary health and developmental services without delays or jurisdictional disputes.

Through Jordan's Principle funding, many Indigenous communities have been able to hire paediatric therapists and establish early intervention programs on reserve, improving equity in service access. [89]

Additionally, the Public Health Agency of Canada funds the Aboriginal Head Start programs for Indigenous children which integrate culture with early education and include developmental screening and referrals.

Evaluations and Outcomes: There have been fewer nationwide studies in Canada comparable to the U.S. NEILS, but smaller evaluations point to positive outcomes.

- A longitudinal study of an Ontario early intervention program found significant gains in children's developmental quotients after one year of intervention, especially in cognitive and motor domains for those who started with delays.

86 Ibid

87 Employment and Social Development Canada. (2019).

88 Williams, R., Clinton, J., & Biscaro, A. (2008)

89 Assembly of First Nations. (2018)

- Parental reports consistently indicate high satisfaction with family-centered practices – parents feel more competent in helping their child develop after participating in IDP or therapy programs.
- Many children who received early intervention in BC's IDP are later found to be meeting developmental expectations by preschool or kindergarten, such that they do not require special education services at school entry (similar to trends seen in the U.S.)

Canada's model can be seen as a decentralized, yet comprehensive system. It combines universal healthcare and screening, targeted in-home developmental support (IDP), specialized therapy services (including physiotherapy), and inclusive early learning.

Government-led programs predominate, often delivered through partnerships with NGO agencies. The strong emphasis on multidisciplinary teams and family participation mirrors global best practices. The Canadian experience provides useful insights into funding and structuring early intervention across different contexts (rural/urban, diverse cultures) and underscores the importance of linking health, social, and educational services in early childhood.

What Thriving Kids can take from international policy and best practice

1. Early detection through universal touchpoints: A consistent finding is that universal child health programs (health visitor checks in UK, well-child pediatric visits with screening in US/Canada) are crucial for catching delays in infancy and toddlerhood.

Thriving Kids should leverage Australia's existing health system (e.g. child and maternal health nurses, GPs, paediatricians) to implement standardized developmental surveillance.

The UK's approach of a mandated 2-year developmental review using tools like ASQ, or Ontario's enhanced 18-month check, could be adapted nationally. Ensuring that every child receives a developmental screen before age 2–3, and training health professionals to know the referral pathways, will build a strong Child Find mechanism (similar to IDEA Part C requirements in the U.S.).

Public awareness campaigns (like CDC's 'Learn the Signs. Act Early.') could be part of Thriving Kids to encourage parents and childcare providers to act on early concerns. Early detection is the first step to reducing the need for later intensive support.

2. Family-centred, home and community delivery: Programs across UK, US, and Canada emphasize providing services in the child's natural environments – usually the home or early childhood centre – and coaching parents. This model not only is more convenient for families, but evidence shows it leads to better generalization of skills. Australia's Thriving Kids should prioritize in-home or community-based interventions over clinic-bound services for mild/moderate delays. The success of Portage home visiting and Part C's home-based therapy model suggests that arming parents with strategies and integrating therapy into daily routines accelerates progress.

By delivering physiotherapy, occupational therapy, or special education strategies in a child's everyday settings, Thriving Kids can mirror this best practice. Involving parents as partners (as all these models do) increases the dosage of intervention the child effectively receives, as parents continue the activities between visits.

Any Australian program should include a strong parent education component so that caregivers feel confident to support their child's development – whether through formal parenting programs (like Incredible Years or Positive Parenting Program) or through one-on-one coaching. Programs like Nurse-Family Partnership and Parents as Teachers, which improved child outcomes via home coaching in other countries, highlight that guiding parents yields measurable benefits even for mild delays.

3. Multidisciplinary teams including physiotherapy: A clear commonality is that the most effective early intervention models use multidisciplinary teams to address all facets of a child's development.

Paediatric physiotherapy is integral when motor delays are present. The U.S. Part C system explicitly lists physical therapy as a required service, and data show many Part C recipients achieve age-appropriate motor

skills by age three with therapy. In Canada and the UK, physiotherapists work alongside other allied health and educators in early intervention teams.

For Thriving Kids, it will be important to fund and deploy mixed teams of professionals. Mild to moderate delays often co-occur across domains; having a joined-up team prevents siloed care and ensures the intervention plan is holistic. Including physiotherapists in the multidisciplinary mix means children with gross motor delays (like late walkers, low muscle tone, mild cerebral palsy) will get appropriate support in the foundational early years. The team around the child approach from GIRFEC and Early Support in the UK could be emulated – for example, assigning each Thriving Kids family a key worker or case coordinator who brings together input from physiotherapists, psychologists, etc., and simplifies navigation for parents.

4. **Inclusive Early Childhood Education and Care (ECEC):** Many reviewed programs integrate with or directly provide early education opportunities.

The rationale is that peer play and learning in inclusive settings benefit children with delays, and such settings can be a platform for interventions. Wales' Flying Start provides free high-quality childcare from age 2, and Northern Ireland''s Sure Start has specialized play programs – these not only foster development but also allow professionals to observe and help children in a social context. In Canada, supported childcare programs ensure kids with delays can attend daycare with extra help.

For Thriving Kids, partnering with the childcare sector and preschools will be essential. This could mean reserving places in quality early learning programs for children identified with delays (perhaps providing subsidies or priority access), and embedding support workers or itinerant therapists to help those children in the center. It also means training ECEC educators in developmental support strategies. Australia already has inclusive education principles; Thriving Kids can bolster these by funding early intervention in Childcare initiatives akin to British Columbia's Supported Child Development. The outcome will be twofold: children improve skills in a natural peer environment, and educators become more skilled in developmental support, lifting overall quality. Furthermore, using ECEC settings can reach families who might be less likely to engage in clinic services – improving equity.

5. Tiered support and referral pathways: The international models show the value of having layers of support intensity. Not every child needs a specialist immediately – some may thrive with some coaching and a stimulating playgroup (as offered by IDP or Sure Start), whereas others will need individualized therapy.

Thriving Kids should be designed as a tiered system. Clear referral pathways must be in place so that families can move between tiers fluidly. Whether a family comes via a child health nurse, a daycare teacher, or self-referral, the system triages them to the appropriate level of support. One practical idea is a single state or national gateway (hotline/website) for Thriving Kids referrals (similar to Help Me Grow's centralized access point), which then directs families to local services after an initial screening. This prevents families from getting lost on long waiting lists; it's a strategy used in some U.S. states to coordinate early intervention and related supports.

6. Evidence-based programs within the system: Several NGO or university-developed programs (with strong evidence) have been successfully integrated into government offerings abroad.

Thriving Kids can adopt a similar approach. For instance, it could incorporate evidence-based parenting programs (Australia's own Triple P or imported ones like Incredible Years) to address behavioral or developmental concerns in a structured way for the mild end of the spectrum. It might also consider partnering with proven models like Nurse-Family Partnership, especially for early detection in babies born into higher-risk circumstances. Using these models can fast-track implementation because the curricula and training protocols are already well defined. Maintaining a robust evaluation component will be important– as seen in the UK's trials and U.S. longitudinal studies.

Thriving Kids should build in outcomes monitoring (using measures like those in Part C, e.g. percentage of children who substantially improve or who no longer need support after the program) to demonstrate its impact and make adjustments.

7. Coordination with existing disability services: In the U.S., Part C is distinct but coordinates with medical providers and the school system; in the UK, early intervention works alongside (and feeds into) the formal

special education needs process; in Canada, early intervention often bridges to school-age rehabilitation services.

Thriving Kids will sit in between Australia's universal services and the NDIS. Many children with mild/moderate delays won't qualify for NDIS support, which is exactly why Thriving Kids is proposed. However, some will later transition to NDIS if a more significant disability is diagnosed. Thriving Kids should have protocols for referral to NDIS when needed and also to coordinate if a child is small supports from both the Scheme and initiative – those should be complementary, not working at cross-purposes.

Aligning with education departments (for school supports) will ensure continuity when a child leaves the early childhood window. A coordinated approach prevents confusion and maximizes resource use, learning from some fragmentation seen overseas. The GIRFEC model of a single plan that spans health, education, and social domains is a worthy blueprint to adapt for Thriving Kids, given Australia's multi-jurisdictional context.

8. Adequate resourcing and workforce: Many programs reviewed faced challenges with staffing and scale. The U.S. GAO report noted shortage of providers as a top issue for Part C, and in some UK areas, capacity issues mean not all children get timely Portage or therapy. For Thriving Kids, planning for workforce development is critical – especially training more pediatric physiotherapists and other therapists in early childhood approaches, and upskilling other professionals (like early educators or nurses) to deliver certain interventions under supervision.

Exploring task-sharing models could help (for example, in some Canadian settings, therapy assistants carry out home practice activities under a physiotherapists guidance to extend reach). Sufficient funding per child is also key. The U.S. spends roughly $~4,000 per Part C child on average, and Wales' Flying Start significantly invested in low caseloads for health visitors – these investments correlate with quality. Thriving Kids' budget should reflect the intensity of services needed for real impact. If it's too low, there's a risk of superficial support that doesn't move the needle. *See Appendices D and E.*

6. Identify mechanisms that would allow a seamless transition through mainstream systems for all children with mild to moderate support needs.

Early Identification and timely action
As evidenced throughout the submission, early identification of developmental issues is crucial for improving a child's long-term trajectory and many systems implement universal developmental surveillance and screening in infancy to catch delays early.

The American Academy of Pediatrics recommends general developmental screening at 9, 18, and 30 months using standardized tools. Tools like the ASQ-3 enable primary care or child health nurses to screen children (1–66 months) across domains; the ASQ-3 has demonstrated sensitivity around 77–84% and specificity ~77–81% for identifying delays.

When potential delays are flagged, paediatric physiotherapists often serve as front-line allied health professionals to assess motor development and identify mild-to-moderate developmental concerns before a formal diagnosis is possible, enabling faster referral for appropriate evaluation or intervention.

This early detection role means a physiotherapist can initiate supports as soon as concerns arise, rather than waiting for a confirmed diagnosis. Research shows that providing intervention during this early window of brain plasticity yields better motor and general developmental outcomes. By capitalising on infants' adaptability, early physiotherapy can prevent small delays from compounding.

Integrated service pathways and referrals
A seamless support pathway requires that no matter which 'door' a family enters – health, early education or community – there's a clear route to get help. Best-practice systems use integrated referral pathways that connect universal services with targeted supports.

In Australia, the federal Early Childhood Approach (formerly ECEI) allows children under six to access early intervention without a diagnosis; referrals can be made on the basis of developmental concerns alone. This needs-based gateway prevents diagnosis from being a gatekeeper to support. A GP or nurse who has concerns can refer the family directly to an Early Childhood Partner or allied health service, rather than telling them to 'wait and see.'

Physiotherapists play a key role in these pathways by bridging sectors. Paediatric physiotherapist often work shoulder-to-shoulder with maternal and child health nurses, GPs, early childhood educators and other professionals for early detection, shared planning and timely supports.In many places, new service models embed physiotherapists within mainstream settings – such as community health centres, playgroups or childcare – to create a seamless continuum. The Australian Physiotherapy Association has advocated to include physiotherapy in existing mainstream checkpoints (baby health visits, early learning centres, schools) so that motor development expertise is on hand.

The 'ask' is to 'embed physiotherapy in integrated, community-based service pathways alongside GPs, nurses and educators', using coaching and practical strategies in natural environments. When such integration exists, referrals feel less like a hand-off and more like a warm handover. In practice this means, a childcare teacher who notes a child's balance issues can consult with an embedded physiotherapist who visits the center weekly, rather than telling parents to find therapy on their own. Similarly, a family doctor can directly refer to a multidisciplinary early intervention team (including a physiotherapist) that works in the community, knowing that team will loop back with updates. Streamlined referral pathways reduce the chance of families falling through cracks. They also ease pressure on specialist clinics by addressing mild delays in the community before they escalate.

Key worker model and case coordination
One proven mechanism for continuity is the Key Worker model, also known as a lead practitioner or care coordinator. In this approach, one professional becomes the single point of contact for the family, coordinating services across health, education, and social sectors.

The key worker guides the family, helping them navigate the often complex system of appointments and supports. This model is widely used in the UK (following the 1989 Children's Act) and increasingly in other countries as best practice for early childhood intervention.

A key worker can come from various disciplines – frequently social work or nursing, but physiotherapists, occupational therapists, psychologists and teachers are also often in this role. A paediatric physiotherapist who knows the child well could act as the key worker, especially if the child's primary needs are motor or physical. As key worker, the physiotherapist would not only deliver therapy but also liaise with speech therapists, educators, pediatricians, and any other involved providers to create a single integrated plan. This prevents fragmentation.

Research on key working shows families experience better coordinated and comprehensive care, quicker access to necessary services, and less stress when a key worker is involved. For example, a case coordinator might set up a joint case conference with the child's preschool teacher, physiotherapist, and speech therapist to agree on shared goals and who will do what. They might help the parents prioritize goals (e.g. improving balance to join playground games) and then make sure each provider supports that aim in their own domain.

The Team Around the Child (TAC) approach formalizes this idea of a small, collaborative team wrapped around the family. It is family-cantered and strengths-based, bringing together all relevant professionals (health, education, disability services) with the parents to set broad long-term goals and coordinated short-term targets.

In a TAC, typically one member is nominated as the lead (often synonymous with the key worker) to coordinate communication and keep the plan on track. This person could be, for instance, a community physiotherapist who has been supporting the child's motor development. By having a single service plan and one lead professional, duplication is minimized and transitions between services are smoother. Families are not left to juggle separate plans from the doctor, the preschool, and the therapist – the key worker helps integrate these into one roadmap.

Studies find that parents strongly prefer having one go-to person rather than a multitude of contacts. This approach reduces the battle parents face in accessing information and services, thereby lowering family stress.

For children with mild to moderate needs, a key worker model can ensure they stay on the radar even if they don't qualify for intensive case management. The physiotherapist as key worker can periodically check on the child's progress across settings and prompt referrals or supports as new needs arise, effectively bridging gaps between systems.

Shared plans and cross-sector collaboration
Another mechanism to enable seamless transitions is the use of shared plans and collaborative practices that span across different service systems. Rather than each sector working in isolation, leading models encourage joint planning and information-sharing – with parental consent and involvement – so that everyone supporting the child is aligned. In some jurisdictions in Australia, early intervention services have moved towards a single planning document (sometimes called a Family Service Plan or a Team Around the Child plan) that captures the child's goals, strategies being used, and roles of various providers.

This plan is co-created with the family and is shared (with permission) with the child's GP, child care educators, therapists, and any relevant support workers. A shared plan means that a child's early childhood educator can know what the physiotherapist is working on (e.g. climbing stairs or balance activities) and can incorporate similar practice during playtime at daycare. Likewise, the physiotherapist can reinforce strategies that an early educator finds helpful for inclusion (e.g. using a little stool so the child can reach the sand table with peers).

One example of cross-sector collaboration is the 'team around the child' meeting convened during key transition points – such as when a child is about to start kindergarten. In New Zealand, the Ministry of Education's early intervention service uses a structured transition process: about 1–2 terms before school entry. The child's key

worker joins with the parents, the new school's Special Education Needs Coordinator (SENCO), receiving teacher, and a Resource Teacher: Learning & Behaviour (RTLB) to create a Transition to School Plan. This plan details the child's strengths, needs, and the supports or classroom strategies required for a successful start. The group decides on actions (e.g. classroom visits, teacher training on using the child's assistive equipment, etc.) and sets a review meeting 4–6 weeks after school begins. Such formalized transition planning ensures continuity – the strategies that helped the child in early childhood settings are communicated to the school, and any new issues that arise in the school environment are fed back to the team.

The paediatric physiotherapist (whether from the health system or as part of the early intervention team) plays an important role here by advising on equipment, physical access, or mobility strategies that will help the child participate in school activities. For example, if a child has mild motor coordination difficulties (Developmental Coordination Disorder), the physio can recommend classroom accommodations (like pencil grips or an inflatable cushion for better posture) to the teacher and can continue monitoring the child's motor skills after school entry.

Best-practice models often designate a lead professional to stay involved during transitions, to 'hold the hand' of the family across the handover. In the New Zealand example, an RTLB (who works in schools) is paired with the early intervention key worker to jointly support the child for the first 4-6 weeks of school. After that, if all is going well, the early intervention service can step back, and the school takes over meeting the child's needs. The family is never left adrift during the change – there is always an overlapping support to ensure a smooth continuum. Shared plans and regular cross-agency communication (case conferences, transition meetings, joint home visits) are scalable strategies because they are more about coordination than expensive new programs. They do require building a collaborative culture and sometimes adjusting privacy rules to allow information sharing for the child's benefit (with consent). However, when done right, they lead to 'one child, one team' even if multiple services are involved. This greatly reduces families' burden of coordinating everything themselves.

Integration with universal services

Integrating support for children with additional needs into universal child services is a key mechanism to catch those with mild-to-moderate delays who might otherwise be missed.

Universal services include maternal and child health nursing programs, general practice, playgroups, and early childhood education and care. By building the capacity of these everyday services to identify and respond to developmental issues, systems can ensure families get help early without ' needing referral to specialist disability services.

Child health nurses and visiting health professionals are often the first point of contact for young children. In places like Australia and the UK, these nurses conduct routine health and development checks in infancy and toddlerhood. Training these nurses to use developmental surveillance tools and refer to allied health is a proven strategy. For example, nurses using parent questionnaires like PEDS (Parents' Evaluation of Developmental Status) can detect parental concerns and trigger further screening or referral.

Many regions now pair or consult physiotherapists alongside nurses at key ages. An innovative approach is having drop-in child development clinics at community centres, where a physiotherapist, speech therapist, or occupational therapist is available to observe children informally and guide parents or other providers. If a toddler at a library story time or playgroup shows motor delays, an on-site or visiting physiotherapist can quietly assess and advise the parent on next steps.

Embedding therapists in such universal contexts not only helps early pick-up but also destigmatizes getting support – it's just part of normal services, so families are less afraid to ask. In ECEC settings, integration means upskilling educators and providing specialist input on inclusion strategies. Many mild support needs (like slightly delayed gross motor skills, mild hypotonia, or sensory issues) can be accommodated in mainstream daycare or kindergarten if staff know how.

Paediatric physiotherapists can serve as consultants or trainers for ECEC staff, teaching them about developmental milestones, safe ways to encourage motor play, and how to adapt activities for different abilities. For example, a physio might help a childcare center set up an inclusive play corner with soft mats, mini stairs, and low ramps so that a child who isn't yet walking can practice pulling up and climbing during free play (while

peers use it as a fun play area too). If a child has balance issues, the physio might suggest seating modifications at group time (like a sturdy cube chair with sides) so the child can sit without toppling and participate fully.

Integration can also take the form of joint programs: some communities run supported playgroups or “toddler gym” groups led by an allied health team. For instance, the former PlayConnect playgroups in Australia (under the Helping Children with Autism program) were free community playgroups that welcomed children with autism or developmental concerns alongside their parents. These groups provided play experiences facilitated by professionals and gave parents a chance to learn therapy strategies in a relaxed setting.

While PlayConnect was discontinued with the transition to NDIS, the model remains a valuable one – it allowed families to access therapeutic guidance without a formal diagnosis or funding package, simply by attending a community play session. Physiotherapists in such settings coach parents on play-based exercises (e.g. games to improve balance or core strength) that they can embed at home.

Another example is school-based allied health programs. Some school districts and early childhood programs internationally employ physiotherapists and OTs to visit mainstream schools or preschools and work with teachers on inclusion. A systematic mapping of school-based allied health interventions found that having therapists collaborate with educators can improve student participation in school routines. By extending this concept down to preschools and child care, children with moderate motor delays can be supported in the least restrictive environment – their regular classroom – rather than being pulled out unnecessarily.

The overarching principle is to make the universal service system competent and confident to handle milder support needs, with specialist help in the background. Families benefit because they don’t have to navigate a separate silo for therapy – the support comes to them through familiar settings. Integration is highly scalable: it leverages existing infrastructure and adds expertise through outreach or co-location. Furthermore, it reinforces the idea that developmental support is part of normal childcare.

Support based on needs, not diagnosis

A consistent theme in effective transitional support is removing the requirement of a formal diagnosis as the ticket to services. For children with mild to moderate delays, strict eligibility criteria can become barriers – many such children may not qualify for disability services or may wait years for an official diagnosis (for example, autism spectrum or developmental delay diagnoses often aren’t confirmed until age three or later).

Best-practice systems implement “no wrong door” and needs-based pathways. The Australian NDIS Early Childhood Approach is one illustration: children under nine with developmental concerns can access early intervention supports without any diagnosis. An early childhood partner organisation will assess the child’s needs and provide short-term interventions or link to services in the community, even if the child never enters the NDIS formally.

This ensures families get timely help. Other countries have similar approaches: for instance, many U.S. states under IDEA Part C will serve infants and toddlers based on developmental delay criteria (usually a certain per cent delay in one or more domains) without requiring a specific condition. What’s crucial in all these is that paediatric physiotherapists help operationalize the ‘needs-not-diagnosis’ ethos.

Because physiotherapists can identify functional delays early on, they often act as the first validators that a child does need extra support. Their assessments (e.g. noting a significant gross motor delay) provide objective evidence to unlock early intervention services or referrals even in the absence of a medical diagnosis. Moreover, physiotherapists frequently collaborate with programs that are open to any child with concerns. For example, community health centers might run drop-in motor clinics or “tummy time” classes that any infant with suspected delay can attend – no paperwork needed. These kind of programs serve as safety nets so that families don’t slip through cracks simply because they don’t meet a strict label or funding threshold.

Removing diagnostic barriers and focusing on functional needs allows for smooth transitions across systems because families aren’t abruptly cut off from help at arbitrary thresholds. Instead, there is a graded continuum: from universal services, to targeted early interventions (physiotherapist, OT, etc.) available based on need, to specialized services if and when truly required.

Standardised digital hand-over protocols
Right now, much of the transition between child health → early education → school → disability/foundation supports is ad hoc. Paediatric physiotherapists can anchor a structured 'handover' at each key transition (e.g. childcare to preschool, preschool to school).

This handover includes motor milestones, participation goals, equipment/adaptations in use, and strategies that work in daily routines. The physiotherapist ensures it travels with the child—digitally (shared record) and physically (summary given to parents/educators).

International example: New Zealand's Transition to School plans mandate a joint meeting with therapists and teachers, ensuring continuity.

Shared digital records with physiotherapist input
Fragmented data is a common reason families fall through cracks. Thriving Kids could leverage platforms like My Health Record, but ensure they include developmental data and therapy plans, not just medical history.

Paediatric physiotherapists document goals, progress, and adaptations in a plain-language format. These records are accessible to parents, GPs, child health nurses, early educators, and school staff (with consent). This reduces duplication and allows smoother pick-up by the next service.

Capacity-building 'rings of support'
Seamless transition is not just about referrals—it's about ensuring mainstream services are confident to hold the child while waiting for, or instead of, specialist support. Physiotherapists are natural teachers and can:

- Train child health nurses to spot motor red flags and embed play-based motor activities in universal checks.
- Coach early childhood educators to adapt environments and embed motor practice in everyday play (e.g. mat time, playground).
- Mentor support workers in community programs to integrate motor-skill activities into group sessions.

This creates a 'ring of support' around the child: even if the physio steps back, the child's everyday adults are confident to carry strategies forward. It's a sustainable way to ensure that children with mild/moderate needs don't regress at transition points.

Flexible entry and exit without losing contact
Families often disengage when services 'end' at a transition (e.g. finish early intervention at 6, wait for school supports). Thriving Kids could build in:

- Step-down supports: less frequent but ongoing check-ins by a physio to ensure gains stick.
- Open re-entry: families can self-refer back if new concerns arise.

International example: This mirrors Canada's Infant Development Programs, where families can re-engage if new issues emerge, without restarting from scratch.

Equity lens at every transition
Seamless transitions must work for First Nations and CALD families in particular. Paediatric physiotherapists can operationalise equity by:

- Using culturally adapted screening tools (e.g. ASQ-TRAK) at universal checkpoints.
- Partnering with ACCOs and bicultural workers for handovers so families aren't lost between mainstream and community-controlled services.
- Providing translated one-page handover plans so information isn't lost due to language barriers.

Seamless transitions for children with mild/moderate needs require structured handovers, shared developmental records, capacity-building of mainstream staff, flexible step-down/re-entry, and culturally safe pathways. Paediatric physiotherapists are ideally placed to lead these because they straddle diagnosis and participation, they are trained in whole-child and whole-system thinking, and they are skilled teachers who can upskill everyone around the child.

Conclusion

Thriving Kids is a once-in-a-generation opportunity to change the lives of children with developmental delay and autism and their families. The APA strongly supports the initiative and its potential to transform early childhood development across Australia.

Physiotherapists are first-contact, movement experts who identify risk and early developmental concerns in infants, including early markers of autism and neuromotor conditions.[90] They provide evidence-based intervention and caregiver coaching, and enable participation in natural environments —consistent with best practice guidance and international best practice.[9192].

As outlined in this submission, physiotherapy is a critical component in early identification, intervention, and ongoing support for children with mild to moderate developmental delays and autism.

International models such as the U.S. IDEA Part C show how embedding physiotherapy within multidisciplinary early childhood systems delivers long-term educational and social benefits. By ensuring equitable access—particularly for First Nations, culturally and linguistically diverse, and rural communities—Thriving Kids can close longstanding gaps while strengthening family confidence, participation and wellbeing.

A coordinated, team-based approach is essential to delivering integrated, high-quality care that meets the unique needs of every child. By embedding physiotherapy within Thriving Kids, we can improve developmental outcomes, enhance school readiness, foster inclusion, and reduce long-term healthcare costs

The APA is committed to supporting the development and successful implementation of Thriving Kids, and this submission details why physiotherapy should plays a central role in its design and delivery.

The APA stands ready to work with government and sector partners to embed physiotherapy at the heart of Thriving Kids, ensuring every child has the chance to thrive—where they live, learn and play.

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Appendix A: Glossary

ACCO – Aboriginal Community Controlled Organisation. Community-based, First Nations–led health and social services.

AEDC – Australian Early Development Census.

ASDetect – Autism detection mobile application (developed by La Trobe University) that uses the Social Attention and Communication Surveillance (SACS) approach for children 11–30 months.

ASQ-3 – Ages & Stages Questionnaires (3rd edition). A parent-completed developmental screening tool for children aged 1–66 months.

ASQ-TRAK / ASQ-TRAK2 – A culturally adapted, interview-based version of ASQ-3 for Aboriginal and Torres Strait Islander families, co-designed with First Nations communities.

Baby Moves – A mobile app that enables parents to video infants' general movements (12–16 weeks corrected age), supporting early identification of risk for cerebral palsy via remote expert scoring.

CND-ED – Complex Neurodevelopmental Disorders and Eligible Disabilities. Medicare Benefits Schedule (MBS) items that provide limited allied health access for children with certain diagnoses.

ENVISAGE / ENVISAGE First Peoples – Evidence-based parent support programs co-designed with families (and with First Nations communities for the First Peoples stream) to build caregiver confidence and capacity.

GAME trial – Goals–Activity–Motor Enrichment trial. An Australian randomised controlled trial demonstrating the effectiveness of early, play-based physiotherapy for infants at risk of cerebral palsy.

GIRFEC – Getting it Right for Every Child (model from the UK)

IDEA – Individuals with Disabilities Education Act (U.S.)

IFSP – Individualized Family Service Plan (U.S.)

MBS – Medicare Benefits Schedule. Australia's publicly funded schedule of medical services, including rebates for allied health.

MRFF – Medical Research Future Fund.

NDIS – National Disability Insurance Scheme.

NECP – National Early Childhood Program for children with disability or developmental concerns (2021–25). Commonwealth initiative funding community-based, digital and playgroup supports to replace Helping Children with Autism and Better Start.

PARCA-R – Parent Report of Children's Abilities – Revised. A validated tool for assessing children's cognitive and language development at around 24 months.

PEDS – Parents' Evaluation of Developmental Status. A brief screening tool organising parental concerns into developmental domains for follow-up.

PHN – Primary Health Network. Regional organisations funded by the Commonwealth to improve coordination of primary healthcare.

START-Play – Sitting Together and Reaching to Play intervention. A physiotherapist-led, home-based program for infants with motor delay, shown to improve motor, cognitive and communication outcomes.

TMC Tool – Targeted Motor Control screening tool. A standardised measure for assessing motor control and detecting early motor concerns.

Appendix B: Evidence-based resources for parents

Tool / Resource	Description	Evidence / Utility	Accessibility
ASDetect App[93]	Free mobile app based on SACS-R, with parent-led observation guided by videos of typical/atypical behaviours.	Early studies show strong concordance with professional-administered SACS-R; improves parent accessibility.	Free – publicly available for parents.
Ages & Stages Questionnaires (ASQ-3)[94]	Parent-completed screening tool (1–66 months) across cognitive, motor, communication, and social–emotional domains. Available in 11 languages, telehealth-friendly.	Sensitivity 0.77–0.84, specificity 0.77–0.81 for identifying developmental delays. Widely validated.	**Licensed (paid)** – requires purchase of questionnaires and scoring guides.
ASQ-TRAK (Talking About Raising Aboriginal Kids)[95]	Culturally adapted version of ASQ-3 for Aboriginal and Torres Strait Islander families.	Improves cultural relevance and engagement for First Nations children.	**Licensed (paid)** – available via adaptation agreements, but designed for Indigenous health contexts.
Baby Moves App[96]	App that allows parents to record videos of their baby's spontaneous movements (General Movements Assessment) and send them to certified assessors for early detection of cerebral palsy.	Designed to facilitate earlier diagnosis: bypasses the need for hospital-based tests, potentially identifying CP earlier than the usual 19 months	**(In development / commercialisation planned)**
Parents' Evaluation of Developmental Status (PEDS)[97]	10 parent-report questions to elicit concerns. PEDS-Developmental Milestones uses milestone checklists with clear cut-offs.	Supports early detection of concerns; recommended to trigger further screening with ASQ or milestone tools.	**Licensed (paid)** – requires manual and forms.
Parent Report of Children's Abilities – Revised (at 2 years)[98]	Parent questionnaire for cognitive & language development at 2 years.	Strong concurrent validity with Bayley-III (ROC 0.83–0.97). Recommended by NICE for preterm children.	**Free** – available online.

93 Barbaro, J., & Yaari, M. (2022)

94 Burgess, A., Luke, C., Jackman, M., Wotherspoon, J., Whittingham, K., Benfer, K., Goodman, S., Caesar, R., Nesakumar, T., Bora, S., Honeyman, D., Copplin, D., Reedman, S., Cairney, J., Reid, N., Sakzewski, L., & Boyd, R. N. (2025).

95 Ibid

96 Alexander, C. F., Hall, S. E., Salt, A., Spittle, A. J., Morgan, C., Grisbrook, T., Ali, A., Amery, N., Davidson, S. A., Thornton, A., Sharp, M., Young, E., Ware, R. S., Silva, D., Ward, R., Badawi, N., Bora, S., Boyd, R. N., Woolfenden, S., Elliott, C., … Valentine, J. (2025)

97 Burgess, A., Luke, C., Jackman, M., Wotherspoon, J., Whittingham, K., Benfer, K., Goodman, S., Caesar, R., Nesakumar, T., Bora, S., Honeyman, D., Copplin, D., Reedman, S., Cairney, J., Reid, N., Sakzewski, L., & Boyd, R. N. (2025).

98 Ibid

Appendix C: The value of physical activity in autism spectrum disorder

There is high-level evidence to support the important of physical activity in autism spectrum disorder. It has impacts beyond physical health and extend to improving executive functioning, social functioning and one meta-analysis also showed it to improve severity of symptoms. One of the greatest challenges is access to and true participation in physical activity. Physiotherapists are equipped to support this.

Method	Reference	Type and NHMRC level of evidence	Who	Principles	Findings
Telehealth options	Shin, Y.; Park, E.J.; Lee, A. Early Intervention for Children With Developmental Disabilities and Their Families via Telehealth: Systematic Review. *J Med Internet Res* **2025**, *27*, e66442, doi:10.2196/66442.	Systematic review, Level I	Health professionals in multidisciplinary teams delivering telehealth services	Family-centred and multidisciplinary approaches	Telehealth can be a viable alternative to traditional approaches, particularly in hard-to-reach areas [1]. A systematic review, investigating telehealth approaches such as videoconferences and websites, can be just as effective as in-person approaches [1].
	Ashburner J, Vickerstaff S, Beetge J, Copley J. Remote versus face-to-face delivery of early intervention programs for children with autism spectrum disorders: Perceptions of rural families and service providers. Research in Autism Spectrum Disorders. 2016;23:1-14.	Level 4			Online services should be preceded with face-to-face services
Exercise interventions	Rivera, R. A., Robertson, M. C., & McCleery, J. P. (2025). Exercise Interventions for Autistic People: An Integrative Review of Evidence from Clinical Trials. *Current psychiatry reports*, *27*(5), 286–306. https://doi.org/10.1007/s11920-025-01597-6	Evidence review/meta-analysis, Level 1	Exercise programs	Physical activity and child-centred approaches	Clear and strong evidence that access to physical activity improves functioning in people with Autism, however, access to and participation in is challenging.

	Wang Y, Qian G, Mao S and Zhang S (2025) The impact of physical exercise interventions on social, behavioral, and motor skills in children with autism: a systematic review and meta-analysis of randomized controlled trials	Systematic review of RCTs, Level 1	Exercise programs delivered by different therapists	Physical activity and child-centred approaches	Exercise interventions improved flexibility, cognitive control, motor skills, coordination, social abilities and "behavioural problems". Exercise is effective to improve various abilities on children with ASD.
Exercise interventions – cycling	Tse, A. C., Liu, V. H., Lee, P. H., Anderson, D. I., & Lakes, K. D. (2024). The relationships among executive functions, self-regulation, and physical exercise in children with autism spectrum disorder. *Autism : the international journal of research and practice*, *28*(2), 327–341. https://doi.org/10.1177/13623613231168944	Quasi-experimental, Level 2	Unclear if health professionals	Physical activity and child-centred approaches	Significant improvement in executive functioning when learning to bike ride. Evidence for cycling programs (stationary bike and learn to ride)
Exercise interventions - hydrotherapy	Mortimer, R., Privopoulos, M. and Kumar, S., 2014. The effectiveness of hydrotherapy in the treatment of social and behavioral aspects of children with autism spectrum disorders: a systematic review. Journal of multidisciplinary healthcare, pp.93-104.	Systematic review, Level 1	Physiotherapists		While there is a lack of quality and up to date evidence guiding the use of hydrotherapy/aquatic based therapy for children's neuromotor task needs (Getz et al 2006), there is evidence to support the use of hydrotherapy for increased engagement, social gains and some general gross motor development skills (Mortimer 2014).

Appendix D: Australian guidelines on best practice for early intervention supports

Summarised in the tables below are domestic and international guidelines which demonstrate best practice in supporting a child's development and explain how physiotherapists demonstrate advanced practice and implement guideline recommendations.

Guideline	Age	Population
National Framework for assessing children's functional strengths and support needs	0–12 years	Includes all children **with or without a formal diagnosis** who require functional assessment to address concerns regarding development
National Guidelines for Best Practice in Early Childhood Intervention (ECIA, 2016)	0–8 years	Infants and young children with disability and/or developmental delay

Recommendations	How Physiotherapy meets guideline care	Risks to development without appropriate support
Holistic and individualised assessment[1]	Physiotherapists assess motor skills, mobility, participation, and physical wellbeing in the context of each child's environment.	**Decline in functioning**: If support needs are not met, children may experience reduced functioning, loss of skills, or limited participation in meaningful activities and life situations **Negative health and safety outcomes**: Unmet needs can compromise a child's health and safety, potentially leading to harm, worsening of existing conditions, or the emergence of secondary problems **Reduced participation and opportunities**: Without timely intervention, children risk being excluded from everyday experiences in home, school, and community life, which are vital for development **Broader social and emotional risks**: Families may face added stress, reduced wellbeing, and increased social or economic pressures if children's support needs are not met **System-level consequences**: Removing or failing to provide supports can cause cascading risks, including reduced functioning, opportunity costs, and unintended negative outcomes
Child and family centred strengths based practice[1,2]	Physiotherapists are trained in goal-setting. Goal setting is performed in a collaborative way, incorporating the child's interests, strengths and the family's priorities.	
Caregiver coaching focused on capacity building[1,2]	Physiotherapists use advice and provide coaching to caregivers in different settings. They provide a treatment plan based on strategies which can be embedded into everyday routines, enabling consistent practice outside therapy sessions.	
Evidence based, activity and participation focused interventions[1,2]	Physiotherapy interventions are grounded in the best available research evidence, combined with clinical decision making and family centered care. Interventions are delivered in natural settings and are goal directed, revolve around play and participation, supporting children to engage meaningfully in daily life.	
Culturally responsive care[1,2]	Physiotherapists are trained and assessed at a tertiary level for competency in being able to adapt assessments and interventions to reflect family culture, language, and values. Physiotherapy practice is guided by cultural safety principles and promotes inclusion and equity in healthcare.	
Professional competency and safeguarding	Physiotherapists are registered and regulated professionals under AHPRA. Codes of ethics, registration standards, and clinical governance ensure safe, ethical, and accountable practice.	
Communication, teamwork and reporting[1,2]	Physiotherapy training includes assessment and demonstrated competency in providing clear written and verbal communication. Physiotherapists are part of multidisciplinary and interdisciplinary care. Physiotherapists can assess functional strengths, support needs, and practical recommendations that empower families and carers and document this in a report.	

Appendix E: Domestic and international policy experience and best practice

The Australian ECI guidelines are currently being updated. The most up-to-date and available are structured and prescriptive, being tailored to the NDIS. The European guidebook has more flexibility for diversity in systems and focuses on values. Both share key areas between their principles and key best practices.

Domain	Europe (EURLYAID) [1]	U.S. DEC RPs (2014) [3]	New Zealand (Te Whāriki/Hepikorua)[[4]	Australia (ECIA 2016) [3]	Autism-Specific Implications
Family / Whānau	Family-centred; capacity-building	Family domain; engagement, empowerment	Whānau partnership; bicultural lens	Family-centred, strengths-based; culturally responsive	Parent coaching for autism-specific strategies (communication, sensory regulation)
Cultural Responsiveness	Acknowledges diversity but not an explicit standard	Embedded across domains, including some notes about diversity but not explicit.	Te Ao Māori integrated	Explicit standard; focus on Aboriginal and/or Torres Strait Islander communities and culturally diverse families.	Autism supports must be culturally valid; avoid one-size-fits-all interventions
Inclusion / Participation	Community/natural contexts	Environment & interaction domains	Belonging (mana whenua); play-based	Inclusive & participatory practice; natural environments	Peer-mediated interventions; sensory supports
Teamwork / Collaboration	Interdisciplinary/system integration	Teaming & collaboration domain	Partnerships with families/communities	Collaborative teamwork; key worker/TAC models	Multidisciplinary autism supports; telehealth for rural areas
Capacity-Building	Embedded principle	Across instruction & teaming	Whānau capability building	Explicit coaching for families, professionals and the community	Parent-mediated interventions, train local educators
Assessment & Outcomes	Values-driven	Detailed assessment domain	Broad outcomes: wellbeing, belonging, contribution	Outcome-based, requires qualified staff, continuous improvement and adherence to national standards.	Functional autism assessments: communication, sensory needs, family goals
Instruction & Interaction	Everyday learning	Instruction & interaction domains	Play, communication (mana reo)	Natural environments, routines	NDBIs, visuals, structured teaching, joint attention
Transition	Continuity across services	Transition domain	Continuity into schooling	Embedded in practice	Structured supports: visual timetables, orientation, collaboration
Leadership / System	System-level collaboration	Leadership domain	Curriculum-led	Standards, accountability (NDIS)	Autism workforce training; rural telehealth systems

Appendix F: APA's Scope of Practice Position Statement

Many recommendations focus on family and child-centred, activity based, and participation focused interventions, which are delivered in natural settings such as the home, early childhood, educational, and community environments. These guidelines consistently recommend interventions within a strengths based, culturally responsive, and co-designed approach that safeguards children and families.

Below is a summary of the APA's Scope of Practice Position Statement which demonstrates how physiotherapists are trained with core skills, knowledge and foundations to provide evidence base and guideline-informed care.

Core skills
Physiotherapists apply child- and family-centred, culturally responsive and evidence-based practice to assess and support children's functional strengths and needs, consistent with the International and Domestic guidelines and framework guiding principles. Their expertise in motor development, participation and physical wellbeing enables them to work collaboratively across home, schooling, and community contexts.[99]

Core knowledge
Physiotherapists integrate biomedical sciences (e.g., anatomy, neurology, pathology, exercise science) with knowledge of child development, rights, and social determinants of health to provide holistic, strengths-based care. This aligns with the World Health Organisation's ICF disability and health framework[100] and the adapted ICF F-Word framework for Child Development (Rosenbaum & Gorter, 2012).[101] Physiotherapists are recognised as experts in mobility and function, with unique skills in applying clinical reasoning to manage participation restrictions.[102]

Foundations
Physiotherapy is a regulated profession, with scope of practice safeguarded by legislation, registration standards, codes of ethics and clinical governance. This ensures practice is safe, ethical, and accountable in the application of the Framework. The APA Position Statement confirms that physiotherapists' scope is defined by their education, training, professional

99 Australian Physiotherapy Association. (2024).
100 World Health Organization. (2001).
101 Rosenbaum, P., & Gorter, J. W. (2012)
102 Australian Physiotherapy Association. (2024).

Appendix G: Physiotherapy and Thriving Kids fact sheet

The APA Valuing Skills Series

Why physiotherapy is essential for Thriving Kids

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Early moves, lifelong impact

Thriving communities begin with thriving kids—early investment in paediatric physiotherapy helps identify and respond to developmental concerns where children live, learn and play.

Thriving Kids aims to identify mild-moderate developmental concerns earlier and provide practical support where children live, learn and play. Paediatric physiotherapy is a cornerstone of this vision because movement is the pathway to exploration, connection, learning and participation.

Early motor delays can signal broader developmental needs. When early motor skills lag, opportunities to explore, communicate, learn and join in everyday activities narrow. By starting early, when the brain is most adaptable, physiotherapists working in partnership with families can give children the best chance to grow and develop their abilities.

Why it matters

Physiotherapists are trained to notice early signs of movement or development concerns, enabling faster referral for the right diagnosis.

Early detection: Gross motor delays are often the earliest signs of mild-to-moderate developmental delay, typically emerging between six and 24 months. Studies show these delays can be detected as early as six months and tend to become more pronounced before formal diagnosis. Early physiotherapy screening and intervention are essential to support timely diagnosis and improved outcomes.

Early intervention: Early physiotherapy builds movement skills and capacity while the brain is most adaptable, leading to better long-term motor and general developmental outcomes.

Relationship-based caregiver coaching: Paediatric physiotherapists provide the right level of support, attunement, and sensitive scaffolding, helping caregivers and educators confidently respond to a child's cues, regulation and supports. Early coaching in caregiver sensitivity and structuring is linked to improvements in children's language and social-emotional development.

Interdisciplinary by design: Paediatric physiotherapists work shoulder-to-shoulder with maternal and child health nurses, GPs, early childhood educators and other allied health professionals for early detection, shared planning and timely supports. Caregivers consistently report that early collaboration and clear communication matter to them.

Together with families, physiotherapists build on children's strengths so they can move, play, and belong in the ways that matter most in everyday life.

Participation and inclusion are the goals: Paediatric physiotherapists focus on participation and inclusion, prioritising access to play, mealtimes, care routines, outdoor and recreational activities, and peer interactions, not just developmental milestones. Participation is both the means and the outcome of successful early childhood development.

Experts in creating motor opportunities: Paediatric physiotherapists apply evidence-based approaches to enhance motor development by modifying environments, optimising positioning and prescribing assistive technology when needed. We use strategies to promote active participation across settings, along with assistive and wearable technology strategically to complement voluntary muscle/motor engagement, reflecting best practice.

Evidence-based, goal-directed, enriched practice: Physiotherapy in infancy and toddlerhood emphasises active, goal-oriented enrichment embedded in real routines, working in partnership with families in everyday settings.

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Physiotherapy

Without it, children miss early identification, and the system misses out on lowering future healthcare and support costs.

Early developmental risk

Physiotherapy assessment means developmental concerns are identified early before formal diagnosis.

Improved efficiencies

Physiotherapists assist mainstream services detect and respond to mild-moderate delays early, reducing escalation to high-cost care.

Strengthens supports outside the NDIS

Physiotherapists provide early assessment, intervention and education to support children's movement and daily functioning outside the NDIS to promote participation and independence in everyday life.

Stronger participation

Early physiotherapy supports developing systems and builds both child and caregiver skills, fostering independence for fuller participation in life. Physiotherapy supports inclusion through adaptation of environments, activities and supports, enabling participation.

Supporting families

Families gain confidence, clarity and support with early intervention. Relationship-based, culturally safe physiotherapy helps caregivers attune to their child's cues, coregulate and offer just-right supports in everyday routines.

The opportunity

Thriving Kids provides the opportunity to catch it when it counts—the largest shifts come when we act during the first 2 years before delays cascade into participation restrictions. Early motor differences can be identified by physiotherapists and responded to before diagnosis is finalised, aligning with *Thriving Kids'* proactive model.

We need to meet families where they are and offer flexible, child and family-focused services in the location and format chosen. Physiotherapy scales across mainstream services and can be delivered through 1:1 support, coaching, group formats, digital check-in and on-floor educator support. Caregivers emphasise the value of timely screening that leads to actionable support, not "watch and wait."

Investing in early intervention physiotherapy is a high-value, preventative strategy. By strengthening foundational motor capacity when brain adaptability is highest, children gain mobility and confidence that carries into play, interactions, learning and daily life. The result is better developmental outcomes and participation now, with fewer intensive and costly supports needed later.

Funders should know

Integrating physiotherapy from day one ensures that every child has the opportunity to move, grow and thrive.

Thriving Kids targets early identification and intervention for children aged 0-8 with mild to moderate delays, enhancing mainstream and community service supports.

- Fund physiotherapy as a core part of early intervention for children 0-8 with mild to moderate developmental delays.
- Include physiotherapy in existing mainstream settings such as health checks, community programs, early learning and education settings.

Early physiotherapy identifies and addresses motor delays before diagnosis, improving developmental outcomes. It reduces the need for costly, intensive interventions later in life, easing pressure on the NDIS and health care systems. Physiotherapy supports child participation, exploration and caregiver confidence, aligning with *Thriving Kids* goals.

Embed physiotherapy in integrated, community-based service pathways alongside GPs, nurses and educators. Use practical adaptations and caregiver coaching to maximise impact in natural environments. Establish new Medicare or funding items to improve accessibility and affordability of physiotherapy services.

Funding physiotherapy within *Thriving Kids* supports sustainable, evidence-based early intervention, delivering long-term social and economic benefit. It represents a strategic government partnership investment that promotes better lifelong outcomes for children and families.

The bottom line

Integrating physiotherapy from the outset of *Thriving Kids* is a smart, scalable investment that leverages the critical early window of brain plasticity. It strengthens outcomes for children, and their families, supports inclusion in everyday environments, and reduces long-term costs across health, education and social systems.

Case study

Ari

Ari is 11 months old, growing up in a multilingual household in Western Sydney. Mum is at home with four kids; Dad works Fly-in Fly-out (FIFO). Support happens where Ari lives and learns, at home and in his early childhood education and care (ECEC) centre.

At the 9–12-month Child & Family Health Nurse visit, the nurse and family noticed:

- Ari couldn't yet sit independently without using his hands to prop, even for brief moments.
- He wasn't pivoting, crawling or bottom shuffling, so he couldn't reach favourite toys, stay on the floor with his cousins, or move to a parent when out of sight.
- At ECEC he misses out on activities and finds it tough to join floor play.

Why that matters: Crawling itself isn't mandatory for every child. Independent sitting and getting to things are. Without a way to sit hands free, turn and move, Ari's access to play, communication and help seeking narrows, key drivers of language and social emotional growth in toddlerhood. Parents consistently report they want services that lift participation in routines.

What the paediatric physiotherapist did – relationship-based, culturally safe, practical

A strengths-based, culturally responsive interview was completed to identify Ari's key people, confirm best language and communication formats, and what matters most to Ari's caregivers (music time at ECEC, joining floor play with cousins, getting to Mum when upset).

Early identification: A standardised, play-based infant motor assessment showed Ari's gross motor skills were below the 5th percentile for age, an at-risk result that calls for immediate early supports embedded in everyday routines. The physiotherapist shared a plain-language one-page summary with the family, sent a same-day note to the GP, and requested a community paediatrician review (developmental + hearing/vision as indicated) while supports proceed, so help starts now, not after a diagnostic queue.

Context:

11 months; multilingual family in Western Sydney; Mum with four kids; Dad FIFO; support at home + ECEC.

Early signs (before diagnosis):

- not yet sitting hands free
- no floor movement
- can't reach toys or seek caregiver
- misses out at ECEC.

Screening pathway:

- 9–12 month nurse visit
- paediatric physio within 10 days
- standardised motor assessment <5th percentile
- early supports start now + routine paediatrician review.

Early intervention, adaptation and inclusion

In collaboration with staff and the parents, and understanding the unique contexts, simple ideas for supporting development and inclusion were developed together, to support Ari being able to sit and play with other children and his cousins, to join in music time and to explore more on his own.

Adapt for inclusion: To support joining in at music and other ECEC activities, firmer mats were used for stability; a low step for short kneel to stand opportunities; stimulating and interested aligned toys placed to invite turning, reaching and movement.

Positioning for success: Caregiver and staff coaching provided positional education to foster participation in play through different postures such as prone and kneeling, while a stable floor seat was introduced for brief bursts of fine motor play. A stander was used at ECEC so Ari could be standing upright and included in music time for short, enjoyable periods. Consequently, equipment was used as an enabler of participation, not a substitute for active play.

Handling and carrying: Caregiver and staff coaching provided education on how to use everyday routines, such as nappy changes, mealtimes and bath times, as opportunities to build trunk control and body awareness. This approach "hides" high-quality developmental practice into ordinary daily care.

Partner with caregivers and educators (not just "coach" them): Together we co-planned with ECEC to pair Ari with peers who love the same songs and pop-up toys, and offered "just-right" help that fades as he succeeds. Adults learned to read early frustration cues and respond with pause > co-regulate > simplify > try again. Sensitive, well-structured interactions like these are linked with better cognitive, language and social-emotional outcomes at two years, especially in children with early vulnerabilities.

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Wrap-around links

Warm handovers kept surveillance ticking with the Child and Family Health nurse; the GP received the summary; ECEC received a one-page inclusion plan (plain language + visuals) so everyone uses the strategies agreed upon, adapting the task and environment to support Ari's participation. With the family's preference, we can also link a bilingual worker/community connector to strengthen cultural fit. Parents consistently report that clear information, inclusive attitudes, and coordinated services are what enable participation.

What changed (weeks > months)

- more floor mobility to turn and reach toys
- longer hands-free sitting and increased ability to explore the environment
- joins group music upright (using a stander for short, happy bursts), first with a familiar adult/peer, then with less help
- clearer help-seeking, Ari vocalises, turns, and starts moving toward Mum/educator when he needs support; caregivers responsive to cues.

Family impact: longer floor time with cousins; daily routines feel calmer and more joyful. Parents in similar situations tell us it's this combination, practical adaptations, shared plans, and attuned adults, that lifts participation and confidence. That mirrors evidence that environment and relationships are decisive levers for participation in early childhood.

Why this matters for Thriving Kids

Early is doable in the mainstream: Gross-motor limits are often the first thing families and educators notice in mild–moderate delays; catching them in the first year lets us support participation before social and communication opportunities narrow.

Participation is the goal and the measure: Success is Ari joining floor play and group time. That aligns with what families value and avoids an impairment-only frame.

Relationships drive outcomes: Sensitive, non-intrusive, well-structured caregiver interaction is associated with better cognitive, language and social-emotional outcomes at two years; building that capacity is core physiotherapy work across early childhood.

Co-designed, culturally safe practice scales: Simple environmental tweaks, visual one-pagers, and family-chosen goals are realistic for ECEC and homes, consistent with adapted experience-based co-design methods developed by Australian teams.

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