

# A new approach to programs for families and children

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) welcomes the Department of Social Services' proposal to establish a single, national program for families and children that is simpler, more flexible and better aligned to community need. The APA strongly supports the intent to invest earlier, strengthen prevention and early intervention, reduce administrative burden, and improve outcomes for children and families.

Physiotherapy has a critical and complementary role to play in achieving the proposed program outcomes. Physiotherapists work across health, education and community settings to support children's development, participation and wellbeing, while building the confidence and capability of parents and caregivers. Their practice is grounded in evidence-based practice, family-centred care and delivery in everyday environments.

The APA supports the consolidation of existing programs into a single national framework with three activity streams spanning universal supports, prevention and early intervention, and intensive family supports. This structure provides an opportunity to better integrate allied health, including physiotherapy, into place-based and multidisciplinary service responses. Physiotherapists are well placed to contribute across all three streams—supporting early identification of developmental concerns, delivering timely intervention, and working as part of wraparound teams for families experiencing more complex challenges.

The APA strongly endorses the focus on prevention and early intervention, particularly for children aged zero to five years. Evidence demonstrates that early intervention improves child participation and resilience, strengthens family wellbeing, and reduces the need for more intensive and costly supports later in life. Physiotherapy contributes to these outcomes through early identification of developmental risk, targeted intervention, and coaching parents and caregivers to embed strategies into daily routines.

The APA also supports the emphasis on connected and integrated services. Physiotherapists are experienced in collaborative models that link health, education and community supports. Funding arrangements that enable genuine integration, including shared assessments, case conferencing and flexible service delivery, will be essential to realising the program's objectives.

Improving outcomes for Aboriginal and Torres Strait Islander children and families must be central to the new program. The APA supports prioritising Aboriginal and Torres Strait Islander community-controlled organisations (ACCOs) in areas with significant First Nations populations and recognises that culturally safe, community-led models deliver the best outcomes. Physiotherapists can contribute effectively within these models when services are co-designed, culturally responsive and delivered in partnership with trusted local organisations.

In summary, the APA supports the proposed new approach to programs for families and children and encourages the Department to explicitly recognise and embed physiotherapy within the program design and guidance. Doing so will strengthen early intervention, support families in the settings where they live and learn, and contribute to more equitable, effective and sustainable outcomes for children and families across Australia.

## Discussion Questions

### Vision and outcomes

*Q: Does the new vision reflect what we all want for children and families?*

**Vision:** *All children and young people are supported by strong families who have the skills and confidence to nurture them.*

**Yes. The APA agree the proposed vision reflects what families, practitioners and communities consistently say they want for children: strong, confident families supported by systems that act early, respond proportionately to need, and enable children to participate meaningfully in everyday life.**

The vision is well aligned with the Early Years Strategy and the new [National Best Practice Framework for Early Childhood Intervention](#) (ECI Framework).

To fully realise this vision, support must centre on **functional participation**—children moving, playing, learning and belonging in home, early childhood education and care, school and community settings. Participation is the mechanism through which children build health, identity and resilience, and through which families gain confidence in supporting their child's development.

Movement is one of the earliest and most actionable indicators of developmental difference. When motor divergence is identified and addressed early, it can unlock gains across language, cognition and social participation. Paediatric physiotherapists are trained to recognise early motor signs and support families through practical, relationship-based coaching embedded into daily routines.

Families are experts on their child. Systems should wrap around them with coordinated, evidence-informed and culturally safe supports that build capability rather than create dependency. This includes access to physiotherapy as a core allied health profession supporting early identification, foundational developmental supports and participation-focused intervention in mainstream settings.

**The vision would be further strengthened by explicitly committing to:**

- › **a connected continuum** of universal, foundational and specialist supports across health, education and community systems; and
- › **closing developmental and participation gaps** for First Nations and CALD children, families in rural and remote communities, and those experiencing adversity, where early developmental vulnerability is highest.

Access to physiotherapy is essential to realising this vision, as part of an integrated system that supports families early, reduces escalation, and enables children to thrive where they live, learn and play.

*Are the two main outcomes what we should be working towards?*

*Why/why not?*

### **Outcome 1: Parents and caregivers are empowered to raise healthy, resilient children**

**Yes. The APA strongly supports this outcome.** It aligns closely with the National Best Practice Framework for Early Childhood Intervention, which identifies building family capability, confidence and quality of life as a primary aim of effective early support.

For families of children with developmental delay, empowerment means more than access to information. It requires timely, practical support that removes barriers, builds skills, and creates connection—particularly early, before challenges escalate. Peer-based programs such as [Now & Next](#) demonstrate how parent confidence and hope can shift when families are supported early and respectfully.

Physiotherapists contribute to this outcome through relationship-based coaching that supports caregivers to read their child's cues, co-regulate, and embed development-supporting movement and play into everyday routines. This approach is associated with improved developmental trajectories, including better language, participation and socio-emotional outcomes for children with developmental delay.

**Empowerment should be measured through outcomes that matter to families and systems, including:**

- › caregiver confidence and stress
- › time from identification of developmental concern to receipt of support
- › school readiness and inclusion;
- › participation in everyday settings; and
- › reduced need for intensive or crisis-driven services over time.

### **Outcome 2: Children are supported to grow into healthy, resilient adults**

**Yes, with the important caveat that children must first be supported to thrive in childhood.** Long-term resilience is built through early experiences of safety, belonging, participation and inclusion, not solely through future-focused outcomes.

Physical development plays a foundational role in this process. Early motor differences, particularly in the first two years of life, are robust markers of broader developmental risk. Early physiotherapy intervention can shift developmental trajectories before challenges consolidate, supporting participation, confidence and learning.

Consistent with the Framework, this outcome also depends on inclusive communities and evidence-informed service systems. Children's resilience is shaped not only by families, but by how well services collaborate, adapt environments, and respond early to emerging need.

## Program structure

### *Will a single national program provide more flexibility for your organisation?*

Yes. For the APA, a single national program would provide greater flexibility and coherence, supporting the reform intent outlined in the discussion paper.

**The APA supports a consolidated DSS program that creates a clearer national architecture to sit alongside ECI Framework and foundational supports, reducing fragmentation across multiple small programs with differing rules, reporting requirements and timeframes.**

For providers delivering services across prevention, early intervention and more intensive family supports, a single program and grant agreement—regardless of activity stream—will simplify contracting and enable services to respond flexibly to local need over time. This is particularly important for allied health providers working across health, education and community settings.

Flexibility should include the capacity to rebalance effort between universal, foundational and more intensive supports as community needs change, without requiring re-tendering or structural program changes. This supports proportionate universalism and enables early, preventive responses rather than crisis-driven escalation.

A single national program also facilitates consistent expectations around evidence-informed practice, cultural safety and outcomes measurement, while still allowing for local, place-based design. This balance is critical to ensuring strong partnerships with state and territory systems, Aboriginal and Torres Strait Islander community-controlled organisations, and local allied health providers.

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

#### Stream 1

##### **National programs and information services**

Activities that have a large geographical footprint, deliver services to all types of families in Australia, and have few or no restrictions regarding who can access the support.

#### Stream 2

##### **Prevention and early intervention**

Evidence-informed services that help prevent problems early and keep families strong and safe.

Programs that support children and young people's development and wellbeing.

#### Stream 3

##### **Intensive family supports**

Evidence-informed services that support families at risk of contact with child protection services.

Support for families facing multiple, complex challenges –

**Yes. The APA supports the three-stream model and the principle of proportionate universalism underpinning it.**

Children and families should be able to access physiotherapy at a scale and intensity that matches their level of need, rather than only after diagnosis, crisis or child protection involvement. The proposed streams enable developmental continuity, with universal supports providing early reach, targeted supports intervening early, and intensive services reserved for families facing compounding challenges.

Physiotherapy services appropriately span all three streams:

Stream	Example
<b>Stream 1</b>  <b>National programs and information:</b>	Physiotherapy-led national resources on motor development, early signs of developmental difference and play; online parent modules; educator training; and tele-advice services that support early recognition and appropriate next steps.
<b>Stream 2</b>  <b>Prevention and early intervention:</b>	Embedded paediatric physiotherapists in child and parent centres, early childhood education and care settings, community hubs and primary care to deliver screening, triage, group programs and relationship-based caregiver coaching in everyday environments.
<b>Stream 3</b>  <b>Intensive family supports:</b>	Physiotherapists working within multidisciplinary teams supporting families facing multiple and complex challenges, including child protection risk, family violence or housing instability, with a focus on safe routines, participation, caregiver capacity and coordinated care.

Support across these streams must include an explicit place for **foundational developmental supports** for children with mild to moderate developmental delay who are not eligible for the NDIS but require time-limited allied health intervention. Without this, families are left to navigate fragmented systems or wait until needs escalate.

The streams reflect current and future needs, provided they are resourced to support early identification, continuity of care and smooth transitions between levels of support as children grow and circumstances change.

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

**Several targeted design changes would strengthen the program's ability to achieve its stated outcomes.**

- › **Explicit adoption of the National Best Practice Framework for Early Childhood Intervention** as the standard for all developmentally-focused activities (rights-based, relationship-based, strengths-based, ecologically-based; everyday settings; teamwork; outcomes-focused).
- › **Funding for coordination and non-face-to-face activities.** Effective early intervention relies on shared assessment, case conferencing, caregiver coaching and coordination across settings. These activities should be explicitly funded to avoid fragmentation, duplication and service silos.
  - **Create explicit expectations that services deliver in natural settings** (home, ECEC, community), not only clinics, and that physiotherapy time includes coaching parents and educators, not just “hands-on” child work.
- › **Support for workforce sustainability and capability.** Longer-term funding agreements should be paired with workforce development initiatives, including training pathways, supervision and incentives to attract and retain allied health professionals, particularly in rural and remote communities.
- › **Ensure program rules allow partnerships and consortiums** (e.g. ACCOs + allied health + peer organisations like small community private clinics, [Now & Next](#) and [Royal Far West](#)) rather than privileging single, large providers.
- › **Outcome measurement aligned to meaningful change.** DEX reporting should prioritise outcomes that reflect family capability and child participation, not just service outputs. Measures such as time to first support, caregiver confidence, participation in everyday settings and successful transitions will better reflect program impact.

## Prioritising investment

1. *Invest early to improve family wellbeing, break cycles of disadvantage, and reduce the need for later interventions – like child protection.*
2. *Prioritise connected, co-located, and integrated services that work together to meet family needs.*
3. *Ensure services are informed by, and respond to, community needs.*
4. *Improve outcomes for First Nations children and families by increasing the number of Aboriginal and Torres Strait Islander community-controlled organisations (also called ACCOs) delivering supports in locations with high First Nations populations.*

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

**Yes. The APA finds the four priorities identified on page four are the right areas for investment to improve outcomes for children and families.**

**Investing early is essential to improving family wellbeing**, preventing escalation of need and reducing reliance on later, more intensive interventions. Developmental vulnerability often emerges in the first year of life, and timely, evidence-informed supports such as physiotherapy can alter trajectories before challenges consolidate.

**Prioritising connected, co-located and integrated services reflects what families consistently report they need:** supports that are easy to access, coordinated and delivered in places they already attend. Integration across health, education and community settings reduces fragmentation, shortens wait times and improves continuity of care.

**Ensuring services are informed by and responsive to community need** is critical to effective and equitable investment. Place-based approaches that draw on local data, partnerships and lived experience are more likely to reach families early and adapt to changing circumstances over time.

**Improving outcomes for Aboriginal and Torres Strait Islander children and families** through increased investment in ACCOs is essential. Culturally safe, community-led services are best placed to support children and families in ways that build trust, participation and long-term wellbeing, consistent with commitments under the National Agreement on Closing the Gap.

Together, these priorities align with the National Best Practice Framework for Early Childhood Intervention and provide a strong foundation for a system that supports families early, reduces inequity and improves outcomes across the life course.

*Are there any other priorities or issues you think the department should be focussing on?*

**Yes. In addition to the priorities outlined in the discussion paper, the APA suggests several cross-cutting issues are critical to the success of the new program.**

- › **Continuity across systems and reforms**  
The program should be designed to align with related reforms across early years, foundational supports, education and disability systems. Clear pathways between universal services, the new program and other systems will reduce fragmentation and improve experiences for children and families.
- › **Workforce capability and sustainability**  
Achieving the program's objectives will depend on a skilled, supported and sustainable workforce. Investment is needed in workforce development, supervision and retention, particularly for allied health professionals delivering early intervention and family supports in rural, remote and disadvantaged communities.
  - **Investing in implementation support** – national training, coaching and quality improvement infrastructure – so services can actually deliver what the policy promises.
- › **Funding for coordination and non-face-to-face activities**  
Effective support for families relies on coordination across services, shared assessment, case conferencing and caregiver coaching. These activities are essential to outcomes but are often unfunded. Explicitly supporting them will strengthen integration and reduce duplication.
- › **Explicitly adopting neurodiversity-affirming, culturally safe and trauma-aware practice expectations**, consistent with ECI principles.
- › **Strengthening parent peer-workforce models** alongside professional supports

## Improving family wellbeing

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

1. Families at risk of child protection involvement.
2. Prevention and early intervention support for children aged 0-5 years.
3. Young parents aged under 25.

Yes. Physiotherapists work with children and families across health, education and community settings, often developmental vulnerability and psychosocial risk cluster among families experiencing adversity, barriers and lacking sufficient supports.

**Families facing adversity often experience intersecting challenges, including developmental vulnerability, reduced access to early supports, social isolation and heightened stress.**

**Physiotherapists can engage with these families through mainstream and soft-entry settings such as child and family centres, early childhood education and care services, community hubs and primary care.** In these environments, physiotherapy supports early identification of developmental concerns and provides caregiver coaching that focuses on everyday routines, movement, play, feeding and transitions, that are central to both child development and family wellbeing.

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. Harnessing physiotherapy through national standardised screening and early intervention in the first 1,000 days will improve participation and reduce the need for intensive, ongoing supports.

Physiotherapists working in homes and ECEC can support parent–child relationships through play, co-regulation and practical adaptations to routines, which directly supports child safety and attachment. Young parents, especially those without strong support networks, benefit from practical, strengths-based coaching in everyday routines and play; physiotherapists can model this in real time, not just in clinic.

Early developmental supports delivered in non-stigmatising settings can strengthen protective factors, support safe and predictable routines. For young parents, hands-on, relationship-based support builds confidence, capability and connection, supporting both parenting capacity and child participation.

These focus areas are therefore well aligned with service priorities, provided the approach enables early access to allied health supports, values prevention and early intervention, and funds integrated approaches that address developmental, social and family needs together.

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

**Families of children with developmental concerns**, delay or disability who are not NDIS participants – including those on waitlists or just below eligibility thresholds – are a critical group; they still need supports such as physiotherapy to avoid deterioration.

**Families in rural, regional and remote communities**, geographic location continues to be a significant barrier to access. Families in rural and remote areas face workforce shortages, longer wait times and reduced service choice. Targeted investment in outreach models, telehealth and workforce incentives is needed to ensure equitable access to early supports.

**Culturally and linguistically diverse families**

Families from culturally and linguistically diverse backgrounds may experience barriers related to language, health literacy and service navigation. Services must be culturally responsive and supported to adapt delivery models to meet the needs of diverse communities.

**To respond effectively to these and previously identified groups, the program should support flexible, evidence-informed delivery approaches that are scalable and family-centred.**

**This includes:**

- › blended peer and professional models
- › family-led goal setting
- › group-based early intervention programs

Movement and regulation groups, parent education programs and caregiver coaching groups, delivered jointly by physiotherapists and other allied health professionals, can provide timely, practical support while building caregiver confidence and peer connection.

Group-based and blended approaches enable early intervention to be delivered efficiently through mainstream and community settings, reduce stigma, and support families before challenges escalate. These models align with the National Best Practice Framework for Early Childhood Intervention by emphasising participation, everyday settings and building family capability.

## Connected, co-located, and integrated services

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

The APA finds that beyond co-location, which has limiting factors, effective connection and coordination for families is achieved through service models that enable shared planning, warm referrals and consistent communication across providers and settings.

#### **Warm referral pathways and active navigation**

Warm referrals are where services actively introduce families to the next provider, share relevant information (with consent), support follow-through and improve continuity. Navigation supports are particularly valuable for families experiencing stress, low health literacy or complex service systems.

#### **Shared intake, screening and triage**

A single or aligned intake process across local services, including shared screening and triage, helps families tell their story once and reduces duplication. Clear criteria for stepping supports up or down supports timely access and reduces waiting until issues escalate.

#### **Joint care planning and case conferencing**

Regular multidisciplinary case conferencing and shared care plans strengthen coordination, particularly for families with multiple needs. This approach supports consistent messaging, aligned goals and efficient use of resources. These activities must be explicitly supported and resourced, as they are central to integrated care.

#### **Family-led goal setting and shared outcomes**

Family-led goals provide a unifying framework across providers and systems. Shared outcomes, particularly those focused on child participation and caregiver confidence, help services coordinate around what matters to families rather than around program boundaries.

#### **Structured partnerships between services and settings**

Formal partnerships and service agreements between community services, allied health, early childhood education and care and schools support consistent referral pathways, role clarity and integrated support across everyday settings where children live, learn and play.

#### **Use of secure information sharing and consent processes**

Clear, standardised consent processes and secure information sharing reduce delays and enable coordination across services, while ensuring privacy and trust. Practical guidance and consistent expectations support implementation across providers.

**These approaches work best when paired with flexible funding and contracting that supports coordination activities (such as case conferencing and shared planning), not just direct service delivery.**

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

- › **Evidence of co-design with families, children, First Nations communities and local organisations** – including governance structures that embed lived experience and local leadership.
- › **Established partnerships/MOUs** with ACCOs, ECEC services, schools, GPs, hospitals and community groups – including shared protocols for screening, referral and joint work.
- › **Demonstrated history of delivering in everyday settings** (home, ECEC, school, community) and adjusting models based on local feedback (e.g. tele-hybrid outreach, key worker models, peer groups).
- › **Workforce profile** showing local employment, inclusion of physiotherapists and allied health, peer workers and First Nations staff, with access to supervision and training in ECI best practice.
- › **Outcomes data** at child, family and community level, and evidence that data is fed back into service improvement.

**Assessment criteria should prioritise:** cultural safety, partnership quality, best-practice alignment, meaningful involvement of parents and children, and demonstrated responsiveness to local needs.

## Responding to community need

### *Beyond locational disadvantage, what else should be considered when allocating funding?*

**Beyond locational disadvantage, funding allocation should consider a range of intersecting factors that influence children's development, family wellbeing and access to early support.**

#### **Developmental vulnerability and unmet need**

Indicators of developmental vulnerability, including AEDC data and local health and education information, should inform funding decisions. Particular attention should be given to communities with high levels of unmet developmental need, including children with mild to moderate developmental delay who may not meet eligibility thresholds for specialist systems.

#### **Complexity and cumulative disadvantage**

Funding should account for the cumulative impact of social adversity, including housing insecurity, family violence, parental mental health challenges, substance use and involvement with multiple service systems. These factors increase service intensity and coordination requirements and should be reflected in funding levels.

#### **Barriers to access and service navigation**

Communities where families experience barriers such as language, low health literacy, stigma or limited service awareness may require additional investment to support outreach, navigation and engagement.

#### **Population dynamics and service demand**

Rapid population growth, high population turnover or changing demographics can place pressure on local services. Funding models should be responsive to shifts in demand over time rather than relying solely on static measures.

#### **Workforce availability and sustainability**

Workforce shortages, particularly in allied health, directly affect service capacity and continuity. Funding allocations should recognise the additional costs associated with recruitment, retention, supervision and professional development in communities with limited workforce supply.

**Digital inclusion and transport barriers** that affect access to group programs, telehealth, and mainstream services.

**The APA contends that considering these factors alongside locational disadvantage will support more equitable, responsive and effective allocation of funding, aligned with the goals of early intervention and prevention.**

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

- › **Present local needs assessment data alongside service utilisation and outcome data** – showing that the service is reaching priority groups and improving participation and wellbeing.
- › **Demonstrate iterative adaptation:** how family and community feedback, including from children, has led to concrete changes in program design (hours, locations, formats, staff mix).
- › **Provide examples where physiotherapy and allied health have been integrated into existing community structures** (ECEC, schools, ACCOs) in response to local requests.
- › **Include outcome measures aligned with ECI and Thriving Kids aims**, for example participation (PEM-CY), family empowerment, parenting confidence and service experience, as used in the APA submission case studies (supplementary document).
- › **Show evidence of collaboration, not competition:** joint submissions, shared training, cross-referral patterns.

## Improving outcomes for Aboriginal and Torres Strait Islander children and families

### *How could the grant process support and increase the number of ACCOs delivering services?*

The grant process can support and increase the number of Aboriginal and Torres Strait Islander community-controlled organisations delivering services by embedding self-determination, flexibility and long-term investment into program design.

- › **Offer ACCO-only funding rounds** and reserved funding pools for ACCO-led proposals in regions with significant First Nations populations.
- › **Co-design guidelines with ACCOs**, ensuring they reflect community priorities, culturally grounded practice and flexible delivery.
- › **Provide capacity-building grants and technical assistance for grant writing**, governance, evaluation and workforce development, including pathways for Aboriginal physiotherapists and other allied health.
- › **Encourage partnership models** in which ACCOs are the lead, with mainstream organisations (including physiotherapy providers) in supporting roles, and require shared governance structures.
- › **Simplify reporting requirements** and align them with ACCO information systems, while respecting data sovereignty and community control.
- › **Align with Closing the Gap commitments.** Grant processes should explicitly align with the National Agreement on Closing the Gap, particularly Priority Reform Two on building the community-controlled sector. This includes tracking investment in ACCOs and measuring success through outcomes defined by Aboriginal and Torres Strait Islander communities.

### *What else should be built into program design to improve outcomes for Aboriginal and Torres Strait Islander children and families?*

- › **Embed the ECI framework principle of cultural safety** at every level: policy, contracts, service design and practice.
- › **Support ACCO-led models** where physiotherapy, occupational and speech therapy and other allied health are integrated into holistic child and family services on Country.
- › **Require all physiotherapists and allied health delivering services to undertake ongoing cultural safety training**, with supervision and mentoring from Aboriginal leaders and practitioners.
- › **Support flexible delivery** (home visits, outreach to remote communities, tele-hybrid models) designed with local Elders and communities.
- › **Ensure program outcomes and evaluation frameworks respect Indigenous data sovereignty**, and incorporate cultural, spiritual and community outcomes defined by communities themselves.
- › **Address fear of child removal** by clearly framing services as voluntary, supportive, and family-strengthening rather than surveillance.

## Measuring outcomes

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

- › A small, consistent core set of outcome measures across four domains (mirroring the ECI Framework): **child, family, community and service**.
- › **For children:** functional participation and motor development (e.g. MABC-2, PEM-CY, Goal Attainment Scaling) and simple participation rubrics suited to ECEC and school settings.
- › **For parents/caregivers:** empowerment, confidence, mental wellbeing, and satisfaction with partnership (e.g. Family Empowerment Scale, Parenting Sense of Competence, MPOC-20).
- › **For services:** time from referral to first contact; proportion of sessions delivered in everyday settings; completion rates; reach into priority groups; use of key worker models.
- › **For communities:** indicators of inclusion (ECEC attendance, school engagement, parent reported sense of belonging) and changes in developmental vulnerability at population level over time.

**Data should be collected in ways that are feasible for small providers, and routinely fed back for local quality improvement, not just central reporting.**

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

The most valuable data to demonstrate positive impact combines summarised, de-identified outcome data with contextual information that shows how services are improving everyday life for children and families.

#### **Summarised, de-identified outcome data showing:**

- › percentage of children achieving their developmental/participation goals;
- › improvements in parent confidence and empowerment;
- › gains in participation at home, ECEC and school (e.g. more children joining play, attending ECEC, included in PE).

**Equity metrics:** reach and outcomes for First Nations, CALD, rural/remote and low-income families.

**Examples of cross-sector impacts:** improved educator confidence, reduced exclusionary discipline, smoother transitions into school

**Short case vignettes** that illustrate how physiotherapy and allied health change everyday life, paired with the quantitative data.

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

For paediatric physiotherapy-led activities, the most relevant SCORE Circumstances domains are:

- › **Family functioning** – because physiotherapy is delivered through caregiver coaching and shared routines, influencing how families function day-to-day.
- › **Community participation and networks** – because the goal is children’s inclusion in ECEC, school, sport, play and community life.
- › **Mental health, wellbeing and self-care** – for both children and caregivers, given the links between developmental vulnerability and later mental health risk.

**It is important to note that the current DEX domains do not yet explicitly name “child development.” Physiotherapy outcome reporting could inform future refinement.**

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

**A standard case study template that prompts services to describe:**

- › child and family context (including culture, community, and strengths);
- › goals set *by* the family;
- › supports provided
- › changes in participation, family confidence and connection, with links to outcome measures.

Guidance on weaving quantitative data (GAS, PEM-CY, empowerment scales) into narrative stories for different audiences.

Prompts to capture cross-sector collaboration (ECEC, schools, ACCOs, health) and how services worked in everyday settings.

Clear advice on consent, de-identification and trauma-aware storytelling, including for First Nations communities (aligned with Indigenous data sovereignty principles).

Optional story formats for families to write or co-author their own case studies.

## Working together

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

Relational contracting means long-term, trust-based partnerships between DSS and providers, with shared outcomes, flexibility in how supports are delivered, and genuine joint problem-solving.

For physiotherapy-led services, it allows investment in workforce development, supervision, innovation and evaluation over time (e.g. multi-year demonstration of embedded physiotherapy in ECEC clusters)

#### **Criteria should include:**

- › proven alignment with ECI Best Practice Framework;
- › strong governance (including lived experience and ACCO representation where relevant);
- › track record of high-quality, culturally safe service delivery and continuous improvement;
- › capacity to collect and use outcome data;
- › willingness to collaborate with local partners and share learning nationally.

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

#### **Use transparent selection processes with clear thresholds:**

- › demonstrated impact (outcomes + evaluation);
- › service to priority cohorts (First Nations, rural/remote, high-vulnerability areas);
- › strong partnerships (with ACCOs, ECEC, schools, health)

**Consider a staged approach:** initial shorter-term “learning” contracts that can progress to full relational contracts once providers demonstrate quality, collaboration and data capability.

**Ensure diversity of providers across geography and type:** ACCOs, specialist ECI services, peer-led organisations, and allied health providers (including physiotherapy-led).

**Engage external experts** and lived experience panels in assessing candidates, not just paper-based scoring.

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