Brotherhood of St. Laurence

Enhanced Early Supports Pilot

Evaluation report

Sarah Watt, Kelly Fawcett, Katy Cornwell, Margaret Olczak and Tanya Oxlade

2025

Brotherhood of St Laurence
Working for an Australia free of poverty

Let's make change that lasts

The Brotherhood of St. Laurence (BSL) is a social justice organisation working towards an Australia free of poverty. Our purpose is to advance a fair Australia through our leadership on policy reform, our partnerships with communities and the quality of our services. Our approach is informed directly by people experiencing disadvantage and uses evidence drawn from our research, together with insights from our programs and services, to develop practical solutions that work. For more information visit <www.bsl.org.au>.

Sarah Watt is a Senior Manager and Margaret Olczak is an Early Childhood Coordinator in BSL's Disability Services Portfolio. Kelly Fawcett is a Senior Policy Officer and Katy Cornwell is Head of Impact and Learning in BSL's Research, Policy and Advocacy Portfolio. Tanya Oxlade is Head of Disability Service, Programs and Innovation in the BSL's Disability Services Portfolio.

Published by

Brotherhood of St. Laurence
67 Brunswick Street
Fitzroy, Victoria 3065
Australia

ABN 24 603 467 024

ARBN 100 042 822

T (03) 9483 1183

www.bsl.org.au

Suggested citation: Watt S, Fawcett K, Cornwell K, Olczak M & Oxlade T, 2025, *Enhanced Early Supports Pilot: evaluation report*, Brotherhood of St. Laurence, Fitzroy, Vic.

© Brotherhood of St. Laurence 2025

Apart from fair dealing for the purpose of private study, research, criticism, or review, as permitted under the *Copyright Act 1968* and subsequent amendments, no part of this paper may be reproduced by any process without written permission. Enquiries should be addressed to the publisher.

Foreword

Strengthening the path to connected, supported and thriving kids

The establishment of Thriving Kids across Australia will deliver much needed early supports for children with developmental delay in mainstream settings. It will give children and families opportunities to access supports outside the National Disability Insurance Scheme (NDIS) through a range of touchpoints. The advent of Thriving Kids is a pivotal moment in both disability and early childhood reforms.

The Brotherhood of St. Laurence (BSL) has designed and trialled an innovative solution to inform the future of this important program. Over a two-year period, we have gathered insights and evidence demonstrating the positive impact early and targeted supports can have on children and their families. We have learnt that early intervention services delivered by a Lead Practitioner where children live, learn and play can make a significant difference for children with developmental delay and achieve outcomes consistent with the ambition of Thriving Kids. With this report, BSL hopes to share these lessons as a potential model to be adopted nation-wide.

By building parents' own capacity to support their child's development, this service improved participants' lives while providing an evidence-based alternative to accessing the NDIS. Fewer than one in four (22%) families went on to submit a NDIS access request at the end of the service. With an average of 16.6 direct contact hours, many families exited the pilot early because they met their identified goals. This means families avoided long waiting lists for NDIS services and received timely access to support at a stage of their child's life when every day makes a difference.

Practitioners assisted families to navigate complex service systems, enabling pathways to a range of other supports when needed. Children and families were supported in the home, in the playground and in early learning settings.

BSL believes the outcomes achieved, both at the individual and systems level, can provide a blueprint for the design of Thriving Kids. Not only has the service led to individual developmental improvements, but it also demonstrates a value-for-money approach to ensuring children can remain in mainstream settings while receiving the supports they need. Ideally delivered within an integrated early years setting, the Enhanced Early Supports Pilot provides an evidence base for the future where all children have the opportunity to thrive.

Travers McLeod

Executive Director, Brotherhood of St. Laurence

Contents

Executive summary	**5**
The challenge	5
About the pilot	5
Key findings	6
Recommendations	7
1 Background and context	**8**
Supports in early childhood	8
Current context for children and families	8
NDIS participation of children	9
Proposed foundational supports	9
Design of the Enhanced Early Supports Pilot	10
2 About the Enhanced Early Supports Pilot evaluation	**12**
Utilising a mixed-methods approach	12
3 Pilot reach and implementation	**15**
KEQ 1: How has the pilot been implemented and who did it reach?	15
4 Outcomes	**20**
KEQ 2: To what extent, and for whom, have key program outcomes been achieved? What enabled this, and what could be strengthened?	20
5 Value for families	**27**
KEQ 3: What is the perceived value of the program for families?	27
6 Recommendations	**31**
7 Conclusions	**32**
References	**33**

Executive summary

The challenge

In Australia it is estimated that one in five children has disability or developmental concerns. The services in place to assist these children and their families often do not meet their needs, and many parents and caregivers experience a lack of support from mainstream services. The supports that do exist are often provided within clinical settings that are decontextualised from the child's everyday life, making it more difficult to apply lessons to real-life situations. Alongside this, governments are considering how to make the National Disability Insurance Scheme (NDIS) more sustainable as more children than anticipated have accessed the scheme, with five per cent of all children under the age of nine in Australia on the NDIS.

The Independent Review of the National Disability Insurance Scheme 2023 (the NDIS Review) proposed a Lead Practitioner model, where a practitioner serves as a key worker who supports families with coaching and capacity-building, and provides relevant information about their child's development.

The NDIS Review further proposed the expansion of existing general foundational supports (for example, provision of information, peer supports and capacity building) and the creation of targeted foundational supports. In August 2025, Minister Butler announced the establishment of Thriving Kids to address the needs of children with developmental delays and concerns. The Enhanced Early Supports Pilot, evaluated in this report, has built a valuable evidence base for what this important new system could include.

In many cases the NDIS is not the most effective support pathway for young children. In parts of the country, including northern and western Melbourne where this pilot took place, families face long wait times to access NDIS and other services – and risk missing opportunities to assist their children at a life stage where every day makes a difference. There continues to be a cohort of children who, for a range of reasons, do not access support through the NDIS or other early interventions, and enter school developmentally vulnerable and under-resourced.

About the pilot

The Enhanced Early Supports Pilot provided individualised early supports in home and community settings to a group of children and their families in Melbourne's west not accessing individual NDIS funding. It provided up to 20 hours' individual service over a 12-month period (January 2024 to January 2025). The pilot involved 154 families in Melton and Brimbank, with 149 completing the program. The families were identified through a referral process and proactive local community outreach. Almost half of the participating caregivers were born outside Australia (47%) or spoke a language other than English at home (48%).

Using a Lead Practitioner model, the pilot worked alongside families with children aged 0–6 with developmental concerns and delays who were not accessing the NDIS. The pilot provided families a practitioner who supported them using a capacity building model. The model included visiting families in their homes or community settings. Staff coached caregivers to identify the needs of their child, connected families to foundational and mainstream supports, and provided information, advice and coaching to support the development of the child.

The team consisted of an experienced Senior Early Childhood Coordinator or a Team Leader who was a qualified teacher. The multi-disciplinary staff members held qualifications in social work, speech pathology and early childhood teaching qualifications with some holding dual qualifications. Additional support was provided by a consultant occupational therapist and speech pathologist. Each team member was the key worker for a number of families (around 30) and arranged regular meeting times ranging from fortnightly to monthly. Meetings were held in places identified by the families as important to them, with settings including family homes, kindergartens, play groups, libraries, parks, toy libraries and early childhood care sites.

Staff worked to build family capacity to set priorities and put in place workable strategies that supported their child's development and participation in family and community life. The pilot prioritised strengthening both informal and formal supports, enhancing child and family wellbeing, encouraging community participation and promoting meaningful inclusion of children in universal settings such as childcare and kindergarten. Consistent with Thriving Kids, it further sought to test this model as a potential targeted foundational support, particularly for young children with developmental differences and their families.

Key findings

The pilot has demonstrated that this model – early intervention services delivered by a Lead Practitioner where children live, learn and play – can make a significant difference for children with developmental delay and achieve outcomes consistent with the ambition of Thriving Kids.

Children made significant improvements on key development measures

- Child development measures using the Ages and Stages Questionnaire (ASQ) screening tool showed significant improvements across all areas, most notably in personal and social skills, communication and problem-solving.

The service provided families the support they needed

- Most families exited the program reporting their needs for support with their child's development had been met. Only 22% of families (less than one in four) went on to submit a NDIS access request at the end of the program.

Caregivers felt better able to support their child

- 91% of caregivers said the program had helped them learn about ways to support their child's learning and development, and 87% reported it helped them connect better with their child.

Caregivers became more confident

- 90% of caregivers reported they were more confident accessing support for their child, compared to 58% at the start of the program.

The pilot prioritised strengthening both informal and formal supports, enhancing child and family wellbeing, encouraging community participation and promoting meaningful inclusion of children in universal settings such as childcare and kindergarten.

Caregivers were more satisfied with the supports they were receiving

- After participating in the pilot, 89% of caregivers said they were satisfied with the supports they were receiving for their child, compared to 64% at the start. 64% found the pilot helped connect them with services in the community to support their child.

Families made progress on their goals

- 92% of caregivers reported that they were satisfied with progress towards the goals they set at the beginning of the program.

Families valued a range of aspects

Caregivers unanimously reported that the pilot was a valuable, high-quality service. In particular, they valued:

- the practical strategies provided by practitioners
- delivery in settings where children live, learn and play
- the lack of waiting time to access supports
- better connecting with their child and the community
- forming a relationship with the practitioner.

Recommendations

The evaluation offers the following recommendations for government:

- Implement the Lead Practitioner model as part of an integrated early years approach
- Within Thriving Kids, provide targeted foundational supports in natural settings, such as those provided by this trial, for children 0–6 with developmental differences.

It also offers recommendations for further enhancements to the model:

- Explore the possibility of delivering the model via an expanded workforce to address workforce supply and demand pressures across the system.
- Build in linkages across a range of integrated services to strengthen families' self-advocacy and improve engagement with community and mainstream systems.
- Strengthen peer support for caregivers through the model, as recommended by the NDIS Review.
- Complete longitudinal follow up to determine sustainability of outcomes.

1 Background and context

Supports in early childhood

In Australia it is estimated that one in five children have disability or developmental concerns (Independent Review into the National Disability Insurance Scheme 2023 (the NDIS Review)). However, parents and caregivers often say they experience a lack of support from mainstream services, with the supports that do exist often being provided in clinical settings that are decontextualised from the child's everyday life. Alongside this, more children than anticipated have entered the NDIS, with five per cent of all children under the age of nine in Australia on the scheme.

Of the 26 recommendations and related actions made by the NDIS Review, three were particularly addressed by the development of this pilot:

- Recommendation 1: Invest in foundational supports to bring fairness, balance and sustainability to the ecosystem supporting people with disability.
- Recommendation 4: Support all people with disability to navigate mainstream, foundational and NDIS service systems.
- Recommendation 6: Create a continuum of support for children under age nine and their families.

The NDIS Review also highlighted that the NDIS is experienced by scheme participants as insufficient in the way it informs, supports and builds the capacity of many families to respond to their children's developmental concerns and needs.

The NDIS Review further proposed the expansion of existing general foundational supports (for example, provision of information, peer supports and capacity building) and the creation of targeted foundational supports. In August 2025, Minister Butler announced the establishment of 'Thriving Kids' to address the needs of children with developmental delays and concerns.

The Enhanced Early Supports Pilot program was designed in response to these findings and builds on best practice evidence regarding coaching, key worker models and early childhood intervention practices (Early Childhood Intervention Australia 2016). It has built valuable information on what a 'Thriving Kids' system could include.

Current context for children and families

Children with developmental delays and developmental concerns are usually connected with a NDIS Early Childhood Partner in the Community (PiTC). At the time of the pilot development, the typical pathways offered for these children were applying for the NDIS or 'early supports' (a targeted short-term intervention of six to eight sessions to address specific developmental concerns such as speech delay; behaviours of concern; toileting).

Most families with children who meet the criteria for NDIS developmental delay or disability apply for NDIS-funded plans. Early supports[1] are not typically offered as an alternative to funding although, at times, children receive a short period of early supports prior to applying for a funded plan.

Additionally, children with developmental concerns who do not meet the NDIS criteria or threshold for developmental delay are offered six to 12 hours of NDIS-funded early supports with an Early Childhood Coordinator through the PiTC. Over the years, the uptake of early supports has been impacted by the diversion of the PiTC workforce into planning functions originally envisaged to be undertaken by NDIA delegates; and by the belief of caregivers that a NDIS plan was the best way to support their child's development. This has been further exacerbated by a lack of understanding among medical and allied health professionals about the availability of early supports for families.

1 https://ourguidelines.ndis.gov.au/early-childhood/early-connections/what-types-early-connections-are-available/connections-early-supports

Alternatively, children who access neither NDIS-funded plans for developmental delay or disability, nor early supports may receive allied health and specialised education support for their developmental needs via:

- Victorian Government Early Childhood Intervention Service – Continuity of Supports program (for children with disability who are ineligible for NDIS-funded plans based on their visa status)
- community health
- private services via Medicare rebated programs (Enhanced Primary Care Program, Chronic Disease Management Plan).

NDIS participation of children

Children have entered the NDIS at higher rates than initially estimated by the Productivity Commission in 2011. This continues to increase year on year. Children make up nearly half of all people on the NDIS (NDIS Review). As of June 2024, about 11 per cent of all Australian six-year-olds were on the NDIS, including 14.2 per cent of six-year-old boys.

Despite high levels of NDIS participation, fund utilisation data indicates that the NDIS may not be the most effective support pathway for young children, particularly in the west and northwest of Melbourne:

- Across Victoria, the 0–6-age participant cohort has consistently demonstrated the lowest plan utilisation percentage (between 62–66% from March 2023 to March 2024).
- More specifically, as of Q2 FY2023-24, Melton (61%), Hobsons Bay (64%), Brimbank (65%) and Wyndham (67%) were in the top 10 of lowest plan utilisation percentages.
- This is notable given that Wyndham, Melton and Brimbank are areas with the largest cohorts of 0–6-year-old NDIS participants.
- These areas have some of the largest proportions of young children (0–4-year-olds) to the rest of their population, with Wyndham at 9%, Melton at 8% and Hobsons Bay at 6% (as of 2022).

Additionally, there continues to be a cohort of children who, for a range of reasons, do not access support through NDIS or other early intervention, and enter school developmentally vulnerable and under resourced.

Proposed foundational supports

One of the recommendations of the NDIS Review was the development and implementation of supports for children with developmental differences or disability outside of the NDIS, described as foundational supports. These supports were envisaged to be co-invested by state, territory and Commonwealth governments, although at the time of writing what these supports will look like, how they will be funded and who will deliver them is undecided.

The review proposed that foundational supports include:

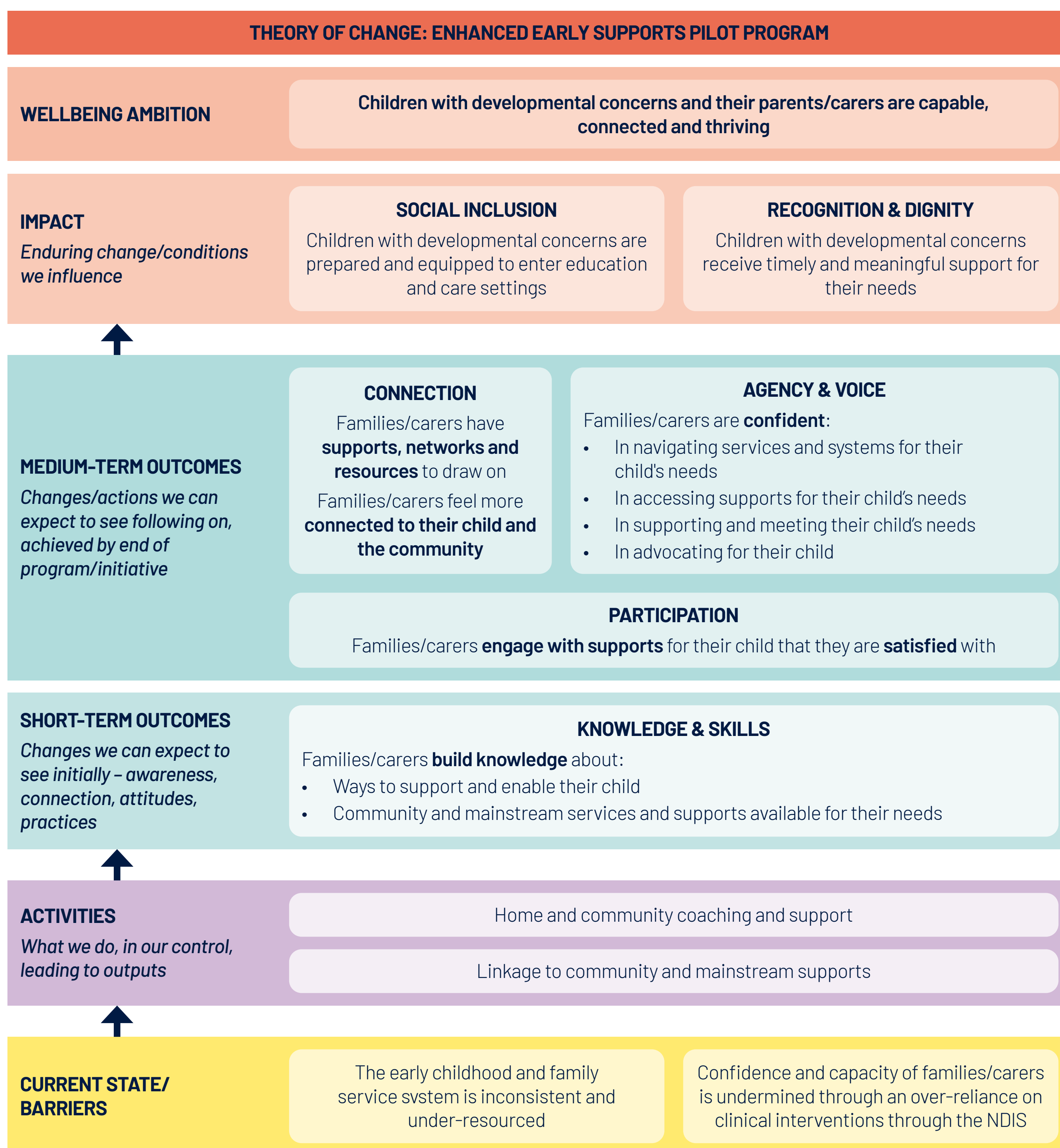
- **General foundational supports:** Information to connect all children and their families to local and accessible supports and include websites, online support, peer support groups, social and emotional support for parents and carers, and parent workshops.
- **Targeted foundational supports:** Supports that function as a bridge between mainstream services, such as early childhood education and care (ECEC) settings and schools, and the specialist supports provided through the NDIS. These supports may include access to allied health services, one-off or low-cost assistive technology, or one-on-one assistance for caregivers to equip them with skills and information.

The objective of these targeted supports is to empower families earlier by helping them understand their role in supporting their child's learning and development and provide them with the necessary skills, confidence and support to raise their children using contemporary approaches to disability (DSS 2024b).

Design of the Enhanced Early Supports Pilot

This pilot sought to test elements of the Lead Practitioner model proposed in the NDIS Review through the provision of targeted foundational supports. The Lead Practitioner is a key worker who supports families with coaching and capacity building and provides relevant information about their child's development. The Enhanced Early Supports Pilot was also designed to address a key concern raised by BSL's 2023 submission to the federal government's development of the Early Years Strategy that '[s]ignificant social and economic advantages are gained by investing in the early years. Yet our current early childhood development system is inaccessible, confusing and unaffordable, particularly for those who need it most' (BSL 2023, p. 1).

Figure 1: Theory of change



The pilot program model design was informed by a range of evidence-based practice resources including 'Practitioner as Coach' (Parenting Research Centre 2021); *The key worker: resources for early childhood intervention professionals* (Alexander & Forster 2012); *The early childhood coaching handbook* (Rush & Shelden 2020); and the *Routines-based early intervention* approach developed by Dr Robin McWilliam (2010).

The model was developed from this evidence-based research using individualised coaching delivered by an experienced and qualified early years practitioner. Coaching was selected as a way of developing the confidence and capacity of the caregiver to meet the needs of their child or children, built on best practice principles by recognising the caregiver as the first teacher of their child, and delivered in settings chosen by the caregiver. This contrasts with the office-based delivery offered by private practitioners or community-based services.

As described in the theory of change above, the pilot's ambition was for capable, connected and thriving children and families. Through support and service within home and community settings, coaching and capacity building, and linkage to community and mainstream services, the pilot sought to address the barriers of an under resourced, fragmented early childhood and family service system and an over-reliance on clinical and specialised interventions for children. The pilot provided timely and adequate services and supports, and building knowledge, skills, connection and confidence. In doing this, it focused on supporting greater engagement and satisfaction with supports, and fostering social inclusion, recognition and dignity for children with developmental concerns and their families.

The pilot provided timely and adequate services and supports and coaching to build knowledge, skills, connection and confidence.

2 About the Enhanced Early Supports Pilot evaluation

The NDIS Review proposed several recommendations, particularly for better ways to support children with developmental concerns and differences. These recommendations included developing the Lead Practitioner role; better foundational supports for all Australians with disability; and targeted foundational supports for children.

The evaluation of the Enhanced Early Supports Pilot seeks to contribute lessons from and insights into the role and value of enhanced early intervention supports for children with developmental concerns and their families. This is based on several recommendations of the NDIS Review including the Lead Practitioner and the need for targeted foundational supports to address the needs of children with developmental differences or concerns. In doing so, it will offer new perspectives on the development of early intervention service models in the early childhood development space.

Conducted 12 months into the pilot, when most of the initial cohort of families had exited the program and new cohorts were beginning, the evaluation is both formative – supporting learning and adaptation for a future iteration of the pilot, and summative – exploring outcomes of the pilot for the first cohort of families. It presents findings and opportunities centred around three key evaluation questions (KEQs):

- KEQ 1: How has the pilot been implemented and who did it reach?
- KEQ 2: To what extent, and for whom, have key program outcomes been achieved? What enabled this, and what could be strengthened?
- KEQ 3: What is the perceived value of the program for families?

Utilising a mixed-methods approach

To answer the KEQs, the evaluation draws on quantitative and qualitative methods. Pilot reach and outcomes are explored through family-level service delivery data and caregiver self-report surveys. Semi-structured interviews with staff and caregivers and a sensemaking workshop with staff, serve to triangulate, surface and layer perceptions and experiences of the pilot.

The NDIS Review proposed several recommendations, particularly for better ways to support children with developmental concerns and differences.

Table 1: Method for answering KEQs

KEQ	Method/source
How has the pilot been implemented and who did it reach?	Family-level service delivery data on entry: • Demographics • Family relationships and supports (ecomap) • Service utilisation and satisfaction • Child development screening assessment (Ages and Stages Questionnaire (ASQ)) • Goal development and assessment (Goal Attainment Scaling (GAS) Light)
To what extent, and for whom, have key program outcomes been achieved? What enabled this, and what could be strengthened?	Family-level service delivery data on entry and exit Caregiver survey on entry and exit
What is the perceived value of the program for families?	Caregiver survey on exit Semi-structured interviews – caregivers Focus group – practitioners

Family-level service delivery data includes information collected through routine service delivery such as family demographics, pre/post-mapping of family relationships and supports (ecomaps), and pre/post-child development screening assessments (ASQ). This data was de-identified and submitted to the evaluation team at the time of collection via a secure survey platform and not stored by practitioners. Similarly, caregivers were invited to complete surveys at their entry and exit consultation sessions to capture service experience and outcomes. Child and family data was linked across caregiver surveys and practitioner reports following standard data linkage methods (DSS 2023).[2]

Evaluation sample

The evaluation covers the period from commencement of the pilot in January 2024 to end of January 2025. The data evaluated represents families who completed the pilot during this period.

While caregiver surveys had a high completion rate (124 at entry and 94 at exit out of a total 144 families exiting by January 2025), it was only possible to match approximately half of the families across all four data collection points (caregiver surveys at entry and exit and practitioner reports at entry and exit).[3] Therefore, the analysis includes results for all families at entry, all families at exit and the change in outcomes for those who could be matched across entry and exit (see Table 2).

Semi-structured interviews were conducted with 16 caregivers and eight staff who either delivered or developed the pilot. Four direct service delivery staff participated in a sensemaking workshop.

2 Due to NDIA contractual obligations, no identifiable data can be stored or accessed through BSL systems. Family details were entered into a secure survey form, but upon submission a purpose-built survey script was activated to generate a linkage key and de-identify all data. This enabled responses across the four family-level data collection points to be matched without storing any personal or identifying data.

3 The linkage key required specific information to be consistently collected. Unfortunately this did not happen across the four data collection points, which meant that not all data points could be matched.

Table 2: Sample sizes for data sources

Data source	Number of responses/ participants
Caregiver survey at entry	124
Caregiver survey at exit	94
Caregiver survey matched across entry and exit	71
Practitioner report at entry	126
Practitioner report at exit	99
Practitioner report matched across entry and exit	77
Matched across caregiver and practitioner at entry	99
Matched across caregiver and practitioner at entry	84
Matched across entry and exit	59
Semi-structured interviews	16 caregivers 5 direct service staff 3 leadership staff
Sensemaking workshop	4 direct service staff

3 Pilot reach and implementation

KEQ 1: How has the pilot been implemented and who did it reach?

This question is explored considering the stages of a family's journey through the pilot: referral and enrolment, service delivery through coaching, goal setting, accounting for context and utilising a multidisciplinary team, and exit.

Referrals and proactive outreach met a high demand for the service offer

The pilot connected with 154 families in Melton and Brimbank through a referral process. This process began in January 2024 and by May 2024, the target for service numbers had been met.[4] Referrals continued to be accepted until the end of June 2024.

Referrals were received directly from local PiTC Early Childhood staff who met families and determined they were likely to have their needs met via an expanded early supports service offer. Some 57% of referrals to the pilot came from these channels.

The remaining 43% came from proactive outreach to local community and mainstream referrers. These included preschool field officers, maternal child health nurses, paediatricians, community health services workers, word of mouth, local council workers and ECEC staff.

A small number of families self-referred.

Of the 154 children and families, 10 did not enrol in the pilot. Some 126 went on to participate in the pilot between January 2024 and January 2025. Families who did not continue or exited the pilot early did so for various reasons. A number of families chose to apply for NDIS access immediately, or connected with alternate services or programs and did not participate. Others did not feel they needed additional support or moved out of the region. Some families said they did not have time to participate in the program.

Families expressed gratitude for the timeliness and accessibility of the pilot, with many indicating confusion and complexity around the availability of supports for their child:

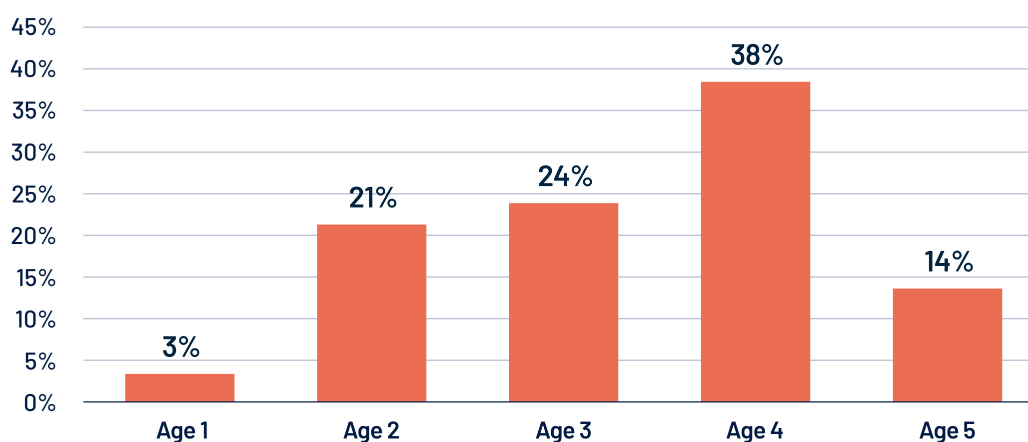
> ***Prior to this program I didn't have any idea – I thought a child has to have a diagnosis before we could receive any type of support at all.***
>
> ***Parent***

4 The target for service numbers was between 120–144 children and the lower threshold of this number was reached by May 2024. This was within four months of telling referrers and the community about the new service offer.

Reaching a diverse cohort

Participating children ranged from 18 to 60 months, with the majority being between 36 and 60 months old at entry.

Figure 2: Age of children at entry



Primary caregivers were predominantly female (88%), living in coupled households (77%) and about half (48%) were university educated. Families were culturally and linguistically diverse – with close to half born outside Australia (47%) and speaking more than one language at home (48%). The majority were Australian citizens (76%), with some permanent residents (16%).

Table 3: Caregiver demographics

Characteristic	Demographic	Per cent of primary caregivers
Gender	Female	88%
	Male	12%
University educated		48%
Language and cultural background	Speaks more than one language at home	48%
	Aboriginal or Torres Strait Islander origin	4%
	Born outside Australia	47%
Residency status	Australian citizen	76%
	Permanent resident	16%
	Temporary resident	5%
	Other	3%
Household make-up	Couple with child(ren) or other dependent(s)	77%
	One parent/carer with child(ren) or other dependant(s)	11%
	A group of other family/relatives	10%
	Other	1%

The design elements provided effective support

As outlined in the introduction, the model of delivery was connecting each family to a Lead Practitioner, whose role was to support them using a strengths-based and capacity building model for the service duration. The Lead Practitioner's role included giving information and advice; in partnership with the caregiver, identifying and addressing goals and needs; and meeting these through coaching and capacity building. The four main design elements included:

- coaching and capacity building
- participation-based goal setting
- context-specific service
- delivery through a multi-disciplinary team

Coaching and capacity building

Coaching was delivered as the approach to building the capacity of caregivers to select strategies and develop plans for working towards priority goals for their child. Drawing from a synthesis of research on coaching practices and incorporating theories and practices of adult learning, behavioural and goal-focused approaches, Rush and Shelden (2020) define coaching as:

> ***An adult learning strategy in which the coach promotes the learner's (coachee's) ability to 1) reflect on their actions to determine the effectiveness of an action or practice and 2) develop a plan for refining and using the action in immediate and future situations.***
>
> ***The Early Childhood Coaching Handbook***

Pilot staff were trained in Rush and Shelden's model for coaching in early childhood settings. They were introduced to the key elements of coaching outlined in the handbook and additional practice resources published by the Family Infant and Preschool Program.

Additionally, BSL Early Childhood staff were trained in the 'Practitioner as Coach' content in 2021 by the Parenting Research Centre. The training materials and resources were also used for staff training and guidance in implementing coaching with parents and caregivers.

The coaching approach was effective and highly valued, but required mindset shifts, ongoing training and support

The pilot sought to use the coaching interactions during home and community visits to help caregivers enhance their ability to interact with their children in ways that supported the child's development. Coaching was to be integrated into everyday routines to help caregivers identify strategies, practise these strategies during visits, reflect on their interactions with their children, solve challenges, reflect and share feedback on strategies that caregivers had trialled between sessions, and plan ways to implement new or adapted strategies between visits.

However, pilot staff initially lacked confidence using the coaching approach with caregivers, observing that families and the community often had a perception that direct, therapeutic services were preferred and expected. This prompted the development of additional collateral and scripting to enable staff to explain the approach to collaborative decision-making and emphasise the value of between-session work to families and the community. Pilot staff were also supported with further training, refreshers and regular reflective practice opportunities.

While initially surprised at the coaching approach, caregivers found that working together on goals and strategies was helpful. Caregivers said:

> ***I didn't know there would be a team of professionals working together with you like speech [pathologists] and helping to come up with strategies, I didn't expect this, but it was great.***

> ***[Practitioner] worked with me on [child]'s individual goals, but also helped teach me how to help her reach these goals as well and broke it up into achievable steps. If I didn't understand something, she would explain it to me in a way that I did understand and would make sure that I understand and feel comfortable with what we were going to be working on. It was collaborative.***

> ***[The pilot has been helpful in] learning more about how to deal with [child]'s behaviours, support her with her confidence and helping us to achieve her goals together.***

Participation-based goal setting

Participation-based goal setting was completed with families after developing a shared understanding of the family and child's current ecosystem (ecomap). Through a routines-based conversation, the practitioner and family discussed the child's participation in everyday family and community life, focusing on their engagement, social relationships and independence within these activities and emphasising the child's current and potential participation. This approach contrasted with domain or skill-based goal setting, as it centred around the child's meaningful participation in everyday life and routines.

Participation-based goal setting enabled identification of practical, everyday strategies

When describing the most helpful aspects of the pilot, caregivers identified practical, everyday strategies that supported their functional and participation-based goals:

> ***[The pilot] helped me with different strategies to try with him when taking him out of the house.***

> ***Helping us with strategies with the routine and communication that we could try at home.***

> ***It has helped me with different techniques and ideas in tackling everyday issues with my child.***

Context-specific service delivery

A key component of the pilot model was the delivery of the pilot in settings where children live, learn and play.

Research strongly supports the importance of providing services and support for children with developmental differences in natural settings where they live, learn and play (DSS 2024a). These environments, including homes, ECEC settings and community spaces including parks, program spaces and libraries offer familiar and meaningful contexts that enhance the effectiveness of interventions. Studies show that children are more likely to generalise and maintain new skills when they are taught in their everyday environments.

Context was critical to effective and accessible support

Families and staff provided strong and consistent feedback in surveys, interviews and workshops that the location for service being at home, in childcare, at kindergarten or at a community space was important and improved the effectiveness of the work. They said:

> ***I am so thankful that she came to my home. It really helped.***

> ***It has been great that [practitioner] could see his surroundings and how he behaves at kinder and at home.***

> ***[Practitioner] was able to observe my child in real-life environment and recommend accordingly.***

By embedding strategies and developmental opportunities into daily routines, families said they were able to practice strategies they chose in real-life, real-time situations, which led to better outcomes.

Many families described:

- sessions in the home as being convenient and comfortable
- sessions in the home allowing children to be themselves
- sessions in the home and ECEC settings allowing the practitioner to observe behaviours that typically occur.

Pilot staff identified that delivery of the pilot in the home and other settings made the program more accessible. One explained:

> ***I feel like we were able to connect with certain families who would not have otherwise engaged ... One [caregiver] had social anxiety and at the start [of the pilot] didn't really leave the house at all. [Another caregiver] said to me ... 'if this was at your office we just wouldn't have come' ... I guess [we are] really making it easy for families [by] going into their home. They didn't have to leave.***

Delivery by a multidisciplinary team

The pilot was delivered by a multidisciplinary team consisting of five practitioners and one senior practitioner with consulting allied health practitioners.

> ***We aimed to recruit staff with different languages and cultural backgrounds and profession[al] backgrounds. We ended up with social workers, teachers, speech pathologist and then [we had a] consulting occupational therapist last year.***
>
> ***Pilot staff member***

Staff valued case consultation using expertise across a multidisciplinary team

In individual interviews and throughout the sensemaking workshop, staff reported that structured peer coaching opportunities through case consultations and team meetings enabled sharing ideas and staff support. This was essential to providing responsive and individualised service to families.

Short-term support was effective in reaching goals

The pilot allowed for up to 20 direct contact hours, with the practitioners and caregivers identifying goals to be achieved during this period. On average, families received 16.6 direct contact hours and were engaged in the pilot for eight months. Most families exited early having met their goals (43%) or transitioned to access NDIS funding (18%). Some 26% of families exited having completed the full 20 direct contact hours and 83% of families exited having achieved at least one of their goals.[5]

Table 4: Outcomes described at point of exit

Reason for exit	Total
Goals met	43%
Completed 20 contact hours	26%
Child transitioned to access NDIS/Early Childhood Intervention Services Continuity of Support (ECIS CoS)[6]	18%
Support no longer required	4%
Moved out of area	2%
Support not helpful/suitable	2%
Other reason	5%

On average, families received 16.6 direct contact hours and were engaged in the pilot for eight months.

5 Measured using Goal Attainment Scaling (GAS) Light.

6 22% of total children referred requested NDIS access by the end of the service.

4 Outcomes

KEQ 2: To what extent, and for whom, have key program outcomes been achieved? What enabled this, and what could be strengthened?

Articulated in the theory of change (Figure 1), the pilot's ambition of capable, connected and thriving children and caregivers is expected to be achieved through building carer knowledge, skills and confidence as well as engagement with and connection to quality supports, networks and the community. The extent to which these outcomes have been achieved is explored through responses to questions in the entry and exit caregiver surveys.

The pilot helped build knowledge, skills and connection

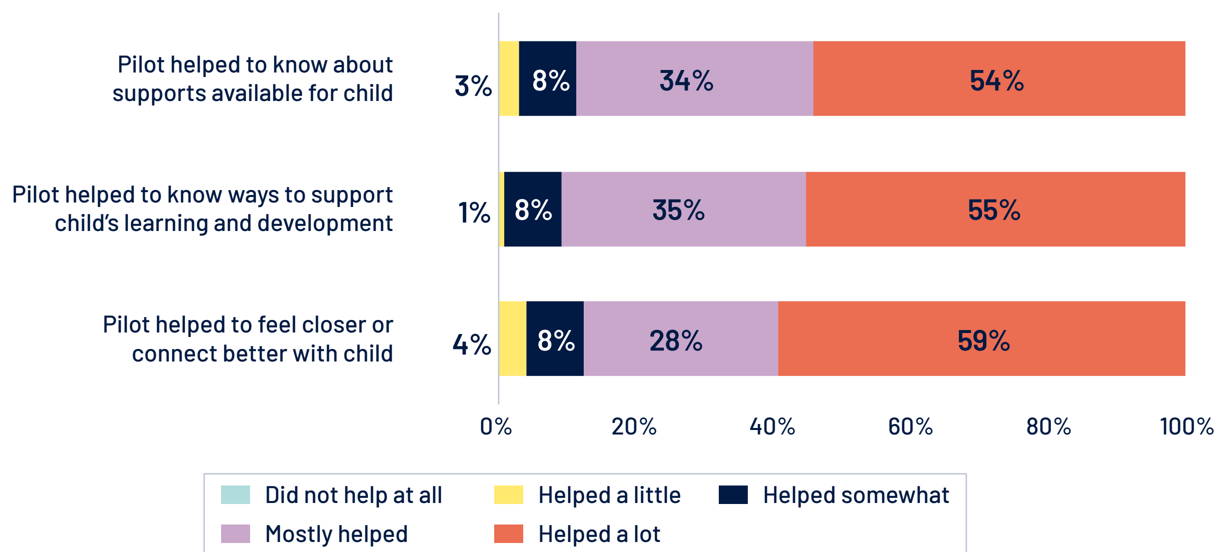
Families overwhelmingly reported the pilot helped build their knowledge, skills and connection with their child.

In exit surveys, 89% of caregivers felt the program had helped 'mostly' or 'a lot' to learn about supports available for their child and 91% had learnt about ways to support their child's learning and development (Figure 3).

In particular, caregivers appreciated learning practical approaches to support their child. As one said:

> ***I learnt how to structure evenings and mornings to have a less stressful environment.***

Figure 3: Change in caregiver knowledge, skill and connection



Caregivers similarly reported the pilot had helped them 'mostly' or 'a lot' to feel closer or connect better with their child (87%). One said:

> ***I think the program is very good for me, it was so, it helped me to connect with my son as well, I can connect with him more. Yeah, better than before.***

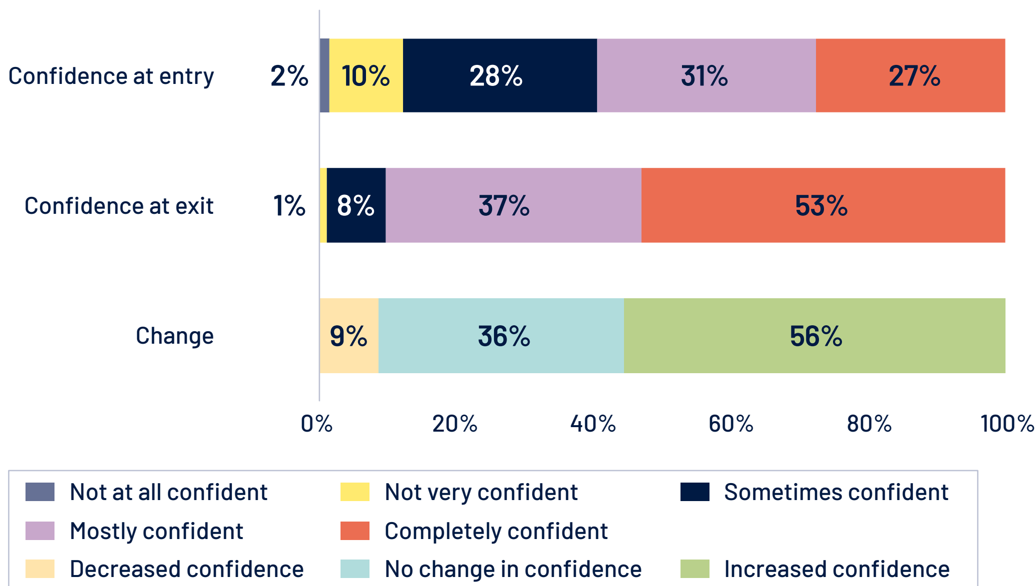
Caregivers are more confident after participating in the pilot

At both the start and the end of a family's time in the pilot, caregivers were asked about their confidence in a number of areas: confidence accessing support for their child, confidence supporting their child's learning and development, and comfort to speak with educators and other professionals about their child's needs (family self-advocacy).

At exit, 90% of caregivers reported being 'mostly' or 'completely' confident accessing support for their child, compared to only 58% at entry. Among those families able to be matched across entry and exit surveys, 56% reported increased levels of confidence. A small number of caregivers (9%) reported decreased confidence.

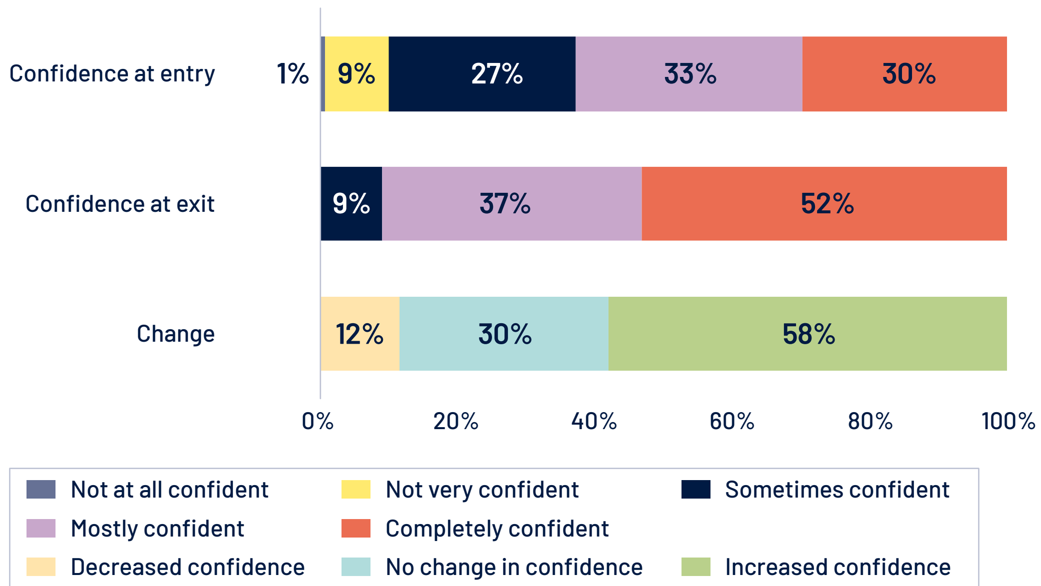
Similar results were seen for caregiver confidence in supporting their child's learning and development: 89% reported they were 'mostly' or 'completely' confident by the end of the pilot compared to 63% at the beginning.

Figure 4: Caregiver confidence accessing support



At exit, 90% of caregivers reported being 'mostly' or 'completely' confident accessing support for their child.

Figure 5: Caregiver confidence supporting child learning and development

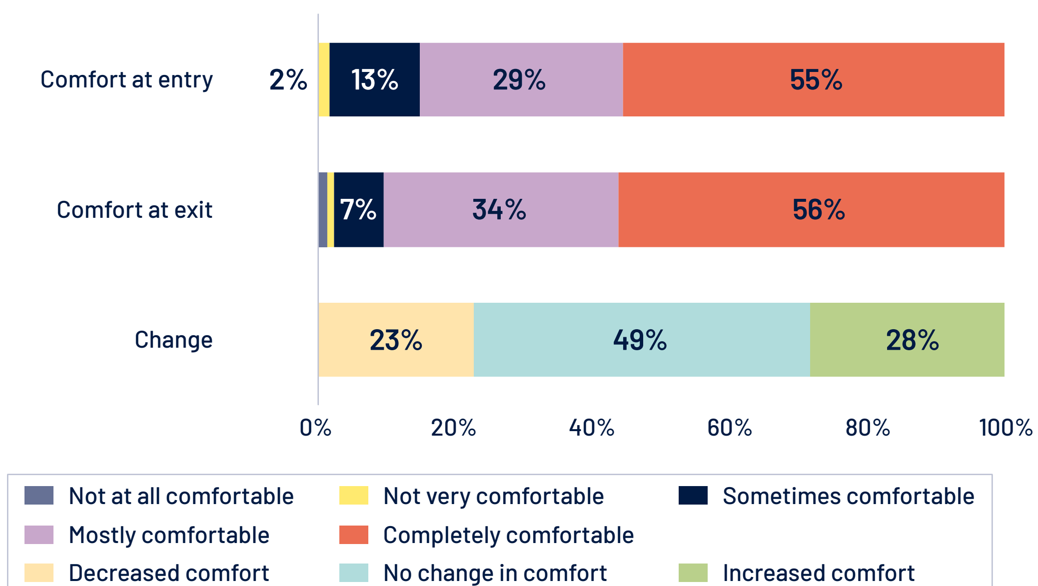


There were mixed results around improvements in family self-advocacy, reflected through reported level of comfort speaking with educators or professionals about their child's development. Very high levels of comfort were reported at entry (84% mostly or completely comfortable) and this increased slightly to 90% at exit – largely through an increase in the 'mostly comfortable' category (from 29% at entry to 34% at exit). Such high levels at entry could be reflective of overestimation bias due to families' limited experience engaging with educators or professionals at the beginning of the pilot (Kruger & Dunning 1999).

For the families able to be matched across entry and exit surveys, 28% reported an increase in level of confidence and 23% reported a decrease.

These mixed results, and that this effect was not observed in the other self-reported confidence measures, suggest a need for further exploration to understand and refine efforts to build family self-advocacy.

Figure 6: Caregiver comfort speaking with educators and other professionals about child's development



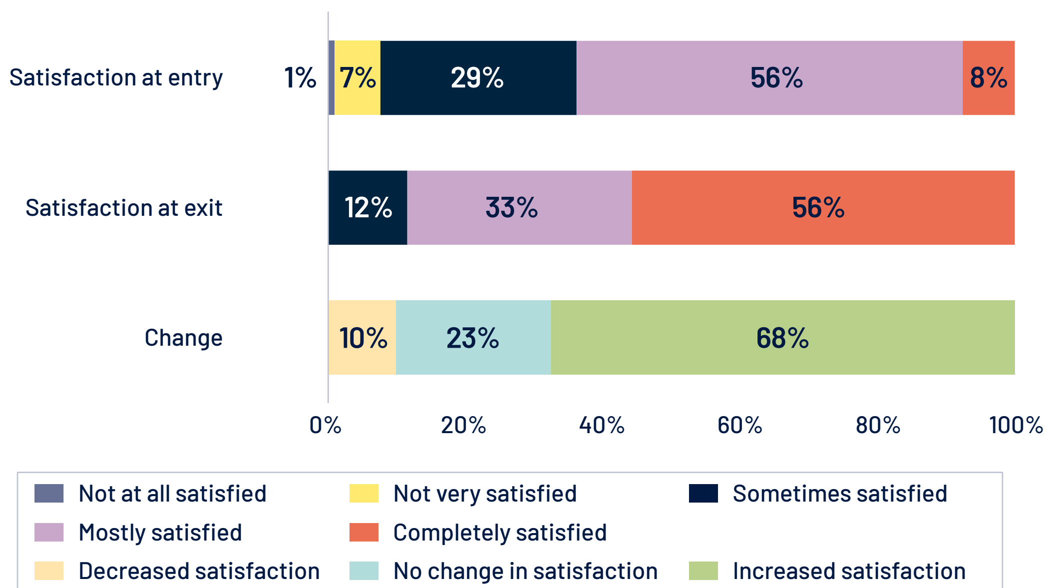
Caregivers are more satisfied with the supports they are receiving and are more connected to support

Caregivers reported large increases in satisfaction with the supports they were receiving for their child at the end of the program: 89% were 'mostly' or 'completely' satisfied with the supports they were receiving for their child at exit, compared to 64% at entry. Some 56% reported they were 'completely satisfied' at exit compared to only 8% at entry. It is not surprising to see such large increases, as families may well have chosen to participate in the pilot because of dissatisfaction with previous supports.

Caregivers felt the pilot had helped them to better connect with supports, networks and communities:

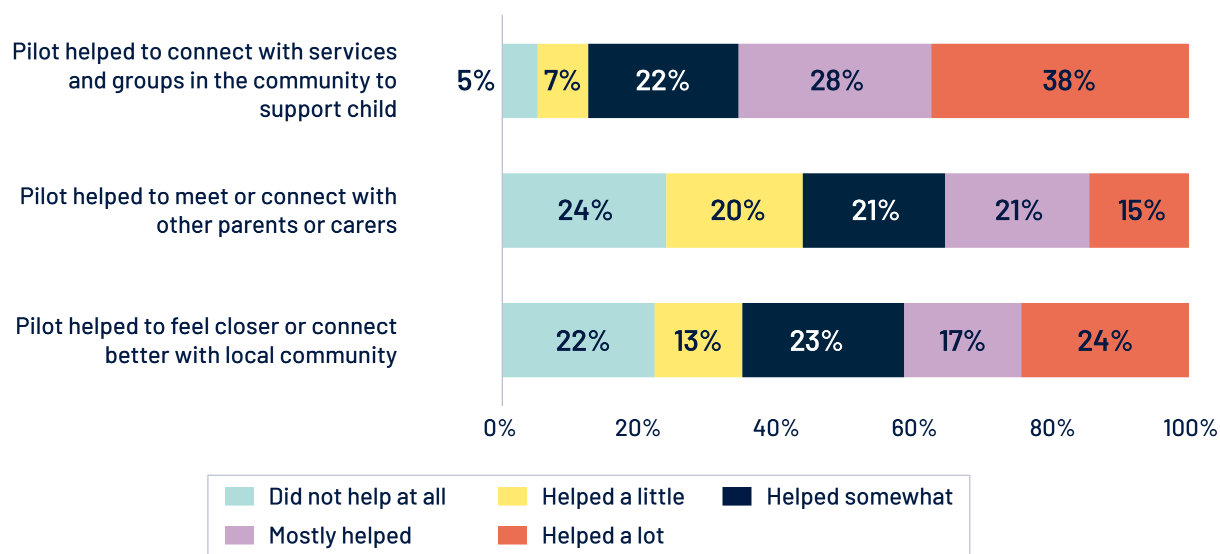
- 64% found the pilot 'mostly helped' or 'helped a lot' to connect with services and groups in the community to support their child(ren)
- 41% found the pilot 'mostly helped' or 'helped a lot' to make them feel closer or connect better with their local community.

Figure 7: Caregiver satisfaction with supports received for child



89% were 'mostly' or 'completely' satisfied with the supports they were receiving for their child at exit.

Figure 8: Caregiver connection to supports, networks and community at exit



The value of linking families with these supports was also reflected by pilot staff. One shared:

> ***A number of families that I worked with were quite isolated and I was able to connect them with different services that were already out there in the community ... whether that was a facilitated play group or a local library ... I linked multiple families with specific mental health supports when they needed it. I found it wasn't just for the child ... I helped families to find services because sometimes just providing information is not enough. They didn't feel confident to talk to these services. I sat with families using an interpreter and supported them to ... call to get an appointment.***

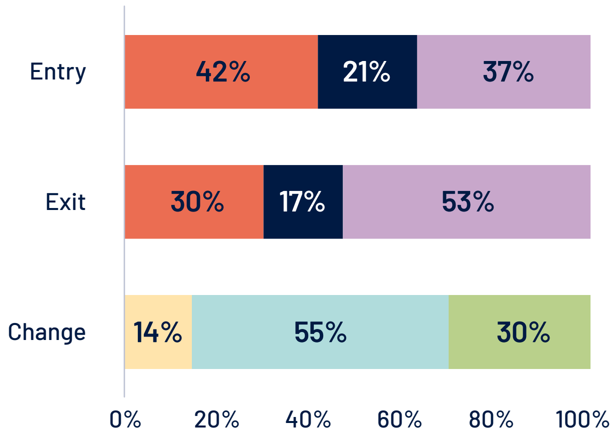
There were weaker and mixed results, however, around the pilot's role connecting caregivers to peer supports, such as other parents or carers. Some 36% identified that the pilot helped them connect with other parents or carers 'mostly' or 'a lot', with the remainder stating the pilot did not help at all (24%); helped a little (20%); helped somewhat (21%). This result is not surprising, as peer support was not a distinctive feature of the pilot design. There could, however, be value in exploring the potential for peer support opportunities within the service offering.

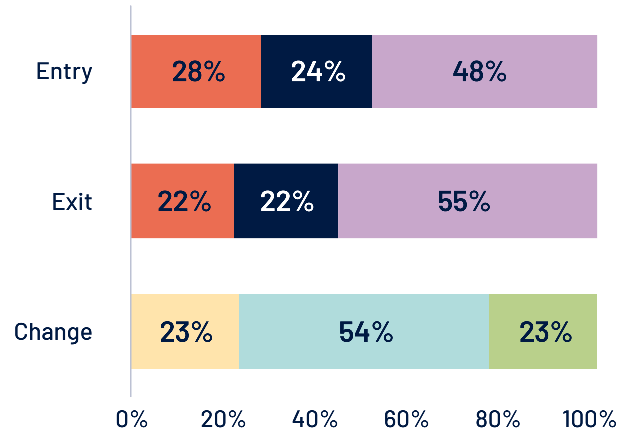
Child development scores improved

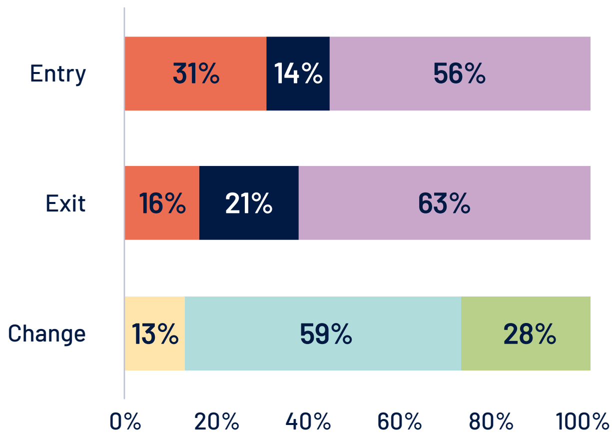
The ASQ was completed with families at entry and exit as part of routine developmental screening. In the questionnaire, children are assessed via parent report across five domains: communication, fine motor, gross motor, problem-solving and personal-social. Scores below the age-appropriate cutoff indicate a child is two standard deviations below usual child development trajectory in that domain and would benefit from additional supports. Upon entry to the pilot, children were most likely to be below the developmental cutoff in communication (42%), followed by problem-solving and personal-social (31%), and fine motor development (28%). Only 16% of children participating in the pilot were below the cutoff for gross motor development on entry to the pilot (see Figure 9).

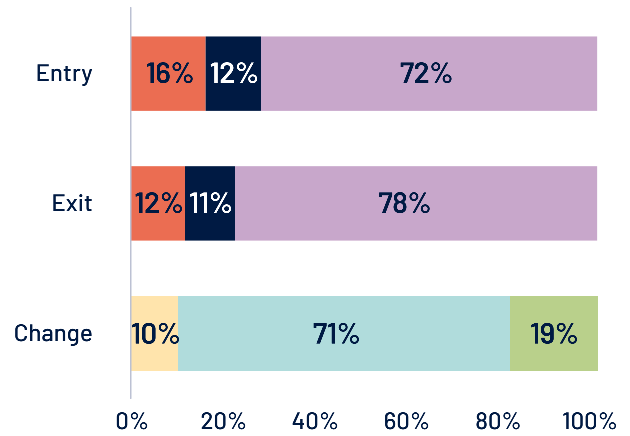
Despite the short duration of the pilot, improvements were seen across children in all domains, with much lower proportions of children below the cutoff at exit. Among the children able to be matched across entry and exit, 32% of children had improved their score (moved up from either 'below' or 'close to' cutoff) in personal-social, 30% in communication and 28% in problem-solving. There were smaller developmental gains in the fine motor and gross motor domains.

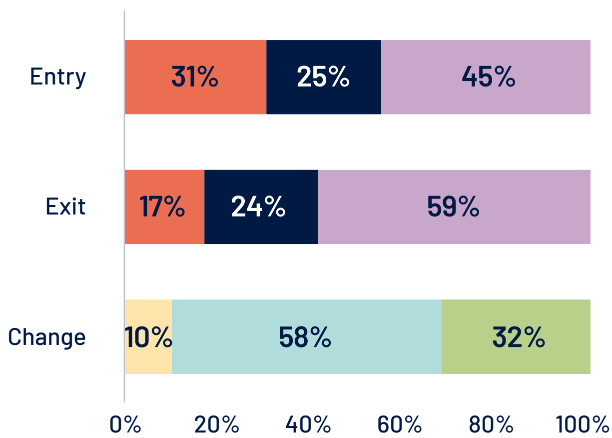
Figure 9: ASQ results for children at entry and exit

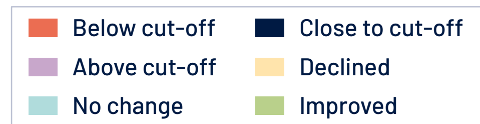












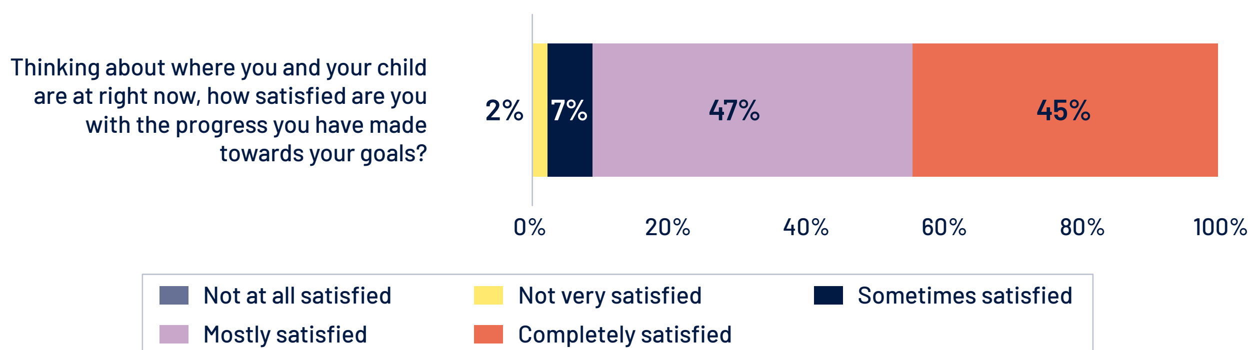
Caregivers are satisfied with progress towards goals

Caregivers reported high levels of satisfaction with the progress made towards their goals, with 45% 'completely satisfied' and a further 47% 'mostly satisfied'.

Less than one in four (22%) of families went on to submit an NDIS access request at the end of the service.

The remainder of children exited the program reporting they had their goals met and were connected with local and mainstream services that enabled their children's development.

Figure 10: Caregiver satisfaction with progress towards goals



Caregivers also indicated that the strategies and skills they had developed would provide sustained support and use for their family:

> ***[Practitioner] has given me strategies that I can implement in the long term.***

> ***We keep adapting now, sometimes we have to adapt things that we are doing, we try to work out what is going on with him and what I find more triggering – helps me to step away and work out the 'why' of the behaviour.***

Less than one in four (22%) of families went on to submit an NDIS access request at the end of the service.

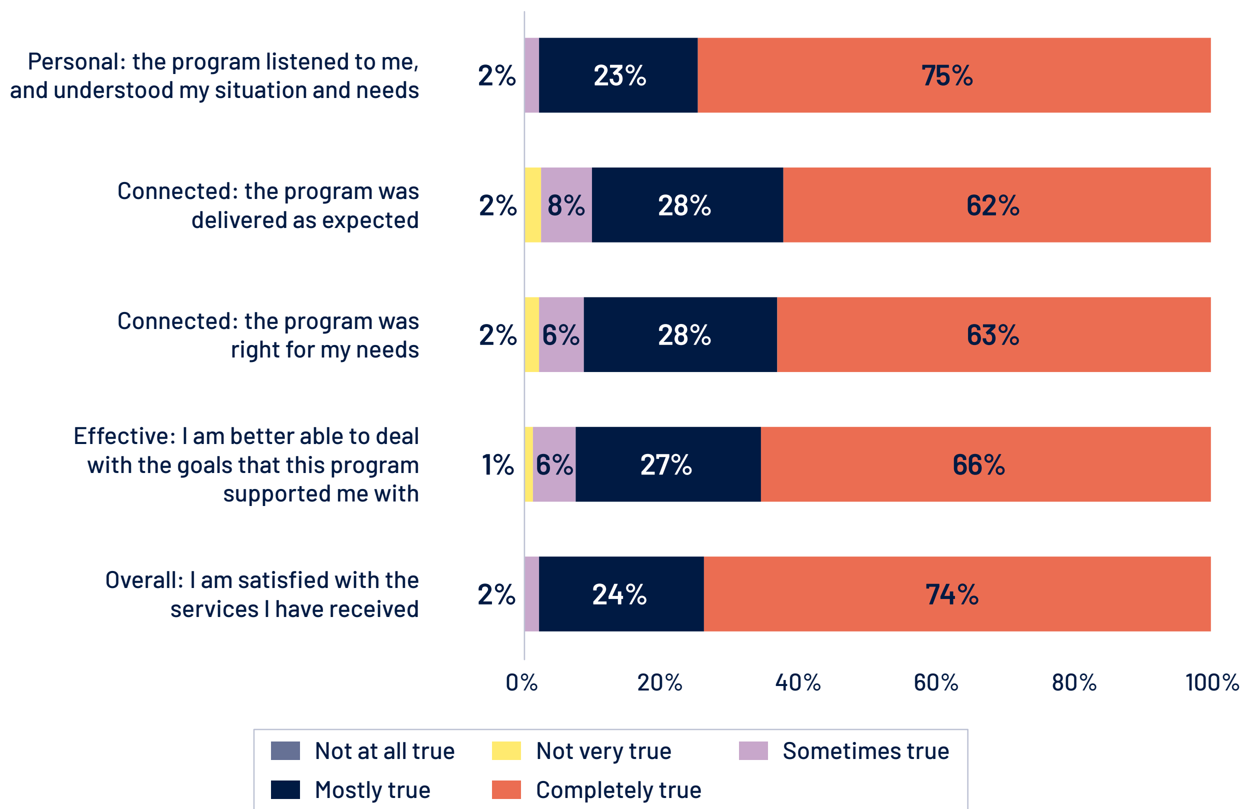
5 Value for families

KEQ 3: What is the perceived value of the program for families?

Overall, caregivers reported the pilot was a high-quality service that was valuable to them and their child. This was reflected in results from caregiver exit surveys at the end of the program:

- 98% said it was 'mostly' or 'completely true' that the practitioner listened to them and understood their situation and needs.
- 90% reported it was 'mostly or completely true' that the program was delivered as expected.
- 91% reported it was 'mostly' or 'completely true' that the program was right for their needs.
- 93% reported it was 'mostly' or 'completely true' that they are better able to deal with the concerns that brought them to seek the service.
- 98% reported it was 'mostly' or 'completely true' that they were satisfied with the services they received.

Figure 11: Caregiver satisfaction with service quality



Parents and caregivers in the pilot highlighted additional valuable elements of the service quality through interviews and survey comments, which included:

- the provision of practical strategies they could test and trial with their child
- the provision of the pilot in settings familiar to their child
- the lack of waiting time to access supports
- an improvement in community connections
- the support offered through forming a relationship with the practitioner.

Practical strategies were important to families

Providing practical strategies helped caregivers respond to their child's emotions, improve communication, and support learning and development. They said they found it effective to try strategies at home and within everyday contexts:

> ***[Practitioner] has given me strategies which have been a great help with his big emotions – now I can notice signs of when he is getting dysregulated and put the strategies in place.***

> ***I learnt to say one instruction at a time and to clearly say what I wanted him to do so it is easier for him.***

Delivery in settings where children live, learn and play was a major drawcard

Families resoundingly reported that holding sessions in the home and ECEC settings was extremely valuable, for several reasons.

Sessions in the home were convenient and comfortable for the family:

> ***[it] takes away a bit of stress when you've already got a lot going on. You know that that's just around the corner at home from drop offs and other things that you've got going on and it doesn't feel as though you have too many appointments in a day.***

> ***We didn't have to go out anywhere. We didn't have to pick the kids up and [settle them] and waste time and get them in the car. And then they get all grouchy and, you know, annoyed. They're in their own home environment ... So it's better for them.***

Sessions in familiar settings allow the child to be themselves, enabling the practitioner to observe typical behaviours:

> ***It was good that they were in my home because, [practitioner] could see [my child] in his normal environment and how he acted at home because I believe that he's quite high masking ... So when we're out in public, he is not the same kid.***

> ***My child specifically ... she does some stimming[7] things, but she hides them if she's out in public, or if she doesn't really know people. She'll mask. But she was comfortable enough to do that in front of [practitioner]. Which is I feel is important.***

> ***[Practitioner] can see his behaviour ... in the home, it's totally different. [Then] in the school, it's totally different.***

7 Repetitive movements or noises.

Caregivers felt that more appropriate support was provided following in-situ observation of observing children's typical behaviours:

> ***[Practitioner] showed me how to do things, which is how I learn, and talked me through it as we were doing it. There was a couple of times when [child] did get really frustrated while [practitioner] was here and start throwing his toys around. And [practitioner] was ... sitting with us, showing me and talking me through it.***

Caregivers valued receiving information from practitioners about their child's inclusion, participation and capabilities in ECEC settings. They said they would not have received this information otherwise:

> ***She'd observe at the kindergarten for an hour and then she'd let us know what she'd seen because, with the teachers, they're being so busy you don't really get a lot of information. So [practitioner] was able to tell us a lot of stuff that we would not have known at all.***

> ***[Practitioner] was able to visit the daycare and kindergarten to talk to the teachers. All the information was shared with me, and I was listened to.***

> ***[Practitioner] would go see her [at kindergarten], watch her and come back here. We love the fact that [practitioner] could go to the kindergarten and observe what she was doing. At one stage, [child] couldn't open the lunch box and we didn't know ... So, [practitioner] ... said to us, how about we change the lunch box because she's having difficulty. So that worked well.***

The lack of waiting time to access supports was valuable

Caregivers reported that being able to commence the pilot within a short time frame, compared to the time wait to commence allied health intervention or receive NDIS funding, was appealing. As two reported:

> ***If we were to apply for NDIS, it will take a long time, but if we go through the pilot program they'll be able to help us and then they'll also help us move on to NDIS if we wanted to.***

> ***I thought he needed NDIS funding. This came up. I was happy to entertain the pilot and try it out. With my first born [who has NDIS funding], I knew the NDIS waiting list and stuff was a bit of a pain. I liked that we got in contact with someone earlier on.***

This was reinforced through staff interviews, where they remarked on the value of not having to wait for supports. One said:

> ***... they didn't have to wait. That is something that parents talked about a lot, if they were looking for an allied health specialist or something like that, there was always just such a long wait list to get into the public system, and even for private ... that we could come to them pretty much immediately and start working with them was definitely helpful.***

'That is something that parents talked about a lot, if they were looking for an allied health specialist or something like that, there was always just such a long wait list ...'

Families connected better with their child and community

Families valued how, through implementing the practical strategies at home, they were able to better understand and connect with their child:

> ***New ideas and strategies which were very relevant and helpful in connecting with my child. I got to learn and interact better with my child.***

Connecting families to local and community services was also a highly valued element of the pilot. Caregivers said:

> ***[Practitioner] has informed me of groups that are able to assist me with my child.***

> ***Connecting me to a playgroup has been really good for us, we love it there – the playgroup leader has also told me about some other things in the community that the kids can go to.***

> ***The program helped me to start her in childcare and it helped her with speech.***

Forming a relationship with the practitioner was highly valued

Caregivers valued the relationship they formed with the practitioner, who they described as having positive attributes such as being genuine, non-judgemental and supportive. Many caregivers complemented their practitioner. They valued seeing the same person each time they met and appreciated the support they provided and their approachable and helpful ways of working.

In exit surveys, caregivers consistently identified their practitioner in response to the survey question 'What was most useful about this program?':

> ***Having an approachable case worker [practitioner] who is understanding and helpful.***

> ***Having someone to talk to and listen to our concerns.***

> ***Meeting with [practitioner] and discussing my concerns with my child and with parenting. Venting my concerns and not being judged.***

Practitioners provided valued emotional support and counselling to families, supporting both the caregivers and the children:

> ***Yeah, it was like it was not like she was just there for [child]. She was there for both of us and that was really, really helpful just to have someone there that I could try to that I could, that would listen to me. That would, you know, help me think about things in a different perspective.***
>
> ***Caregiver***

In some cases, the support contributed to supporting the broader wellbeing for families:

> ***When [practitioner] came into our lives I was ... struggling ... I ended up quitting my job because of the stress of family court and working full-time and learning to be well. There was a lot of domestic violence and having her help during that period ... I don't know what I would have done without her to be completely honest.***
>
> ***Caregiver***

Staff members also reported they found it beneficial and fulfilling to spend time with families, offering active coaching support and focusing less on administrative elements or indirect family work.

> ***Probably the biggest [most valuable] thing for me would have been the relationships that I had built with the families.***
>
> ***Pilot staff***

6 Recommendations

Findings from this evaluation surface several key policy implications in the context of major reform in the disability supports landscape, alongside some opportunities to further develop the model. Our recommendations are as follows:

Implement the Lead Practitioner role as intended by the NDIS Review. The Australian Government should accept the recommendations from the NDIS Review on Lead Practitioners, and the National Disability Insurance Agency should roll out the Lead Practitioner role for families with children with developmental differences across Australia as soon as possible. The Enhanced Early Supports Pilot has demonstrated that the Lead Practitioner role effectively delivered support to families. Having one point of contact was highlighted by families as a key benefit of this model.

Provide targeted foundational supports such as those provided by the Enhanced Early Supports Pilot for children 0–6 with developmental differences. These should be commissioned by the Department of Health, Disability and Ageing and related state jurisdictions as part of the foundational supports rollout as soon as possible to meet the growing community need outside the NDIS. The model demonstrated by this pilot can be expanded to be part of the recent Thriving Kids program recently announced by Minister Butler that will roll out from July 2026 to support children with developmental differences outside of the NDIS.

Explore the possibility of delivering the model via an expanded workforce with varied professional backgrounds or diploma-level early childhood training. The pilot demonstrated positive outcomes for children using a team of staff with similar professional backgrounds and training (with the support of a structured case consultation model). Given the difficulties with recruiting allied health and Bachelors-degree trained educator staff to provide context-specific, community-based support to children with developmental concerns, it may be a practical workforce response to test the implementation of the model with staff with other qualifications or experience.

Further explore findings to understand and deliver improvements in families' self-advocacy. The pilot did not demonstrate clear improvements in family self-advocacy with educators and other professionals. While the levels of reported competency in self-advocacy were high at entry to the pilot, there may be benefit in further exploration of this finding to refine efforts to build family self-advocacy.

Include peer support for caregivers in any future iterations of the pilot. Parents and caregivers reported the pilot was helpful connecting them with supports, networks and community, particularly in terms of supporting their child. However, this was not a specific focus of the pilot, but happened incidentally. This represents an opportunity for any future iterations of the pilot to consider what role peer support could play in the model.

Complete longitudinal follow up to determine sustainability of outcomes. The pilot was successful delivering the short and medium-term outcomes of increased caregiver knowledge, skills, confidence, connection, satisfaction with goal achievement and service satisfaction. Further longitudinal studies should be undertaken to determine whether these outcomes are sustained over time without further intervention.

7 Conclusions

The evaluation findings indicate the Enhanced Early Supports Pilot was successful in terms of outcomes, the value families saw in the program and staff perceptions. In particular, there is a demonstrated need for the pilot across a diverse cohort of families, and the pilot design and implementation effectively delivered outcomes for families.

The outcomes and the perception of the value of the pilot to families include:

- the pilot helped build knowledge, skills, connection and the confidence of caregivers
- after exiting the pilot, caregivers were more satisfied with the supports they were receiving in the community and were more connected to support
- the pilot delivered improvements in children's development and caregivers were satisfied with progress towards goals
- caregivers found practical strategies provided during the pilot, and delivery in home and early childhood settings useful
- caregivers found value in forming a relationship with their practitioner
- caregivers saw value in the lack of waiting time and not needing a diagnosis to access services when needed.

References

Alexander S & Forster J 2012, *The key worker: resources for early childhood intervention professionals*. Noah's Ark Inc., Malvern, Vic.

Brotherhood of St. Laurence (BSL) 2023, *Submission to the early years strategy*, Brotherhood of St. Laurence, Fitzroy, Vic.

Department of Social Services (DSS) 2023, *The data exchange protocols*, Commonwealth of Australia, Canberra.

-- 2024a, *Foundational supports for children with developmental concern, delay and/or disability and their families, carers and kin Consultation Paper*, Commonwealth of Australia, Canberra.

-- 2024b, '*Foundational supports for children, families, carers and kin*', information sheet, Commonwealth of Australia, Canberra.

Early Childhood Intervention Australia 2016, *National guidelines best practice in early childhood intervention*, Early Childhood Intervention Australia.

Independent Review into the National Disability Insurance Scheme (NDIS Review) 2023, *Working together to deliver the NDIS: independent review into the national disability insurance scheme: final report*, (Prof. Bruce Bonyhady AM and Lisa Paul AO PSM, co-chairs), Commonwealth of Australia, Canberra.

Kruger J & Dunning D 1999, 'Unskilled and unaware of it: how difficulties in recognizing one's own incompetence lead to inflated self-assessments', *Journal of Personality and Social Psychology*, vol 77, no 6, pp 1121–34, doi: *10.1037//0022-3514.77.6.1121*.

McWilliam RA 2010, *Routines-based early intervention: supporting young children and their families*, Brookes Publishing, Baltimore.

Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability 2023, *Final report*, (commissioners: the Honourable Ronald Sackville AO KC (Chair of the Royal Commission), Ms Barbara Bennett PSM, Dr Rhonda Galbally AC, Ms Andrea Mason OAM, Dr Alastair McEwin AM, the Honourable John Ryan AM), Commonwealth of Australia, Canberra.

Rush DD & Shelden ML 2020, *The early childhood coaching handbook* (2nd ed.), Brookes Publishing, Baltimore.

Enhanced Early Supports Pilot

Evaluation report

Sarah Watt, Kelly Fawcett, Katy Cornwell, Margaret Olczak and Tanya Oxlade
2025

Acknowledgement of Country

The Brotherhood of St. Laurence acknowledges the Traditional Custodians of the land and waterways on which our organisation operates. We pay our respects to Aboriginal and Torres Strait Islander Elders past and present.

Brotherhood of St Laurence
Working for an Australia free of poverty