



EARLY YEARS AUTISM TOOLKIT

A Practical Evidence-Informed Guide for Inclusive Early Childhood Settings, Family Partnership,
Communication, Play, Regulation and Development

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Global Autism Research Center (GARC)

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Publication Information

Purpose and audience

This toolkit is designed for early years teachers, nursery and preschool practitioners, childcare staff, teaching assistants, inclusion leads, special educators, early intervention professionals, speech-language and occupational therapy partners, child-development teams, and leaders responsible for inclusive early childhood provision. It translates evidence-informed principles into practical decisions that support autistic young children to communicate, participate, play, learn, regulate, build relationships and experience safety and belonging.

Scope

The toolkit is intended for early childhood settings from infancy through the transition into primary school, with greatest practical focus on nursery, preschool and kindergarten-age children. It is deliberately international and does not replace national early-years frameworks, disability law, safeguarding rules, health pathways, staffing ratios, licensing requirements or individualized plans. Local requirements must always be verified.

Educational, developmental, clinical and legal notice

This publication is educational and does not diagnose autism or any developmental condition. Observations in an early years setting can identify support needs and inform conversations with families and qualified professionals, but diagnosis and formal screening must follow relevant professional and local pathways. New regression, seizures, serious feeding difficulty, sudden loss of skills, suspected pain, breathing difficulty, dehydration, serious injury, abuse concerns or other urgent changes require appropriate health or safeguarding action.

Language, dignity and neurodiversity

This toolkit generally uses identity-first language ("autistic child") while recognizing that families and individuals may prefer different language. The child is never a diagnosis, a behaviour plan or a collection of deficits. Practice should support communication, participation, comfort, development and autonomy rather than training a child to appear non-autistic. Harmless self-regulatory movement, focused interests and alternative communication should not be suppressed simply for social conformity.

Evidence approach

The guidance draws on World Health Organization and UNICEF early childhood development and autism resources, NICE guidance, CDC developmental monitoring materials, the DEC Recommended Practices, inclusive early childhood principles, and established evidence on responsive caregiving and family-centred early intervention. The recommendations are synthesized for practical use and are not copied from source publications. Selected references appear at the end of the toolkit.

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REVIEW CYCLE

GARC intends to review this toolkit periodically and earlier if major evidence or authoritative guidance changes. Early years providers should also review local safeguarding, health, inclusion, medication, toileting, nutrition and emergency procedures on the schedule required in their jurisdiction.



Foreword

The early years are not a race to make a child look typical. They are a period in which adults can shape environments, relationships and routines so that a young child can communicate, explore, play, learn and feel secure. For autistic children, the quality of this fit matters enormously because sensory load, communication barriers, unpredictability and adult interpretation can either open or close access to ordinary childhood experiences.

Young children communicate through far more than speech. They reach, move away, repeat, pause, vocalize, gesture, lead an adult, use pictures, sign, point, type, use a communication device, or show changes in body state. A skilled early years team learns to notice these signals, respond contingently, model accessible communication and create many low-pressure opportunities for the child to influence what happens next.

Inclusive early childhood practice is therefore not a list of autism techniques. It is a way of organizing the environment around responsive relationships, predictable routines, accessible communication, meaningful play, family partnership, health and safety, and careful observation of what actually helps the child participate. This toolkit is designed to make that approach operational.

Global Autism Research Center (GARC)

Practical Toolkits Series



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HOW TO USE THIS TOOLKIT

Start with the Quick Start pages and the child profile. Choose two or three barriers that are most limiting participation or wellbeing. Make small environmental or communication changes, observe their effect, and review with the family and team. The goal is useful change, not maximum intervention.



Quick Start: The First 10 Days

The first goal is not to complete a perfect assessment. It is to learn enough about the child to make the setting safer, more understandable and more participatory while building trust with the family.

- ☐ Ask the family what the child enjoys, how the child communicates, what tends to cause distress, and what reliably helps.
- ☐ Observe the child across several ordinary routines rather than relying on a single structured activity.
- ☐ Confirm how the child requests, refuses, chooses, asks for help, indicates pain or discomfort, and shows "finished" or "more".
- ☐ Make the daily sequence visible using objects, photos, symbols, drawings or words at the child's level of understanding.
- ☐ Identify the loudest, brightest, most crowded and least predictable parts of the day and reduce avoidable sensory load.
- ☐ Create a calm, supervised recovery space that is available before distress becomes severe.
- ☐ Plan regular opportunities for child-led play and shared attention without requiring eye contact or scripted social behaviour.
- ☐ Learn the child's eating, allergy, seizure, medication, toileting, sleep/rest, mobility and emergency information that the setting legitimately needs.
- ☐ Agree a simple family-setting communication method focused on high-value information, not constant surveillance.
- ☐ Define two short participation goals that can be observed, such as joining a routine with fewer prompts, using a choice board, tolerating a transition with visual support, or returning to play after a break.

IMMEDIATE ESCALATION

Follow local emergency or safeguarding procedures for immediate danger, suspected abuse or neglect, serious injury, breathing difficulty, severe allergic reaction, prolonged or unusual seizure activity, dehydration, credible poisoning risk, unexplained major regression, or another urgent health or safety concern.



Quick Start: Essential Child Snapshot

Area	What the team should know now
Communication	How the child understands information; how the child requests, refuses, protests, chooses, asks for help and shares interest.
Strengths and interests	Preferred people, toys, topics, movement, sensory experiences, songs, books, routines and play themes.
Sensory access	Responses to sound, light, touch, smell, movement, clothing, temperature, crowds and messy play.
Predictability	How much advance warning, visual structure, object cues or routine consistency is useful.
Regulation	Early signs of overload; effective co-regulation; preferred recovery spaces and activities.
Play and learning	What motivates exploration; how the child imitates, solves problems, uses objects and joins shared activities.
Daily care	Eating, drinking, toileting, dressing, hygiene, sleep/rest and personal care routines.
Health and safety	Allergies, seizures, medications, pain indicators, mobility needs, wandering/elopement risk and emergency instructions under local policy.
Family priorities	What the family most wants the setting to understand or support right now.
Child influence	How the child can meaningfully say yes, no, more, stop, help, finished and choose between options.

PRESUME COMPETENCE, OBSERVE ACCESS

A young child may understand more than they can show in a busy, language-heavy or unfamiliar setting. Do not use speech, eye contact, sitting still or speed of response as proxies for understanding.



SECTION 1

Understanding Autism in Early Childhood

A practical foundation for noticing differences, reducing barriers and responding to the child rather than to assumptions.

- Understand autism as a diverse neurodevelopmental condition with highly variable strengths and support needs.
- Expect development to be uneven across communication, play, movement, self-care, learning and regulation.
- Interpret behaviour in context: environment, communication, sensory load, health, sleep, hunger, demand and relationships all matter.

GARC PRACTICE PRINCIPLE

The central early years question is not whether the child behaves typically. It is whether the child can access relationships, communication, play, learning, care routines and safety with dignity.

1.1 Autism is not one early childhood profile

Autism is a diverse group of conditions related to brain development. Characteristics may be detected in early childhood, but individual presentation varies substantially. Autistic children may differ in social communication, interaction, transitions, patterns of interest or activity, and sensory responses. Abilities and support needs can change over time and across contexts. [1]

Domain	Possible early years implications
Communication	Speech may be absent, emerging, delayed, scripted or fluent. Receptive language may differ from expressive language. Alternative communication may be essential.
Social interaction	A child may prefer observing, parallel play, one-to-one interaction, predictable games or brief social contact. Eye contact is not a valid measure of interest or attachment.
Play	Play may be repetitive, highly focused, sensory, object-centred, movement-based or imaginative in less obvious ways. Interests can be powerful routes into learning.
Sensory processing	Noise, touch, messy textures, movement, smell, clothing, light or crowds may strongly influence participation and distress.
Movement and regulation	Repetitive movement, pacing, jumping, spinning, humming or hand movements can support regulation, enjoyment or concentration.
Daily living	Eating, sleep, toileting, dressing and personal care may require careful adaptation because of sensory, motor, communication or medical factors.
Developmental profile	Skills can be advanced in one area and delayed in another. Averages can hide what the child can do with the right access.



1.2 Development is interaction, not only maturation

Early development occurs through repeated interactions between the child and people, objects, routines and environments. WHO and UNICEF emphasize responsive caregiving, early learning, health, nutrition, safety and security as interdependent foundations for early childhood development. [2][3] For autistic children, accessibility must be built into these foundations rather than added after difficulty appears.

1.3 Look for barriers before labels such as refusal

Ask first	Avoid
Is the child confused, overloaded, tired, hungry, in pain, unable to communicate, facing an unclear transition, or being asked to tolerate an inaccessible sensory experience?	Assuming manipulation, naughtiness, laziness, lack of attachment, defiance or low ability without evidence.

REGRESSION MATTERS

Loss of previously established language, social or motor skills should be taken seriously and discussed through appropriate health and developmental pathways. NICE recommends specific referral action for regression in young children. [4]



SECTION 2

The GARC 10-Point Early Years Practice Framework

A simple operating model for translating inclusion into repeatable daily practice.

- Use the framework to plan the environment, routine and adult response before a problem emerges.
- Apply it at child, room and whole-setting levels.
- Review outcomes in terms of participation, communication, wellbeing, development and independence.

GARC PRACTICE PRINCIPLE

Early intervention is not defined by intensity alone. It is defined by whether support is timely, individualized, family-centred, functional, evidence-informed and useful in the child's real life.

2.1 The 10 points

Point	Practice focus
1. Know the child	Strengths, interests, communication, health, culture, routines, sensory profile and family priorities.
2. Make communication accessible	Support understanding and expression with AAC, visuals, gesture, objects, signs, modelling and adequate wait time.
3. Build predictable routines	Use consistent sequences and prepare for change without making the environment rigid.
4. Design sensory access	Reduce avoidable overload and provide safe movement and recovery options.
5. Follow the child into play	Use interests and child-led activity to build engagement, communication and learning.
6. Teach through everyday routines	Embed learning in arrival, snack, toileting, play, outdoor time, tidy-up and transitions.
7. Co-regulate before expecting self-regulation	Use calm adult presence, reduced language, predictable support and recovery time.
8. Partner with families	Share expertise, listen to priorities and avoid making families coordinate fragmented systems alone.
9. Coordinate across professionals	Translate recommendations into ordinary routines and agree who is responsible for what.
10. Review what actually changes	Track functional outcomes such as participation, communication, distress, recovery, independence and family confidence.

2.2 Use the framework as a decision filter

When a child is struggling, teams can quickly ask: Do we understand the child? Is communication accessible? Is the routine predictable? Is sensory load manageable? Is the task developmentally and



functionally meaningful? Are adults co-regulating rather than escalating? Have we heard the family? Are professionals aligned? What outcome are we measuring?

LOW-TECH FIRST

Many high-value supports are simple: a photo, object cue, first-then board, clear container showing "finished", quieter table, predictable song, extra response time, smaller group, familiar adult, or a choice between two options.



SECTION 3

Development, Strengths, Autonomy and Child Voice

Support development without turning every moment of childhood into therapy.

- Observe what the child can already do and what conditions make that competence visible.
- Create real choices and respect refusal within safe limits.
- Use strengths and interests as learning assets, not as rewards that must always be earned.

GARC PRACTICE PRINCIPLE

A child's right to influence what happens does not begin when speech develops. Choice, refusal, preference and consent can be supported from the earliest years.

3.1 Build from strengths

Strength-based practice is not ignoring areas of difficulty. It means beginning with the child's existing competencies, motivations and successful contexts, then using them to expand access. A child who loves letters, water, spinning objects, songs, vehicles or maps is giving the team information about attention, learning and connection.

3.2 Make autonomy concrete

Autonomy opportunity	Example
Choose	Two visible snack options, two play areas, two songs, two sensory tools.
Refuse	A reliable "no/stop" response that adults notice and honour when safe.
Pause	A break card, gesture, object or movement to signal "not now".
Ask for help	Model a sign, symbol, button, word, gesture or handover routine.
Finish	A clear way to show the activity is complete and transition away.
Change mind	Allow a child to reverse a choice when practical rather than treating choices as contracts.

3.3 Child voice in the early years

Child voice may be expressed through approach and avoidance, gaze shifts, body orientation, reaching, taking an adult to an item, vocalization, repeated actions, AAC, sign, speech or changes in regulation. Adults need to distinguish "not communicating" from "not using the form of communication the adult expected."

3.4 Developmental goals should improve life

- ☐ Phrase goals around participation or useful skills, not appearance.
- ☐ Prioritize functional communication, safety, play, self-care, relationships and access to learning.
- ☐ Avoid goals whose only purpose is eye contact, quiet hands, typical toy use, or suppression of harmless self-regulation.



- ☐ Build generalization into real routines rather than expecting a clinic-room skill to transfer automatically.
- ☐ Keep time for ordinary childhood: exploration, rest, connection, humour and preferred play.

A BETTER GOAL

Instead of "will sit appropriately for circle time for 20 minutes," consider "will participate in group routine using an agreed seating or movement option and communication supports for a developmentally appropriate duration."



SECTION 4

Communication, AAC and Early Interaction

Make communication possible before judging participation, behaviour or social interest.

- Support both understanding and expression.
- Use AAC early when useful; speech is not a prerequisite for access to AAC.
- Respond to communication attempts so the child learns that communication changes the world.

GARC PRACTICE PRINCIPLE

Communication is a right, not a reward for calm behaviour or correct performance.

4.1 Communication is broader than speech

Young autistic children may communicate through body movement, gesture, sign, pictures, objects, leading, facial expression, vocalization, speech, text or speech-generating devices. The goal is a reliable system that lets the child influence routines, express needs and interests, and participate in relationships.

4.2 Support understanding

- ☐ Get physically near enough for access without forcing face-to-face positioning.
- ☐ Use short, concrete language matched to the child's comprehension.
- ☐ Pair key words with gesture, objects, photos, symbols or demonstration.
- ☐ Allow processing time before repeating or rephrasing.
- ☐ Show what "finished" means and what happens next.
- ☐ Avoid long strings of questions when the child is stressed.

4.3 Model AAC without testing

AAC is most useful when adults model it during real interactions. Point to, touch or activate key symbols while speaking naturally. Do not require the child to imitate every model. Ensure the system is physically available across routines, not stored in a cupboard or brought out only during therapy.

Communication function	Examples to model
Request	more, open, help, turn, drink, swing
Refuse / protest	no, stop, finished, different, break
Comment	fun, loud, big, again, wow
Choice	this, that, inside, outside
Social connection	hi, look, my turn, your turn
Body / health	hurt, toilet, tired, hungry, too loud



4.4 Interaction should not become performance

Support

Shared enjoyment, turn-taking, imitation, following the child's focus, responsive pauses, joining repetitive play respectfully, expanding communication.

Avoid

Demanding eye contact, blocking access to desired items solely to force communication, repeated quizzing, removing AAC, or treating all solitary play as a deficit.

COMMUNICATION UNDER STRESS

When distress rises, expressive language often drops. Reduce language, offer familiar visuals or AAC, and prioritize safety and co-regulation. Do not interpret loss of speech under stress as deliberate refusal.



SECTION 5

Play, Joint Engagement and Learning Through Routines

Use play as a route to relationship, communication, curiosity and development without controlling every action.

- Follow the child's interests and join before redirecting.
- Recognize sensory, repetitive and object-focused play as meaningful forms of engagement.
- Embed learning in routines and naturally occurring motivation.

GARC PRACTICE PRINCIPLE

Play is not valuable only when it looks symbolic, social or age-typical. The adult task is to expand access and shared meaning while preserving enjoyment.

5.1 Observe before teaching

Watch what the child chooses when adults do not direct the activity. Note what holds attention, what patterns repeat, which sensory qualities matter, whether the child accepts another person nearby, and what creates shared enjoyment. This information guides how to enter play without disrupting it.

5.2 The join-expand-pause cycle

1. Join the child's current focus using similar materials or a predictable action.
2. Expand by adding one small variation, word, symbol, turn, sound, movement or problem to solve.
3. Pause long enough for the child to respond in any accessible way.
4. Respond to the child's signal and keep the interaction enjoyable.
5. Exit or simplify if the child shows overload, disengagement or clear refusal.

5.3 Everyday routines are learning environments

Routine	Possible learning opportunities
Arrival	Greeting choice, schedule check, belongings, transition object, self-advocacy.
Snack	Choice, requesting, waiting, opening containers, sensory tolerance without coercion, social participation.
Outdoor play	Movement, turn-taking, safety, joint attention, problem solving, communication.
Tidy-up	Sequence, categorization, matching, transition, "finished" concept.
Story / song	Anticipation, repetition, participation through gesture/AAC, choice of song or book.
Personal care	Body awareness, communication, predictability, consent, independence steps.
Departure	Review, transition, belongings, family communication.



5.4 Do not make all play instructional

Children need time in which adults are not continuously prompting, recording or shaping behaviour. Protect periods of child-led play and rest. Development is supported by secure, responsive relationships and opportunities for early learning, not by turning every minute into a drill. [2][3]

RESPONSIVE CAREGIVING

WHO and UNICEF emphasize observing, interpreting and responding to a child's signals as a foundation of early development. [3] The early years setting can extend this principle beyond the home.



SECTION 6

Sensory Access and the Early Years Environment

Reduce avoidable sensory load so the child can use energy for play, communication, learning and relationships.

- Audit the environment from the child's sensory perspective.
- Provide choice and recovery options rather than requiring endurance.
- Use occupational therapy input when needs are complex, persistent or safety-related.

GARC PRACTICE PRINCIPLE

A sensory support is useful when it improves access, comfort, regulation or participation - not because it is fashionable or labelled "sensory."

6.1 Common environmental pressure points

Pressure point	Possible adaptations
Noise	Smaller group, quieter zone, soft furnishings, predictable warning before alarms/appliances, hearing protection when appropriate.
Lighting	Natural light, reduced glare, avoid flicker where possible, alternative work/play area.
Touch	Warn before touch, avoid unnecessary hand-over-hand prompting, offer tools for messy play, respect clothing sensitivities.
Movement	Planned opportunities to climb, push, carry, jump or move where safe; avoid requiring stillness as proof of attention.
Crowding	Stagger transitions, defined personal space, smaller group activities, clear pathways.
Smell	Ventilation, fragrance-aware practice, distance from strong food or cleaning smells when possible.
Visual load	Reduce clutter in key areas, use clear containers/labels, present fewer choices at once when needed.

6.2 Create a recovery space, not a punishment corner

- ☐ Accessible without the child having to become highly distressed first.
- ☐ Visually calm and physically safe.
- ☐ Not used for exclusion or humiliation.
- ☐ Contains only supports known to help this child or group of children.
- ☐ Allows adult co-regulation nearby when needed.
- ☐ Has a clear, supportive way to return to the routine.



6.3 Sensory difference can look like behaviour

Covering ears, dropping to the floor, fleeing, avoiding messy materials, removing clothing, seeking crashing input, chewing objects, refusing a room or repeatedly opening and closing items may be partly sensory. Interpretation should remain functional and individualized rather than assuming one explanation for all children.

SAFETY FIRST

Sensory preference does not override medical or physical safety. Mouthing non-food items, unsafe climbing, elopement, head injury or other high-risk behaviour requires specific risk assessment and appropriate professional input.



SECTION 7

Predictable Routines, Transitions and Visual Supports

Make time, sequence, expectations and change easier to understand.

- Use visual, object and environmental cues that match the child's developmental level.
- Prepare for change while preserving flexibility.
- Teach transitions as routines rather than relying on repeated verbal commands.

GARC PRACTICE PRINCIPLE

Predictability should reduce uncertainty, not create a setting so rigid that any variation becomes impossible.

7.1 Match the visual to the child

Support level	Examples
Object cue	Cup for snack, nappy/toilet item for personal care, outdoor hat for outside.
Photo	Actual photo of room, adult, activity, toilet, playground or transport.
Symbol / drawing	Simple picture sequence, choice board, first-then board.
Written word	Useful for children who recognize words or letters strongly.
Timer / countdown	Visual timer, countdown strip, number of turns remaining.

7.2 Transition sequence

1. Show or signal what is ending.
2. Give a concrete cue for what happens next.
3. Allow a predictable completion step such as "one more turn" when feasible.
4. Use a transition object, visual or adult cue consistently.
5. Reinforce arrival in the next routine with immediate clarity about what to do.

7.3 Prepare for unusual events

- ☐ Use photos or a short sequence for visitors, trips, fire drills, room changes or celebrations.
- ☐ Identify which parts are known and which are uncertain.
- ☐ Offer a retreat or reduced-participation option for high-intensity events when possible.
- ☐ Tell the family early when preparation at home may help.
- ☐ Review afterwards: what was harder than predicted and what support worked?

VISUALS SHOULD CREATE INDEPENDENCE

A visual support is successful when it reduces uncertainty or dependence on repeated adult prompting. If adults must constantly point, physically guide or quiz the child, redesign the support.



SECTION 8

Regulation, Distress and Positive Support

Understand distress as information and reduce preventable escalation.

- Identify early signs and intervene before crisis intensity.
- Use co-regulation and environmental change before adding demands.
- After an incident, analyze patterns without blaming the child or family.

GARC PRACTICE PRINCIPLE

The goal is not a perfectly calm child. The goal is a child who is increasingly safe, understood, able to recover and able to communicate needs in accessible ways.

8.1 Regulation is relational and contextual

Young children rely heavily on adults for co-regulation. A calm, predictable adult can reduce language, lower demands, slow the pace, offer familiar sensory support, and help the child move toward a more manageable state. Expectations for independent self-regulation must be developmentally appropriate.

8.2 Think in phases

Phase	Adult priorities
Baseline	Connection, predictable routine, communication access, sensory fit, teach useful skills.
Early stress	Reduce language, clarify next step, offer break/choice, reduce sensory or social load.
Escalation	Safety, space, minimal demands, calm adult presence, avoid crowding and power struggles.
Recovery	Time, hydration/toileting/comfort as needed, low-demand re-entry, no immediate interrogation.
Review	Later, identify triggers, unmet needs, communication gaps, health factors and prevention actions.

8.3 Behaviour support should be functional

Repeated behaviour may communicate escape from overload, access to a preferred activity, need for movement, pain, confusion, connection, fatigue, hunger, or difficulty with a skill. Teams should collect enough context to form a reasonable hypothesis and test supportive changes. Formal functional assessment should follow local professional standards when complexity or risk warrants it.

8.4 Restrictive and aversive practices

Physical restraint, seclusion and other restrictive practices carry significant ethical and safety concerns and are regulated differently across jurisdictions. They should never be treated as ordinary behaviour management. Settings must follow local law and policy, use prevention, document and review incidents, and ensure staff are trained for any legally permitted emergency procedure.



MEDICAL RULE-OUT

New or sudden distress, self-injury, sleep disruption, toileting change, loss of appetite, head-hitting, withdrawal or aggression may be associated with pain or illness. Consider health assessment when the pattern changes unexpectedly.



SECTION 9

Inclusive Early Learning and Participation

Design early learning around access, active engagement and developmentally meaningful participation.

- Use multiple ways to engage, understand and respond.
- Keep expectations meaningful without insisting on one form of participation.
- Plan inclusion across free play, group time, outdoor play, meals, care routines and community experiences.

GARC PRACTICE PRINCIPLE

Inclusion is not physical presence alone. A child should have real opportunities to belong, communicate, make choices, learn and influence the activity.

9.1 Plan for participation, not compliance

Routine	Possible participation options
Circle / group time	Sit, stand, move at edge, hold a prop, use AAC, join for selected parts, respond through gesture.
Art / messy play	Use tool, glove, dry materials, different texture, observe first, choose alternative medium.
Music	Move, watch, use instrument, request song, wear hearing protection where appropriate.
Story	Hold book, turn pages, match object, point to picture, use repeated phrase, listen from nearby.
Peer play	Parallel play, shared materials, structured turn, cooperative role, brief adult-facilitated exchange.
Outdoor	Movement, sensory exploration, construction, water/sand, quiet observation, supported peer activity.

9.2 Teach skills in context

A skill learned in a structured adult-led task may not transfer automatically. Whenever possible, teach communication, waiting, turn-taking, dressing, requesting help, problem solving and self-care within the routines in which the skill will be used.

9.3 Use prompting carefully

- ☐ Give the child time before adding a prompt.
- ☐ Use the least intrusive prompt likely to help.
- ☐ Avoid unnecessary physical guidance.
- ☐ Fade prompts deliberately so adult support does not become part of the task.
- ☐ Reinforce natural success - access, completion, connection, mastery - not only external rewards.



9.4 Observe meaningful outcomes

Useful early years measures include frequency of spontaneous communication, ability to participate in routines, time engaged in chosen activity, distress frequency and duration, recovery time, independence steps, peer access, caregiver confidence and generalization across people or settings. Data should answer a question, not become surveillance.

THE ACTIVITY IS ADJUSTABLE

If a routine repeatedly requires distress, restraint, excessive prompting or removal from peers, the first assumption should be that the environment or task needs redesign - not that the child needs more pressure.



SECTION 10

Eating, Toileting, Sleep, Rest and Daily Living Routines

Support care routines with dignity, predictability and attention to medical, sensory and developmental factors.

- Separate skill-building from coercion.
- Recognize that feeding, toileting and sleep difficulties can have health causes.
- Coordinate with families so routines are understandable and realistic across contexts.

GARC PRACTICE PRINCIPLE

Daily living support is most effective when the child understands what is happening, has an accessible way to communicate, and is treated with privacy and respect.

10.1 Eating and drinking

Autistic children may have restricted food repertoires, strong texture or smell preferences, oral-motor differences, gastrointestinal problems, allergies, anxiety or rigid routines around food. The early years setting should protect nutrition and safety, avoid shaming, and refer concerns that exceed educational scope.

- ☐ Know allergies, choking risk and medically required dietary restrictions.
- ☐ Allow the child to communicate "no", "finished", "different", "drink", "help" and discomfort.
- ☐ Avoid force-feeding, withholding food as punishment, or pressuring a child to taste as a condition of access to preferred food.
- ☐ Make seating, utensils, smells and noise manageable where possible.
- ☐ Escalate concerns about weight loss, dehydration, choking, swallowing difficulty or severe restriction to appropriate health professionals.

10.2 Toileting and personal care

Toileting readiness and progress vary. Constipation, pain, sensory aversion, interoception, motor skills, communication and previous negative experiences can affect success. Follow family and health plans, use consistent visual routines, protect privacy and avoid punishment for accidents.

10.3 Sleep, fatigue and rest

Poor sleep can affect regulation, attention, appetite and participation. Early years staff should share patterns they observe, provide appropriate rest opportunities within the setting, and avoid treating fatigue-driven difficulty as wilful behaviour. Persistent or severe sleep concerns belong in health pathways.

10.4 Dressing, hygiene and independence

Task	Support principle
Hand washing	Visual sequence; tolerate sensory needs; teach one step at a time.



Task	Support principle
Coat / shoes	Stable routine, accessible fasteners, extra time, practice outside rushed transition.
Nappy / toileting care	Predictable language, privacy, consent cues, clean and safe procedure.
Tooth / oral care where relevant	Gradual familiarization; avoid forcing; coordinate with family and health advice.
Rest routine	Predictable place, object, sensory conditions and wake-up sequence.

DO NOT MISS PAIN

Constipation, reflux, dental pain, ear infection, eczema, injury and other health problems can present as distress or behaviour change when a young child cannot easily report symptoms.



SECTION 11

Health, Safeguarding, Safety and Dignity

Protect the child without turning support into surveillance, restriction or loss of ordinary childhood.

- Use clear health and emergency plans for known risks.
- Teach safety through accessible communication and environmental design.
- Protect privacy and safeguarding rights in all care routines.

GARC PRACTICE PRINCIPLE

Safety planning should increase access to life, not simply reduce movement and choice.

11.1 Individual health information

Area	Setting responsibility
Allergy / anaphylaxis	Know signs, emergency medication process, trained staff and emergency sequence under local rules.
Seizures	Know the child-specific seizure plan, when emergency services are required and who is trained to respond.
Medication	Follow jurisdictional rules for storage, administration, documentation and consent.
Pain / illness	Know the child's typical indicators and escalation route.
Mobility / motor needs	Ensure safe access, positioning, equipment and supervision as advised.
Communication in emergency	Keep AAC or essential communication accessible whenever possible.

11.2 Wandering / elopement risk

Some children may move quickly toward preferred places or away from distress without understanding environmental hazards. Prevention combines environmental safety, close supervision appropriate to risk, accessible communication, predictable transitions, identification of triggers, and teaching of functional alternatives. Locked or restrictive environments must comply with local law and safeguarding standards.

11.3 Safeguarding and body autonomy

- ☐ Teach and model that the child can signal stop, no, help and pain.
- ☐ Explain personal care before it happens using accessible communication.
- ☐ Use the least intrusive assistance needed.
- ☐ Protect privacy during changing and toileting.
- ☐ Do not require affection, hugging or physical greeting.
- ☐ Record and escalate safeguarding concerns according to local procedure, not through informal team discussion only.



11.4 Privacy and information sharing

Share the minimum information necessary for the child's support and safety. A diagnosis should not become corridor conversation. Photos, behaviour logs, health information and family details require appropriate consent, access control and retention procedures under applicable law and policy.

EMERGENCY PLANS MUST BE USABLE

A plan that exists only in a file is not an emergency system. Relevant staff must know where the plan is, what they are expected to do, and how communication will be supported during an emergency.



SECTION 12

Family Partnership, Culture and Home-Setting Continuity

Treat families as essential knowledge partners while respecting that home and early years settings are different environments.

- Listen before advising.
- Align around a small number of high-value priorities.
- Respect family culture, language, resources, routines and preferences.

GARC PRACTICE PRINCIPLE

Family-centred practice is not asking families to deliver every intervention. It is building a partnership in which information, decisions and responsibilities are shared respectfully.

12.1 What families often know first

Families may know subtle signs of pain, overload, fatigue, illness, emerging communication, food changes or sleep difficulty before staff do. NICE guidance emphasizes taking parent or carer developmental concerns seriously. [4] Early years settings should create a clear route for families to share concerns and priorities.

12.2 A useful family conversation

Ask	Why it matters
What does your child love?	Builds connection and motivation from strengths.
How does your child tell you yes, no, help, pain, finished and more?	Creates communication continuity.
What usually makes routines easier or harder?	Identifies environmental variables.
What are you most concerned about right now?	Keeps priorities grounded in family reality.
What has not worked or felt wrong in previous support?	Prevents repetition of harmful or unhelpful approaches.
What would meaningful progress look like in the next three months?	Creates functional, reviewable goals.
What language and communication format works best for your family?	Supports accessibility and cultural respect.

12.3 Avoid family overload

- ☐ Use one agreed communication channel where possible.
- ☐ Coordinate requests across professionals instead of sending multiple separate forms.
- ☐ Do not assume families can attend unlimited meetings or deliver hours of home practice.



- ☐ Offer clear written summaries after significant meetings.
- ☐ Separate essential safety information from optional ideas.
- ☐ Refer families to practical support and services when needs extend beyond the setting.

12.4 Culture and language

Beliefs about disability, child development, eye contact, independence, feeding, adult-child interaction and help-seeking vary across cultures. Ask rather than assume. Use qualified interpretation when required for important health, safeguarding or planning conversations rather than relying on a child or family member to interpret sensitive information.

HOME AND SETTING DO NOT NEED TO BE IDENTICAL

Consistency is useful for core communication and safety systems, but a child can learn that different environments have different routines. The aim is understandable variation, not total sameness.



SECTION 13

Developmental Monitoring, Referral and Multidisciplinary Collaboration

Notice development carefully, share concerns responsibly and connect families with appropriate support without turning educators into diagnosticians.

- Use ongoing developmental observation as part of ordinary early years practice.
- Distinguish monitoring from formal screening and diagnosis.
- Create coordinated referral and feedback pathways across education, health and family systems.

GARC PRACTICE PRINCIPLE

Early identification matters because timely support can improve access and development, but the quality of the pathway matters as much as the speed.

13.1 Developmental monitoring

Developmental monitoring is the ongoing observation of how a child plays, learns, communicates, acts and moves over time. Families, early childhood providers and health professionals can all contribute. CDC materials describe monitoring as a collaborative, ongoing process and distinguish it from formal screening using validated tools. [5]

13.2 Monitoring is not diagnosis

Early years staff can

Observe patterns; document examples; compare progress over time; listen to family concerns; implement access supports; discuss concerns respectfully; follow local referral pathways.

Early years staff should not

Tell a family that a child definitely has autism based on classroom observation alone; use an informal checklist as a diagnosis; delay needed support until a diagnosis arrives; share suspicions widely.

13.3 When concerns arise

1. Gather concrete examples across routines and dates.
2. Check whether health, hearing, vision, sleep, language exposure or major life changes may also be relevant.
3. Discuss observations with the family using neutral, specific language.
4. Explain the local pathway for developmental screening, health review, early intervention or diagnostic assessment.
5. Continue reasonable support for identified needs while assessment is pending.
6. Coordinate information so the family does not repeatedly retell the same history.

13.4 Formal screening pathways vary

In the United States, CDC materials summarize recommendations for developmental screening at 9, 18 and 30 months and autism-specific screening at 18 and 24 months, with additional screening when concerns



arise. [5] These ages should not be treated as a universal global rule; follow the relevant national or local health pathway.

13.5 Multidisciplinary collaboration

Professional / partner	Useful contribution in early years
Family / caregiver	Priorities, communication history, health context, cultural knowledge, successful routines.
Early years practitioner	Naturalistic observation across routines, participation data, environmental knowledge.
Speech-language professional	Communication, language, AAC, feeding/swallowing within scope.
Occupational therapist	Sensory, motor, participation and daily living analysis within scope.
Paediatric / developmental team	Medical, developmental and diagnostic assessment.
Psychology / behaviour professional	Developmental, learning or behaviour assessment within qualification and local pathway.
Nutrition / feeding specialists	Nutrition, restricted eating, growth, feeding safety where indicated.

COORDINATE, DO NOT STACK THERAPIES

More professionals are not automatically better. A coordinated team should agree the child's highest-priority outcomes, embed strategies in ordinary routines and reduce contradictory advice or excessive intervention burden.



SECTION 14

Leadership, Staff Competence and Inclusion Quality Improvement

Build a reliable setting-wide system so inclusion does not depend on one unusually skilled practitioner.

- Define minimum practice standards across all rooms and shifts.
- Train staff in communication, sensory access, positive support, safeguarding and family partnership.
- Use data and family feedback to improve the environment, not just to count incidents.

GARC PRACTICE PRINCIPLE

A high-quality autism-inclusive early years setting is one where good practice survives staff absence, busy days, transitions and change.

14.1 Minimum setting-wide standards

- ☐ Every child has an accessible way to communicate core needs and choices.
- ☐ Visual or object-based routine supports are available where useful.
- ☐ Staff can identify early signs of distress and agreed co-regulation supports.
- ☐ Health, allergy, seizure and safeguarding plans are current and accessible to relevant staff.
- ☐ Personal care protects dignity and privacy.
- ☐ Families know who their primary contact is.
- ☐ Staff know how to raise developmental concerns without diagnosing.
- ☐ Incidents trigger prevention review, not only consequence review.
- ☐ Transitions between rooms or into school include structured handover with family consent.
- ☐ Leaders review participation and wellbeing data, not only attendance and incidents.

14.2 Staff competence model

Level	Expected capability
All staff	Autism awareness, communication respect, safeguarding, sensory basics, positive support, emergency procedures.
Key person / lead practitioner	Individual profile, family partnership, routine adaptation, progress review, team communication.
Inclusion lead / SENCO equivalent	Complex planning, referral pathways, professional coordination, coaching and quality audit.
Leader / manager	Policy, staffing, training, risk systems, data, complaints, family experience and continuous improvement.



14.3 Quality indicators

Indicator	Examples
Access	Time included in ordinary routines; availability of communication and sensory supports.
Communication	Spontaneous requests/refusals/comments; AAC availability; adult response to communication.
Wellbeing	Distress frequency/duration; recovery time; family-reported stress; child engagement.
Independence	Reduction in unnecessary adult prompts; participation in self-care and transitions.
Relationships	Trusted adult connections; peer access; family confidence.
Safety	Incident patterns; near misses; plan implementation; safeguarding follow-through.
Continuity	Quality of transitions, handovers and multidisciplinary coordination.

14.4 Review without blame

Quality improvement asks what in the system can be changed. If several children struggle during the same transition, the transition may be poorly designed. If AAC is available only when one specialist is present, the system is fragile. If incidents rise after staffing changes, the response should include supervision and competence review rather than assuming child deterioration.

MEASURE THE SETTING TOO

Do not collect data only about the child. Track adult response time, availability of communication, environmental triggers, prompt levels, consistency of supports and whether agreed changes were actually implemented.



SECTION 15

GARC Early Years Tools, Templates and Checklists

Reusable pages for child profiles, family partnership, communication, play, sensory access, regulation, care routines, referral and quality review.

- Print or adapt only the tools that answer a real practical question.
- Keep forms concise enough that staff can use them during ordinary work.
- Review and retire tools when they no longer add value.

GARC PRACTICE PRINCIPLE

The best template is one that improves a decision, a conversation or a child's access. A completed form is not an outcome.

Tool 1 - One-Page Child Access Passport

Field	Notes
Child name / preferred name	
Date of birth / age	
Primary family contact	
Key person / lead practitioner	
What I love / strengths	
How I communicate	
How I say yes / no / help / stop / finished	
What helps me understand	
Sensory needs and supports	
Early signs I am overloaded	
What helps me recover	
Health / safety essentials	
Family priorities right now	
What adults should never assume about me	



Tool 2 - Family Conversation Guide

Use at entry, after major change, or when the plan no longer fits. The purpose is listening and alignment, not interrogation.

Prompt	Family notes / agreed action
What brings your child joy?	
How does your child communicate important messages?	
What routines are hardest right now?	
What does your child do when tired, unwell, in pain or overwhelmed?	
What has helped in previous settings or at home?	
What has felt unhelpful or disrespectful?	
Which two priorities matter most over the next 8-12 weeks?	
Who else is involved and what should we coordinate?	
Preferred language / communication method for the family	
Next review date	



Tool 3 - Communication and AAC Profile

Function	Current reliable method	Adult model / support	Generalization target
Request			
Refuse / stop			
Choose			
Ask for help			
Say finished			
Comment / share interest			
Report pain / discomfort			
Toilet / body needs			
Social greeting / connection			

AVAILABILITY CHECK

Can the child access the communication system during outdoor play, snack, personal care, transition, transport and distress - not only during a speech-language session?



Tool 4 - Sensory Environment Scan

Area	Potential barrier	Current adaptation	What to test next
Arrival / entrance			
Main room			
Group area			
Meal / snack area			
Toilet / changing area			
Outdoor space			
Corridor / transition route			
Rest / sleep area			
Celebrations / events			

Observation note: What changed in the child's participation when the environment changed?



Tool 5 - Play and Engagement Observation

Observation	Record
Activity / materials	
What the child chose without prompting	
What held attention	
Sensory qualities that appeared important	
How the child included or excluded adults	
How the child responded when an adult joined	
Communication observed	
Small expansion attempted	
Child response to expansion	
What to try next	

OBSERVATION DISCIPLINE

Describe what happened before interpreting why. "Child covered ears when blender started" is stronger data than "child was being difficult."



Tool 6 - Routine Participation Map

Routine	What child does now	Barrier	Support to test	Success indicator
Arrival				
Free play				
Group / song				
Snack / meal				
Outdoor				
Personal care				
Tidy-up				
Departure				



Tool 7 - Visual Routine Planner

Step	Visual / object cue	Adult words	Child action / choice	Finished signal
1				
2				
3				
4				
5				
6				
7				

Routine: _____ Date tested: _____ Review: _____



Tool 8 - Transition Support Planner

Question	Plan
What is ending?	
What happens next?	
How will the child know?	
What warning is useful?	
Can the child complete one final step / turn?	
Transition object / visual	
Likely sensory or crowding barrier	
Adult role	
Recovery option if transition fails	
What will count as improvement?	



Tool 9 - Regulation and Distress Support Plan

Phase	What we may see	What adults should do	What to avoid
Comfortable / engaged			
Early stress			
Escalating			
High distress / crisis			
Recovery			

Possible contributors to review

- ☐ Pain / illness
- ☐ Sleep / fatigue
- ☐ Hunger / thirst
- ☐ Toileting / constipation
- ☐ Noise / light / touch / crowding
- ☐ Unexpected change
- ☐ Communication breakdown
- ☐ Task too difficult or too easy
- ☐ Social pressure
- ☐ Loss of preferred activity
- ☐ Medication or health change



Tool 10 - Functional Observation Record

Date / time	Before: context and trigger	What happened	Adult / environment response	What happened next

USE PATTERNS, NOT PUNISHMENT

The record is for understanding variables and testing prevention. It is not a behaviour scorecard and should not be used to shame the child or family.



Tool 11 - Positive Support Hypothesis

Behaviour / concern defined neutrally:

Most common contexts:

Possible child need / function:

Possible health / sensory contributors:

Prevention and replacement plan

Before the routine	Communication to teach / model	Environmental change	Adult response	Review measure



Tool 12 - Mealtime Support Profile

Area	Current information / plan
Allergies / medical restrictions	
Safe textures / foods	
Foods / textures currently refused	
Preferred seating / utensils	
Noise / smell considerations	
Communication for more / stop / finished / drink / help	
Choking / swallowing plan if applicable	
What adults should not do	
Health professional input / review date	



Tool 13 - Toileting and Personal Care Support Profile

Area	Plan
Current toileting stage / family routine	
Communication for toilet / stop / help	
Visual sequence	
Sensory factors	
Constipation / pain concerns and health plan	
Clothing / motor support	
Privacy and dignity safeguards	
Accident response	
Reinforcement / natural success	
Review date	



Tool 14 - Rest, Sleep and Fatigue Note

Area	Observation / plan
Typical sleep information shared by family	
Signs of fatigue in setting	
Preferred rest environment	
Sensory needs during rest	
What helps waking / transition back	
Patterns affecting participation	
Health discussion needed?	
Review date	



Tool 15 - Health and Emergency Quick Sheet

CONFIDENTIALITY

Store and share this tool according to local health-information and privacy rules. Only staff who need the information for care and safety should access it.

Field	Information
Child	
Primary emergency contact	
Allergies / anaphylaxis	
Seizure plan	
Medication responsibilities	
Other medical conditions	
How child communicates pain / distress	
Mobility / positioning	
Emergency communication method / AAC	
Emergency services threshold / plan location	
Last reviewed by / date	



Tool 16 - Developmental Monitoring Concern Record

Use concrete examples. This tool is not a diagnostic or screening instrument.

Area	Observation with date / context	Impact on participation	Family discussion / next step
Communication			
Social interaction / shared engagement			
Play / learning			
Movement / motor			
Daily living / self-care			
Sensory / regulation			
Regression / loss of skill			

Referral / consultation route used:



Tool 17 - Multidisciplinary Meeting Planner

Before meeting	Notes
Child / family priorities	
Top 2-3 participation concerns	
What is already working	
Relevant health / safety context	
Data / examples to bring	
Decisions needed	

Decision record

Action	Owner	By when	How success will be checked



Tool 18 - Transition to New Room or School Handover

Handover area	Essential information
Strengths and interests	
Communication / AAC	
Visual and routine supports	
Sensory access	
Regulation / distress plan	
Eating / toileting / personal care	
Health / safety	
Peer / social preferences	
Family priorities	
What new staff should do on day 1	

TRANSITION PRINCIPLE

Share enough to create continuity without defining the child by past difficulty. Include what works, what the child enjoys and how to build trust.



Tool 19 - Early Years Inclusion Self-Audit

Statement	Yes	Partly	No	Action
Children can communicate core needs in accessible ways.				
Families have a clear primary contact.				
Visual/object supports are used consistently where helpful.				
Sensory barriers have been reviewed in every major routine.				
Staff respond to early distress before escalation.				
Personal care protects privacy and dignity.				
Health and emergency plans are current.				
Child-led play is protected.				
Staff know how to raise developmental concerns without diagnosing.				
Multidisciplinary advice is embedded into ordinary routines.				
Transitions are planned with families.				
Leaders review participation and wellbeing, not only incidents.				



Tool 20 - 30-Day Early Years Action Plan

Week	Priority	Actions	Owner	Evidence of improvement
1	Know the child and remove urgent barriers			
2	Communication and predictability			
3	Play, participation and regulation			
4	Family review and system adjustment			

Three non-negotiables for this child

1.

2.

3.



Tool 21 - 90-Day Review Dashboard

Outcome	Baseline	Current	Direction	Next decision
Spontaneous communication				
Participation in key routines				
Distress frequency / duration				
Recovery time				
Independence / prompt level				
Peer / adult connection				
Family confidence / priority progress				
Safety / health incidents				

REVIEW QUESTION

Which changes should we KEEP because they clearly help, CHANGE because benefit is unclear, or STOP because they are ineffective, burdensome or distressing?



Appendix A - Role-Specific Quick Guides

Early years practitioner / key person

- ☐ Know the child's communication system and priorities.
- ☐ Observe across ordinary routines.
- ☐ Make choices and transitions visible.
- ☐ Respond early to sensory or regulation needs.
- ☐ Share concise, useful information with the family.

Teaching assistant / support practitioner

- ☐ Support access to peers and play rather than becoming the child's permanent gatekeeper.
- ☐ Wait before prompting.
- ☐ Model communication in natural routines.
- ☐ Fade support when the child can succeed with less help.
- ☐ Record patterns, not judgments.

Inclusion lead / SENCO equivalent

- ☐ Coordinate child-level planning and referral pathways.
- ☐ Coach staff in ordinary routines.
- ☐ Ensure recommendations are practical and measurable.
- ☐ Audit AAC, sensory access, distress support and transition quality.
- ☐ Protect family partnership from fragmented professional demands.

Setting leader / manager

- ☐ Make inclusion a setting-wide responsibility.
- ☐ Maintain training and supervision.
- ☐ Ensure health, safeguarding and restrictive-practice policies are current.
- ☐ Allocate time for team coordination.
- ☐ Review participation, wellbeing and family experience data.

Therapist / specialist working with the setting

- ☐ Translate recommendations into real routines.
- ☐ Model strategies with the staff who will implement them.
- ☐ Specify what staff should look for to know a strategy is helping.
- ☐ Plan generalization and prompt fading.
- ☐ Keep family and child priorities visible.



Appendix B - Common Myths and Better Questions

Myth / shortcut	Better question
"No eye contact means no connection."	How does this child show interest, trust, enjoyment or attention?
"They are too young for AAC."	What communication system can we make available now?
"Repetitive play is not real play."	What is the child exploring, regulating or enjoying, and how can we join respectfully?
"They need to get used to the noise."	What access barrier is the noise creating, and what adaptation improves participation?
"A diagnosis must come before support."	What need can we support today while assessment continues?
"Toilet accidents are behavioural."	What developmental, communication, sensory, constipation, pain or routine factors should we review?
"More therapy is always better."	Which support improves the child's real participation and family life with acceptable burden?



Appendix C - Glossary

Term	Plain-language meaning
AAC	Augmentative and alternative communication; methods that supplement or replace speech, including objects, pictures, symbols, sign, boards and devices.
Co-regulation	Support from another person that helps a child move toward a manageable level of arousal, attention or emotion.
Developmental monitoring	Ongoing observation of how a child grows and changes in play, learning, communication, movement and behaviour.
Developmental screening	Use of a standardized, validated tool by appropriately trained people to identify whether further evaluation may be needed.
Early intervention	Supports and services provided early in development to improve participation, learning, communication, functioning and family capacity.
Elopement / wandering	Leaving a supervised or safe area unexpectedly, sometimes toward a preferred place or away from distress.
Family-centred practice	An approach that respects family priorities, knowledge, culture and decision-making while sharing responsibility for support.
Interoception	Sensing internal body states such as hunger, thirst, pain, temperature, bladder fullness or heartbeat.
Prompt fading	Deliberate reduction of adult help as the child gains control of a skill.
Responsive caregiving	Observing, interpreting and responding appropriately to a child's signals and needs.
Stimming	Repetitive movement, sound or sensory behaviour that may support regulation, expression, concentration or enjoyment.
Visual support	A visual or object-based representation such as schedule, sequence, choice board, label, photo, timer or cue used to improve understanding or independence.



Appendix D - Selected Authoritative Resources

Source	Useful for	Website
World Health Organization (WHO)	Autism; nurturing care; early childhood development; caregiver skills training.	who.int
UNICEF	Early childhood development, Care for Child Development, disability inclusion and caregiver support.	unicef.org
NICE	Autism recognition, referral, diagnosis, support and management for children and young people.	nice.org.uk
CDC Learn the Signs. Act Early.	Developmental monitoring and family/provider resources; screening information in the U.S. context.	cdc.gov/act-early
Division for Early Childhood (DEC)	Recommended Practices across family, interaction, instruction, environment, assessment, teaming and transition.	dec-sped.org
NAEYC / DEC Inclusion Statement	Early childhood inclusion principles and participation in ordinary settings.	naeyc.org

USE LOCAL PATHWAYS TOO

Eligibility, early intervention systems, disability rights, safeguarding, medication administration, staffing, screening and diagnostic pathways differ across jurisdictions. Pair this toolkit with verified local policy and professional standards.



References and Evidence Notes

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6. **World Health Organization.** Caregiver skills training for families of children with developmental delays or disabilities - Introduction. 2022. <https://www.who.int/publications/i/item/9789240048836>
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9. **DEC / NAEYC.** Early Childhood Inclusion: A Joint Position Statement. Available through NAEYC position statements. <https://www.naeyc.org/node/1729>
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EVIDENCE NOTE

This toolkit translates broad evidence and authoritative guidance into practical early years principles. It does not claim that every strategy is appropriate for every child. Supports should be individualized, family-centred, goal-linked, monitored for benefit, and revised when they do not improve participation, communication, wellbeing or development.



GARC Early Years Action Summary

Use this final page as a concise handoff between the family, key person and wider team. Keep priorities small enough to implement consistently.

Current priority	Support / environmental change	Owner	Review date

Child influence and family priorities

What the child clearly enjoys / seeks:

How the child says no / stop / help:

What the family wants us to focus on:

Keep / Change / Stop

KEEP because it helps	CHANGE because...	STOP because...

GARC CLOSING PRINCIPLE

The strongest early years support does not ask a young autistic child to spend the day proving they can tolerate inaccessible environments. It builds communication, relationships, predictability, safety, play, learning and autonomy around the child from the beginning.